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CHAPTER 1 - INTRODUCTION TO MERCY MARICOPA ADVANTAGE HMO

1.0 Welcome
Welcome to Mercy Maricopa Advantage (MMA)! Our ability to provide excellent service to our enrollees is dependent on the quality of our provider network. By joining our network, you are helping us serve those who need us the most.

1.1 About Mercy Maricopa Advantage
Mercy Maricopa is sponsored by Mercy Care Plan, an Arizona non-profit with a 28-year history of providing innovative Medicaid managed care administration, and Maricopa Integrated Health System (MIHS), a public health care system caring for the citizens of Maricopa County for 135 years. Both organizations are committed to the community and have experience collaborating with Arizona health care providers who offer high-quality, person-centered health care and deliver holistic, individualized care outcomes.

Mercy Care Plan is sponsored by Dignity Health and Carondelet Health Network, both nationally known mission-driven, faith-based health care systems. Mercy Maricopa selected Aetna Medicaid, as plan administrator, providing comprehensive plan management services.

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

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

Please refer to the AHCCCS website and the CMS website for further information regarding their respective requirements.

1.3 MMA Overview
MMA is a CMS approved Medicare Advantage HMO Special Needs Plan (SNP) covering dual eligible individuals with both Medicare and Medicaid (AHCCCS) medical assistance.

1.4 MMA Policies and Procedures
MMA has robust and comprehensive policies and procedures in place throughout it’s’ departments that assure all compliance and regulatory standards are met. Policies and procedures are reviewed on an annual basis and required updates made as needed.
1.5 Eligibility
Mercy Maricopa Advantage (HMO SNP) is a Coordinated Care Plan with a Medicare contract and a Medicaid contract with the Arizona Department of Health Services, Division of Behavioral Health Services. Enrollment in Mercy Maricopa Advantage depends on contract renewal. Mercy Maricopa Advantage is offered in Maricopa County and provides coverage for Medicare Part A and Part B benefits and Medicare Part D prescription drugs.

AHCCCS operates the Medicaid program. The Arizona Department of Behavioral Health Services manages the eligibility requirements for deciding if a person suffers from a chronic or serious mental illness. People who have AHCCCS and a SMI are enrolled with a Regional Behavioral Health Authority (RBHA). In Maricopa County, the RBHA is Mercy Maricopa Integrated Care. Individuals enrolled in Mercy Maricopa Integrated Care and who have both Medicare Parts A and B, can enroll in Mercy Maricopa Advantage. Mercy Maricopa Integrated Care and Mercy Maricopa Advantage will then coordinate the enrollees’ AHCCCS (Medicaid) and Medicare benefits.

Individuals who meet the following plan eligibility requirements may enroll:
- Have Arizona Health Care Cost Containment System (AHCCCS) (Medicaid) benefits; and
- Are an individual with a chronic or serious mental illness (SMI) referred for Regional Behavioral Health Authority (RBHA) services; and
- Have both Medicare Parts A and B; and
- Reside in Maricopa County; and
- Have not been diagnosed with end-stage renal disease (ESRD), exceptions may apply.

If an individual loses eligibility for either AHCCCS or Medicare benefits, MMA is required to terminate their MMA plan coverage and provide appropriate enrollee notification.

1.6 Annual Notice of Change
MMA plan benefits are subject to change annually. Enrollees are provided with written notice regarding the annual changes by the date specified by CMS. The CMS Annual Election Period begins on October 15 each year for enrollees and ends on December 7. Providers can access the MMA website on or around October 15 for information on the individual plan and benefits that will be available for the following calendar year.

1.7 Model of Care
The Model of Care for the MMA Special Needs Plan (SNP) offers an integrated care management program with enhanced assessment and management for enrolled dual eligible enrollees. The processes, oversight committees, provider management, care management, and coordination efforts applied to address enrollee needs result in a comprehensive and integrated model of care.

This program addresses the needs of enrollees who are often frail, elderly, and coping with disabilities, compromised activities of daily living, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues.

The program’s combined provider and care management activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the program include:
• Improving access to essential services such as medical, mental health, social services and preventive health services;
• To assist enrollees in accessing appropriate and timely care (including medical and preventive health services, mental health services, and social services);
• Improving access to affordable care;
• Improve coordination of care through an identified point of contact;
• Improve seamless transitions of care across healthcare settings and providers;
• Assure appropriate utilization of services and assure cost-effective service delivery.

MMA efforts to assure cost-effective health service delivery include, but are not limited to the following:
• Review of network adequacy
• Clinical reviews and proactive discharge planning activities.
• Implementation of an integrated Case Management Program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care/services.

Many components of an integrated care management program impact enrollee health. These include:
• Comprehensive enrollee assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
• Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status, and allow enrollees to reside in the least restrictive environment possible.
• Assessments and care plans that identify an enrollee’s greatest needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
• Case manager referrals and predictive modeling software that identify beneficiaries at increased risk for nursing home placement, functional decline, hospitalization, emergency department visits, and death. This information is used to intervene with the most vulnerable enrollees in a timely fashion.

Overall program goals will be evaluated by measuring the following:
• The proportion of enrollees that show the minimum number of primary care provider visits during a calendar year as compared to others.
• Enrollee satisfaction with health services using the Consumer Assessment of Healthcare Providers and Systems.
• Enrollee self-rating of overall health.

1.8 CMS Website Links

MMA administers the plan in accordance with the contractual obligations, requirements and guidelines established by the Centers for Medicare & Medicaid Services (CMS). There are several manuals on the CMS website that may be referred to for additional information. Key CMS On-Line Manuals are listed below:
1.9 Medicare Coverages

- **Part A** – Hospital Insurance; pays for inpatient care, skilled nursing facility care, hospice and home health care.
- **Part B** – Medical Insurance; pays for doctor’s services, and outpatient care such as lab tests, medical equipment, supplies, some preventive care and some prescription drugs.
- **Part C** – Medicare Advantage Plans (MA): combines Part A and B health benefits through managed care organizations; most plans include Part D (MAPD plans).
- **Part D** – Medicare Prescription Drug Plan: helps pay for prescription drugs, certain vaccines and certain medical supplies (e.g. needles and syringes for insulin). Part D coverage is available as standalone Prescription Drug Plan (PDP) or integrated with medical benefit coverage (MAPD).
CHAPTER 2 – MMA CONTACT INFORMATION

2.0 Health Plan Contacts

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Telephone Number</th>
<th>Health Plan Web Address</th>
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<td></td>
<td>866-602-1979 toll-free</td>
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Part D Coverage Determination and Exception Requests

CVS Caremark processes Part D coverage determination and exception requests on behalf of Mercy Maricopa Advantage.

*NOTE: If you are requesting a formulary exception, please include a statement supporting with your request.

A copy of the Coverage Determination Request Form is available on our MMA member website and can be submitted electronically.

Providers may also initiate a request by calling CVS Caremark at 1-855-582-2023, Monday through Friday 8:00 a.m. to 8:00 p.m. Arizona time.

Faxed requests:
MED D Clinical Operations
Coverage Determinations
1-855-571-3009

Mailed Requests:
CVS Caremark Part D Services
Coverage Determinations
P.O. Box 52000
MC109
Phoenix, AZ 85072-2000

Provider Credentialing (MMA)

Providers wishing to contract with MMA may fax a letter of interest with a copy of their W-9 to 860-975-3201, Attn: Network Development and Contracting. Contract requests will be reviewed and the requesting provider will be notified of contract status within 10 business days. Please note that providers must be board certified or board eligible. To determine the status of a contract request, please call 602-453-6148.
2.1 Health Plan Authorization Services

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<td>Medical or Dental Prior Authorization</td>
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<td>Medical and Dental Fax: 860-902-8747</td>
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<td>You may also call our main number.</td>
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<tr>
<td>MMA Claim Disputes</td>
<td>Phone: 602-586-1880</td>
</tr>
<tr>
<td></td>
<td>Toll-Free: 866-602-1979</td>
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<tr>
<td>Part D Coverage Determination and Exceptions Requests</td>
<td>CVS Caremark</td>
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<td>1-855-582-2023, Monday through Friday 8:00 a.m. to 8:00 p.m. Arizona time</td>
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<td>Fax: MED D Clinical Operations Coverage Determinations 1-855-571-3009</td>
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<tr>
<td>Behavioral Health, including Behavioral Health Crisis Line</td>
<td>Phone: 800-876-5835</td>
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<th>Community Resource</th>
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<tr>
<td>Arizona’s Smokers Helpline (Ashline)</td>
<td>Address: P.O. Box 210482</td>
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<tr>
<td></td>
<td>Tucson, AZ  85721</td>
</tr>
<tr>
<td></td>
<td>Phone: 800-556-6222</td>
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<tr>
<td></td>
<td>Fax: 520-318-7222</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="http://www.ashline.org">www.ashline.org</a></td>
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| Community Information and Referral | Address: 2200 N. Central Avenue, Suite 601  |
|                                    | Phoenix, AZ  85004                           |
|                                    | Phone : 602-263-8856                         |
|                                    | 800-352-3792 (area codes 520 & 928)          |
|                                    | Website: http://www.cir.org/                 |

| Other Behavioral Health Services     | Please refer to our Provider Outreach Manual (Coming Soon!) for additional resource information. |
CHAPTER 3 - PROVIDER RELATIONS

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

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

A Provider Relations representative is assigned to each provider’s office. You may reach your representative directly by calling 602-586-1880 or 866-602-1979.

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

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

Providing Enrollee Care

4.1 Medicare/AHCCCS Registration
Each provider must be registered with an active National Provider Identification (NPI) number as well as an active AHCCCS provider ID number in order to coordinate benefits and process claims.

4.2 Medicare Opt Out Providers
As specified by Medicare laws, rules and regulations, physicians may “opt out” of participating in the Medicare program and enter into private contracts with Medicare beneficiaries. If a physician chooses to opt out of Medicare due to private contracting, no payment can be made to that physician directly or on a capitated basis for Medicare-covered services. The physician cannot choose to opt out of Medicare for some Medicare beneficiaries but not others, or for some services but not others. MMA is not allowed to make payment for services rendered to MMA enrollees to any physician or health care professional that has opted out of Medicare due to private contracting, unless the beneficiary was provided with urgent or emergent care.

Providers are listed on the Opt Out Listing, which is published by Noridian.

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

4.3 – Appointment Availability Standards

<table>
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<th>Emergency Services</th>
<th>Urgent Care</th>
<th>Preventative &amp; Routine Care</th>
<th>High Risk</th>
<th>Wait Time in Office Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>Same Day</td>
<td>Within 24 hours</td>
<td>Within 21 days</td>
<td>Less than 45 minutes</td>
<td></td>
</tr>
</tbody>
</table>
4.4 Telephone Accessibility Standards

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

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

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

4.5 Covering Physicians

Provider Relations must be notified if a covering physician is not contracted or affiliated with MMA. This notification must occur in advance of providing coverage and MMA must provide authorization. Reimbursement to covering physicians is based on the MMA Fee Schedule. Failure to notify MMA of covering physician affiliations may result in claim denials and the provider may be responsible for reimbursing the covering physician.

4.6 Verifying Enrollee Eligibility

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

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

**MMA Secure Web Portal:** Coming soon! Further information will be available at [www.MercyMaricopaAdvantage.com](http://www.MercyMaricopaAdvantage.com) as soon as the MMA Secure Web Portal is implemented. For more detail please refer to section 4.7 MMA Secure Web Portal.

**MMA Telephone Verification:** The current process should be to call Member Services to verify eligibility at 602-586-1880. To protect enrollee confidentiality, providers are asked for at least three pieces of identifying information such as enrollee identification number, date of birth and address, before any eligibility information can be released. When calling MMA, use the prompt for the providers.

**Panel Roster:** Monthly panel rosters are found on the secure website portal. For more detail, please refer to section 4.7 MMA Secure Web Portal.

### 4.7 MMA Secure Web Portal

MMA provides a web-based platform enabling health plans to communicate healthcare information directly with providers. Users can perform transactions, download information, and work interactively with enrollee healthcare information. The following information can be attained from the MMA Secure Web Portal platform once it becomes available:

- **Enrollee Eligibility Search** – Verify current eligibility of one or more enrollees. Please note that eligibility may also be verified through the AHCCCS website.
- **Panel Roster** – View the list of enrollees currently assigned to the provider as the PCP.
- **Provider List** – Search for a specific health plan provider by name, specialty, or location.
- **Claim Status Search** – Search for provider claims by enrollee, provider, claim number, or service dates. Only claims associated with the user’s account provider ID will be displayed.
- **Remittance Advice Search** – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user’s account provider ID will be displayed.
- **Authorization List** – Search for provider authorizations by enrollee, provider, authorization data, or submission/service dates. Only authorizations associated with the user’s account provider ID will be displayed.
- **Submit Authorizations** – Submit an authorization request on-line. Three types of authorization types are available:
  - Medical Inpatient
  - Outpatient
  - Durable Medical Equipment – Rental
- **Healthcare Effectiveness Data and Information Set (HEDIS)** – Check the status of the enrollee’s compliance with any of the HEDIS measures. A “Yes” means the enrollee has measures that they are not compliant with; a “No” means that the enrollee has met the requirements.
4.8 Enrollee Temporary Move Out of MMA Approved Service Area

CMS defines a temporary move as:

- An absence from the MMA approved service area of six months or less, and
- Maintaining a permanent address/residence in the service area.

An MMA plan enrollee is covered while temporarily out of the MMA approved service area for emergent, urgent, post-stabilization and out-of-area dialysis services. If an enrollee permanently moves out of the MMA plan service area or is absent for more than six months, the enrollee will be dis-enrolled from MMA.

4.9 Coverage of Renal Dialysis – Out of Area

MMA pays for renal dialysis services obtained by an MMA plan enrollee from a contracted or non-contracted Medicare-certified physician or health care professional while the enrollee is temporarily out of MMA’s service area (up to six months).

4.10 Health Risk Assessment

An initial health risk assessment of each new MMA plan enrollee will be performed within 90 days of their enrollment in the MMA plan and annually thereafter. This health risk assessment is completed by telephone or in person. The information obtained through the health risk assessment survey will be used to set up their individualized care plan and shared with the enrollee’s PCP.

4.11 Preventive or Screening Services

Providers are responsible for providing appropriate preventive care for eligible enrollees. These preventive services include, but are not limited to:

- Welcome to Medicare exam, which is covered during the first 12 months of enrollment in Part B.
- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations.
- Well woman visits (female enrollees may go to a contracted obstetrician/gynecologist for a well woman exam once a year without a referral).
- Age and risk appropriate health screenings.

4.12 Educating Enrollees on their own Health Care

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

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

4.13 Emergency Services
Prior authorization is not required for emergency services. In an emergency, enrollees should go to the nearest emergency department.

For immediate assistance and intervention, if an enrollee is having a behavioral health emergency, please call MMA’s 24–hour Behavioral Health Crisis Line at 800-876-5835.

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

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

4.15 Primary Care Physicians (PCPs)
The primary role and responsibilities of primary care physicians participating in MMA network include, but are not be limited to:

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

The PCP is responsible for rendering, or ensuring the provision of, covered preventive and primary care services to the enrollee. These services will include, at a minimum, the treatment of routine illnesses, immunizations, health screening services and maternity services, if applicable.

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

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

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

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

Primary Care Providers (PCPs) should only refer enrollees to MMA network specialists. If the enrollee requires specialized care from a provider outside of the MMA network, a prior authorization is required.

4.17 Women’s Health Specialists
MMA enrollees have direct access to mammography screening services at a contracted radiology facility without a referral, as well as direct access to in-network women’s health specialists for routine and preventive services.

4.18 Direct-Access Immunizations
MMA enrollees may receive influenza and pneumococcal vaccines from any network provider without a referral, and there is no cost to the enrollee if it is the only service provided at that visit. A PCP copayment will apply for all other immunizations that are medically necessary.

4.19 Second Opinions
An enrollee may request a second opinion from a provider within the MMA contracted network. The provider should refer the enrollee to another network provider within an applicable specialty for the second opinion. Enrollee request for a second opinion from a non-contracted provider must be pre-approved by MMA’s Prior Authorization Department.
4.20 Provider Assistance Program for Non-Compliant Enrollees

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

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

Documenting Enrollee Care

4.21 Enrollee’s Medical Record

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

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

Each enrollee is entitled to one copy of his or her medical record free of charge. Enrollees have the right to amend or correct medical records. The record must be supplied to the enrollee within fourteen (14) days of the receipt of the request.
All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements.

- Enrollee identification information on each page of the medical record (i.e., name or AHCCCS identification number and CMS identification number)
- Documentation of identifying demographics including the enrollee’s name, address, telephone number, AHCCCS identification number and CMS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Initial history for the enrollee that includes family medical history, social history and preventive laboratory screenings (the initial history for enrollees under age 21 should also include prenatal care and birth history of the enrollee’s mother while pregnant with the enrollee)
- Past medical history for all enrollees that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received
- Immunization records (required for children; recommended for adult enrollees if available)
- Dental history if available, and current dental needs and/or services
- Current problem list
- Current medications
- Documentation, initialed by the enrollee’s PCP, to signify review of:
  - Diagnostic information including:
    - Laboratory tests and screenings
    - Radiology reports
    - Physical examination notes, and
    - Other pertinent data.
  - Reports from referrals, consultations and specialists
  - Emergency/urgent care reports
  - Hospital discharge summaries
  - Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when an enrollee’s health status changes or new medications are prescribed
  - Behavioral health history
  - Documentation as to whether or not an adult enrollee has completed advance directives and location of the document
  - Documentation related to requests for release of information and subsequent releases, and
  - Documentation that reflects that diagnostic, treatment and disposition information related to a specific enrollee was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the enrollee’s health care.
b) **Medical Record Maintenance** – The provider must maintain enrollee information and records for the longer of six (6) years after the last date provider services were provided to enrollee, or the period required by applicable law or Government Sponsor directions. The maintenance and access to the enrollee medical record shall survive the termination of a Provider’s contract with MMA, regardless of the cause of the termination.

### 4.22 Access to Facilities and Records

Medicare laws, rules and regulations require that contracted providers retain and make available all records pertaining to any aspect of services furnished to MMA plan enrollees or their contract with the MMA for inspection, evaluation and audit for the longer of:

- A period of 10 years from the end of the contract period of MMA contract;
- The date the Department of Health and Human Services, the Comptroller General or their designees complete an audit; or
- The period required under applicable laws, rules and regulations.

### 4.23 Confidentiality and Accuracy of Enrollee Records

Contracted providers must safeguard the privacy and confidentiality of and ensure the accuracy of any information that identifies an MMA plan enrollee. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.

Specifically, MMA’s contracted providers must:

- Maintain accurate medical records and other health information.
- Help ensure timely access by enrollees to their medical records and other health information.
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information and enrollee information.

### 4.24 Advance Directives

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

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

### 4.25 Medical Record Audits

MMA will conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when MMA is responding to an inquiry on behalf of a member or provider, administrative responsibilities or quality of care issues. Providers
must respond to these requests within fourteen (14) days or in no event will the date exceed that of any government issues request date. Medical records must be made available to AHCCCS for quality review upon request. MMA shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions.

4.26 Documenting Enrollee Appointments
When scheduling an appointment with an enrollee over the telephone or in person (i.e. when an enrollee appears at your office without an appointment), providers must verify eligibility and document the enrollee’s information in the enrollee’s medical record.

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

MMA encourages providers to use a recall system. MMA reserves the right to request documentation supporting follow up with enrollees related to missed appointments.

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

4.29 Respecting Enrollee Rights
MMA is committed to treating enrollees with respect and dignity at all times. Enrollee Rights and Responsibilities are shared with staff, providers and enrollees each year. Enrollee rights are incorporated herein and may be reviewed on the MMA Member website by clicking on the above link.

4.30 Provider Marketing
MMA and their contracted providers must adhere to all applicable Medicare laws, rules and regulations relating to marketing. Per Medicare regulations, “marketing materials” include, but are not limited to, promoting MMA, informing Medicare beneficiaries that they may enroll or remain enrolled in MMA, explaining the benefits of enrollment in MMA or rules that apply to enrollees, or explaining how Medicare services are covered under MMA.

Regulations prevent MMA from conducting sales activities in healthcare settings except in common areas. MMA is prohibited from conducting sales presentations and distributing and/or accepting enrollment applications in areas where patients primarily intend to receive health care services. MMA is permitted to schedule appointments with beneficiaries residing in long-term care facilities, only if the beneficiary requests it.
Physicians and other health care professionals may discuss, in response to an individual patient’s inquiry, the various benefits of Medicare Advantage plans. Physicians are encouraged to display plan materials for all plans with which they participate. Physicians and health care professionals can also refer their patients to 1-800-MEDICARE, the State Health Insurance Assistance Program; the specific Medicare Advantage Organization’s marketing representatives; or the CMS website for additional information. Physicians and health care professionals cannot accept MMA plan enrollment forms. MMA follows the federal anti-kickback statute and CMS marketing requirements associated with Medicare marketing activities conducted by providers and related to Medicare plans. Payments that MMA makes to providers for covered items and/or services will be fair market value, consistent with an arm’s length transaction, for bona fide and necessary services, and otherwise will comply with relevant laws and requirements, including the federal anti-kickback statute.

For a complete description of laws, rules, regulations, guidelines and other requirements applicable to Medicare marketing activities conducted by providers, please refer to Chapter 3 of the Medicare Managed Care Manual found on the CMS website.

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

4.32 Cultural Competency
The Partnership for Clear Health Communication (PCHC) defines health literacy as the ability to read, understand and act on health information. Health literacy relates to listening, speaking, and conceptual knowledge. Health literacy plays an important role in positive patient outcomes. According to PCHC, people with low functional Health Literacy:

- Have poorer overall health status.
- Are less likely to adhere to treatment and incur a greater number of medication/treatment errors.
- Require more health related treatment and care, including 29-69% higher hospitalization rates.
- Increase higher health care costs - health care costs as high as $7,500 more per annum for a person with limited health literacy.
To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ program. MMA supports the Ask Me 3™ program, as it is an effective tool designed to improve health communication between patients and providers.

An Ask Me 3 Poster is also available to be displayed in your office.

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, MMA is required to ensure that Limited English Proficient (LEP) enrollees have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

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

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

4.33 Health Literacy – Limited English Proficiency (LEP) or Reading Skills
MMA complies with federal and state laws by offering interpreter and translation services, including sign language interpreters, to LEP enrollees. This service affords enrollees access to health care and benefits by providing a range of language assistance services at no cost to the enrollee or provider. MMA strongly recommends the use of professional interpreters, rather than family or friends. Bilingual staff enrollees are available in the Member Services department to assist LEP enrollees and a TTY line is available for enrollees who are hearing impaired. Further, MMA provides enrollee materials in other formats to meet specific enrollee needs. Providers must also deliver information in a manner that is understood by the enrollee.

To access telephone interpretation services to assist enrollees who speak a language other than English or who use sign language, please call Voiance directly at either of the following phone numbers:

**Clinical Services:** 1-877-756-4839, pin 1030

**Non-Clinical Services:** 1-877-756-4839, pin 1028

Voiance provides over the telephone interpretation services in over 200 languages. This service is available at no cost to you or the enrollee. Additional information regarding Voiance is
available on the MMA Provider website under the Provider Notification titled Telephone Interpretation Services.

The PCP is responsible for providing appropriate services so that enrollees understand their health care needs and the enrollee is compliant.

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

4.35 PCP Assignments
MMA enrollees may select their PCP or if no choice is made at the time of enrollment, MMA will automatically assign a PCP. Enrollees have the right to change their provider at any time. Enrollee eligibility changes frequently, as a result, providers must verify eligibility prior to delivering services.

4.36 Plan Changes
Medicare beneficiaries who qualify for Medicare and Medicaid are considered “dual eligible” and are entitled to a CMS defined Special Election Period allowing enrollment or disenrollment anytime during the calendar year. Enrollment elections are effective the first of the month following receipt of the election request. Dis-enrollments are effective the last day of the month upon receipt of the enrollees’ written request or upon notification from CMS that the enrollee has enrolled in a new plan. To maintain their eligibility for Medicare Part D, it is recommended that an enrollee select another MAPD plan or if they elect to return to Original Medicare, they must elect a standalone Part D plan, which will automatically dis-enroll them from MMA. Dis-enrolling from MMA will not affect their AHCCCS plan assignment.

Provider Guidelines and Plan Details

4.37 Cost Sharing and Coordination of Benefits
Providers must adhere to all contract and regulatory cost sharing guidelines. When an enrollee has other health insurance, such as a commercial carrier, MMA will coordinate payment of benefits in accordance with the terms of the PHP’s contract and federal and state requirements.

4.38 Clinical Guidelines
To help provide MMA members with consistent, high-quality care that utilizes services and resources effectively, we have chosen certain clinical guidelines to help our providers. These are treatment protocols for specific conditions as well as preventive health guidelines.
Please note that these guidelines are intended to clarify standards and expectations. They should not:

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

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

4.39 Office Administration Changes and Training Requirements
Providers are responsible to notify MMA’s Provider Relations of changes in professional staff at their offices (physicians, physician assistants or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact your Provider Relations representative to schedule any needed staff training.

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

- Medical records standards
- Fraud and abuse training
- Compliance training
- Behavioral health step therapy for members with depression, post-partum depression, anxiety and attentive deficit/hyperactivity disorder (ADHD) in compliance with the AHCCCS medical policy manuals (appendices E and F)
- PCP training regarding behavioral health referral and consultation services
- Model of Care training

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

4.40 Contract Additions or Physician Terminations
In order to meet contractual obligations and state and federal regulations, providers must report any terminations or additions to their contract at least 90 calendar days prior to the termination or change in order for MMA to comply with CMS’ member notification requirements. Providers are required to continue providing covered services to enrollees until the effective date of their contract termination.

CMS requires that MMA make a good faith effort to provide written notice of a termination of a contracted physician at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the physician whose contract is terminating. However, please note that when a contract termination involves a PCP, all enrollees who are patients of that PCP must be notified.
4.41 Continuity of Care
Providers terminating their contracts without cause are required to continue to treat MMA enrollees until the treatment course has been completed or care is transitioned. Authorization may be necessary for these services. Enrollees who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. MMA is not responsible for payment of services rendered to enrollees who are not eligible.

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

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

You can also download a mobile app to find federally-funded health centers on the Health Resources and Services Administration (HRSA) website.

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

4.42 Contract Changes or Updates
Providers must report any changes to demographic information to MMA at least 90 calendar days prior to the change in order to be in compliance with contractual obligations and state and federal regulations. Providers are required to continue providing services to enrollees throughout the termination period. For information on where to send change information, refer to the Table 4.42.1, Provider Record Updates (below).

4.42.1 – Provider Record Updates

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>Notification Requirements</th>
<th>Send To</th>
<th>Notice Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual or group name</td>
<td>Must mail updated W-9 and letter describing change and effective date</td>
<td>Provider Relations</td>
<td>90 days</td>
</tr>
<tr>
<td>Tax ID number</td>
<td>Must mail updated W-9 and letter describing change and effective date</td>
<td>Provider Relations</td>
<td>90 days</td>
</tr>
<tr>
<td>Type of Change</td>
<td>Notification Requirements</td>
<td>Send To</td>
<td>Notice Requirement</td>
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</tr>
<tr>
<td>Address</td>
<td><strong>Must</strong> fax 860-975-0841 or mail</td>
<td>Provider Relations</td>
<td>90 days</td>
</tr>
<tr>
<td>Staffing changes, including physicians leaving the practice</td>
<td><strong>Must</strong> fax 860-975-0841 or mail letter describing change and effective date</td>
<td>Provider Relations</td>
<td>90 days</td>
</tr>
<tr>
<td>Adding new office locations</td>
<td><strong>Must</strong> fax 860-975-0841 or mail letter describing change and effective date</td>
<td>Provider Relations</td>
<td>90 days</td>
</tr>
<tr>
<td>Adding new physicians to current contract</td>
<td><strong>Must</strong> fax 860-975-0841 or mail letter describing change and effective date</td>
<td>Provider Relations</td>
<td>90 days</td>
</tr>
</tbody>
</table>

4.43 Credentialing/Re-Credentialing
Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses and DEA certificates are also required. Please note that providers may not treat MMA enrollees until they are credentialed. Providers must also be board certified.

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

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

4.46 Receipt of Federal Funds, Compliance with Federal Laws and Prohibition on Discrimination
Payments received by contracted providers from MMA for services rendered to plan enrollees include federal funds; therefore, MMA’s contracted providers are subject to all laws applicable to recipients of federal funds, including, without limitation:
- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84;
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91;
- The Rehabilitation Act of 1973;
- The Americans With Disabilities Act;
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law;
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.);
- The anti-kickback statute (section 1128B(b) of the Social Security Act); and
- HIPAA administrative simplification rules at 45 CFR parts 160, 162 and 164.

In addition, our contracted providers must comply with all applicable Medicare laws, rules and regulations, and, as provided in applicable laws, rules and regulations, contracted providers are prohibited from discriminating against any MMA plan enrollee on the basis of health status.

4.47 Financial Liability for Payment for Services
In no event should MMA contracted providers bill an MMA plan enrollee (or a person acting on behalf of an MMA plan enrollee) for payment of fees that are the legal obligation of MMA. However, a contracted provider may collect deductibles, coinsurance or copayments from MMA plan enrollees in accordance with the terms of the enrollee’s Evidence of Coverage.

Note: CMS issued a memo dated September 17, 2008, (“CMS Guidance”) providing guidance regarding balance billing by providers of certain individuals enrolled in both Medicare Advantage plans and a State Medicaid plan (“Dual Eligible beneficiaries”). More specifically, this CMS Guidance states that providers are prohibited from balance billing Dual Eligible beneficiaries who are classified as Qualified Medicare Beneficiaries (QMB) for Medicare Parts A and B cost sharing amounts. The CMS Guidance explains that providers must accept Medicare and Medicaid payment(s), if any, as payment in full. A QMB has no legal liability to make payment to a provider or Medicare Advantage plan for Medicare Part A or B cost sharing, and a provider may not treat a QMB as “private pay patient” in order to bill a QMB patient directly. In addition, the CMS Guidance states that federal regulations require a provider treating an individual enrolled in a State Medicaid plan, including QMBs, to accept Medicare assignment. Providers participating in Medicare networks are required to comply with all of the requirements set forth in this CMS Guidance.
CHAPTER 5 - COVERED AND NON COVERED SERVICES

5.0 Coverage Criteria
All Medicare-covered services must be medically necessary, and except for emergency or urgently needed care, or otherwise authorized by MMA, must be provided by a participating PCP or other qualified participating providers. Benefit limits apply.

Participating providers are required to administer covered services to MMA enrollees in accordance with the terms of their contract and enrollee’s benefit package.

5.1 Covered Services
MMA has specific covered and non-covered services. To review MMA covered benefits and services please refer to our Mercy Maricopa Advantage Member Services website. The page titled Member Materials contains a copy of the current MMA Summary of Benefits and Evidence of Coverage.

5.2 Non Covered Services - MMA
- Services that are not reasonable or necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by MMA as a covered service.
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or under a Medicare-approved clinical research study or by our plan. Detailed information regarding Medicare Clinical Trial policies can be found on the CMS website. Experimental procedures and items are those items and procedures determined by MMA and the Original Medicare Plan to not be generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
- Private room in a hospital, unless medically necessary.
- Private duty nurses.
- Charges for personal convenience items, such as a telephone or television in a room in a hospital or skilled nursing facility.
- Nursing care on a full-time basis in the enrollee’s home.
- Custodial care provided in a nursing home, hospice, or other facility setting when the enrollee does not require skilled medical care or skilled nursing care. “Custodial care” is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered. These services may be covered for some enrollees under their Medicaid health plan benefits.
- Homemaker services. These services may be covered for some enrollees under their Medicaid health plan benefits.
- Charges imposed by immediate relatives or enrollees of the household. These services may be covered for some enrollees under their Medicaid health plan benefits.
- Meals delivered to the home.
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as the unaffected breast, to produce a symmetrical appearance.
- Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Supportive devices for the feet, with one exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
- Acupuncture.
- Dentures.
- Naturopath services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under MMA, we will reimburse veterans for the difference. Enrollees are still responsible for our Plan cost-sharing amount.
CHAPTER 6 - BEHAVIORAL HEALTH

6.0 Behavioral Health Overview
MMA covers behavioral health services under certain conditions that include:
- Partial hospital program and intensive outpatient programs.
- Medication monitoring.
- Counseling by an Independent Licensed Social Worker, Psychologist, Psychiatrist or Nurse Practitioner (first ten visits are covered without Prior Authorization for contracted providers).
- Inpatient psychiatric services with a limitation on freestanding psychiatric hospitals. There is a 190 day limit for free standing psychiatric hospitals. If the enrollee goes to a behavioral health unit contained in the hospital this limit does not apply.
- Substance Abuse Treatment - MMA enrollees will receive behavioral health services through contracted MMA providers. Other related services may be provided by MMA.

6.1 MMA Behavioral Health Emergency Services
If an enrollee is in a behavioral health crisis, call the MMA Behavioral Health Crisis Line at 800-876-5835. Medicare covers medically necessary services. MMA enrollees are eligible for behavioral health services through contracted behavioral health providers.

6.2 PCP and Behavioral Health Provider Responsibilities for Behavioral Health Care Services
Enrollees should be screened by their PCP for behavioral health needs during routine or preventive visits. If a PCP feels that an enrollee needs behavioral health services, referrals for these services should be coordinated through the enrollee’s behavioral health coordinator.

Behavioral health providers must coordinate care with the enrollee’s PCP and other medical specialists. Since an enrollee may self-refer for behavioral health services, this will ensure all aspects of the enrollee’s health care are addressed.

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

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

The PCP should also document and initial signifying review receipt of information received from a behavioral health provider who is treating the enrollee.
The behavioral health providers should supply the PCP with information regarding services that they are providing so that they may be included in the enrollee's permanent medical record.
CHAPTER 7 – MMA SUPPLEMENTAL BENEFITS AND SERVICES

7.0 Dental Services Overview
Medicare covers limited non-routine dental care – surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor.

MMA provides additional supplemental dental benefits, which include preventive dental services which cover limited oral exams and cleaning, fluoride treatments and dental x-rays may be covered.

MMA provides a $1,800.00 allowance for comprehensive dental services, which include:
- Extractions
- Endodontic – Root Canals
- Periodontics – Gum Treatment
- Restorative Services including Fillings, Replacement of Defective Fillings, Removal of Decay, Single Unit Crowns
- Anesthesia Services, when appropriate with a covered dental service

To review MMA covered benefits and services; please refer to our Mercy Maricopa Advantage Member Services website. The page titled Member Materials contains a copy of the current MMA Summary of Benefits and Evidence of Coverage.

A list of codes for both preventive and comprehensive services is available on MMA’s website titled Mercy Maricopa Advantage Dental Benefit Matrix.

7.1 Vision Services Overview
Medicare covers the following services:
- Exams to diagnose and treat diseases and conditions of the eye.
- Annual glaucoma screening for eligible enrollees at risk for glaucoma.
- One (1) pair of Medicare covered eye glasses or contact lenses after each cataract surgery.

The following additional vision services are covered:
- One (1) supplemental routine eye exam per year for $0 cost share
- Eyewear – eye glasses (lenses and frames) and contact lenses ($200.00 limit for eye glasses and contact lenses every two years)

7.2 Hearing Services Overview
Medicare covers the following services:
- Diagnostic hearing and balance exams
The following additional hearing service is covered:
• $1,200.00 allowance for hearing aids every three (3) years

7.3 Podiatry Services Overview
Medicare covers the following services:
• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet.
• Routine foot care for enrollees with certain medical conditions affecting the lower limbs.

The following additional podiatry service is covered:
• One (1) supplemental routine podiatry visit every 3 months for $0 cost share

7.4 Chiropractic Services Overview
Medicare covers the following services:
• Manual manipulation of the spine to correct subluxation

The following additional chiropractic services are covered:
• Twelve (12) supplemental routine visits per year for $0 cost share
CHAPTER 8 - CASE MANAGEMENT AND DISEASE MANAGEMENT

8.0 Case Management and Disease Management Overview
MMA has a comprehensive case management program. The Medical Case Management team considers the medical, social and cultural needs of enrollees by targeting, assessing, monitoring and implementing services for enrollees identified as "at risk." Case Management services are available for all eligible enrollees, however, enrollees who are identified as "at risk," such as transplant, hemophilia and HIV enrollees, or those who are high-service utilizers are assigned a case manager.

A wide spectrum of services are available for enrollees, providers and families who need assistance in finding and using appropriate health care and community resources. The MMA case management staff:
- Considers the medical, social and cultural needs of enrollees in targeting, assessing, monitoring and implementing services for enrollees.
- Provides assistance to enrollees and families in navigating through the complex medical and behavioral health systems.

Please refer to the Clinical Practice Guidelines located on the MMA Provider website.

This site contains the treatment protocol related to:
- Diabetes
- Asthma
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Community Acquired Pneumonia (CAP)
- Major Depressive Disorder in Adults
- HIV
- Attention Deficit/Hyperactivity Disorder (ADHD)

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

8.2 Case Management
Case management services are provided to medically complex enrollees. The enrollees are assigned to an RN, LPN or social work case manager who works closely with the PCP and enrollee to coordinate care and services. The case manager also collaborates with community
resources, home health services and PCPs to coordinate medical care and assure appropriate access to medical and social services.

Enrollees who meet any of the following criteria and do not fall under other identified categories of case management also will be considered for case management services:

- High utilizers of services
- Frequent inpatient readmissions
- Substance abusers
- Poor compliance with prescribed medical treatment
- Experiencing social problems that are impacting medical care
- Overuse of emergency department
- Complex care needs

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

8.3 HIV/AIDS

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

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

8.4 Disease Management

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

The objectives of disease management programs are to:

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

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

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

Providers play an important role in helping enrollees manage this chronic disease by promoting program goals and strategies, including:
- Preventing chronic symptoms
- Maintaining “normal” pulmonary function
- Maintaining normal activity levels
- Maintaining appropriate medication ratios
- Preventing recurrent exacerbation and minimizing the need for emergency treatment or hospitalizations
- Providing optimal pharmacotherapy without adverse effects
- Providing education to help enrollees and their families better understand the disease and its prevention/treatment

8.6 Chronic Obstructive Pulmonary Disease (COPD)
The COPD Disease Management program is designed to decrease the morbidity and mortality of enrollees with COPD. The goal of the program is to collaborate with providers to improve the quality of care provided to enrollees with COPD, decrease complication rates and utilization costs, and improve the enrollees’ health. The objectives of the COPD Disease Management program are to:
- Identify and stratify enrollees
- Provide outreach and disease management interventions
- Provide education through program information and community resources
- Provide provider education through the COPD guidelines, newsletters and provider profiling

8.7 Congestive Heart Failure (CHF)
The CHF Disease Management program is designed to develop a partnership between MMA, the primary care provider and the enrollee to improve self-management of the disease. The
program involves identification of enrollees with CHF and subsequent targeted education and interventions. The CHF Disease Management Program educates enrollees with CHF on their disease, providing information on cardiac symptoms, blood pressure management, weight management, nutritional requirements and benefits of smoking cessation.

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

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

8.9 Active Health
MMA has contracted with Active Health Management to administer a patient health-tracking program with providers.

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

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

Examples of “Care Consideration” are:
- If the enrollee is a diabetic and there are no records that the patient has had their eyes checked or an HgA1c lab has been done.
- If the patient has a heart condition and there are no records to show that the enrollee is on any type of drug to lower cholesterol.
CHAPTER 9 - CONCURRENT REVIEW

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

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

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

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

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

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

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

9.3 Physician Medical Review

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

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

For inpatient denials, hospital staff is verbally notified when MMA is stopping payment. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending or referring physician may dispute the finding of the medical director informally by phone or formally in writing. If the finding of the medical director is disputed, a formal claim dispute may be filed according to the established MMA claim dispute process.
**CHAPTER 10 - PHARMACY MANAGEMENT**

**10.0 Pharmacy Management Overview**
Prescription drugs may be prescribed by any authorized prescriber, such as a PCP, specialist, attending physician, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The formulary identifies all of the Part D prescription drugs covered by MMA. The formulary has been approved by CMS and the drugs have been selected by the Pharmacy and Therapeutics Committee (P&T Committee) to ensure that they are clinically appropriate to meet the therapeutic needs of our enrollees in a cost effective manner.

Please note that all formulary utilization management restrictions are approved by CMS and the P&T Committee.

**10.1 Updating the Formulary**
MMA’s formulary is continuously reviewed by the P&T Committee and prescription drugs are added or removed based on objective, clinical and scientific data and market changes. All updates to the formulary must be approved by CMS and adhere to CMS formulary guidance on changes. Considerations include efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

Key considerations:
- Therapeutic advantages outweigh cost considerations in all decisions to change drugs listed in the formulary. Market share shifts, price increases, generic availability and varied dosage regimens may affect the actual cost of therapy.
- MMA formulary must adhere to CMS formulary guidance and requirements.
- Products are not added to the list if there are less expensive, similar products on the formulary.
- When a drug is added to the formulary, other drugs in the same category may be removed.

**10.2 Notification of Formulary Updates**
MMA must follow CMS policy regarding formulary changes. MMA may add drugs to the formulary or delete utilization management requirements at any time during the year. After March 1st each year, MMA may only make maintenance changes to the formulary, such as replacing a brand name drug with a new generic, or modifications to quantity limits based on new drug safety information. CMS limits non-maintenance formulary changes and must be approved by CMS. Examples of non-maintenance formulary changes include addition of utilization maintenance, increasing cost-sharing of preferred drugs, changing status of preferred drugs, or removing dosage forms. If approved enrollees currently taking the affected drugs are exempt from non-maintenance changes until the remainder of the calendar year. MMA will provide notice to affected enrollees at least 60 days prior to removing a covered Part D drug from the formulary. If the FDA deems a drug unsafe or it is removed from the market by its manufacturer, MMA will provide a retrospective notice as soon as possible. A list of
Formulary changes is maintained on the MMA website. MMA may notify providers of changes to the formulary through the MMA website.

Federal Part D regulations require MMA to have a formulary that contains at least two Part D prescription drugs in each approved category, and all drugs (but not necessarily all dosage forms) in the six special classes listed below:

- Antidepressants
- Antipsychotic
- Anticonvulsants
- Antiretroviral
- Antineoplastics
- Immunosuppressant

Both generic and brand name drugs are covered by MMA, but some drugs are statutorily excluded from coverage under Medicare Part D, or are excluded for certain indications. Excluded drugs include, but are not limited to:

- Drugs for anorexia, weight loss or weight gain;
- Fertility drugs;
- Erectile Dysfunction drugs;
- Drugs for cosmetic purposes or hair growth;
- Drugs for symptomatic relief of cough and cold (exceptions may apply);
- Prescription vitamins and mineral products (except pre-natal vitamins and fluoride preparations);
- Electrolytes/Replenishers
- Non-prescription drugs;
- Drugs covered under Medicare Part A or Part B (exceptions may apply)

For 2013, barbiturates and benzodiazepines are therapeutic classes that are covered by Medicare Part D and are represented on the formulary. As with other therapeutic classes, not all drugs in these categories are covered under the MMA Formulary. Phenobarbital is only covered by Medicare Part D for the indications of cancer, epilepsy and chronic mental health disorders.

### 10.3 Pharmacy Transition of Coverage Process

New enrollees (within their first 90 days) taking prescription drugs that are not on the MMA formulary, or formulary drugs that are subject to certain restrictions, such as prior authorization or step therapy, will receive a temporary transitional fill of up to a 30-day supply of a non-formulary drug, or a formulary drug requiring prior authorization at a retail pharmacy. Enrollees and their prescribing physician will receive a letter instructing them to consult with their prescribing physician to decide if they should switch to an equivalent drug that is on the MMA formulary or to request a formulary exception in order to get coverage for the drug. Only drugs that are covered under Medicare Part D are eligible for Transition Fills. Part B medications will not receive a Transition Fill.
MMA will not pay for additional fills for the drug(s), unless the prescriber submits a request for a coverage determination or formulary exception and MMA approves. If a formulary exception is approved, the approval will be valid through the remainder of the calendar year, unless prescribed for a lesser period.

10.4 LTC/ Nursing Facility
If a new enrollee is a resident of a long term care facility, MMA will cover multiple fills of a temporary transitional fill of up to a 98-day supply (unless the prescription is written for less) within their first 90 days of enrollment. MMA will also cover an additional 31-day emergency supply (unless the prescription is for fewer days) for an enrollee past the first 90 days while MMA processes a requested coverage determination.

If the enrollee has unplanned level of care changes, (e.g., discharged from a hospital to a home, or ending a stay at a long term care facility and returning home), MMA will provide an emergency 31-day supply of a currently prescribed drug to transition the enrollee to their new level of care setting. The enrollee and the enrollee’s physician will receive a letter notifying them that they will need to transition to a prescription drug on our formulary or request a coverage determination.

Please note that the MMA transition policy applies only to Part D drugs filled at a network pharmacy.

10.5 Part D Pharmacy Co-Payments
Co-payments for covered Part D prescription drugs are mandatory per federal regulations. MMA enrollees are required to pay a small co-pay for each prescription drug they receive. The maximum co-pay an enrollee has to pay for drugs is based on federal Low Income Subsidy (LIS) thresholds. Certain enrollees may have a $0 co-pay.

10.6 Pharmacy Benefits Manager
CVS Caremark is the Pharmacy Benefit Manager (PBM) that MMA has contracted to administer the MMA Medicare prescription drug benefit. MMA enrollees will have access to CVS Caremark participating pharmacies. CVS Caremark is responsible to review and process Medicare Part D Coverage Determinations and exception requests initiated by MMA enrollees or their physicians. Contact information for CVS Caremark is available in Chapter 2 of this manual.
CHAPTER 11 - QUALITY MANAGEMENT

11.0 Quality Management Overview
MMA works in partnership with providers to continuously improve the care given to our enrollees. The MMA Quality Management (QM) Department is comprised of the following areas:

- The Quality of Care Review Unit monitors the quality of care provided by the PHP network, as well as the review and resolution of issues related to the quality of health care services provided to enrollees.
- The Prevention and Wellness Unit is responsible for quality improvement activities and clinical studies using data collected from providers and encounters.
- The Credentialing Unit is responsible for provider credentialing/recredentialing activities.

11.1 Quality Management Department Responsibilities
The QM Department is responsible for development of Clinical Practice Guidelines and policies related to quality management. Whenever possible, MMA adopts practice guidelines from national organizations known for their expertise in the area of concern. Please refer to the Clinical Practice Guidelines located on the MMA Provider website.

Providers may also request copies from the QM Department or their Provider Relations representative.

11.2 Measurement Tools
MMA must measure performance using measurement tools specified by CMS and report its performance to CMS. MMA is required to make available to CMS information from these measures to provide enrollees with a means to assess the value they receive for their health care dollar and to hold health plans responsible for their performance. As a contracting medical provider, you may be required to assist in medical record data collection.

11.3 Chronic Care Improvement Program
MMA is required to have a Chronic Care Improvement Program (CCIP). This program must identify enrollees with multiple or sufficiently severe chronic conditions who meet criteria for participation in the program, and must have a mechanism for monitoring enrollee participation in the program. As a contracting medical provider, you may be required to assist in medical record data collection or verification to confirm eligibility or participation in the CCIP.
CHAPTER 12 - REFERRALS AND AUTHORIZATIONS

12.0 MMA Organization Determination Process
Medicare beneficiaries enrolled in MMA are entitled to request an Organization Determination (OD), which is a decision/determination concerning the rights of the enrollee with regard to services covered by Medicare and/or MMA, and any decision/determination concerning the following items:

- Reimbursement for coverage of emergency, urgently needed services or post-stabilization care.
- Payment for any other health services furnished by a provider or supplier other than the organization that the enrollee believes are Medicare covered or, if not covered by Original Medicare, should have been furnished, arranged for or reimbursed by the organization.
- The provider’s or organization’s refusal to provide coverage of an item or service the enrollee has not received but believes should be covered.
- Discontinuation of coverage of a service, if the enrollee disagrees with the determination that the coverage is no longer medically necessary.

Enrollees or their providers can request an expedited or standard pre-service OD decision (e.g. prior authorization). MMA will review and process the request in accordance with the CMS requirements and timeframes. MMA will notify the enrollee of its decision as quickly as the enrollee’s health condition requires, but no later than 14 calendar days. MMA must automatically provide an expedited OD if the physician believes a standard review may seriously jeopardize the life, or health of the enrollee, or the enrollee’s ability to regain maximum function. An expedited review is completed within 72 hours. If the enrollee requests reimbursement for a service already received, it will be reviewed as a request for a payment OD. If the enrollee’s request is denied, the enrollee may exercise their appeal rights.

12.1 Prior Authorizations (Pre-Service Organization Determinations)

- **Laboratory Services:** Prior authorization is **NOT** required for approved in office lab procedures that are CLIA certified. MMA is contracted with Sonora Quest to provide laboratory services. All lab services must be performed by Sonora Quest unless approved by MMA under the prior authorization process.

- **Prior Authorization:** Prior authorization must be obtained from MMA when referring enrollees outside of the PHP network and/or prior to the enrollee receiving a service that requires PA.

- **Radiology Services:** Prior authorization **IS** required for certain radiology services. The prior authorization summary on the MMA website contains additional information on services that require prior authorization.

- **Infusion or Enteral Therapy Services:** Prior authorization **IS** required for any medically necessary services rendered by an infusion or enteral provider.

- **Durable Medical Equipment (DME):** DME equipment and related services may require prior authorization.
For more detail regarding prior authorization requirements, please review MMA’s Prior Authorization web page, or MMA’s Evidence of Coverage.

**12.2 Referrals for Services**

- **Laboratory Services:** PHP’s will be held accountable for non-authorized referrals to non-participating labs and the enrollee must be held harmless.
- **Referrals:** Providers must only refer enrollees to MMA participating PHPs.
- **Radiology Services Referrals:** PHPs must refer enrollees to MMA network radiology providers. Certain radiology services require prior authorization before enrollee is referred.
- **Infusion or Enteral Therapy Referrals:** PHPs must refer enrollees to MMA participating infusion or enteral provider.
- **Durable Medical Equipment (DME) Referrals:** PHPs must refer enrollees to a participating DME provider.

**12.3 Prior Authorization and Coordination of Benefits**

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

**12.4 Prior Authorization Contacts**

- **Inpatient Hospital and Hospice Services**
  Fax: 855-773-9287

- **Pharmacy Prior Authorization**
  MED D Clinical Operations
  Coverage Determination Fax: 855-571-3009

- **Medical or Dental Prior Authorization**
  Medical and Dental Fax: 860-902-8747
**CHAPTER 13 - ENCOUNTERS, BILLING AND CLAIMS**

**Encounters**

**13.0 Billing Encounters and Claims Overview**

The MMA Claims Department is responsible for claims adjudication, resubmissions, claims inquiry/research and provider encounter submissions to CMS.

MMA is required to process claims in accordance with Medicare claim payment rules and regulations.

Physicians and health care professionals must use valid International Classification of Disease, 9th Edition, Clinical Modification (ICD-9 CM) codes and code to the highest level of specificity. Complete and accurate use of current CMS’ Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association’s (AMA) Current Procedural Terminology (CPT), procedure codes are also required. Hospitals and physicians using the current Diagnostic Statistical Manual of Mental Disorders for coding must convert the information to the official ICD-9 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk-Adjustment Processing System.

- The ICD-9 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Report all secondary diagnoses that impact clinical evaluation, management and/or treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

Again, failure to use current coding guidelines may result in a delay in payment and/or rejection of a claim.

**13.1 CMS Risk Adjustment Data Validation**

Risk Adjustment Data Validation (RADV) is an audit process to ensure the integrity and accuracy of risk-adjusted payment. CMS may require MMA to request medical records to support randomly selected claims to verify the accuracy of diagnosis codes submitted. Medicare Advantage plans like MMA, are annually selected for data validation audits by CMS.

It is important for physicians and their office staff to be aware of risk adjustment data validation activities because MMA may request medical record documentation. Accurate risk-adjusted payment depends on the accurate diagnostic coding derived from the enrollee’s medical record.
The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no later than January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to fairly and accurately adjust payments made to MMA by CMS based on the health status and demographic characteristics of an enrollee. CMS requires MMA to submit diagnosis data regarding physician, inpatient and outpatient hospital encounters on a quarterly basis, at minimum.

CMS uses the Hierarchical Condition Category payment model referred to as CMS-HCC model. This model uses the ICD-9 CM as the official diagnosis code set in determining the risk-adjustment factors for each enrollee. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-9 CM codes by disease groups known as HCCs.

Physicians and health care professionals are required to submit accurate, complete and truthful risk adjustment data to MMA. Failure to submit complete and accurate risk adjustment data to CMS may affect payments made to MMA and payments made by MMA to the physician or health care professional organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for an enrollee can increase their medical costs. The CMS-HCC model for coexisting conditions that should be coded for hospital and physician services are as follows:

- Code all documented conditions that coexist at time of encounter/visit and that require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Physicians and hospital outpatient departments should not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out” or “working” diagnosis. Rather, physicians and hospital outpatient departments should code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results or other reason for the visit.

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted by MMA. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient and physician diagnoses submitted by the provider to MMA. In addition, Medicare Advantage regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules and regulations. CMS may adjust payments to MMA based on the outcome of the medical record review.
For more information related to risk adjustment, visit the Centers for Medicare and Medicaid Services CSSC Operations website.

**Billing and Claims**

**13.2 When to Bill a Enrollee**
All PHPs must adhere to federal financial protection laws and are prohibited from balance billing any MMA enrollee beyond the enrollee’s cost sharing.

An enrollee may be billed **ONLY** when the enrollee knowingly agrees to receive non-covered services under both MMA and Mercy Maricopa.

- Provider MUST notify the enrollee in advance that the charges will not be covered under MMA or Mercy Maricopa.
- Provider MUST have the enrollee sign a statement agreeing to pay for the services and place the document in the enrollee’s medical record.

**13.3 When to File a Claim**
All claims and encounters must be reported to MMA, including prepaid services.

**13.4 Timely Filing of Claim Submissions**
In accordance with contractual obligations, claims for services provided to a MMA enrollee must be received in a timely manner. MMA’s timely filing limitations are as follows:

- **New Claim Submissions** – Claims must be filed on a valid claim form within 180 days (6 months) from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the patient.
- **Claim Resubmission** - Claim resubmissions must be filed within 365 days (1 year) from the date of provision of the covered service or eligibility posting deadline, whichever is later. The only exception to this is if a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Please submit any additional documentation that may effectuate a different outcome or decision.

Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial.

Non-contracted providers rendering prior authorized services follow the same timely filing guidelines as Original Medicare guidelines.

**13.5 Cost Sharing and Coordination of Benefits**
MMA must first identify payers that are primary to Medicare, the amounts payable to those payers, and must then coordinate benefits for its Medicare enrollees with these payers. These payers may include but are not limited to:

- Group health plans that cover working aged individuals and their spouses
- Group health plans that cover individuals entitled to Medicare based on a diagnosis of end-stage renal disease
- Workers’ compensation plans
- Property and casualty insurance plans
- Liability and no-fault insurance plans, including self-insured plans.

If an enrollee receives covered benefits that are covered under another insurance policy or plan, MMA may bill or authorize a provider to bill any of the following:
- The insurance carrier, the employer or any other entity that is liable for payment for the services.
- The Medicare enrollee, to the extent that the carrier has paid him or her, employer or other entity for covered medical expenses.

Medicare Secondary Payer (MSP) rules established under the Medicare Advantage program supersede any state laws, regulations, contract requirements or other standards that would otherwise apply to Medicare Advantage Plans, only to the extent that those state laws are inconsistent with MSP standards.

MMA has the right to authorize providers to collect and retain funds subject to coordinate benefits procedures. For example, if MMA receives a claim for payment of covered services, but it is the responsibility of another insurer, MMA is permitted to return the claim to the provider with instructions to bill the third party.

Coordination of benefits will be handled as follows between:
- **Mercy Maricopa Advantage (Primary) and Mercy Maricopa (Secondary):** For enrollees enrolled in both Mercy Maricopa plans, MMA is primary payer and Mercy Maricopa is secondary.
- **Mercy Maricopa Advantage and Another AHCCCS Plan:** If an MMA enrollee has an AHCCCS plan, the provider is responsible for coordinating benefits and claims submissions.
- **MMA, Mercy Maricopa and Another Health Plan:** If an enrollee has insurance other than MMA and Mercy Maricopa (e.g. group health coverage), the provider is responsible for determining if the other insurance is primary over MMA.

For MMA enrollees enrolled in both Mercy Maricopa and MMA, any cost sharing responsibilities will be coordinated between the two payers. For the most part, providers only need to submit one claim to Mercy Maricopa and MMA and benefits will be automatically coordinated. There may be exceptions to this, which are covered in this chapter under the section titled *Instruction for Specific Claim Types, sections 13.8 – 13.25.*

**13.6 Injuries Due to an Accident**
Medicare law only permits subrogation in cases where there is a reasonable expectation of third party payment. In cases where legally required insurance (i.e. auto-liability) is not actually in force, MMA is required to assume responsibility for primary payment.
### 13.7 How to File a Claim

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

#### 13.7a – Claim Form Type

<table>
<thead>
<tr>
<th>Service</th>
<th>Claim Form Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and professional services</td>
<td>CMS 1500 Form</td>
</tr>
<tr>
<td>Hospital inpatient, outpatient, skilled nursing and emergency room services</td>
<td>CMS UB-04 Form</td>
</tr>
<tr>
<td>General dental services</td>
<td>ADA 2006 Claim Form</td>
</tr>
<tr>
<td>Dental services that are considered medical services (oral surgery, anesthesiology)</td>
<td>CMS 1500 Form</td>
</tr>
</tbody>
</table>

Instructions on how to fill out the claim forms can be found at the following AHCCCS website addresses:

- [CMS 1500 Form](#)
- [CMS UB-04 Form](#)
- [ADA 2006 Claim Form](#)

2) Complete the claim form.
   
a) Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
   
b) The claim form may be returned unprocessed (unaccepted) if illegible or poor quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

3) Submit **original** copies of claims electronically or through the mail (do **NOT** fax). To include supporting documentation, such as enrollees’ medical records, clearly label and send to the Claims Department at the correct address.
   
a) Electronic Clearing House
   
   Providers who are contracted with MMA can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
   
   - Contact your software vendor directly for further questions about your electronic billing.
   
   - The EDI vendors that MMA uses are as follows:
<table>
<thead>
<tr>
<th>Vendor</th>
<th>Payer ID</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1-817-684-8500</td>
</tr>
<tr>
<td>Emdeon</td>
<td>33628</td>
<td><a href="http://www.emdeon.com">www.emdeon.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-877-363-3666, Option 1 for Sales</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-866-RELAY-ME (1-866-735-2963 ext. 2)</td>
</tr>
</tbody>
</table>

Contact your Provider Relations representative for more information about electronic billing. Additional information can be attained by accessing the Mercy Maricopa Advantage Provider Notification titled *Electronic Tools*. All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and MMA policies and procedures.

b) Through the Mail

### 13.7b Claim Submission Addresses

<table>
<thead>
<tr>
<th>Claims</th>
<th>Mail To</th>
<th>Electronic Submission*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Mercy Maricopa Integrated Care and Mercy Maricopa Advantage Medical Claims P. O. Box 64835 Phoenix, AZ 85082-4835</td>
<td>Through Electronic Clearinghouse</td>
</tr>
<tr>
<td>Dental</td>
<td>Mercy Maricopa Integrated Care and Mercy Care Advantage Dental Claims P. O. Box 62978 Phoenix, AZ 85082-2978</td>
<td>Through Electronic Clearinghouse</td>
</tr>
<tr>
<td>Refunds</td>
<td>Mercy Maricopa Advantage Attention: Finance Department P.O. Box 64835 Phoenix, AZ 85082-4835</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

*See individual sections for further information: [13.14 Claim Resubmission](#) and [13.15 Claim Disputes](#).
13.8 Correct Coding Initiative

MMA follows the same standards as Medicare’s National Correct Coding Initiative (CCI) policy and performs CCI edits and audits on claims for the same provider, same recipient, and same date of service.

MMA utilizes ClaimCheck as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Information regarding our unbundling software, Clear Claim Connection, will be available in the near future through MMA’s Secure Web Portal.

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

Providers will have access to Clear Claim Connection through MMA’s website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

13.9 Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

13.10 Incorrect Coding

Examples of incorrect coding include:

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

13.11 Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. MMA can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:
Modifier 59 – Distinct Procedural Services - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

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

Modifier 50 – Bilateral Procedure - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. MMA follows the same billing process as CMS and AHCCCS when billing for bilateral procedures. Services should be billed on one line reporting one unit with a 50 modifier.

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

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


13.12 Checking Status of Claims
Providers may check the status of a claim by accessing MMA’s Secure Web Portal (coming soon) or by calling the Claims Inquiry department.

Online Status through MMA’s Secure Web Portal
MMA encourages providers to take advantage of using online status, as it is quick, convenient and can be used to determine status for multiple claims. More information will be available in the near future to register for a secure login.

Calling the Claims Inquiry Department
The Claims Inquiry Claims Research (CICR) Department is also available to:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing:
  - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
  - Excludes rebilling a claim (the entire claim must be resubmitted with corrections, see section 13.14 Claim Resubmission).

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

13.13 Payment of Claims
MMA processes claims and notifies the provider of outcome using a Remittance Advice. Providers may choose to receive checks through the mail or electronically. MMA encourages providers to take advantage of receiving Electronic Remittance Advices (ERA), as you will receive much sooner than receiving through the mail, enabling you to post payments sooner. Please contact your Provider Relations representative for further information on how to receive ERA.

Remittance Advice samples are also available. Links to those remits are available under the section 13.26 Provider Remittance Advice in this Provider Manual.

Through Electronic Funds Transfer (EFT), providers have the ability to direct funds to a designated bank account. MMA encourages you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check.

Submit this form along with a voided check to process the request. Please allow at least 30 days for EFT implementation. Your Provider Relations representative will assist you with this.

Additional information can be attained by accessing MMA’s Provider website and reviewing the document titled Electronic Tools.

13.14 Claim Resubmission
Providers have twelve (12) months from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute reconsideration or claim dispute.
Providers may resubmit a claim that:

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

Include the following information when filing a resubmission:

- Use the Resubmission Form.
- An updated copy of the claim. All lines **must** be rebilled.
- A copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as “Resubmission” at the top of the claim in black ink and mail to appropriate claims address as indicated in **13.7b Claim Address Table**.

Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to deny as a duplicate.

**13.15 Claim Disputes**

Conditions for payment are outlined in PHP’s contractual agreement and fee schedule with MMA. Claim payments are adjudicated in accordance with the provider agreement. CMS prohibits Medicare Advantage plans from applying the mandated Medicare enrollee appeal process to participating providers. PHPs are encouraged to contact the Claims Department with questions on how their claim paid. MMA will work with the provider to resolve the issue if an error is discovered. In some situations, MMA may require the provider to resubmit the claim for reprocessing. Please note that MMA contracted providers do not have appeal rights and cannot balance bill the enrollee.

**13.16 Non-Contracted Provider Reconsiderations**

A provider that does not have a contractual arrangement with MMA, on his or her own behalf, is permitted to file a standard appeal (reconsideration) for a denied claim payment only if a waiver of liability form is completed and submitted with the appeal. The **Waiver of Liability** form is a binding agreement which the provider has agreed to hold the enrollee financially harmless, regardless of the outcome of the appeal. The provider must submit the appeal with the required documentation and be received by MMA within 60 calendar days of the Remittance Advice for the claim denial.

If MMA receives the appeal without the completed waiver of liability form, the request will be held for up to 60 days after the request is received. If MMA does not receive the form by the conclusion of the appeal time frame, MMA will forward the case to the independent review entity with a request for dismissal.
MMA will notify the provider of a decision in writing no later than 60 days after receipt of the appeal and waiver of liability form.

To appeal a claim denial, write a letter and mark the top of the request “appeal” and include the following:

- Statement indicating basis for appeal
- A signed Waiver of Liability
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information, clinical records or documentation

Send information to:

Mercy Maricopa Advantage  
Attention: Appeals Department  
4350 E. Cotton Center Boulevard, Building D  
Phoenix, AZ 85040  
Fax: 602-351-2300

13.17 Provider Payment Dispute Resolution Process for Non-Contracted Providers

Providers that do not have a contractual relationship with MMA have access to a Medicare Advantage Payment Dispute Process. If the non-contracted provider believes that the payment amount received for a service provided to a MMA plan enrollee is less than the amount they would be entitled to receive under Original Medicare, or provider disagrees with a decision made by MMA to pay for a different service than the service for which was billed, the provider has the right to dispute the payment amount.

To file a payment dispute, please send your written dispute to:

Mercy Maricopa Advantage  
Appeals Department  
Attention: Provider Payment Dispute Department  
4350 E. Cotton Center Boulevard, Building D  
Phoenix, AZ 85040  
602-351-2300 (fax)

Please provide MMA with all appropriate documentation to support your payment dispute (e.g., remittance advice and letter addressing your concerns). You must submit your payment dispute to MMA no later than 60 days from the date you initially received the disputed payment from MMA.

MMA will review your payment dispute and respond to you within 30 days from the time the provider payment dispute is first received by MMA. If we determine that you are owed additional payment amounts after reviewing your payment dispute, we will pay you this
additional amount, including any interest owed under federal law, if applicable. We will inform you in writing if the payment dispute is not decided in your favor.

**Instruction for Specific Claims Types**

**13.18 MMA General Claims Payment Information**
MMA claims are always paid in accordance with the terms outlined in the PHP’s contract. Prior authorized services from Non-Participating Health Providers will be paid in accordance with Original Medicare claim processing rules.

**13.19 Skilled Nursing Facilities (SNF)**
Providers submitting claims for SNFs should use CMS UB-04 Form. Refer to the Skilled Nursing Facility Guidelines for additional information.

Providers must bill in accordance with standard Medicare RUGS billing requirement rules for MMA, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the CMS website.

The coordinating claim on the Medicaid side will require separate billing in accordance with the provider contract. This is one of the few situations where billing requirements differ on the MMA side versus the Mercy Maricopa side.

**13.20 Home Health Claims**
Providers submitting claims for Home Health should use CMS 1500 Form.

Providers must bill in accordance with their contract terms. Non-Participating Health Providers must bill according to CMS HHPPS requirement rules for MMA. For additional information regarding CMS Home Health Prospective Payment System (HHPPS), please refer to the website.

**13.21 Dental Claims**
- Claims for dental services should be submitted on the standard American Dental Association form ADA 2006 Claim Form.
- Services provided by an anesthesiologist or medically related oral surgery procedure should be submitted on CMS 1500 Form.

**13.22 Durable Medical Equipment (DME) Rental Claims**
Providers submitting claims for DME Rental should use CMS 1500 Form.

DME rental claims are only paid up to the purchase price of the durable medical equipment.

There is a billing discrepancy rule difference between Days versus Units for DME rentals between MMA and Mercy Maricopa. Units billed for MMA equal 1 per month. Units billed for Mercy Maricopa equal the amount of days billed. Since appropriate billing for CMS is 1 Unit per
month, in order to determine the amount of days needed to determine appropriate benefits payable under Mercy Maricopa, the claim requires the date span (from and to date) of the rental. Mercy Maricopa will calculate the amount of days needed for the claim based on the date span.

13.23 Same Day Readmission
Providers submitting claims for inpatient facilities should use CMS UB-04 Form.

There may be occasions where an enrollee may be discharged from an inpatient facility and then readmitted later that same day. MMA defines same day readmission as a readmission with 24 hours.

**Example:**
Discharge Date: 10/2/10 at 11:00 a.m.
Readmission Date: 10/3/10 at 9:00 a.m.

Since the readmission was within 24 hours, this would be considered a same day readmission per above definition.

13.24 Hospice Claims
The only claims payable during a hospice election period by MMA would be for the additional benefits covered under MMA that would not normally be covered under Original Medicare covered services. All other claims need to be resubmitted to Original Medicare for processing, regardless of whether they are related to hospice services or not. Please refer to our provider notification titled Hospice Election Coverage While Covered Under Mercy Maricopa Advantage for additional information.

13.25 HCPCS Codes
There may be differences in what codes can be billed for Medicare versus Medicaid. MMA follows Medicare billing requirement rules, which could result in separate billing for claims under Mercy Maricopa. While most claims can be processed under both MMA and Mercy Maricopa, there may be instances where separate billing may be required.
Remittance Advice

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

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

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Mercy Maricopa for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Mercy Maricopa due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Mercy Maricopa after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
- Enrollee/Patient Name
- ID
- Birth Date
- Account Number
- Authorization ID, if Obtained
- Provider Name
- Claim Status
- Claim Number
- Refund Amount, if Applicable

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

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

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

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

More information is available in this Provider Manual under section 4.7 MMA Secure Web Portal regarding Remittance Advice Search.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact your Provider Relations representative to assist you with this process.
CHAPTER 14 – MMA ENROLLEE GRIEVANCES AND APPEALS

14.0  Grievances
Grievances are defined as any enrollee complaint or dispute, other than one involving an adverse organization determination, expressing dissatisfaction with the manner in which MMA or a delegated entity provides health care services, regardless of whether any remedial action can be taken. Enrollees or their representative may make the complaint or dispute, either orally or in writing, to MMA, a provider, or a facility. An expedited grievance may also include a complaint that MMA refused to expedite an OD or reconsideration, or invoked an extension to an OD or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet the accepted standards for delivery of health care.

Examples of grievance issues include, but are not limited to quality of care provided, accessibility, availability or quality of services, interpersonal relationships, cultural barriers, insensitivity, or failure to respect an enrollee’s rights.

14.1  Filing and Resolving Grievances
MMA will review and attempt to resolve any enrollee grievance under the Medicare grievance process. Enrollees are encouraged to submit verbally or by writing to MMA Member Services:

Mercy Maricopa Advantage
Member Services Department
4350 E. Cotton Boulevard, Building D
Phoenix, AZ 85040
Phone: 602-586-1880
Toll Free: 866-602-1979
Fax: 602-351-2313

Enrollees should submit a grievance no later than 60 days after the event or incident that precipitates the grievance. Grievances received after 60 days will be reviewed, tracked and trended. MMA will investigate the complaint and respond to the grievance in accordance with CMS requirements. MMA will notify the enrollee of its decision as expeditiously as the enrollee’s health condition requires, but no later than 30 days after the date MMA receives the grievance.

14.2  Quality Improvement Organization - Quality of Care Grievances
An enrollee may file a grievance regarding concerns of the quality of care received with MMA, or with the CMS contracted Quality Improvement Organization (QIO). In Arizona, the QIO is Health Services Advisory Group (HSAG), which is located at:
14.3 Enrollee Initiated Appeals (Reconsiderations)
MMA enrollees have the right to appeal an adverse organization determination by MMA if they disagree with the decision to deny a requested benefit or service, or one that involves a denied claim or reimbursement request. Reconsiderations must be submitted in writing within 60 calendar days of the date of the denial notice sent to the enrollee. MMA may extend this timeframe if the enrollee provides evidence of “good cause”.

14.4 Filing an Appeal on Behalf of a Enrollee
Regardless of whether the enrollee files a standard appeal, or asks for an expedited review, the enrollee can solicit the help of a friend, lawyer, advocate, relative, physician, or someone else. The enrollee can appoint a trusted individual to represent them as an appointed representative. The appeal must include the enrollee’s Appointment of Representative (AOR) form, or legal representative documents. Enrollees are encouraged to contact the Medicare Rights Center toll free at 1-888-HMO-9050 for assistance in filing an appeal.

14.5 How to Appoint a Representative
The enrollee may appoint an individual to act as their representative to file an appeal by completing the following steps:

- Complete the 07/05 edition of the CMS Appointment of Representative (AOR) 1696 form.
- Provide the enrollee’s name, Medicare number and the AOR-1696 form that appoints an individual as the enrollee’s representative (Note: an enrollee may appoint a physician, relative, friend, attorney or advocate).
- The enrollee must sign and date the form.
- The appointed representative must also sign and date this form.
- The appointed representative must include this signed form with the appeal.
- A contracting physician may serve as an enrollee’s representative upon appointment.

A non-contracted health care provider that has furnished a service to an enrollee may file a standard appeal of a denied claim if he/she completes the Medicare’s Waiver of Liability form that attests the provider will not hold the enrollee financially liable regardless of the outcome of the appeal.

14.6 Standard Appeal Resolution
- MMA’s Appeals team will review its initial decision. A medical director, who was not involved in the original determination, will review the reconsideration based on known evidence of Medicare coverage and medical necessity.
• MMA will issue a decision as expeditiously as the enrollee’s health requires, but no later than 30 days from receipt of the request.
• The timeframe may be extended by up to 14 days if the enrollee requests the extension or if MMA needs additional information and the extension may benefit the enrollee. MMA will make a decision as expeditiously as the enrollee’s health requires, but no later than the end of any extension period.
• If MMA decides in the enrollee’s favor, MMA will provide or authorize the requested service as expeditiously as the enrollee’s health requires, but no later than 30 days from the date the request was received.
• When MMA upholds its original decision to deny, MMA will automatically forward the case file to the CMS contracted Independent Review Entity (IRE), MAXIMUS Federal Services. The IRE will review the case to determine if MMA made the decision based on Medicare regulations and guidelines. MAXIMUS Federal Services will notify the enrollee or representative of the final decision.
• If the enrollee disagrees with the IRE decision, and the amount in dispute reaches a certain threshold, an appeal may be submitted to an Administrative Law Judge.

14.7 Expedited Reconsideration Resolution

• Enrollees have the right to request an expedited decision affecting medical treatment if the enrollee or their physician believes that applying the standard decision timeframe could seriously jeopardize the enrollee’s life, health or ability to regain maximum function. To request an expedited review, the enrollee, the enrollee’s appointed or legal representative, or physician may submit a written reconsideration request to MMA.
• If the enrollee has submitted a standard appeal, their physician may change the appeal to an expedited review by calling the MMA Appeals unit.
• If MMA decides, based on medical criteria, that the situation is time-sensitive, or if any physician requests an expedited review, MMA will issue a decision as expeditiously as the Enrollee’s health requires, but no later 72 hours after receiving the request.
  o This timeframe may be extended up to 14 days if the enrollee requests the extension or if the plan needs additional information and the extension benefits the enrollee. MMA will make a decision as expeditiously as the enrollee’s health requires, but no later than the end of the 14 day extension period.
• If the request does not meet the definition of time sensitive, it will be handled within the standard review process. The enrollee will be informed in writing that the request for expedited review has been denied and that the standard timeframe will be applied. If the enrollee disagrees with MMA’s decision to deny the request for the expedited timeframe, the enrollee may file an expedited grievance with MMA.
14.8 Submitting an Appeal

Submit an appeal to:

Mercy Maricopa Advantage
Appeals Department
4350 E. Cotton Center Boulevard, Building D
Phoenix, AZ 85040
Fax: 602-351-2300
CHAPTER 15 - MMA ENROLLEE COVERAGE DETERMINATIONS, EXCEPTIONS, APPEALS AND GRIEVANCES FOR PRESCRIPTION DRUGS

15.0  Medicare Prescription Drug Coverage Determinations
MMA provides Medicare Part D prescription drug coverage to MMA enrollees. CVS Caremark is the Pharmacy Benefit Manager (PBM) that MMA has contracted to administer the MMA Medicare prescription drug benefit. MMA enrollees will have access to CVS Caremark participating pharmacies.

CVS Caremark is responsible to review and process Medicare Part D Coverage Determinations and Exception requests initiated by MMA enrollees, their authorized representative and/or their prescribing provider.

While typically prescribing providers submit requests for a coverage determination, enrollees have the right to request a coverage determination concerning a prescription drug they believe they are entitled to receive under their plan, including:
- Basic prescription drug coverage.
- The amount, if any, that the enrollee is required to pay for a drug.

CVS Caremark will process coverage determinations under the standard timeframe of 72 hours, unless the prescriber has indicated that the enrollee would be harmed if the standard timeframe is applied. In these cases, CVS Caremark will process the review under the expedited timeframe of 24 hours, or as fast as the enrollee’s health condition requires. If CVS Caremark fails to process the request within the required timeframe, CMS requires the request to be submitted to the Independent Review Entity, MAXIMUS Federal Services. Should this occur, MMA will notify both the enrollee and the prescribing provider that MAXIMUS will conduct the review.

An MMA enrollee, their authorized representative and/or their prescribing provider may submit a request to MMA to make a coverage determination for a formulary exception. MMA has provided a form on the MMA’s Member and Provider website titled MMA Pharmacy Coverage Determination Request Form. The request for a coverage determination must be filed directly with CVS Caremark. If an enrollee or their authorized representative submits an exception request, CVS Caremark will reach out to the prescribing provider to obtain their supporting statement. This information must be received before the request can be reviewed.

Providers may also initiate a request by calling CVS Caremark at 1-855-582-2023, Monday through Friday 8:00 a.m. to 8:00 p.m. Arizona time.

Faxed requests:
MED D Clinical Operations
Coverage Determinations: 1-855-571-3009
A coverage determination is any decision made by MMA regarding a request for Part D drug benefit or payment. There are two (2) types of coverage determinations:

- **Formulary UM Requirements** – A request for approval for a formulary UM requirement such as prior authorization, step therapy and quantity limitations.
- **Formulary Exceptions** - Request for Part D prescription drug not listed on the formulary or a request for an exception to the formulary UM requirements.

### 15.1 Formulary Exceptions

As a Medicare Part D Prescription Drug Plan, MMA must approve a formulary exception to the MMA Formulary if it is determined the requested drug treatment is medically necessary. CVS Caremark is responsible to review and process Medicare Part D Coverage Determinations and Exception requests initiated by MMA enrollees, their authorized representative and/or their prescribing provider. CVS Caremark is required to follow specific review guidelines to determine if a request meets CMS-defined criteria for formulary exception.

Based on the information given by prescribing provider, CVS Caremark must review for evidence of medical necessity, which is required to support an approval. The prescriber should provide any medical records that support their position. If CVS Caremark is unable to determine medical necessity, they will deny the request.

The prescribing physician must provide a written supporting statement that the requested prescription drug is medically required and all other applicable formulary drugs and dosage limits would NOT be as effective because:

- All covered drugs on the formulary have been tried and failed, or caused or would have caused adverse effects;
- The number of doses available under a dose restriction has either been ineffective or based on sound clinical evidence and medical/scientific evidence is likely to be ineffective, or would adversely affect patient compliance due to known physical or mental characteristics of the enrollee;
- The formulary alternatives on the formulary or required under step therapy requirements has either been ineffective or based on sound clinical evidence and medical/scientific evidence is likely to be ineffective, or would adversely affect patient compliance due to known physical or mental characteristics of the enrollee; or would likely cause harm.

Medical documentation to support the prescriber’s request is recommended. If CVS Caremark does not receive the prescriber’s supporting statement, they will base their review on the information available and the request may be denied.

Once the physician’s supporting statement is received and CVS Caremark has made a coverage determination for a formulary exception, CVS Caremark will notify the enrollee or the enrollee’s appointed representative and the prescribing physician involved as expeditiously as the enrollee’s health condition requires, but no later than 72 hours for standard requests, and no later than 24 hours for expedited requests.
For a complete description of MMA’s coverage determination and exceptions process, and how to contact MMA if you are assisting an enrollee with this process, please refer to the Complaints, grievances and appeals section available on the MMA website.

15.2 How To File a Part D Prescription Drug Redetermination (Appeal)

 An enrollee or enrollee’s representative or prescribing physician or other prescriber may request a redetermination (appeal) if a request for a Part D prescription drug coverage determination is denied.

 A standard redetermination request must be filed orally or in writing to the MMA Appeals Department within 60 calendar days from the date of the notice of the coverage determination. If the representative is appointed, the request must include the enrollee’s written Appointment of Representative form to file an appeal on their behalf.

 Submit an appeal to:
  Mercy Maricopa Advantage
  Appeals Department
  4350 E. Cotton Center Boulevard, Building D
  Phoenix, AZ 85040
  Fax: 602-351-2300

 MMA will issue a decision within 7 calendar days for a standard redetermination. If waiting for the standard timeframe would seriously affect the enrollee’s health, MMA will complete an expedited redetermination within 72 hours. The redetermination timeframe is calculated from the date and time the redetermination request is received by MMA, and if a request involves a formulary exception that was denied for lack of a prescriber’s supporting statement, the timeframe begins when the statement is received. Medical documentation to support the request is typically required.

 If MMA upholds their original decision to deny, the enrollee or their appointed or legal representative may submit an appeal in writing to MAXIMUS Federal Services, the CMS contracted independent review entity (IRE). Prescribers must be appointed by the enrollee in order to submit an appeal to the IRE. If the representative is appointed, the appeal must include the Appointment of Representative form. Legal representative documentation is required for legal representatives to file on the enrollee’s behalf. The written appeal must be sent to the IRE within 60 calendar days after the date of the appeal denial notice from MMA.
IRE reconsideration requests can be mailed or faxed to:

MAXIMUS FEDERAL SERVICES
3750 Monroe Ave., Suite #703
Pittsford, NY 14534-1302

Fax: (585) 425-5301
Toll free fax: (866) 825-9507
Toll free customer service: (877) 456-5302
CHAPTER 16 – FRAUD, WASTE AND ABUSE

16.0 Fraud, Waste and Abuse Overview

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

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

CMS requires that Medicare Advantage have a compliance plan that guards against potential fraud, waste and abuse under 42 C.F.R. §422.503 (b)(4)(vi) and 42 C.F.R §423.504(b)(4)(vi).

CMS combats fraud by:

- Close coordination with contractors, provider and law enforcement agencies.
- Developing Medicare Program compliance requirements that protect stakeholders.
- Early detection through medical review and data analysis.
- Effective education of physicians, providers, suppliers and beneficiaries.

A provider’s best practice for preventing Fraud, Waste and Abuse is to:

- Develop a compliance program.
- Monitor claims for accuracy - ensure coding reflects services provided.
- Monitor medical records – ensure documentation supports services rendered.
- Perform regular internal audits.
- Establish effective lines of communication with colleagues and staff enrollees.
- Ask about potential compliance issues in exit interviews.
- Take action if you identify a problem.
- Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

16.1 Fraud, Waste and Abuse Defined

Fraud: An intentional act of deception, misrepresentation, or concealment in order to gain something of value.

Waste: Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practice. Abuse refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss.

Examples of Fraud, Waste and Abuse include:
Charging in excess for services or supplies.
Providing medically unnecessary services.
Billing for items or services that should not be paid for by Medicare.
Billing for services that were never rendered.
Billing for services at a higher rate than is actually justified.
Misrepresenting services resulting in unnecessary cost to the Medicare program, improper payments to providers, or overpayments.
Physical or sexual abuse of enrollees.

Fraud, Waste and Abuse can incur risk to providers:
- Participating in illegal remuneration schemes, such as selling prescriptions.
- Switching a patient prescription based on illegal inducements rather than based on clinical needs.
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider.
- Theft of a prescriber’s Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing log-in information.
- Falsifying information in order to justify coverage.
- Failing to provide medically necessary services.
- Offering beneficiaries a cash payment as an inducement to enroll in Part D.
- Selecting or denying beneficiaries based on their illness profile or other discriminating factors.
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services – for example, by not referring a patient to an appropriate provider.
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the patient failed to keep. Another example is a “gang visit” in which a physician visits a nursing home billing for 20 nursing home visits without furnishing any specific service to individual patients.
- Double billing such as billing both Medicare and the beneficiary, or billing Medicare and another insurer.
- Misrepresenting the date services were rendered or the identity of the individual who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-covered service that was rendered.

Fraud, Waste and Abuse can incur risk to individuals as well:
- Unnecessary procedures may cause injury or death.
- Falsely billed procedures create an erroneous record of the patient’s medical history.
- Diluted or substituted drugs may render treatment ineffective or expose the patient to harmful side effects or drug interactions.
- Prescription narcotics on the black market contribute to drug abuse and addition.

In addition, enrollee fraud is also reportable and examples include:
- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit.
- Attempting to use the enrollee identity card to obtain prescriptions when the enrollee is no longer covered under the drug benefit.
- Looping (i.e., arranging for a continuation of services under another beneficiaries ID).
- Forging and altering prescriptions.
- Doctor shopping is when a beneficiary consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

### 16.2 CMS Requirements

Federal law requires MMA to have a Compliance Plan. MMA must:
- Create a Compliance Plan that incorporates measures to detect, prevent, and correct fraud, waste, and abuse.
- Create a Compliance Plan that must consist of training, education, and effective lines of communication.
- Apply such training, education and communication requirements to all entities which provide benefits or services under MMA.
- Produce proof from related entities to show compliance with these requirements.

Anyone can report a compliance concern to the MMA Compliance Officer as follows:

E-mail: [MercyMaricopaCompliance_fraud-abuse@Aetna.com](mailto:MercyMaricopaCompliance_fraud-abuse@Aetna.com)

### 16.3 Seven Key Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written Standards of Conduct and Policies and Procedures that promote MMA’s commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
2. Designation of a Compliance Officer: Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
3. Effective Compliance Training: Development and implementation of regular, effective education, and training.
4. Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
5. **Disciplinary Mechanisms**: Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in CMS programs.

6. **Effective Lines of Communication**: Between the compliance officer and the organization’s employees, managers, and directors and enrollees of the compliance committee, as well as related entities.
   - i. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, will maintaining confidentiality.
   - ii. Related entities must report compliance concerns and suspected or actual misconduct involving MMA.

7. **Procedures for responding to Detected Offenses and Corrective Action**: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

### 16.4 Relevant Laws that Apply to Fraud, Waste and Abuse

There are several relevant laws that apply to Fraud, Waste and Abuse:

**The False Claims Act (FCA)**
The False Claims Act (FCA) was enacted in 1863 to fight procurement fraud in the Civil War. The FCA has historically prohibited knowingly presenting or causing to be present to the federal government a false or fraudulent claim for payment or approval.

The FCA was recently amended through the American Recovery and Reinvestment Act of 2009 (ARRA) to expand the scope of liability and give the government enhanced investigative powers. FCA liability now extends to subcontractors working on government funded projects as well as those who submit claims for reimbursement to government agents and state agencies. This may indicate FCA liability for claims submitted to MMA.

**Anti-Kickback Statute**
The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program.

Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

**Beneficiary Inducement Statute**
The Beneficiary Inducement Statute prohibits certain inducements to Medicare beneficiaries, i.e., waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or fails to collect coinsurance or deductible amounts after making reasonable collection efforts.
**Self-Referral Prohibition Statute (Stark Law)**
Prohibits physicians from referring Medicare patients to an entity with which the physician or physician’s immediate family enrollee has a financial relationship – unless an exception applies.

**Red Flag Rule (Identity Theft Protection)**
Requires “creditors” to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

**Health Insurance Portability and Accountability Act (HIPAA)**
- Transaction standards
- Minimum security requirements
- Minimum privacy protections for protected health information
- National Provider Identifier numbers (NPIs)

**OIG and GSA Exclusion Program**
Prohibits identified entities and or individuals excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

### 16.5 Administrative Sanctions
Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare provider number application.
- Suspension of provider payments.
- Addition to the OIG List of Excluded Individuals/Entities (LEIE).
- License suspension or revocation.

### 16.6 Civil Monetary Penalties (CMPS), Litigation and Settlements
The Social Security Act authorizes the imposition of CMPs when Medicare determines that an individual or entity has violated Medicare rules and regulations. Typically penalties involve assessments of significant damages such as CMPs up to $25,000 for each Medicare Advantage enrollee adversely affected.

The United States Attorney’s Office may file a civil suit or decide that the interest of the Medicare Program is best served by settling a case out of court. The civil suit or settlement may include a Corporate Integrity Agreement (CIA, which requires the individual or entity to accomplish specific goals (e.g., educational plan, corrective action plan, reorganization) and be subject to period audits by the federal government.

### 16.7 Potential Civil and Criminal Penalties
- False Claims Act – For each false claim the penalty could range from $5,500.00 - $11,000.00. If the government proves it suffered a loss, the provider is liable for three times the loss.
- Anti-Kickback Statute – Up to five years in prison and fines of up to $25,000.00 for violations of the Anti-Kickback Statute. If a patient suffers bodily injury as a result of the scheme, the prison sentence may be 20+ years.

16.8 Remediation
Remediation may include any or all of the following:
- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
  - Automatic disbarment
  - Prison time

16.9 Exclusion Lists
MMA is required to check the OIG and General Services Administration (GSA) exclusion lists for all new employees and at least once a year thereafter to validate the employees and other entities that assist in the administration or delivery of service to Medicare beneficiaries are not included on such lists.

The OIG list of Excluded Individuals/Entities (LEIE) can be found at on their website by clicking the link.

16.10 Reporting Potential Fraud, Waste, and Abuse
Anyone who suspects enrollee or provider fraud, waste, and abuse may report it as follows:

**Special Investigations Unit (SIU):**
- By Phone: 1-800-338-6361
- By Fax: 1-860-975-9719
- By E-Mail: aetnasiu@aetna.com

All are continuously monitored by SIU personnel. We encourage everyone to use these.

**Office of Inspector General:**
- By Phone: 1-800-HHS-TIPS (1-800-447-8477)
- By Fax: 1-800-223-2164
  (no more than 10 pages please)
- By E-Mail: HHSTips@oig.hhs.gov
- By Mail: Office of the Inspector General
  HHS TIPS Hotline
  P.O. Box 23489
  Washington, DC 20026