FALL 2011

Mercy Care Plan | Mercy Care Advantage HMO SNP | Mercy Healthcare Group

Provider Newsletter

CONTENTS

2011-2012 Mercy Care Plan Benefit Changes

Effective October 1, 2011, there are three new benefit changes that will be implemented by Mercy Care Plan in accordance with AHCCCS benefit changes. The three changes are as follows:

- Respite Care – reduction of hours from 720 to 600 hours per plan year (effective 10/1/11–9/30/12). This will impact both adults and children through MCLTC.
- Twenty-five day inpatient hospital limitation per plan year (effective 10/1/11–9/30/12). This will impact all adults (21 years and older) and only applies to facility services (not professional services) in the acute and MCLTC programs. Observation services also count as inpatient days.

  Exceptions include:
  - Inpatient days for behavioral health services.
  - Governmentally operated burn units.
  - Transplant services which are reimbursed under component pricing.
  - Certain Medicare beneficiaries for whom Mercy Care is responsible for copays and deductibles. (This would apply to QMB members where MCP or MCLTC is the secondary payer).
- Mercy Care Fee Schedule reduced by 5% (effective 10/1/11). The rate reduction also applies to dental services.

Provider Notifications were recently posted to Mercy Care Plan's website that contain additional detail regarding these benefit changes. Please refer to Mercy Care's Provider Notifications on our website at:

www.MercyCarePlan.com

Additional information regarding the AHCCCS benefit changes can be found on the AHCCCS website at:

http://www.azahcccs.gov/shared/news.aspx#Benefits

Billing on a CMS 1500 Form

A CMS 1500 editable form template has recently been added to our Forms section for each website, along with a Provider Notification that provides billing instructions titled, **Billing on a CMS 1500 Claim Form**. This document will assist you in filling out a CMS 1500 form if needed. Please feel free to reference this document as needed.

Claims Coding for EPSDT and Well Child Visits

A recent Provider Notification was posted to our website regarding Claims Coding for EPSDT and Well Child Visits that may be of interest to you. It is available at the following website:

www.MercyCarePlan.com

The following codes are payable under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Well-Child Visits:

CPT Codes for Preventive Medicine Services:

- 99381 New Patient Under 1 Year
- 99382 New Patient (Ages 1 – 4 Years)
- 99383 New Patient (Ages 5 – 11 Years)
- 99384 New Patient (Ages 12 – 17 Years)
- 99385 New Patient (Ages 18 – 39 Years)
- 99391 Established Patient Under 1 Year
- 99392 Established Patient (Ages 1 – 4 Years)
- 99393 Established Patient (Ages 5 – 11 Years)
- 99394 Established Patient (Ages 12 – 17 Years)
- 99395 Established patient (Ages 18 – 39 Years)
- 99431 Newborn Care (History and Examination)
- 99432 Normal Newborn Care

OR

CPT Codes for Evaluation and Management Services:

- 99201 - 99205 New Patient
- 99211 - 99215 Established Patient

In conjunction with ICD-9 Diagnosis codes:

- V20.2 Routine Infant or Child Health Check
- V70.0 Routine Medical Examination (Routine)
- V70.3 – V70.9 General Medical Examination

AND

Not in Conjunction with Category of Service:

- 03 Respiratory Services
- 06 Physical Therapy
- 07 Speech/Hearing Therapy
- 11 Dental
- 12 Pathology & Laboratory
- 13 Radiology
- 15 Durable Medical Equipment & Supplies
- 30 Home Health Nurse Services
- 31 Non-Emergency Transportation
- 40 Medical Supplies

Please Note: Providers who bill for administration of vaccines under the Federal Vaccines for Children program must bill the appropriate CPT code for the immunization with the "SL" (state supplied vaccine) modifier.

CuraScript Pharmacy

CuraScript Pharmacy, Inc. is a specialty pharmacy that provides oral and injectable drugs that are not often available at local retail pharmacies. Mercy Care Advantage has entered into an agreement with CuraScript Pharmacy, Inc. to provide specialty medications to members and provider offices. Please refer to the Specialty Medication Authorization Form that is located on Mercy Care Advantage's website under the Forms section at:

http://www.mercycareplan.com/mca/providers/forms.aspx

A Specialty Medication List is available that lists the specialty medications requiring prior authorization. A recent Provider Notification has been posted to our website explaining the process and lists the specialty medications. The provider notification titled **MCA Speciality Medication Authorizations** is available on MCA's website at:

http://www.mercycareplan.com/mca/providers/provider_notifications.aspx

The Speciality Medication Authorization Form must be used for any medications on the Specialty Medication List. Once you complete the Specialty Medication Authorization Form, it should be faxed to 1-800-871-6898 prior to dispensing the medication.

The Mercy Care Advantage Pharmacy Department will review the request for prior authorization. If the request is approved, you will be notified via fax. CuraScript will mail the drug directly to your office within three (3) business days of an approval. If your request is urgent, the medication will be shipped within forty-eight (48) hours of an approval. If your request for a specialty medication is not approved, Mercy Care Advantage will notify you and the member of the decision in writing. If you have any questions, please contact Mercy Care Advantage's Pharmacy Prior Authorization Unit at 1-602-263-3000 or 1-800-624-3879.

Don't Get Dropped AZ

As previously mentioned in our Summer 2011 Newsletter, Don't Get Dropped AZ is a grassroots joint campaign by Keogh Health Connections and the Arizona Association of Community Health Centers that encourages AHCCCS members to renew coverage online.

As you are aware, AHCCCS has announced an enrollment freeze of adults without children. After July 8, 2011, no new adults without children will be accepted. Adults without children who are currently enrolled in AHCCCS will be able to continue enrollment, but will not be able to reenter the program if they fail to renew on time.

Mercy Care is assisting in this member awareness effort by providing monthly letters to PCP's listing affected members in their practice. This joint effort will enable our PCPs to assist in contacting members in their practice to remind them to timely renew their coverage online.

Additional information regarding renewal is available at the following website:

www.HealtheArizona.org

For a list of groups that will provide renewal assistance and additional information regarding the Don't Get Dropped AZ campaign, please reference the following website:

www.DontGetDroppedAZ.org

Renewal date information is available by calling (602) 542-9935 (Phoenix area) or by calling (800) 352-8401 (outside the Phoenix area).

Electronic Remit Requests

Additional information regarding Electronic Remit Requests through the 835 process will be released shortly. We are currently working with our vendor on this and further instruction outlining the process should be updated to our website within the next two weeks. Using a combination of EDI/EFT/ERA will definitely assist your practice in faster turnaround of billing, receiving payment and reconciling your patient accounts. Please watch for this exciting update!

Electronic Submission of COB Claims

Great news! Mercy Care is pleased to announce that we're rolling out the ability for your practice to submit claims electronically when other insurance is the primary payer. This will occur on **October 1, 2011**. It will no longer be necessary for you to drop this type of claim to paper for processing. All claims will be coordinated with the primary payer's payment at the line level.

As a reminder, if your practice currently does not submit claims electronically, we encourage you to do so. The benefits of electronic claim submissions include:

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

Your continued partnership with Mercy Care is appreciated and will help reduce unnecessary costs to both the Medicaid and Medicare programs. Please contact your Provider Relations Network Consultant or Account Manager by calling Mercy Care at (602) 263-3000 or (800) 624-3879 and press the Express Service Code 631 for further information regarding electronic submissions.

Flu Shots - It's That Time of Year!

Everyone age 6 months and older should get a flu vaccine each year. This recommendation has been in place since February 24, 2010 when the **CDC's Advisory Committee on Immunization Practices (ACIP)** voted for "universal" flu vaccination in the U.S. to expand protection against the flu to more people. While everyone should get a flu vaccine each flu season, it's especially important that certain people get vaccinated either because they are at high risk of having serious flu–related complications or because they live with or care for people at high risk for developing flu–related complications. These include:

- People 50 years of age and older
- People of any age with certain chronic medical conditions
- Children younger than 5, but especially children younger than 2 years old
- People who live in nursing homes and other long–term care facilities
- People who live with or care for those at high risk for complications from flu, including:
    - Health care workers
    - Household contacts of persons at high risk for complications from the flu
    - Household contacts and out of home caregivers of children less than 6 months of age (these children are too young to be vaccinated)

Flu vaccine shipments began in August and will continue throughout September and October until all vaccine is distributed. Providers are encouraged to begin vaccinating their patients as soon as flu vaccine is available, even as early as August.

Please visit the following websites for additional information regarding the flu:

www.flu.gov

http://www.cdc.gov/flu/flu_vaccine_updates.htm

http://www.azdhs.gov/flu

Please also reference Mercy Care's Provider Notification titled, 2011-2012 Influenza Guidelines, located on Mercy Care's website,

Laboratory Services Network and CLIA Waived In-Office Lab Codes Effective 10/1/11

Effective October 1, 2011, Mercy Care Plan will implement changes to its laboratory services network. Please note the following updates:

- Sonora Quest Laboratories, a subsidiary of Laboratory Sciences of Arizona, will be the only provider of laboratory services for all of our Acute, DDD, ALTCS, Mercy Healthcare Group (MHG) and Mercy Care Advantage (MCA) membership. If your practice location does not presently have a relationship with Sonora Quest Laboratories, please contact their Sales Support Department at (602) 685-5285. Sonora Quest Laboratories will work closely with your practice to assure a smooth transition takes place.
- ALL genetic testing requests must be authorized in advance. The prior authorization staff will direct you to the appropriate laboratory service provider for the test that you are requesting.
- Pregnant women
- Please DO NOT send any Mercy Care members to a hospital reference laboratory for services. All laboratory testing can be provided by Sonora Quest Laboratories.
- The following codes have been removed from the CLIA Waived list that was previously provided, as they have been determined to be non-CLIA Waived by AHCCCS:
    - 81000 – *Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy*
    - 85025 – *Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count*
    - 85027 - Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count
    - 85610 QW - *Prothrombin time*
    - 85007 – *Blood count; blood smear, microscopic examination with manual differential WBC count*
    - 87220 - *Tissue examination by KOH slide of samples from skin, hair, or nails for fungi, or ectoparasite ova or mites (e.g., scabies)*

    The above codes will no longer be allowed to be completed in-office. They must be referred to Sonora Quest Laboratories.
- Mercy Care Plan will follow AHCCCS' CLIA Waived In-Office Lab list. The following labs will be payable when performed in the physician's office:

continued on page 5>

CPT Code	CPT Description
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81025	Urine pregnancy test, by visual color comparison methods
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use

CPT Code	CPT Description
83026	Hemoglobin; by copper sulfate method, non-automated
83036 QW	Hemoglobin; glycosylated (A1C)
83037 QW	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
85013	Blood count; spun microhematocrit
85014 QW	Blood count; hematocrit (Hct)
85018 QW	Blood count; hemoglobin (Hgb)
85651	Sedimentation rate, erythrocyte; non-automated
86308 QW	Heterophile antibodies; screening
86580	Skin test; tuberlosis, intradermal
87210 QW	Smear, primary source with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)

CPT Code	CPT Description
87804 QW	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
87880 QW	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A

MCA Annual Wellness Visit

Mercy Care Advantage (HMO SNP) members get an Annual Wellness Visit for a $0 copay regardless of QMB or non-QMB status.

The annual wellness visit is a time for patients to talk to their primary care provider (PCP) about his/her health concerns and/or questions. It is also a good time for the PCP to verify that any recommended tests or screenings that are appropriate for the patient have been ordered or reviewed.

Remember you can check the status of your MCA patient's compliance with any of the HEDIS measures using Mercy-OneSource. "Yes" means that the member has measures that they are not compliant with; "No" means that the member has met the requirements.

Mercy Care Advantage (MCA) encourages our members to ask questions during the annual wellness visit! We recently mailed a reminder out to all MCA members reminding them to schedule their annual wellness visit and bring along the "Good Questions for Your Good Health." flyer from the Ask Me 3™ program.

Please remember to bill Mercy Care Advantage for this service JUST like you would bill Medicare, using the appropriate coding to reflect the services rendered.

An excellent resource is the Medicare Preventive Services document available at the CMS website:

continued on page 6>

http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

For additional information regarding MercyOneSource, please access the MercyOneSource Provider Web Navigation Guide under MercyOneSource Info on the Mercy Care Advantage website at:

http://www.mercycareplan.com/MercyOneSourceInfo.aspx

Medicare Compliance Documentation

As a reminder, it's very important to maintain medical records in compliance with Medicare. Mercy Care Advantage would like to share with you some key hints and tips. Important requirements include:

- Required to accurately document the disease burden of each enrollee.
- Documentation must be clear and complete to substantiate the coding and pass an audit by CMS.
- Ensures additional funding for chronic disease management and additional services for high risk populations:
    - Maximizes reimbursement to the health plan for resources already spent on the management of chronic illness.
    - Predicts the cost of managing the care of chronically ill enrollees for the next calendar year.

Documentation Guidelines

- Must be complete & legible
- Patient name must be on every page
- Date of service must be on every page
- Appropriate provider signature and credentials must be included
- Substantiation of documented condition and its Assessment, Evaluation, Monitoring and Treatment

Document every acute and chronic diagnosis specifically

- Diagnosis must include the word "chronic", if appropriate
- Do not use lab values to replace diagnosis
- Use words not symbols, i.e. *hypercholesterolemia* instead of ↑ chol; HTN
- Use only generally recognized abbreviations

Assessment

- Use "words" not "symbols" for a diagnosis. Symbols are ok for substantiating documentation, but not for a diagnosis.
- Clearly establish "Cause & Effect" (secondary to, with, complications of)

Plan

Treatment

Status Codes (historical or "walking around")

Clearly document "Status Post" Codes *(Gastrostomy, Cystostomy ,Ileostomy, Colostomy, Tracheostomy, Amputation, Dialysis, Transplant, Mechanical Ventilator Dependence, etc)*

Key Words

- Acute
- Due to
- Chronic
- Status post
- In remission
- Manifestation of
- Complications of
- Dominant or Non Dominant
- Chronic with acute exacerbation

Examples of Key Words to Document

- Acute pancreatitis
- Alcohol Dependency, in remission
- Chronic DVT
- Chronic Bronchitis
- Chronic Hepatitis C
- Chronic Kidney Disease due to uncontrolled DM Type II
- Chronic foot ulcer related to DM Type II
- Late Effect CVA, Hemiplegia, dominant side
- Major Depression, recurrent

EXAMPLES:

Diabetes with Complications *(Renal,* Circulatory, Neurologic, Opthalmic, other)

Establish cause and effect relationship:

Diabetic Nephropathy

PVD secondary to DM

Type II DM with diabetic neuropathy

Hypercholesterolemia

o *Assessment: cholesterol 226*

o *Plan: continue statins, dietary counseling*

o *Treatment: Crestor*

CHF

o *Assessment: increased pedal edema, crackles to bilateral bases*

o *Plan: increase diuretic, check CXR & BNP*

o *Treatment: Lasix, Coreg*

CKD, Stage2

o *Assessment: Cr 1.6*

o *Plan: check renal panel*

o *Treatment: continue to monitor renal function*

No Show Appointments

Mercy Care has recently been receiving a lot of inquires into the recent legislation that was passed under S.B. 1357, allowing a physician or primary care provider (PCP) to charge a $25.00 fee if a member misses an appointment and does not cancel the appointment in advance. **Mercy Care would like to reiterate that this legislation is currently not in effect.**

This piece of legislation has built into it language that indicates it is dependent on CMS approval. CMS has not approved this as of yet, so it is not in effect. Until we receive direction from AHCCCS that this has been approved by CMS, a provider cannot charge a $25.00 fee for a no show appointment. Failure to render services due to non-payment of the fee is currently a violation of the provider's contract, as well as the AZ Administrative Code.

As soon additional clarification is received from AHCCCS, it will be passed along to our provider community.

Obstetrical Billing

A recent Provider Notification was posted to our websites regarding Obstetrical Billing that will be effective with dates of service October 1, 2011. Highlights of the provider notification include:

Referrals

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

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

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

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

- Coordinate the member's maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.
- When necessary, refer members to other practitioners in accordance with the MCP referral policies and procedures.

- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology standards:
  - Through twenty-eight weeks of gestation – once every four weeks
  - Between twenty-nine and thirty six weeks gestation every two weeks
  - After the thirty-sixth week – once a week
  - Schedule first-time appointments within the required time frames
    - Members in first trimester – within seven calendar days
    - Members in third trimester – within three calendar days
    - High-risk Members – within three calendar days of identification or immediately when an emergency condition exists.

Prior Period Coverage (PPC)

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

Payment of TOB Package

Effective with dates of service on or after October 1, 2011, Mercy Care will reimburse Obstetrics services on a fee for services basis. Billing should be in accordance with Current Procedural Terminology (CPT®) rules.

Multiple Births

The initial delivery of the first baby will be payable at the appropriate fee for service rate and should be billed with the appropriate CPT delivery code that applies. Subsequent delivery of each additional baby should be billed with appropriate **delivery only** code with a 51 modifier appended to each.

continued on page 8>

Obstetrical Billing (continued from page 7)

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

Broken TOB Package

There may be times when a transfer of care may occur from one provider to another during the course of a pregnancy. If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to a referral to another physician for delivery, this would be considered a broken TOB package.

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

Authorization is required for the TOB package. If there is a broken TOB package, it is incumbent upon the provider to notify Prior Authorization to end date the first provider's care and add an authorization for the second provider's care so that the appropriate broken TOB package can be tracked.

Please refer to Mercy Care's websites for additional prior authorization guidelines for each plan. Since services are paid at a fee for service rate, prior authorization guidelines will apply to all services that require prior authorization.

Maternal/Fetal – High Risk Pregnancy

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

Please refer to the Provider Notification titled **Obstetrical Billing** for additional detail, including several coding scenarios and appropriate billing examples. It is available at the following locations:

www.MercyCare.com

www.MercyCareAdvantage.com

www.MercyHealthcare**Group.com**

Prior Authorization Updates

Mercy Care has recently updated our Prior Authorization lists for each plan. The most recent lists are posted and available for your review at:

www.MercyCarePlan.com

www.MercyCareAdvantage.com

www.MercyHealthcareGroup.com

A recent Provider Notification has been posted that provides you with a summary of the changes made to the prior authorization lists. Please refer to the Provider Notifications section on the websites for the Provider Notification titled, **Prior Authorization Updates**.

Please note that prior authorizations will only be issued for services performed by a contracted provider. If you are unsure whether a provider is contracted or not, please contact Member Services at 602-623-3000, 1-800-624-3879 or search for contracted providers on our websites at the above listed website addresses.

Proper Coding – Use of the 59 Modifier

Mercy Care promotes correct claims coding including the appropriate use of modifiers. To support this effort and our goal of physician education, outlined below are summary guidelines to assist you with the appropriate usage of Modifier 59.

Modifier 59 – Distinct Procedural Service

The American Medical Association's 2011 CPT Manual includes the following description for the use of this modifier: "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

Appropriate Modifier 59 Use

- Use modifier 59 when billing a combination of codes that would either not normally be billed together (i.e. mutually exclusive procedures) or would ordinarily be bundled together, but there are extenuating circumstances that should allow payment for both codes.
- Circumstances in which it would be

appropriate to allow both codes separately include:

- Different session or patient encounter
  - Example: Patient is seen in the emergency department for an open wound of an extremity requiring simple closure (12002). The patient returns to the emergency department in the afternoon with a closed radial fracture (25600). According to the National Correct Coding Initiative (NCCI), a simple wound closure is a component of a closed radial fracture, however, because the services were not performed at the same session or the same site, it would be appropriate for the physician to append modifier 59 to the simple closure code.
- Different procedure or surgery
  - Example: Patient is seen for the performance of a cystourethroscopy (52000). During the course of the exam the physician notices some debris in the bladder which cannot be irrigated through the cystoscope. After the cystoscope is withdrawn, the physician irrigates the bladder by hand through a catheter (51700). According to the NCCI, irrigation is a component of a cystoscopy, however, because the irrigation was not done as a component of the cystoscopy, but rather as a separate service, it would be appropriate for the provider to append modifier 59 to the irrigation code.
- Different site or organ system
  - Example: A skin graft and an allograft in different locations.
- Separate incision/excision
  - Example: A ventral and umbilical hernia repair through two different incisions.
- Separate lesion
  - Example: A biopsy of the skin of the neck is performed at the same session as an excision of a benign lesion of the face.
- Separate injury
  - Example: A fracture of the left femoral condyle and a fracture of the left greater trocanter of the femur.

Inappropriate Modifier Use

- Appending this modifier to Evaluation and Management codes.
- Using modifier 59 as a replacement for modifier 24 (Unrelated E/M during postoperative period by the same physician), 25 (Separate and distinct E/M service on same day as procedure), 78 (Return to operating room) or 79 (Unrelated procedure during postoperative period by same physician).
- Using modifier 59 in place of modifier 51 (Multiple procedures).
- Using modifier 59 when 2 procedures performed at the same time, through the same incision, as part of one global procedure (i.e. an arthroscopic knee chondroplasty in the same compartment as an arthroscopic knee meniscectomy).

Modifier Reimbursement

- Codes appended with modifier 59 are subject to multiple procedure guidelines as appropriate.

For further information on the appropriate use of modifiers, please refer to:

Centers for Medicare & Medicaid Services

http://www.cms.hhs.gov/mcd/

American Medical Association

http://search.ama-assn.org/

Provider Fairs

Mercy Care Provider Relations has been conducting Provider Fairs during the past quarter, concentrating on Mercy Care 101 – Back to Basics. The fairs have been very successful to date.

If you did not get the opportunity to participate in the most recent fairs, rest assured we will be conducting more in the future. We strongly encourage your participation in our Provider Fairs, as they will help you to get the answers you need regarding Mercy Care processes or specific questions pertinent to your practice. The fairs are fun, informative and give the opportunity for key personnel to meet with you!

Website Updates

Our website has recently improved as follows:

- The search function is now working. Key words can be typed in the upper right hand corner of our website. When you click on the Go button, it will bring up the document(s) that apply.
- Please note that we now have scrolling news to keep you up to date with the most recent information placed on our website.

Mercy Care is Proud to Introduce…

Lorry Bottril

Chief Operating Officer

Mercy Care Plan

Prior to her current position, Ms. Bottrill was the chief financial officer of Mercy Care Plan, overseeing financial planning and financial management for the plan. Before joining Mercy Care Plan, Ms. Bottrill was regional finance officer for Health Net of Arizona, serving as lead financial officer responsible for financial management for the Arizona health plan and heading the finance team for the national senior products division. In addition, she has worked in senior management positions for both Ovations

Ms. Bottrill has also served as vice president of operations at PacifiCare and Uniprise, specialty lines of business of UnitedHealth Group with responsibilities for claims, customer service, billing and enrollment services for the Arizona, Nevada and Colorado markets with HMO, PPO, ASO and Medicare product lines. She started with PacifiCare in 1994 as a financial analyst, advancing to manager of finance, manager of accounting, director of finance operations, director of network management and director of strategic development.

Before her tenure with PacifiCare, Ms. Bottrill was a senior auditor for Deloitte and Touche. Ms. Bottrill is a certified public accountant with more than 15 years of experience in the health care industry.

She is a graduate of the University of Arizona, majoring in accounting and finance. She has completed more than 40 hours of continuing professional education per year in accounting, audit, tax, software systems and management skills.

MERCY CARE PLAN
MERCY CARE ADVANTAGE
MERCY HEALTHCARE GROUP

Address:

4350 E. Cotton Center Boulevard,

Building D

Phoenix, AZ 85040

Phone Numbers:

(602) 263-3000 or

(800) 624-3879

Web Site Addresses:

www.MercyCarePlan.com

www.MercyCareAdvantage.com

www.MercyHealthcareGroup.com

Our Mission

Southwest Catholic Health Network Corporation (SCHN) d/b/a Mercy Care Plan is a not-for-profit corporation founded by Carondelet Health Network and St. Joseph's Hospital & Medical Center, a Catholic Healthcare West facility. SCHN is **committed** to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, especially of the poor and for persons with special needs.

Our Vision

SCHN will lead the transformation of the care delivery model by:

- Enhancing care coordination and collaboration across the continuum (Sponsors, SCHN, provider network).
- Enhancing health literacy and patients' accountability in their health.
- Seeking a long-term partnership with our provider network by offering effective and personalized services.
- Impacting the care and outcome of high risk/complex patients.
- Applying learning and capabilities to other patient populations to improve community health outcomes.

Our Values

Passion: SCHN will pursue its mission with enthusiasm, optimism and diligence.

Stewardship: SCHN will act prudently, focusing on the interests of those we serve.

Teamwork: SCHN will collaborate with others to create exceptional results.

Advocacy: SCHN will work on behalf of the underserved to improve health outcomes.