Children's Mercy Pediatric Care Network

www.cmpcn.org

PROVIDER ADMINISTRATION MANUAL (PAM)

CHILDREN'S MERCY PEDIATRIC CARE NETWORK
2400 Pershing Road, Suite 125, P.O. Box 411596
Kansas City, MO 64141
Phone: (888) 670-7261
www.cmpcn.org

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IMPORTANT CONTACT NUMBERS

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2400 Pershing Road, Suite 125
P.O. Box 411596
Kansas City, MO 64141
Phone: (888) 670-7261
www.cmpcn.org

CLINICAL SERVICES DEPARTMENT

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CMPCN Prior Authorization Fax ....(888) 670-7260

CMPCN Prior Authorization Phone ....(877) 347-9367

Children's Mercy Nurse Advice Line ....(888) 670-7264

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USING THE
CMPCN PROVIDER ADMINISTRATION MANUAL

The first part of the PAM contains information about the CMPCN:

- Introduction to the Children's Mercy Pediatric Care Network
- What to Look for on the Member ID Card
- CMPCN Service Area Map
- Physician/Provider Process and Procedures
- Member Access to Health Care and Services

Following the CMPCN-specific information, there are several tabbed ***Health Plan*** sections.

Each section contains specific information about a health plan contracted with CMPCN for medical management services.

CMPCN will send your office updated health plan information as we contract with additional plans. Please add new health plan information to this manual when you receive it from CMPCN.

CMPCN will also notify you when we update this PAM. Also, the current PAM is available on the CMPCN website, www.cmpcn.org.

We hope this document will be a helpful resource for your office.

Kathy Ripley-Hake
Director, Provider Relations
Children's Mercy Pediatric Care Network
krhake@cmpcn.org
816-559-9379

PEDIATRIC CARE NETWORK INTRODUCTION

WHO WE ARE

Children's Mercy Pediatric Care Network (CMPCN) is an integrated pediatric network that coordinates the medical care of pediatric patients enrolled in various managed care organizations (MCOs). CMPCN is comprised of Children's Mercy Hospital and its employed physicians, community pediatricians and other health care providers in the Kansas City area. CMPCN contracts with MCOs to provide all medical services for one global fee. These MCOs delegate certain administrative functions to CMPCN including medical management, provider credentialing, and disease management programs.

CMPCN uses a team-based approach to reduce barriers, export resources and expertise from Children's Mercy, and support patient-centered medical homes for the providers in our network. Ultimately we are focused on better alignment of the payment model and the care delivery model so that the focus can truly be on the right care, at the right time, in the right setting.

The CMPCN's service and enrollment area encompasses 13 counties in Missouri and Kansas. The Service area includes Jackson County in Missouri and Johnson and Wyandotte Counties in Kansas, and the 10 contiguous counties in the Kansas City metropolitan area. See page 3 for a map of the CMPCN enrollment area.

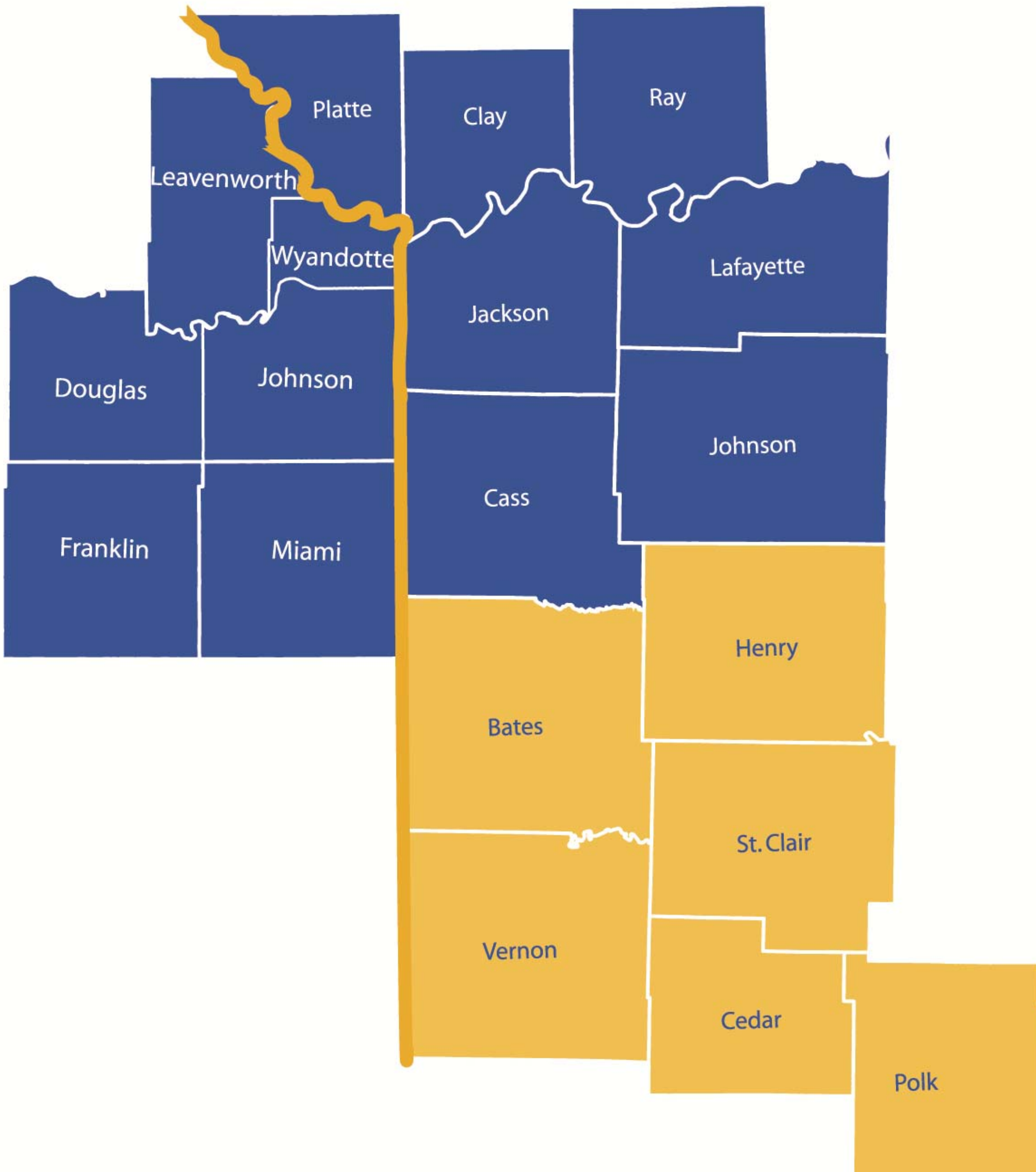
CMPCN provides delegated medical management services to members through its contracts with MCOs. CMPCN members can be identified by the CMPCN logo which will be indicated on the patient's identification card. Members are eligible to be a CMPCN member if they are covered by Kansas or Missouri Medicaid and are enrolled with one of the MCOs with whom CMPCN has a contract, and are assigned to a Primary Care Provider (PCP) with an office located within the CMPCN enrollment area.

The CMPCN is responsible for the care of enrolled children in Kansas that are twenty-one years or younger and in Missouri who are twenty years or younger if they are assigned to a PCP in the CMPCN service area.

WHAT TO LOOK FOR ON THE ID CARD

The following logo will appear on the member ID card if their PCP is located in the Children's Mercy Pediatic Care Network service area. See example of member ID card in specific Health Plan sections.

CHILDREN'S MERCY PEDIATRIC CARE NETWORK SERVICE AREA*



Missouri: CMPCN members are defined as Western Missouri MO HealthNet members (under the age of 20) who have selected or are assigned to a Primary Care Provider located within one of the 13 counties in the CMPCN catchment area noted here.

** Counties in blue are the enrollment area for CMPCN as of June 1, 2012. Counties in gold are counties that will be added to the CMPCN enrollment area in the future.*

PHYSICIAN/PROVIDER PROCESS & PROCEDURES

ROLE OF THE PRIMARY CARE PROVIDER (PCP)

The Primary Care Provider (PCP) is an integral part of the Children's Mercy Pediatric Care Network. CMPCN considers the following provider types to be eligible as PCPs: Family Practice, General Practice, Internal Medicine, Pediatrics, Nurse Practitioners, Rural Health Clinics, and Federally Qualified Health Centers.

The following is an overview of the responsibilities that the PCP assumes in the management of a member's health care needs:

- At each appointment, verify member eligibility before rendering services
- Verify you are the PCP of record on the member ID card; if not, have member complete the CMPCN PCP change request form and fax to CMPCN to have member assigned to your panel
- Provide, coordinate and/or direct all health care needs of members
- Work with CMPCN Case Managers in developing plans of care for members receiving case management services
- Perform, track, report and conduct all appropriate HCY/EPSDT exams for Health Plan members
- Direct members only for specialty services not performed within the scope of PCP practice
- Promote access to quality care by utilizing participating CMPCN specialists, hospitals and ancillary providers
- Contact CMPCN for those services identified as requiring prior authorization, prior to the services being performed.
- Administer the established policies and procedures of the Utilization Management Plan and other policies and procedures set forth in the Provider Administration Manual
- Responsible for providing and/or coordinating twenty-four (24) hour accessibility for members which includes but is not limited to the coordination of coverage with other participating providers
- Conducting periodic behavioral health screens to determine if the member needs behavioral health services

MEMBER TERMINATION PROCESS

A PCP may request the removal of a member from his/her panel when supporting documentation is provided to CMPCN addressing one of the issues listed below. The documentation must include PCP's attempts of intervention/education that have been provided to member to correct the behavior.

- Repeated failure to follow a recommended health care treatment plan. A request to dis-enroll a patient can occur after one verbal and one written warning of the implication and possible effect of non-compliance with treatment plan
- Chronic missed appointments for new or follow-up visits
- Behavior that is consistently disruptive, unruly, abusive or uncooperative
- Evidence of falsifying or providing misleading medical history

A PCP must provide written notice to member of identified issue(s) and plans to terminate relationship if identified behaviors continue. PCP will send a copy of letter to the practice's assigned CMPCN Case Manager. The CMPCN Case Manager will outreach to the identified member to assess situation and identify barriers that may be contributing to the behavior causing the removal request. The CMPCN Case Manager and CMPCN Medical Director will contact PCP to discuss findings and work collaboratively on a member action plan to correct behavior if appropriate. The plan will include specific goals, timeframes, expectations and consequences. The PCP and CMPCN Case Manager will discuss action plan with the member and provide a copy of the plan to the member.

If member does not follow corrective action plan or PCP and CMPCN agree member should be moved immediately, the following steps will be taken:

- PCP will notify the member in writing by certified mail advising the reason for termination and to choose another PCP within 30 days.
- PCP must manage the care of member with CMPCN assistance if needed for urgent and emergent services during this time period.
- CMPCN Case Manager will work with the member and health plan to facilitate the selection/transition to a new PCP.

ROLE OF THE SPECIALIST

The following is an overview of the responsibilities that the specialty provider assumes when providing care to a CMPCN member:

- Verify member eligibility before rendering services. The Specialist provider may direct the member to receive diagnostic, home care, inpatient, outpatient, or additional consultations services but must follow CMPCN's prior authorization guidelines if applicable.
- The Specialist is to communicate to the PCP in writing to ensure continuity of care and to advise him/her of any need for on-going treatment. Mail or fax all summaries, evaluations or recommendations within two (2) weeks from the visit and/or date of service.
- For Specialists who provide Well Woman screenings, if the screening identifies the need for additional medical visits/treatments this must be coordinated with the member's PCP.
- If PCP contacts a specialist telephonically for a non-hospitalized patient, the specialist should respond within one (1) business day.

Specialist Responsibilities

- The specialist must maintain timely communication with the PCP.
- The ordering provider is responsible for obtaining any needed prior authorization.

CREDENTIALING/RECREDENTIALING

CMPCN follows the National Committee of Quality Assurance (NCQA) standards to credential and re-credential providers. This process ensures that providers who serve CMPCN members have appropriate training and qualifications to provide high quality care. All providers who apply to join the network must provide the following documents:

Primary Care Providers and Specialists

- The Council for Affordable Quality HealthCare (CAQH) standard application or the State approved application
- Curriculum vitae
- Copy of current State Medical License
- Copy of current DEA certification
- Copy of current BNDD certification (if applicable)
- Copy of current malpractice coverage certificate
- ECFMG Certification (if applicable)
- Copy of Board Certificate (if applicable)
- Copy of completed IRS W-9 form
- Signed CMPCN contracts

Ancillary or Hospital Providers

- CMPCN application
- Copy of current State License

- Copy of current malpractice coverage certificate
- Copy of completed IRS W-9 form
- Accreditation certificate when applicable
- Medicare/Medicaid certification
- CLIA certificate

Re-credentialing

CMPCN re-credentials all providers at least every three (3) years in accordance with NCQA standards. In addition to the re-verification of portions of the information obtained during the initial credentialing process, additional information is reviewed. CMPCN reviews the application specifically for any changes in malpractice history, work history and application responses. Member complaints/grievances, quality issues and utilization management practices are also reviewed as part of the process.

With the exception of information determined by CMPCN to be peer review protected, providers have the right to request in writing, and to subsequently review, any information obtained by CMPCN to support its evaluation of the provider credentialing/re-credentialing application. Providers also have the right to correct any erroneous information. The CMPCN Credentialing Manager is the primary contact to request a review of information relative to the credentialing/re-credentialing application or for the need to provide corrected information.

Providers may request information regarding the status of their credentialing/re-credentialing application by contacting the Provider Relations Department.

MEMBER ACCESS TO HEALTHCARE AND SERVICES

SCHEDULING APPOINTMENTS AND WAITING TIMES

The following CMPCN service standards must be maintained by all participating CMPCN providers.

CMPCN Providers agree to abide by the access and appointment standards set by CMPCN which may be altered from time to time at the discretion of CMPCN and its Medical Director. Providers upon request shall provide periodic reports to CMPCN to show adherence to access/appointment standards. CMPCN PCP practices must have 24-hour/7-day availability to CMPCN members.

APPOINTMENT STANDARDS – MO HEALTHNET

Waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments do not exceed one hour from the scheduled appointment time.

Non Maternity appointment standards:

- Urgent care appointments for illness/injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services) appointments within twenty-four (24) hours.
- Routine care, with symptoms: (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever): Appointments within one (1) week or five (5) business days whichever is earlier.
- Routine care, without symptoms: (e.g. well child exams, routine physical exams): Appointments within thirty (30) calendar days.

Maternity appointment standards:

- First trimester appointments must be available within seven (7) calendar days of first request.
- Second trimester appointments must be available within (7) calendar days of first request.
- Third trimester appointments must be available within three (3) calendar days of request.
- High risk pregnancies must be available within three (3) calendar days of identification of high risk or immediately if an emergency exists, require emergency obstetrical care.

TWENTY-FOUR HOUR ACCESS TO CARE

The CMPCN is required to ensure that access to care is provided twenty-four (24) hours a day, seven (7) days a week. It is important that every physician/provider understand the mutual responsibility which the CMPCN and the individual physician/provider has for providing emergency services, urgent care services and routine appointments/services.

CMPCN members should be instructed to contact the PCP's office for any follow up care after an Emergency Room visit (i.e. suture removal, dressing change, etc.).

The PCP is responsible for providing care or directing access to care twenty-four (24) hours a day, seven (7) days a week. This involvement ensures the overall quality and continuity of care for the member as well as supporting the efficient use of available resources.

Members should be educated to access care after normal office/business hours by contacting his/her PCP or the Children's Mercy Nurse Advice Line. Nurse Advice is a twenty-four (24) hour telephonic nurse line and this phone number is located on the member's ID card. It's available to all members to help answer questions regarding medical concerns based on physician approved protocols; contacting the PCP and/or covering physician; and/or assist the member in obtaining emergency services.

The Children's Mercy Nurse Advice Line phone number is (888) 670-7264.

ON CALL COVERAGE

Providers agree to ensure services are available twenty-four (24) hours a day, seven (7) days a week, which may require the use of back up on call coverage. The coordination and provision of on call coverage is the sole responsibility of the participating provider.

When you require on-call coverage from a provider outside of your practice, the following should be taken into consideration:

- Inform the covering provider that he/she may receive calls from CMPCN members.
- Provide your on-call covering provider a list of participating CMPCN providers.
- Provide him/her with the Nurse Advice Line number 1-888-670-7264 to assist in coordinating services after hours.
- Provide the CMPCN contact phone numbers to assist in coordination of services and/or to answer questions during normal business hours.

CMPCN does not recognize after hours tape recordings that do not contain appropriate physician/provider contact instructions or that state automatic referrals of members to emergency departments and/or urgent care centers as acceptable coverage arrangements.

COPY OR ACCESS TO MEMBER MEDICAL RECORDS

All member records must be made available to authorized representatives of the State of Missouri MO HealthNet Agency, Department of Health and Human Services within thirty (30) days of request.

Upon written request of a member, guardian or legally authorized representative of a member, the Provider shall furnish a copy of the medical records of the member's health plan history and treatment rendered within 30 days of the initial request. Members are entitled to one (1) copy of their medical record per year at no cost to the member. The fee for additional copies shall not exceed the actual code of the time and materials used to compile, copy, and furnish such records.

GENERAL BILLING REQUIREMENTS

Providers must bill for all services provided to members regardless of payment methodology, this includes all capitated services. Providers must submit claims on a UB04 Form or HIPAA complaint file format for electronic claims or Centers for Medicare and Medicaid Services ("CMS") 1500 forms with current CMS coding, current International Classification of Diseases, Ninth Revision (ICD-9) and Current Procedural Terminology Fourth Edition (CPT-4) or their successor forms/formats.

Claims may be submitted electronically through the appropriate clearinghouse specific to the Members Payer.

Payer	Clearinghouse	Payer ID
HealthCare USA	Gateway EDI	00550
HealthCare USA	Emdeon	25133

PAPER CLAIMS

HealthCare USA
P.O. Box 7629
London, KY 40742-7629

CLAIMS PAYMENT

For all covered services provided to CMPCN members, the CMPCN will ensure that payers agree to process and make applicable payment to Provider for all clean claims based on the defined State Statutory requirements. The CMPCN will require payers to abide by the State prompt payment requirements. The timely payment of a claim is based on the claim received date and not the date of service.

TIMELY FILING

CMPCN providers shall submit claims for all services (including capitated services) within thirty days of the date of service. CMPCN agrees that claims will not be denied for timely filing if they are submitted after thirty days but not more than one hundred eighty days from the date of service.

The following claims are exempt from the above timely filing requirements:

1. Claims that involve coordination of benefits should be submitted within 180 days of the payment date on the primary carrier EOB.
2. Claims where CMPCN Provider, after commercially reasonable diligence, are unable to identify the patient as a Member.

Appeals of timely filing denials should be sent to the CMPCN for review. You must provide documentation of timely filing as well as follow up within the 180 days to overturn a timely filing denial. If filing electronically, CMPCN providers should submit a copy of the secondary

payer report from the clearinghouse confirming that the claim was received by the payer timely. If filing paper, documentation from the practice management system showing the date the claim was originally filed with the payer as well as the follow up that was done during the 180 day time limit.

CMPCN providers have one year from the date of service to appeal a denied claim. CMPCN providers have one year from the initial explanation of benefits from the payer to submit a corrected claim for reconsideration.

COORDINATION OF BENEFITS

By law, Medicaid is the payer of last resort. CMPCN is only responsible for payment of covered services after all other sources of payment have been exhausted. The only exceptions to this policy are claims for:

- Services that are provided to a member on whose behalf child support enforcement is being carried out by the Missouri Department of Social Services, Division of Child Support Enforcement
- EPSDT

The CMPCN uses the Benefits-Less-Benefits (BLB) methodology when coordinating benefits with a primary carrier.

BLB means if the primary carrier has paid more than what CMPCN would have paid as the primary carrier, CMPCN will not pay any additional amounts. If CMPCN would have paid more than the primary carrier paid, CMPCN pays the difference between what we would have paid and what the primary carrier paid, up to the member's primary carrier responsibility.

Examples:

Scenario #1				
Total Billed Amount	**Primary Payment**	**Primary Carrier Member Responsibility**	**CMPCN Allowable**	**CMPCN Secondary Payment**
$125.00	**$56.00**	**$44.00**	**$50.00**	**$0.00**
Since the amount CMPCN allows is less than what the primary carrier paid, CMPCN will not pay any amount as the secondary carrier.				

Scenario #2				
Total Billed Amount	**Primary Payment**	**Primary Carrier Member Responsibility**	**CMPCN Allowable**	**CMPCN Secondary Payment**
$125.00	**$44.00**	**$56.00**	**$50.00**	**$0.00**
Since the amount CMPCN allows is greater than what the primary carrier paid, CMPCN will pay up to the CMPCN allowed amount less the primary carrier's payment but not in excess of the member's primary carrier responsibility.				

BALANCE BILLING

CMPCN providers are contractually prohibited from billing members for the balance of a covered service, disputed payment or a denied service. CMPCN members can only be billed for non-covered services and if they agreed in writing prior to rendering of services to be financially responsible for the non-covered service.

FRAUD AND ABUSE

Fraud definition as defined by MO HealthNet – Any type of intentional deception or misrepresentation made by an entity or person in a capitated managed care organization (MCO), primary care case management (PCCM) program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.

Abuse definition as defined by MO HealthNet – Practices in a capitated MCO, PCCM program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the MO HealthNet program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for healthcare. The abuse can be committed by an MCO, contractor, subcontractor, provider, State employee, MO HealthNet beneficiary, or MO HealthNet managed care enrollee, among others. It also included beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that results in unnecessary cost to the MCO HealthNet program or MCO, contractor, subcontractor, or provider. It should be noted that MO HealthNet funds paid to an MCO, and then passing to subcontractors, are still MO HealthNet funds from a fraud and abuse perspective.

Examples of Fraud –

- Letting someone else use their health plan insurance card
- Using multiple physicians to acquire abusive drugs
- Billing for services not provided
- Billing for more expensive services than actually provided

If you believe you have information relating to health care fraud, abuse or waste please contact Chad Moore, JD, MHA, CMCPN Director of Operations at 816-559-9374.

PCP Change Form

Facsimile Transmittal

To:	Supervisor, Customer Service	Fax:	(816) 265-6211 PCP CHANGE ONLY
From:		Date:	
Re:	PRIMARY CARE PROVIDER CHANGE		

☐ HealthCare USA

THE MEMBER LISTED BELOW HAS REQUESTED THEIR PCP BE CHANGED TO THE FOLLOWING PROVIDER EFFECTIVE TODAY:

Provider (New PCP Assignment): ____

Provider NPI Number: ____

Provider Phone Number: ____

Member Name	
Member ID Number	**Member DOB: / /**
Member/Parent/Guardian	
Member Address	
Telephone Number	
Member/Parent/Guardian Signature (REQUIRED)	**Today's Date: / /**

Office Staff Name (please print):____

Office Staff Signature: ____

PLEASE ALLOW UP TO FIVE (5) BUSINESS DAYS FOR PROCESSING PCP CHANGE REQUESTS

--Confidential Notice-

The information contained in this transmission is privileged and confidential. It is intended for the use of the individual(s) and /or entity(ies) named above only. If you are not the intended recipient, you are hereby notified that any unauthorized disclosure, copying distribution or taking of any action in reliance upon the contents of the telecopied materials is strictly prohibited. If you receive this transmission in error, please notify us immediately to arrange for the return of this material. Thank You.

Referral Form

Children's Mercy Pediatric Care Network www.cmpcn.org

Clinical Services phone: 1-888-670-7262
Prior Authorization phone: 1-877-347-9367

Referral Form for Case Management and Disease Management – Fax to: 1-888-670-7260

Member Name:

Member ID:

Gender: ☐ Male ☐ Female **DOB:**

Referral Source
Name: ____________ Office/clinic: ____________
Phone: ____________ Fax: ____________ Today's date: ____________

Referral Reason/ Dx:

Asthma	Case management	Diabetes	OB
☐ Missed appointments ☐ Needs asthma education reinforcement ☐ New diagnosis ☐ OB member with asthma ☐ Rx non-adherence ☐ OTHER (specify below)	☐ Autism ☐ Chronic medical condition (list: ____________) ☐ Complex medical needs ☐ Frequent use of ER services ☐ Lead Toxicity ☐ Med/Behavioral Health needs ☐ New diagnosis (specify below) ☐ Non-compliance with treatment plan ☐ Premature birth with complications ☐ Rx non-adherence ☐ Special Healthcare Needs ☐ Transplant ☐ OTHER (specify below)	☐ Pre-diabetes ☐ Type I new diagnosis ☐ Type I new to insulin ☐ Type I recent/multiple DKA episodes ☐ Type I uncontrolled ☐ Type II new diagnosis ☐ Type II new to insulin ☐ Type I or type II recurring hypoglycemia ☐ Type II uncontrolled ☐ OTHER (specify below)	☐ Chronic medical condition affecting pregnancy ☐ History of PIH, HELLP, or Fatty Liver of pregnancy ☐ History of preterm labor ☐ HIV ☐ Hyperemesis gravidarum ☐ Incompetent cervix ☐ Multiple birth pregnancy ☐ Placenta previa ☐ Substance abuse ☐ Under age 18 ☐ OTHER (specify below)

Referral Reason/ Dx Notes:	
PCP/ Specialists:	
Caregivers/ Family:	
Recent Clinical History including: • Hospitalizations • Medications • ER visits • BMI	

Prior Authorization Quick Guide

Children's Mercy
Pediatric Care Network
www.cmpcn.org

Children's Mercy Pediatric Care Network Prior Authorization Quick Guide

Prior Authorization Phone.... 1-877-347-9367

Prior Authorization Fax......... 1-888-670-7260

Clinical Services Phone........ 1-888-670-7262

Inpatient Admissions: Scheduled and non-emergent inpatient admissions require notification and clinical information at least 2 business days prior to the services being rendered. Emergent services require notification to CMPCN within 10 calendar days after admission. The participating providers are responsible for communication of clinical information to CMPCN.

Other Medical Services: The services listed below require prior authorization from CMPCN prior to the date of service. All services require phone or fax notification and clinical information at least 2 business days prior to the services being rendered.

NOTE: Failure to request and receive prior authorization from CMPCN may result in denial of claims. All claims are subject to verification of eligibility and benefits. Authorization does not guarantee payment.

Covered codes requiring prior authorization are listed at www.cmpcn.org. This list does NOT include non-covered codes. Some codes are not covered by Medicaid. If you have questions about a code not on the list, call the CMPCN Prior Authorization Line at 1-877-347-9367.

Service Category	Description/Notes	
Admissions	• Inpatient Admissions • Rehabilitation Facility Admissions	• Skilled Nursing Facility Admissions • Pre and Post Admissions for Transplant Patients
Dental/Medical	• Oral Surgery • TMJ related services	
DME/Devices/Supplies (vendors should do prior auth)	• Code specific - *see CMPCN website for covered codes that require authorization*	
Diagnostic Radiology/ Procedures	• Pet Scans	
Formula/Enteral Nutrition		
General Surgery, Plastic and Cosmetic Procedures	• All Potentially Cosmetic Services and Procedures (Examples: scar revision, varicose vein procedures, skin tags, etc.) • Breast Surgery (reduction, reconstruction or augmentation) • Obesity related procedures • Otoplasty	
Home Health/Infusion Services	• Enteral Nutrition Supplies and Pumps • Formula • Hospice Services • Private Duty Nursing	• PT, OT, ST • Respite care • Skilled Nursing Services (beyond the first visit)
OB Care	• Prenatal Care requires notification via the *Pregnancy Notification Form (PNF)* following the first OB Appointment.	
Out of Network/ Out of Area Services	• All out of network services: Inpatient, Outpatient, Physician Office, Home Care, etc.	
Outpatient Services	• Full or Partial Day Rehabilitation • Hyperbaric Oxygen Therapy • Neuropsychological Testing/ Developmental Delay Testing • Observation stays	• Pulmonary Rehabilitation • Rehab Services: PT, OT (beyond evaluation and 3 therapy sessions) • Speech Therapy (beyond evaluation)
Prosthetics and Orthotics	• Code specific - *see CMPCN website for covered codes that require authorization*	
Spinal Cord Stimulator		
Vagal Nerve Stimulator		

Prior Authorization Form

PRIOR AUTHORIZATION FORM

INSTRUCTIONS: Please call or fax the following information to Children's Mercy Pediatric Care Network. CMPCN will verify benefits, eligibility, and provider network status and make you aware of non-covered services. Within 48 hours or two business days CMPCN will call you with a determination. Authorization numbers issued for covered services should be included on claims submitted.

Payment is subject to eligibility status and benefits that are in effect at the time services are provided. CMPCN will not assume financial responsibility for services where prior notification does not occur according to CMPCN policies. You must notify CMPCN if additional services or an extension is required.

PLEASE CHECK ONE: ____Urgent ____Routine Prior Authorization #______________ (if applicable)

Date Form Completed	Member Name
Member ID # & DOB	Service Start Date/Requested Visits/Treatment Duration
Requesting Physician/Practitioner	Provider of Services
Diagnosis/Treatment	Admission Facility (if appropriate)

Please complete the information below and attach any necessary supporting clinical documentation needed for service consideration. Please include the specific service and number of visits, if applicable.
Please refer to your CMPCN Provider Quick Guide, or the CMPCN Website. (www.cmpcn.org)

Service or Item Requested:____

Length of need or # of visits/items:______________________________________

CPT/HCPCS **Code(s):**____

DME-**Include code** and description of item(s):____________________________

____

Request: NEW________________________ EXTENSION______________________

Physician's Order (Attach Copy):____

Medical Necessity Documentation (Attach Documentation):_____________________

Home Health – Copy of Order and Plan of Care:______________________________

Therapy – Copy of Evaluation and Plan of Care:______________________________

Contact Name (please print):____

Contact Telephone: ______________________ Fax: __________________________________

Toll Free Phone: 877-347-9367 **Toll Free Fax: 888-670-7260**

Prior Authorization Form:

Private Duty Services

Children's Mercy
Pediatric Care Network

Toll Free Phone: 877-347-9367 **Toll Free Fax: 888-670-7260**

PRIVATE DUTY SERVICES

PRIOR AUTHORIZATION FORM

Date Form Completed	**Member Name**
Member ID & DOB	**Service Start Date/Duration**
Requesting Provider	**Provider of Service**
Diagnosis	**# of Private Duty Nursing Hours Requested per Day or Week**
CPT Codes	**# of Personal Care Hours Requested per Day or Week**
Requestor's Name	**Requestor's Phone/Fax**

Instructions: Please complete this form at initiation of private duty services, every 90 days thereafter, and any time there are changes in participant's needs. Complete sections 1 & 2 if requesting authorization for private duty nursing. In addition, complete section 3 if requesting authorization for personal care assistant.

CMPCN will verify benefits, eligibility, and provider network status and make you aware of non-covered services. Within 48 hours or two business days CMPCN will call you with a determination. Authorization numbers issued for covered services should be included on claims submitted. Payment is subject to eligibility status and benefits that are in effect at the time services are provided. CMPCN will not assume financial responsibility for services where prior notification does not occur according to CMPCN policies. You must notify CMPCN if additional services or an extension is required.

Fax completed form with physician order and private duty assessment/progress notes to: 888-670-7260.

Section 1 – Technology/Nursing Needs: Select all technology and nursing needs that apply:

Technology Needs	**Frequency**	**Check if indicated**
Ventilator	Continuous	
Ventilator	Intermittent	
Tracheostomy (without vent)	n/a	
CPAP/BIPAP (without trach)	All	
Oxygen	At least 8hr/day	
Oxygen (unstable sats)	At least 8hr/day	
J/G Tube	Continuous	
J/G Tube (with reflux)	Continuous	
NG Tube	Continuous	
NG Tube	Bolus	
IV Therapy	Continuous	
Nursing Needs	**Frequency**	
Tracheal suctioning	Q1-2hrs	
	Q3-4hrs	
	< Q4hrs	
Enteral Feedings	Continuous	
	Q2hrs	
	Q3hrs	
	Q4hrs	
Severe Seizure Activity Requiring Intermittent Intervention Daily	At least once daily	

Nursing Needs (con't)	**Frequency**	**Check if Indicated**
Daily Baseline IV Medications (do not include those given for acute illness)	6 or more	
	4-5	
	3 or less	
Intermittent Urinary Catheterization	Q4hrs	
	Q8hrs	
	Q12hrs	
	Q Day or PRN	
Sterile Dressing Changes	Q8hrs or less	
	< Q8hrs	
IV/Hyperalimentation	Continuous	
	8-16 hrs	
	4-7 hrs	
	< 4hrs	
Special Treatments (total per day including routine nebulizers, chest PT, etc.)	4x/day	
	3x/day	
	2x/day	
Special I/O Montoring (adjustments in IVF are based on I/O data)	4x/day	
	3x/day	
	2x/day	
Other (list):		

Children's Mercy
Pediatric Care Network

Toll Free Phone: 877-347-9367 **Toll Free Fax: 888-670-7260**

PRIVATE DUTY SERVICES

PRIOR AUTHORIZATION FORM

Member Name	Member ID & DOB

Section 2 - Psychosocial Needs: Please describe any psychosocial issues this member/family has related to the need for private duty services such as support system, family constellation, safety, shelter, unmet ADL's.

Psychosocial Needs

Section 3 - Personal Care Assistant: If ADL's are not met, and authorization is requested for personal care assistant, indicate level of care for each of the following needs:

Non-skilled Need	Level of Care	Check if Indicated
Ambulation, transfers, bed mobility	Needs Assistance	
	Total Care	
Incontinence Care (n/a for children <3yrs	Needs Assistance	
	Total Care	
Oral feeding assistance (n/a for children <3yrs)	Needs Assistance	
	Total Care	
Personal Care	Needs Assistance	
	Total Care	
Range of Motion	Needs Assistance	
	Total Care	
I/O Monitoring (routine)	Needs Assistance	
	Total Care	

For internal use only

Total points assigned: ________________ **Case Manager** ____ **Date** ______________

Prior Authorization Form:

Therapy

THERAPY PRIOR AUTHORIZATION FORM

INSTRUCTIONS: Please fax the following information to Children's Mercy Pediatric Care Network **888-670-7260**. CMPCN will verify benefits, eligibility, and provider network status and make you aware of non-covered services.

Within 48 hours or two business days CMPCN will call you with a determination or inquiry for additional information. Authorization numbers issued for covered services should be included on claims submitted.

Payment is subject to eligibility status and benefits that are in effect at the time services are provided. CMPCN will not assume financial responsibility for services where prior notification does not occur according to CMPCN policies. You must notify CMPCN if additional services or an extension is required.

PLEASE CHECK ONE: _______Initial request _____Extension of service*

***Prior Authorization #___________________ (if request is for an extension of services)**

Date Form Completed	Member NAME
Requesting Provider's Name	Member ID# and DOB
Provider of Therapy Service	Service Start Date / Diagnosis

THERAPY REQUESTED:

TYPE	FREQ / Week	Estimated Duration	Length of visit/day
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Date of initial evaluation:			

DOES THE MEMBER HAVE AN IEP or IFSP?

_______YES**________NO **IF YES PROVIDE A COPY WITH THIS REQUEST

Location of service	Home	Office	Outpatient hospital	Rehab center	

EVALUATION:

Functional Impairment; Including Percent if Developmental Delay:

- Limitations: ________MILD _________MODERATE _________SEVERE

____

***Include copies of; initial evaluation, Plan of Care, IEP/IFSP (if applicable) and progress notes if extension is requested.**

YOUR CONTACT NAME____________________YOUR CONTACTPHONE__________________

Children's Mercy Pediatric Care Network phone 877-347-9367 fax 888-670-7260

Case Management

Quick Guide

Children's Mercy
Pediatric Care Network
www.cmpcn.org

Clinical Services Phone........ 1-888-670-7262

Prior Authorization Phone 1-877-347-9367

Prior Authorization Fax......... 1-888-670-7260

If you have or are aware of pediatric patients with any of the following diagnoses or needs, please refer them to Case Management by calling CMPCN Clinical Services at 1-888-670-7262.

- AIDS/HIV
- Abuse and/or Neglect/Domestic Violence
- Anxiety
- Autism
- Behavioral health/Substance abuse
- Burns with greater than 3-day hospital stay
- Cancer
- Cardiovascular diseases
- Cerebral Palsy
- Chronic pain
- Children with Special Health Care Needs
- Conditions requiring long-term IV antibiotics or TPN
- Conditions requiring long-term rehabilitative services
- Congenital Abnormality
- Cystic Fibrosis
- Degenerative Neuromuscular Diseases (Multiple Sclerosis, ALS, Guillan Barre')
- Diabetes (newly diagnosed or uncontrolled)
- Failure to thrive
- Frequent ER visits for non-emergent care
- Hepatitis C
- Home Health services greater than 7 visits
- Homelessness
- Hospice services
- Immunological Disorders
- Inpatient hospital > 21 days
- Lead Poisoning Levels 10 and above
- Pervasive Developmental Disorder
- Pregnancy, High Risk/Maternal Complications
- Premature births with complications
- Rehabilitation Services - Inpatient
- Renal failure
- Sickle Cell Disease
- Transplants
- Wound Care Center Services
- Other Chronic or Disabling Diseases/Conditions

Children's Mercy Pediatric Care Network Case Management Quick Guide

Children's Mercy Pediatric Care Network adopts the Case Management Society of America's definition:

> *Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes.*

CMPCN provides Case Managers who utilize their experience and working knowledge of the health care delivery system to assist providers and patients in accessing appropriate services.

Case Management Services Primary Functions

- Identification of patients who have or are at risk of developing complex medical and/or behavioral needs
- Utilize evidence-based clinical practice guidelines to develop individualized care plans
- Establish prioritized goals in collaboration with patients and their provider(s)
- Assist patients with implementation of a self-management plan
- Serve as an advocate and educator for the patient and the family, facilitating access to care through the health care delivery system and community resources
- Assist patients in achieving an optimal level of wellness and function by facilitating timely and appropriate health care services
- Reduce inappropriate inpatient hospitalizations and utilization of emergency room services
- Promote clinical care that is consistent with scientific evidence and patient preferences
- Ensure the integration of medical and behavioral health services
- Educate the patient in self-advocacy and self-management
- Achieve cost efficiency in the provision of health services while maximizing health care quality
- Mobilize community resources to meet the needs of patients

Levels of Case Management

CMPCN's Case Management is stratified into three levels:

- Complex Case Management
- Case Management
- Care Coordination

What Patients Can Expect

CMPCN has a unique, high-touch case management program with the ability to provide face-to-face case management using Registered Nurses for high-risk patients with complex needs.

What Providers Can Expect

- Communication from a Case Manager when a case is opened
- Assistance in establishing patient-specific treatment goals
- Assistance in reinforcing the Plan of Care
- Case Managers accompanying patients to appointments, when requested
- Notification when case is closed

www.cmpcn.org Website Guide Sheet

24/7 Nurse Advice

Patient Education Handouts and Provider Tools
www.cmpcn.org/resources

Home | Contact | Site Map | Nurse Advice Line: 1-888-670-7264

Google Custom Search

integrated health care for Kansas City kids

Home | About Us | Clinical Services | Resources | News | Presentations | Contact Us

Health Headlines

- CDC Flu Shot Information for Health Professionals
- Vaccine Resources from Children's Mercy Hospitals and Clinics
- Provider Resources for Vaccine Conversations with Parents
- Children's Mercy Continuing Medical Education and Conferences

Provider Resources and Tools

- Provider Administration Manual (PAM)
- Case Management Quick Guide
- Prior Auth Quick Guide and Prior Auth Form
- Private Duty Services Prior Auth Form
- PCP Change Form
- Referral Form
- Asthma and Diabetes resources
- Children's Mercy Child Health Library
- Children's Mercy Health Sciences Library
- Children's Mercy Provider Portal
- Community Social Service Organizations

See all resources and tools ...

Who We Are and What We Do

Children's Mercy Pediatric Care Network (CMPCN) is an integrated pediatric network that coordinates the medical care of pediatric patients.

CMPCN is comprised of Children's Mercy Hospitals and Clinics, community pediatricians, and other health care providers in the Kansas City area.

CMPCN uses a team-based approach so that the focus can truly be on the right care, at the right time, in the right setting.

Learn more ... CMPCN Service Area

Main Phone: 816-559-9372 or 888-670-7261

Prior Auth Phone: 816-559-9389 or 877-347-9367

Clinical Services: 816-559-9390 or 888-670-7262

Prior Auth Fax: 816-842-0843 or 888-726-5890

P.O. Box 411596, Kansas City, MO 64141

CMPCN Home Page
Provider Tools/Resources
Case Management
OB Case Management
Utilization Management
Asthma Management
Diabetes Management

About Us
CMPCN Service Area
CMPCN Leadership
Contact CMPCN
Announcements
Site Map
Website Terms of Use

Health Headlines

Child Health Library

Community Resources
www.cmpcn.org/community

PEDIATRIC CARE NETWORK
MEDICAL MANAGEMENT PROGRAMS

UTILIZATION MANAGEMENT

NOTE: Failure to request and receive a prior authorization from Children's Mercy Pediatric Care Network (CMPCN) may result in denial of payment. This also applies to Pregnancy Notification Forms (PNF). All claims are subject to verification of eligibility and benefits. Authorization does not guarantee payment. See the Prior Authorization Guide.

Inpatient Admissions: Scheduled and non-emergent inpatient admissions require notification and clinical information at least two (2) business days prior to the services being rendered. Emergent services require notification to the CMPCN within ten (10) business days after admission. The participating providers are responsible for communication of clinical information to the CMPCN. Newborns remaining in the hospital after the mother is discharged require an authorization for continued inpatient services.

Medical Review Process: Medical review is conducted to confirm the medical necessity of treatments or services rendered, as well as the appropriateness of the care setting. Medical review requires evaluation of specific clinical information that is obtained from onsite reviewers, over the telephone, or from written communication. CMPCN Resource Nurses compile all pertinent clinical information gathered from the treating practitioners/staff, review the information using medical necessity decision criteria and consider individual patient needs, as well as the local healthcare delivery system. Once the review is complete, the Resource Nurse confirms medical necessity, the appropriateness of the care setting, and authorizes the requested service. When the Resource Nurse is not able to confirm the medical necessity and appropriateness of care setting, the case is referred to a Board Certified physician for review. Any denial decisions are done by a Board Certified physician.

Providers and members have the right to a copy of the criteria used in making decisions about requests. If you would like a copy of the criteria, please contact the CMPCN Prior Authorization Department at 1-877-347-9367 or fax your request to 1-888-670-7260. The CMPCN will mail or fax you a written copy of the criteria within three (3) business days of your request.

Contacting UM: Medical review staff members are available for questions related to prior authorization and coverage: Monday – Friday; 8:00am – 5:00pm. They can be reached by toll free phone at 1-877-347-9367 or toll free fax at 1-888-670-7260. The same toll free phone number and toll free fax number are available 24/7 for communication of utilization management issues. Information left after normal business hours should include: caller's name, caller's contact number, member name, and member ID number. The request will be responded to the next business day.

Statement on Incentives: The Children's Mercy Pediatric Care Network makes all review decisions based only on the appropriateness of care and service, the existence of coverage for the member, and his or her unique health needs. The CMPCN never rewards or provides financial incentives to its employees, practitioners, providers, or any other individual to deny services or to make decisions that result in underutilization.

If you would like to discuss a decision with a CMPCN Medical Director, you may call the Prior Authorization Department at 1-877-347-9367 and ask to speak with the Medical Director.

CASE MANAGEMENT PROGRAM

The CMPCN offers case management (CM) to eligible members. CM is a system that focuses on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring and coordinating services and resources needed by members and families with complex issues; ensuring and facilitating the achievement of quality, clinical and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative quality or cost impact and creating opportunities and systems to enhance outcomes.

The goal of CM is to help members regain optimum health or improved functional capacity, in the right setting and in a cost effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with goals, monitoring and follow-up.

The objectives of the case management program are to:

- Assist the member in achieving an optimal level of wellness and function by facilitating timely and appropriate health care services
- Reduce inappropriate inpatient hospitalizations and utilization of emergency room services
- Promote clinical care that is consistent with scientific evidence and member preferences
- Ensure the integration of medical and behavioral health services
- Educate the member in self-advocacy and self-management
- Achieve cost efficiency in the provision of health services while maximizing health care quality
- Mobilize community resources to meet needs of members

Circumstances that warrant referral to the case management team include but are not limited to:

- Presence of progressive, chronic, or life-threatening illness
- Need for inpatient or outpatient rehabilitation
- Terminal illness
- High risk pregnancies
- Acute/traumatic injury, or an acute exacerbation of a chronic illness
- Complex social factors
- Children with Special Health Care Needs
- Multiple hospitalizations or emergency room visits

To refer a patient for CMPCN's case management services, call Clinical Services at 1-888-670-7262.

OB CASE MANAGEMENT PROGRAM

In addition to our general case management program, we have a focused OB management program for high risk pregnancies. The following applies to our OB program:

- The attending provider must submit a Pregnancy Notification Form (PNF) for all CMPCN members once pregnancy has been confirmed. This PNF is utilized for claim payment of OB services as well as screening by CMPCN Case Managers to determine a member's risk factors for the current or previous pregnancies.
- Once the OB services have been authorized, all OB office visits and services, including OB ultrasounds and non-stress tests (NST) do not require an authorization when performed by a participating provider.
- Any additional services require additional authorization by the CMPCN Case Manager. The Case Manager may attend clinic visits and is the provider's primary contact for any OB related issues, such as home visits, education, and assessments for risk factors that may require a referral for social services interventions, non-compliant and/or transportation issues.
- Once the delivery occurs the Case Manager may perform a site visit and assist the member with enrollment in WIC, HCY/EPSDT scheduling, continued medical care, birth control, and home health visits as individually appropriate.

High Risk/Complicated Pregnancy

In high risk or complicated pregnancies, additional office visits or services outside of the standard global OB package may be needed. CMPCN recognizes these situations and have changed our reimbursement for high risk pregnancies to our OB providers.

If one or more of the criteria is met below, include the 22 modifier with the delivery CPT code and the OB provider is paid an additional 20% of the delivery fee. *These high risk diagnoses must be indicated in the OB authorization for proper reimbursement.*

- Age under 18
- Placenta previa
- History of PIH, HELLP or Fatty Liver of pregnancy
- Chronic medical conditions that are being aggressively treated (*i.e.,* gestational diabetes, chronic hypertension, asthma)
- Multiple birth pregnancy – current pregnancy
- Hyperemesis gravidarum
- History of three or more habitual abortions
- History of one previous still birth diagnosed with neonatal neurologic disorder
- History of preterm labor
- HIV
- Grand multiparity of seven or more pregnancies
- Hemoglobinopathy (*i.e.,* Sickle Cell Anemia or Thalassemia Major)
- Substance abuse (*i.e.,* illicit drugs) – current
- Incompetent cervix os – current pregnancy
- Psychosis (*i.e.,* diagnosis confirmed by a psychiatrist)
- STD (*i.e.,* Syphilis, Gonorrhea, Chlamydia) – current

MEDICAL HOME/DISEASE MANAGEMENT PROGRAMS

The Patient-Centered Medical Home (PCMH) model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered.

A PCMH has six core functions and attributes:

- Comprehensive Care
- Patient-Centered
- Coordinated Care
- Accessible Services
- Quality and Safety
- Payment Reform

Examples of medical home/disease management resources include:

- CMPCN will assign a Resource Nurse and a Registered Nurse Case Manager to your office to support coordination of care for your patients and assist with outreach, facilitate referrals, etc. Your Case Manager can work with you to:
    - identify patients with potential case management needs (e.g., non-compliance with treatment plan, chronic conditions, etc.) and facilitating outreach
    - identify health care alternatives for patients
    - connect patients to community services

- CMPCN will assign a Certified Disease Management Specialist to your office. Your Disease Management Specialist will:
    - train office staff on evidence-based clinical guidelines for diagnosing and managing asthma and diabetes
    - train office staff how to teach patients and families about their chronic disease consistent with national guidelines/best practices.
    - provide disease-specific education to patients on the behalf of the PCP in support of the physician's plan of care and to increase disease self-management skills.

- CMPCN will help you identify patients needing annual prevention/wellness through Gaps in Care analysis and conduct outreach on your behalf.

- CMPCN facilitates creation of patient education materials to help patients understand their conditions.

- CMPCN provides interpretation/translation services and cultural resources to help provider offices serve patients with respect.

Asthma and Diabetes Management Programs for Primary Care Providers

Our medical home/disease management program also includes disease specific programs for asthma and diabetes. These programs are designed to educate providers, office staff, and patients on appropriate diagnosis, treatment and management of asthma and diabetes. Both programs are based on nationally recognized evidenced-based guidelines that can be accessed on the CMPCN website: www.cmpcn.org.

The Asthma and Diabetes Management Programs for primary care providers create a unique partnership between the CMPCN educators, the providers and the patient. Certified asthma and diabetes educators teach the programs at the PCP office using a standardized curriculum centered on evidenced-based guidelines. The programs target best practices and underscore the patient-provider partnership, self-management skills and improved health care utilization. Additionally, the educators are available to work side-by-side with clinic staff to reinforce skills and foster behavior changes for effective asthma and diabetes management. Providers can refer CMPCN members to a Disease Management Specialist to reinforce self-management skills.

The educator follows up with biannual chart reviews to track clinic progress in applying best practices and meets with staff to discuss positive behavior changes, challenges and goals. To learn more about the asthma or diabetes management programs for PCPs, call Clinical Services at 1-888-670-7262.

Member Eligibility

All CMPCN members with a diagnosis of, or at risk for, asthma and/or diabetes are automatically enrolled in a disease management program. Patients can decline to participate at any time by calling CMPCN Clinical Services at 1-888-670-7262. The CMPCN uses the following sources to identify and enroll members:

- Data sources: claims or encounter data; utilization management or case management
- Physician referral
- Patient self-referral

Health Plan Information:

HealthCare USA (MO HealthNet)

HEALTHCARE USA - CMPCN ID CARD

HealthCare USA PCN Member ID Card

PCN Logo

Member Card

Name: JOHN SAMPLE
HealthCare USA #: [XXXXXXXX]
Date of Birth: XX.XX.XXXX
MO HealthNet ID #: [XXXXXXXXXX]
Effective Date: XX.XX.XXXX
Primary Care Provider: DOCTOR NAME
PCP Phone: XXX-XXX-XXXX

In case of emergency, go to the nearest emergency room or call 911.
Notify HealthCare USA within 24 hours or soon as medically possible.

24 Hour Nurse Line

IMPORTANT NUMBERS FOR MEMBERS:
Pharmacy Line (questions or problems): 1-800-392-2161 or 1-573-751-6527
Member Service Line (questions or problems): 1-800-566-6444
24 Hr. Nurse Line (medical questions or emergencies): 1-888-670-PCN4(7264)
Behavioral Health Services (questions or problems): 1-800-377-9096
Dental & Vision Services (questions or problems): 1-800-566-6444

PCN Prior Authorization Phone Number

IMPORTANT NUMBERS & ADDRESSES FOR PROVIDERS:
Eligibility: 1-800-295-6888 Authorizations: 1-877-347-9367
Medical Claims Address & Phone: HealthCare USA Claims
PO Box 7629 London, KY 40742; 1-800-295-6888
Emdeon- Payor ID Name: Coventry Health Care- Payer ID Number 25133
Gateway EDI- Payer ID Name: HealthCare USA- Payor ID Number 00550
Behavioral Health Claims Address & Phone: MHNet Claims
PO Box 7802 London, KY 40742; 1-866-992-5246
Dental Claims Address & Phone: DentaQuest of MO
12121 N. Corporate Pkwy. Mequon, WI 53092; 1-888-307-6547
Vision Claims Address & Phone: March Vision Care
6701 Center Drive West Ste 790
Los Angeles, CA 90045; 1-888-493-4070

IMPORTANT NOTICE for HealthCare USA (MO HealthNet) PROVIDERS
Regarding the Integration of Operations by FHP & HCUSA
Changes effective 7/1/2012

As you are aware, effective January 1, 2012, HealthCare USA of Missouri, LLC (HCUSA), a subsidiary of Coventry Health Care, Inc., began managing all of Children's Mercy Family Health Partners' (FHP) MO HealthNet Managed Care business as the Children's Mercy Family Health Partners contract with MO HealthNet has been assigned to HealthCare USA.

HealthCare USA and Family Health Partners have been working together to assure a smooth transition process for members and providers since the beginning of the year. We have completed the necessary technology infrastructure changes to begin loading FHP member eligibility information and begin processing legacy FHP MO HealthNet member claims in the HealthCare USA system beginning 7/1/2012.

There are a few key changes related to member eligibility verification and claim submission which we want to share with you. All of the following changes will be **effective as of July 1, 2012**.

- New HCUSA Member ID cards for legacy FHP members
- Member eligibility verification process
- Claim submission Disease Management Program changes
- Precertification requirements for CMPCN providers and members
- Updated HCUSA-CMPCN Quick Reference Guide
- Frequently Asked Questions (FAQ)

New HCUSA Member ID cards for legacy FHP members

On or before July 1, 2012, all legacy FHP members will be issued HealthCare USA id cards. We will discontinue the use of the FHP id cards for MO HealthNet members.

Member eligibility verification process beginning 7/1/2012 - Legacy FHP (MO HealthNet)

Effective 7/1/2012, all legacy FHP member eligibility information will be housed in the HealthCare USA system. Please utilize the HCUSA provider portal, (www.directprovider.com) or the MO HealthNet eligibility system (www.EMOMED.com) to confirm the day specific eligibility status of MO HealthNet members.

Please discontinue using the FHP 's secure website (www.fhp.org) to confirm eligibility for MO Healthnet.

Claim submission process beginning 7/1/2012 - Legacy FHP (MO HealthNet)

Beginning 7/1/2012, all legacy FHP member claims will be processed by HealthCare USA. Please submit ALL claims for legacy FHP members to HealthCare USA under Emdeon payor id #25133 or to the HCUSA paper claims address. This includes claims for all dates of service beginning 7/1/2012 .

Please discontinue using the FHP 's secure website (www.fhp.org) for submission of MO HealthNet member claims on and after 7/1/2012.

Case and Disease Management Program changes

Effective 7/1/2012, case and disease management (DM) programs for **non-CMPCN** members will be administered by HealthCare USA. HealthCare USA provides case and disease management services for members identified with certain diseases or conditions. HealthCare USA has the following case and disease management programs:

- Asthma, Diabetes, Heart Failure, Coronary Artery Disease, COPD
- Hi-Risk OB, Special Needs, Lead, and NICU Graduates
- Major Depression (provided by the behavioral health company MHNet)

For CMPCN disease management programs, please refer to the CMPCN website at www.cmpcn.org for more information.

Reminder - Precertification requirements for CMPCN and non-CMPCN members

Please note effective 7/1/2012, all **non-CMPCN** members fall under the HCUSA Pre-Authorization requirements. Starting 6/25/2012, all prior authorization requests for **non-CMPCN** members should be called in to the HCUSA Pre-Auth Line at 800-882-9666. The HealthCare USA Authorization directory and PA fax forms can be found on the HCUSA website at www.hcusa.org.

All prior authorization requests for **CMPCN** members must be called in to the CMPCN at **(877) 347-9367.** Please refer to the CMPCN Quick Reference Guide on the CMPCN website www.cmpcn.org for PA guidelines which apply to CMPCN members.

Frequently Asked Questions (FAQ)

For your reference we have developed a post integration FAQ to assist your practice. If you have additional questions which were not covered in the FAQ, please contact your FHP or HCUSA Provider Relations Representative.

Updated Quick Reference Guide

Please refer to the updated HCUSA-CMPCN Quick Reference Guide for all key contact information related to member eligibility, claims submission and prior authorization.

If you have any questions, please contact your FHP or HCUSA provider relations representative at (800) 347-9363 or (800) 213-7792 ext. 7240.

Sincerely,

Kim Covert
CEO
HealthCare USA of Missouri, LLC

Attachments:
- Updated HCUSA-PCN Quick Reference Guide
- Frequently Asked Questions

HEALTHCARE USA
A Coventry Health Care Plan

Quick Reference Guide - MISSOURI
HCUSA-CMPCN (MO HealthNet) -Effective 7/1/2012

Children's Mercy Pediatric Care Network

Program	MO HealthNet Program (MISSOURI)	
Plan/Product	HCUSA (non-CMPCN)	Children's Mercy Pediatric Care Network CMPCN
HealthCare USA Eligibility Verification	HCUSA Member Services: (800) 566-6444 Website: www.directprovider.com Net support: (866) 629-3975	
State Eligibility Website	MO HealthNet: www.emomed.com **IMPORTANT NOTE**: ALL legacy FHP members will be listed as HealthCare USA on the State eligibility website beginning 02/01/2012. Claims for all legacy FHP members should be submitted to HCUSA after 7/1/2012, regardless of the date of service.	
Member Services	HCUSA: (800) 566-6444	Contact HCUSA for HCUSA-CMPCN members
Prior Authorization Phone and Fax Numbers	HCUSA PH: (800) 882-9666 HCUSA FX: (866) 341-1327 Auth request fax form available on website	CMPCN PH: (877) 347-9367 CMPCN FX: (888) 670-7260 Auth request fax form available on website
Website	www.hcusa.org Authorization Directory	www.cmpcn.org Prior Authorization Quick Guide
Claim Submission Address/Payor ID	HealthCare USA PO Box 7629 London, KY 40742-7629 Emdeon: 25133 NOTE: ALL legacy FHP member claims should be submitted to HCUSA, regardless of the date of service.	Send HCUSA CMPCN member claims to HCUSA
Claims Customer Service Contact	HCUSA: (800) 295-6888	Contact HCUSA for HCUSA-CMPCN members
Provider Relations	Contact your HCUSA/FHP Provider Relations Representative or call HCUSA Provider Relations (800) 213-7792, ext 7240	CMPCN: (816) 559-9379 Email: krhake@cmpcn.org
Appeals Address	HealthCare USA Appeals PO Box 7091 London, KY 40742 -7091	Send HCUSA member/ provider complaints/appeals to HCUSA
Dental	DentaQuest (www.dentaquest.com) (800) 566-6444	Contact DentaQuest for HCUSA members
Vision	MARCH Vision: (888) 493-4070 Website: www.marchvisioncare.com	Contact MARCH Vision for HCUSA members
Behavioral Health	MHNET: (800) 377-9096 Website: www.MHNET.com	Contact MHNET for HCUSA members
Transportation	MTM: (800) 688-3752	MTM: (800) 688-3752
Pharmacy	Contact MO HealthNet: (800) 392-8030	Contact MO HealthNet: (800) 392-8030

Data Classification: Public Domain Use

Rev. 5/29/12

HEALTHCARE USA
A Coventry Health Care Plan

Frequently Asked Questions for HCUSA/FHP Post Integration
Missouri program – Changes Effective 7/1/2012

	Question	Answer
Claim Submission Changes	Where do legacy FHP member claims get submitted beginning 7/1/2012?	After 7/1/2012, all HCUSA and FHP claims should be submitted to HealthCare USA, regardless of the date of service. Please discontinue submitting claims directly to FHP after 7/1/2012.
	What will happen if claims are submitted to FHP after 6/30/12?	All member eligibility information will be maintained in the HCUSA system. You may experience a claim rejection or denial if claims are submitted directly to FHP beginning 7/1/2012. To ensure proper handling of claims, please submit ALL claims to HCUSA after 6/30/2012.
	Will the FHP secure site be available after 7/1/2012?	The FHP secure site will be available for claim inquiries through the remainder of 2012 for claims which were processed by FHP. Please submit all legacy FHP (MO HealthNet) member claims to HealthCare USA beginning 7/1/2012.
	Where do providers send corrected claim submissions with dates of service prior to 7/1/2012?	All claims, including corrected claims, should be submitted to HealthCare USA. Please discontinue submitting claims directly to FHP after 6/30/12.
	Who can I contact for claims/ customer service before and after 7/1/2012?	For Legacy FHP member claims submitted prior to 7/1/2012, call FHP customer service. After 7/1/2012, call HealthCare USA. Please refer to the Quick Reference guide for all contact information.
Member Eligibility	What changes in verification of Eligibility do providers need to be aware of on and after 7/1/2012	As of 7/1/2012, member eligibility verification must be completed using the HealthCare USA provider portal (www.directprovider.com) or via the state website (www.emomed.com). As of 7/1/12, HealthCare USA will no longer continue to load or update MO HealthNet member eligibility on the FHP website.
	How will members appear on EMOMED?	On the state's website, www.emomed.com, all members will be listed as HealthCare USA. Claims for ALL members beginning 7/1/2012 should be submitted to HealthCare USA.
PRIOR AUTHORIZATIONS	Are there any prior authorization changes?	HCUSA and CMPCN have not made any changes to our respective prior authorization policies.
	Where do providers submit prior authorization requests for members beginning 7/1/2012?	Prior authorization requests for legacy FHP/HCUSA (non-CMPCN) members should be submitted to HCUSA's Prior Authorization team. If the member is a CMPCN member, you will need to call the CMPCN prior authorization department at (877) 347-9367. Please refer to the Quick Reference Guide for contact information.
	When will the HCUSA prior authorization guidelines be applicable?	HCUSA prior authorization guidelines are applicable to all HCUSA MO HealthNet members who are NOT in the CMPCN, meaning there is no CMPCN logo on the member's ID card. Please refer to the Quick Reference guide for information on where to call for PA requests for CMPCN vs. non-CMPCN members.
	What will happen if I call in the PA request to the wrong entity?	Procedures are in place with CMPCN and HCUSA prior authorization teams to transfer provider calls to the correct entity. Please make sure you have the member's ID number available.
	What are the Prior Authorization guidelines for the CMPCN?	The CMPCN has their own authorization guidelines which can be found on their website www.cmpcn.org or by calling the CMPCN Prior authorization team at (877) 347-9367. CMPCN members have been issued an ID card which notes "Children's Mercy Pediatric Care Network" on the ID card.
	If a member's inpatient admission spans before and after 7/1/2012, is an new authorization required?	HCUSA/FHP and the CMPCN are working closely to identify any members who have admission spans before and after July1st. To ensure authorization information has been transferred over, please be sure to review the HCUSA Provider portal (www.directprovider.com) or call our PA team.
	For procedures scheduled on/after 7/1, when will HCUSA PA accepting the requests?	HCUSA's PA team will begin reviewing PA requests beginning 6/25/2012 for legacy FHP members scheduled on and after 7/1/12.
CUSTOMER SERVICE	Who do providers contact for claims or member service inquiries?	Call HCUSA Customer Service for all HCUSA member service or claim inquiries. Please refer to the Quick Reference Guide for contact information.
	What is the process for members to change their PCP?	Call HCUSA Customer Service for all HCUSA member service or claim inquiries. Please refer to the Quick Reference Guide for contact information.

Data Classification – Public Domain

Revised 5/29/2012

RESPONSIBILITIES OF CMPCN AND HEALTHCARE USA

FUNCTION	RESPONSIBILITY
Adverse Determination Letters	CMPCN
Behavioral Health	HealthCare USA
Case Management Programs	CMPCN
Concurrent Review	CMPCN
Credentialing	CMPCN for CMPCN-contracted network providers
Dental	HealthCare USA
Disease Management (Asthma & Diabetes)	CMPCN
Discharge Planning	CMPCN
HEDIS Reporting	HealthCare USA
Member Appeals	HealthCare USA If your request for services is denied, you have the right to file an appeal. You can file an appeal in writing, with HealthCare USA (formerly Family Health Partners), or you can ask for a State Fair Hearing, or you can do both. Call HealthCare USA (formerly Family Health Partners) at 1-800-347-9363 and tell them you want to file an appeal. TDD users, call 1-888-374-9361. If you speak another language you can ask for an interpreter at no cost to you. Or you can write: QM Appeals Nurse HealthCare USA (formerly Family Health Partners) P.O. Box 411806 Kansas City, MO 64141 HealthCare USA (formerly Family Health Partners) must make a decision on your appeal within thirty (30) days of receiving it.
Member Grievances and Complaints received by CMPCN	HealthCare USA
Nurse Advice Line	CMPCN, through Children's Mercy Nurse Advice Line: 1-888-670-7264
Patient Outreach and Education	CMPCN through PCPs in coordination with HealthCare USA

FUNCTION	RESPONSIBILITY
Peer to Peer – for CMPCN Decisions	CMPCN
Preauthorization of all Services. Includes, but not limited to, medical necessity determinations of Acute Inpatient Admissions, SNF Admissions, Rehab Admissions, LTAC Admissions, Outpatient Surgeries, Observation and Diagnostic procedures on the Prior Authorization List	CMPCN
Retrospective Review, Level of Care location & coverage determination (Rehab/SNF/HHC, etc.)	CMPCN
Transitional Care Program	CMPCN
Transplant and Clinical Trials	CMPCN

Other Important
Health Plan
Updates

(insert updates as needed for future reference)