Provider Manual

MercyCare Health Plans™

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About MercyCare

MercyCare is pleased to have you as a network provider for our members in southern Wisconsin and northern Illinois.

The MercyCare Provider Manual is designed to convey our policies and procedures, including provider services, prior authorization, claims, and eligibility.

Please visit mercycarehealthplans.com for the most current version of our Provider Manual. MercyCare reserves the right to revise or alter the material and information detailed in this manual at any time.

Why MercyCare?

MercyCare has been providing dependable, quality, affordable health care coverage since 1994. MercyCare and Mercyhealth together, offer a complete continuum of health care services readily available to its members close to home.

MercyCare and Mercyhealth give you access to Mercyhealth's seven hospitals, and 85+ primary and specialty care facilities throughout 55 northern Illinois and southern Wisconsin communities. Mercyhealth also offers post-acute services (home health care, home health equipment, hospice), full-service pharmacies and retail services.

Live well. We'll insure you do.

Contact MercyCare

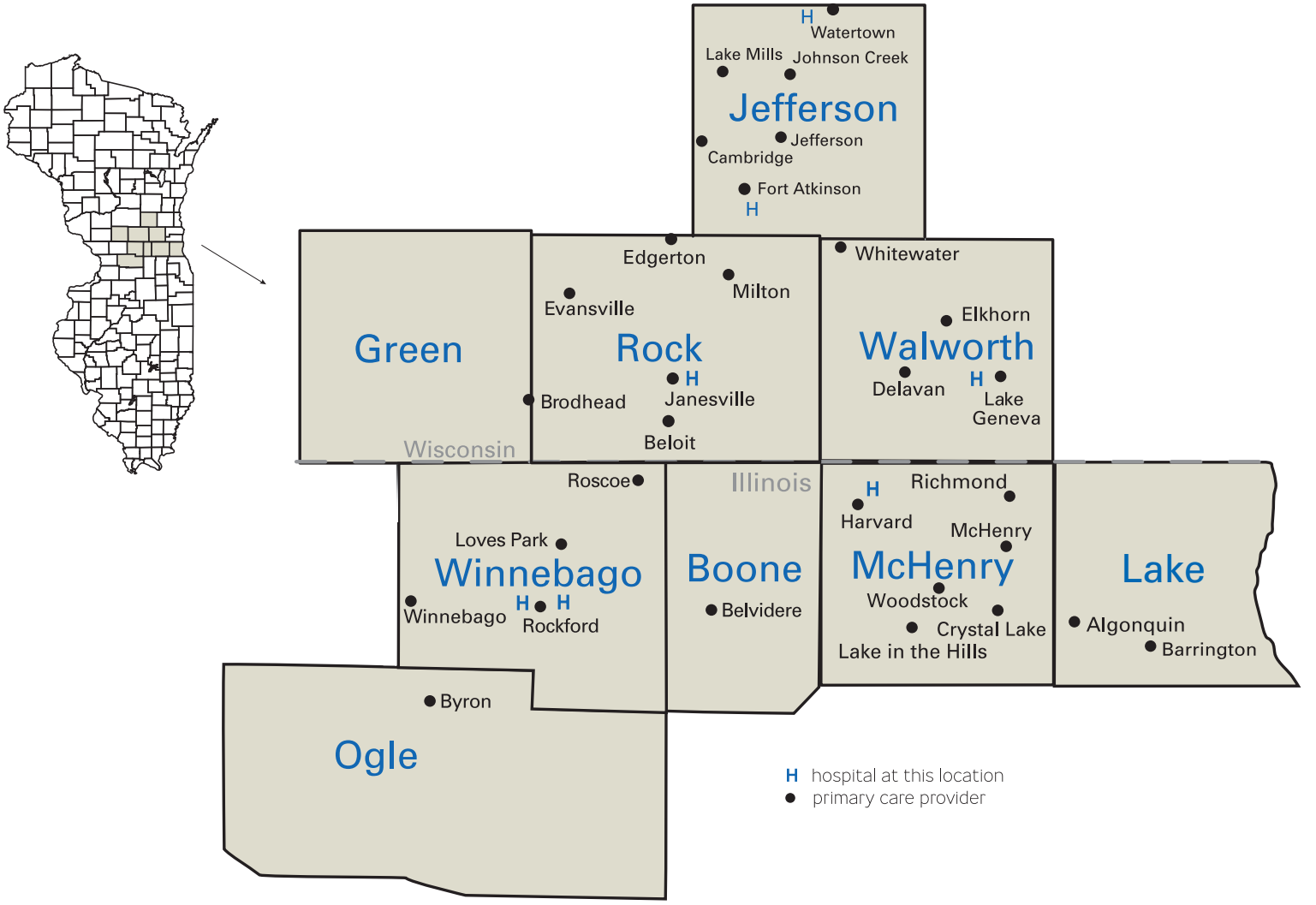
Hours:	Monday through Friday, 8 am-4:30 pm CST (closed 11:30 am-1 pm)
Mailing address:	PO Box 550 Janesville, WI 53547-0550
Office address:	580 N. Washington St. Janesville, WI 53548
Customer Service:	Wisconsin: (800) 895-2421 Illinois: (877) 908-6027
Fax:	(608) 752-3751
Website:	mercycarehealthplans.com
Email:	mcare@mhemail.org

MercyCare Department Contacts

Claims:	Wisconsin: (800) 895-2421 Illinois: (877) 908-6027
Customer Service	Wisconsin: (800) 895-2421 Illinois: (877) 908-6027
Sales:	Josh Mummery (608) 758-7738 jmummery@mhemail.org
Network Development Contracting:	Contracting (608) 758-7707 mercycareprovidermaint@mhemail.org
Credentialing:	Sheryl Kealy (608) 563-7398 skealy@mhemail.org
Medical Management:	Quality Health Specialist (800) 757-6825
IS – PLANLINK:	Wisconsin: (800) 895-2421 Illinois: (877) 908-6027

MercyCare HMO Provider Area

Wisconsin and Illinois



Provider Appeals

The following applies to contracted providers:

A. Provider can submit to MercyCare an appeal for denied services.

1. Appeals can be submitted:

a) Via self-composed business letter using a mail delivery service
b) Using the electronic MercyCare Provider Appeal form on mercycarehealthplans.com under providers, business forms and documents and sent via internal Mercyhealth email or Mercyhealth interoffice mail service
c) Using Plan Link

B. Unless noted otherwise, the appeal must be received by MercyCare within one year of the Date of Service (DOS) that is being appealed.

1. The provider must include specific information in their letter for a provider appeal:

a) Date appeal is being requested
b) Member's name
c) Member's date of birth
d) Member's member number (if available to the provider)
e) Date(s) of service
f) Revenue code/CPT code
g) Claim amount in question
h) Total claim amount
i) Description of request
j) The listed denial reason on the explanation of benefits (EOB)

2. A Quality Health Specialist (QHS) Team Lead performs the intake and a basic review to determine if the service can be approved at this level.

a) If the service can be approved at the QHS Team Lead level, modifications will be made to the authorization for processing.
b) QHS Team Lead meets with the Claims Department for processing of these claims.
c) No letter is completed by the QHS Team Lead, as they will receive their payment and explanation of payment from the Claims Department as part of processing the claim.

3. If the service cannot be approved at the QHS Team Lead level, the appeal is reviewed with the Medical Director for determination.

a) If the Medical Director approves; the above steps in 2. b) and 2. c) will be followed.
b) If the Medical Director upholds the denial, a rationale will be provided. Other resources will be utilized as necessary to gather all relevant information, such as the Director of Compliance, the Director of Contracting or others as needed.
c) The QHS Team Lead will complete a letter to the provider that submitted the appeal.

Member Appeals

An appeal may be filed whenever MercyCare denies coverage of a service to a member. Members may appeal either the denial of a health service prospectively or the denial of payment for a health service the member received.

Physicians may obtain a copy of our member appeals process through MercyCare's Provider Relations Department.

Physician's Responsibility

There is a limited time frame in which appeals must be conducted, in accordance with section 2.10 of the provider agreement, MercyCare physicians must comply with requests for medical information as requested.

Expedited Member Appeals

Physicians may request expedited appeals when they certify that the standard process would seriously jeopardize the life of the member or his/her ability to regain maximum function. A few examples of some of the circumstances under which members may obtain expedited appeals include:

- Hospital discharge (terminated or reduced coverage for continued stay)
- Medications, services or durable medical equipment required to prevent serious harm
- Members with a terminal illness

State Insurance Regulatory Bodies

In addition to a MercyCare Health Plans grievance/appeal, members may also contact their State's insurance regulatory agency listed below:

Wisconsin:
Office of the Commissioner of Insurance Complaints Department
125 S. Webster St.
PO Box 7873
Madison, WI 53707-7873
Toll-free: (800) 236-8517/TDD: (608) 266-3586
Fax: (608) 264-8115
Email: ocicomplaints@wisconsin.gov
Website: oci.wi.gov

Illinois:
Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington St.
Springfield, IL 62767-0001
Toll-free: (877) 527-9431/TDD: (217) 524-4872
Fax: (217) 558-2083
Email: Consumer_complaints@ins.state.il.us
Website: mc.insurance.illinois.gov/messagecenter.nsf

Claim Submission

Definitions

Clean Claim — Clean claims are invoices properly submitted in a timely manner and in the required format that do not require MercyCare to investigate, develop or acquire additional information from the provider or other external sources. The claims should have no defect, impropriety or particular circumstance requiring special treatment that prevents timely payment from being made, including any lack of required, substantiating documentation.

Non-clean Claim — Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. These errors or omissions result in MercyCare requesting additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or access to other information necessary to resolve discrepancies. In addition, claims with issues relating to payment including, but not limited to, issues regarding medical necessity or claims not submitted within the identified filing limit are also defined as non-clean.

Clean Claim Requirements

The following information is required for a clean claim to be accepted for processing:

- Full patient name
- Patient's date of birth
- Valid and properly formatted member identification number
- Complete service level information
  - Date of service
  - Industry standard diagnosis codes
  - CMS defined industry-standard place of service codes
  - Industry standard procedure codes (e.g., CPT, ICD-9 CM, ICD-10CM)
  - Charge information and units
- Service provider's name, address and National Provider Identifier (NPI)
- Provider's federal tax identification number (TIN)
- Only one servicing provider per claim
- All mandatory fields must be complete and accurate

Missing or incomplete information will result in a claim being returned to the provider. Refer to your contract for your timely filing limits.

Payment

MercyCare reimburses claims for covered services within an average of 30 calendar days after receipt of a clean claim or in compliance with applicable state laws.

Electronic Claims

Benefits: Filing electronic claims results in fewer claim errors, more control over claim data accuracy, improved cash flow and lower operating costs.

Request Electronic Claim Submission: MercyCare does not take direct submissions from providers for electronic claims. MercyCare uses Optum Insight clearinghouse. Providers should work with their clearinghouse or billing software vendor to get EDI claims to Optum Clearinghouse, using payer ID 39114.

More information about submitting electronically through our clearinghouse can be found at provider.linkhealth.com/#/.

Helpful Hints for Electronic Claims Submissions

Claim Receipt Date: The electronic claim receipt date is the date the claim is accepted into MercyCare's claims adjudication system; it is not the date of submission.

Electronic Claim Reports: Review all electronic claim reports provided by MercyCare or the intermediary (e.g., clearinghouse).

Rejected Claim Assistance: Rejection notices are delivered via the clearinghouses. Providers need to work with their clearinghouse or billing software vendor to understand why claims are rejected.

Paper Claims

MercyCare enters paper claims using OCR (Optical Character Recognition) technology. Failure to use the standard CMS/UB claim forms or failure to fill out all applicable fields or misalign your entries will result in your claim being returned.

Claim Receipt Date: The paper claim receipt date is the date the claim is received in the MercyCare claims mail room; claims received after 2 pm are assigned the following day's receipt date.

Claim Submission Addresses: Please mail any paper claims to MercyCare at:
MercyCare Health Plans
PO Box 550
Janesville, WI 53547-0550

CMS-1500 Billing

Block	Information
17	Referring (ordering) provider's name, if billed for specialist office visit or ancillary services.
17b	Referring (ordering) provider's National Provider Identifier (NPI) number.
23	Prior authorization number, when applicable.
24a	If billing a range of dates on one claim line, the dates must be consecutive (date ranging is acceptable for inpatient stay management, hemodialysis management, radiation therapy management, hospice care, VNA/home health care).
24d	- Industry standard CPT codes are required for all professional services. - Use HCPCS Level II codes to define pharmacy, DME, ambulance and other services specifically identified to use these codes. - When applicable, use the appropriate industry standard CPT-4 or HCPCS modifiers with the codes. - Use unlisted CPT codes only when necessary; if used, clinical supporting documentation must accompany the claim.
24e	All medical and dental/oral surgery claims must indicate an industry standard diagnosis code for proper claims.
24j	Servicing provider's NPI if different from 33a.
31	Rendering provider's name and signature.
33	Rendering provider's group name (if applicable), payment address and individual provider NPI or group NPI.
33a	Rendering provider's group name (if applicable), payment address, and individual provider NPI or group NPI.

Special Considerations for Group and Individual Providers

Group Provider	Individual Provider
Claims are to be submitted to MercyCare using a single identifier for all providers within a group. Examples include: • Physical, occupational or speech therapy • Some ER, anesthesia, radiology or pathology groups • Independent lab • Ancillary facility (e.g., Home Care, DME, ART, Early Intervention)	Claims are to be submitted using a different identifier for each physician in the practice to bill for rendering their provider services. This individual provider identifier is also used by Primary Care Physicians as their referring identifier. Examples include: • Physicians within a group practice • Solo practitioners

Paper Claim		Paper Claim	
17b	Referring provider NPI	17b	Referring provider NPI
24J	Group NPI	24J	Individual provider NPI
25	TIN1	25	TIN1
31	Supplier signature	31	Physician signature
33	Billing provider name and address	33	Billing provider name and address
33a	Group NPI	33a	Billing group NPI
33b	Group NPI	33b	Individual provider NPI

Failure to submit in accordance with these instructions will result in your claim being denied.

UB-04 Billing

Use the UB-04 claim form to submit paper claims for facility (technical) services.

- Use one claim line when billing global services.
- To facilitate paper claims processing, make sure that the following information appears in the proper UB-04 Claim Form locator, when applicable:

Form Locator	Information
17	Patient status is required for inpatient medical, SNF, hospice and outpatient hospital services.
31–34	MercyCare requires all accident-related occurrence codes to be reported, especially when related to a motor vehicle accident (MVA).
42	A maximum of 22 services may be billed on one claim form, with total charges entered on the 23rd line.
44	Enter industry standard HCPCS or CPT-4 codes, depending on contractual agreement.
45	For outpatient claims, report a separate date for each day of service.
46	Enter number of units of service by day, visit, hour or minute, as applicable, for each service rendered on each reported line - Inpatient: Enter number of day - Ancillary: Enter number of units where applicable - Outpatient: Enter number of units when HCPCS or CPT-4 codes are used
56	NPI of servicing provider.
60	ID numbers assigned to MercyCare members should always include the alpha prefix and the two-digit suffix when indicated on the id card.
63	MercyCare–assigned authorization number.
66	Enter the industry standard diagnosis code.
72	E-code information is mandatory for MVA.
74 A & B	If more than one procedure is performed, it must be listed.
76	Ordering/attending physician's NPI.
76	Performing physician's NPI is a required field if a procedure is performed.

Contracts and Credentialing

Notify MercyCare of any roster and location additions, deletions, or changes, by contacting our Contracting Department.

If you leave your current practice to open or join a new practice, it is possible that your new practice does not have a contractual agreement with MercyCare. Contact Contracting, listed on page 3, to verify contract status. Contracting serves as the contact for all your MercyCare contracting questions.

Credentialing

MercyCare is comprised of Mercyhealth-employed and select contracted practitioners and provider organizations that meet criteria based on non-discriminatory industry quality and NCQA-based standards.

Practitioners are defined as people who provide services. Provider organizations are defined as facilities such as hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, and behavioral health inpatient, residential and ambulatory care settings.

MercyCare credentials the following practitioner types:

- Medical Doctors (MD)
- Doctors of Osteopathy (DO)
- Doctoral level and master's level psychologists (PhD)
- Chiropractors (DC)
- Dentists (DDS/DMD)
- Optometrists (OD)
- Podiatrists (DPM)
- Physician Assistant –Certified (PAC)
- Advanced Practice Nurse Prescriber (APNP)
- Licensed Clinical Social Worker (LCSW)
- Clinical Substance Abuse Counselor (CSAC)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Marriage and Family Therapist (LMFT)
- Physical Therapist (PT)
- Occupational Therapist (OT)
- Audiologist (Aud)
- Speech Language Pathologist (SLP)
- Telehealth providers

Credentialing is initiated simultaneously to Mercyhealth hiring or select contracting and includes submission of a completed credentialing application and supporting documents which are primary-source verified and maintained in the credentialing database. Reports and directories are produced and published from the verified credentialing data.

Practitioner Prerequisites

Practitioner prerequisites include:

- Valid, current unrestricted license in the state where the practitioner will practice
- Valid, current DEA in the state where the practitioner will practice and, when applicable, a controlled substance certificate (CSC)
- Board certification is not required, but if board certified, the board must be recognized by the American Board of Medical Specialties (ABMS).
- Medical education background outlined
- Complete work history in mm/yy to mm/yy format, including explanation for any gaps
- Evidence of current malpractice coverage
- Hospital affiliation with a MercyCare participating hospital or explanation of admitting arrangements.
- Current attestation to the correctness and completeness of the application

Practitioner applications and supporting information are confidentially retained at MercyCare. Applicants have the right to review information submitted to support their credentialing application. Applicants have the right to correct erroneous information. Upon request, applicants have the right to be informed of the status of their application.

Upon review by the MercyCare Medical Director or the MercyCare Credentials Committee, applicants will be notified as to the decision regarding participation in MercyCare.

Any credentialing questions should be directed to the MercyCare Provider Credentialing Coordinator, Sheryl Kealy at skealy@mhemail.org.

Changes in a practitioner's status must be communicated to the MercyCare Provider Credentialing Coordinator in writing. Changes may include, but are not limited to, change of practitioner status from accepting new patients to no longer accepting new patients; changes in clinic rotation site(s); updates in directory listings; practitioner name changes; corporation name changes; change in EIN.

Re-credentialing is performed between 24 and 36 month intervals to maintain current and accurate credentialing information. The re-credentialing process includes submission of a re-credentialing application and re-attestation to the correctness and completeness of the information provided along with supporting documents or an up-to-date CAQH profile. Re-verification of information is performed, and the file is presented for Director or Committee approval.

Provider organization's (facility) initial credentialing is performed simultaneous to contracting and includes confirmation of the following elements:

- Facility is in good standing with state and federal regulatory bodies
- Facility has been reviewed and approved by an accrediting body (if applicable)
- Health plan conducts on-site quality assessment if the facility is not accredited
- Proof of facility Medicare and Medicaid billing eligibility
- Malpractice insurance

Member Rights and Responsibilities

The goal of MCHP is to assure that all of our members receive appropriate quality health care. MCHP strives to help all members develop a relationship with a primary care physician (PCP) who coordinates and manages their medical care. MCHP member rights and responsibilities are communicated to members as follows in the annual member hand book. The handbook is available atmercycarehealthplans.com/current-members/member-handbooks-and-annual-notices/

As a member, you have the right to:

- Receive information about the MercyCare organization, services, practitioners, hospitals, other providers, and member rights and responsibilities.
- Be treated with respect and recognition of your dignity and right to privacy.
- Discuss openly and freely all planned treatments, procedures, and services regardless of cost or benefit coverage and participate with your practitioners in making decisions about your health care.
- Confidentiality of your personal health information as described in your HIPAA Notice of Privacy Practices.
- Know how to obtain health care services.
- Know what your benefits are.
- Understand the purpose and probable results and risks of treatment.
- Voice complaints or appeals about the organization or care provided by calling customer service at (800) 895-2421 (WI) or (877) 908-6027 (IL), and receive a timely response.
- Make recommendations regarding the organization's member rights and responsibilities policies by contacting customer service at (800) 895-2421 (WI) or (877) 908-6027 (IL).
- Participate with practitioners in making decisions about your health care.

As a member, you are responsible to:

- Provide information about your past illnesses, hospitalizations, medications and other matters concerning your health that will help our practitioner understand your health care needs and provide appropriate care.
- Understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible. Follow plans and instructions for care that you have agreed to with your practitioner(s).
- Read your MercyCare member handbook, certificate of coverage, schedule of benefits and provider directory so that you understand how to use your MercyCare benefits.
- Choose a PCP with whom you will coordinate your care.
- Identify yourself as a MercyCare member by presenting your MercyCare insurance card before receiving health care services.
- Pay your co-payments at the time of your visit.
- Keep your appointments.
- Discuss any questions you have about your health with your practitioner.
- Notify MercyCare of address, telephone or other status changes within 30 days of the change.

Case and Medical Management

Population Health Management

MercyCare uses a population health management (PHM) program to focus on keeping members healthy, health and wellness education, patient safety, outcomes across healthcare settings, and complex case management. Data, including reports on the social determinants of health, member self-health appraisals, claims data and electronic health records, are integrated and used to identify and assess the needs of relevant member subpopulations. Specific health goals are determined at quarterly Population Health Task Force Committee meetings and are based on current national health concerns (e.g. opioid overuse), HEDIS® measures, and MercyCare objectives. Member and provider interventions are developed based on previous experience, resource availability, and Task Force Committee approval. Case Managers, the health and wellness educator, and quality initiatives specialists are integral members providing these interventions (e.g. pediatric vaccination calls, preventative screening calls, case management, and individualized member education).

Health and Wellness Education

MercyCare has a health and wellness educator available for members living with certain chronic health conditions, such as diabetes, hypertension, and cardiovascular disease. The health and wellness educator will work with your patient to help them better manage their chronic disease, by ensuring they have completed recommended labs, understand their prescribed medications, provide education on the disease if needed, problem solve any barriers keeping them from achieving your treatment goals, and serve the patient as an advocate. If you have a patient with MercyCare insurance coverage and feel he or she would benefit from one of these free programs, call MercyCare Customer Service at (800) 752-3431 and ask to talk to the Health and Wellness Educator.

Complex Case Management

MercyCare Complex Case Management Program is designed to have a registered nurse case manager help your patient with complex conditions better understand their illnesses, navigate through the types of care required and develop a self-management plan. The MercyCare Complex Case Management Program follows standards set by the Case Management Society of America. MercyCare case managers help patients find resources, facilitates connection with services and advocates on behalf of your patient. If you have a patient with MercyCare insurance coverage and want to find out if the Complex Case Management Program could help your patient, call (800) 895-2421 and ask to speak with one of our Complex Nurse Case Managers.

Primary Care Physicians

Our national health care system continues to be stressed by ever-increasing costs. Meanwhile, national morbidity and mortality statistics indicate that younger cohorts of Americans have lower quality of life and decreased life expectancies largely because of lifestyle choices that are leading to increased morbid obesity, diabetes, cardiovascular disease and orthopedic disabilities.

Under these conditions, expectations of the ultimate payors of health care—employers, federal and state governments—continue to increase. They are all pressing for payment reforms that compensate providers for addressing the long-term issues that are the underlying cause of these increasing morbidity statistics with quality, patient-centered solutions. Current payment systems promote expensive episodic care and "rescue" care rather than cost-effective evaluations and preventive care. The value of primary care is being reemphasized for the first time in decades based on studies showing that robust primary care services are associated with lower cost and higher quality of life in the Medicare program.

New Technologies

MercyCare evaluates new and existing technologies for possible inclusion in the member benefit package. New technology can be a service, treatment, procedure, treatment facility, equipment, drug, device or supply. Health care determinations are based on expert opinion, however, benefit packages may have exclusions for certain types of services or procedures. Some criteria that may be used for evaluation of new technologies are:

- Is it commonly performed or used on a widespread geographic basis
- Is the service generally accepted by the US medical profession to treat a specific bodily injury or sickness
- The failure rate or side effect of the technology is acceptable
- The technology is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans
- Published scientific evidence and expert reviews
- Input from network specialists who have expertise in the technology being evaluated
- Review, input, and final determination by the network providers on the Quality Utilization Management Committee
- The Hayes Medical Technology Directory, government regulatory bodies such as Centers for Medicare and Medicaid Services (CMS) or National Comprehensive Cancer Network, and GeneReview® (NCBI), are some but not all of the sources used by MercyCare as an aid in developing coverage determinations that are based on scientific evidence and proven to be safe and effective. Network providers will receive notification of new technology that is approved for the membership by MercyCare. Notifications may be sent via email or in the annual mailing to providers.
- You may submit requests for review to the Medical Director at officeofmedicaldir@mhemail.org.

MercyCare Products and Primary Care

All MercyCare products allow members to directly access or self-refer to specialists, including outpatient behavioral health specialists, within the member's provider network without a referral from their PCP.

MercyCare members are strongly encouraged to select a PCP and notify us of their selection.

We believe it is important for members to choose a primary care physician (PCP) in order to have one physician responsible for their preventive health care and to help navigate through the complexity of the modern health care system. We encourage primary care physicians to have expectations of their

patients in this regard and to actively refer their members to the network specialists of their choice. Except in the case of conditions that are better treated in emergency departments and urgent care clinics, it is always most desirable for a patient to have access to their primary care physician. Therefore MercyCare regularly monitors accessibility standards that outline the length of time in which a member should be able to obtain an appointment.

For access to primary care physicians, the standards are as follows:

- Regular and routine care visits — 28 calendar days
- Urgent care appointments — 48 hours
- Physician office wait times should be no longer than 15-20 minutes.

Expectations of Primary Care Physicians

MercyCare expectations for primary care providers are listed below:

1. Gaps in preventive care are addressed at all visits. *Example: A middle-aged woman presents with a possible sinus infection. Doctor documents that she is overdue for her mammogram, discusses with patient and places an order.*
2. Chronic conditions aggravating the chief complaint are brought up with the patient at that visit. *Example: A 300-pound individual presents to clinic with knee pain, probably early osteoarthritis, r/o internal derangement. Physician documents discussion of obesity as a contributing factor and gets the patient to agree to a dietary consult and a follow up for monitoring.*
3. Ensure that all their patients have an annual preventive visit. The annual preventive visit should document all of the patient's "status" and chronic conditions. This is necessary for the health plan to get adequate reimbursement from governmental payors and therefore have adequate funds to pay our physicians. Additionally, many larger employers hire consultants who use claims to determine estimated risk-adjusted costs. If our network physicians inadequately document the morbidity of our population, the employer concludes that our costs are exorbitant for our relatively healthy population and business is lost to a competitor.
4. The American Academy of Pediatrics' immunization schedule is actively promoted and followed with an emphasis on completing HPV, meningococcal and DPT vaccinations by the patient's 13th birthday as a standard of care.
5. USPSTF recommendations are followed for preventive care.
6. Substance use disorders are identified and addressed effectively.
7. Sexual activity in teenagers is identified, chlamydia screenings completed annually, and effective contraception recommended.
8. Referrals to other physicians are generally consultative and most conditions are then treated in the primary care office. Patients are referred to network specialists.
9. All services provided are to be within the scope of authorizations given by the health plan, in keeping with current national standards of care, common billing conventions and MercyCare guidelines and policies. Services not meeting these requirements will not be paid and—depending on contractual agreements—will be your or your patient's liability. MercyCare posts some current clinical practice guidelines at mercycarehealthplans.com/providers/ for your convenience.
10. Office visit wait times should be no longer than 15-20 minutes.

11. Treatment and services should be provided in a fair, impartial and consistent manner, including the member's freedom to exert their rights without adversely affecting their treatment
12. Providers who object to providing care due to an ethical, moral, or religious objection to providing a service for a member should immediately contact MercyCare Quality Health Management Department Staff. The Medical Director, or a designated staff member under the supervision of the Medical Director, will evaluate the member's care needs and work with the member and other network providers to make sure the patient's care is not adversely affected.
13. Pediatricians should assist their patients in a transition from their practice to adult care. If you need assistance finding adult network providers for patients aging out of your pediatric practice, call MercyCare at (800) 895-2421 in Wisconsin or (877) 908-6027 in Illinois.

Out-of-Network Requests

Members are expected to use network specialists unless the services needed cannot be provided within the MercyCare network. Services obtained outside of the MercyCare network are not covered or eligible for payment unless there is an out-of-plan referral from a network provider approved by MercyCare prior to obtaining service. For additional information on referral and out of network requests and other policies and procedures, please read further in the Medical Management Forms Section.

Specialists (Medical Management)

MercyCare Products and Primary Care-Background

All MercyCare products currently allow our members to directly access or self-refer to all specialists, including outpatient behavioral health, within the member's provider network without a referral from their primary care physician.

MercyCare strongly encourages members to select a PCP and notify the health plan of their selection.

We believe it is important for members to choose a PCP in order to have one physician responsible for their preventive health care and to help navigate through the complexity of the modern health care system. We encourage primary care physicians to have expectations of their patients in this regard and to actively refer their members to the network specialists of their choice.

Expectations of Specialists

1. Support the role of primary care by referring patients back to their primary care physician when further specialty care is unnecessary.
2. Encourage members to establish with a primary care physician.
3. Be familiar with our pre-certification list. Submit pre-certification requests at least 14 days prior to a surgery date.
4. All services provided are to be within the scope of authorizations given by the Health plan, in keeping with current national standards of care, common billing conventions and MercyCare guidelines and policies. Services not meeting these requirements will not be paid, and, depending on contractual agreements, will be your or your patient's liability.
5. MercyCare posts some current clinical practice guidelines on mercycarehealthplans.com/providers/clinicalpracticeguidelines.
6. If our member requires tertiary care for services not available within the member's network of providers, a referral must be submitted and reviewed by MercyCare before the services are obtained. Tertiary care services not available within our network services in Wisconsin and Illinois, should be referred to the University of Wisconsin Hospital and Clinics, Madison, WI.
7. Treatment and services should be provided in a fair, impartial and consistent manner, including the member's freedom to exert their rights without adversely affecting their treatment.
8. Providers who object to providing care due to an ethical, moral, or religious objection to providing a service for a member should immediately contact MercyCare Quality Health Management Department Staff. The Medical Director or the designated staff member under the supervision of the Medical Director, will evaluate the member's care needs and work with the member and other network providers to make sure the patients care is not adversely affected.

For additional information on referral and out-of-network requests and other policies and procedures, see page 17 of this document.

Medical Management Forms

Network providers with access to Mercyhealth EPIC/Tapestry are required to submit all referrals and prior authorizations via Mercyhealth EPIC/Tapestry.

If you are a network provider and do not have access to Mercyhealth EPIC/Tapestry and you would like to request approval to obtain access to submit referrals and prior authorizations via EPIC Care Plan Link, please call Contracting at (800) 752-3431.

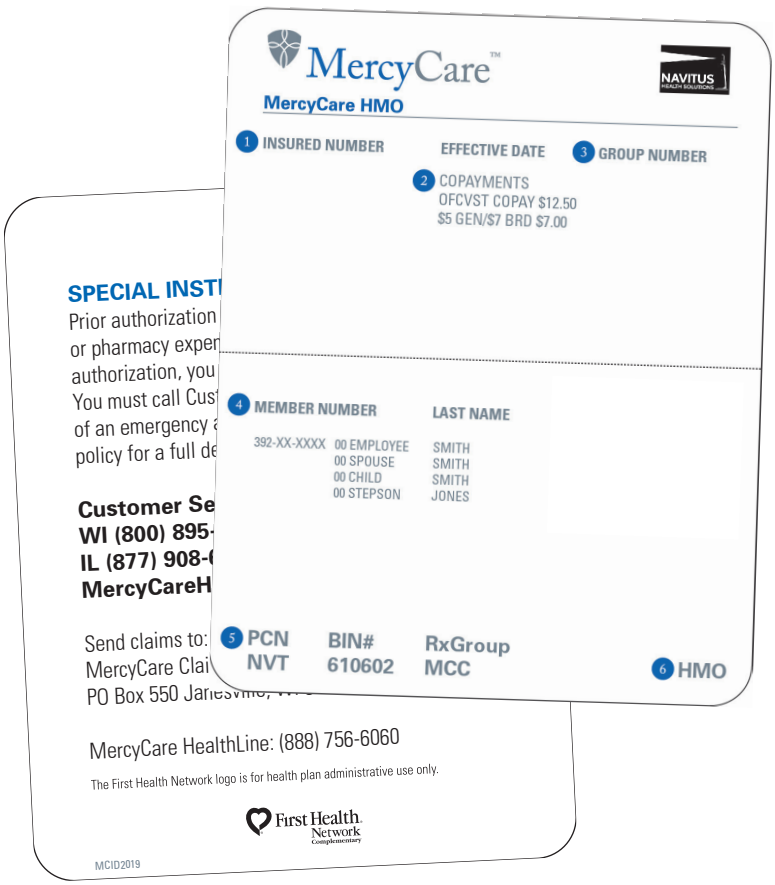
Providers who do not have access to Mercyhealth EPIC/Tapestry may submit a MercyCare Referral Form. The Quality Health Management staff at MercyCare will enter the referral into EPIC/Tapestry for you. Paper forms must contain complete information in all fields in order to be processed.

Where to Get a Referral Form

Online:	mercycarehealthplans.com/providers
Customer Service:	Wisconsin (800) 895-2421 Illinois (877) 908-6027

Member Identification Cards

MercyCare members receive ID cards that have information needed by providers to check a member's eligibility and benefits, and to submit claims. The ID card features the member name, ID number, group number and MercyCare contact information.



1. INSURED NUMBER: Identification number
2. CO-PAYMENTS
3. GROUP NUMBER: How MercyCare identifies your benefit package
4. MEMBER NUMBER: Personal ID number
5. PLAN ID: Designates your pharmacy plan
6. NAME OF PLAN: Type of plan you have

Pharmacy Management

As part of the continuing effort to control cost and monitor quality, MercyCare periodically reviews pharmacy utilization. The review process is carried out through the MercyCare Pharmacy and Therapeutics (P&T) Committee. Members of the P&T Committee include physicians and pharmacists. Committee activities may include drug profile review, correspondence with health care providers regarding drug utilization, and in some cases, correspondence with members related to medication use and formulary compliance. In addition, MercyCare publishes a drug formulary to assist health care providers in selecting the most cost-effective prescription medications for their patients.

MercyCare Drug Formulary

The MercyCare formulary has been designed to be comprehensive in addressing all therapeutic areas. Please indicate "may substitute" on prescriptions that are available as a generic. There may be occasions when an unlisted drug is desired for medical management of a specific patient because of allergies, therapeutic failure or specific clinical situations. In those infrequent instances, the unlisted medication may be requested through the Drug Exception process. Medication requests are reviewed by the MercyCare Clinical Pharmacist or Director of MercyCare Pharmacy Services using existing prior authorization (PA) criteria, current medical literature and manufacturer drug information.

Prior authorization medications have specific medical criteria that the MercyCare Clinical Pharmacist or Director of MercyCare Pharmacy Services uses to evaluate the request. Criteria for authorization are approved by the MercyCare P&T Committee. Non-formulary or prior authorization medications may be obtained for a patient by submitting a referral in Tapestry. Providers who do not have Tapestry access may fax a drug request form to (608) 758-7726.

The formulary is updated on a continuous basis, so check regularly to ensure you are aware of any changes. MercyCare reserves the right to change the formulary at any time without notice. Copies of the formulary, drug request forms and prior authorization criteria may be obtained at mercycarehealthplans.com or by calling MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL).

MercyCare Requests for Formulary Review

MercyCare welcomes health care provider input and participation. If you believe a drug should be included on the MercyCare formulary, send a written request to the Director of MercyCare Pharmacy Services. Requests for formulary changes are reviewed quarterly by the MCHP P&T Committee.

Formulary Options

MercyCare offers different formulary options to its members, based on the number of tiers. The member's drug plan depends on the benefit selected by the employer or individual. If you have questions about which formulary is available for a member's drug plan, call MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL).

MercyCare's formulary options include:

Two Tier

- Tier 1 is for preferred generic drugs, and some preferred brand name drugs, and has the lower co-payment.
- Tier 2 covers selected preferred brand name drugs, select generic drugs, and clinically appropriate non-covered drugs that have been prior authorized by MercyCare, and has the higher co-payment.

Three Tier

- Tier 1 is for preferred generic drugs, and some (but not all) preferred brand name drugs, and has the lowest co-payment.
- Tier 2 covers preferred brand name drugs and select generic drugs, and has the second lowest co-payment.
- Tier 3 represents all non-preferred drugs and clinically appropriate non-covered drugs that have been prior authorized by MercyCare, and has the highest co-payment.

Four Tier

- Tier 1 is for preferred generic drugs, and some (but not all) preferred brand name drugs, and has the lowest co-payment.
- Tier 2 covers preferred brand name drugs and select generic drugs, and has the second lowest co-payment.
- Tier 3 represents all non-preferred drugs and clinically appropriate non-covered drugs that have been prior authorized by MercyCare, and has the third lowest co-payment.
- Tier 4 covers only selected generic drugs, selected brand name drugs, specialty drugs, and clinically appropriate non-covered specialty drugs (with prior authorization from MercyCare), and has the highest co-payment.

Pharmacy Formulary Key

The formulary is divided by alphabetical index and then category/class. The back of the formulary also has specific sections:

- Prior Authorization Drug List
- Over-the-Counter (OTC) Medications
- Mandatory Specialty Pharmacy (MSP) Medications
- Smoking Cessation Agents
- Quantity Limit (QL) Medications

In drug classes where there are several products on the market, only certain products within that class may be on the formulary. By limiting the products available, it is possible to reduce drug costs through the use of generic drugs and cost-effective choices. The key below demonstrates the meaning of the symbols in the formulary.

Formulary Key	
OTC	Over-the-Counter. Specific OTC products are covered with a prescription.
LD	Limited Distribution. Available through limited pharmacies. The specific pharmacy may be listed next to the drug on the formulary.
MSP	Mandatory Specialty Pharmacy Program. Specialty Pharmacy will be used to dispense selected medications. Members will select a Mercyhealth pharmacy to obtain the prescribed medication. A different network specialty pharmacy may be designated, depending on the drug and/or plan.
PA	Prior Authorization. PA criteria established. The P&T Committee has decided that PA drugs be used only in specific circumstances. Prescribers must follow the PA procedure to request coverage. Please see the Prior Authorization Procedure section for more detail. Prescriber must follow PA procedure to request coverage for PA drug. If denied or if PA was not submitted by the prescriber, the member pays 100% of the medication cost.
QL	Quantity Limits are established to promote safe, appropriate, and cost-effective use of specific classes of medications for both formulary and non-formulary agents. All members may receive a maximum of 30 days supply unless otherwise specified by drug rider, certificate, or summary plan description or by quantity limits listed in the formulary.
NC	Not Covered. Check the formulary for alternative medications that are covered. Drug Exception Procedure: Please see the Drug Exception section for more detail. If the physician believes that a drug not covered or not found on MercyCare formulary is necessary for the patient, then he or she must apply for the drug exception. Prescriber's office must submit a referral in Tapestry. Providers who do not have access to Tapestry may fax a drug request form to MercyCare at (608) 758-7726. Forms are available at mercycarehealthplans.com.

Drug Coverage for MercyCare

- Patient's medical condition and appropriate given the patient's medical history; and
- Prescribed in a manner consistent with its FDA approval and manufacturer recommendations; and
- Prescribed in its most cost-effective dosing regimen; and
- Used in a manner consistent with any and all guidelines and criteria developed, adopted, or researched by MercyCare.
- Most members can receive a supply of medication not exceeding 30 days for one copay. Some members have an enhanced benefit allowing them to receive up to a 90-day supply of certain medications. The MercyCare Customer Service Department can verify if the member has the enhanced benefit, and identify the drugs that can be prescribed in the larger supply.
- Covered drugs are only those available on a prescription basis; exclusions include most over-the-counter (OTC) medications. A limited number of OTCs are available and listed in the formulary.
- Insulin, diabetes monitoring products, and associated syringes and needles are covered.
- Generally, there is no coverage for other injectable medications unless it is included under the prior authorization process.

Prescription drug coverage applies to drugs provided to ambulatory patients and dispensed by the MercyCare network of retail pharmacies. The pharmacy benefit plan is managed internally. Co-payment amounts vary, depending on the plan selected by the employer group or individual. Each member's MercyCare identification card, schedule of benefits, and/or drug rider indicates the co-payment amount required for each prescription.

Limited additional coverage exists under the medical benefit for drugs administered on an outpatient basis in the physician's office. Drugs administered to hospitalized patients are covered directly in MercyCare's payment to the hospital and are also excluded from the prescription drug coverage.

Generic Medications

MercyCare covers and encourages the use of generic medications. Generic medications have the same active ingredient as the brand name and have undergone vigorous scientific comparison studies that are approved by the federal Food and Drug Administration (FDA). If a brand-name medication is not available in a generic form, your patients must pay a higher copay as outlined in their policy. Copay amounts are indicated on their prescription drug rider or schedule of benefits.

Non-covered Drugs and Expenses

Prescription drug benefits are not available for the following*:

- A prescription drug prescribed by a non-participating provider when:
  - the member was seeking care from this non-participating provider for reasons other than treatment of an emergency medical condition; or
  - the member did not receive prior authorization to see this non-participating provider.
- Prescription drugs not listed on the formulary, unless we approve an exception request.
- Prescription drugs newly approved by the FDA that we have not evaluated.
- Fertility drugs
- Replacement of any lost, stolen, or destroyed prescription drugs.
- Therapeutic devices or appliances, including hypodermic needles or syringes (except for diabetic supplies listed on the formulary)
- Any prescription drug or medicine that is administered or delivered to you by the health care provider.
- A brand name prescription drug when a generic is available, unless indicated as covered on the formulary.
- A generic or brand name prescription drug that:
- Is available over-the-counter; and
- The over-the-counter version is listed as covered on the formulary.
- A non-formulary prescription drug that is available over-the-counter, even if you have a prescription.
- A specialty prescription drug that is not obtained from the designated specialty pharmacy.
- Any drug or medicine that is taken by or administered to you while you are a patient in a licensed hospital, rest home or sanitarium, extended care facility, convalescent hospital, skilled nursing facility or similar institution.
- Any drug labeled "Caution: Limited by Federal Law to Investigational Use" or other wording with similar intent; experimental drugs; or FDA-approved drugs used for non-FDA-approved uses, or FDA-approved drugs used in non-FDA-approved regimens, even if you are charged. This exclusion does not include any prescription drug that meets the following criteria:
  - the drug is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; and
  - the drug is FDA-approved, including phase-3 investigational drugs; and
  - if the drug is an investigational new drug, it is prescribed and administered in accordance with the treatment protocol approved by the FDA for investigational new drugs.
- Anabolic steroids
- Growth hormones
- Brand name anti-obesity and anorexients (weight loss drugs), unless listed as covered on the formulary.
- Any prescription drug that is not medically necessary.
- Any prescription drug for a non-covered procedure or service, or the treatment of a complication from a non-covered procedure or service.
- Any prescription drug for a sickness or bodily injury not covered by the plan.

- Medication, other than prescription drugs or preferred OTC drugs, for which a member does not have a prescription.
- Prescription drugs that a member is entitled to get without charge under any Worker's Compensation laws or any municipal state or federal program.
- Nutritional supplements.
- Any prescription drugs dispensed to a member prior to the member's effective date of coverage under this policy, or after the member's policy termination date.
- Any drug when used for cosmetic treatment.
- Any drug when used for treatment of hair loss or hair growth.
- Unless listed as covered on the formulary, any medication used to obtain, treat, or enhance sexual performance and/or function, even if the problem is caused by organic diseases or a mental health condition.
- Any prescription drugs administered by injection, except for insulin injections and injections approved for coverage by our pharmacy and therapeutics committee.
- Homeopathic medications.
- Special formulations of covered drugs, such as sustained release, which are intended primarily for member convenience.
- Special packaging of covered drugs intended primarily for member convenience. This includes drugs that are not prescribed in their most cost-effective dosing regimen.
- Any drug used to treat hyperhidrosis.

*Exclusions may vary depending upon the plan.

Prior Approval (PA) Procedure

Drugs indicated with a PA are not covered unless they have been prior authorized by MercyCare. The health care provider must apply for prior approval for a specific patient and a specific drug and dose. The request must fulfill PA criteria. This ensures that these drugs are used in a manner consistent with all of the criteria cited in the section Covered Prescription Drugs. If you need a copy of PA criteria for specific drugs, please visit mercycarehealthplans.com, or call Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL).

The following information will be needed when requesting prior approval:

1. Patient name, member number, and date of birth
2. Health care provider name, phone number and fax number
3. Drug, strength and dosage form
4. Duration of therapy
5. Documentation of medical necessity

The provider's office must submit a referral in Tapestry. Providers who do not have access to Tapestry may fax a drug request form to MercyCare at (608) 758-7726 or visit mercycarehealthplans.com.

The MercyCare Clinical Pharmacist or Director of MercyCare Pharmacy Services will contact the health care provider if other information is needed, such as lab data or diagnosis.

If approved, patient information is updated electronically to allow the patient to obtain the drug from any participating pharmacy. If the request is denied, the physician and member will be notified in writing of the denial and appeal rights.

Drug Exceptions

This section does not apply to non-covered drugs.

If the provider believes that a drug not found on the MercyCare formulary is necessary for the patient then the provider must apply for the drug exception.

Drug exception criteria:

1. Patient previously treated with the drug and it would be dangerous to the patient's health or unreasonably difficult to switch patient to formulary alternatives, or
2. The requested drug is medically necessary and all formulary alternatives (including drugs from other drug classes) are inappropriate for the patient, or have failed.

In addition, the drug must be:

1. Medically necessary for the patient's medical condition, and appropriate given the patient's medical history; and
2. Prescribed in a manner consistent with its FDA approved indication(s) and manufacturer recommendations; and
3. Prescribed in its most cost-effective dosing regimen; and
4. Used in a manner consistent with any and all guidelines and criteria developed, adopted, or researched by MercyCare.
5. Not listed as an exclusion in the member's drug rider or certificate.

All exceptions are subject to approval from MercyCare.

Specialty Pharmacy Program

Prescription list

Actemra
Afinitor
Aranesp
Avonex
Capecitabine (Xeloda)
Cimzia
Cosentyx
Dalfampridine ER (Ampyra)
Dificid
Elmiron
Enbrel
Enoxaparin (Lovenox)
Epogen
Extavia
Forteo
Fulphila
Genotropin
Gilenya
Glatiramer (Copaxone)
Humira
Imatinib (Gleevec)
Isotretinoin (Accutane)
Kevzara
Neulasta
Orencia
Otezla
Procrit
Pulmozyme
Rebif
Retacrit
Riluzole (Rilutek)
Sensipar
Simponi
Temozolomide (Temodar)
TOBI
Tymlos
Udenyca
Vancomycin (Vancocin)
Xeljanz
Xifaxan
Zarxio

MercyCare uses Mercyhealth pharmacies, which are categorized as specialty pharmacies. Only these specialty pharmacies are used to dispense the select medications listed at left.

Some medications require prior authorization from MercyCare. After the request has been received and approved, MercyCare members are required to select a Mercyhealth pharmacy to obtain the prescribed medication. For more information, call MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL).

Although every attempt is made to ensure this listing is current, those drugs included or excluded are subject to change at any time. Call MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL) to confirm medications you are taking still apply.

Frequently asked questions

Q. When should I re-order my prescription(s)?

Re-order when you have 10 to 14 days of medication remaining.

Q. How do I pay for my order?

You may pay by credit card or flexible spending card. Checks and money orders are accepted for in-store pick-ups only.

Q. Where can I learn more about my medication?

Significant information pertaining to the use of your medication, possible side effects and instructions, are enclosed in each package.

Please call (608) 755-8700 or (877) 597-6627 for further assistance.

Pharmacy Locations

Mercyhealth Pharmacy–East
(608) 754-5194
3524 E. Milwaukee St.
Janesville, WI
Drive-up service available

Mercyhealth Pharmacy–Mall
(608) 754-0286
1010 N. Washington St.
Janesville, WI

Mercyhealth Pharmacy–Milton
(608) 868-6777
725 S. Janesville St.
Milton, WI

Mercyhealth Pharmacy–Riverside
(815) 971-1100
8201 E. Riverside Blvd., Ste. 1022
Rockford, IL

Mercyhealth Pharmacy–Walworth
(262) 245-2319
Hwys. 50 and 67
Lake Geneva, WI

Mercyhealth Pharmacy–West
(608) 741-6980
1000 Mineral Point Ave.
Janesville, WI

Mercyhealth Pharmacy–Woodstock
(815) 337-4116
2000 Lake Ave.
Woodstock, IL

Pick up your prescription on your way home with Mercyhealth Pharmacy Express:
- Visit pharmacy.mercyhealthsystem.org
- Choose the Mercyhealth pharmacy where your prescription is located
- Enter your prescription number
- Pick up your prescription on your way home

Or, call (877) 597-6627 to use our convenient Mercyhealth Mail Order Pharmacy and have your prescriptions delivered by mail.

Pharmacy Glossary

Certificate of Coverage This is issued to a MercyCare member and summarizes the terms, conditions and limitations of his or her health care coverage.

Co-payment The member's portion that the member is required to pay for certain covered expenses provided under their policy. A co-payment can either be a fixed dollar amount or a percentage of the total fee.

Covered Expense A service or supply specified in the certificate and the schedule of benefits for which benefits will be provided.

Formulary The comprehensive listing of prescription drugs available to a member.

Generic A prescription drug available from more than one drug manufacturer that has the same active therapeutic ingredient as the brand or trade name prescription drug prescribed.

Group The employer, which includes any individual, partnership, association, corporation, business trust, or any person or group of persons acting directly or indirectly in the interest of an employer in relation to an employee, for which one or more persons is gainfully employed.

Medically Necessary or Medical Necessity Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine.

Non-participating Pharmacy Any pharmacy that does not have a contractual relationship with us for the provision of pharmacy services or supplies to members.

Non-preferred Drug All drugs not on our preferred drug list.

Over-the-Counter (OTC) These drugs are on the preferred drug list and covered only with a prescription.

Participating Pharmacy Any pharmacy that has contracted with us to provide pharmacy services or supplies to members.

Preferred Drug Name brand, generic or over-the counter drugs listed on our preferred drug list.

Prescription Drug Any medicinal substance, the label of which, under the federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

Schedule of Benefits A summary of coverage and limitations provided under the policy.

MercyCare Plan Offerings

Who do we cover?

- Group
  - Large group (51+ total employees)
  - Small group (50 or less total employees)
- Individual and family
- Medicare Select (supplement)
- Medicaid

What insurance plans do we offer?

- HMO plans (Health Maintenance Organization) – HMO plan includes Mercyhealth providers and contracted providers.
  - Contracted providers: MercyCare contracts with Fort Healthcare, Watertown Regional Medical Center and others to provide health care to our members.
- EPO plans (Exclusive Provider Option) – EPO plan contracts exclusively with Mercyhealth providers.
- PPO plans (Preferred Provider Option) – PPO plans have two levels of care:
  - In-network providers – Mercyhealth and Firsthealth
  - Out-of-network coverage for providers outside of that network
- Health Savings Accounts (HSA) – These plans use our HMO network and give members the opportunity to put money aside in a specific health savings account to help cover future medical expenses.

Provider Performance Expectation

It is essential that providers assist MercyCare in ensuring both cost-effective, evidenced-based utilization of services and quality.

Performance Measures – Healthcare Effectiveness Data Information Set® (HEDIS)

HEDIS is a set of performance measures used by the majority of health plans across the nation. HEDIS data is collected annually though surveys, medical records, and claims.

MercyCare, as an NCQA-accredited health plan, must collect HEDIS data and report the results of the data collection.

MercyCare's HEDIS results are shared publicly. Employers and potential members can use the results to determine the quality and value to help guide their health plan purchasing decisions.

The table on page 32 contains HEDIS measures with outcomes that practitioners have the most control over.

HEDIS Measures for Child and Adolescent Health

HEDIS Measure	Description
Childhood immunization status	Children who have the following immunizations by their 2nd birthday: • 4 DtaP/DT • 3 IPV • 1 MMR • 3 H influenza type B • 3 hepatitis B • 1 chickenpox vaccine (VZV) • 4 pneumococcal conjugate vaccine • 1 hepatitis A • 2 or 3 rotavirus • 2 flu vaccines
Immunizations for adolescents	Adolescents who have had the following immunizations by their 13th birthday: • 3 HPV • 1 meningococcal • 1 Tdap or Td
Follow-up care for children prescribed ADHD Medication	Members aged 6-12 and newly dispensed a medication for attention deficit/hyperactivity disorder that had appropriate follow-up care. Two rates are reported: • One follow-up within 30 days of initiating medication • A total of three follow-up visits over 10 months
Appropriate testing for members with pharyngitis	Members 3 years and older who were dispensed an antibiotic only after obtaining a strep test. • If a member has another diagnosis justifying the antibiotic, no strep test is necessary. Nonsuppurative otitis media is not considered a diagnosis that justifies an antibiotic.
Appropriate treatment for members with upper respiratory infection	Members aged 3 months and older who were diagnosed with an upper respiratory infection (URI) and were not dispensed an antibiotic. • If a member has another diagnosis justifying the antibiotic, they are excluded from this measure. Nonsuppurative otitis media is not considered a diagnosis that justifies an antibiotic.
Weight assessment and counseling for nutrition and physical activity	Members aged 3-17 who had any outpatient visit. Evidence of the following must be documented in the record. • BMI percentile • Counseling for nutrition and physical activity

HEDIS Measures for Adults

HEDIS Measure	Description
Chlamydia screening in women	Women 16-24 years of age who are sexually active, pregnant or dispensed contraceptives who had a screening for chlamydia during the current calendar year. Patients still need screening if birth control prescription is for acne.
Cancer screening (breast, colorectal or cervical)	Breast cancer screening: • Women 50-74 years of age who had a mammogram to screen for breast cancer within the last two years. Colorectal cancer screening: • Men and women 50-75 years of age who had appropriate screening for colorectal cancer. Cervical cancer screening: • Women 21-64 years of age who had cervical cytology within the last three years. • Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years. • Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) contesting within the last five years.
Antidepressant medication management	Adults with a diagnosis of Major Depressive Disorder (MDD) and who were dispensed and remained on their antidepressant medication for at 180 days with no gap in refills longer than 31 days.
Avoidance of antibiotic treatment for acute bronchitis/bronchiolitis	Members age three months and older who were diagnosed with bronchitis or bronchiolitis who were not dispensed an antibiotic. • If a patient has another diagnosis justifying the antibiotic, they are excluded from the measure. Nonsuppurative otitis media is not considered a diagnosis that justifies antibiotic use.
Prenatal and postpartum care	Timeliness of prenatal care: • Pregnant women who had a visit with a PCP or an OB/GYN for their pregnancy in the first trimester. Postpartum care: • Pregnant women who had a postpartum visit with a PCP or an OB/GYN between 7-84 days after delivery.
Controlling high blood pressure	Members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year. • If a patient has a blood pressure reading over 140/90 mm Hg, a second blood pressure reading should be taken no matter the clinic location.

Quality Health Management

Affirmation Statement

1. Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage.
2. MercyCare does not specifically reward practitioners or other individuals for issuing denials of coverage or service or care.
3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Criteria notice

MercyCare uses the most current version of the following criteria for benefit determination:

- The member's Certificate of Coverage, Summary Plan Description and Schedule of Benefits
- Change Healthcare InterQual® Level of Care Criteria-Medical and Surgical
  - Medical Acute Inpatient and Alternative Levels of Care Adult
  - Medical Acute Inpatient and Alternative Levels of Care Pediatric
- Change Healthcare InterQual® Level of Care Criteria: for Behavioral Health (BH) Acute, Residential, Partial Hospitalization and Intensive Outpatient:
  - BH: Adult and Geriatric Psychiatry
  - BH: Child and Adolescent Psychiatry
  - BH: Substance Use Disorders
  - BH: Procedures
- Change HealthCare InterQual® Care Planning Criteria: Imaging
- Change Healthcare InterQual® Care Planning Criteria: Procedures
- Change Healthcare InterQual® Molecular Diagnostics (Genetic Testing)
- Change Healthcare InterQual® Care Planning Durable Medical Equipment
- Hayes® Medical Technology Directory
- National Comprehensive Cancer Network (NCCN) Clinical Guidelines/ Drug and Biological Compendium
- Federal Drug Administration (FDA) Guidelines
- CMS National Coverage Determinations for Durable Medical Equipment and Supplies
  - Except when specifically excluded or limited as stated in the member's certificate of coverage, summary plan description or schedule of benefits.
- MercyCare policies for specific procedures, devices, or drugs
- The member's pharmacy benefit and formulary
- GeneReviews® (NCBI)
- UpTo Date®

The criteria listed above and medical management policies are reviewed and revised as needed annually by the medical and behavioral health management staff at MercyCare. They are reviewed and approved annually by the MercyCare Quality Utilization Management Committee.

Call MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL) to request a copy of a specific set of criteria be faxed, emailed or mailed to you.

The entire set of Change Healthcare® criteria can be reviewed at our office. Call MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL) for more information.

Notice of MercyCare Quality Health Management Staff Availability

Business hours:	Monday-Friday, 8 am-4:30 pm CST
Customer Service:	Wisconsin: (800) 895-2421 or Illinois: (877) 908-6027
Quality Health Management:	(800) 757-6825
Fax:	(608) 758-7726

- Confidential personal voice mail and fax receiving services available 24 hours per day, 7 days per week.
- 24-hour, toll-free phone service
- Referrals via EPIC/Tapestry or fax can be submitted 24 hours per day, 7 days per week.
- Fax referrals, voice mails and non-urgent communications received after business hours will be responded to on the next business day.

Free for members

Language assistance and language translators for members are available and can be accessed through MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL).

TDD/TTY services for the deaf, hard of hearing and speech impaired: (800) 947-3529

State of Wisconsin Employee Trust Fund (ETF) (Medical Management)

The following require Prior authorization for ETF Members:

A. Procedures on the MercyCare Prior Authorization List

B. High-tech Radiology Procedures: Non Emergent CT Scans, MRIs, and Cardiac Stress Tests ordered by a primary care physician.

C. Referrals to neurosurgery or spinal surgeon for diagnosis of low back pain: The member must have had: (Policy: MS 102 Low Back Pain Referrals)
   - History of low back pain for > or equal to 3 months that has persisted despite an adequate trial of medication; and
   - A three-month history of conservative therapy (physical therapy/spinal manipulation trial or physiatry referral)
   - Prior authorization is not required for a member who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty referral.

D. Coordination of Care after Discharge from Hospital: ETF members greater than age 18 years who had acute inpatient admission greater than 24 hours for the diagnosis of pneumonia, myocardial infarction, or congestive heart failure will receive a follow-up call after discharge.

Utilization Management

Utilization management (UM) is the process of evaluating and determining the appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure the appropriate use of resources. MercyCare works in partnership with members and practitioners to promote the comprehensive delivery of health care services.

MercyCare QHMD consists of registered nurses and pharmacists, as well as quality management support staff. QHMD bases its decisions on appropriateness of care and services, nationally recognized criteria (Mckesson Interqual® and Hayes Medical Technology®), the member's benefit package and certificate of coverage. Utilization management decisions may include inpatient hospital admissions, outpatient procedures, behavioral health transitional and inpatient services, skilled nursing facility admissions, out-of-network referral requests, and rehabilitation and home health services. The MercyCare Medical Director and Behavioral Health Medical Director (Psychiatrist) are responsible for designing, executing, and fully implementing an appropriate utilization management program in their respective areas of expertise and provide direct supervision of all utilization management activities. A staff of experienced registered nurses conducts the day to day UM program implementation services and oversees all approval review decisions. A licensed physician reviews all denials that are based on medical necessity determinations.

Annually, a comprehensive review of the MercyCare Utilization Management (UM) Medical and Behavioral Health Plan is completed by the licensed UM staff. It is then presented to the Quality Health Management Committee.

Utilization Management Plan

Annually, MercyCare, together with the Medical Director and the Medical Director of Behavioral Health, reviews, revises, and implements our Utilization Management (UM) Plan. The Utilization Management Plan establishes our program structure and health care aspects for the Medical and Behavioral Health Programs. The UM plan defines the scope, process and information sources used to determine benefit coverage and medical necessity. The UM plan and the policies attached to the UM Program define UM staff responsibilities, the process for denial determinations, including how to contact a reviewer at MercyCare who made a determination, and how to file an appeal. The review of the previous year UM plan and the current year UM plan together with the policies are presented annually for review, discussion and approval by the MercyCare UM Committee.

Obtain a copy of the review of the previous year's UM plan, or the current UM plan, by calling MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL).

MercyCare Quality Improvement Utilization Management (QIUM) Committee

The MercyCare Medical Director serves as the chairperson for the QIUM Committee. The committee includes the Behavioral Health Medical Director and other physicians with diverse specialties. The MercyCare QIUM Committee is responsible for review of the MercyCare Medical and Behavioral Health UM plan including, but not limited to: UM policies, procedures, criteria and policies used to make determinations, new technology policies, adherence audits, and UM data to determine patterns of over- or under-utilization, including components related to behavioral health. You may obtain a copy of the policy or criteria used to make determinations by contacting the Quality Health Management Department at (800) 895-2421 (WI) or (877) 908-6027 (IL).

Referrals

MercyCare has an extensive network of participating providers and specialists. If the specialty care that a participating MercyCare PCP wants the member to receive is available within the member's MercyCare provider network, the PCP will direct the member to an in-network specialist. MercyCare does not require pre-approved referrals to specialists within the member's provider network. If medically necessary care is not available from a network provider, the PCP or another network practitioner may submit a referral for services with an out-of-network provider.

Network providers with access to Mercyhealth EPIC/Tapestry are required to submit all referrals and prior authorizations via Mercyhealth EPIC/Tapestry.

If you are a network provider and do not have access to Mercyhealth EPIC/Tapestry and you would like to request approval to obtain access to submit referrals and prior authorizations via EPIC Care Plan Link, email mercycareprovidermaint@mhemail.org.

For network providers without access to EPIC Care Plan Link or Mercyhealth EPIC/Tapestry, please use the MercyCare Referral and Prior Authorization Form or call our Prior Authorization Department at (800) 757-6825.

If a MercyCare Commercial Plan is secondary to another Commercial Plan, determination of primary insurance must be obtained by the provider prior to submitting a request to MercyCare.

All out-of-network services require prior authorization for:
- HMO
- EPO
- MHS EPO
- Exchange and Off Exchange EPO and HMO
- Il Commercial
- Il Off Exchange
- Medicaid
- Medicare Supplement

If Mercyhealth EPIC/Tapestry creates a referral record from a referral order, or any other process where a referral record is created, the referral record must be processed by MercyCare.

EPIC/Tapestry may create referrals even if the service is not on a list for prior authorization/medical review. Once a referral record has pended for review at MercyCare, providers should not manually change the status of a referral record to no re-cert required or any other status, as this could affect referral processing and claims payment.

Prior Authorization List

MercyCare reserves the right to alter or amend this list based on coding or benefit changes, or any other circumstance. MercyCare will make every effort to notify providers of a change. If you have any questions or concerns regarding this process, call MercyCare at (800) 895-2421 (WI) or (877) 908-6027 (IL).

Prior Authorization	Coverage Options	Medicaid	Medicare Select	ETF
Abortion	NC	X	NC	NC
Arthroscopic surgery: Knee and shoulder	X	X	X	X
Autism treatment and therapy (intensive and non-intensive ABA therapy, occupational therapy, speech therapy, physical therapy). Psychological, neuropsychological testing. Network consults for evaluation and diagnosis do not need prior authorization.	X	OT, ST, PT: YES. See Applied Behavioral Therapy	NC	X
Bariatric surgery (Only in benefit for MHS EPO, PPO, Medicaid and Federal Employee group)	X	X	X*	NC
Behavior health residential treatment Mental Health and Substance Use Disorder (Facility will pre-certified directly with MCHP)	X	NC	Out-of-Network only	X
Behavioral health: Inpatient, Intensive Outpatient (IOP**), Partial Hospitalization (PHP**), (MH and SUD) Network	X	X	Out-of-only	X
Biofeedback: Covered for torticollis, urinary incontinence and headaches only	X	X	Out-of-Network only	X
Chiropractor visit: Pre-certified required post 10 visits	X	X	X	X
Circumcision: Outpatient AND if member is >30 days old	X	X	Out-of-Network only	X
CT scan: For EPIC/Tapestry users, a referral order creates a referral record that must be processed. Tapestry will pend for review any CT scans that must be medically reviewed.	X	X	Out-of-Network only	X
DME/medical supplies***	X	X	Out-of Network only	X
Genetic testing	X	X	X	X

Coverage Options = Exclusive Provider Option (EPO) , Health Maintenance Option (HMO), Preferred Provider Option (PPO) Mercyhealth EPO, Mercyhealth PPO; **Medicaid** = Mercyhealth Medicaid **Medicare Select** = Mercyhealth Medicare Select Option; **ETF** = Employee Trust Fund; **X** = YES, prior authorization is required; **NC** = not covered; **NA** = No pre-certification required. *No pre-cert required for Medicare-covered services with a network provider. *Plan only covers services covered by Medicare **No prior authorization required if PHP and/or IOP obtained at Mercyhealth Behavioral Health clinics or facility ***Network DME/supply vendor will PA directly with MCHP any DME/supplies that require PA

Prior Authorization *continued*

Prior Authorization	Coverage Options	Medicaid	Medicare Select	ETF
Home health and home infusions (HH and HI providers will prior authorize with MercyCare)	X	X	X	X
Hospice (facility will prior authorize with MercyCare)	X	X	Out-of-Network only	X
Hospital services: Inpatient or Observation: Elective scheduled admissions: Admitting MD submits PA. Unplanned or Emergent Admits: Facility will PA directly with MercyCare.	X	X	Out-of-Network only	X
Hysterectomy or hysteroscopy	X	X	Out-of-Network only	X
Infertility/reproductive endocrinology procedures	X	NC	Out-of-Network only	X
Laser treatment: Blue light laser (96567, J7308)	X	X	Out-of-Network only	X
Laser treatment: Xtract (96920, 96921, 96922)	X	X	Out-of-Network only	X
Laser treatment: Any other	X	X	Out-of-Network only	X
Medications that are administered in outpatient and office settings – Select infusible drugs require pre-authorization as indicated in tapestry. For a current list of J codes that require pre-authorization call MercyCare Customer Service.	X	X	Out-of-Network only	X
MRI/MRA: All non-partcipating or non-Mercyhealth providers need PA. For MHS EPIC/Tapestry users, a referral order creates a referral record. The referral record must be processed. EPIC/only Tapestry will send for review all non-emergent MRI scans ordered by a PCP.	X	X	Out-of-Network	X

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Prior Authorization *continued*

Prior Authorization	Coverage Options	Medicaid	Medicare Select	ETF
Neuropsychological and psychological testing	X	X	Out-of-Network only	X
Neurosurgery (any procedure)	X	X	Out-of-Network only	X
Oral surgery: Except impacted wisdom teeth (D7220, D7230, D7240) extraction and service is being provided by network provider at their clinic.	X	X	NC	X
Pain pump implantable or implantable nerve stimulator	X	X	Out-of-Network only	X
PET scan	X	X	Out-of-Network only	X
Reconstructive/cosmetic surgery: including but not limited to blepharoplasty, rhytidectomy; lipectomies; abdominoplasty; otoplasty; scar revision or treatment, laser, any procedure considered cosmetic	X	X	Out-of-Network only	X
Rhinoplasty or septoplasty	X	X	Out-of-Network only	X
Skilled nursing facility admission (facility will PA directly with MCHP)	X	X	Out-of-Network only	X
Sterilization (male or female)	NA	X	Out-of-Network only	X
TMJ: Surgery, procedures, treatments, DME or supplies	X	X	Out-of-Network only	X
Total joint replacement: any joint	X	X	Out-of-Network only	X

Coverage Options = Exclusive Provider Option (EPO) , Health Maintenance Option (HMO), Preferred Provider Option (PPO) Mercyhealth EPO, Mercyhealth PPO; **Medicaid** = Mercyhealth Medicaid **Medicare Select** = Mercyhealth Medicare Select Option; **ETF** = Employee Trust Fund; **X** = YES, prior authorization is required; **NC** = not covered; **NA** = No pre-certification required. *No pre-cert required for Medicare-covered services with a network provider. *Plan only covers services covered by Medicare **No prior authorization required if PHP and/or IOP obtained at Mercyhealth Behavioral Health clinics or facility ***Network DME/supply vendor will PA directly with MCHP any DME/supplies that require PA

Prior Authorization *continued*

Prior Authorization	Coverage Options	Medicaid	Medicare Select	ETF
Transplant evaluations and transplants	X	X	X	X
Varicose vein surgery and/or laser treatment and/or injection for veins	X	X	Out-of-Network only	X

LEGEND: **Coverage Options** = Exclusive Provider Option (EPO) , Health Maintenance Option (HMO), Preferred Provider Option (PPO) Mercyhealth EPO, Mercyhealth PPO; **Medicaid** = Mercyhealth Medicaid **Medicare Select** = Mercyhealth Medicare Select Option; **ETF** = Employee Trust Fund; **X** = YES, prior authorization is required; **NC** = not covered; **NA** = No pre-certification required. *No pre-cert required for Medicare-covered services with a network provider. *Plan only covers services covered by Medicare **No prior authorization required if PHP and/or IOP obtained at Mercyhealth Behavioral Health clinics or facility

Medical, Behavioral Health and Pharmacy Requests are Categorized as Listed	
Pre-service requests Non-urgent; 14 days	Any care or service that must be approved in advance of the member obtaining services. Your certificate of coverage and schedule of benefits list services that must be prior authorized by MercyCare. Your network practitioner has the list of surgical procedures that must be prior authorized by MercyCare. Non-urgent requests for services will have a decision made as soon as possible but within 14 days of the request for services. The request date for non-urgent services will be the day it is received by MercyCare. Non-urgent requests for services that are received at MercyCare after the close of business will be marked as received on the next business day.
Pre-service urgent requests: 72 hours	Any request for medical care or treatment that, if the decision was delayed more than 72 hours from the receipt of the request, the delay could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Pre-service urgent requests may also include requests where a practitioner who knows the member's medical condition can state that a delay of more than 72 hours in the decision process would subject the member to severe pain that could not be adequately managed without the care or treatment that is being requested. Decisions will be made within 72 hours of receiving the request. Pre-service urgent requests do not include services received at an urgent care center or emergency department. MercyCare does not prior authorize or require pre-certification of services received in an urgent care facility or emergency department.
Concurrent review: 24 hours of receipt of information	A review for services that have been previously approved and the course of treatment is ongoing. Concurrent review is typically associated with inpatient hospitalizations, skilled nursing care or ongoing ambulatory care. It will include an ongoing assessment of your care to ensure appropriate care, treatment, length of stay, and discharge planning. All inpatient admissions require notification to MercyCare of the admission. MercyCare is notified of Mercyhealth facility admissions via a daily EPIC report.

Medical, Behavioral Health and Pharmacy Requests are Categorized as Listed	
Urgent concurrent review: 24 hours	A review of services when the treatment is ongoing and the hospital admission or services were not previously approved. MercyCare will make a coverage decision within 24 hours of receiving the information.
Post-service requests: 30 days	All emergent admissions require notification to MercyCare. Please contact MercyCare within 24 hours of admission or as soon as possible. MercyCare is notified of emergent admissions to a Mercyhealth facility via a daily EPIC report.
Other benefit limitations	Any request for care or services after the service has already been provided. This may include a request for an out-of-network appointment that a member has already attended or a hospital inpatient stay from which the member has been discharged prior to MercyCare being notified of the admission. The member may have other benefit limitations depending on their individual Schedule of Benefits and/or Certificate of Coverage. Some benefits may be limited. Please call MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL) for benefit and eligibility information.

Written Notification

Written notification will be sent to the member and the requesting practitioner for approved referral requests for out-of-network services. This notification will state what services are approved. If you do not receive a written approval from MercyCare, then the services have not been approved. Notifications will be sent based on member availability and provider status on EPIC or Plan Link in this order of eligibility:

Member: 1. EPIC/MyChart, 2. United States Postal Service (USPS) Mail

Provider: 1. EPIC/In Basket, 2. Fax, 3. USPS Mail

Denial Information

When referral or requests for medical or behavioral health services are denied, MercyCare will notify the member and the referring practitioner in writing of the denial decision. The written denial notice will contain the reason for the denial, a reference to the benefit provision, guideline, protocol, or other criteria on which the decision is based, and notification how the member, their designated representative, or their treating practitioner can obtain a copy of the actual benefit provision, guideline, protocol or criteria on which the denial decision was based.

The denial notification will include a toll-free number and information on how the treating or referring provider may contact the reviewer at MercyCare who made the determination.

The denial notification will also contain written notification to the member and their treating practitioner of their appeal rights, including the right of the member to submit written comments, documents or other information relevant to the appeal. The denial notification will also have an explanation of the appeal process, including the right to member representation or a representative of the member's choice, including an attorney to attend the hearing, the time frames for deciding appeals, and a description of the expedited appeal process for urgent pre-service or urgent concurrent denials. The denial notice will explain that if the requested service is for urgent care or ongoing treatment, how the member may request an expedited external review concurrently with the internal appeal process at MercyCare. The denial notification will also notify the member and their referring physician of the Independent Review Process for Wisconsin or Illinois if applicable. The appeal will include a person to review the case who was not involved or subordinate to anyone who was involved in the denial.

Prior to an appeal, within 14 days of the denial decision, the provider can request a peer-to-peer discussion with the physician who made the decision or the Medical Director. This can be done by calling (800) 757-6825 and giving the three best times/days for a call back to the provider. This can also be done by directly calling the Medical Director but there may be a delay in response if the Medical Director is not in the office at the time of the call. Peer-to-peer requests after 14 days may be attempted based on availability of the Medical Director.

Durable Medical Equipment

MercyCare uses:

- Change Healthcare Interqual® Ambulatory Care Planning Criteria for Durable Medical Equipment and Supplies (DME)
- The member's certificate of coverage, summary plan or rules unique to his or her plan.
- Centers for Medicare and Medicaid Services (CMS) Coding System (HCPC) Manual and National Coverage Determinations, except when specifically excluded or limited by criteria as stated in the member's certificate of coverage or schedule of benefits or policy.
- Items specifically excluded or limited by the member's certificate of coverage, summary plan document or schedule of benefits or policy

The decision whether to rent or purchase an item of DME is determined by MercyCare based upon:

- The CMS Quarterly Fee Schedules; The HCPC code for the requested item listed as a Capped Rental (CR) shall be approved as a Capped Rental
- The Member's Certificate of Coverage, Summary Plan Description, and Schedule of Benefits.

Replacement and quantity limitations for each item shall be based on CMS National Coverage Determinations and Policies

- Medicare Claim Processing Manual, Chapter 15
- In the absence of any program instructions from Medicare, five (5) years shall be the reasonable useful lifetime of a piece of equipment.

MercyCare Medicaid DME and Supplies: MercyCare uses the Forward Health/ State of Wisconsin Policies and Fee Schedules to determine if the requested item is a covered code, eligible for rental or purchase, and life expectancy. In addition, we use Change Healthcare Interqual® Durable Medicaid Equipment to determine medical necessity of the requested item. Determinations of what codes/items require Prior Authorization is determined by MercyCare.

MercyCare Medicare Select Plan: MercyCare will only cover items covered by Medicare.

If you order durable medical equipment, orthotics or prosthetics or medical supplies from a network DME provider, the network DME provider will obtain the needed prior authorization for the ordered item.

The ordering provider does not need to submit the referral.

Genetic Testing

Genetic testing requires prior authorization. Genetic counseling is required before genetic testing is ordered.

Genetic counseling is covered when:
- It is associated with a covered and approved test; or
- It is for the purpose of deterring if a specific genetic test is appropriate.

Genetic testing is covered with prior authorization from the plan when:
- The is test is not considered experimental or investigational.
- The test is medically necessary.
- The results will affect the course of medically necessary treatment.

Non-covered genetic services:
- Direct to consumer genetic testing
- Paternity testing
- Fetal sex determination
- Genetic testing of a non-plan member
- Genetic counseling that is associated with non covered genetic tests
- Genetic testing when the results do not provide direct medical benefit to the plan member

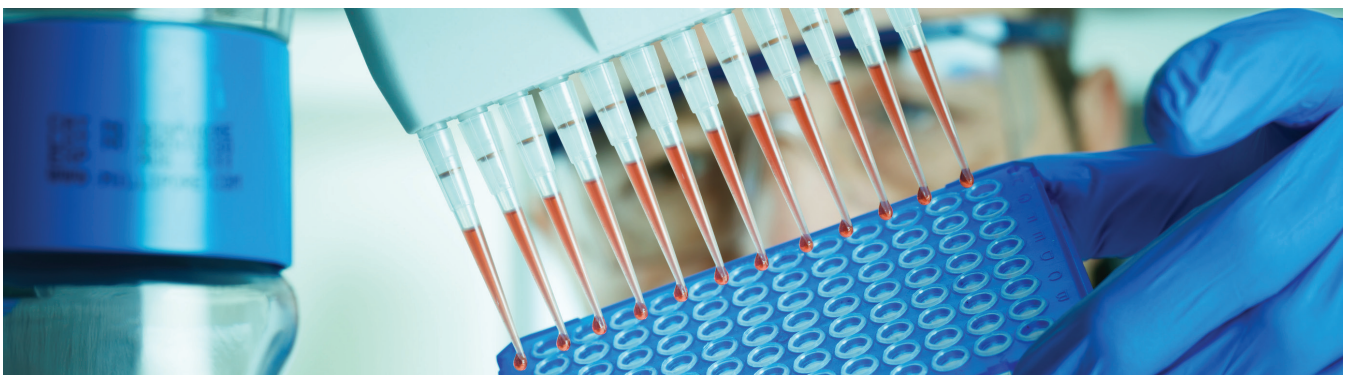
Plan Link Provider Access Portal

To access the MercyCare Plan Link Portal, to obtain information on demographic and claim information, email mercycareprovidermaint@mhemail.org.

Contact Us with Questions

For questions you may have regarding this provider manual please refer to page 3 of this document.

If you would like printed copies of any of the documents mentioned in this manual, call MercyCare Customer Service at (800) 895-2421 (WI) or (877) 908-6027 (IL). Documents will be mailed to you via the US Postal Service.



Live well.
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