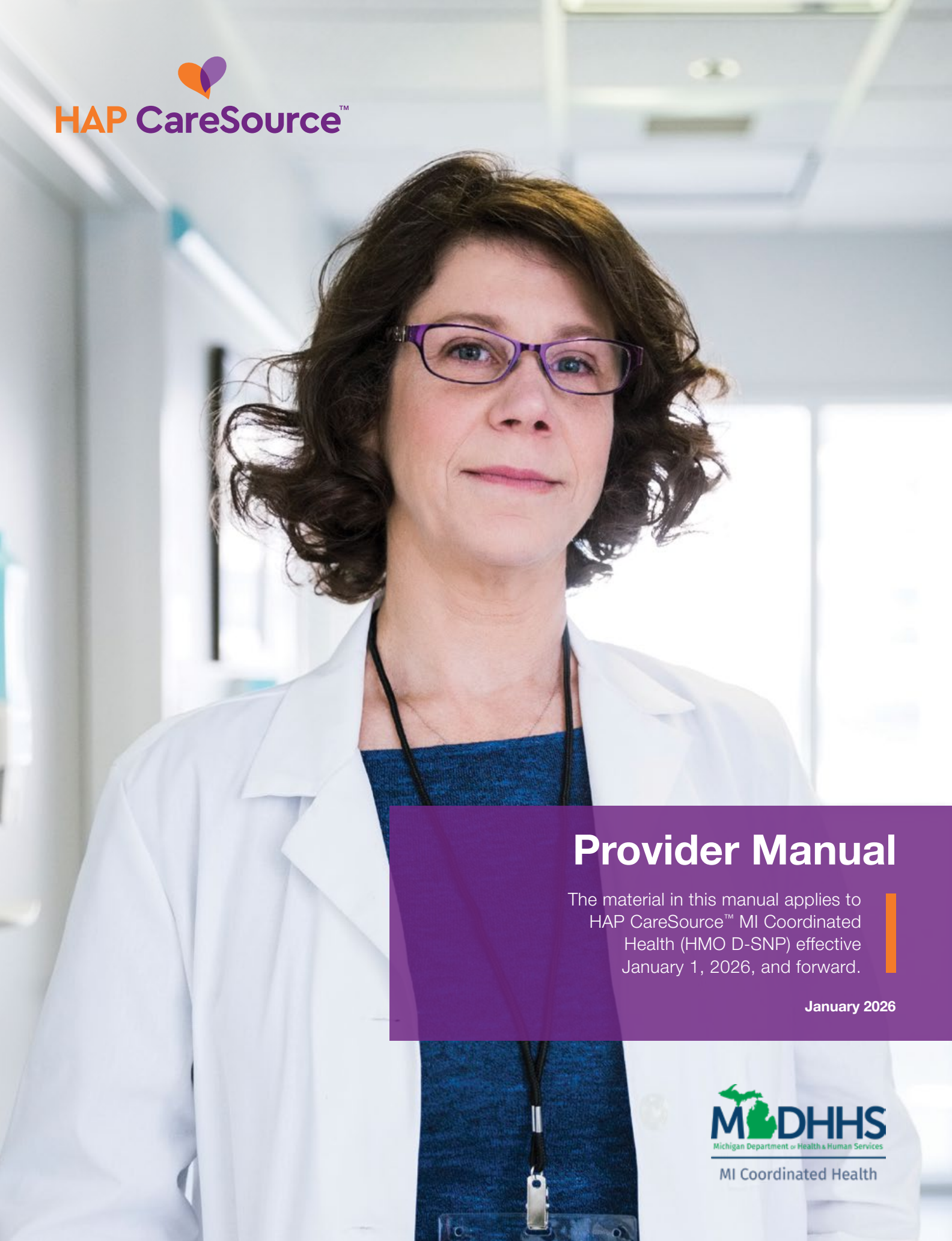
HAP CareSource™



Provider Manual

The material in this manual applies to HAP CareSource™ MI Coordinated Health (HMO D-SNP) effective January 1, 2026, and forward.

January 2026

MDHHS Michigan Department of Health & Human Services

MI Coordinated Health

Table of Contents

Section 1: Overview

HAP CareSource™ MI Coordinated Health (HMO D-SNP)

HAP CareSource MI Coordinated Health provides high-quality, seamless and cost-effective care through coordinated, person-centered services meeting the unique needs of all members who are dual eligible for both Medicare and Medicaid. We work collaboratively with our contracted network providers to improve the quality of care while limiting duplication of services and ensuring cost-effective plans of care. All services provided are consistent with the Medicare and Medicaid manuals, guidance, memoranda and other related documents.

We provide services for MI Coordinated Health in regions 10 and 12, which are Macomb and Wayne counties.

We contract with primary care physicians (PCPs) and specialty physicians who are licensed in Michigan as either a medical doctor (MD) or a Doctor of Osteopathic Medicine (DO). All HAP CareSource Medicaid and HAP CareSource MI Coordinated Health physicians must meet credentialing standards and uphold the managed care philosophy of the Plan. Providers that participate with HAP Medicare Advantage participate with MI Coordinated Health.

HAP CareSource™ Medicaid Plan

HAP CareSource, a Michigan Medicaid Health Plan, is a partnership between Health Alliance Plan of Michigan (HAP) and CareSource. It's a nonprofit, taxable corporation and accredited by the National Committee on Quality Assurance (NCQA). It has a contract with the Michigan Department of Health and Human Services (MDHHS) to provide health care services to Michigan Medicaid (including Children's Special Health Care Services [CSHCS]) and Healthy Michigan Plan (HMP) members in regions 6, 7, 9 and 10.

- Region 6 – Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair and Tuscola counties
- Region 7 – Clinton, Eaton, Ingham counties
- Region 9 – Jackson, Hillsdale, Lenawee, Livingston, Monroe and Washtenaw counties
- Region 10 – Macomb, Oakland and Wayne counties

HAP CareSource follows guidelines from the MDHHS which can be found in the MDHHS Medicaid Provider Manual. The Manual contains coverage, billing and reimbursement policies for Medicaid, HMP, CSHCS, Home and Community-Based Services (HCBS), Maternity Outpatient Medical Services (MOMS) and other health care programs administered by the MDHHS.

The MDHHS communicates updates to Michigan Medicaid policy and the Medicaid Provider Manual through policy bulletins, which can be found at https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers/policyforms/policy-letters-and-forms. Select *Policy, Letters or Forms.* You'll find *The Medicaid Provider Manual* and *Michigan Medicaid Approved Policy Bulletins.*

Mission Statement

HAP CareSource MI Coordinated Health is committed to providing excellence in our managed care product lines for our members through fiscally responsible programs that ensure access to and the delivery of cost-effective and high-quality medical services.

About Health Alliance Plan

Health Alliance Plan (HAP) is a Michigan-based, nonprofit health plan that provides health coverage to individuals and companies of all sizes. For more than 60 years, HAP has partnered with leading doctors, hospitals, employers and community organizations to enhance the health and well-being of the lives it touches. HAP offers a product portfolio with six distinct product lines: Group Insured Commercial, Individual, Medicare, Medicaid (using the HAP CareSource name), Self-Funded and Network Leasing. HAP excels in delivering award-winning preventive services, disease management and wellness programs, as well as personalized customer service. For more information, visit hap.org.

About CareSource

CareSource is a nonprofit, nationally recognized managed care organization with over two million members. Headquartered in Dayton, Ohio since its founding in 1989, CareSource administers one of the largest Medicaid managed care plans in the United States. The organization offers health insurance, including Medicaid, Health Insurance Marketplace and Medicare-Medicaid products. As a mission-driven organization, CareSource is transforming health care with innovative programs that address the social determinants of health, health equity, prevention and access to care. For more information, visit: **CareSource.com**, follow @CareSource on X, or like CareSource on Facebook.

HAP CareSource offers:

- **HAP CareSource Medicaid** in Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola, Wayne, Jackson, Livingston, Washtenaw, Hillsdale, Lenawee, Monroe, Clinton, Eaton and Ingham counties
- **HAP CareSource MI Coordinated Health** (Medicaid and Medicare combined) in Macomb and Wayne counties

The information below is a high-level overview of the Medicaid and MI Coordinated Health programs. Detailed information can be found at www.michigan.gov/mdhhs.

MDHHS determines which program is most beneficial to the member upon application. They will enroll the member in the appropriate program based on the categories of need and income.

Program	Description	Eligibility Criteria
Children's Special Health Care Services* **Persons with Special Health Care Needs**	It is for children and some adults with special health care needs and their families.	• Qualifying medical condition • Age: - Children must be under the age of 26 - Persons 26 and older with cystic fibrosis, sickle cell, or certain hereditary blood coagulation disorders commonly known as hemophilia may also qualify • Citizenship: - A U.S. citizen - A documented non-citizen who has been admitted for permanent residence - A non-citizen legally admitted migrant farm worker (i.e., seasonal agricultural worker) • Must be a Michigan resident • For additional details or to submit a Medical Eligibility Referral Form (MERF) for an individual, please visit Children's Special Health Care Services (michigan.gov)
Medicaid	Comprehensive health care coverage provided by the state for people of all ages with low income at or below the federal poverty level	Determined by the state. Criteria include: • Age • Income • Financial resources • Other information
MI Coordinated Health	Complete health care coverage for people in specific Michigan counties who are age 21 and over and currently enrolled in both Medicare and Medicaid	• Age 21 and older • Enrolled in both Medicare and Medicaid • HCBS/long term support services (LTSS) programs • Not enrolled in hospice • Live in Macomb or Wayne counties

*See the following pages for more details.

Children with Special Health Care Services Program

Children with a serious chronic medical condition could be eligible for CSHCS—a State of Michigan program that serves children (and some adults) at no cost. Currently there are over 2,700 diagnoses that qualify a member for CSHCS.

CSHCS works with many agencies to provide resources and services. A few examples are below:

Family Center for Children and Youth with Special Health Care Needs (Family Center)

This center provides support networks and training programs. It also offers:

- CSHCS Family Phone Line – a toll-free phone number **1-800-359-3722** available Monday through Friday from 8 a.m. to 5 p.m. Eastern Time (ET)
- Parent-to-parent support network
- Parent/professional training programs
- Financial help to attend a conference about CSHCS medical conditions
- Financial help for siblings of children with special needs to attend conferences and camps

The Children with Special Needs (CSN) Fund

The CSN Fund helps families get items that are not covered by Medicaid or CSHCS. Examples of items include:

- Wheelchair ramps
- Van lifts and tie-downs
- Therapeutic tricycles
- Air conditioners
- Adaptive recreational equipment
- Electrical service upgrades for eligible equipment

Members can call **1-517-241-7420** to see if they qualify for help.

County Health Departments

The member's county health department can help them find local resources, such as:

- Schools
- Community mental health care
- Respite care
- Financial support
- Childcare
- Early On program
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program

Section 2: Network Development and Contracting Process

Joining HAP CareSource MI Coordinated Health Plan

To join the HAP CareSource MI Coordinated Health Plan, visit hap.org/providers, select Join HAP, then complete the appropriate application.

Changes in Existing Provider Information

We have a Provider Change Form that you can use to update existing provider information such as:

- Billing and office address changes
- Ownership changes
- Tax ID changes
- Terminations from HAP CareSource MI Coordinated Health
- Changes to patient accepting status
- Provider type or specialty changes or additions
- Transferring networks

You can also find it on the HAP.org/Providers webpage.

Simply download the form, complete it and then email it to providernetwork@hap.org. Note: If you are part of a physician organization/physician hospital organization, do not send the form directly to HAP. All changes must be submitted from your Physician Organization or Physician Hospital Organization. Someone will reach out to confirm information and/or we will respond within 24-48 hours if we have any questions.

Provider Terminations by HAP CareSource MI Coordinated Health

HAP CareSource MI Coordinated Health may immediately terminate a provider contract, pursuant to the termination provisions set forth in the Provider Agreement. Grounds for immediate termination include:

- Conviction of Medicaid or Medicare fraud or any other fraudulent activity
- Failure to meet or comply with HAP CareSource MI Coordinated Health credentialing requirements
- Suspension or exclusion from the state Medicaid program, federal Medicare program or any other governmental public-sector program
- The possibility of the member's safety or care being adversely affected by the contract's continuation

Notice to the member will be provided by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice.

For more information, see the *Termination of Providers Policy* in the Credentialing section.

Network Adequacy

HAP CareSource MI Coordinated Health monitors their provider networks to ensure reasonable availability and accessibility of medical care and services for members. We review the following at least annually:

- Mapping of the location of providers within required time and distance standards to where a member lives
- Telephone accessibility and appointment availability audit of wait times and availability of providers for new and existing patients

We make our best effort to ensure minority-owned or controlled agencies and organizations are represented in the provider network.

Physician Incentive Disclosure

HAP CareSource MI Coordinated Health does not pay financial incentives to practitioners or providers to withhold any health care or health care related services. HAP CareSource MI Coordinated Health does not make decisions about hiring, promoting, or terminating practitioners, providers or other staff based on the likelihood that the individual supports, or tends to support, the denial of benefits or services. HAP CareSource MI Coordinated Health does not reward practitioners, providers, or other individuals for issuing denials of coverage. HAP CareSource MI Coordinated Health makes decisions on evidence-based criteria and benefits coverage.

Our Pledge

HAP CareSource MI Coordinated Health continually strives to ensure that its members receive all necessary services at the appropriate time and in the appropriate setting. Utilization management decision-making is based on the appropriateness of care and service and the existence of coverage. HAP CareSource MI Coordinated Health does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. HAP CareSource MI Coordinated Health decisions are not based on incentives. HAP CareSource MI Coordinated Health does not offer financial incentives to encourage inappropriate underutilization of covered services.

Clinical Criteria

To assist in the continual improvement of health care delivery, practitioners and physicians may obtain clinical criteria or discuss utilization management decisions. Criteria used in decision-making may include, but is not limited to, state criteria, evidence-based criteria and HAP CareSource policies.

To discuss a utilization management decision or process with a physician reviewer or health care professional reviewer or to obtain a copy of the criteria used in the decision-making process, practitioners may contact HAP CareSource MI Coordinated Health at **1-833-230-2159**. Please have the member's name and HAP CareSource MI Coordinated Health ID number available to assist in accessing the case. HAP CareSource MI Coordinated Health physician reviewers are board certified and have current Michigan licenses to practice without restriction.

Section 3: Credentialing

HAP CareSource MI Coordinated Health ensures all practitioners applying for affiliation meet rigorous credentialing standards prior to approval for participation. All credentialing and recredentialing decisions are non-discriminatory and not based on an applicant's race, ethnic or national identity, gender, age, or sexual orientation. Providers have the right to be informed of their application status throughout the credentialing process.

- Providers have the right to review information submitted to support their credentialing application upon request to the HAP CareSource MI Coordinated Health Credentialing department. HAP CareSource MI Coordinated Health keeps all submitted information locked and confidential.
- Providers have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing department prior to presenting to the Credentialing Committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner will be notified and given the opportunity to correct this information prior to presenting to the Credentialing Committee.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department.

Primary Care Physicians

A PCP is an MD or DO who is listed as a general practice, family medicine, pediatrician, or internal medicine practitioner. Obstetrician Gynecologist (OB/GYN) practitioners and other specialists may be designated as a PCP if they agree to provide care for all medical conditions. PCPs must provide or arrange for coverage of services 24 hours per day, seven days per week. PCPs must be available to see patients a minimum of 20 hours per practice location per week.

Who is Credentialed and Recredentialed?

HAP CareSource MI Coordinated Health credentials and recredentials the following practitioners:

- Allopaths
- Acupuncturists (credentialed as an exception)
- Board certified behavior analysts
- Certified nurse midwives
- Certified registered nurse anesthetists
- Chiropractors
- Dentists (only oral and maxillofacial surgeons providing care under medical benefits)
- Fully licensed psychologists (PhD or PsyD)
- Licensed professional counselors
- Master level psychologists
- Master level social workers
- Nurse practitioners
- Optometrists
- Osteopaths
- Podiatrists
- Physician assistants
- Psychiatric clinical nurse specialists
- Marriage and Family Therapists (MFT)

Who is Not Credentialed?

HAP CareSource MI Coordinated Health does not credential:

- Practitioners who practice exclusively within the inpatient setting and provide care for members being directed to the hospital or another inpatient setting (i.e., hospitalists, pathologists, radiologists, anesthesiologists, neonatologists and emergency room physicians)
- Practitioners who practice exclusively within freestanding facilities
- Practitioners who provide care for members being directed to the facility
- Locum tenens providers
- General dentistry providers

Verification

All potential provider candidates seeking credential certification must complete a Council for Affordable Quality Healthcare application. HAP CareSource MI Coordinated Health verifies:

- Board certification
- Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificates
- Education and training
- Hospital affiliations
- Licensure
- Malpractice history
- Work history
- Sanction information

Provider Disclosure of Ownership and Control Interest Statement Form Collection Process

Per regulations 42 CFR 457.935, 42 CFR 455.104-455.106 and 42 CFR Part 420, Subpart C sections 1124, 1124A, 1126, and 1861(v)(1)(i) of the Social Security Act, all network providers must complete a Disclosure of Ownership Interest Statement form. We provide the form in the provider application packet for initial credentialing. This form is also collected at change of ownership for existing providers or during the recredentialing cycle.

The HAP CareSource MI Coordinated Health Contracting and Credentialing teams will maintain the disclosure information in a manner which can be periodically searched for exclusions and provided to MDHHS per relevant state and federal laws and regulations.

All sections of the Disclosure of Ownership and Control Interest Statement form must be completed. Incomplete forms will not be accepted for contracting and credentialing. They will be returned to the provider for processing.

The form can be found online. Visit Join HAP.

Credentialing Policy and Process

HAP CareSource MI Coordinated Health uses a rigorous credentialing and recredentialing process to ensure our network providers meet regulations and accreditation standards, as required. You can find our credentialing policy in Appendix B of this Manual.

Ongoing Monitoring

We conduct ongoing monitoring of practitioner sanctions, complaints, and quality and safety issues within 30 days of release and take appropriate actions against practitioners when an occurrence of poor quality is identified.

Collecting and Reviewing Medicaid Sanctions

Reviews for Medicaid sanctions are completed within 30 calendar days of its release by the reporting entity. The review includes verifying practitioners' Medicaid and Medicare status from a query of one of the following:

- American Medical Association (AMA) Physician Master File Entry
- Federal Employees Health Benefits (FEHB) Program Department Record, published by the Office of Personnel Management, Office of the Inspector General
- National Practitioner Data Bank (NPDB) – Healthcare Integrity and Protection Data Bank (HIPDB)
- List of Excluded Individuals and Entities (maintained by OIG), available on the internet
- Medicare and Medicaid Sanctions and Reinstatement Report, distributed to federally contracted organizations
- State Medicaid agency or intermediary and the Medicare intermediary
- System for Award Management (SAM) – SAM.org, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts and certain types of Federal financial and non-financial assistance and benefits

Collecting and Reviewing Sanctions or Limitation on License

Reviews for sanctions or limitations on license are reviewed within 30 calendar days of its release by the reporting entity. This includes reviews of physician sanctions or limitation on licensure status from a query of one of the following:

- Disciplinary Action Report, published by the Michigan Department of Consumer and Industry Services
- NPDB-HIPDB

Reviews Non-Physician Health Care Practitioner Sanctions or Limitation on Licensure

Reviews for non-physician health care practitioner sanctions or limitations on license are reviewed based on a status from a query of one of the following:

- Appropriate state agencies
- NPDB-HIPDB
- State licensure or certification board

Reviewing Provider/Practitioners Self-Reporting and Individual/Employee Screening

- Providers are required to self-report claim/payment errors immediately to HAP CareSource MI Coordinated Health.
- Providers are required to conduct screening on individuals/employees to be compliant MDHHS-OIG guidelines.

Provider Performance Improvement Policy

The Performance Improvement Process is used to improve provider performance, when it has been determined that the provider is not meeting standards. HAP CareSource MI Coordinated Health has a well-defined Performance Improvement Process to improve provider performance. Behaviors that may lead to the initiation of the Provider Performance Process include but are not limited to,

- failure to comply with HAP CareSource MI Coordinated Health Policies and Procedures
- non-compliance with physician profiling performance improvement plan
- violation of provider contract
- acting in a manner that jeopardizes the health or safety of an enrollee
- fraud, waste and abuse that affects accreditation or licensure
- failure to correct such behaviors may lead to termination

You can find our Provider Performance Policy in Appendix B of this Manual.

Termination of Providers Policy

HAP CareSource MI Coordinated Health may terminate the privileges of a provider when it is determined that the provider has failed to comply with credentialing policies and procedures, violated his/her contract, or has acted in a manner that jeopardizes the health or safety of members; failure to report instances of non-compliance; failure to assist in the resolution of compliance issues, fraud, waste or abuse; or affects HAP CareSource MI Coordinated Health Plan's accreditation or licensure. You can find our Termination of Providers Policy in Appendix B of this manual.

Background Check

MDHHS may require additional screenings and/or background checks as a part of their verification process and as deemed required by their Provider Manual and policies. For more information about these requirements, visit MDHHS's website and review to this link.

Section 4: Provider Services

Communicating with Providers

HAP CareSource MI Coordinated Health communicates with its provider network via HAP CareSource MI Coordinated Health's website at **HAPCareSource.com**. It contains the most up-to-date information including:

- Pertinent policies and procedures
- Clinical guidelines
- Provider Manual with information such as:
  - Billing information
  - Prior authorization guidelines
  - Appeals process
  - Fraud, waste and abuse information
  - Member rights
  - More policies and procedures
- A newsroom with ad hoc announcements including but not limited to:
  - New policies and policy changes
  - New processes and process changes
  - New programs or initiatives

The MDHHS communicates updates to Michigan Medicaid policy and the Medicaid Provider Manual through policy bulletins which can be found at www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers. Select *Policy, Letters and Forms*. You'll find the *Medicaid Provider Manual* and *Michigan Medicaid Approved Policy Bulletins*.

Member Advocacy

HAP CareSource MI Coordinated Health does not prohibit any participating practitioner or allied health professional from discussing treatment options with members, regardless of benefit coverage, or from advocating on behalf of a member in any grievance, appeal, utilization review process, or individual authorization process to obtain health care services. HAP CareSource MI Coordinated Health will never take punitive action against a practitioner who requests an expedited resolution of an appeal or supports a member's appeal. Practitioners may freely communicate with patients about their treatment, including medication treatment options, regardless of benefit coverage limitations. Since the member's participation is an integral part of making decisions about their treatment and care, HAP CareSource MI Coordinated Health encourages providers to develop care plans with their patients or their patients' guardians or representatives. The provider may inform members of the provider's affiliation or change in affiliation.

Primary Care Physician (PCP) — Coordinator of Care

The PCP is responsible for supervising, coordinating and providing primary care to HAP CareSource MI Coordinated Health members. A PCP is a Medical Doctor (MD) or a Doctor of Osteopathic Medicine (DO) who is listed as a practitioner in family practice, general practice, internal medicine, or pediatrics. The PCP is selected by the member or assigned to the member and develops a Plan of Care collaboratively with the member, specialists, social workers, hospitals, rehabilitation clinics, other clinicians and family members.

OB/GYN practitioners, physician assistants, nurse practitioners and other specialists may be designated as PCPs if they agree to act as the PCP for certain chronic conditions or circumstances.

Female members are provided access to a women's health specialist within the provider network to provide for women's necessary preventive and routine health care services. This is in addition to the member's designated PCP if that provider is not a women's health specialist.

All HAP CareSource MI Coordinated Health Plan PCP's must participate with both Medicare and Medicaid.

PCP Reporting Requirements

Participating PCPs must submit all encounters with assigned members to HAP CareSource MI Coordinated Health Plan since HAP CareSource MI Coordinated Health Plan is required to submit this information to the MDHHS.

Payment Structure

Fee-For-Service

The PCP fee-for-service contract will process claims for all primary care and referral services at amounts equal to the current Medicaid fee-for-service rates.

PCP Incentive Program

HAP CareSource MI Coordinated Health has a pay-for-performance program, also called Best Practice Incentive Program for PCPs. Payment is based on quality outcomes for specific measures. Annually, we review our Best Practice Incentive Program and may revise it based on quality outcomes from the measurement year and goals set for the upcoming year.

Note: HAP CareSource MI Coordinated Health reserves the right to use practitioner performance data for activities designed to improve quality of care and services and overall member experience.

PCP Accessibility and Availability

PCPs are required to:

- Provide 24-hour a day, seven days a week PCP telephone coverage to your HAP CareSource MI Coordinated Health patients.
- Be available to see HAP CareSource MI Coordinated Health patients a minimum of 20 hours per location per week.
- Give written prior notice to HAP CareSource MI Coordinated Health of alternative coverage arrangements during times of non-availability. PCPs should encourage their members to contact them whenever possible, prior to seeking health care services outside of their office.
- Be actively enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) on date of service. CHAMPS is a MDHHS system for processing and managing Medicaid enrollment, claims, and other related functions for both providers and beneficiaries.

Pharmacy Access Requirements

For HAP CareSource MI Coordinated Health, pharmacy services are available:

1. Urban – one within two miles
2. Suburban – one within five miles
3. Rural – one within fifteen minutes

PCP Request for Member Transfer

Sometimes, a HAP CareSource MI Coordinated Health member may make it medically impossible to safely, or prudently, render care. Examples include:

- Forging or altering prescriptions
- Fraud or misrepresentation
- Medical non-compliance
- Patient and physician incompatibility
- Violent or life-threatening behavior

As a result, the PCP may request the member to transfer to another MI Coordinated Health provider or be removed from the Health Plan. The transfer process is outlined below.

PCP process

1. Submit a written request to the HAP CareSource MI Coordinated Health Medical Director to transfer or disenroll the member. The request must:
   - Clearly indicate the reason for the request and the specific incidents that led to the request.
   - Include supporting documentation including medical records, police or security reports, incident reports.
2. The PCP should wait for HAP CareSource MI Coordinated Health to notify the member in writing of the issue.

HAP CareSource MI Coordinated Health process:

1. The Medical Director or designee reviews the documentation and requests clarification or additional information from the PCP as appropriate.

   Note: failure to respond to such requests will result in denial of the transfer or disenrollment.
2. If the request for transfer or disenrollment is approved, HAP CareSource MI Coordinated Health will send the appropriate notice to the member, PCP and the MDHHS, if necessary. The member must receive 30 days advance notice to allow adequate time to select another provider or make other arrangements for health care services.

For more information, please contact HAP CareSource MI Coordinated Health Provider Services at **1-833-230-2159**.

Access to Care Standards for Medicaid Plan

All providers must offer office hours to HAP CareSource MI Coordinated Health members that are no less than those offered to commercial members or for HAP fee-for-service members. In addition, per the HAP CareSource MI Coordinated Health Provider Agreement, all providers must follow the appointment and timely access to care standards for the Medicaid plan. The standards for each are outlined below.

Appointment Time Access Standards

Appointment Lead Time for Primary Care

As a HAP CareSource MI Coordinated Health provider, you must provide 24-hour, seven days a week availability to your HAP CareSource MI Coordinated Health patients by telephone. Whether through an answering machine or taped message used after hours, patients should be given the means to contact their PCP or a backup provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your backup provider and only recommends emergency room use for after hours.

Type of Care	Standard
Routine Care	Within 30 business days of request
Non-Urgent Symptomatic Care	Within 7 business days of request
Urgent Care	Within 48 hours

Type of Care	Standard
After-Hours Care	Physicians or their designee shall be available by telephone 24 hours per day, 7 days per week
Emergency Services	Immediately 24 hours/day, 7 days a week
Wait Time in Office: How long before member is seen by the provider after checking in with the receptionist	Less than 30 minutes
Specialty Care	Within 6 weeks of request
Wait time in office: How long before a member is seen by provider after checking in at front desk	Less than 30 minutes
Prenatal care – Initial prenatal appointment (Medicaid only) Note: Appointment should be with an obstetrician, PCP, certified nurse midwife or other advanced practice registered nurse with experience, training and demonstrated competence in prenatal care.	• If enrollee is in third trimester: within 3 business days of enrollee being identified as pregnant • If there is any indication of the pregnancy being high risk (regardless of trimester): within 3 business days

Appointment Lead Time for Mental Health

Type of Care	Standard
Life-Threatening Emergency: An acute, potentially life-threatening situation such as significant impairment in functioning, expressed suicidality or homicidality, and/or possible impending withdrawal	Immediate access to emergency room services
Non-Life-Threatening Emergency: An acute, potentially non-life-threatening situation such as significant impairment in functioning, expressed suicidality or homicidality, and/or possible impending withdrawal	
Urgent Care: A psychiatric condition warranting more immediate services, but which is not life threatening	Access to care within 48 hours of request
Initial Routine: A psychiatric condition warranting treatment, but is not life threatening and does not result in severe impairment in functioning	Access to care within 10 business days of request

Appointment Lead Time for Dental

Note: Monitoring is conducted by Delta Dental

Type of Care	Standard
Emergency Dental Services	Immediately 24 hours per day, 7 days per week
Routine Care	Within 21 business days of request
Preventive Services	Within 6 weeks of request
Urgent Care	Within 48 hours
Initial Appointment	Within 8 weeks of request

Monitoring

Annually, compliance with our appointment time access standards is monitored through the following physician surveys:

Survey	What's Measured
After Hours Study	PCP offices meet our standard for reaching a physician after office hours
Appointment Lead Time	How long it takes to schedule well, sick, and urgent visits with doctor offices
Coordinated Mental Health Management Lead Time	How long it takes to schedule non-urgent and urgent mental health doctor appointments

We also monitor member complaints regarding access issues that are reported to the HAP CareSource MI Coordinated Health Appeals and Grievance team and Member Services.

We may contact physicians who have deficient results from surveys to provide education on our standards.

Section 5: Doula Information

Enrollment

Michigan Medicaid is reimbursing for doula services provided to individuals covered by or eligible for Medicaid insurance. Doula providers seeking reimbursement for their professional services to Medicaid beneficiaries are required to be on the MDHHS Doula Registry and enrolled as a Medicaid provider.

To provide services to HAP CareSource MI Coordinated Health members, doulas must be part of the HAP CareSource MI Coordinated Health network. Once certified per the MDHHS guidelines, doulas can enroll with us. Here are the steps.

1. Visit hap.org/providers
2. Select *Join HAP*
3. Select *Community Health Worker, Doula, Maternal Infant Health Program Providers, Michigan Diabetes Prevention Program Provider*
4. Complete the *Doula Form*
5. Complete the *HAP Disclosure of Ownership and Control Interest Statement Form*
6. Submit the *Forms* and required documents per the instructions on the *Doula Form*

For more information on Doula requirements and guidelines, please review the final MDHHS policy.

Doula Reimbursement

To obtain doula reimbursement, you can submit claims for doula services to HAP CareSource MI Coordinated Health. Here are the options:

- **Electronic Submission:** Use Availity clearinghouse CS Payer ID: MIMCDCS1 (Medicaid) or MIMCRCS1 (MI Coordinated Health)
- **Paper Claims: Mail the paper claims to the following address**
  HAP CareSource MI Coordinated Health
  P.O. Box 1186
  Dayton, Ohio 45401-1186

Please ensure that you use the pregnant or postpartum member's HAP CareSource MI Coordinated Health ID number.

- Claims must include a primary diagnosis code to support the services billed.
  - In addition, doulas are encouraged to report the appropriate ICD-10 diagnosis codes within the range of Z55-Z65 to describe any relevant social determinants of health. For example:
    - Z56.1 change of job, Z59.1 inadequate housing, Z59.4 lack of adequate food and safe drinking water.

Doula services are to be reported as follows:

Visit Type	Procedure Code	Modifier	Primary Diagnosis Codes	Limit per pregnancy
Prenatal Visits and Postpartum Visits	S9445	HD	Prenatal: Z33.1 Postpartum: Z39.2	12 total visits
Attendance at labor and delivery	T1033	HD	Z33.1	1 visit

Section 6: Member Services

The Member Services department is the first point of contact for members. Member Services representatives are trained to respond to all member and provider questions and concerns. Members should refer to their HAP CareSource MI Coordinated Health member ID card for contact information.

Providers can contact HAP CareSource MI Coordinated Health Provider Services at **1-833-230-2159**, Monday through Friday from 8 a.m. to 6 p.m. ET.

PCP Assignment

New members enrolled in a HAP CareSource MI Coordinated Health can select a HAP CareSource MI Coordinated Health PCP at the time of plan selection or HAP CareSource MI Coordinated Health will assign one to them no later than 30 days after the effective date of enrollment. PCP assignments are based on the member's zip code in relation to the PCP's office zip code.

Member Accessibility to PCP Services

HAP CareSource MI Coordinated Health is committed to ensuring accessible and timely medical care and services for all members as outlined below.

- Members have a PCP for routine medical care and specialty referrals.
- HAP CareSource MI Coordinated Health provides reasonable availability and accessibility to primary care by ensuring that the size of the contracted provider network is adequate and contains providers who are available to members within 30 minutes travel time and/or 30 miles of the member's residence.
- All HAP CareSource MI Coordinated Health PCPs must be available, make the appropriate coverage available in their absence, for their assigned HAP CareSource MI Coordinated Health members on 24 hours a day, seven days per week basis, for urgent care and emergency care referrals.

Member Request for PCP Transfers

Members in HAP CareSource MI Coordinated Health have the right to request a transfer to another HAP CareSource MI Coordinated Health PCP. They can call the Member Services number on the back of their HAP CareSource Coordinated Health Member ID card.

HAP CareSource MI Coordinated Health reserves the right to immediately transfer any member to another PCP, specialist, ancillary provider or hospital, if the member's health or safety is in jeopardy.

Member Complaints and Grievance Resolution

HAP CareSource MI Coordinated Health has a centralized process to address, resolve and track all member complaints and grievances. All members receive written information outlining this process in their Welcome Packet.

HAP CareSource MI Coordinated Health receives complaints and grievances in several ways, including but not limited to Member Services, email, member portal, and in writing. The Grievance and Appeals department investigates, tracks and responds to all member complaints and grievances. A HAP CareSource MI Coordinated Health representative may contact PCP offices during the investigation. A prompt response from the PCP is important and appreciated.

All formal complaints and grievances are tracked monthly and quarterly and reported to the Quality Improvement Committee and the Board of Managers. A semi annual report is submitted to the MDHHS per contractual requirements.

Provider Complaints and Grievance Resolution

HAP CareSource MI Coordinated Health will thoroughly investigate each provider complaint using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying the HAP CareSource MI Coordinated Health written policies and procedures. Providers are permitted to submit complaints to HAP CareSource MI Coordinated Health regarding HAP CareSource MI Coordinated Health's policies, procedures or any aspect of the administrative functions. All provider complaints should be clearly documented. Matters involving denials or claims payment should be submitted through the appropriate claim payment dispute or appeals process noted below.

HAP CareSource MI Coordinated Health
Attn: Grievance and Appeals
P.O. Box 1025
Dayton, OH 45401-1025

HAP CareSource MI Coordinated Health will resolve all provider complaints within 90 days. We ensure that HAP CareSource MI Coordinated Health executives with the authority to require corrective action are involved in the provider complaint process.

Dental Care

Dental care is an important part of your patient's overall health. HAP CareSource MI Coordinated Health partners with Delta Dental for dental services. Dental services will be covered for:

- Adults aged 21 and older

HAP CareSource MI Coordinated Health members receive their member ID card with a contact phone number for Delta Dental.

Below is a high-level overview of the dental benefits for your HAP CareSource MI Coordinated Health patients.

- Preventive dental services, such as oral evaluations, routine cleanings, x-rays, sealants, and fluoride treatments.
- Routine dental care includes:
  - Diagnosis and treatment of oral health conditions to prevent deterioration to a more severe level or minimize/reduce the risk of development of dental disease or the need for more complex dental treatment.
    - Examples include but are not limited to services such as fillings and space maintainers
- Crowns (one in five years)
- Root canals
- Periodontal evaluation, maintenance
- Dentures (one in five years)

If your HAP CareSource MI Coordinated Health patients have questions about their dental benefits, they can call the Member Services number on the back of their HAP CareSource MI Coordinated Health member ID card.

Members can find a dentist online and entering the Delta Dental Member Portal. They can also call HAP CareSource MI Coordinated Health Member Services at **1-833-230-2057**.

Prior to servicing the member, the dental office needs to call Delta Dental customer service for information and billing help. They can be reached at **1-866-558-0280** (TTY: 711).

- Monday through Friday from 8 a.m. to 8 p.m. ET (member)
- 8:30 a.m. to 8 p.m. ET, **1-866-558-0280** (TTY users call 711) for information and billing help. Automated system available 24 hours a day, seven days a week.

For more information, providers can visit the Delta Dental Office Resources.

Dental Care for Children

The State of Michigan's Medicaid program covers dental care for children under the Healthy Kids Dental Program. The state contracts with Delta Dental and Blue Cross Blue Shield of Michigan. Together, they provide a network of dentists for children ages 0-20. Children are enrolled automatically and will receive an ID card from their dental plan. The card will have the phone number for their plan.

- BCBSM Healthy Kids Dental - bcbsm.com/healthy-kids-dental - 800-936-0935
- Delta Healthy Kids Dental - deltadentalmi.com/healthy-kids-dental - 866-696-7441

Language Interpretation and Services

HAP CareSource MI Coordinated Health is committed to maintaining open lines of communication with all members and providers. We've contracted with vendors to provide language interpretation services and services for communicating with hearing- and speech-impaired members. This is a free service for our

members. For more information, members can call the Member Services number on the back of their HAP CareSource MI Coordinated Health member ID card. Providers can call HAP CareSource MI Coordinated Health Provider Services at **1-833-230-2159**.

HAP CareSource Benefits and Covered Services

It's important that members get the care they need when they need it. There are no counseling or referrals that we would not provide because of moral or religious grounds. We cover all services covered by Medicare and Michigan Medicaid. This includes behavioral health services and long-term support services (LTSS) provide all covered services that the MDHHS provides.

Services Covered by HAP CareSource MI Coordinated Health

The following are covered services without copays:

- Ambulance and emergency medical transportation
- Care management services
- Certified nurse midwife care
- Certified pediatric and family nurse practitioner care
- Chiropractic care, up to 18 visits per calendar year, limited to specific diagnoses and procedures
- Contraceptive medications and devices
- Custodial Care
- Durable medical equipment and supplies
- Emergency care
- End-stage renal disease (ESRD) services
- Family planning services
- Health education and outreach
- Hearing care – hearing exams, supplies, hearing aids and batteries are covered
- Hearing aids are covered for all ages
- Home health care services and wound care, including medical and surgical supplies
- Home and Community Based Services (HCBS)
- Hospice services
    - Inpatient hospital services
    - Outpatient hospital services
    - Diagnostic and therapeutic services: diagnostic lab, X-ray and imaging services
- Infusion therapy
- Maternal Infant Health Program (MIHP)
- Maternity
    - Hospital and physician care
    - Certified nurse midwife services
    - Doula services

  - Parenting and birthing classes
  - Doula services – one labor visit and six pre/postpartum visits
  - Prenatal care
  - Newborn care – for the month of birth
  - Home care services
  - Breast pumps, i.e., hospital-grade electric, personal-use double electric and manual
- Medically necessary weight reduction services
- Mental health services – outpatient
- Psychiatric Collaborative Care in PCP office
- Podiatry services
- Preventive services required by the Patient Protection and Affordable Care Act
- Prescription drugs
  - Prescription and over-the-counter drugs on the formulary list as covered by Medicare Part D or Medicaid, with up to a 102-day supply for maintenance medications (drugs that are taken daily)
- Professional care services by physicians or other health care professionals
  - Certified pediatrics and family nurse practitioner care
  - Preventive care and screenings
  - Routine pediatric and adult immunizations
  - Health education
  - Second opinion from a provider
  - Services of other doctors when referred by the member's PCP
  - Services provided by local health departments
- Prosthetic devices and orthotics
- Radiology examinations and laboratory procedures
- Prevention, diagnosis and treatment of health impairments
- Rehabilitative nursing care – intermittent or short-term restorative or rehabilitative services up to 45 days in a nursing facility
- Restorative or rehabilitative services in a place of service other than a nursing facility
- Screening mammography and breast cancer services
- Skilled nursing facility
- State Plan Personal Care Services
- Supplemental Services
- Therapy (physical therapy, occupational therapy, speech therapy)
- Tobacco cessation treatment, including prescription and over-the-counter drug and support programs
- Treatment for sexually transmitted diseases (STDs)
- Transportation for medically necessary covered services

- Vaccines
- Vision services

Some Medicaid services are covered by the State. These include:

- Inpatient hospital psychiatric care
- Intermittent or short-term restorative or rehabilitative services (after 45 days in a nursing facility)
- Substance use care including screening and assessment, detox, intensive outpatient counseling, other outpatient counseling and Methadone treatment
- Outpatient partial hospitalization psychiatric care

Services Not Covered by Medicaid

- Elective abortions and related services
- Experimental or investigational drugs, procedures or equipment
- Elective cosmetic surgery
- Services for treatment of infertility

HAP CareSource MI Coordinated Health will not pay for services or supplies received that are not covered by Medicare or Medicaid.

Provider Responsibilities

HIPAA and Protected Health Information (PHI)

In the day-to-day business of patient treatment, payment and health care operations, HAP CareSource MI Coordinated Health and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide PII to be appropriately protected wherever it is stored, processed and transferred while conducting normal business. As a provider, you should be taking measures to secure your sensitive provider data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure Protected Health Information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace and shred it when no longer needed.
- Ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

There may be times when we share patient information with you or ask you to share with us. HAP CareSource MI Coordinated Health, like you, is a covered entity under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment or health care operations.

HIPAA Notice of Privacy Practices

Members are notified of HAP CareSource's privacy practices as required by the HIPAA. HAP CareSource's Notice of Privacy Practices includes a description of how and when member information is used and disclosed within and outside of the HAP CareSource organization. The notice also informs members on how they may obtain a statement of disclosures or request their medical claim information and how they may file a complaint with the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) related to their privacy. HAP CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, PHI of members.

As a provider, please remember:

- Follow the HIPAA regulations for all covered entities.
- Only make reasonable and appropriate uses and disclosures of PHI for treatment, payment and health care operations.
- Disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the HIPAA regulation 45 CFR 164. For example, providers may disclose patient information to HAP CareSource for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others.

Thank you for your assistance in providing requested information to HAP CareSource in a timely manner.

Sensitive Health Diagnoses

When a patient has a sensitive health diagnosis (e.g., treatment for drug/alcohol use, genetic testing, HIV/AIDS, mental health or sexually transmitted diseases), you should verify if the patient has granted consent to share health information.

Log in to the HAP CareSource Provider Portal at **HAPCareSource.com** > Login > Provider Portal and search for the HAP CareSource patient using the Member Eligibility option. A message displays if the patient has not consented to sharing sensitive health information. If the patient has not consented, you may not have access to all the patient's health information on the Provider Portal.

Please encourage your HAP CareSource MI Coordinated Health patients who have not consented to complete a Member Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located on **HAPCareSource.com** > Members > Tools and Resources > Forms. The Member Consent/HIPAA Authorization Form can also be used to designate a person who can speak on the patient's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the patient specifies.

Member Consent

When you check eligibility on the Provider Portal, you can also determine if a member has granted consent to share their health information with their past, current and future treating providers. A message displays on the Member Eligibility page if the member has not consented to sharing their health information.

Please encourage HAP CareSource members who have not consented to complete our Member Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located at **HAPCareSource.com** > Providers > Forms.

The Member Consent/HIPAA Authorization Form can also be used to designate a person to speak on the member's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the member specifies.

Americans with Disabilities Act

Providers are required to comply with Americans with Disabilities Act (ADA) standards, including but not limited to:

- Providing waiting room and exam room furniture that meets the needs of all enrollees, including those with physical and non-physical disabilities
- Accessibility along public transportation routes and/or providing enough parking
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities
- Providing secure access for staff-only areas

The ADA prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, providers may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities and follow ADA accessibility standards for new construction and alteration projects. Furthermore, providers' diagnostic equipment must accommodate individuals with disabilities.

HAP CareSource MI Coordinated Health network providers, in accordance with 42 CFR 438.206(c)(3), must provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities. HAP CareSource MI Coordinated Health and its network providers will comply with the ADA (28 CFR 35.130) and the Rehabilitation Act of 1973 (29 U.S.C. 794) and will maintain capacity to deliver services in a manner that accommodates the needs of its members.

For more information about the ADA, go to www.ada.gov.

Sign Language and Interpretation Assistance

HAP CareSource MI Coordinated Health offers on-site sign and language interpreters as well as over-the-phone (OPI) and video remote interpreting (VRI) when appropriate, for medical appointments outside of the surgical, hospital or emergency room setting*. These services are available to HAP CareSource MI Coordinated Health members who are hearing impaired, do not speak English or have limited English-speaking proficiency. These services are available at no cost to the member or provider. As a provider, you are required to identify the need for interpreter services for your HAP CareSource MI Coordinated Health patients and offer assistance to them appropriately.

To arrange services, please contact our Provider Services department at **1-833-230-2159**. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

* HAP CareSource MI Coordinated Health requires hospitals, emergency rooms and skilled nursing facilities, at their own expense, to offer sign and other language interpreters for members who are deaf or hard of hearing, do not speak English or have limited English-speaking proficiency. This includes providers that perform in-office surgeries. These services should be available at no cost to the member.

Culturally Competent Care

Consistent with federal mandate 42 CFR 438.206 (2), Access and Cultural Considerations, HAP CareSource MI Coordinated Health participates in efforts to promote the delivery of services in a culturally competent manner to all members. Participating providers must also meet the requirements of this mandate and any applicable state and federal laws or regulations pertaining to provision of services and care.

We expect providers to follow all state and federal civil rights laws. We do not discriminate, exclude or treat people differently based on race, color, national origin, disability, age, religion, sex (which include pregnancy, gender, gender identity, sexual preference and sexual orientation), or based on marital, health or public assistance status. All people should have a fair and just chance to be as healthy as they can be. HAP CareSource MI Coordinated Health will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the U.S. Department of Health and Human Services (HHS).

Electronic Health Records

HAP CareSource MI Coordinated Health encourages, supports and facilitates provider adoption and the effective utilization of electronic health records (EHR), including for population health and quality improvement. For network providers who have not yet adopted EHR, while HAP CareSource MI Coordinated Health will not endorse a specific system, HAP CareSource MI Coordinated Health will help to educate providers on the opportunities for better integration, potential interoperability and quality gap closure stemming from EHR use. HAP CareSource MI Coordinated Health will also work with providers to align real-time sources to use EHR information within our organization and across care management entities within HAP CareSource and providers.

Providers who are interested in these opportunities should contact the HAP CareSource MI Coordinated Health provider relations team in order to assess and coordinate engagement opportunities for EHR. You can find your assigned Provider Representative by visiting **HAPCareSouce.com** > Providers > Provider Overview > Contact Us.

Key Contract Provisions

To make it easier for you, we have outlined key components of your contract. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. As a reminder, providers should also continue to reference the requirements contained within the provider agreement. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Member's Rights and Responsibilities

HAP CareSource MI Coordinated Health members have many rights and responsibilities. These are important to ensure they get quality care. Our staff and providers follow these rights. Below are the member rights and responsibilities. They are also published in their Member Handbook.

HAP CareSource MI Coordinated Health

Member Rights:

As a member of our health plan, you have the following rights:

- To receive information about HAP CareSource MI Coordinated Health, our services, our practitioners and providers and member rights and responsibilities.
- To receive all services that our plan must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.

- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss information on any appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To get information on any medical or behavioral health care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask for, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless we have to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or our plan must talk to you about what could happen, and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See your member handbook for information.
- To be able to get all HAP CareSource MI Coordinated Health written member information from our plan:
  - At no cost to you.
  - In the prevalent non-English languages of members in HAP CareSource MI Coordinated Health's service area.
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from our plan and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will).
- To file any complaint about not following your advance directive with the Michigan Department of Health and Human Services (MDHHS).
- To be free to carry out your rights and know that HAP CareSource MI Coordinated Health, HAP CareSource MI Coordinated Health's providers or MDHHS will not hold this against you.
- To know that we must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider in our network for Medicaid-covered woman's health services.

- To be able to get a second opinion for Medicaid-covered services from a qualified provider in our network. If a qualified provider is not able to see you, we must set up a visit with a provider not in our network.
- If HAP CareSource MI Coordinated Health is unable to provide a necessary and covered service in our network, we will cover these services out of network for as long as we are unable to provide the service in network. If you are approved to go out of network, this is your right as a member and will be provided at no cost to you.
- To get information about HAP CareSource MI Coordinated Health from us.
- To make recommendations regarding HAP CareSource MI Coordinated Health's member rights and responsibility policy.
- To make recommendations regarding a change in HAP CareSource staff.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Michigan Department of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

Member Responsibilities

As a member of HAP CareSource MI Coordinated Health you must also be sure to:

- Have an in-network primary care provider (PCP).
- Use only approved primary care providers (PCPs).
- Keep scheduled doctor (specialist) appointments, be on time, and if you have to cancel, call 24 hours in advance.
- Follow the plans and instructions for care you have agreed upon with your doctors and other health care providers.
- Always carry your HAP CareSource member ID card and present it when receiving services.
- Never let anyone else use your HAP CareSource member ID card.
- Notify your county caseworker and HAP CareSource MI Coordinated Health of a change in your phone number or address.
- Contact your PCP after going to an urgent care center or after getting medical care outside of HAP CareSource MI Coordinated Health's covered counties or service area.
- Let HAP CareSource MI Coordinated Health and your county caseworker know if any member of your family has other health insurance coverage.
- Provide the information that HAP CareSource MI Coordinated Health and your health care providers need in order to provide care for you.
- Understand as much as possible about your health conditions and take part in reaching goals that you and your PCP agree upon.
- Let us know if you suspect health care fraud or abuse.

Transportation

We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other Medicaid covered services, whether those services are

provided by the Medicaid health plan or through the MDHHS directly. In some cases, we may provide bus tokens or if the member has their own vehicle or someone else to drive, they can request mileage reimbursement.

Emergency Transportation

- If members need transportation for a life-threatening emergency, they are advised to call 911 for an ambulance.
- If members need same-day transportation for urgent care or care that is not life-threatening, they are advised to call Member Services at **1-833-230-2057** for HAP CareSource MI Coordinated Health.
- HAP CareSource MI Coordinated Health will cover emergency transportation and hospital-billed ambulance services to and from a nursing facility or member's home.

Routine (Non-Emergency) Transportation

We provide members with transportation to the doctor, dentist, or pharmacy if they do not have a way to get there. Members are advised to call HAP CareSource MI Coordinated Health Member Services three business days before the appointment to schedule their transportation. The Member Services phone number can be located on the back of their HAP CareSource MI Coordinated Health member ID card.

We provide rides via bus, car, van, or wheelchair van. If a family member or guardian drives them, we will reimburse them for mileage or cab services. Family members, guardians, and cab drivers are subject to background checks and sanction screenings prior to reimbursement. We require two days' notice to schedule transportation; however, a member can request same-day transportation for an urgent non-emergency appointment.

Members are reminded to:

- Advise if they need a wheelchair van or car seat
- Advise if anyone, such as a caregiver or child, will be going with them
- Have picture ID or their child's HAP CareSource MI Coordinated Health member ID card on hand to show the driver
- Be ready one hour before the appointment time
- Call as soon as possible if they need to cancel

Transportation is available 24 hours per day, seven days a week, 365 days per year.

Additional transportation services include the following:

- Ongoing services, such as dialysis, chemotherapy, substance use disorder (SUD) treatment services, physical therapy, speech therapy and occupational therapy.

Services for Maternal Infant Health Program (MIHP), or other the MDHHS-approved evidence-based home-visiting program, allow enrolled pregnant and infant beneficiaries to access health care and pregnancy-related appointments and for a mother to visit their hospitalized infant. Pregnancy-related appointments include those for oral health services, Women, Infants and Children (WIC) services, mental or SUD treatment services, and childbirth and parenting education classes.

Medically necessary, non-emergency ambulance transportation to Pre-Paid Inpatient Health Plans (PIHP) and Community Mental Health Services Program (CMHSP) related services is available.

Section 7: Member Eligibility and Enrollment

The MDHHS determines the member's eligibility for public assistance.

Michigan ENROLLS, the enrollment broker for Michigan Medicaid programs, provides educational material about the Medicaid health plans available in the member's county. Michigan ENROLLS assists Medicaid members in choosing the health plan of their choice. If the member doesn't choose a health plan, Michigan ENROLLS will auto assign one to them.

Plans are notified monthly via a data file exchange of the Medicaid members enrolled in their Plan.

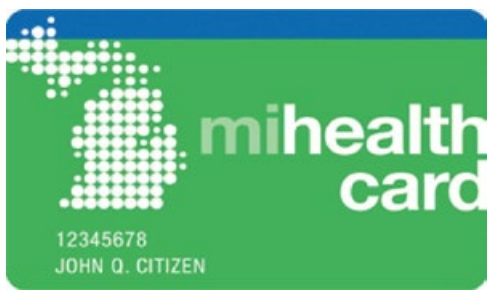
New Members

HAP CareSource MI Coordinated Health mails a Welcome Packet with plan and benefit information to new members within 10 business days from receipt of enrollment data from the MDHHS.

ID Cards

HAP CareSource members carry two member ID cards:

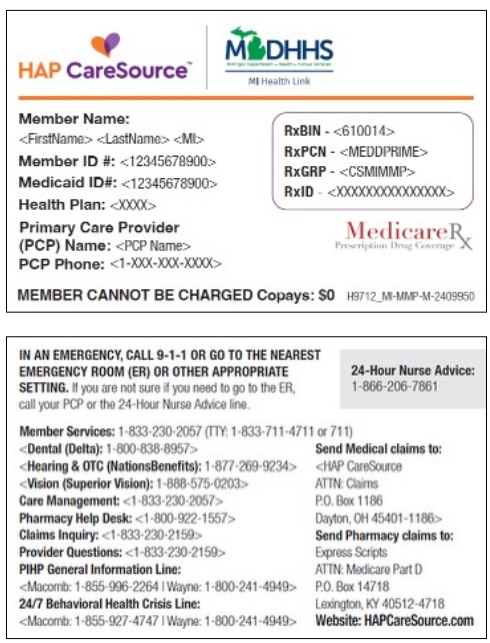
Michigan Medicaid ID Card (mihealth card)
This card identifies the member is enrolled in Michigan Medicaid.



HAP CareSource MI Coordinated Health member ID cards:

Note:

- Possession of a HAP CareSource MI Coordinated Health member ID card does not guarantee member eligibility or coverage.
- Providers must verify eligibility prior to services being rendered to guarantee payment.
- Any member who abuses their member ID card by allowing others to use it to fraudulently obtain services will be reported to the MDHHS or the Centers for Medicare and Medicaid Services (CMS) for immediate termination from the Plan.
- If you suspect a non-eligible person using a member's ID card, please report the occurrence to the HAP CareSource MI Coordinated Health at 1-833-230-2159.


HAP CareSource | MDHHS MI Health Link

Member Name:
<FirstName> <LastName> <MI>
Member ID #: <12345678900>
Medicaid ID#: <12345678900>
Health Plan: <XXXX>
Primary Care Provider (PCP) Name: <PCP Name>
PCP Phone: <1-XXX-XXX-XXXX>

RxBIN - <610014>
RxPCN - <MEDDPRIME>
RxGRP - <CSMIMMP>
RxID - <XXXXXXXXXXXXXXX>

MedicareRx Prescription Drug Coverage

MEMBER CANNOT BE CHARGED Copays: $0 H9712_MI-MMP-M-2409950

IN AN EMERGENCY, CALL 9-1-1 OR GO TO THE NEAREST EMERGENCY ROOM (ER) OR OTHER APPROPRIATE SETTING. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

24-Hour Nurse Advice: 1-866-206-7861

Member Services: 1-833-230-2057 (TTY: 1-833-711-4711 or 711)
<**Dental (Delta):** 1-800-838-8957>
<**Hearing & OTC (NationsBenefits):** 1-877-269-9234>
<**Vision (Superior Vision):** 1-888-575-0203>
Care Management: <1-833-230-2057>
Pharmacy Help Desk: <1-800-922-1557>
Claims Inquiry: <1-833-230-2159>
Provider Questions: <1-833-230-2159>
PIHP General Information Line:
<Macomb: 1-855-996-2264 | Wayne: 1-800-241-4949>
24/7 Behavioral Health Crisis Line:
<Macomb: 1-855-927-4747 | Wayne: 1-800-241-4949>

Send Medical claims to:
<HAP CareSource
ATTN: Claims
P.O. Box 1186
Dayton, OH 45401-1186>
Send Pharmacy claims to:
Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718
Website: HAPCareSource.com

Verifying Eligibility

Providers must verify member eligibility prior to rendering services as it can change monthly. Services provided when a member is not enrolled in the HAP CareSource MI Coordinated Health will not be covered. Providers can verify eligibility by one of the methods below.

Method	Instructions
HAP CareSource MI Coordinated Health Provider Portal	• Log in at https://www.caresource.com/mi/providers/provider-portal/medicaid/ • Once on the HAP CareSource MI Coordinated Health Provider Portal, select *Member Eligibility* (Note: PCPs can get a list of their assigned members by selecting *Click Here to View Member Roster*. The list is updated monthly). • Call HAP CareSource MI Coordinated Health at **1-833-230-2159**.
Availity Portal	• Availity.com
CHAMPS	• Web portal • Provider support: **1-800-292-2550, option 5, then 2**
Phone Options	• HAP CareSource MI Coordinated Health at **1-833-230-2159** • CHAMPS provider support: **1-800-292-2550, option 5, then 2**

Disenrollment from a Plan

HAP CareSource MI Coordinated Health

HAP CareSource MI Coordinated Health does not verbally, in writing or by any other action or inaction, request or encourage a HAP CareSource MI Coordinated Health member to disenroll except when the member:

- Has a change in residence* (includes incarceration).
- Loses entitlement to either Medicare Part A or Part B.
- Loses Medicaid eligibility.
- Dies.
- Materially misrepresents information regarding reimbursement for third-party coverage.

*When members permanently move out of the HAP CareSource MI Coordinated Health service area or leave the HAP CareSource MI Coordinated Health service area for over six consecutive months, they must disenroll from HAP CareSource MI Coordinated Health.

- **Special disenrollment**

  HAP CareSource MI Coordinated Health may initiate special disenrollment requests to the MDHHS if the member exhibits any of the following:

  - Violent or threatening behavior involving physical acts of violence
  - Making physical or verbal threats of violence against contracted providers, staff, or the public at HAP CareSource MI Coordinated Health locations
  - Stalking

Section 8: Referrals and Authorizations

HAP CareSource MI Coordinated Health does not require referrals to see an in-network specialist. The specialist may require a referral from the member's PCP. Some services and procedures require prior authorization. Prior authorizations must be obtained prior to services being rendered.

Urgent requests should be marked urgent. Urgent requests will be accepted when the member or their physician believes waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

Referrals and prior authorization for services should be made to in-network providers whenever possible. Contracted providers can be found in our online provider directory through Find a Doctor. To refer a member to an out-of-network provider, call our Utilization Management department at **1-833-230-2159** for HAP CareSource MI Coordinated Health authorization requests.

Non-contracted providers should call our Utilization Management department at **1-833-230-2159** for HAP CareSource MI Coordinated Health authorization requests.

Submitting a Prior Authorization Request

The member's PCP or the servicing provider (i.e., durable medical equipment (DME) provider, specialist) obtains the prior authorization online by logging into the HAP CareSource Provider Portal and selecting *Authorizations*, or via fax at 844-633-0399.

Supporting clinical documentation must be included with all requests.

Requests must be timely, complete and legible. Otherwise, the results may be:

- Delays in processing the request
- Prior Authorization denials

Criteria Used in Decision Making

HAP CareSource MI Coordinated Health uses objective and evidenced-based criteria when determining the medical appropriateness of requested health care services. This includes criteria from:

- Federal regulations (NCD/LCD)
- State regulations
- InterQual/MCG (formerly known as Milliman Care Guidelines)
- The state of Michigan
- HAP CareSource MI Coordinated Health Clinical Policies

Decisions are based on the accepted local practice of medicine and health delivery system characteristics and patient's information including, but not limited to:

- Age (adult vs. pediatric)
- Comorbidities
- Current treatment progress
- Home environment, when applicable
- Individual needs
- Medical complications
- Psychosocial situation

Authorization decisions are sent as follows:

- Approvals: We send a letter to the member. We notify providers by fax, phone or through the Provider Portal.
- Denials: We send a letter to the member and requesting provider.

Copies are retained in the member's medical record.

Medical Necessity Defined

For members 21 years of age and older, covered services which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and for which there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly. Without limitation, medically necessary services for members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development; attain, regain, or maintain functional capacity; or improve, support, or maintain the member's current health condition. HAP CareSource MI Coordinated Health determines Medical Necessity on a case-by-case basis, taking into account the individual needs of the member.

Prior Authorization Decision Time Frames

Request Type	Time Frame
Non-Urgent Pre-Service	A decision will be provided as quickly as the clinical condition warrants, not to exceed 7calendar days.
Urgent Pre-Service	A decision will be provided within 72 hours of receipt of the request.
Post-Service Decisions	A decision will be provided within 30 calendar days of the request.

Prior Authorization Requests

Only certain procedures, care or equipment require an approved authorization. For example:

- Bariatric services
- Breast reconstruction
- Chiropractic services
- Cosmetic surgery (i.e., rhinoplasty)
- Durable medical equipment
- Genetic testing
- Nursing facility care/skilled nursing facility care
- Sleep studies
- Transplant services

For a complete list of services that require authorization, reference the Procedure Code Lookup Tool.

Per the terms of our contract with the MDHHS, members may access any of the following services directly, without prior authorization or referral from their PCP:

- Emergency room services-facility and professional components
- Emergency transportation
- Family planning services or OB services at any provider
- Services provided by Federally Qualified Health Centers (FQHC)
- Services provided by Public Health Departments
- STD services at any provider
- Well-child exams with a contracted pediatrician
- Well-women exams with a contracted provider

Skilled Nursing

HAP CareSource MI Coordinated Health members have a skilled nursing benefit of 100 skilled days per benefit period.

Important

- This benefit covers inpatient admissions to physical rehabilitative facilities, not substance abuse rehabilitation facilities.
- The medical director or designee reviews the admission request for appropriateness of admission, length of stay, etc.

Second Opinions

HAP CareSource MI Coordinated Health covers second opinions. If an in-network provider isn't available for a second opinion, the member can visit an out-of-network provider. An approved prior authorization is required and there is no cost to the member.

Vision Services

Routine vision services include eye examination (refraction), lenses and frames. Members in the HAP CareSource MI Coordinated Health can access vision services directly by contacting EyeMed at **1-866-939-3633**. Contracted vision providers are in our online Provider Directory at findadoctor.caresource.com.

Nonroutine eye examinations are a Medicaid benefit for the purpose of evaluation and treatment of chronic, acute, or sudden onset of abnormal ocular conditions.

Mental Health Care

HAP CareSource MI Coordinated Health complies with and supports the MDHHS' compliance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, 42 CFR 438.3(e((1)(ii), and 42 CFR 438 Subpart K, as applicable to covered services.

HAP CareSource MI Coordinated Health members requiring outpatient mental health services may obtain these services by self-referring to a contracted psychiatrist or contracted mental health care provider.

HAP CareSource MI Coordinated Health does not cover inpatient mental health admissions, partial hospitalization and other intensive mental health services. Authorization must be granted by the local PIHP in the county where they live.

HAP CareSource MI Coordinated Health does not cover substance abuse services. Members should be referred to the PIHP in the county where they live.

For emergencies, members can go to the closest hospital that provides psychiatric services.

Case Management

The HAP CareSource MI Coordinated Health Case Management Program assists members in following the plan of care prescribed by their physician. It helps them regain or maintain optimum health or functional capability in the right setting in a cost-effective manner. Participation in case management is voluntary and members can terminate at any time. All enrolled HAP CareSource MI Coordinated Health members have an assigned Care Coordinator. Members have the right to refuse active care management activities.

A comprehensive evaluation of the social well-being, mental health and physical health is done to determine the barriers to adhering to the plan of care.

Goals are set in conjunction with all parties involved in the member's care. The Program is dependent upon the cooperative participation of HAP CareSource MI Coordinated Health, contracted ancillary providers, physicians, hospitals and the member, to ensure timely, effective and medically realistic goals.

To initiate an evaluation for case management services, contact the Care Management department at **1-833-230-2159**.

All members within the CSHCS and Foster Care populations are aligned with a Care Coordinator who acts as the main point of contact for these members/families. In addition, our team supports these members with health care transition. Providers can refer members who have needs to our Case Management team by emailing HAPCareSourceCMTeam@CareSource.com.

Elective Hospital Admissions

Authorization is not required prior to the member's admission to the hospital. All inpatient stays require an authorization. **However, the procedure or surgery may require prior authorization**. The hospital is responsible for obtaining the authorization within 24 hours or the next business day after the admission. Requests can be submitted online. Log in at HAP CareSource Provider Portal and select *Authorizations*. Include appropriate clinical information. Physicians and hospitals are subject to non-payment if procedures are deemed medically inappropriate. We review all hospital admissions using:

- Federal regulations (NCD/LCD)
- State regulations
- Clinical Practice Guideline
- MCG®/Interqual

Emergent Hospital Admissions

Providers are not required to call HAP CareSource MI Coordinated Health prior to – or at the time of – an emergent inpatient admission. Authorization requests should be submitted after admission to allow collection of the appropriate clinical data. You can log in at HAP CareSource Provider Portal and select *Authorizations*. The hospital is responsible for obtaining the authorization within 24 hours or the next business day after the admission. All hospital admission requests are reviewed using:

- Federal regulations (NCD/LCD)
- State regulations
- Clinical Practice Guideline
- MCG®/Interqual

Providers can check approval status online by logging in at HAP CareSource Provider Portal and selecting *Authorizations*.

Laboratory Services and Genetic Testing

We provide coverage for laboratory services. Prior authorization is required for genetic testing. Authorization is required for most genetic and molecular laboratory tests. Refer to the Procedure Lookup Tool.

Section 9: Hospital Notification and Review

Below is our policy on specific guidelines surrounding hospital facility notification for members who require hospitalization.

Urgent/Emergency Care and Inpatient Admissions

- HAP CareSource MI Coordinated Health Utilization Management department does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms and does not require notification or pre-approval for emergency medical treatment provided in the ER or other outpatient setting.
- HAP CareSource MI Coordinated Health is financially responsible for reimbursing care provided for Emergency Medical Conditions and urgently needed services rendered by contracted and non-contracted providers without regard to pre-certification or timely notification (including when a representative of the HAP CareSource MI Coordinated Health instructs the member to seek emergency services). HAP CareSource MI Coordinated Health may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP, HAP CareSource MI Coordinated Health, or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. HAP CareSource MI Coordinated Health requests notification of emergency inpatient admissions for purposes of care coordination.
    - **Post-stabilization care services.** After services for Emergency Medical Conditions or urgently needed care, HAP CareSource MI Coordinated Health is financially responsible for post-stabilization care services provided by a contracted or non-contracted provider that were pre-approved by HAP CareSource MI Coordinated Health; or were not pre-approved, either because HAP CareSource MI Coordinated Health did not respond to a request for pre-approval within one hour after being notified or because HAP CareSource MI Coordinated Health could not be contacted for pre-approval. HAP CareSource MI Coordinated Health remains responsible until the member is discharged from the hospital or is transferred to a contracted facility.
    - HAP CareSource MI Coordinated Health is financially responsible for post-stabilization care services that were not pre-approved until:
        - A HAP CareSource MI Coordinated Health physician with privileges at the treating hospital assumes responsibility for the member's treatment;
        - A HAP CareSource MI Coordinated Health physician assumes responsibility for the care through transfer;
        - The representative and the treating physician reach an agreement concerning the member's care; or
        - The member is discharged.
    - HAP CareSource MI Coordinated Health must cover post-stabilization care services, regardless of whether the services were provided in the HAP CareSource MI Coordinated Health's network, which are not pre-approved by a HAP CareSource MI Coordinated Health within one hour of a request for pre-approval of further post-stabilization care services.

Non-Emergency Admissions (Elective and Long-Term Acute Care)

Non-emergency admissions to an acute care hospital, inpatient rehabilitation facility, a long-term acute care facility, skilled nursing facility whether contracted or non-contracted, require pre-certification based on contractual agreements.

- Contracted facilities: The contracted facility or the referring physician is responsible for obtaining pre-certification for an elective admission. The facility must also notify HAP CareSource MI Coordinated Health within 24 hours or the next business day following the elective admission. HAP CareSource MI Coordinated Health reserves the right to deny payment to contracted facilities (no member liability) if the pre-certification and/or notification requirements are not met.
- Non-contracted facilities: HAP CareSource MI Coordinated Health will accept a pre-certification request for an elective admission from a non-contracted facility or the referring physician. Once pre-certified, the non-contracted facility is responsible for notifying HAP CareSource MI Coordinated Health within the 48 hours of the admission.

Admission Notification Process

- The requesting facility can submit authorization requests for concurrent/urgent/emergency or standard admission via the HAP CareSource Provider Portal, 24 hours per day, seven days per week.
- Pre-service: The HAP CareSource MI Coordinated Health Intake teams accept notification of a member's admission by the admitting facility or by the member or members' representative via the Provider Portal, fax, or phone call prior to the member being discharged.
- Post-service: The HAP CareSource MI Coordinated Health Intake teams accept notification of a member's admission by the admitting facility or by the member or member's representative via the Provider Portal, fax, phone call or through receipt of a claim the HAP CareSource MI Coordinated Health Claims department.

Once HAP CareSource is notified:

- **Prior to the admission:** Once the emergency has been treated and stabilized, HAP CareSource MI Coordinated Health determines whether the admission is appropriate using the standardized clinical criteria.
  - If the hospital is non-contracted or out of network, HAP CareSource MI Coordinated Health assesses for the appropriateness of a transfer to a contracted or in-network facility.
- **After the admission, either while the member is still inpatient or after discharge:** HAP CareSource MI Coordinated Health reviews the inpatient admission for clinical appropriateness (contracted or non-contracted).
  - Per CMS, urgent or emergency medical services at a hospital cannot be denied if the denial would result in member liability. Upon stabilization, the member cannot be transferred unless the attending physician agrees that the member is stable. In addition, the member cannot be discharged from the hospital unless the attending physician agrees and has written a discharge order.
- Cases involving determinations of emergency and post-stabilization care must be referred to a HAP CareSource Medical Director.

Section 10: Billing and Reimbursement

We make every effort to ensure prompt and accurate claims processing, adjudication and payment.

We contract with CMS and the MDHHS. We follow billing guidelines for claims processing under each contract unless otherwise indicated in this section.

If you have questions or need assistance, please call us at **1-833-230-2159**.

CHAMPS

Per the MDHHS, all providers serving Medicaid beneficiaries must be enrolled in CHAMPS. This is the state's online Medicaid enrollment and billing system. It ensures all providers who participate in Medicaid comply with federal screening and enrollment requirements.

The MDHHS has issued final deadlines for CHAMPS enrollment:

- **For dates of service on or after January 1, 2019**, MDHHS will prohibit contracted Medicaid Health Plans and Dental Health Plans from making payments to typical providers not actively enrolled in CHAMPS. Examples of typical providers include, but are not limited to, physicians, physician assistants, certified nurse practitioners, dentists and chiropractors.
- **For dates of service on or after July 1, 2019**, MDHHS fee-for-service and Medicaid Health Plans will prohibit payment for prescription drug claims written by a prescriber who is not enrolled.

For more information on CHAMPS and to enroll, visit michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers.

Verifying Member Eligibility

Providers must verify member eligibility and effective dates of health plan enrollment before rendering covered services. You can verify member eligibility by one of the methods below.

Method	Details
CHAMPS online	• Web portal
CHAMPS Provider Support	• **1-800-292-2550, option 5, then 2**
HAP CareSource Provider Portal	• View the HAP CareSource Provider Portal webpage to review login instructions
Availity Portal	• Availity.com
HAP CareSource Provider Services	• Call **1-833-230-2159**

The HAP CareSource Medicaid plan follows the MDHHS for covered services. Members in the HAP CareSource MI Coordinated Health are entitled to all covered services provided by traditional Medicare and Medicaid Managed Care.

EFT Registration

HAP CareSource MI Coordinated Health has partnered with ECHO Health, Inc. to deliver provider payments. ECHO offers three payment options:

1. Electronic fund transfer (EFT) – preferred
2. Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

*Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.

Visit our Claims webpage at **HAPCareSource.com** > Providers > Provider Portal > Claims, for additional information about getting paid electronically and enrolling in EFT.

Simply complete the enrollment form and fax it back to ECHO Health, HAP CareSource's EFT partner, at **440-835-5656** or enroll at https://enrollments.echohealthinc.com/EFTERADirect/CareSource.You will need to have your TIN, an ECHO draft number and the corresponding dollar amount (of a prior payment from ECHO from any payer) to enroll through the link. ECHO Health will work directly with you to complete your enrollment in EFT.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) through a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EOP) from the HAP CareSource Provider Portal.

Filing Limitations

Type of claim	Filing time frame
Encounters for capitated services	Submit within 30 days from the date of service
Initial claim for non-capitated services	Submit within 365 days from beginning date of service
COB claims where other carrier is primary when primary carrier was billed within their filing limits and the carrier's EOP identifies payment or denial of the claim	Submit within 365 days from beginning date of service or 120 days from primary payer's EOP date.
Claims appeals	Please see the Claims Disputes section of this Manual for additional information.
Claim complaints or disputes	Please see the Claims Disputes section of this Manual for additional information.

Ensure Claims Get Paid

All HAP CareSource MI Coordinated Health claims must be submitted to HAP CareSource MI Coordinated Health as follows:

How to Submit Claims – HAP CareSource MI Coordinated Health	
Electronic	Use Availity clearinghouse CS Payer ID: **MIMCRCS1**
Provider Portal	**HAP CareSource Provider Portal**
Paper Claims	HAP CareSource MI Coordinated Health Attn: Claims P.O. Box 1186 Dayton, OH 45401
Paper Grievance and Appeals	Please see the Claims Disputes section of this Manual for additional information.

Claims prior to the effective dates listed above should be billed to the prior HAP Empowered Payer ID.

Please refer to the HAP CareSource MI Coordinated Health Provider Transition Quick Reference Guide on the Quick Reference Materials webpage.

Refer to the Quick Reference Materials webpage for HAP CareSource MI Coordinated Health Provider Transition.

Electronic Visit Verification

Electronic Visit Verification (EVV) is a process for electronically capturing point-of-service information for certain home and community-based services. CMS established requirements for all states to use EVV in accordance with the 21st Century Cures Act. This act requires HAP CareSource MI Coordinated Health to use EVV when processing Personal Care Services claims and Home Health Care Services claims. HAP CareSource MI Coordinated Health complies with the requirements of CMS and the applicable state regulatory body as required by EVV and is dedicated to helping providers navigate this process successfully.

Out-of-Network Providers

Out-of-network providers must follow the HAP CareSource MI Coordinated Health authorization requirement and claims submission processes. If you have any questions, please contact us at **1-833-230-2159**.

Prior Authorization: Out-of-Network Providers

Some services and procedures require prior authorization. It must be obtained before services are rendered. Claims submitted from out-of-network providers for services requiring prior authorization but not obtained will be denied.

For a complete list of services that require authorization, refer to the Procedure Code Lookup Tool.

Payment Procedure

- All paper claims and encounters are date stamped on the day received.
- Claims are processed in accordance with State and/or Federal Prompt Pay regulations.
- Payment for all non-capitated, authorized, medically necessary services are paid at current Medicaid fee schedules. **Note:** Contracted rates supersede this statement.
- Providers may not balance bill HAP CareSource MI Coordinated Health members for unauthorized services if the member had no prior knowledge of liability for the service.

Provider Capitation Payment

Provider capitation payments are processed around the fifteenth of every month. Payments are calculated based on assigned membership and the contracted per member per month (PMPM) rates from the claims processing system. This process will capture any member retro enrollments or disenrollments dating back up to six months. Actual payments are disbursed by ECHO Health.

To change your disbursement preference (physical check or EFT), please visit ECHO Health's website.

To view or download any remit detail, please visit HAP CareSource's Provider Portal. Remit information is available in both PDF and CSV formats. Information provided includes member name, address, ID and capitation paid amount.

Provider Portal Directions:

- Log into the HAP CareSource Provider Portal
- Select Claims > Payment History > Capitation Payments
- Search for payments and remit information by:
  - Check number **OR** payment dates

For questions or concerns regarding your capitation payments, please contact your provider representative.

Clean Claims

- HAP CareSource MI Coordinated Health pays clean claims in accordance with State and/or Federal Prompt Pay regulations.
- A clean claim will be considered when a written itemization of any documents or other information needed to process the claim has been supplied to HAP CareSource MI Coordinated Health.
- If any mandatory or conditional information is missing, the claim is considered unclean.
- Unclean claims will be returned or rejected within 60 days.

Returned Claims

- Paper claims are returned when they can't be entered due to invalid information such as the billing provider not being in system, or the member not being enrolled in the HAP CareSource MI Coordinated Health.
- It's important to resubmit these claims within filing time limits.

Resubmission of Rejected Claims

- Claims are rejected when pertinent information is available to enter the claim in the system, but information needed to complete the reimbursement adjudication process is missing. There is no record of the claim in the adjudication system and a remittance advice will not be provided. Claims rejected will be communicated through EDI 999 or 277 file based on type of rejection. Paper claim rejections will be communicated through a Rejection Letter.
- Be sure to review your EDI 277 Health Care Claim status response transactions report for claims RTP (returned to provider) for correction and resubmission within the timely filing requirements. Resubmission of rejected claims requires a new claim submission claim frequency of one original.

Overpayments

To the extent the provider detects an overpayment from HAP CareSource MI Coordinated Health, the provider will send a notice of the overpayment:

- Via the HAP CareSource Provider Portal
  - Identify the claim(s) that are included in the overpayment, select recovery request, and complete the fields to submit the overpayment recovery takeback request
- Via Mail:

  HAP CareSource MI Coordinated Health
  P.O. Box 632128
  Cincinnati, OH 45263-2128

If the parties agree that an overpayment has occurred, and on the amount of the overpayment, such overpayment will be returned to HAP CareSource MI Coordinated Health within 60 days of identification of the overpayment. The overpayment amount will be offset from future claim payment until the overpayment amount is satisfied.

Checking Claims Status

Contracted and non-contracted providers can check claims status by one of the methods below.

- Log in to the HAP CareSource Provider Portal and select *Claims*.
  (Note: There's a link to view date of service (DOS) prior to October 1, 2023 information).
- Log in to the HAP CareSource Provider Portal and select *Remittance Advice*.
  (Note: There is a link to view DOS prior to October 1, 2024 information).
- Call HAP CareSource MI Coordinated Health Provider Services at **1-833-230-2159**.

Claim Editing Guidelines for Attending/Ordering/Referring Fields

HAP CareSource MI Coordinated Health follows the MDHHS claim editing guidelines for attending/ordering/referring fields for all claim types. Please see bulletin, MSA 21-45 here, for details. Listings of allowed attending provider types for inpatient hospitals and outpatient hospital providers can be found under *Attending Provider Tips* on the MDHHS website.

Remittance Advice and Explanation Codes

For	Process
A remittance advice for dates of service Oct. 1, 2023, and forward (HAP CareSource) or Jan. 1, 2024, and forward (HAP CareSource MI Coordinated Health)	Log in to the HAP CareSource Provider Portal and select Remittance Advice.
835 files	If you don't get an 835 from HAP CareSource MI Coordinated Health today, contact your clearing house and give them HAP CareSource's payer ID MIMCDCS1 or HAP CareSource MI Coordinated Health's payer ID: MIMCRCS1.

Be sure to review the explanation codes on your remittance advice (RA).

- They indicate the reason a service line was rejected.
- They give information about service lines and may point out potential problems.

For a description of the explanation codes, log in at **HAPCareSource.com**.

General Billing Guidelines

Providers are prohibited by law from collecting any Medicare Part A and B cost share from members who are also eligible and enrolled in a state Medicaid program when that Medicaid program is responsible for paying the Medicare cost share amounts for such members. Providers shall accept the amounts paid by HAP CareSource MI Coordinated Health, if any, pursuant to any Medicaid or other delegated agreement with a state as payment in full for a member's cost share. HAP CareSource MI Coordinated Health and providers may not impose cost shares that exceed the amount permitted with respect to the member under Title XIX if the member were not enrolled in a HAP CareSource MI Coordinated Health plan.

To the extent you are contracted with HAP CareSource for a member's Medicare benefit, then for covered services under the member's Medicare benefit, HAP CareSource will reimburse as set forth in your contract for the Medicare benefit. To the extent you are contracted with HAP CareSource for a member's Medicaid benefit, then for services that are not covered under the member's Medicare benefit but that are covered services under the member's Medicaid benefit, HAP CareSource will reimburse as set forth in your contract for the Medicaid benefit.

- Submit claims for complete episode of care.
- Do not bill future dates of service.
- Do not submit single claim with date span across calendar years except in the case of inpatient facility MS-DRG and APR-DRG billing.
- Submit supporting documentation for unlisted CPT/HCPCS codes.
- Interim billing is not accepted.
- Indicate the appropriate HAP CareSource MI Coordinated Health product name in the upper right corner on CMS-1500 claim form and in field 61 on the CMS-1450 (UB-04) form.

- Claims and encounters must be computer generated or typed and signed by the servicing provider and submitted via:
  - **Paper:** CMS-1500 claim form or CMS-1450 (UB-04) claim form
  - **Electronically:** through the clearing house Availity
- Handwritten entries are not acceptable anywhere on the claim.
- Electronic signatures are acceptable.
- Mandatory items on claim forms must be completed or the claim cannot be processed. Refer to claim form submission guidelines within this section.
- Conditional items, if applicable, on claim forms are required or the claim may not be processed. Refer to claim form submission guidelines within this section.
- Blank items may be left empty and will not affect claims processing. Refer to claim form submission guidelines within this section.
- All claims must contain an NPI number submitted as follows:
  - Field 24 J of CMS-1500 rendering provider is conditional, required when different from billing provider and must be an entity type of (1) individual
  - FL 56 of the UB-04 form
- Submit the member ID number as follows:
  - Product: HAP CareSource MI Coordinated Health
  - Billing ID: Use the 11-digit member ID number from the HAP CareSource MI Coordinated Health member ID card.

For more information and instructions on completing claim forms, visit cms.gov and click on *Regulation and Guidance*, then under *Guidance*, click on *Manuals*.

Claim Form Submission Guidelines - CMS-1500 Version (02-12)

Legend

- **Mandatory** - Must be completed. If blank, the claim can't be processed.
- **Conditional** - If applicable, it is required. If left blank, the claim can't be processed.
- **Blank** - May be left empty and will not affect the processing of your claim.

Field Locator	Status	Description
1	Blank	Patient/Insured Information
1a	Mandatory	Insured's ID Number as shown on insured's ID card
2	Mandatory	Enter the patient's last name, first name and middle initial (if any) in that order.
3	Mandatory	Enter the patient's eight-digit birthdate (MMDDYY) and sex.
4	Conditional	Mandatory if the patient has other insurance primary to Medicaid

Field Locator	Status	Description
5	Blank	Enter patient's current address.
6	Conditional	If item 4 is complete, check the appropriate box, Patient relationship to Insured.
7	Conditional	Complete if items 4 and 11 are completed.
8	Blank	Reserved for National Uniform Claim Committee (NUCC) use.
9	Conditional	Mandatory if item 11d is YES.
9a	Conditional	Enter second insurance policy or group number for policyholder in item 9.
9b	Blank	Reserved for NUCC Use.
9c	Blank	Reserved for NUCC Use.
9d	Conditional	Enter insurance plan name or program name for policyholder in item 9.
10a	Mandatory	Check YES or NO if condition is employment related.
10b	Mandatory	Check YES or NO if condition is related to an auto accident. If YES, indicate state postal code.
10c	Mandatory	Check YES or NO if condition is related to accident other than auto.
10d	Blank	Claim codes (Designated by NUCC)
11	Conditional	Mandatory if patient has insurance primary to Medicaid. Enter primary insurance policy group number.
11a	Conditional	Enter date of birth (MMDDYY) and sex for policyholder in item 4.
11b	Conditional	Enter the employer's name or school for policyholder in item 4.
11c	Conditional	Enter insurance plan name or program name for policyholder in item 4.
11d	Conditional	Check YES, if appropriate and complete item 9 – 9d.
12	Blank	Patient or authorized person's signature
13	Blank	Insured's or authorized person's signature
14	Conditional	If item 10b or 10c is YES, date of accident must be reported.
15	Blank	Other date
16	Blank	Dates patient unable to work in current occupation
17	Mandatory	Enter the referring/ordering physician's name.
17 a, b	Mandatory	17a: Enter other ID# of the provider in item 17, if available. 17b: Enter NPI# of referring, ordering or supervising provider.

Field Locator	Status	Description
18	Conditional	Report the admit and discharge dates for services during an inpatient hospital stay.
19	Conditional	May leave blank at this point or enter documentation or remarks as required
20	Blank	Outside lab charges
21	Mandatory	Enter the ICD_10 CM (i.e., using 4th or 5th digits) or ICD-10 diagnosis codes, using up to 7 characters, to the highest level of specificity that describes the patient's condition. Enter the applicable ICD indicator to identify which version of the ICD is being reported. Maximum of 12 diagnosis can be entered.
22	Conditional	Resubmission code 7 and original form number
23	Conditional	Enter the prior authorization number for services requiring an authorization or the 10-digit CLIA number as appropriate. For authorization requirements, check the Procedure Code Lookup Tool.
24A	Mandatory	Report all services provided on the same day for the same patient using only one claim form to ensure correct benefit coverage. Enter the month, day and year for each procedure, using the format "MM/DD/YY." Date spans on a single claim should not cross years.
24 B, C	Mandatory	Enter the appropriate 2-digit place of service. Emergency indicator Y=yes, N=no
24D	Mandatory	Procedures, services or supplies (CPT or HCPCS) modifier
24E	Mandatory	Diagnosis pointer
24F	Mandatory	Enter your charge without decimals, commas or dollar signs.
24G	Mandatory	Enter the number of units.
24H	Blank	EPSDT/Family Plan
24I	Mandatory	Qualifying ID if other than NPI
24J	Conditional	Rendering Provider ID number shaded area for non-NPI number's; non-shaded area, NPI required
25	Mandatory	Enter the provider's Federal Tax ID or Social Security Number.
26	Mandatory	Enter the patient account number assigned by the provider or supplier.
27	Blank	Accept Assignment.
28	Mandatory	Enter sum of charges in 24F.

Field Locator	Status	Description
29	Conditional	Report amount of other insurance payment.
30	Blank	Reserved for NUCC Use.
31	Mandatory	Signature of provider or supplier and date
32	Mandatory	Enter name and address of facility where services were rendered.
33 A, B	Mandatory	Billing provider's or supplier's name, address, zip code and phone number (a) Billing provider's NPI (b) other ID number
Note: The provider ID number entered in box 33 must correspond with the EIN or SSN entered in box 25 and the provider in box 31. If they don't match, the W-9 information on file will be returned for invalid provider information.		

UB-04 CMS-1450 Claims Form

For efficient claims processing, please follow the guidelines below.

- Refer to the National Uniform Billing Committee Manual for details on field locator data to be submitted. Visit nubc.org for more information.
- Electronic submission is strongly encouraged.
- For paper submissions, use the red UB-04 form.
- Handwritten claims are not acceptable and will be returned.
- Print must be dark enough to read easily.

UB-04 Field Locator	Field Status	Description of Field	Information to be Included
1	Mandatory	The name and service location of the provider submitting the bill	Billing provider name, street address and telephone number
2	Mandatory	Pay to name and address	Address where payments are to be sent if different than FL 1
3a	Mandatory	Patient control number	Patient's unique alphanumeric number assigned to facilitate records and posting of payments.
3b	Conditional	Medical or health record number	The number assigned to the patient's medical or health record by the provider

UB-04 Field Locator	Field Status	Description of Field	Information to be Included
4	Mandatory	Type of bill	A code indicating the specific type of bill. The first digit is a leading zero. Do not include the leading zero on electronic claims.
5	Mandatory	Federal tax number	Number assigned to the provider by the federal government for tax reporting
6	Mandatory	Statement covers period	The beginning and ending service dates of the period included on this bill. The from date should not be confused with the admission date in FL 12. Report all services provided to the same patient using only one claim form to ensure correct benefit coverage. Enter both from and through dates using the MM/DD/YY format. Outpatient claims date spans on a single claim should not cross years.
7	Blank	Reserved	
8	Mandatory	Patient name and identifier	Last name, first name and middle initial of the patient and the patient identifier as assigned by the payer
9	Mandatory	Patient address	The complete mailing address of the patient
10	Mandatory	Patient birth date	In MM/DD/YY
11	Mandatory	Patient sex	M, F or U=unknown
12	Mandatory	Admission or start of care date	Start date for episode of care. For inpatient this is the date of the admission.
13	Conditional	Admission hour	The code referring to the hour during which the patient was admitted to the facility
14	Mandatory	Priority or type of visit	A code indicating the priority of the admission or type visit
15	Mandatory	Source of referral of admission or visit	A code indicating the source of the referral of the admission or visit

UB-04 Field Locator	Field Status	Description of Field	Information to be Included
16	Mandatory	Discharge hour	Code indicating the discharge hour of the patient from inpatient care
17	Mandatory	Patient discharge status	A code indicating the disposition of discharge status of the patient at the end service
18-28	Conditional	Condition codes	A code used to identify conditions or events relating to this bill that may affect processing (alphanumeric sequence)
29	Blank	Reserved	The accident state field contains the two-digit state abbreviation where the accident occurred.
30	Blank	Reserved	
31-34, 35-36	Conditional	Occurrence codes and dates	The code and associated date defining a significant event relating to the bill that may affect payer processing. Refer to NUBC Manual for list of codes.
37	Blank	Reserved	
38	Conditional	Responsible party name and address	The name and address of the party to whom the bill is being submitted
39-41	Conditional	Value codes and amounts	A code structure to define amounts or values that identify data elements necessary to process the claim as qualified by the payer organization
42	Mandatory	Revenue code	Code that identifies specific accommodation, ancillary services or unique billing arrangements
43	Blank	Revenue description	The standard abbreviated description of the related revenue code included on the bill
44	Conditional	HCPCS, accommodation rates and HIPPS rate codes	The HCPCS applicable to ancillary service and outpatient bills, accommodation rate for inpatient bills, HIPPS rate codes
45	Mandatory	Service date	The date in MM/DD/YY format the outpatient service was provided

UB-04 Field Locator	Field Status	Description of Field	Information to be Included
46	Mandatory	Service units	A quantitative measure of services rendered by revenue category to or for the patient
47	Mandatory	Total charges	Total charges for the primary payer for both non-covered and covered charges
48	Conditional	Non-covered charges	Noncovered charges for destination payer as it pertains to the related revenue code
49	Blank	Reserved	
50	Conditional	Payer identification	
51	Conditional	Health plan identification number	The number used by the health plan to identify itself
52	Conditional	Release of information certification indicator	Code indicates whether the provider has a signed statement from the patient on file permitting the provider to release data to another organization
53	Mandatory	Assignment of benefits	Code indicates provider has a signed form authorizing the third-party payer to remit payment directly to the provider
54	Conditional	Prior payments	The amount the provider has received to date by the health plan toward payment of this bill
55	Conditional	Estimated amount due	The amount estimated by the provider to be due from the indicated payer
56	Mandatory	National provider identifier	The unique identification number assigned to the provider submitting the bill
57	Blank	Other billing provider identifier	A unique identification number assigned to the provider submitting the bill by the health plan
58	Mandatory	Insured's name	The name of the individual under whose name the insurance benefit is carried.

UB-04 Field Locator	Field Status	Description of Field	Information to be Included
59	Mandatory	Patient's relationship to insured	Code indicating the relationship of the patient to the identified insured
60	Mandatory	Insured's unique identifier	The unique number assigned by the health plan to the insured
61	Conditional	Insured's group name	The group or plan name through which the insurance is provided to the insured
62	Conditional	Insured's group number	The identification number, control number or code assigned by the carrier to identify the group under which the individual is covered
63	Conditional	Treatment authorization code	A number or other indicator that designates that the treatment indicated on this bill has been authorized by the payer
64	Conditional	Document control number	The control number assigned to the original bill by the health plan as a part of internal control
65	Conditional	Name of insured's employer	The name of the employer that provides health care coverage for the insured individual in FL 58
66	Mandatory	Diagnosis and procedure code qualifier (ICD-9 and ICD-10 version indicator)	The qualifier that denotes the version of International Classification of Diseases
67	Mandatory	Principal diagnosis code and present on admission indicator	The ICD-9CM codes or ICD-10 describing the principal diagnosis. POA reporting y=yes, n=no, u=unknown
67a-q	Mandatory	Other diagnosis code	The ICD-9CM or ICD-10 diagnosis codes that coexist at the time of admission
68	Blank	Reserved	
69	Mandatory	Admitting diagnosis code	The ICD-9CM or ICD-10 diagnosis code describing the patient's diagnosis at the time of inpatient admission

UB-04 Field Locator	Field Status	Description of Field	Information to be Included
70a-c	Mandatory	Patient's reason for visit	The ICD-9CM or ICD-10 diagnosis codes describing the patient's reason for visit at the time of outpatient registration
71	Conditional	Prospective payment system	The PPS code assigned to the claim to identify the DRG based on the grouper
72a-c	Conditional	External cause of injury code	The ICD diagnosis codes pertaining to external cause of injuries, poisoning or adverse effect
73	Blank	Reserved	
74	Conditional	Principal procedure code and date	The ICD code that identifies the principal procedure performed. Enter the date of that procedure.
74a-e	Conditional	Other procedure codes and dates	The ICD codes identifying all significant procedures other than the principal procedure
75	Blank	Reserved	
76	Conditional	Attending provider name and identifiers	The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.
77	Conditional	Operating physician name and identifiers	The name and identification number of the individual with the primary responsibility for performing the surgical procedures
78-79	Conditional	Other individual provider names and identifiers	The name and ID number of the individual corresponding to the provider type category indicated in this section of the claim
80	Conditional	Remarks field	Area to capture additional information necessary to adjudicate the claim
81	Blank	Code-code field	To report additional codes related to a form locator or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set

Ordering, Referring and Attending Providers – Requirements for HAP CareSource MI Coordinated Health Claims

Below are requirements for ordering, referring and attending providers when submitting claims.

- The name and NPI of the ordering, referring or attending provider must be reported on all claims for services rendered as a result of an order or referral when applicable.
- Ordering, referring and attending providers must be enrolled and active in the Michigan Medicaid program on the date the claim is adjudicated.
- Ordering, referring and attending providers must be one of the following provider types:

- **Physician**	- **Dentist**
- **Physician Assistant**	- **Podiatrist**
- **Nurse Practitioner**	- **Optometrist**
- **Certified Nurse Midwife**	- **Chiropractor (limited to spinal x-rays only)**

- The following provider types are allowed to be reported as attending providers in addition to the above provider types for institutional claims by FQHC, RHC and THC providers.

- Clinical Psychologist	- Licensed Psychologists (Doctoral Level)
- Clinical Social Workers	- Social Workers (Master's Level)
- Clinical Nurse Specialist	- Professional Counselors (Master's Level)
- Marriage and Family Therapists	- Limited License Psychologist (Master's or Doctoral)

You can find order and referral requirements for specific services in the Michigan Medicaid Provider Manual. Visit michigan.gov\mdhhs, *Assistance Programs; Medicaid; Providers; Policy, Letters and Forms; Medicaid Provider Manual*.

Examples of services that require an order or referral include, but are not limited to:

- Ambulance nonemergency transports
- Ancillary services for beneficiaries residing in nursing facilities (i.e., chiropractic, dental, podiatry, vision)
- Childbirth/parenting and diabetes self-management education
- Consultations
- Diagnostic radiology services, unless rendered by the ordering physician
- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
- Hearing and hearing aid dealer services
- Home health services
- Hospice services
- Laboratory services
- Certain mental health and substance abuse children's waiver services

- Certain MIHP services
- Pharmacy services
- Private duty nursing services
- Certain School based services
- Therapy services (occupational therapy [OT], physical therapy [PT] and speech therapy [ST])
- Certain vision supplies

We're confident following these guidelines can help reduce claim errors.

NDC Reporting Requirement for Physician Administered Drugs

Providers and hospitals are required to report the National Drug Code (NDC) when billing for a physician administered drug on electronic and paper claim formats. This requirement is for HAP CareSource MI Coordinated Health claims.

Billing guidelines can be found in the MDHHS Medicaid Provider Manual. You can find the manual here. Please refer to the following sections:

- Billing and Reimbursement for Institutional Providers: Section 7.19 – Injections
- Billing and Reimbursement for Professionals: Section 6.4 – Ancillary Medical Services

Nine-Digit Zip Code Reminder

In 2012, health care providers covered by the Health Insurance Portability and Accountability Act (HIPAA) who submit transactions electronically were required to use version 5010 standards for claims and other specific electronic transactions.

In addition, 5010 requires providers to report a nine-digit zip code as part of their practice's street address and when they report a service facility address.

Claims submitted without a nine-digit zip code will reject during preprocessing.

NPIs on CMS 1500 Claim Submission

There are two types of NPIs—individual or organization. **When submitting claims electronically**, the NPIs must match the entity type being submitted within any of the loops that have individual or organizational NPIs. For example,

- Entity type = 1: Must be used when submitting an individual NPI
- Entity type = 2: Must be used when submitting an organizational NPI

Claims submitted with the incorrect entity type and NPI combination in any loop will be rejected with the following message:

- NPI and entity type qualifier combination does not align in NPPES or is not active in NPPES.

Below are instructions for the information to submit in Form Locator 32 and 33.

Form Locator	Billing Instructions
32	• If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. • When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider.
33	Use the "billing" NPI that you would expect to receive payment under. For example: • If you're an individual provider and want to be paid under the individual NPI, then report the individual NPI in box 33a of the CMS-1500 claim form. • If you're a physician group and want to be paid under the group NPI, then report the group NPI in box 33a of the CMS-1500 claim form.

For more information, refer to the National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual at nucc.org. Providers submitting claims electronically can refer to the 837 Implementation Guide for instructions.

Taxonomy Codes Required on Professional Claims

Taxonomy codes are required when submitting professional claims for all HAP CareSource lines of business. This is consistent with National Uniform Billing Guidelines and is critical for accurate and timely claims processing. Taxonomy codes should be submitted as follows:

- **On a CMS-1500 claim form**

Rendering	Box 24i should contain the qualifier ZZ Box 24j should contain the taxonomy code
Billing	Box 33b should contain the qualifier along with the taxonomy code
Referring	If a referring provider is indicated in box 17 on the claim, then Box 17a should contain the qualifier of ZZ along with the taxonomy code in the next column.

- **Electronic submission**

  Follow the 5010 Implementation Guide for submitting a PRV segment at the billing or rendering level. Please see details below.

Billing	PRV01 = BI PRV02 = PXC PRV03 = taxonomy code
Rendering	PRV01 = PE PRV02 = PXC PRV03 = taxonomy code

Claims may deny if the taxonomy is missing or incorrect.

Specific Claim Coding Requirements

Coordination of Benefits (COB)

- Medicaid is the payer of last resort.
- Providers must report all other insurance or liability coverage using all other payment resources before submitting a claim to HAP CareSource MI Coordinated Health.
- An EOP or explanation of benefits from the primary carrier must accompany the claim to coordinate benefits.
- Professional, facility and ancillary services not covered by the primary insurance carrier and billed to HAP CareSource MI Coordinated Health must comply with our authorization requirements to be reimbursed. See Referrals and Authorizations section in this Manual.
- It's highly recommended to submit COB claims electronically and indicate the primary insurance detail payments lines in loop 2400. COB claims may be submitted on paper with other insurance explanation of payment attached.
- We follow Medicare Secondary Payer Provisions for Medicare and Medicaid dual-eligible HAP CareSource MI Coordinated Health members. For more information, visit cms.gov and search for *Medicare Secondary Payer (MSP) Manual*.

Durable Medical Equipment, Prosthetics and Orthotics

When billing for equipment and supplies, be sure to follow these guidelines:

- *From* and *To* dates are required on the claim
- Always include the appropriate modifier on all DMEPOS claims when applicable

Evaluation & Management (E&M) Billing Guidelines

We follow CMS payment guidelines. HAP CareSource MI Coordinated Health does not pay for E&M services that require a face-to-face encounter, and the patient is not seen.

For more information, visit cms.gov. Click on *Regulations and Guidance*, and under *Guidance*, click on *Manuals*. Under *Manuals*, *Internet-Only Manuals (IOMs), Medicare Claims Processing Manual*. Select *Chapter 12 - Physicians/Non-physician Practitioners* and go to *Section 30.6.7, 6.9 Payments for Office, Other Outpatient and Inpatient Hospital Visits*.

Two E&M Services on Same Date of Service

We will pay two E&M office visits billed by a physician, or physician of the same specialty from the same group practice, for the same beneficiary on the same day when it is documented that the visits were for unrelated problems in the office, off-campus outpatient hospital or on-campus outpatient when the E&M procedures are billed for unrelated problems and could not have been provided during the same encounter.

In a hospital inpatient setting, only one E&M is allowed per day, per physician or covering physicians in the same group or specialty. If physicians with different specialties are responsible for different aspects of the patient's care, both visits may be billed with different diagnoses. We follow CMS payment guidelines.

For more information, visit cms.gov. Click on *Regulations and Guidance*, and under *Guidance*, click on *Manuals*. Under *Manuals* click on *Internet-Only Manuals (IOMs), Medicare Claims Processing Manual*.

Select *Chapter 12 - Physicians/Non-physician Practitioners* and go to *Section 30.6.7, 6.9 Payments for Office, Other Outpatient and Inpatient Hospital Visits*.

Emergency Services

- Medical emergency is defined as services necessary to treat an emergency medical condition.
- Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child
  - Serious impairment to bodily functions or serious dysfunction of any bodily organ or part
- Pursuant to our agreement with the MDHHS, HAP CareSource provides coverage for emergency services and medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (42 USCS 1395 dd (a)).
- HAP CareSource MI Coordinated Health members may receive emergency screening and stabilization services without prior authorization.

Federally Qualified Health Centers, Rural Health Clinics and Tribal Health Centers

- For services performed on or after Aug. 1, 2017, FQHC, RHC and TCH can submit claims by one of the methods below.
  - **Electronic:** Use the ASC X12N 837 5010 institutional format.
  - **Paper:** Use the National Uniform Billing Code claim form.
- Claims submitted after the date above using the professional claim formats CMS-1500 or 837P will be denied. For more information refer to the Medicaid Policy Bulletin: MSA 17-10 and MSA 17-24. You can find these bulletins when you visit **Michigan.gov/mdhhs** and select: *Doing business with MDHHS; Information for Medicaid Providers; Providers; Policy, Letters and Forms*.

Long-Term Support Services

- Long-term supports and services include:
  - Nursing facility services
  - State plan personal care services
  - Supplemental services for individuals who live in the community and do not meet nursing facility level of care determination
  - HAP CareSource home and community-based services and waiver services for individuals who live in the community and meet nursing facility level of care determination (LOCD) based on the LOCD tool.
- These services require authorization.
- Claims can be submitted via:
  - **Electronically:**
    Use ASCX12N 5010 837 I (institution)
    Use ASCX12N 5010 837 P (professional)
  - **Paper:** CMS-1500 claim form or UB-04 claim form based on the service type

Per Diem Services

Service codes that are per diem CPT/HCPCS codes must be reported per day. Date spans are not accepted for per diem CPT/HCPCS codes.

Modifier N1, N2, N3 for Home Oxygen Use

Following CMS guidelines, HAP CareSource MI Coordinated Health requires providers to use modifiers N1, N2, N3 (based on sat % group) in place of the KX modifier for home oxygen use.

Modifier GA- Pre-service notice of non-coverage was provided by HAP CareSource

- Use Modifier GA when:
  - The Plan made an organization determination and gave the member an Integrated Denial Notice before the member received the non-covered services.
  - The member refused your offer of obtaining a pre-service determination and wanted to proceed with the service.
  - The member wanted to proceed with the service and doesn't want to appeal a denial of coverage notice from HAP CareSource MI Coordinated Health.
- If you bill for a non-covered service using modifier GA and a plan provider has not referred the enrollee, the claim will go to patient liability, and you may bill the member.
- If you bill for a non-covered service without using the GA modifier, HAP CareSource MI Coordinated Health will deny your claim and it will go to provider liability.

Urgent Care Services

- Bill appropriate level E&M codes for urgent care services. Also include the appropriate codes for all other services provided on the same day.
- Providers will be reimbursed at the Medicaid fee schedule. You can find fee schedules when you visit **Michigan.gov/mdhhs**. Click on *Assistance Programs*, then *Medicaid*, then *Providers*, then *Billing and Reimbursement*, then *Provider Specific Information*.
- For authorization information, log in to the HAP CareSource Provider Portal.

Telemedicine Services

HAP CareSource MI Coordinated Health follows telemedicine billing guidance from the MDHHS. All telemedicine services, as allowed on the Michigan Medicaid telemedicine database and submitted on professional claim format (CMS-1500 form or 837P equivalent), require both:

- Place of service that would be reported as if the beneficiary were in-person for the visit
- The appropriate telemedicine modifier
- Modifier 95 – audio and visual telecommunication
- Modifier 93 – audio-only telecommunication

Services submitted on an institutional claim format (UB-04 form or 837I equivalent) require:

- The appropriate National Uniformed Billing Committee (NUBC) revenue code, appropriate CPT/HCPCS code and Modifier 95 or Modifier 93, must be used. Telemedicine claims without these indicators may be denied.

For more information, please refer to the MDHHS policy bulletins MMP 23-10 and MMP 24-06 which can be found here.

Therapy Services

Therapy services furnished to HAP CareSource MI Coordinated Health members must be billed with the appropriate therapy modifier used to identify PT, OT or ST services. Services should also be reported with the appropriate modifier that represents the nature of the therapy performed. Modifier 96 should be used when habilitative services are rendered. Therapy services submitted without these modifiers may be denied.

Billing Members

Providers who accept a patient that is a HAP CareSource MI Coordinated Health member, the member cannot be billed for:

- Medicaid-covered services, providers must inform the beneficiary before the service is provided if HAP CareSource MI Coordinated Health does not cover the service.
- Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain prior authorization, or the claim is over one year old and has never been billed to HAP CareSource MI Coordinated Health.

Balance Billing

- Providers may not balance bill HAP CareSource MI Coordinated Health members for unauthorized services if the member had no prior knowledge of liability for the service.
- Cost-sharing does not apply to dual-eligible members in HAP CareSource MI Coordinated Health or HAP CareSource dual eligible. For more information, visit cms.gov. Select *Training and Education* > *Find your Provider Type* > *Health and Drug Plans* > *Medical Learning Network® Provider Compliance*.

Balance Billing by Provider Type – HAP CareSource MI Coordinated Health

The table below is from the Medicare Managed Care Manual – Chapter 4 – Benefits and Beneficiary Protections, Section 170.2 (Medicaid).

Type of Provider	Balance Billing Rules
Plan contracted and non-contracted providers that are original Medicare participating providers	Balance billing not allowed.
Non-contracted, non-Medicare participating providers	Bill HAP CareSource MI Coordinated Health the difference between the member's copayment or coinsurance and the original Medicare limiting charge, which is the maximum amount original Medicare requires a Medicare Advantage Organization to reimburse a provider.
Non-contracted, non-Medicare participating DME suppliers	Bill HAP CareSource MI Coordinated Health the difference between the member's cost-sharing (copayment or coinsurance) and your charges.

Claim Disputes

HAP CareSource MI Coordinated Health allows contracted and non-contracted providers to submit claim disputes on payment decisions made by HAP CareSource MI Coordinated Health.

HAP CareSource MI Coordinated Health will resolve all disputes within 30 calendar days. There is one level of internal claim disputes. Any further disputes by contracted providers must follow the Binding Arbitration Process or Rapid Dispute Resolution. All non-contracted providers who wish to pursue the denial further must go through the Rapid Dispute Resolution with the state of Michigan.

All claim disputes must be submitted within 60 days of receipt of the date of payment or the date of the original claim rejection from HAP CareSource MI Coordinated Health. All disputes must include a cover letter indicating basis for dispute and the additional documentation supporting the dispute. Resubmission of a denied claim alone does not constitute a dispute.

Providers can dispute claims by following the processes outlined below. All disputes must be submitted in writing either by mail or the Provider Portal:

HAP CareSource MI Coordinated Health
Attn: Grievance and Appeals
P.O. Box 1025
Dayton, OH 45401-1025
HAP CareSource Provider Portal

Claims disputes must include the following claim information:

- A cover letter documenting reason for dispute
- Member details
- Date of service
- Claim number
- Additional documentation supporting the dispute
- Reference to the previously processed claim

There is one level of internal claim dispute within the plan.

HAP CareSource MI Coordinated Health will respond to dispute requests within 30 days of receipt.

Dispute	Process
Level 1	Submit dispute within 60 days of original claim denial.* HAP CareSource MI Coordinated Health reviews the disputes and approves or upholds denial. If denial is upheld, HAP CareSource MI Coordinated Health will send a letter to the provider advising which additional rights they have should they disagree with our decision.
Level 2	Submit dispute within 60 days of claim dispute.

Dispute	Process
Account Receivable Reconciliation Group (ARRG)	For non-contracted hospital providers that have signed the Hospital Access Agreement, disputes will be referred to the AARG. The AARG is comprised of HAP CareSource MI Coordinated Health stakeholders that meet no less than every 90 days to reconcile outstanding bills and payments. All appeal decisions will be finalized at the AARG.
Decision	If the original decision is overturned and the service is approved, the claim will be reprocessed for payment. A letter will be sent to the provider notifying them of the Approval and that payment will be forthcoming within 2-3 weeks.
Unresolved	Where a disputed claim, or group of similar claims, remains, the hospital, provider or HAP CareSource MI Coordinated Health may submit a request to MDHHS for Rapid Dispute Resolution (RDR) process.
Arbitration/Rapid Dispute Resolution	• The RDR process can be found in the Medicaid Provider Manual and should be followed for non-contracted hospital providers that have signed the Hospital Access Agreement. • Non-contracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the RDR process. • The Binding Arbitration process can be requested by non-hospital providers or hospital providers that have not signed the Hospital Access Agreement after they have exhausted our internal provider dispute process.

*Appeals received after 60 days will be returned with a letter indicating untimely filing and no action will be taken.

Denials – When to Submit a Corrected Claim Versus a Dispute

Corrected claim submission

If we deny a service for missing or incorrect information, and you agree with our decision and want to submit a corrected claim, then:

- Follow our process for Claim Corrections in this manual.

Important!

Providers have one year from the date of service to submit a corrected claim.

Denials include, but are not limited to:

- Incorrect date of service
- Incorrect diagnosis or ICD-10 Manual guidelines not followed
- Missing NDC
- Inaccurate CPT/HCPCS/REV code
- Missing modifiers or incorrect modifiers (with the exception of the modifiers listed below), such as anatomical, DME, therapies
- Over billed units

Disputes

If you disagree with the denial and submitting a corrected claim will not resolve the issue, then:

- Submit an appeal letter and medical records within 60 days of the original denial date
- Do **not** keep submitting corrected claims to resolve a denial issue
- The denial must be resolved on the original claim

You can find the appeals process in this Manual.

Denials include, but are not limited to:

- Mutually exclusive procedures
- Units billed appropriately
- Exceeds clinical guidelines
- Included in the global surgical package
- Modifier missing – see list of modifiers below

Missing Modifiers Requiring Appeal and Corrected Claim

If we deny a service for an unsupported modifier or you determine modifiers 24, 25, 27, 57, 59, 76, 91, XE, XS, XP, or XU should have been billed, then:

- Submit an appeal with medical records and a hard copy corrected claim.
- Do not just add a modifier on the claim that would bypass the edit/denial. This may cause the service to be denied again.

Important!

- Modifiers XE, XS, XP, and XU give greater reporting specificity in situations where you used modifier 59 previously. Use these modifiers instead of modifier 59 whenever possible.
- Only use modifier 59 if no other, more specific, modifier is appropriate.
- All modifiers must be supported in the medical records.

Claim Corrections

To ensure proper payment, please follow the process below.

For	Instructions
Paper claims	• Institutional claims enter 7 for replacement or 8 for cancel in box 4 – Type of Bill on the UB-04 with the HAP CareSource MI Coordinated Health claim number to replace in field 64 Document Control Number • Professional claims enter 7 for replacement or 8 for cancel in box 22 on the CMS-1500 with the HAP CareSource MI Coordinated Health claim number to replace in Original Ref No field
Electronic claims	• Loop 2300 Segment CLM composite element CLM05-3 should be 7 or 8 • Loop 2300 Segment REF element REF01 should be F8 indicating the following number in REF02 is the HAP CareSource MI Coordinated Health claim number to replace

Important! Be sure to include the original HAP CareSource MI Coordinated Health claim number and bill frequency code (7 for replacement; 8 for cancel) per billing standards.

Replacement (xx7)

Replacement billing should be used when there are data changes to an originally submitted claim which would result in additional payment or corrections to the claim. The replacement claim identifier should be used for any claim that is not the original submission. Claims submitted without the replacement claim identifier may result in the claim being denied as a duplicate to the original claim. When a replacement claim is submitted correctly, we will:

- Adjust the original claim submission
- Process the new replacement claim

Important

For reconsiderations on a claim outcome with no update or change in data, you can:

- Call HAP CareSource MI Coordinated Health Provider Services at **1-833-230-2159**
- Follow the online Claims Adjustment Process

Cancel (xx8)

Cancel bill types reflect the elimination of a previously submitted claim in its entirety for a specific provider, patient, payer, insured and "Statement Covers Period."

HAP CareSource MI Coordinated Health uses the cancelled claim as the indicator to adjust the original claim in full. This indicates the claim should not have been submitted.

Post-Payment Review

HAP CareSource MI Coordinated Health reserves the right to review claims and encounters to determine:

- **Appropriate billing code**
- **Benefit level for service**
- **Completeness of claim**
- **Duplication of service**
- **Eligibility of member**
- **Prior authorization as indicated**

When the services rendered appear to exceed the customary level of care, HAP CareSource MI Coordinated Health may require medical records, reports, treatment records, or discharge summaries as appropriate.

Quarterly Claim Audits

Quarterly, HAP CareSource MI Coordinated Health's Payment Integrity department conducts claim audits per state requirements. These audits are a random selection of 100 claims paid within the previous quarter to ensure:

- The services billed are supported in the medical records
- The medical records follow the requirements in the medical record maintenance policy within this manual

Process to obtain medical records

Two attempts are made to obtain medical records to support claim denials. We send letters to providers, each with a 30-day due date. If records are not returned by the deadline from the second letter, the entire claim will be denied due to no response to medical records request. No further action will be taken.

Process for medical records that do not support services

If the medical records submitted do not support the services billed or follow HAP CareSource MI Coordinated Health billing guidelines, we will send a letter to the provider with our findings. Providers have 30 days from the date of the letter to submit an appeal. If an appeal is not received, we will take the payment back for the unsupported services. No further action will be taken.

These services cannot be billed to the patients.

Coding Validation Process

HAP CareSource MI Coordinated Health has a code validation process to ensure specific modifiers have been used correctly. As you know, claims should always be coded to the level of specificity for the services rendered. Diagnosis codes and modifiers should be appropriately appended so they follow the national guidelines. Reported services should be supported in the patient's medical record.

Below is an overview of our process.

Modifiers

We will review the following modifiers:

Modifier	Definition
22	Increased Procedural Services. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should be appended to an evaluation and management (E&M) service.
25	Indicates a significant, separately identifiable E&M service was performed by the same physician or other qualified healthcare professional on the same day of a procedure or other services.
59	Distinct procedural service. Used to identify procedures/services, other than E&M services, that are not normally reported together but are appropriate under the circumstances.
XE	Separate Encounter, a service that is distinct because it occurred during a separate encounter. Only use XE to describe separate encounters on the same date of service.
XS	Separate Structure, a service that is distinct because it was performed on a separate organ/structure
XP	Separate Practitioner, a service that is distinct because it was performed by a different practitioner
XU	Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service

Resources

Here are national resources for more detailed information on these modifiers.

- American Medical Association *Coding with Modifiers, 6th edition*
- Current Procedural Terminology Manual
- The Center for Medicare and Medicaid Services National Correct Coding Initiative
- CMS Claims Processing Manual

Prepayment review

Claims submitted with the above modifiers on or after September 5, 2022, will pend for a prepayment review. Registered nurses with coding credentials will use nationally sourced guidelines to review information on the claim and the patient's claim history.

Review outcome

After the review is completed, claims will either process for payment or deny. Providers can appeal a denial decision. Please refer to Claims Disputes section in this Manual. A nurse will review medical records and supporting documentation to determine if the denial was appropriate or if it should be overturned and processed for payment.

We are confident this process will improve the accuracy of claims processing.

Enhanced Clinical Editing Processes

We continuously work to enhance our claims payment accuracy solutions. This involves a regular review of standard billing practices and claims payment accuracy guidelines that will be updated in this manual periodically.

Edits in this section apply to all HAP CareSource MI Coordinated Health lines of business. **Note:** For HAP CareSource MI Coordinated Health claims, if an edit doesn't follow the MDHHS guidelines, then the MDHHS guidelines supersede the edit in the table below.

We have guidelines to promote correct coding that are national in scope, simple to understand and come from the following sources:

- The CMS medical coding guidelines
- American Medical Association (AMA) CPT coding guidelines
- Local and regional Medicare guidelines
- The MDHHS guidelines for HAP CareSource MI Coordinated Health claims

The table below is a sample of our enhanced guidelines for outpatient facility and professional claims. This is not an all-inclusive list. It will be updated from time to time.

Topic	Description and Guidelines
Add-On Codes	• Certain procedure codes are commonly performed and billed in addition to the primary procedure. • They should never be reported as a standalone service. • These codes are identified in the AMA CPT manual with a plus (+) symbol. • They're also listed in Appendix D of the CPT Manual. • Add-on codes in the HCPCS Level II Manual and the ADA Dental Services Manual are identified with "list separately in addition to code for primary procedure" or "each additional" language within the code description. • If an add-on code is submitted and the primary procedure has not been identified on the same or different claim, HAP CareSource MI Coordinated Health will deny the add-on code as an inappropriately coded procedure.
Ambulatory Surgery Center Edits	• The following services will be denied if billed without an approved ASC surgical procedure for claims submitted with place of service 24: - Radiology - Drugs and biologicals - Devices - Brachytherapy source

Topic	Description and Guidelines
Ambulance Edits	• If a provider does not submit an origin modifier combined with a destination modifier for ambulance services, it will be denied. • Ambulance claims submitted with non-covered origin and destination modifiers will be denied. • ALS emergency services will be denied when billed without a diagnosis that supports ALS emergency services. • ALS or BLS non-emergency services will be denied when billed without a diagnosis that supports ALS/BLS non-emergency services.
Anesthesia Edits	When more than one anesthesia CPT code (00100 – 01999) can be used for a surgery, then the lower based unit anesthesia code should be billed. If not, the service will be denied to be rebilled correctly.
Assistant Surgeon Edits	• Reimbursement for an assistant surgeon will be denied when billed by the primary surgeon. • Only one assistant surgeon will be allowed for a surgical procedure.
Bundled services	• There are several services or supplies CMS bundles into the payment for other related services. These services are grouped into three categories: 1. Not separately payable when billed on the same day as other payable services (Status Indicator P). 2. Not payable under any circumstances (Status Indicator B). 3. Injection services (Status Indicator T).
Correct Coding Edits	• When multiple CPT/HCPCS codes are billed together without modifiers to denote different sides, but there is a single code that describes the same procedure/services under one code, the service will be denied and to be rebilled under the correct code. • Nuclear medicine procedure will be denied when billed without a radiopharmaceutical imaging agent on both outpatient and professional claims. • Certain procedures will be limited to one unit per day regardless of appended modifier. • 99441-99443 (Telephone E&M services), G2010 (Remote evaluation of recorded video and/or image), G2012, or G2252 (Brief check in by MD/QHP) will be denied when an E/M service has been billed on the same day, previous seven days, or following day with the same primary diagnosis.
Detailed Fetal Anatomical Ultrasound with Evaluation	According to HAP CareSource MI Coordinated Health policy, which is based on the Society of Maternal Fetal Medicine, a detailed fetal anatomic exam (76811 or 76812) is not intended to be the routine ultrasound performed for all pregnancies.

Topic	Description and Guidelines
Device and Supply	CMS has established a policy regarding the billing of implant devices and implant procedure codes. This policy identifies certain implant procedures that require an implant device to be billed along with the implant procedure, or vice versa. When one is billed without the other and they are required to be billed together, the billed service will be denied. **Example:** 92982 (PTCA) will be denied if billed without C1725 (Catheter, transluminal, angioplasty, non-laser) or C1885 (Catheter, transluminal, angioplasty, laser).
Diagnosis-Age Rules	• Certain diagnosis codes are identified as being specific to certain age groups. • All services on a claim billed with one of these codes will deny if: - It's the only diagnosis on the claim. - It doesn't match the age of the patient on the claim for the date of service. • This policy looks at all diagnoses on a claim.
Diagnosis Criteria	CMS has determined that for certain services, for that procedure to be covered, it must be billed with a diagnosis to indicate the criteria for the service has been met. If the service is billed without one of the requisites diagnoses, the service will be denied. Example: CMS requires a diagnosis of morbid obesity for bariatric surgery procedures. If not billed on claim, then the service will be denied.
Diagnosis Edits	Ultrasound, abdominal aorta, screening study for abdominal aortic aneurysm [AAA] (CPT 76706) will be denied when the appropriate diagnosis based the patient age and gender is not billed per CMS guidelines.
Diagnosis Requirement	Effective Oct. 1, 2021, end stage renal disease (ESRD) facilities must submit a principal diagnosis of end stage renal disease (ICD-10 code N18.6) for claims submitted with bill type 0720-072Z (clinic-hospital based or independent renal dialysis center) and a condition code of 84 (dialysis for acute kidney injury). Dialysis for acute kidney injury (AKI) is excluded from this policy.
Drug and Biologics Edits	• When a drug is FDA approved, there are criteria required to be met for that drug to be prescribed. Below are some of the edits and HCPCS codes that these edits may be applied to: - J0256, J0257, J9042, J9145, J9176, J9228, J1950, J3380, J1300, J0881, J0882, J0885, J2505, J9035, J9305, J9308, J1745, J9217, J9271, J9306, J9312, J9311, J9315, J9355, J2357, J0178, J2778, J7318, J7320, J7321, J7322, J7323, J7324, J7325, J7326, J7327, J7328, J7329, J2353, J9041, J9044, J1300, J9299 - A9513, Q5108, Q5111, Q0138, Q0139, C9257, Q5103, Q5104, Q5109

Topic	Description and Guidelines

Drug and Biologics Edits *(Continued)*	• When an FDA approved indication or an approved off-label indication is not present on the claim, the claim will be denied. Indications are, but not limited to:
	  - Diagnosis that the drug is to be used for
	  - Dosage and Max Dosage Over Time
	  - Frequency
	  - Route of Administration
	  - Lab Requirements
	  - Age Restrictions
	  • Examples of Indications edits:
	  - J2505, Q5108, or Q5111 will be denied when billed by any provider less than 10 days prior to the administration of a cytotoxic chemotherapy drug.
	  - J1950 will be denied when billed and the patient is greater than 11 years of age, and the patient's gender is female, and the diagnosis on the claim is central precocious puberty.
	  - Limit J1950 to 24 combined units every 48 weeks and the diagnosis on the claim is prostate cancer.
	• Chemotherapy drug administration code (96401-96450, 96542-96549, G0498, Q0083-Q0085) will be denied when billed with a drug that is administered using non-chemotherapy administration codes and a drug that is administered using chemotherapy codes has not been billed for the same date of service by any provider.
	• Intravenous push chemotherapy administration (96409, 96411) will be denied when billed with specific drugs codes and no other drug administered by chemotherapy administration has been billed for the same date of service by any provider.
	• Limit 96415 to one unit when billed with specific drug codes and no other chemotherapy drug administered by IV infusion for greater than one hour has been billed for the same date of service by any provider.
	• Drug administration services other than for subcutaneous technique (96365-96371, 96373-96379, 96402-96450, 96542, 96549, or G0498) when billed with specifics codes and no other drug has been billed for the same date of service by any provider.
	• Any code other than a drug code when billed with modifier JW (drug amount discarded/not administered to any patient) will be denied.
	• A drug when billed with modifier JW (drug amount discarded/not administered to any patient) and another claim line does not exist for the same drug on the same date of service will be denied.
	• Duplicate drug codes when the same code with the same units has been billed on a different claim by any provider for the same date of service will be denied.

Topic	Description and Guidelines
Drugs	Effective Nov. 1, 2022, for Q5112, Q5113, Q5114, Q5116, or Q5117: • Deny when billed with units representing a multiple of an entire vial (42, 84, or 126 units) and another claim line for the same drug does not exist on the same claim for the same date of service.
Duplicates	• Any claim submitted by a physician or provider for the same service provided to a single patient on a specified date of service that was included on a previously submitted claim. • When new claims and claim lines are received, they are compared against other claims and claim lines in both history and in the same new claim batch. • Claims for multi-specialty groups operating under the same tax ID and specialty are processed in a slightly different manner. - Additional specific criteria, such as specialty, are used to make the determination to ensure providers within the tax ID do not edit against each other when treating the same member on the same date of service.
Durable Medical Equipment and Supplies Edits	• Indwelling catheters (A4311-A4313, A4314-A4316, A4338-A4346) will be limited to three units when billed separately or in any combination every three months. • E0935 (CPM device) is limited to one unit per day when billed by any provider within three weeks of the original arthroplasty. • According to national CMS policy, certain items are not payable because they are considered not primarily medical in nature; not medical equipment; a non-reusable supply; or a convenience item. These items will be denied as non-covered items when billed. Any non-covered durable medical equipment.
Evaluation and Management Services	• The AMA defines a new patient as "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." Otherwise, the patient is considered an established patient. • Only one E/M code should be billed for a single date of service by the same provider group and specialty regardless of place of service. • When E/M services are billed on the same date as other therapeutic or diagnostic services, they shouldn't be billed unless they're separate and distinct services. • Annual exams or screening services should be billed as new or established patient preventive medicine visits, not as consultations. • Preventive medicine visits may include, but are not limited to, the following: - Gynecologic screening services - Screening Pap Smear (Q0091) - Cervical or vaginal cancer screening; pelvic and clinical breast examination (G0101)

Topic	Description and Guidelines
Evaluation and Management Services *(Continued)*	- Prostate cancer screening; digital rectal examination (G0102) - Visual screening - Preventive medicine counseling codes • Please refer to AMA guidelines for correct use of E/M services codes and modifiers. • Reimbursement for additional services considered part of the pediatric critical care inter-facility transport codes (99466-99467) and critical care codes (99291-99292) will be denied. • Interprofessional telephone/internet consultation (99446-99449 or 99451) will be denied when billed and any face-to-face service has been billed on the same date or in the previous 14 days.
Global Surgery	• The global surgery package includes all necessary services normally provided by the surgeon before, during and after a surgical procedure. • The global surgery package only applies to surgical procedures that have global periods of 0, 10 and 90 days. • Global surgery only applies to primary surgeons and co-surgeons. • The following items are included in the global surgery package: - Preoperative and same day E/M visits after the decision is made to operate. - All post-operative E/M visits and services for 10-day and 90-day surgeries related to the primary procedure per CMS guidelines. - Anesthesia services billed by the surgeon are not reimbursed separately. - Care management services (99487-99490) or transitional care management services (99495-99496) performed within 90 post-operative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of provider ID and specialty, and the diagnosis is a complication of surgical and medical care, or an aftercare diagnosis will be denied. - Care management services (99487-99490) or transitional care management services (99495-99496) when billed with modifier 24 and a major surgical procedure with the global postoperative period has been billed in the previous 10/90 days and the E/M diagnosis is a complication of surgical and medical care or an aftercare diagnosis will be denied. - Care management services (99487-99490) or transitional care management services (99495-99496) performed within the global postoperative days of a 10/90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of provider ID and specialty, and the diagnosis is a complication of surgical and medical care, or an aftercare diagnosis will be denied.

Topic	Description and Guidelines
Global Surgery *(Continued)*	- Care management services (99487-99490) or transitional care management services (99495-99496) performed within the global postoperative days of a 10/90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of provider ID and specialty, and the diagnosis is a complication of surgical and medical care, or an aftercare diagnosis will be denied. - Evaluation and management services performed within the global postoperative days of a medical or surgical service will be denied when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis. - Evaluation and management services performed within 10 postoperative days of a 10-day medical or surgical service will be denied when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the E/M service has a primary diagnosis associated to the 10-day medical or surgical service. - Evaluation and management services will be denied when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E/M diagnosis is a complication of surgical and medical care or an aftercare diagnosis. - Evaluation and management services will be denied when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E/M service has a primary diagnosis associated to the 10-day medical or surgical service.
ICD-10 Correct Coding	• In addition to ensuring ICD-10 diagnosis codes are coded to the highest level of specificity, and appropriate diagnosis to age codes are being submitted, there are unique coding attributes of the ICD-10 CM code set and coding conventions that also need to be observed. • Per coding guidelines, principal, primary or the only diagnosis submitted on a claim should never be one of the following: - External causes - Manifestation codes - Sequela codes • “Diagnosis to diagnosis pointer” and “diagnosis to modifier” edits are also new to the editing rules for ICD-10. If a diagnosis code for left side is used in the header, the line pointer or line modifier must match to the left side or service lines may be denied for inappropriate coding.

Topic	Description and Guidelines
ICD-10 Correct Coding *(Continued)*	• For many diagnosis codes, laterality has been built into the codes. These edits will look at the service and/or modifier billed to the diagnosis code to make sure the service was billed correctly. These edits also review diagnosis to diagnosis to determine if multiple diagnoses billed for a single service is appropriate. Claims billed inaccurately will be denied and to be rebilled correctly. **Example:** X-ray of foot 73620 with LT (left) modifier with a diagnosis of pain in right foot M79.671 - This claim would be denied since the modifier of left doesn't match the diagnosis showing right foot. • All services received with a manifestation code billed as the only diagnosis on the claim will be denied. • Any procedure or service received with an ICD-10-CM sequela (7th character "S") code billed as the only diagnosis on the claim will be denied. • Any procedure or service received with an ICD-10-CM sequela (7th character "S") code billed in the primary, first listed or principal diagnosis position will be denied.
IMRT	Additional billings of 77301 (IMRT plan) when billed more than one date of service in eight weeks will be denied.
IMRT with IGRT Delivery	Per ASTRO coding guidance: • If a facility bills for the IMRT, with IGRT delivery, they should bill for 77385 or 77386 depending on the complexity of the scan. • The facility should not bill 77014 and should appropriately bill 77385 or 77386 based on the complexity of the scan administer for IMRT with IGRT. • Hospitals should modify their chargemaster to include IGRT within IMRT delivery. However, do not bill or report IGRT Technical Component separately with IMRT. • If a physician bills for IMRT with IGRT delivery, they should bill G6001, G6002, G6017 and/or 77014. Note: The provider should be billing CPT 77387 for IGRT related treatment in conjunction with IMRT delivery codes.
Inpatient Only Services	• CMS has identified certain services that may only be performed in a facility setting due to: - The invasive nature of the procedure - The need for postoperative care following surgery - The underlying physical condition of the patient requiring surgery • When these services are performed in an office setting, they will be denied.

Topic	Description and Guidelines
"Incident To" Services	• Per CMS guidelines, "incident to" services are provided as an integral, although incidental, part of the physician's personal, professional services in the course of diagnosis or treatment of an illness or injury. • "Incident to" services should not be billed in: - An inpatient hospital - An outpatient department (including the emergency department) - A military treatment facility setting
Maximum Allowable Units of Service	When a provider bills for a quantity of services that exceed the amount the health plan feels is reasonable for a given period of time, the units considered excessive will be denied. Maximum unit settings have been established for different time periods, such as per day, per year, and in some cases other time periods. The maximum allowable unit settings have been defined through a combination of various sources: • Procedure code definitions • Anatomical site definitions • Clinical guidelines suggested by specialty societies or physician panelists considered experts in their fields. • CMS' reimbursement limitations and code status indicators • Other analytics and research **Example:** Code 97032 is defined as "Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes." If one hour of this type of therapy is allowed per day, then the daily maximum unit for code 97032 would be set at four, and any units greater than four per day will be denied. [15 minutes X 4 = 60 minutes (1hour)] Note regarding the use of Anatomical Modifiers - Anatomical modifiers E1-E4 (Eyes), FA-F9 (Fingers), and TA-T9 (Toes) have a maximum allowable of one unit per anatomical site. Any service billed with an anatomical modifier for more than one unit of service will be adjusted accordingly.
Modifiers	HAP CareSource MI Coordinated Health follows CMS usage for modifiers. This includes, but is not limited to: • Modifiers used to identify who provided the medical care (QZ, AH, etc.) • Modifiers used to add more information (E1, CA, etc.) • Modifiers used for durable medical equipment or by suppliers (RR, KX, etc.) • ABN specific modifiers (GA, GX, GY, GZ, etc.) • Modifiers which impact the pricing of the code (51, 54, As, etc.)

Topic	Description and Guidelines
National Correct Coding	• The National Correct Coding Initiative or NCCI is a collection of bundling edits created and sponsored by CMS. They are separated into two major categories: 1. Column I and Column II procedure code edits (previously referred to as "Comprehensive" and "Component") 2. Mutually Exclusive procedure code edits • CCI edits are for services performed by the same provider on the same date of service only. They don't apply to services performed within the global surgical period. • Each CCI code pair edit is associated with a policy as defined in the National Correct Coding Initiative Policy Manual. Effective dates apply to code pairs in CCI and represent the date when CMS added the code pair combination to the CCI edits. • Code combinations are processed based on this effective date. • Termination dates also apply to code pairs in CCI. This date represents the date when CMS removed the code pair combination from the CCI edits. • Code combinations are refreshed quarterly.
National Coverage Determinations	• According to CMS policy, certain lab services are payable when billed with specific diagnoses. • These services will be denied in the absence of one of the designated covered diagnoses identified in the NCD coding manual which can be found at cms.gov, then select: - Regulations and Guidance - Manuals - Internet-Only Manuals - 100-03 Medicare National Coverage Determinations (NCD) Manual • Chapter 1 – Coverage Determinations, Part 3, Sections 170-190.34
National Coverage Edits (CMS)	• E0748 (electrical osteogenesis stimulator) when billed and a diagnosis of post-surgical arthrodesis status is not present. • E0760 (ultrasonic osteogenesis stimulator) when billed without a required diagnosis will be denied. • Subsequent service, supply or device will be denied when modifier CA (procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission) has been reported in the past for the same patient by any provider. • 77080 or 77085 will be denied when billed without a covered diagnosis based on CMS guidelines and HAP CareSource MI Coordinated Health's BAM. • G0102 or G0103 will be denied when billed and the patient is under 50 years of age.

Topic	Description and Guidelines
National Coverage Edits (CMS) *(Continued)*	• 84153 (prostate specific antigen [PSA], total) will be denied when billed more than twice in a patient's lifetime by any provider with a diagnosis of carcinoma in situ of the prostate. • Any combination of G0420-G0421 (face-to-face educational services related to the care of chronic kidney disease) if billed for more than 6 units in a patient's lifetime by any provider will be denied. • 99201-99397 or 99420-99499 (evaluation and management service) will be denied when billed with 99406 or 99407 (smoking and tobacco cessation counseling visit) on the same date of service. • G0422 or G0423 (intensive cardiac rehabilitation) when billed in any place of service other than 11 (office), 19 (outpatient hospital-off campus), or 22 (outpatient hospital-on campus) will be denied. • G0438 (annual wellness visit; initial visit) will be denied when billed more than once in a patient's lifetime. • Subsequent service, supply or device will be denied when modifiers PM (post-mortem), P6 (brain dead) or QL (pronounced dead after ambulance called) have been reported in the past for the same patient by any provider. • E/M services and outpatient clinic visits billed without a distinct services modifier when performed with continuous overnight oximetry monitoring (94762) will be denied. • FQHC new patient visit (G0466 or G0469) will be denied when reported for PPS payment and any professional service has been billed in the previous three years.
National Drug Code (NDC) Numbers	Deny claim lines containing expired NDC numbers. According to CMS policy, providers are required to report valid NDC numbers for the given date of service. For example: the NDC number has surpassed the allowed obsolete period of 30 months (913 days) set in the standard NDC reference sources.
Non-Obstetric Transvaginal Ultrasound and Non-Obstetric Transabdominal Ultrasound	Pelvic ultrasound (76856 or 76857) and transvaginal ultrasound (76830) evaluate the patient for the same conditions at the same session. Therefore, they represent redundant services. HAP CareSource MI Coordinated Health will not pay separately for the pelvic echography unless there are extenuating circumstances as to why both studies had to be performed.
Oxygen	• Modifier KX should be appended to oxygen and oxygen equipment only when all the coverage criteria have been met. • Modifiers GA, GY and GZ should be appended to oxygen and oxygen equipment when all the coverage criteria have not been met. • The oxygen and oxygen equipment (E0424-E0447, E1390-E1392, E1405-E1406, K0738) will also be denied when modifier KX, GA, GY or GZ are not submitted. (for Commercial and Medicare)

Topic	Description and Guidelines
Place of Service	• Certain codes are allowable only in specific places of service. For example, hospital admission codes, 99221-99223 can only be billed for hospital places of services such as POS 21 inpatient hospital or POS 51 psychiatric inpatient facility. • Medical and surgical supplies and DME when billed with professional fee revenue codes (0960-0989) in an outpatient facility or inpatient facility setting will be denied. (CMS-1450)
Procedure-Modifier Rules	• Procedure code modifier combinations are reviewed and validated. • Modifiers that affect reimbursement or show that separate and distinct services occurred may override incidental or mutually exclusive edits. • Appropriate use of modifiers to identify the correct anatomic site is required. • Modifier use may be subject to retrospective review. • Per AMA and CMS code definitions, procedures billed with incorrect modifiers will be denied as inappropriately coded procedures.
Procedure Code Definition	Throughout the T-4 Manual and CMS HCPCS Manual, the publishers have provided instructions on code usage. MMM has adopted edits that support correct coding based on the definition or nature of a procedure code or combination of procedure codes. These edits will either bundle or re-code procedures based on the appropriateness of the code selection. **Example:** CPT code 73510 (X-ray, hip, unilateral complete) billed on one line with modifier LT (left side) and on a second line with modifier RT (right side) will be replaced with 73520 (X-ray, hips, bilateral).
Professional Component and Technical Component	• Most diagnostic radiology services and some laboratory services are reimbursed based on the concept that these services are divided into the following components: 1. **Professional component.** Describes the physician work portion of the procedure. This portion is identified by appending modifier 26 to the appropriate lab or radiology procedure. 2. **Technical component.** Describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service. This portion is identified by appending modifier TC to the appropriate lab or radiology procedure. • The CMS Medicare Physician Fee Schedule has certain indicators that note if the professional or technical component concept applies. If the professional or technical component don't apply, it's inappropriate to append modifier 26 or TC. **Example:** CPT 90707 (MMR vaccine) is listed as a PC/TC Indicator 9 code. Since a vaccine wouldn't have a professional or technical component, it's inappropriate to append modifier 26 or TC to this service.

Topic	Description and Guidelines
Radiation Therapy	Limit any combination of Treatment devices, simple; intermediate; complex (77332-77334) to seven units in eight weeks by any provider and the diagnosis is not head neck cancer, or prostate cancer, and a complex therapy service has not been billed for the same date of service or within two weeks (before or after).
Revenue Code Validation	• Revenue codes are four-digit codes used to classify types of service. They are necessary for accurate hospital outpatient claims processing and are required for processing of all outpatient facility claims. If revenue codes are not present on a claim, the charges will be denied. There are also policies enforcing the appropriate use of revenue codes on outpatient facility claims. • Revenue codes not recognized by CMS will be denied. • The claim line will be denied when the revenue code and the HCPCS code do not match. • Many revenue codes are required to be billed with a CPT/HCPCS code. If these revenue codes are not submitted with a valid CPT/HCPCS code, the charges will be denied. **Example:** Revenue code 0510 (clinic) is required to be billed with a HCPCS code. If billed without one, the charges will be denied. • Alternatively, the CPT/HCPCS codes billed must be appropriate for use with the billed revenue code. If the codes do not match, the charges will be denied. **Example:** If a provider bills 71010 (chest x-ray) and the revenue code associated to the procedure is not 0324 (chest x-ray), then 71010 will be denied as a revenue code/HCPCS code mismatch. • Certain revenue codes are not appropriate for use with outpatient hospital claims billed by facilities. If these revenue codes are billed by facilities for outpatient claims, the claims will be denied. Specifically, room and board revenue codes 010X-021X are intended to be used only in the inpatient hospital setting.
Same/Similar Services Performed Recently Edits/ Once Per Lifetime Edits	• Subsequent claims after initial reimbursement are made for once-in-a-lifetime services will be denied. • Claims after two reimbursements are made for once-in-a-lifetime services which can be performed bilaterally will be denied. • Certain ophthalmology services when performed on the same side as a previous eye enucleation, evisceration, or exenteration by any provider will be denied. • Ophthalmology services that are bilateral in nature when billed without modifier 52 (reduced service) following a previous eye enucleation, evisceration, or exenteration by any provider will be denied. • Certain lower limb services when performed on the same side as a lower extremity amputation by any provider will be denied.

Topic	Description and Guidelines
Same/Similar Services Performed Recently Edits/ Once Per Lifetime Edits *(Continued)*	• Subsequent claims after initial reimbursement are made for once-in-a-lifetime services will be denied. • Claims after two reimbursements are made for once-in-a-lifetime services which can be performed bilaterally will be denied. • Certain ophthalmology services when performed on the same side as a previous eye enucleation, evisceration, or exenteration by any provider will be denied. • Ophthalmology services that are bilateral in nature when billed without modifier 52 (reduced service) following a previous eye enucleation, evisceration, or exenteration by any provider will be denied. • Certain lower limb services when performed on the same side as a lower extremity amputation by any provider will be denied. • Certain gastric services that are performed after a total gastrectomy by any provider will be denied. • Certain upper limb services when performed on the same side as an upper extremity amputation by any provider will be denied. • Certain renal services that are performed after a total nephrectomy by any provider will be denied. • Certain services related to the lung that are performed after a total pneumonectomy by any provider will be denied. • Certain services related to the uterus that are performed after a total hysterectomy by any provider will be denied. • Certain thyroid services that are performed after a total thyroidectomy by any provider will be denied.
Self-Administered Drugs	According to CMS policy, coverage for drugs that are furnished 'incident to' a physician's service is allowed provided that the drugs are not usually self-administered by the patients who take them. When these items are billed, they will be denied. An exception applies when drug J0129 (Injection, abatacept) or J2354 (Injection, octreotide) is reported with modifier JA (Administered intravenously).
Special treatment procedures	Special treatment procedure (i.e., total body irradiation, hemibody radiation, per oral or endocavitary irradiation) (77470) will be denied when billed by any provider without a qualifying diagnosis on the claim, and a complex therapy service has not been billed for the same date of service or within two weeks (before or after).
Surgical pathology	• According to the AMA CPT Manual, “A specimen is defined as tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. Service codes 88302 through 88309 describe all other specimens requiring gross and microscopic examination and represent additional ascending levels of physician work. Levels 88302 through 88309 are specifically defined by the assigned specimens.”

Topic	Description and Guidelines
Surgical pathology *(Continued)*	• Our enhanced guidelines will enforce the diagnosis meeting the level of surgical pathology reported. For example, the AMA CPT Manual states CPT 88302 should be used for the examination of: - Appendix, incidental - Fallopian tube, sterilization - Fingers/toes, amputation, traumatic - Foreskin, newborn - Hernia sac, any location - Hydrocele sac - Nerve - Skin, plastic repair - Sympathetic ganglion - Testis, castration - Vaginal mucosa, incidental - Vas deferens, sterilization • 88302 should not be used for examination of specimens not included in this list.

If you have any questions, contact the HAP CareSource MI Coordinated Health Provider Services at **1-833-230-2159**.

National Correct Coding Initiative

The HAP CareSource MI Coordinated Health claims edit system incorporates National Correct Coding Initiative methodologies for all products. More information can be found at cms.gov. Select *Medicare*, then, under Coding, *National Correct Coding Initiative Edits*.

Reimbursement methodologies include:

- NCCI procedure-to-procedure edits that define pairs of HCPCS/CPT codes that should not be reported together for multiple reasons.
- Medically Unlikely Edits (MUE's) and units-of-service edits that define for each HCPCS/CPT code:
  - The number of units of service beyond the reported number of units allowed
  - The surgical procedure billed that should be considered as a component of the global surgical fee

Providers may not:

- Bill HAP CareSource MI Coordinated Health members for a denied service based on NCCI code pair edits or MUEs.
- Use an Advance Beneficiary Notice of non-coverage to seek payment from members.

Facility Inpatient Claims Edits

Edits will be applied to claims submitted with:

- Questionable admission-principal diagnosis
- Unacceptable principal diagnosis

This affects all HAP CareSource MI Coordinated Health claims. Please see details below.

Questionable Admission-Principal Diagnosis

Per the ICD Manual and CMS policy, questionable admission-principal diagnosis only codes are not sufficient justification for admission to an acute care hospital.

Claims submitted with a principal diagnosis from the questionable admission diagnosis list will be denied. A replacement claim with a valid principal diagnosis code will need to be submitted.

Examples from questionable admission-principal diagnosis only list:

- Diabetes mellitus without complication (E11.9, E13.9)
- Obesity related (E66.09, E66.1, E66.8, E66.9)
- Impacted cerumen (H61.2-H61.23)
- Essential (primary) hypertension (I10)
- Bundle branch block (I44.4-I44.7, I45.0, I45.1-I45.19)
- Elevated prostate specific antigen (R97.2-R97.21)
- Elevated blood pressure reading without hypertension (R03.0)
- Asymptomatic HIV infection status (Z21)
- Fitting and adjustment of cardiac pacemaker/defibrillator/other device (Z45.0-Z45.09)

Unacceptable Principal Diagnosis

Per the ICD Manual and CMS policy, there are certain diagnosis codes that do not describe a current illness or injury, but only describe the circumstance that influences the patient's health, or the underlying cause of the injury or illness. These codes are considered unacceptable as a principal diagnosis for an inpatient admission.

Claims submitted with the principal diagnosis from the Unacceptable Principal Diagnosis list will be denied. A replacement claim with a valid principal diagnosis code will need to be submitted.

Examples of unacceptable principal diagnoses:

- Malignant neoplasm associated with transplanted organ (C80.2)
- Graft-versus-host disease (D89.81-D89.813)
- NMI Coordinated Health MI Coordinated Health tine dependence (F17.200, F17.201, F17.210, F17.211, F17.220, F17.221, F17.290, F17.291)
- Glaucoma (H40.12-H40.1394, H40.15-H40.159)
- Cardiac tamponade (I31.4)
- Hepatopulmonary syndrome (K76.81)
- Malignant ascites (R18.0)
- Rabies contact (Z20.3)

Section 11: Clinical Appeals

If you disagree with a clinical decision regarding medical necessity, we make it easy for you to be heard. Please see the information below this section about how to submit appeals and disputes. Providers can submit appeals on the HAP CareSource Provider Portal or in writing to the address or fax number listed below based on the appeal type.

After receiving a letter from HAP CareSource MI Coordinated Health denying coverage, a provider with member written consent or a member or their authorized representative can submit a pre-service or post-service clinical appeal.

Clinical appeals are reviewed by nurses and physicians not involved in any prior review. They are also reviewed by practitioners with expertise and knowledge appropriate to the item, service, or drug being requested.

The member, the provider, and the Authorized Representative are provided reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person or in writing, including documents or other additional information relating to the appeal any time prior to the resolution of the appeal. Members, providers, and authorized representatives should be aware that there is limited time to submit this information, particularly in the case of an expedited appeal.

HAP CareSource MI Coordinated Health Pre-Service Appeal: A denial of an authorization for a service prior to being completed. Members, providers or the member's representative with member written consent, have 60 days from the date of the receipt of the authorization denial, which is presumed to be five days from the date on the notice, to submit a standard pre-service appeal. This is considered a member appeal and all member appeals, pre- or post-service, will be resolved within 30 days plus any extension, if applicable, for a standard appeal. Part B drug standard appeals will be resolved within seven calendar days and may not be extended. For Children's Specialized Health Care Services (CSHCS) Program appeals, the plan makes a determination no later than 10 calendar days after an appeal is received.

See 'Extending an Appeal" for more information on extensions.

HAP CareSource MI Coordinated Health will review documentation for Good Cause for late filing of an appeal. The pre-service appeal must be accompanied by a valid consent form. The form is available on our webpage. Please see 'Expediting Clinical Appeals' for more information on expedited clinical appeals. Pre-Service appeals for Medicare or Overlap services that are not approved by HAP CareSource MI Coordinated Health are forwarded to the Independent External Reviewer (IRE) by HAP CareSource for Level 2 appeal, or in the event that HAP CareSource MI Coordinated Health does not make a timely decision. Members may have additional levels of appeal. Members may also appeal through Department of Insurance and Financial Services (DIFS) for an external review or request a state fair hearing for Overlap or Medicaid Services denied on appeal.

HAP CareSource MI Coordinated Health Provider Appeal: Participating providers should refer to the process for "Claim Disputes." Non-participating providers may submit a claim appeal within 60 calendar days from the remittance notification date, which may include clinical review for medical necessity. Please refer to the "Non-Participating Provider Appeals and Disputes" section for more information. Provider appeals are resolved within 60 calendar days. Non-contract provider appeals for Medicare or Overlap services that are not approved by HAP CareSource are forwarded to the IRE by HAP CareSource MI Coordinated Health for Level 2 appeal, or in the event that HAP CareSource does not make a timely decision.

Appeal Type	Address	Fax Number
Pre-Service or Pre-Service Expedited	HAP CareSource MI Coordinated Health Attn: Grievance and Appeals P.O. Box 1025 Dayton, OH 45401-1025	HAP CareSource MI Coordinated Health **Standard Appeals/Disputes:** 1-937-396-3492 **Expedited Appeals:** 1-937-396-3507
Post Service	HAP CareSource MI Coordinated Health Attn: Grievance and Appeals P.O. Box 1025 Dayton, OH 45401-1025	

Expediting Clinical Appeals

If you feel that the standard appeal time frame of 30 days could seriously jeopardize the life or health of your patient, or their ability to regain maximum function, you may ask us to expedite a clinical appeal. HAP CareSource MI Coordinated Health does not take any punitive action against providers for requesting expedited resolution or supporting their patient's expedited request. Please refer to the time frames for submitting appeals and requirements for Pre-Service appeals for HAP CareSource MI Coordinated Health members.

HAP CareSource MI Coordinated Health will review appeals as expeditiously as the member's medical condition requires, and expedited appeals are resolved no later than 72 hours of receipt, unless the time frame is extended, or the appeal request does not meet expedited review time frame. Please see "Denied Expedited Appeals" for more information about what happens if a request for expedited appeal review is denied, and "Extending an Appeal" for more information about extensions. HAP CareSource MI Coordinated Health will make reasonable efforts to provide oral notice of the appeal resolution to the member and representative in addition to written notification. Providers will also receive notification of the appeal decision.

Please note, there is a limited amount of time to submit additional information for expedited clinical appeals. HAP CareSource MI Coordinated Health will conduct outreach and work with the provider, member, and representative to obtain any needed information for the expedited appeal.

Denied Expedited Clinical Appeals

If HAP CareSource MI Coordinated Health decides not to expedite the clinical appeal because the criterion for expedited review is not met, HAP CareSource MI Coordinated Health will transfer the request to a standard appeal timeframe beginning the day the expedited request was received. The plan will make reasonable effort to provide the member prompt oral notice of the decision not to expedite the appeal in addition to a written notice of the decision. HAP CareSource MI Coordinated Health members will be offered expedited grievance rights about this decision. A letter will also be sent to the member and representative notifying of the reason for the decision to not expedite the appeal, notifying that the appeal is being transferred the standard appeal time frame, and will include the member's grievance rights and time frames, as applicable, as well the right to request an expedited appeal with provider support of serious jeopardy to life or health.

Extending an Appeal

Members may request that HAP CareSource MI Coordinated Health extend the time frame to resolve any medical necessity appeal request by up to 14 days. HAP CareSource MI Coordinated Health may also request an extension of up to 14 days, if the extension is in the member's best interest. HAP CareSource MI Coordinated Health will make reasonable efforts to give prompt oral notice to the member or representative of the delay and will notify the member or representative in writing the reasons for the extension and inform the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. HAP CareSource MI Coordinated Health will issue its determination and authorize or approve the service if the appeal is approved, as expeditiously as the member's health condition requires, but no later than upon the expiration date of the extension.

Appeal Level

HAP CareSource MI Coordinated Health contracted and non-contracted providers have one appeal level with the plan.

Providers have 60 days from the date of the initial organization determination to request a claims payment appeal. HAP CareSource MI Coordinated Health has 30 calendar days to review and respond to the request. HAP CareSource MI Coordinated Health members in the CSHCS program have 10 calendar days to resolve. Here is the process:

1. Submit a written request along with any supporting documentation.
2. HAP CareSource MI Coordinated Health non-contracted providers must include a completed, signed Waiver of Liability form.
3. Mail request, documentation and Waiver of Liability (if applicable) to:

   Mail:
   HAP CareSource
   Attn: Grievance and Appeals
   P.O. Box 1025
   Dayton, OH 45401-1025

4. Fax: Standard Appeals/Disputes: 1-937-396-3492

Note: If the Waiver of Liability is incomplete or unsigned, the appeal will be dismissed, and HAP CareSource MI Coordinated Health will send a letter to the provider advising of the reason for decision.

Difference between Healthcare Management (HCM) Appeals and Peer-to-Peer Review

HCM Appeals: A full chart review is done by HAP CareSource MI Coordinated Health. These are conducted when the patient has been discharged from the hospital and authorization is still trying to be obtained by the provider.

When a DRG post-pay audit with a full chart review is conducted by one of HAP CareSource's contracted vendors, the only time HAP CareSource MI Coordinated Health will override vendor findings is when an audit determination was made to change the DRG to observation, but HAP CareSource MI Coordinated Health has already conducted a full chart review (HCM Appeal) and approved an inpatient stay.

If a full chart review was not done by HAP CareSource MI Coordinated Health, then the audit determination will be upheld, and the provider will have to appeal directly to the vendor as instructed.

Member Grievances Filed Directly with Provider

Per your Provider Agreement with the HAP CareSource MI Coordinated Health, you are required to cooperate and participate in all aspects of our grievance system. Providers must send any grievances they receive directly from a member to us.

Mail:
HAP CareSource MI Coordinated Health
Attn: Grievance and Appeals
P.O. Box 1025
Dayton, OH 45401-1025

Fax:
Standard Appeals/Disputes: 1-937-396-3492
Expedited Appeals: 1-937-396-3507

Provider Appeal Process

Appeal type	Process and Requirements
Pre-Service A request to change the decision on any case or service that must be made in whole or in part in advance of the member obtaining medical care or services	• The provider is notified of their appeal rights and procedure. • The member, provider or representative with written member consent has up to 60 calendar days from the date of receipt of the initial determination to file an appeal. Please note - for HAP CareSource MI Coordinated Health, the date of receipt of the initial determination is presumed to be five days after the date of the written initial determination date. **Pre-service appeals with member consent follow the member appeal process.** • Pre-service appeals may be submitted orally or in writing to the address listed above, on the HAP CareSource Provider Portal or to fax number above. • If initial denial is issued by a HAP CareSource MI Coordinated Health Medical Director, a physician reviewer not involved in the initial denial reviews the case. The physician reviewer will be the same specialty as the requesting physician with similar credentials and licensure. • Standard appeals are resolved in 30 days plus any extension. Expedited appeals are resolved in 72 hours plus any extension. Part B appeals are resolved in 7 days and cannot be extended, and appeals for CSHCS members are resolved in 10 days. **Level 2 – HAP CareSource MI Coordinated Health Only** Second-level appeal is sent automatically to the IRE for review for Medicare or overlap services submitted by the member or their representative (including providers) which are denied by the plan on appeal.
Post-Service A request to change a decision on any review for care or services that have already been received	• The provider is notified of their appeal rights and procedure. • The provider has up to 60 calendar days from the date of the initial denial letter to file an appeal. • Post-service appeals must be submitted in writing to the address, on the HAP CareSource Provider Portal or the fax number above. • If initial denial is issued by a HAP CareSource Medical Director, a physician reviewer not involved in the initial denial reviews the case. • The appeal will be resolved within 30 calendar days (for HAP CareSource MI Coordinated Health) for member appeals and 10 calendar days for CSHCS members. • Non-contracted providers must include a completed, signed Waiver of Liability form with any post-service requests. **Note:** If the Waiver of Liability is incomplete or unsigned, the appeal will be dismissed, and HAP CareSource MI Coordinated Health will send a letter to the provider advising of the reason for decision.

Appeal type	Process and Requirements
Expedited (Pre-Service) A request to change an urgent care request where the decision could: • Seriously jeopardize the life or health of the member • Jeopardize the member's ability to regain maximum function • Subject the member to severe pain, not managed without the requested care	• The member, or their authorized representative, or their provider with member's written consent may file an expedited appeal for a denied request within 60 calendar days. • When the HAP CareSource MI Coordinated Health Medical Director denies the request for urgent care, written confirmation of the decision is sent to members and providers within 72 hours of receipt of the request. • If appeal involves the termination, suspension, or reduction of previously authorized services, the request with member written consent must be filed within 10 calendar days of HAP CareSource MI Coordinated Health sending the notice. HAP CareSource MI Coordinated Health decides whether to expedite an appeal. When HAP CareSource MI Coordinated Health denies a request for expedited resolution, we will make reasonable efforts to give the member prompt oral notice of the delay and within two calendar days, give the member written notice of the reason for the decision to deny the expedited appeal resolution time frame; inform the member of the right to file a grievance if the member disagrees with that decision, including time frames and procedures for filing a grievance; and inform the member of the right to resubmit a request for an expedited appeal with any physician's support. If the member is in a facility, the provider or facility will be notified on the same business day of the decision. HAP CareSource MI Coordinated Health completes the entire expedited appeal, prompt oral notice is attempted, and Written notification is given within 72 hours. • Due to the time frame requirement to complete the review, please be aware of the limited time to submit additional information. The appeal Medical Director reviewer will be a HAP CareSource MI Coordinated Health provider in the same or similar specialty, independent of each other (i.e., not partners in the same group). The appeal Medical Director reviewer is of same or similar specialty, but not part of the initial denial.

Section 12: Pharmacy

Pharmacy Drug Plan Coverage

We manage prescription drug benefits with a drug formulary that includes Medicare Part D and Medicaid-covered drugs. We use a pharmacy benefit manager (PBM) to process pharmacy claims billed by pharmacies in the network.

Helpful numbers and links for providers

For	Contact
Pharmacy Care Management	HAP CareSource MI Coordinated Health: **1-833-230-2159**, available Monday-Friday, 8 a.m. to 6 p.m. ET
Completed prior authorization forms for HAP CareSource MI Coordinated Health Pharmacy Department	**HAP CareSource MI Coordinated Health** Phone: 1-800-935-6103 Fax (Express Scripts Coverage Review Department): 1-877-251-5896
Completed prior authorization forms for MI Coordinated Health Physician Administered Drugs	**HAP CareSource MI Coordinated Health** Fax: 833-812-0187 OR submit electronically through EviCore
HAP CareSource MI Coordinated Health Formulary and Pharmacy Information	Pharmacy | Michigan – MI Health Link | CareSource
Specialty and Mail Order (Home Delivery) Pharmacy (Pharmacy Advantage) Note: Use of Pharmacy Advantage is optional for members.	**1-800-456-2112** Monday-Friday, 8 a.m. to 6 p.m. ET

Drug Formulary

The Formulary is a list of covered drugs, including drugs that are covered by Medicare Part D or Medicaid. Drugs on the Formulary may have some restrictions, including:

- **Prior authorization (PA):** Specific member information and coverage criteria must be met prior to payment.
- **Step therapy (ST):** Medications noted with step therapy are medications that require the trial and failure of other formulary medications prior to payment for the drug marked step therapy.
- **Quantity limits (QL):** Medications noted with a QL are subject to certain quantity limits.
- **Non-formulary drugs:** Some medications may not be included (covered) on the formulary or drug list.
- **Exception requests:** Providers and members may request an exception to the prior authorization, step therapy or quantity limit criteria, or ask for a formulary exception for a drug that is not on the list.

Formulary and Drug List Changes

We post the drug formularies (drug lists) on the website annually and updates throughout the year. If there are changes that result in drug restrictions or replacements, we will notify affected members and prescribers. We will provide the formulary by mail upon request to providers who do not have fax, email, or internet access.

HAP CareSource MI Coordinated Health Plan Specifics

Formulary

- The current HAP CareSource MI Coordinated Health Formulary can be found **HAPCareSource.com**. You can search for drugs alphabetically or by medical use of a drug. The Formulary may change annually on January 1 and periodically throughout the year.
- You can obtain a printed Formulary by calling Provider Services at **1-833-230-2159**.
- The drug Formulary is a list of covered Medicare Part D and Medicaid drugs. The tier and any restrictions (prior authorization, step therapy, etc.) are also listed for each Medicare Part D or Medicaid covered drug in the formulary listing.

Prior authorization or exception requests

- To request a coverage determination (for prior authorization or an exception), go to Express Scripts or by FAX at 1-877-251-5896.
- For the best patient experience, please review the Formulary prior to writing a prescription for a new drug. If the drug has restrictions, a prior authorization request must be submitted. If the request is not approved in advance, there may be a delay for the member in obtaining their medication from the pharmacy.

Contact information:

For	Contact
Requests for Pharmacy Prior Authorization or Exceptions	Fax: **1-877-251-5896**
Provider Prior Authorization Line	Phone: **1-800-935-6103 (Express Scripts – ESI Coverage Review Department)**
Medical Drug Requests	Fax: **1-833-812-0187** or go to http://www.evicore.com/ to submit coverage reviews)

Drug Utilization Review (DUR) Program

Concurrent DUR is the core of the DUR program. Point-of-service alerts are sent to dispensing pharmacists that identify health and safety concerns when a prescription claim is being processed. Pharmacists can then conduct clinical reviews based on these potential medication issues and act as needed.

Retrospective DUR evaluates a prescription against a patient's prescription history and evidence-based guidelines to alert the prescriber to important, drug-specific, patient-specific health and safety issues and may include a review of both pharmacy and medical claims.

Retrospective DUR alerts prescribers to opportunities to:

- Improve care
- Increase adherence
- Prevent hospitalizations
- Improve health outcomes

Patient-specific alerts are sent to physicians via EHR, fax or letter. Pharmacist point-of-service alerts are sent for drug-disease or drug-drug interactions.

The success of the DUR Program depends on collaboration with prescribers and pharmacists for patient care. Thank you for your willingness to receive and review patient-level information and consider opportunities to improve care.

Prescription Drug Monitoring Program Requirement for Providers

In Michigan, a licensed prescriber must query and review a Michigan Automated Prescription System (MAPS) report for the patient when prescribing or dispensing a controlled substance that exceeds a three-day supply. Best practice is to check MAPS for any controlled substance prescription.

Effective October 1, 2021, Michigan Medicaid providers who prescribe a controlled substance are required to check MAPS for the member's 12-month prescription drug history before prescribing controlled substances. Providers should document this required MAPS check according to Medicaid record retention policy.

As a best practice, Medicaid enrolled pharmacies are encouraged to check MAPS prior to dispensing a controlled substance. These checks are in place for program integrity, quality and safety as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

Questions or need help with opioid management?

Visit the CDC website.

Opioid Dispensing Rules

We employ opioid dispensing rules that align with CMS policy and guidance. These include safety edits at the pharmacy and a Drug Management Program (DMP).

The purpose of the opioid safety edits and DMP is to prompt prescribers and pharmacists to conduct additional safety reviews to determine if the beneficiary's opioid use is appropriate and medically necessary. Plans are expected to implement these safety edits and conduct the DMP in a manner that minimizes any additional burden on prescribers, pharmacists and beneficiaries.

Opioid point of sale (POS) pharmacy safety edits

1. **Opioid care coordination edit**

   Any opioid claim will reject at the pharmacy if:

   - It exceeds a morphine milligram equivalent (MME) dose of 90 mg per day and
   - There is more than one opioid prescriber in the previous six months. This rejection ensures care is being coordinated among providers when there are multiple opioid prescribers. Pharmacies can consult with providers and override this rejection at the point of sale.

2. **Seven-day supply limit for opioid naïve patients**
   - Opioid claims are limited to a seven-day supply when prescribed for opioid-naïve patients, i.e., for acute pain. An opioid naïve patient is identified at the dispensing pharmacy based on the prescription claims history of opioids dispensed. If a beneficiary has not had opioid prescriptions filled in the previous 108 days, the rule set assumes that an opioid is being prescribed to an opioid naïve beneficiary for treatment of acute pain. The pharmacy **cannot** override this edit.

3. **Multiple long-acting opioid medications**
   - If a beneficiary has overlapping prescriptions for two long-acting opioid medications, the new prescription will reject. Pharmacies may override this rejection at the point of sale after confirming with the prescriber that the drug therapy is appropriate.

4. **Concomitant use of benzodiazepines**
   - If a beneficiary has overlapping claims for benzodiazepine and opioid medications, the new prescription will reject. Pharmacies may override this rejection at the point of sale after confirming with the prescriber that concomitant use is appropriate.

The DMP helps ensure beneficiaries use their prescription opioid medications safely. A beneficiary may be eligible for enrollment in the DMP based on the following criteria:

1. Aggregate opioid prescriptions exceed 90 mg MME for any duration during the past six months, AND
2. The beneficiary has three or more prescribers contributing to opioid claims in past six months, AND
3. The beneficiary has three or more pharmacies contributing to the opioid claims in the past six months, OR
4. More than five prescribers contribute to opioid claims regardless of the number of pharmacies dispensing opioids in the past six months.

Beneficiaries who meet the prescription claims criteria undergo a second review for any potential exclusions based on medical criteria. The DMP may not apply to beneficiaries who are residents of a long-term care facility, in hospice care or receiving palliative or end-of-life care, are being treated for active cancer-related pain or have sickle cell disease.

Beneficiaries who meet prescription claims criteria and do not have medical exclusions undergo case management coordinated by personnel with appropriate credentials, such as a pharmacist, to determine whether enrollment in the DMP is appropriate. This is a collaborative process with the prescribers of opioids and may also include HAP CareSource MI Coordinated Health's professional staff of care management nurses, social workers, mental health experts, or physician medical directors.

If a member is at risk for overuse, misuse or abuse of opioid prescription medications, HAP CareSource MI Coordinated Health may limit access to opioids and/or benzodiazepines and/or opioid potentiators (i.e. gabapentin and pregabalin) by utilizing a variety of opioid control tools:

- Requiring the beneficiary to obtain all prescriptions for opioid medications from selected pharmacies
- Requiring the beneficiary to get all prescriptions for opioid medications from selected prescriber(s)
- Limiting the coverage or amount of opioid medications in a specified time period

Any dual-eligible member with a coverage limitation under Part D will have that same drug or quantity restriction under the Medicaid benefit.

We communicate, in writing, with beneficiaries and prescribers prior to putting any limitations or restrictions in place. Members and prescribers have rights to appeal these decisions.

The dispensing pharmacy or a HAP CareSource MI Coordinated Health pharmacist may contact you about a patient's opioid prescription(s) to determine if opioid use is appropriate and medically necessary. During normal business hours, your office will be contacted, or you may be paged. After hours contact will follow your after-hours process as instructed by telephonic recordings or answering services.

For more information on the Medicare Part D opioid safety policies, please visit *A Prescriber's Guide to Medicare Prescription Drug (Part D) Opioid Policies*.

Additional resources to explain federal governmental programs to manage the opioid epidemic are posted here: https://www.cms.gov/About-CMS/Story-Page/prescribing-opioids.

Prescriptions Transition of Care Policy

Under certain circumstances, HAP CareSource MI Coordinated Health offers a temporary supply of a drug to members when the drug is not on the drug list or when it is restricted in some way. To be eligible for a temporary supply, a member must meet the two requirements below:

1. The change to their drug coverage must be one of the following types of changes:
    a. The drug they have been taking is no longer on the Plan's drug list.
    b. The drug they have been taking is now restricted in some way.
2. They must be in one of the situations described below:
    a. **For those members who are new or who were in the plan last year and aren't in a long-term care (LTC) facility:** We will cover a temporary supply of their drug during the first 90 days of their membership in the Plan if they were new and during and the first 90 days of the calendar year if they were in the Plan last year. This temporary supply will be for a maximum of a 30-day supply. If their prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.
    b. **For those members who are new or who were in the plan last year and reside in an LTC facility:** We will cover a temporary supply of their drug during the first 90 days of their membership in the Plan if they are new and during the first 90 days of the calendar year if they were in the Plan last year. The total supply will be for a maximum of a 31-day supply. If their prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 31-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
    c. **For those members who have been in the plan for more than 90 days and reside in an LTC facility and need a supply right away:** We will cover one 31-day supply of a particular drug, or less if their prescription is written for fewer days. This is in addition to the above long-term care transition supply.

Section 13: Quality Management

Quality Management Program for HAP CareSource including HAP CareSource CSHCS and HAP CareSource Healthy Michigan Plan (HMP)

HAP CareSource MI Coordinated Health has an ongoing Quality Assessment and Performance Improvement Program (QAPI) for HAP CareSource members including HAP CareSource CSHCS and HAP CareSource HMP. The program is designed to:

- Improve health outcomes for the HAP CareSource MI Coordinated Health members.
- Coordinate care using evidence-based tools.
- Promote quality care and services.
- Ensure performance and efficiency on an ongoing basis.
- Provide for a systemic data collection of performance and member outcomes.
- Improve timely access to primary, behavioral and specialty care, safety and equity of clinical care and Long-Term Service and Supports (LTSS).
- Advance health equity.
- Promote Continuous Quality Improvement across functional areas to drive process and performance improvement.
- Objectively and systematically monitor and evaluate the appropriateness of clinical and nonclinical member care and services.

HAP CareSource MI Coordinated Health pursues opportunities to improve care and services and resolve identified problems. HAP CareSource MI Coordinated Health, PCPs and specialists have a role in monitoring, maintaining and improving the quality of care and services.

QAPI effectiveness is evaluated annually. You can find a copy of the QAPI program, including progress on our annual goals and the annual evaluation by:

- Visiting: https://www.caresource.com/mi/providers/education/quality-improvement/

Ongoing monitoring of care and services is performed through a review of:

- Administrative data
- HEDIS measure outcomes
- After-hours care surveys
- Appointment wait-time surveys
- Complaints and grievances
- CAHPS and Provider Satisfaction
- Medical records
- On-site facility reviews
- Utilization data

Preventive and Clinical Care Guidelines

HAP CareSource MI Coordinated Health approves and adopts evidence-based nationally recognized standards and guidelines and promotes them to providers to help inform and guide clinical care provided to members.

Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management tools. Guidelines are reviewed at least every two years or more often as appropriate and updated as necessary. They may be found at **HAPCareSource.com** > Providers > Education > Patient Care > Health Care Links. The use of the guidelines allows HAP CareSource MI Coordinated Health to measure their impact on member health outcomes. Review and approval of the guidelines are completed by the Michigan Quality Improvement Consortium (MQIC). These approved guidelines are brought to the Michigan Provider Advisory Committee (PAC) for adoption and the Quality Enterprise Committee (QEC) is notified of the adopted guidelines. Through the analysis of member population demographics and national or state priorities, additional clinical guidelines can be added with a review and approval by the Michigan PAC followed with approval by the QEC. Guidelines may include, but are not limited to:

- Mental Health (e.g., depression)
- Adult health (e.g., hypertension and diabetes)
- Population health (e.g., obesity and tobacco cessation)
- Guidelines are promoted to providers through one or more of the following: newsletters, our website, direct mailings, provider manual and through focused meetings with Provider Engagement Specialists. Information regarding clinical practice guidelines and other health information are made available to members via member newsletters, the member website or upon request. If you would like more information on HAP CareSource MI Coordinated Health Quality Improvement, please call Provider Services at **1-833-230-2159**.

Quality Management Program for HAP CareSource MI Coordinated Health

HAP CareSource MI Coordinated Health has an ongoing QAPI Program for HAP CareSource MI Coordinated Health members. The Program is designed to:

- Improve health outcomes for the HAP CareSource MI Coordinated Health members.
- Coordinate care using evidence-based tools.

- Promote quality care and services.
- Ensure performance and efficiency on an ongoing basis.
- Provide for a systemic data collection of performance and member outcomes.
- Improve timely access to primary, behavioral and specialty care, safety and equity of clinical care and Long-Term Service and Supports (LTSS).
- Advance health equity.
- Promote Continuous Quality Improvement across functional areas to drive process and performance improvement.
- Objectively and systematically monitor and evaluate the appropriateness of clinical and nonclinical member care and services.

HAP CareSource MI Coordinated Health pursues opportunities to improve upon the care and services and resolve identified problems. All departments, primary care and high-volume specialist providers are involved in monitoring, maintaining and improving the quality of care and services.

QAPI effectiveness is evaluated annually. You can find a hard copy of the QAPI including progress on our annual goals and the annual evaluation on our website.

Ongoing monitoring of care and services is performed through review of:

- Administrative data
- HEDIS measure outcomes
- After hours care surveys
- Appointment wait time surveys
- Complaints and grievances
- Consumer and provider surveys
- Medical records
- On site facility reviews

Health and Wellness Programs

We have wellness programs to help our members stay healthy. The programs below are for members in all HAP CareSource MI Coordinated Health unless otherwise noted.

Program	Description
24-Hour Nurse Advice Line	HAP CareSource MI Coordinated Health members have access to 24 hours a day, seven days a week Nurse Advice Line for health information to help with questions about medical care. Nurses are ready to answer questions any time, day or night. The Nurse Advice Line provides trusted, physician-approved information to help guide members' health care decisions. A registered nurse helps with: • Choosing appropriate location for medical care • Finding a doctor or hospital • Understanding treatment options • Achieving a healthy lifestyle • Learning how take medication safely To use 24-Hour Nurse Advice Line, members can call **1-833-687-7360**.

Program	Description
Preventive Health Reminders	HAP CareSource MI Coordinated Health outreaches to members that may be due for preventive health services including: • Annual Well Visits • Blood lead testing • Cervical cancer screening • Child and adolescent vaccines • Colorectal cancer screening • Comprehensive diabetes care • Lead testing • Mammogram screening • Well-child and adolescent visits
Smoking Cessation Program	The Michigan Tobacco Quitline is a free, phone-based program to help members quit using tobacco. Members will work one-on-one with a health coach to develop a quit plan. Members can enroll in the program by self-referral, PCP referral or health plan referral. To refer a member to the program, call **1-800 QUIT NOW (784-8669)**. For more information, call **1-888-654-2200**.
Maternity Program Powered by HAP CareSource Mom and Baby Beginnings	HAP CareSource MI Coordinated Health's Maternity Management program, Mom and Baby Beginnings, supports Medicaid-eligible pregnant women to ensure members have a healthy pregnancy by: • Connecting members with an OB provider • Providing reminders for prenatal and postpartum visits and assisting with scheduling and transportation, if needed • Conducting maternity-specific assessments in order to ensure members are receiving the care that they need • Developing member-centric individualized Care Treatment Plans • Educating on benefits and rewards available while pregnant, including dental services • Connecting members to nurses, social work, mental health services, and lactation support • Referring members to a MIHP. MIHPs offer in home visits to provide education about pregnancy and newborn care. • Checking in after delivery to make sure everyone is doing well For more information or to enroll, members can call **Mom and Baby Beginnings at 1-833-230-2034**.
HAP CareSource MyKids and HAP CareSource MyHealth Rewards and Incentive Program	• Rewards program to support closing gaps in care • Engaging members with insights and benefits of completing healthy activities and earning rewards while doing so For more information, check out HAPCareSource.com webpages: Medicaid and MI Health Link.

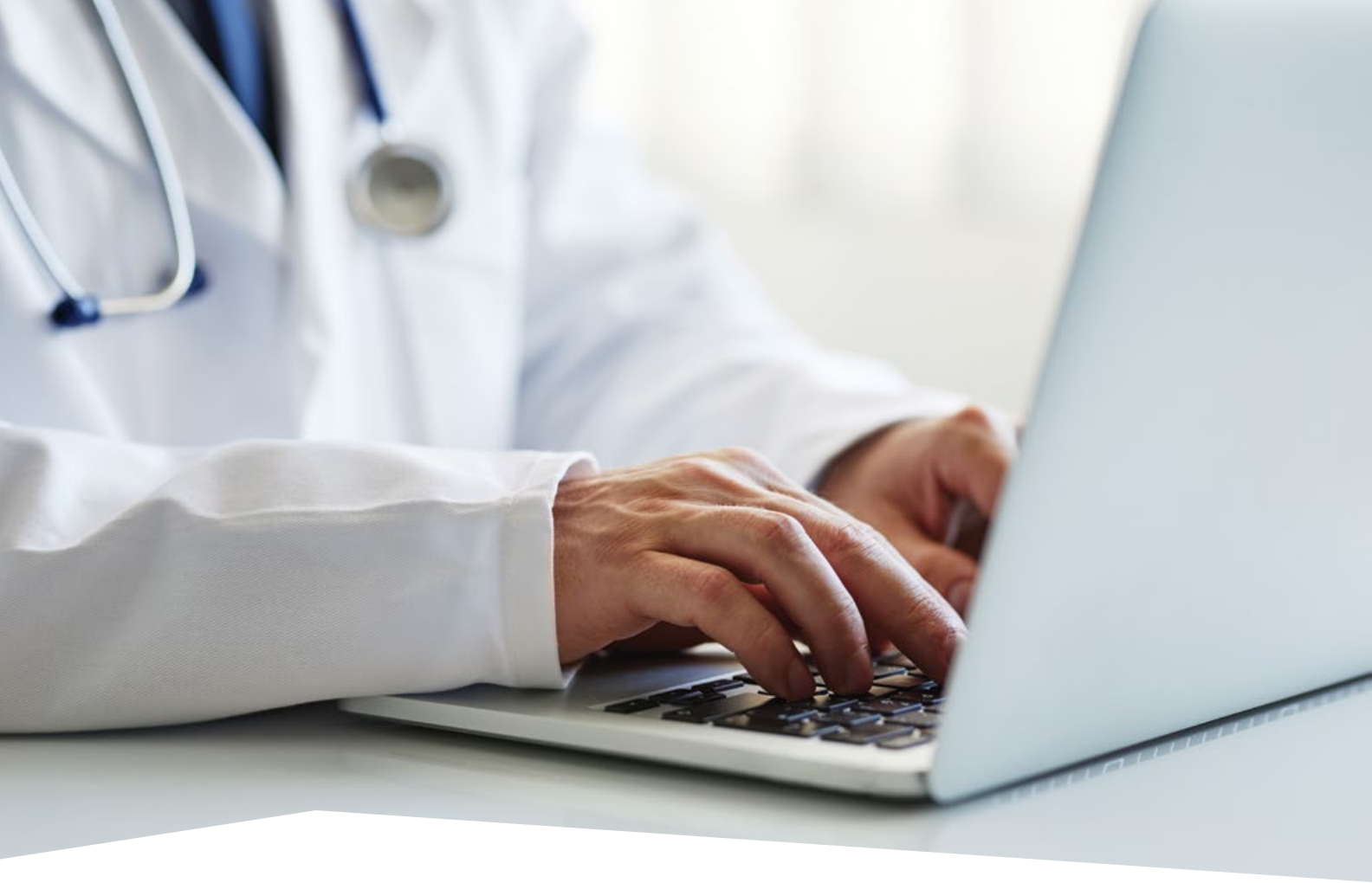
HAP CareSource MI Coordinated Health PrEP Resources

HAP CareSource MI Coordinated Health is working with the MDHHS to increase awareness of Pre-Exposure Prophylaxis (PrEP) treatment. PrEP is a medication that people at risk for human immunodeficiency virus (HIV) acquisition can take to reduce their chances of getting HIV through sex and/or injectable drug use. To educate, inform and increase your awareness of PrEP, please register on the Centers for Disease Control and Prevention (CDC) National Provider Information Network (NPIN) website.

NPIN is a web-based information and resource platform connecting public health partners through collaborative communication and innovative technology solutions for HIV, viral hepatitis, STDs, tuberculosis, and adolescent and school health. NPIN maintains a searchable database of information submitted to the CDC NPIN by the testing center or provider organization.

Information entered into the NPIN database powers tools such as the GetTested testing locator utility and the PrEP Locator tool. Please see a list of resources below:

Resource	Links
CDC Resources	• CDC Guide to Taking a Sexual History • CDC: HIV • CDC HIV Nexus: CDC Resources for Clinicians • CDC Pre-Exposure Prophylaxis (PrEP) • Let's Stop HIV Together Clinician Resources • Sexually Transmitted Infections Treatment Guidelines, 2021
Henry Ford Health	• https://www.henryford.com/services/lgbtq-health
MDHHS Resources	• michigan.gov/MIPrEP • MDHHS PrEP Brochure - michigan.gov (patient-facing) • STI/HIV Operations and Resource System (SHOARS) - michigan.gov
U.S. Preventive Services Task Force	• uspreventiveservicestaskforce.org search for "PrEP"



Section 14: Member Medical Records

Requirements

To promote continuity and quality of member care, HAP CareSource MI Coordinated Health requires all participating providers to maintain their HAP CareSource MI Coordinated Health patient charts in a manner that meets all of the following requirements and ensures the medical record information is organized and readily available when needed.

General

1. Medical records must be maintained in a manner that is current, detailed and organized to facilitate communication and coordination of care.
2. Medical records must be complete, documented accurately, updated in a timely manner, readily accessible, and permit prompt and systematic retrieval of information.
3. Medical records must be maintained in English, legible and fully disclose and document the extent of services provided to members.
4. Medical records should be in a detailed, comprehensive manner that conforms to good professional medical practice, allows effective professional medical review and medical audit processes, and facilitates a system for follow-up treatment.

5. Practitioners and providers must abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. These laws require providers to fully disclose the extent of the services, care, and supplies furnished to our members, as well as support claims billed.

Content and Organization

1. Each page in the record contains the patient's name or ID number.
2. Patient's address, employer, home and work telephone numbers and marital status
3. All entries contain the author's identification, which may be a handwritten signature, unique electronic identifier or initials. Per CMS, a valid signature must be for:
   - For services provided or ordered
   - Handwritten or electronic (note: stamped signatures are allowed if you have a physical disability and can prove to a CMS contractor that you're unable to sign due to that disability)
   - Legible or can be confirmed by comparing it to a signature log or attestation statement.
4. Content is in chronological order.
5. The record is legible to someone other than the writer.
6. Must be signed and dated.
7. Medical records must contain, at a minimum:
   a. Outpatient and emergency care
   b. Specialist referrals
   c. Ancillary care
   d. Diagnostic test findings including laboratory and radiology.
   e. Prescriptions for medications
   f. Allergies and adverse reactions (also documented if no known allergies)
   g. Problem list (including significant illnesses and medical conditions)
   h. Inpatient discharge summaries
   i. Histories and physicals
   j. Immunization records
   k. Documentation of clinical findings and evaluation of each visit
   l. Working diagnosis consistent with findings
   m. Treatment plans consistent with diagnosis.
   n. Preventive services/risk screenings
   o. Other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided.

8. Primary care health records must reflect the following information:
    a. All services provided directly by a practitioner who provides primary care services.
    b. All ancillary services and diagnostic tests ordered by a practitioner.
    c. Reports of all diagnostic and therapeutic services for which a member was referred by a practitioner, (i.e., home health nursing, specialty physician, hospital discharge, PT).
9. Advanced Directives (required for hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, hospices) – whether or not an advance directive has been executed.

Retention, Confidentiality and Accessibility

1. All medical records must be retained for at least 10 years.
2. Records are stored securely.
3. Only authorized personnel have access to records.
4. Staff receive periodic training in member information confidentiality.

Sharing Medical Record Information

1. Practitioners and providers share health record information, as appropriate and in accordance with professional standards.
2. Medical records shall be made available to members, any provider treating a member, and State and Federal agencies as necessary. At a minimum, HAP CareSource MI Coordinated Health requests medical records for record content and quality; peer review; grievance review, and audit reviews.
3. To the extent required by law, appropriate State and Federal agencies shall have the right, upon request, to inspect records at reasonable times, including all accounting and administrative records maintained by the provider.
4. When a patient changes PCPs, the former PCP must forward the patient's medical records or copies of medical records to the new PCP within 10 working days from receipt of a written request.

Mental Health Records

In addition to the standards above, mental health records shall contain the information below.

1. Each patient must have an individual treatment plan, completed by the second visit and include:
    a. Strengths and weaknesses.
    b. Patient input.
    c. Diagnosis.
    d. Short and long-term goals.
    e. Treatment time frames and reassessment dates.
    f. Risk behaviors.
    g. Specific treatment modalities.

h. Treatment referrals.

i. A written consent for treatment must be signed by the patient or legally responsible individual.

Note: Records must be revised as clinically appropriate and be individualized to the patient.

2. Progress notes must contain the following:
   a. Entries by mental health professional responsible for care
   b. Entries by Allied Health professionals participating in the patient's treatment.
   c. Entries documenting each patient encounter.
   d. Session type identified for each patient encounter.
   e. Documentation for "no show" appointments
   f. Evidence of communication with the PCP as well as a signed Release of Information or refusal

Provider Office Education and Training

Below outlines how we educate provider offices on our medical record requirements.

- Requirements are outlined in provider contracts.
- During provider orientation, we provide a demonstration of where they can find the standards.
- Annually, we publish an article in the provider newsroom.
- Provider Services representatives are available to meet with offices to discuss the standards.
- Medical record audits are also completed during site visits based on member complaints. Providers receive education if they are deficient in that area of the audit.

Medical Records Retrieval Policy

Providers shall make records available to HAP CareSource, HAP CareSource MI Coordinated Health and/or State and Federal regulatory agencies when necessary to prove compliance with Federal or State HMO laws, CMS and other federal agency requirements pertaining to Medicare and the Affordable Care Act, or the obligations assumed by HAP CareSource MI Coordinated Health in its subscriber contracts. Records must be made available in a timely manner.

A. Provider must maintain a medical record with complete and accurate information for each member.

B. All medical records must be updated and maintained in a timely fashion.

C. To the extent required by law, appropriate State and Federal agencies shall have the right, upon request, to inspect records at reasonable times, including all accounting and administrative records maintained by the provider.

D. Access standards and procedures for maintaining medical records for HAP CareSource MI Coordinated Health members shall be compliant with MDHHS and CMS CH and HMO licensing requirements, as well as HAP CareSource MI Coordinated Health standards.

E. Medical records shall be made available to members, any provider treating a member, and State and Federal agencies as necessary. At a minimum, HAP CareSource MI Coordinated Health request medical records for the following reasons:

- Record content and quality must support submitted claims.
- Peer review
- Grievance review
- Audit review
- Appeal review

CMS Risk Adjustment Validation Audits

Providers must include supporting documentation in a Medicare Member's medical record for all diagnosis codes submitted to HAP CareSource MI Coordinated Health for payment. Providers must complete such documentation in accordance with CMS's coding guidance in effect at the time of completion. Provider must timely supply HAP CareSource MI Coordinated Health with medical records so that HAP CareSource:

1. Can comply with a CMS Risk Adjustment Data Validation Audit (RADV)
2. Can conduct appropriate oversight and risk mitigation as it relates to HAP CareSource MI Coordinated Health's risk adjustment processes.

   a. Providers must submit complete and accurate risk adjustment data as requirement by CMS. Providers acknowledge Its obligation to cooperate with HAP CareSource and/or CMS during RADV audits and to timely produce (a) requested medical records in accordance with 42 CFR 422.310(e) and/or (b) any required attestations to correct signature deficiencies in the medical records. [42 CFR 422.310].

When requested, the provider must make patient medical records, accounting and administrative records available for audit purposes. Request must be fulfilled within 30 days of initial request or by terms of the contract. If unable to complete by the required submission date, the provider must submit reason for delay in writing with a specific time frame for submission of medical record. If the medical record does not have clear signature or credentials documented, a signature attestation may be required within 10 working days of receipt of the full medical record.

Records must be provided in a format required by law. Medical Records must include:

- Patient's condition or diagnosis legibly documented
- Name of patient on each page
- Date of service the visit took place (include both admit and discharge date for inpatient records) Physician legible signature and date
- Physician credentials

Provider will maintain medical records related to covered services rendered by provider for ten (10) years.

- Inability to produce a medical record for a covered service will result in the following:
  - **First occurrence:** written warning and retrieval of paid amount made to the provider.
  - **Second occurrence:** written warning and retrieval of paid amount made to the provider. Incident will be reviewed at Provider Peer Review Committee meeting.
  - **Third occurrence:** Termination of participation with HAP CareSource MI Coordinated Health and retrieval of paid amount made to the provider.

Section 15: Hepatitis C Virus

Frequently Asked Questions for Providers

In 2021, the MDHHS announced a public health campaign, We Treat Hep C. It's aimed at eliminating hepatitis C virus (HCV) in Michigan. The initiative involves:

- Increasing the number of people who are tested for HCV.
- Increasing the number of providers who treat HCV.
- Expanding access to HCV curative treatments.

Hepatitis C Facts

Hepatitis C is a liver infection caused by the hepatitis C virus. It's spread through contact with blood from an infected person. Hepatitis C can be a short-term illness that resolves spontaneously. However, for most people who become infected with HCV, it becomes a chronic infection. Chronic HCV can result in serious, even life-threatening, health problems like cirrhosis and liver cancer.

People with HCV often have no symptoms and do not feel sick. When symptoms appear, they often are a sign of advanced liver disease. In Michigan, about 115,000 people are known to have HCV. However, that number may be as high as 200,000 considering those undiagnosed. Screening, testing and treatment can save and prolong life. For more information visit Michigan.gov/WeTreatHepC.

Below are some frequently asked questions about HCV.

Member Outreach

1. **How do we educate members on hepatitis C?**

   We send a letter to all HAP CareSource members, age 18 and older. The letter has general information about HCV and the importance of testing. We also send letters to newly enrolled members. Letters were also sent to all HAP CareSource MI Coordinated Health members.

2. **How do we help members who need transportation for testing or treatment?**

   Members can call our Member Service team to schedule a ride. They can be reached at **1-833-230-2053 (TTY: 711)** for Medicaid or **1-833-230-2057** for HAP CareSource MI Coordinated Health. Information about the transportation benefit can be found:

   - On the HAP CareSource MI Coordinated Health website
   - In the Member Handbook

Testing

1. **What testing guidelines should be followed?**

   The CDC recommends all adults ages 18 and older should be tested for HCV at least once in a lifetime. Pregnant women should be tested during each pregnancy. The table below outlines the CDC recommendations for HCV screening. Providers are encouraged to make this testing part of routine primary care.

For	CDC Recommendations
Universal hepatitis C screening	• Hepatitis C screening at least once in a lifetime for all adults aged 18 years and older, except in settings where the prevalence of HCV infection (HCV RNA-positivity) is less than 0.1%* • Hepatitis C screening for all pregnant women during each pregnancy, except in settings where the prevalence of HCV infection (HCV RNA-positivity) is < 0.1%*
One-time hepatitis C testing regardless of age or setting prevalence among people with recognized conditions or exposures	• People with HIV • People who ever injected drugs and shared needles, syringes, or other drug preparation equipment, including those who injected once or a few times many years ago. • People with selected medical conditions, including persons who ever received maintenance hemodialysis and persons with persistently abnormal ALT levels. • Prior recipients of transfusions or organ transplants, including people who: - Received clotting factor concentrates produced before 1987. - Received a transfusion of blood or blood components before July 1992 - Received an organ transplant before July 1992 - Were notified that they received blood from a donor who later tested positive for HCV infection. - Health care, emergency medical and public safety personnel after needle sticks, sharps, or mucosal exposures to HCV-positive blood - Children born to mothers with HCV infection
Routine periodic testing for people with ongoing risk factors, while risk factors persist	• People who currently inject drugs and share needles, syringes, or other drug preparation equipment. • People with selected medical conditions, including people who ever received maintenance hemodialysis.
Any person who requests hepatitis C testing	These persons should receive it, regardless of disclosure of risk, because many persons might be reluctant to disclose stigmatizing risks.

*Determining prevalence: In the absence of existing data for hepatitis C prevalence, health care providers should initiate universal hepatitis C screening until they establish that the prevalence of HCV RNA positivity in their population is less than 0.1%, at which point universal screening is no longer explicitly recommended but may occur at the provider's discretion.

Source: https://www.cdc.gov/hepatitis-c/hcp/diagnosis-testing/?CDC_AAref_Val=https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm

2. **What does HCV screening involve?**

   Screening for HCV involves measuring antibody to HCV in a person's serum. A reactive or positive test (detection of the antibody) is not a diagnosis of the disease. It only means a person was previously exposed to the virus. Note:

   - If the antibody test is reactive, then:
     - A nucleic acid test (known as a polymerase chain reaction [PCR] test) for HCV ribonucleic acid (RNA) is needed to determine if the person currently has active HCV infection. (Note: Often, the antibody test and the RNA test can be performed on a single blood draw, with a positive antibody test automatically reflexing to the HCV RNA test).
   - If the HCV RNA test is positive, then:
     - HCV treatment can be prescribed.

   Be sure to follow the CDC HCV testing algorithms. They can be found here.

3. **How does HAP CareSource MI Coordinated Health help members who test positive?**

   Our Case Managers assess the current treatment status. They will help resolve any issues or barriers to receiving treatment.

4. **Does HAP CareSource MI Coordinated Health have any initiatives to routinize testing?**

   Yes. We have the following initiatives:

   - Our Care Management team has developed an outreach plan for:
     - Members needing HCV screening.
     - Members diagnosed with HCV.
   - We ensure the member is connected with their primary care physician. We continue to provide ongoing support and follow up.
   - Part of our maternity care program ensures the member gets all recommended screenings. HCV screening is included.
   - Part of the health screening of new members includes HCV screening questions. Our care management team will follow up with members who have not completed screening.
   - We added information on hepatitis C screening and treatment to:
     - **The Welcome Packet for new members**
     - The Member Handbook
     - The member newsletter
     - Our website
   - Our Care Management team partners with the following groups to outreach to members:
     - Community-based organizations
     - Homeless shelters
     - Local health departments
     - FQHC's

5. **Does HAP CareSource MI Coordinated Health have any initiatives to increase HCV testing and treatment among persons with a history of substance use?**

   All members, including those with a history of substance abuse, are encouraged to get HCV testing and treatment. Our Care Management teams collaborate with PIHPs on shared members during monthly meetings. HCV testing and treatment for these members is addressed when applicable.

Treatment

1. **What is the recommended treatment for HCV?**

   Recently, direct-acting antivirals (DAA) were developed to treat hepatitis C. DAAs are oral medications that can cure the disease when taken daily for several weeks. They have few side effects or contraindications.

   The MDHHS has a three-year agreement with the manufacturer AbbVie to expand access to the DAA MAVYRET® (glecaprevir/pibrentasvir). MAVYRET is an oral prescription medication. It's used to treat adults and children ages 3 and older with HCV.

   Providers are encouraged to enroll their patients receiving MAVYRET into the MAVYRET Nurse Ambassador program. Information can be found here.

   To minimize medication barriers, prescriptions for DAAs should be written for the full course of therapy in one fill. In most cases, this is an eight-week supply. If you prescribe the full course of therapy in one fill, the pharmacy can fill it in one prescription.

2. **How does HAP CareSource MI Coordinated Health Plan ensure members with an HCV diagnosis are linked to a provider familiar with HCV treatment?**

   Our Care Management team will help coordinate care with the member's PCP. If specialist care is needed, we'll help find contracted providers close to the member's home. We'll also help with scheduling appointments.

   If members need transportation for testing or treatment, they can call our Member Services team to schedule a ride. They can be reached at **1-833-230-2053 (TTY: 711)** for Medicaid or **1-833-230-2057** for HAP CareSource MI Coordinated Health. Information about the transportation benefit can be found:

   - On the HAP CareSource MI Coordinated Health website
   - In the Member Handbook

3. **How does HAP CareSource MI Coordinated Health follow up with members receiving treatment to offer support on medication adherence?**

   Monthly, the Pharmacy team reviews pharmacy claims for members newly diagnosed with Hepatitis C. If there are no claims for treatment, this information is shared with Care Management. Based on information from Care Management, if applicable the Pharmacy team outreaches to the provider for discussion of Hep C diagnosis, education on Hep C treatment options (Mavyret as preferred), education on the "We Treat Hep C" program and education on the Mavyret Nurse Ambassador Program.

Each week, the Pharmacy team reviews for new treatment members for outreach. The Pharmacy team contacts the member to discuss their specific Hep C treatment, medication adherence, and education on Hep C. If the member filled less than the full course of treatment, the Pharmacy team may outreach to the prescriber and the pharmacy with reminders about prescribing/dispensing the full course of treatment at one time.

HAP CareSource MI Coordinated Health also communicates with pharmacy providers related to medication treatment:

- Electronic bulletins to the pharmacy network
- Reach-out to individual pharmacies when needed to facilitate medication adherence.

4. **Does HAP CareSource MI Coordinated Health track members with an HCV diagnosis and no record of treatment?**

   Yes. A report is shared with Care Management teams monthly to facilitate review and follow up.

Resources

1. **Where can I find helpful resources about HCV?**

   MDHHS has partnered with several organizations for resources to help providers treat HCV patients. Please see the table below.

For	Contact
Consulting line for all health care professionals with questions about HCV treatment	Henry Ford Health **313-575-0332** 8 a.m. to 5 p.m. Monday through Friday ET
• **On-demand webinars** • **Live training events** • **Office hours** • **Other resources for health care professionals on treating HCV**	Midwest AIDS Training and Education Center (MATEC) at Wayne State University School of Medicine Division of Infectious Diseases https://matecmichigan.com/clinical-resources
Education and case consultation on HCV **Additional resources**	https://www.msms.org/About-MSMS/News-Media/we-treat-hep-c-initiative-mdhhs-partners-with-professional-consultation-programs-to-offer-free-hepatitis-c-training-and-resources-for-health-care--providers
Notification of new training opportunities and events	Send a request to be added to the listserv: Email MDHHS-Hepatitis@michigan.gov

Section 16: Vaccines, MCIR and Reporting Communicable Diseases

Vaccines

State law requires providers who administer vaccines to HAP CareSource MI Coordinated Health members to obtain the vaccines through the Vaccines for Children (VFC) program. Enrollment in this program helps the member to receive vaccines during their visit. This is a federal program that makes vaccines available to immunize children aged 18 and under who are Medicaid eligible. HAP CareSource MI Coordinated Health encourages pediatricians to be registered in the VFC program. To enroll in the VFC program, please check this link. Vaccines can be obtained free of charge from local health departments (LDH).

Requirements for Reporting to the Michigan Care Improvement Registry (MCIR)

Providers who administer immunizations are required to report them to the MCIR.

For questions, registration, training resources and technical assistance, visit mcir.org. MCIR can also help you improve your immunization rates by running reminder/recall reports.

Requirements for Reporting to the Local Health Department (LDH)

The state, HAP CareSource MI Coordinated Health provider contract requires providers to report communicable diseases to the local health department.

The Alliance for Immunization in Michigan (AIM)

The Alliance for Immunization in Michigan (AIM) was formed in 1994 to focus on a broad spectrum of immunization issues in Michigan. AIM's mission is to promote immunizations across the lifespan through a coalition of health care professionals and agencies.

For vaccine information and resources, visit https://www.aimtoolkit.org/health-care/patient-education.php.

Section 17: Continuity of Care

Members are expected to seek medical services from participating providers within the network. While in good standing, if a PCP or specialist terminates their contract with HAP CareSource MI Coordinated Health, the terminated provider may continue to serve their HAP CareSource MI Coordinated Health members to ensure continuity of care.

Continuity of care can occur when a member is being treated by the terminated provider and the member is:

- In an active course of treatment for an acute episode or chronic illness or acute medical condition. An active course of treatment is one in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes.
- In the second or third trimester of pregnancy.
- Terminally ill.

If the member is an active care plan as described above, the terminated provider can continue treating the member for a period up to 90 days or until the member sees another provider for the condition being treated for.

If the provider has any HAP CareSource MI Coordinated Health patients who meet the above criteria and is willing to continue treating them on a fee-for-service basis, the provider should follow the process below:

- Identify the patient on the list and document the reason for continuing their care.
- Fax the list back to HAP CareSource MI Coordinated Health at **248-663-3780**.
- HAP CareSource MI Coordinated Health will send a confirmation letter to the provider that outlines the continued treatment conditions for each member that the provider agrees to continue treating.
- The provider will be allowed to continue treatment as a non-par provider with appropriate prior authorization for up to 90 calendar days for:
  - Members in active treatment for an acute or chronic medical condition
  - Members through the acute phase of the condition being treated.
  - Members through the postpartum period of six weeks postdelivery for women in the second and third trimester of pregnancy
  - A terminally ill member for the remainder of their life
- You must share information regarding the treatment plan with HAP CareSource MI Coordinated Health.
- You must follow the HAP CareSource MI Coordinated Health utilization management policies and procedures.
- You can’t charge or balance bill the member for services.
- You will be reimbursed at current Medicaid fee-for-service rates.

If the provider is not willing to continue treating the member, HAP CareSource MI Coordinated Health will work with the provider and the member to develop a transition plan to a new PCP or specialist.

Section 18: Ensuring Culturally Appropriate Care

To ensure our members receive culturally appropriate care, our providers are expected to follow the guidelines below.

- Provider and each individual providing services on its behalf shall accept all eligible members, provide physical access, reasonable accommodations and accessible equipment for eligible members with physical or mental disabilities, and not segregate eligible members in any way or treat them in a location or manner different from other persons receiving health care services.
- Provider and each individual providing services on its behalf shall promote the delivery of services in a culturally responsive manner to all eligible members including those with limited proficiency in English, deaf and hard of hearing, and with diverse cultural and ethnic backgrounds.
  - A person's cultural background shall be recognized and valued in the decision-making process.
  - Provide culturally competent care by listening and making accommodations for patients' diverse beliefs and practices.
  - Provide culturally competent care by being aware of own assumptions, including those related to the culture of medicine and attempting a posture of cultural humility and respect toward those who hold different and perhaps conflicting assumptions from their own.
- Provider and each individual providing services on its behalf shall not discriminate against eligible members on any grounds prohibited by law, including without limitation on the basis of:

- **Age**
- **Ancestry**
- **Color**
- **Creed**
- **Disability**
- **Gender identity**
- **Health status**
- **Marital status**
- **Membership in HAP CareSource MI Coordinated Health**
- **National origin**
- **Physical or mental handicap**
- **Race**
- **Religion**
- **Source of payment**
- **Sexual orientation**

- Provider and each individual providing services on its behalf also agree to comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq. and 47 USC 225)
- Providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollees with disabilities (both congenital and acquired disabilities), or other special population served by HAP CareSource MI Coordinated Health. This responsiveness includes the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those with a vision or hearing impairment.
- Providers, including multilingual network providers, must understand and comply with their obligations under State or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist network providers to meet these obligations. HAP CareSource MI Coordinated Health Enrollees can call our Member Services department at **1-833-230-2053** for Medicaid or **1-833-230-2057** for MI Coordinated Health (found on the back of the member ID card) or their HAP CareSource MI Coordinated Health Care Coordinator for free interpreter assistance.

- Network providers and interpreters/translators are available for HAP CareSource MI Coordinated Health enrollees who are deaf or vision- or hearing-impaired.
- Providers have a strong understanding of disability, recovery, and resilience cultures and LTSS.

Cultural Competency Training Resources

To ensure providers have a strong understanding of culturally competent care, training is encouraged. Please see the resources below.

Organization and Description	Link
The Office of Minority Health at The U.S. Department of Health and Human Services, sponsors Think Cultural Health Free, continuing education e-learning programs, designed to help you provide culturally and linguistically appropriate services (CLAS).	Education - Think Cultural Health (hhs.gov) Then choose the appropriate provider type.
The Centers for Disease Control and Prevention offers three online health literacy courses for health professionals: • Health Literacy for Public Health Professionals (free continuing education) • Fundamentals of Communicating Health Risks • Effective Communication for Healthcare Teams: Addressing Health Literacy, Limited English Proficiency and Cultural Differences (free continuing education)	Find Training | Health Literacy | CDC
National LGBTQIA+ Health Education Center Educational programs and resources to optimize quality, cost-effective health care for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority (LGBTQIA+) people.	www.lgbtqiahealtheducation.org
John Hopkins University of Medicine Office of Diversity, Inclusion and Health Equity Offers a central repository for diversity, equity and inclusion (DEI) education and learning.	https://www.hopkinsmedicine.org/diversity

Section 19: Philosophy of Care

HAP CareSource MI Coordinated Health providers will deliver services consistent with these philosophies:

- Person-centered planning: The principles of person-centered planning are:
  - Each member has strengths and the ability to express preferences and to make choices.
  - The member's choices and preferences shall always be honored and considered.
  - Each member has gifts and contributions to offer to the community and can choose how supports, services and treatment may help them utilize their gifts and make contributions to community life.
  - Person-centered planning processes maximize independence, create community connections and work towards achieving the individual's dreams, goals and desires.
  - A person's cultural background shall be recognized and valued in the decision-making process.
- Self-determination: All individuals, regardless of if they have a disability, have the civil right to live the way they want to live. The principles of self-determination are:
  - Freedom to decide how one wants to live his or her life.
  - Authority over a targeted amount of dollars.
  - Support to organize resources in ways that are life enhancing and meaningful to the individual.
  - Responsibility for the wise use of public dollars and recognition of the contribution individuals across disability and aging can make to their community.
- Recovery: An individual's journey of healing and transformation to live a meaningful life in a community of his or her choice while striving to achieve maximum human potential. It's not the role of providers to make decisions for members, but to provide education about the possible outcomes that may result from various decisions.
- Independent living: Living just like everyone else and having opportunities to make decisions that affect one's life, being able to pursue activities of one's own choosing and being limited only in the same ways as one's nondisabled neighbors.

HAP CareSource MI Coordinated Health providers are accountable for:

- Member satisfaction.
- Health care access to comprehensive and quality medical care and preventive services.
- Promoting shared responsibility for health care decisions with members and their families and caregivers.
- Providing culturally competent care by listening and making accommodations for patients' diverse beliefs and practices.
- Being aware of their own assumptions, including those related to the culture of medicine and attempting a posture of cultural humility and respect toward those who hold different and perhaps conflicting assumptions from their own.

Section 20: Confidentiality; Fraud, Waste and Abuse; and Whistleblower Protection

Confidentiality Policy

HAP CareSource MI Coordinated Health ensures that employees, PCPs and participating providers or physicians, through their contracts, hold confidential all information obtained through examination, care or treatment of members or patients. HAP CareSource MI Coordinated Health will only divulge such information with appropriate authorization, by law or as medically or administratively necessary to provide services to our members. HAP CareSource MI Coordinated Health do not share any member-specific information with employers. Measures to protect the records from loss, tampering, alteration, destruction and unauthorized or inadvertent disclosure will be taken by the responsible persons. Any record that contains clinical, social, financial, or other data on a member will be maintained in strictest confidence. Only authorized persons with a need to know have access to confidential information. The Quality Improvement Committee reviews and approves the confidentiality policies and annual compliance training occurs with the Health Insurance Portability and Accountability Act.

The State Medicaid Agencies, Department of Health and Human Services, manages the Medicaid recipient's routine consent to release information during their application for Medicaid. HAP CareSource MI Coordinated Health do not enroll members. This function is performed by the State of Michigan. The routine consent covers future, known or routine needs for use of personal health information, such as for treatment, coordination of care, quality assessment and measurement including member surveys, accreditation and billing. The State of Michigan does not require any special consent. HAP CareSource MI Coordinated Health practitioners are required to use a release of information form when members wish to have their records copied or released.

HAP CareSource MI Coordinated Health protect the confidentiality of information about members consistent with the needs to conduct business without divulging more information than is necessary for treatment, payment and operations.

Information that is held confidential includes personal health information such as name, date of birth, address, gender, medical record information, claims, benefits and other administrative data that are personally identifiable. This includes all forms of PHI, oral, written and electronic forms of member information. If a member is unable to give consent, the member's legal guardian may authorize the release of personal health information and have access to information about the patient.

Health plan associates sign a confidentiality statement upon employment.

Reporting Fraud, Waste and Abuse

HAP CareSource MI Coordinated Health is committed to the prevention, detection and correction of any criminal conduct.

Any HAP CareSource MI Coordinated Health associate (member, employee, provider, first tier and downstream related entity and their governing bodies) must share this commitment to remain compliant, lawful and ethical conduct.

The HAP CareSource MI Coordinated Health Program Integrity Special Investigations Unit (SIU) is dedicated to detecting, preventing and investigating all reported issues of potential, suspected, or known cases of fraud, waste and abuse and issues of non-compliance resulting from fraudulent and abusive actions committed by providers, contractors, subscribers and employees.

Fraud is the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

The acts may be committed for the person's own benefit or for the benefit of another party. In order to be considered fraud, the act must be performed knowingly, willfully and intentionally.

Examples:

A. To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced.

B. Intentionally misrepresenting who provided the services, altering claim forms, electronic claim records or medical documentation.

Waste refers to the over-utilization of services or practices that result in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return, or an act or instance of wasting. Waste goes beyond fraud and abuse and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

Examples:

A. Providing services that are not medically necessary (i.e., unnecessary diagnostic testing).

B. A provider prescribing medication without validating if the member still needs them.

Abuse involves provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. Abuse is similar to fraud except that there is no requirement to prove or demonstrate that abusive acts were committed knowingly, willfully and intentionally.

Examples:

A. Prescribing drugs, equipment or services that are not medically necessary.

B. Billing for services not provided.

C. Billing more than once for the same service.

D. Prescribing high quantities of controlled substances without medical necessity.

E. Unbundling services to obtain higher reimbursement.

F. Scheduling more frequent return visits than are needed.

G. Billing drugs for inpatients as if they were outpatients.

H. Retaining overpayments made in error by HAP CareSource MI Coordinated Health.

I. Failing to comply with federal and/or state law.

*This list is not exhaustive.

All reported cases of suspected fraud, waste and abuse are monitored and handled by the HAP CareSource MI Coordintaed Health Program Integrity SIU.

If you suspect any provider, member, employee, or contractor of HAP CareSource MI Coordinated Health of potential fraud, waste or abuse of Medicare or Medicaid assets, please contact us immediately. We have a 24-hour, toll-free fraud hotline. You can also mail your concern. Please see information below. The report can be filed anonymously so you are not required to leave your name or any contact information.

- Phone: Navex FWA Hotline **1-844-415-1272**
- Fax: 1-800-418-0248
- Email: **Fraud@CareSource.com**
- Mail: HAP CareSource MI Coordinated Health
  Attn: Program Integrity
  P.O. Box 1940
  Dayton, OH 45401-1940

You may also report your concern to Medicaid, MDHHS, Office of Inspector General by:

- Phone: **1-855-MI-FRAUD (643-7283)**
- Mail: MDHHS-OIG
  P.O. Box 30062
  Lansing, Michigan 48909
- Visiting: Michigan.gov\fraud

Whistleblower Protection

As discussed in more detail in the Compliance Program and the policies, employees are responsible for internally reporting compliance issues including issues that raise false claims concerns, fraudulent activity, or noncompliance to the code of conduct. It is the policy of the company that no employee who makes a report of alleged wrongdoing will be subjected to reprisal, harassment, retribution, discipline, or discrimination by company or any of its employees or agents based on having made the report. Any employee or agent who engages in any such reprisal, harassment, retribution, discipline, or discrimination against a good faith reporter may be subject to disciplinary action as deemed appropriate by the company.

The Michigan Whistleblowers' Protection Act provides protection to employees who report a violation or suspected violation of state, local or federal law. The Michigan Medicaid False Claims Act provides protection for employees who initiate, assist, or participate in a proceeding or court action under this law or who cooperate or assist with investigations conducted under this law.

The Federal False Claims Act contains protections for employees who are discharged, demoted, suspended, or discriminated against in retaliation for their involvement in False Claims Act cases.

Section 21: Model of Care - HAP CareSource MI Coordinated Health

The target population for HAP CareSource MI Coordinated Health Program consists of Medicare and Medicaid eligible individuals, defined as Medicare beneficiaries who are also eligible for full Medicaid benefits. The service area for the HAP CareSource MI Coordinated Health product is Macomb and Wayne Counties in Michigan.

The HAP CareSource MI Coordinated Health develops, implements, maintains and monitors the Special Needs Plan Model of Care. The Model of Care services as an operational infrastructure for care management processes and systems that enable HAP CareSource MI Coordinated Health to provide coordinated care for the special needs HAP CareSource MI Coordinated Health program members.

The HAP CareSource MI Coordinated Health Model of Care focuses on:

- Understanding the population's needs based on ongoing evaluation of the membership profile.
- Infrastructure to determine, verify and track eligibility.
- Identification of the most vulnerable members.
- Establishing community partnerships to address the needs of the most vulnerable members.
- Roles, responsibilities and qualifications of clinical and administrative staff that works with the HAP CareSource MI Coordinated Health members.
- Care management processes such as completion of initial and annual Health Risk Assessments, completion of an individualized care plan, face to face encounters, involvement of an interdisciplinary care team and care transition protocols.
- Maintaining specialized expertise in the provider network.
- Use of Clinical Practice Guidelines and Care Transition protocols by network providers and practitioners.
- Development, implementation and oversight of Model of Care training across the provider network.
- Quality Management and Performance Improvement through the development of Quality Performance Improvement Plan, identification and tracking of measurable goals and health outcomes, measuring member experience and continuous Quality Improvement evaluations.

Specially Tailored Services Geared Toward the Most Vulnerable Population

HAP CareSource MI Coordinated Health understands how vulnerable the population is and therefore, has added benefits specific to their known unique needs. These value-added services and benefits include:

- A $0 copay for generic and brand drugs
- Care Coordination - A nurse or social worker helps the beneficiary navigate the managed care system and attain optimal health. All beneficiaries get a health risk assessment and inter-disciplinary plan of care.
- Health and Wellness Programs - Includes smoking cessation, preventive health outreach for services due such as vaccinations and colorectal cancer screening and disease management programs for diabetes, asthma and hypertension.

- A 24/7 health information line.
- An emergency response service benefit for high-risk individuals. Persons must meet certain criteria and must be approved by the medical director.
- Podiatry for medically necessary foot care.
- Vision Care - One routine eye exam every two years and up to one pair of glasses, including lenses and frames, every two years.
- A hearing test.
- Dental Care - includes an oral exam, fluoride treatment, X-rays and cleaning.

The additional services that HAP CareSource MI Coordinated Health provides to our most vulnerable beneficiaries depend on the beneficiary's needs and goals. The following examples show some of the vulnerable beneficiary categories and the additional services for which they are eligible:

- **Frail:** In-home physical therapy and occupational therapy assessments and treatment, transportation to and from medical appointments, in-home safety assessment and emergency response system.
- **Disabled:** In-home physical therapy and occupational assessments and treatment, transportation to and from medical appointments, in-home safety assessment and emergency response system.
- **End-stage renal disease:** Nutrition counseling, transportation to and from dialysis and medical appointments, educational materials on cooking, renal disease and medications and a medication reconciliation program.
- **Beneficiaries near the end of life:** Hospice information, home health aides, nursing care in home, transportation to medical appointments and emergency response system.
- **Beneficiaries with multiple and complex conditions:** The beneficiary's personal care coordinator works with them to navigate the managed care system and attain optimal health, emergency response system, health and wellness programs including smoking cessation, preventive health outreach for services such as vaccinations and colorectal cancer screening and disease management programs for diabetes.

Integrated Care Bridge or Electronic Care Bridge

HAP CareSource MI Coordinated Health maintains an Integrated Care Bridge to facilitate timely and effective information flow between the plan, provider, Michigan Health Information Network Shared Services (MiHIN) and the PIHPs. The Care Bridge can directly exchange information for dually served members of the healthcare team for more efficient care.

Care Coordination

Every beneficiary is assigned to a HAP CareSource MI Coordinated Health care coordinator based on the beneficiary's assigned risk level and individual needs. HAP CareSource MI Coordinated Health will allow the beneficiary or his or her authorized representative a choice in the selection of a HAP CareSource MI Coordinated Health care coordinator.

The care coordinator must be either a Michigan: licensed registered nurse, licensed nurse practitioner, licensed physician's assistant, licensed Bachelor's prepared social work; limited license Master's prepared social worker; or limited license Bachelor's prepared social work; or a clinical nurse specialist.

The registered nurse (RN) care coordinators have experience in a variety of settings such as acute care, long term care, home care, mental health, infusion centers, social work and Area Agencies on Aging to meet the needs of the HAP CareSource MI Coordinated Health population. The Social Worker (SW) care coordinator is a master's level social worker eligible for State of Michigan certification as a Certified Social Worker. They have knowledge of community resources and problems unique to the Medicare and Medicaid population, such as that acquired during one to two years of work experience. They have a professional level of analytical skills to analyze and solve problems and develop viable intervention plans.

Care coordinators report to the Case Management Team Lead and are responsible for the following:

- Conducting, collecting and reviewing the health risk assessment (HRA), including analyzing and stratifying the beneficiary's health care needs based on the HRA.
- Contacting the beneficiary and reviewing the HRA with them.
- Identifying any medical or social impediments to care.
- For persons with special health care needs, collaborating with the member's providers and HAP CareSource MI Coordinated Health Utilization Management team to ensure direct access to specialist care appropriate for the member's condition and identified needs.
- Determining the beneficiary's ability to follow a prescribed plan of care.
- Initiating and implementing a plan of care with attainable goals in conjunction with all health care providers and community agencies.
- Modifying the plan as necessary through monitoring and re-evaluation to accommodate changes in treatment or progress.
- Contacting the beneficiary on a predetermined schedule to evaluate interventions.
- Presenting questionable cases to the medical director for review.
- Entering authorizations for approved services into the system per HAP CareSource MI Coordinated Health procedures.
- Assuring maintenance and sharing of records and reports.
- Assuring HIPAA compliance.
- Maintaining paper-based and electronic information systems.

The HAP CareSource MI Coordinated Health care coordinator will use the results of the Level I and Level II assessment, when indicated, to develop a person-centered Individual Integrated Care and Supports Plan with the member and ICT chosen by the member. The plan of care will include a review and analysis of the member's:

- **Current health status:** Including fall risk, multiple chronic conditions such as diabetes, chronic obstructive pulmonary disease, congestive heart failure and cancer.
- **Clinical history:** Including disease onset, hospitalizations, treatment history, medications, past surgeries, psychiatric conditions and acute exacerbations due to nonadherence to medications and polypharmacy.
- **Activities of daily living:** Including functional ability to perform ADLs, identified deficiencies in vision, hearing or speech limitations, toileting, incontinence issues, bathing, transferring, and mobility including fall risk, eating and swallowing and dressing. It includes assessment of instrumental activities of daily living such as housework, shopping, phone use and money management.

- **Mental health status:** Including psychosocial and cognitive functions such as checking for orientation to person, place and time, wandering issues, threat to self or others and displaying unsafe or extreme bizarre habits. This includes checking for depression, using the screening tool and a history of other psychological conditions.
- **Life planning:** When appropriate, help member complete a living will, advance directive and power of attorney and forward those documents to the PCP.
- **Cultural and religious limitations or preferences:** Including language, treatment choices and facilitation of access to culturally acceptable heath care for the beneficiary, such as informing beneficiary of providers who are located close to their home and speak the same language.
- **Caregiver resources:** Including family involvement and identification of care giver who can participate in developing and implementing plan of care. Communication occurs with the beneficiary and if one has been identified, their caregiver.
- **Benefits:** This includes eligibility issues and financial barriers. Can help identify available community resources and special programs for treatment of conditions including hospice. The care coordinator ensures that referrals are for covered services and facilitates accessing these services. They also educate the beneficiary on the benefits for both Medicare and Medicaid and help resolve any LIS eligibility issues. The case manager facilitates the coordination of the member to work with Michigan Medicare/Medicaid Assistance Programs (MMAPS) in our service area to also help them understand their benefits.
- **Case management plan with short- and long-term goals:** Upon completion of the HRA and the welcome call, the care coordinator works with the beneficiary to develop short term goals that can be achieved within three to six months and long-term goals that can be achieved within nine to twelve months. The goals are mutually agreed upon with the care coordinator, the beneficiary and, with consultation, the PCP. They are based on immediate needs the beneficiary identifies, including their preferences for care and their future goals to improve their health status. These goals include the member's life goals.
- **Additional resources:** Additional resources may be identified during the care plan development. For example, for fall risk or mobility issues, additional resources may include physical therapy, a home safety evaluation and vision and hearing testing. The Care Manager communicates these additional resources to the PCP.
- **Transition of care plan:** When a member's care is transitioned to another setting, such as transfer to hospital or skilled nursing facility, the care plan is adjusted to reflect their current environment and outcome possibilities.
- **Near end-of-life issues:** The plan of care in Guiding Care includes the documentation of completion of the member's advance directives and power of attorney. Add-on services include MMAP counselors, hospice counselors and other disease related foundations.
- **Barriers:** These may include issues with understanding medical instructions, motivation to change, finances and transportation. The care coordinators discuss the plan of care by phone and send the member the ICT brochure. It is written at a sixth grade reading level to help them understand the information. The beneficiary receives a welcome packet that informs them of the Medicare and Medicaid benefits. They receive a welcome call from the Member Services representatives who answer their questions and discuss the Medicaid and Medicare benefits. The free transportation benefit is discussed with beneficiaries when they enroll to help eliminate transportation barriers. All contact with members is meant to motivate them to follow the plan of care. While their financial costs for medical care are covered through either Medicare or Medicaid, financial incentives are offered for completion of preventive services such as mammograms.

- **Follow-up schedule:** Includes documentation of appointments such as counseling, specialty physician and wound clinic to reflect member's adherence to the plan. Appointment scheduling, attendance and follow-up are documented in the Guiding Care system. Appointment results and referral provider recommendations are also documented in the Guiding Care system. For example, if a PCP provides a home care referral for wound dressing changes and IV infusion of antibiotics, the care coordinator facilitates the referral for that care and sets up the arrangements with wound care and IV infusion. The care coordinator would document wound dimension over time, give the member self-care instructions and update the PCP on the member's status. This would also be reflected in the plan of care and in Guiding Care.
- **Self-management plan:** Includes monitoring symptoms, activity, BP, blood sugars, etc. The member's self-management is an integral part of the care plan. The care coordinator confirms the member understands how to monitor symptoms related to their disease process. Referrals to home care are made to assist in educating the members on self- management activities such as monitoring blood pressure, sugar level, daily weights, temperature and wound appearance. It includes education on reporting symptoms to their PCP.
- **Progress assessment:** Upon completion of the HRA, the HAP CareSource MI Coordinated Health care coordinator works with the member to develop short-term goals (ones that can be achieved within three to six months) and long-term goals (ones can be achieved within nine to twelve months). The goals are mutually agreed upon with the care coordinator, the member and the PCP. They are based on the immediate needs identified by the member, including member preferences for care and future goals to improve their health status.

The time frame for reevaluation is individualized based on the member's plan of care. If the member does not meet a goal, the goal is revised, or a new goal is established with the member, based on their input. An annual, comprehensive reevaluation is done after the annual HRA is completed.

Integrated Care Team

The member is the center of the Integrated Care Team (ICT). The HAP CareSource MI Coordinated Health care coordinator ensures that the member has access to and input in the development of an ICT to ensure the integration of medical, mental health, psychosocial care and LTSS based on the HRA. The ICT is person-centered, built on the member's specific preferences and needs and delivers services with transparency, individualization, accessibility, respect, linguistic and cultural competence and dignity.

The ICT honors the member's choice about their level of participation. This choice will be revisited periodically by the care coordinator as it may change. The care coordinator will include a person familiar with the member's needs, circumstances and preferences when the member cannot participate fully in or report accurately to the ICT. It is the member's right to determine the appropriate involvement of other members of the ICT based on the needs identified in the HRA, in accordance with applicable privacy standards.

The care coordinator and the member are responsible for setting and facilitating ICT meetings and facilitating communication among ICT members. LTSS and PIHP support coordinators will be members of ICTs, as applicable, to encourage communication and collaboration between HAP CareSource MI Coordinated Health, PIHPs and other providers. The HAP CareSource MI Coordinated Health care coordinator is responsible for assuring the ICT process, but the member may request his or her LTSS or PIHP supports coordinator remain the main point of contact about their care.

Long Term Services and Supports (LTSS) – HAP CareSource MI Coordinated Health Members

Qualified HAP CareSource MI Coordinated Health members have access to a variety of LTSS and home and community-based services (HCBS) to help them meet daily needs for assistance independently and improve their quality of life.

LTSS and HCBS benefits are provided over an extended period, mainly in member homes and communities. They are also available in facility-based settings (e.g., nursing facilities and supplemental services which could include personal care services), or as outlined in a member's individual integrated care and supports plan.

Overall, the HAP CareSource MI Coordinated Health model of care promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care. HAP CareSource MI Coordinated Health care managers work closely with community partners and HCBS providers to expedite evaluation and access to services.

The HAP CareSource MI Coordinated Health program provides seamless coordination between medical care, LTSS, HCBS and mental health and substance use benefits covered by Medicare and Medicaid.

Home and Community Based Services (HCBS Waiver) that our plan pays for include:

- Adult day program
- Assistive technology
- Chore services
- Environmental modifications
- Expanded Community Living Supports
- Fiscal Intermediary Services
- Home delivered meals
- Individualized Goods and Services
- Non-medical transportation
- Preventive nursing services
- Private duty nursing
- Respite care services
- Vehicle Modifications

The above services require prior authorization.

Section 22: HAP CareSource MI Coordinated Health Member Information

To learn about HAP CareSource MI Coordinated Health's relationship with members, refer to the Evidence of Coverage or the Member Handbook on **HAPCareSource.com**.

Appendix A: Appeals and Grievance Information for Members

HAP CareSource MI Coordinated Health Members

Below is the information we provide to members in their HAP CareSource MI Coordinated Health Member Handbook regarding filing a grievance and appeal.

Grievances and Appeals

We want you to be happy with the services you get from our providers. If you are not satisfied, you can file a grievance or appeal.

Grievances are complaints that you may have if you are unhappy with our plan or if you are unhappy with the way a staff person or provider treated you. Appeals are complaints related to your medical coverage, such as treatment decision or a service that is not covered or denied. If you have a problem related to your care, talk to your doctor. Your doctor can often handle the problem. If you have questions or need help, call HAP CareSource MI Coordinated Health at **1-833-230-2057 (TTY: 711)**.

Grievance Process

We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, let us know right away. If you aren't happy with us or your doctor, you can file a grievance at any time. HAP CareSource MI Coordinated Health has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits. These are examples of when you might want to file a grievance.

- Your provider or a(n) HAP CareSource MI Coordinated Health staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a(n) HAP CareSource MI Coordinated Health staff member was rude to you.
- Your provider or a(n) HAP CareSource MI Coordinated Health staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling HAP CareSource MI Coordinated Health at **1-833-230-2057 (TTY: 711)**. You can also file your grievance in writing via mail or online at:

HAP CareSource MI Coordinated Health
Attn: Grievance and Appeals
P.O. Box 1025
Dayton, OH 45401-1025

Online: HAPCareSource.com

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling **1-833-230-2057 (TTY: 711)**. We will let you know when we have received your grievance. We may contact you for more information.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your "representative." If you decide to have someone represent you or act for you, inform HAP CareSource MI Coordinated Health in writing with the name of your representative and their contact information. Your grievance will be resolved within 30 calendar days of submission. We will send you a letter of our decision.

Appeal Process

An appeal is a way for you to ask for a review of our actions. If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get an "Adverse Benefit Determination" letter from us. This letter will tell you the following:

- The adverse benefit determination the contractor has made or intends to make.
- Your right to be provided upon request and free of charge, copies of all documents, records, and other information used to make our decision.
- What action was taken and the reason for it.
- Your right to file an appeal and how to do it.
- Your right to ask for a State Fair Hearing and how to do it.
- Your right in some circumstances to ask for an expedited appeal and how to do it.
- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services.

You may appeal within 60 calendar days from the date of the receipt of the Adverse Benefit Determination letter which is presumed to be five days from the date on the notice. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not telling you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

You can file your appeal on the phone by calling HAP CareSource MI Coordinated Health at **1-833-230-2057 (TTY: 711)**. You can also file your appeal in writing via mail or online at:

HAP CareSource MI Coordinated Health
Attn: Grievance and Appeals
P.O. Box 1025
Dayton, OH 45401-1025

Online: HAPCareSource.com

You have several options for assistance. You may:

- Call Member Services at **1-833-230-2057 (TTY: 711)** and we will assist you in the filing process.
- Ask someone you know to assist in representing you. This could be your primary care provider or a family member, for example.
- Choose to be represented by a legal professional.

To appoint someone to represent you, either:

1. Send us a letter informing us that you want someone else to represent you and include in the letter their contact information or,
2. Fill out the CMS 1696 Appointment of Representative Form.

You may call and request the form or find this form online at: https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf.

We will send you a notice saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. If the appeal has to do with a medical decision, the provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service.

HAP CareSource will send our decision in writing to you within 30 calendar days of the date we received your appeal request. HAP CareSource MI Coordinated Health may request an extension up to 14 more days in order to get more information before we make a decision. You can also ask us for an extension if you need more time to get additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative Notice of Internal Appeal Decision. The Notice of Internal Appeal Decision will tell you what we will do and why.

If HAP CareSource's decision agrees with the Notice of Adverse Benefit Determination, you may have to pay for the cost of the services you got during the appeal review. If HAP CareSource MI Coordinated Health's decision does not agree with the Notice of Adverse Benefit Determination, we will approve the services right away.

Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.

How Can You Expedite Your Appeal?

If you or your provider believes our standard timeframe of 30 calendar days to make a decision on your appeal will put your life or health at risk, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal. Expedited appeal requests must be made within 10 calendar days of the date of the Notice of Adverse Benefit Determination. We will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the Notice of Internal Appeal Decision.

How Can You Withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same available methods as you have for filing the appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. HAP CareSource MI Coordinated Health will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call HAP CareSource MI Coordinated Health at **1-833-230-2057 (TTY: 711)**.

What Happens Next?

After you receive the Notice of Internal Appeal Decision in writing, you do not have to take any action, and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or asking for an External Review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services (DIFS). You can choose to ask for both a State Fair Hearing and an External Review or you may choose to ask for only one of them.

State Fair Hearing Process

You, your representative, or your provider can ask for a State Fair Hearing with MOAHR. You must do this within 120 calendar days from the date of your appeal denial notice. A Request for Hearing form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. If you asked for services to continue in your health plan appeal and want to continue your services during the State Fair Hearing process, you must ask for a State Fair Hearing within 10 calendar days of the date on the decision notice. If you do not win this hearing, you may be responsible for paying for the services provided to you during the hearing process. You may be required to pay the cost of services provided while the appeal or the State Fair Hearing is pending. You can also ask for a State Fair Hearing if you do not receive a decision from us within the required time frame.

Call HAP CareSource MI Coordinated Health at **1-833-230-2057 (TTY: 711)** if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

If the standard time frame for review would jeopardize your life or health, you may be able to qualify for an expedited State Fair Hearing. If you qualify for one, MOAHR must give you an answer within 72 hours. However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions, you can call MOAHR at 1-800-648-3397. You can mail or fax the state hearing form to:

Mail: Michigan Office of Administrative Hearings and Rules Michigan
Department of Health and Human Services
P.O. Box 30763
Lansing, MI 48909

Fax: 1-517-763-0146

External Review of Appeals

You, your representative, or your provider can ask for an external review with DIFS under the Patient's Right to Independent Review Act – PRIRA. You must do this within 127 calendar days from the date of your appeal denial notice. An External Review form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. You can submit the form to:

DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal. You can also ask for an External Review if you do not receive a decision from us within the required time frame. You, your Authorized Representative, or your doctor can also request a fast appeal decision from DIFS within 10 calendar days after receiving a final determination. DIFS will decide if the request meets expedited or standard criteria. An Expedited or Fast External Review may be granted if an expedited appeal review has been requested with the plan, the request is filed within 10 days of receipt of adverse determination, and a doctor states a fast review is needed due to risk to the life or health of the member. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

Department of Insurance and Financial Services (DIFS)
Office of Research, Rules, and Appeals - Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Or call: 1-877-999-6442
Fax: 1-517-284-8838
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

Dental Grievance and Appeals

If you have questions about a dental claim, want to file a grievance/complaint call Delta Dental at 1-866-558-0280.

You also have the right to ask Delta Dental to review their denial decision by asking for an internal appeal by calling Delta Dental 1-866-558-0280 or in writing via fax or mail.

Delta Dental
Attn: Medicaid Grievance and Appeals
P.O. Box 9230
Farmington Hills, MI 48333-9230

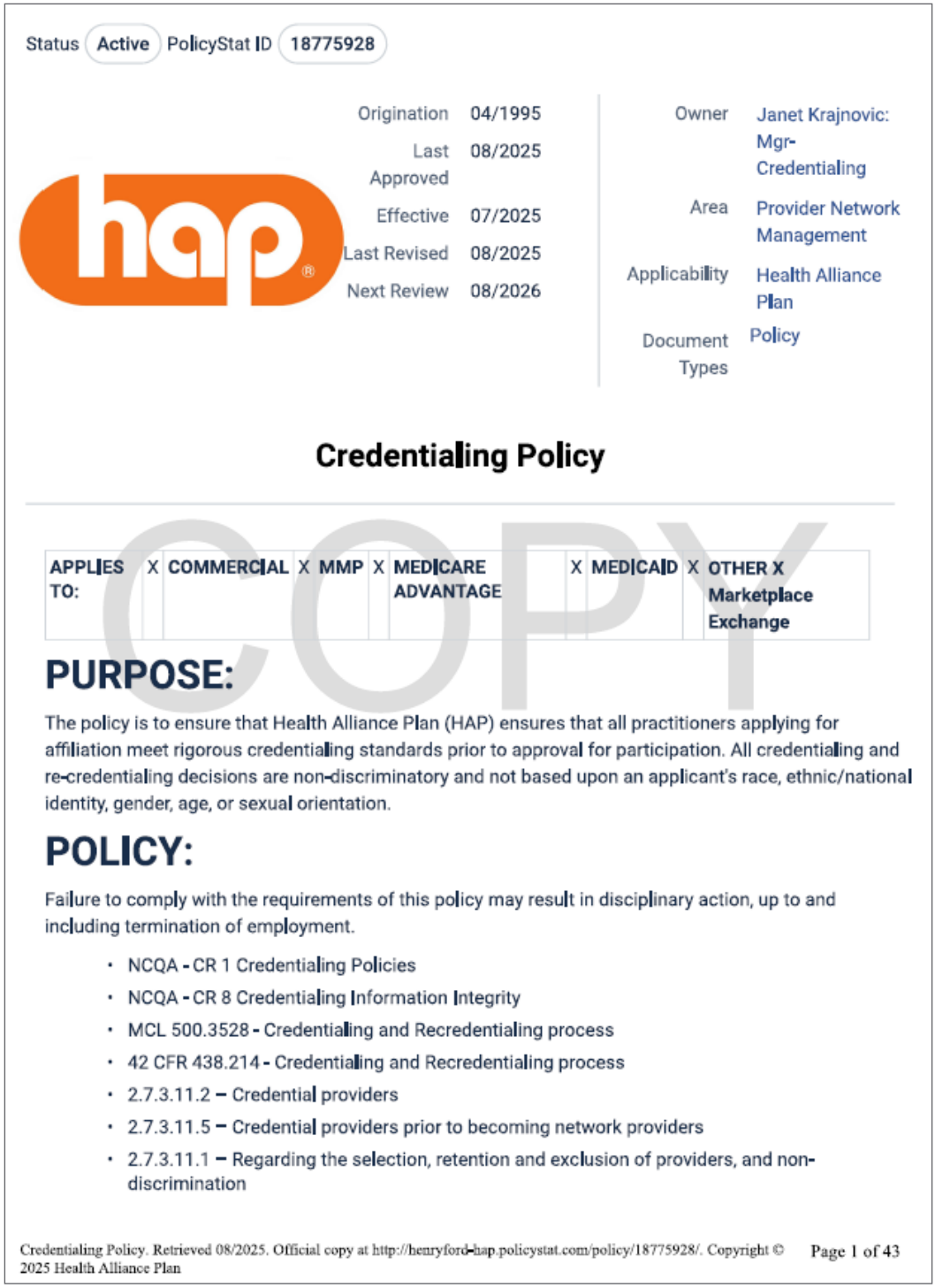
Fax: 517-381-5527

For more information, refer to the member's handbook.

Appendix B

Credentialing Policy and Process

The most up-to-date policies can be found when logging in at HAP.org. You can then select “Policies” under “Resources”



Status Active PolicyStat ID 18775928

Origination	04/1995
Last Approved	08/2025
Effective	07/2025
Last Revised	08/2025
Next Review	08/2026

Owner	Janet Krajnovic: Mgr-Credentialing
Area	Provider Network Management
Applicability	Health Alliance Plan
Document Types	Policy

Credentialing Policy

APPLIES TO:	X	COMMERCIAL	X	MMP	X	MEDICARE ADVANTAGE		X	MEDICAID	X	OTHER X Marketplace Exchange		

COPY

PURPOSE:

The policy is to ensure that Health Alliance Plan (HAP) ensures that all practitioners applying for affiliation meet rigorous credentialing standards prior to approval for participation. All credentialing and re-credentialing decisions are non-discriminatory and not based upon an applicant's race, ethnic/national identity, gender, age, or sexual orientation.

POLICY:

Failure to comply with the requirements of this policy may result in disciplinary action, up to and including termination of employment.

- NCQA - CR 1 Credentialing Policies
- NCQA - CR 8 Credentialing Information Integrity
- MCL 500.3528 - Credentialing and Recredentialing process
- 42 CFR 438.214 - Credentialing and Recredentialing process
- 2.7.3.11.2 – Credential providers
- 2.7.3.11.5 – Credential providers prior to becoming network providers
- 2.7.3.11.1 – Regarding the selection, retention and exclusion of providers, and non-discrimination

Credentialing Policy. Retrieved 08/2025. Official copy at http://henryford-hap.policystat.com/policy/18775928/. Copyright © 2025 Health Alliance Plan

Page 1 of 43

- 2.8.3.11.3 – Recredentialing Performance Monitoring process

DEFINITIONS:

Credentialing: The process of obtaining and verifying credentials.

Recredentialing: The process of reassessing and revalidating the qualifications of an existing provider.

CAQH: The Council for Affordable Quality Healthcare - Provider Data Portal.

Primary Source Verification: The process by which the credentialing departments validate credentialing information.

NCQA: National Committee on Quality Assurance, a non-profit organization dedicated to improving health care quality.

CMS: Centers for Medicare and Medicaid Services

MDHHS: Michigan Department of Health and Human Services

DIFS: Michigan Department of Insurance and Financial Services

PROCEDURE:

HAP has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. This policy is put into place that HAP will comply with NCQA, CMS, State of Michigan, DIFS and all regulatory and accreditation standards in the development and management of Credentialing.

Responsible Party (Who)	Step	Action Taken (Does What)
Manager, Credentialing Department, Credentialing Committee Chair	A	**Types of practitioners to credential and recredential:** This policy applies to practitioners who have an independent relationship including Allopath's (MD), Osteopaths (DO), Dentists (DDS) (only oral and maxillofacial surgeons providing care under medical benefits), Podiatrists (DPM), Chiropractors (DC), Nurse Practitioners (NP) including Psychiatric Nurse Practitioners, Physician Assistants (PA), Certified Nurse Midwives (CNM), Optometrists (OD), fully licensed Psychologists (PhD/PsyD), Master Level Psychologists (LLP), Addiction Medicine Specialists, Master Level Social Workers (LMSW), Licensed Professional Counselors (LPC), Marriage and Family Therapists (MFT), Certified Genetic Counselors (CGC), Board Certified Behavior Analysts (BCBA), and Acupuncturists are credentialed as an exception based on the health

		plan's need. PCP availability: A PCP is described as a MD or DO who is listed as a General Practice, Family Medicine, Pediatrician, or Internal Medicine Practitioner. OB/Gyn practitioners and other specialists may be designated as a PCP if they agree to provide care for all medical conditions. PCPs must provide or arrange for coverage of services 24 hours per day, 7 days per week. PCPs must be available to see patients a minimum of 20 hours per practice location per week. Practitioners who do not need to be credentialed are those who practice exclusively within the inpatient setting and provide care for organization members only as a result of members being directed to the hospital or another inpatient setting, Hospitalists, Critical Care Medicine, Pathologists, Radiologists, Anesthesiologists, Certified Registered Nurse Anesthetists, Neonatologists, and Emergency Department physicians, practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and general dentistry. HAP does not perform provisional credentialing. HAP does not credential locum tenens practitioners.
Credentialing Department, Credentialing Committee Chair	B	**Credentialing Information Integrity: HAP has credentialing information integrity polices and procedures, audits credentialing information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues. HAP maintains and safeguards the integrity of information used in the initial credentialing and recredentialing process against inappropriate documentation and updates.** **Scope of Credentialing Information: HAP specifically protects each of the following types of credentialing information:** • The practitioner application and attestation. • Credentialing documents received from

the source or agent.

- Documentation of credentialing activities:
  - Primary Source Verification (PSV) dates. All PSV"s must be signed, dated and initialed unique indentifier.
  - Report dates (e.g., sanctions, complaints, identified adverse events).
  - Credentialing decisions.
  - Credentialing decision dates.
  - Signature or initials of the verifier or reviewer.
- Credentialing Committee minutes.
- Documentation of clean file approval.
- Credentialing checklist

Staff Responsible for Performing Credentialing Activities:

- The Credentialing Manager, Credentialing Leads, and Credentialing Coordinators are responsible for documenting credentialing activities.
- The Credentialing Manager, Credentialing Leads, and Credentialing Coordinators are authorized to add, modify, edit, and update the credentialing information.
- The Credentialing Manager and Credentialing Leads are authorized to delete credentialing information.
- The Credentialing Chair (HAP Senior Medical Director) is authorized to add, modify, edit, update and delete the Clean File list and the Credentialing Minutes.
- The Credentialing Manager and Credentialing Leads is responsible for oversight of credentialing information integrity functions, including auditing.

Process for Documenting Updates to Credentialing Information:

A. Authorized users may update existing

credentialing information under the following circumstances including, but not limited to:

- Update information during the credentialing or recredentialing process.
- Update information between credentialing cycles.
- Update expired verifications during or between cycles.
- Update practitioner demographics including but not limited to; change in name, address, specialty, and etc.
- Remove erroneous data or documentation.

B. Authorized users are required to update credentialing information according to the following process:

- Date and time the information was updated.
- What information was updated which can include but not limited to correcting typographical errors, changing practitioner information, updating expirables, or deleting information.
- Why the information was updated which can include but not limited to name change, notifications from the state or federal sources, user data entry error, or address change.
- Staff who updated the information by a unique identifier using initials or signature.

Process for Inappropriate Documentation and Updates: The following documentation and updates to credentialing information are inappropriate:

credentialing information under the following circumstances including, but not limited to:

- Update information during the credentialing or recredentialing process.
- Update information between credentialing cycles.
- Update expired verifications during or between cycles.
- Update practitioner demographics including but not limited to; change in name, address, specialty, and etc.
- Remove erroneous data or documentation.

B. Authorized users are required to update credentialing information according to the following process:

- Date and time the information was updated.
- What information was updated which can include but not limited to correcting typographical errors, changing practitioner information, updating expirables, or deleting information.
- Why the information was updated which can include but not limited to name change, notifications from the state or federal sources, user data entry error, or address change.
- Staff who updated the information by a unique identifier using initials or signature.

Process for Inappropriate Documentation and Updates: The following documentation and updates to credentialing information are inappropriate:

- Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
- Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as a new credential).
- Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
- Attributing verification or review to an individual who did not perform the activity.
- Updates to information by unauthorized individuals.

Auditing, Documenting and Reporting Information Integrity Issues:
The Credentialing Manager performs an audit of the credentialing staff documentation and updates at least annually.
If the Credentialing Manager finds inappropriate documentation and updates, the Manager will immediately notify the Credentialing Committee Chair (HAP's Senior Medical Director) and the Director of Provider Network Management by email and schedule a meeting to discuss the audit findings.
The consequences of finding inappropriate documentation and updates depend on the severity of the violation, internal policies and legal requirements. Consequences can include:

- Verbal or written warning for minor, unintentional misuse or first-time-offenses
- Corrective action plan, which requires the employee to correct behavior within a specified time frame
- Termination of employment for serious or repeated violations especially if intentional fraud or misconduct is found.

If fraud or misconduct is identified, the

Credentialing Manager or Credentialing Committee Chair will notify the National Committee for Quality Assurance (NCQA) via the NCQA Reporting Hotline at 844-440-0077 or on-line at https://www.lighthouse-services.com/ncqa.

Information Integrity Training: The Credentialing Manager annually trains the credentialing staff on the following:

- Inappropriate documentation and updates as defined in Element A, Factor 4.
- Auditing, documenting, and report information Integrity issues:
    - Training by the Credentialing Manager informs the credentialing staff of
        - Audits of staff documentation and updates in credentialing files
        - The proces for documenting and reporting inappropriate documentaion and updates by and Credentialing staff member to the Credentialing Manager, Credentialing Committee Chair and the Director of Provider Network Management and NCQA when fraud and midconduct are identified.
        - The consequences for inappropriate documentation and update.
- The Credentialing provides training material to the Credentialing staff and documents when the training occured.

Credentialing Department	C	**Primary source verifications used, how information is received, dated, and stored for credentialing and recredentialing:** The Credentialing Staff uses the following sources to verify credentialing information: Council for Affordable Quality Healthcare Provider Data Portal (CAQH) application, state licensing boards, Drug Enforcement Administration (DEA), NCQA acceptable sources for education, training, and board certification for physicians and non-physicians, and the National Practitioner Data Bank (NPDB) according to the policy discussed below. All primary source verifications (PSV's) are received electronically from the primary source, printed in Adobe PDF, and are stored in the practitioner's credentialing file in a secure location only accessible by the Credentialing Staff at G:HMS/Credentialing/A- Credentialing Virtual File Room. The Credentialing Coordinator and/or Credentialing Lead who verified the primary source information dates and acknowledges receipt and source of information with a unique electronic signature or initials. In addition, the Credentialing Coordinator and Credentialing Lead use a checklist that includes for each PSV, the source used, the data of verification, the signature or initials of the person who verified the information and the report date if applicable. PSV's are documented which includes the name of the NCQA approved source, the date of verification, the unique electronic signature or initials of the Credentialing Coordinator/Credentialing Lead who verified the information and the report date, if applicable.If the PSV is obtained via the Internet the verification will contain the URL address in the header, or footer and clearly identify the source of the primary source verification. The credentialing application which includes PSV documentation, the CAQH application and other documents which complete the credentialing file such as, but not limited to, Credentialing Committee meeting minutes, clean files approval lists, approval and denial letters, and correspondence with practitioners is saved electronically in the secure drive with Adobe PDF. The credentialing file is saved

on a secure drive; G:/HMS/Credentialing which is only accessible by the Credentialing Department and Credentialing Committee Chair. The Credentialing Staff are responsible for maintaining the security of the credentialing documents while processing the file. Documents may not be altered.

Licensure: Verification time limit: 120 calendar days.
HAP verifies a current, valid license to practice and a controlled-substance license as applicable in states where the practitioner provides care to its members is present, is within the prescribed time limit of 120 calendar days and is active at the time of the Credentialing Committee's decision. Practitioner names will be recorded in the credentialing database as verified on the practitioner's state license. The names must match the name as displayed on the state license. Degrees must match what has been verified through primary source verification.

- Obtains Internet verification, oral or written verification directly from the State of Michigan Department **of Licensing and Regulatory Affairs (LARA)** or certification agency.
- Obtains either oral, written, or Internet verification for all other state licenses utilizing the appropriate state-licensing agency.
- Review of information of sanctions, licensures, or scope of practice covers the most recent five-year period available through the data source.
- Information on state sanctioning activity from the State of Michigan Department of Consumer and Industry Services Bureau of Health Services at the time of license verification.

DEA or CDS Certificates: Verification time limit: Prior to the credentialing decision.
HAP verifies a current and valid DEA or CDS certificate with no restrictions or limitations (if applicable) in each state where the practitioner

provides care to members through one of the following. Verification is obtained prior to the credentialing decision. Recent graduates, or fellows applying for initial credentialing or practitioners who move from another state, and their DEA is pending, may have a HAP covering practitioner for up to six months until they obtain their DEA. Documentation will be included in the practitioner's credentialing file who the designated HAP provider will be writing prescriptions on their behalf. The practitioner must notify HAP by email, when their DEA is active and will provide a copy of the DEA. The DEA number, issue date, and expiration date will be data entered in the credentialing software system. The Credentialing Staff will verify and confirm with the DEA agency. The documentation will be saved in the practitioner's credentialing file.

- Confirmation with the state pharmaceutical licensing agency, where applicable
- A copy of DEA or CDS certificate
- Documented visual inspection of the original certificate
- Confirmation with the DEA or CDS agency
- Confirmation with the American Medical Association (AMA) Physician Master File
- American Osteopathic Association Official Osteopathic Physician Profile Report
- The DEA and CDS certificate are not applicable to chiropractors.

Education and Training: Verification time limit: Prior to the Credentialing decision.
Practitioners must have completed at least three years of post-graduate medical education in an approved internship and/or residency program (MD or DO) or DO's with only one-year post-graduate training before 1989 in an approved program and board certification.
Verification of board certification meets the requirement for verification of education and training since medical specialty boards verify both.

HAP verifies the highest of the three levels of education and training obtained by the practitioner prior to the credentialing decision. Graduation from medical or professional school, residency, if appropriate, and board certification, if appropriate. The agencies/authorities recognized at the time of this policy are the following:

- The Accreditation Council for Graduate Medical Education (ACGME)
- American Medical Association (AMA) Physician Master Profile
- The American Osteopathic Association (AOA)
- Royal College of Physicians and Surgeons of Canada
- The American Podiatric Medical Association (AMPA) Council on Podiatric Medical Education
- Graduation from a Commission on Dental Accreditation (CODA) accredited training program – Oral Surgeons
- Completion of an accredited psychologist program with an approved internship/ clinical practice requirement
- Completion of an accredited nurse midwife program, nurse practitioner, clinical nurse specialists with an approved internship/clinical practice requirement
- Chiropractic College
- Graduate from an optometry program that is accredited by the Accreditation Council on Optometric Education (ACOE) of the American Optometric Association (AOA). Optometrists must complete a four-year post-baccalaureate Doctor of Optometry Degree program.
- Completion of a master's degree in social work (MSW) with a major focus of study in the treatment of Behavioral Medicine or equivalent field, as defined by the Michigan Board of Examiners of Social Work.

- Master's Degree from a program approved by the State of Board of Counseling
- Master's or doctoral degree in Psychology (LLP's)
- Doctoral degree in Psychology (Psychology)
- Graduate from an educational program that is accredited by the Commission on Accreditation for Marriage and Family Education (COAMFTE), OR 1) Graduate with a master's or doctoral degree from a regionally accredited institution that includes a) three courses (at least 6 semester or 9 quarter hours) in family studies; b) three courses (at least 6 semester or 9 quarter hours) in family therapy methodology; c) three courses (at least 6 semester or 9 quarter hours) in human development, personality theory, or psychopathology; d) at least 2 semester or 3 quarter hours in ethics, law and standards of professional practice; e) at least 2 semester or 3 quarter hours in research. (Marriage and Family Therapy -MFT)
- Possession of a minimum of a bachelor's and a master's degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine, or a field related to behavior analysis and approved by the Behavior Analyst Certification Board and must obtain the Board-Certified Behavior Analyst Certification.

Board Certification: Verification time limit: 120 calendar days.
HAP verifies board certification and documents the expiration date within the 120 calendar daytime limit including lifetime certification status. If the medical board does not provide the expiration date for a practitioner's board certification, verification of the board certification status and date of verification is documented within the practitioner's file.

Board Certification is verified by one or more of the following HAP recognized agencies/authorities are:

- American Board of Medical Specialties (ABMS Certifacts)
- American Osteopathic Association (AOA) Physician Profile Report
- Royal College of Physicians and Surgeons of Canada
- American Board of Addiction Medicine
- American Board of Genetic Counseling (ABGC)
- American Board of Medical Genetics and Genomics (ABMGG)
- American Board of Sleep Medicine
- American Board of Oral and Maxillofacial Surgery
- American Podiatric Medical Association (APMA)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Lower Extremity Surgery (ABLES)
- American Board of Multiple Specialties in Podiatry (ABMSP)
- American Board of Podiatric Medicine (ABPM)
- American Midwifery Certification Board (AMCB)
- National Commission on Certification of Physician Assistants
- Nurse Practitioners meet the advanced practice certification standards of one of the following certification organizations:

a. American Nurses Credentialing Center (ANCC)
b. American Academy of Nurse Practitioners
c. National Certification Board of Pediatric Nurse Practitioners and Nurses, Inc.
d. National Certification Corporation (NCC) for obstetric, gynecologic, and neonatal

nursing specialties

e. Oncology Nursing certification corporation
f. Pediatric Nursing Certification Board
g. American Association of Critical-Care Nurses

Work History: Verification time limit: 120 calendar days.
HAP obtains a minimum of the most recent five years of relevant work history through the practitioner's application or curriculum vitae within 120 calendar daytime limit. Relevant experience includes work as a health professional. If the practitioner has practiced fewer than five years from the date of verification of work history, the time frame starts at the date of initial licensure. The application or curriculum vitae must include the beginning and ending month and year for each position the practitioner's employment experience. If the practitioner has had continuous employment for five years or more with no gaps in work history providing the year is acceptable.

- Clarify either verbally or in writing each gap in employment that exceeds six months.
- If the gap in work history exceeds one year, the practitioner clarifies the gap in writing.
- Document its review of work history, including any gaps, within the credentialing file.
- Work history can be documented on the application, CV, or checklist. Documentation will include the signature or initials of staff who reviewed work history and the date of review.

Malpractice History: Verification time limit: 120 calendar days.
HAP obtains confirmation of the past five years of history of malpractice settlements from the malpractice carrier or the National Practitioner Databank (NPDB) within 120 calendar daytime limit.

The five-year period may include residency or fellowship years. HAP does not need to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship.

Hospital Affiliation:
HAP verifies all current hospital affiliations as attested to on the application. In the event of a "red flag," previous hospitals affiliations are also verified.

Sanction Information: Verification time limit: 120 calendar days.
HAP reviews and evaluates State sanctions, restrictions on licensure, limitations on scope of practice, and Medicare and Medicaid Sanctions prior to making a credentialing/recredentialing decision. HAP verifies state sanctions, restrictions on licensure and limitation on scope of practice in all states where the practitioner provides to or has provided care to members. for the most recent 5-year period available. If practitioners are licensed in more than one state in the most recent 5-year period, the query will include all states in which they provided care. The practitioner's file will contain sufficient documentation to demonstrate that the credentialing information is present at the time of the credentialing decision within the 120 calendar daytime limit from the following agencies/sources:

- NPDB
- State Medicaid agency or intermediary and the Medicare intermediary
- List of Excluded Individuals and Entities (maintained by the Office of Inspector General (OIG), available over the Internet
- Medicare Exclusion Database
- Michigan Department of Health and Human Services (MDHHS) Sanction Provider List, available over the Internet
- Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel

Management, Office of the Inspector General

- The System for Award Management (SAM) web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits
- The American Medical Association (AMA) Physician Master File entry
- Federation of State Medical Board (FSMB)
- Centers for Medicare and Medicaid Service (CMS) Preclusion Provider List

Application: Verification time limit: 180 calendar days.

CAQH application must include a signed current attestation confirming that the application is to be accurate and complete within the required time frame of 180 calendar days prior to the Credentialing Committee's decision. If the signature attestation exceeds 180 calendar days before the credentialing decision, the practitioner must re-attest that the information on the application is current and complete. The CAQH application is received electronically and saved in an electronic format with the date of receipt. The Credentialing Coordinator is responsible for maintaining the security of the document.

The application must also include the following:

- Reasons for inability to perform the essential functions of the position.
- Lack of present illegal drug use.
- History of loss of license and felony convictions.
- History of loss or limitation of privileges or disciplinary actions.
- Current malpractice insurance coverage.
- Practitioner race, ethnicity and language.
- Current and signed attestation confirm the correction and completeness of the

		application.
Credentialing Coordinators, Credentialing Leads, Credentialing Manager and Credentialing Committee Chair	D	**Authorization to Modify Information:** The Credentialing Coordinators and/or Credentialing Leads in the Credentialing Department are authorized to data enter, review, add, edit, update, and modify credentialing data in accordance with existing procedures. The Credentialing staff may have to modify credentialing data or documentation with the credentialing application. Authorized users may modify under the following circumstances including, but not limited too: • Update information during the credentialing or recredentialing process. • Update information between credentialing cycles. • Update expired verifications during or between cycles. • Remove erroneous data or documentation. **Inappropriate Documentation and Updates: The Credentialing staff identifies that the following documentation and updates to credentialing information are inappropriate:** • Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifying date, ongoing monitoring dates). • Creating documents without performing the required activities (e.g., photcopying a prior credential and update information as a new credential). • Fraudulently altering existing documents (e.g. Credentialing Committee minutes, clean file reports, ongoing monitoring reports). • Attributing verification or review to an individual who did not perform the activity. • Updates to information by unauthorized individuals.

		Inappropriate documentation will be tracked with the existing credentialing software and outcomes of the audits will be reported immediately to the Credentialing Committee Chair and Director of Provider Excellence for review and determination of action. The consequence of said actions depends on the severity of the violation, internal policies and legal requirements. Consequences could include, verbal or written warning for minor, unintentional misuse or first-time-offences. Corrective Action Plan, which requires the employee to correct behaviour within a specified time frame, Termination of Employment for serious or repeated violations especially if intentional fraud or abuse is found. The credentialing information is gathered from PSV's, credentialing application, and documents to support the credentialing application. Only the Credentialing Manager and/or Credentialing Lead are authorized to delete credentialing information. Deletions are only made once data is reviewed, verified to be incorrect or duplicated. This applies to verification source information from credentialing and recredentialing, modified credentialing verification information, all information associated with credentialing/recredentialing of practitioners, includes all credentialing data related to CR 2 - CR5. The credentialing software allows which fields can be added, modified, and/or read only according to the user. All requests for access to the credentialing database and/or secured shared drive are reviewed by the Credentialing Manager to evaluate appropriateness and to determine the security group based on the staff member role. Access is defined based on the user's job function and level of authority to access, modify or delete information. The individual shall be assigned based on job responsibilities. User access within the credentialing software are assigned read, write, and delete capabilities. Each user has a unique identifier and password. These ID's and passwords shall not be shared, or the user may be subject to disciplinary action, including possible termination. If

		access is not granted, the Credentialing Manager will communicate the denial to the requester, including the reason for the denial. The credentialing software system tracks the adds, modifications and/or changes with an audit log. The audit log identifies the staff member who made the data entry, what change was added, modified, and/or deleted, identifies the time the change was made and date the change was made. The report is run monthly. The Credentialing Manager and/or Credentialing Lead review the report regularly to monitor compliance. If there is a discrepancy between the information provided by the applicant and the PSV, the Credentialing Coordinator will follow the policy and process for resolving discrepancies in information which may include contacting the applicant and/or the PSV for clarification. The credentialing information that was modified, includes the documentation, along with the staff who made the change. Documentation is included in the credentialing file must contain the date of the entry and the name/initials of the staff member who made the entry. Only the Credentialing Committee Chair are authorized to access, review, modify, and delete information in the Credentialing Committee meeting minutes to correct inaccuracies such as typographical errors, data, or practitioner information. The clean files approval is by the Credentialing Committee Chair or designee. The Credentialing Committee minutes and clean file approvals are located in a secure drive. The Credentialing Committee Chair has a unique identifier and password.
Credentialing Coordinator, Credentialing Lead, and Credentialing Manager	E	**Credentialing Process Audit and Analysis:** The Credentialing Manager or Credentialing Lead conducts at least annually an audit for inapropriate documentation and updates that include the following. • Falsifying credentialing dates (e.g. liensure dates, credentialing decison dates, staff verifier dates, ongoing

monitoring dates).

- Credentialing documents without performing the required activities.
- Fraudulently altering existing documetns (e.g. credentialing minutes, clean file reports, ongoing moiroing reports)
- Verifications or review to a credentialing staff that did not perform the activity
- Unauthorized individuals making updates to information

The audit universe includes practitioner files for all initial credentialing decisions and all recredentialing decisions made or due during the look-back period. The organization randomly audits a sample of practitioner files from the audit universe using 5% or 50 files, whichever is less. The random sample includes at least 10 credentialing files and 10 recredentialing files.
The Credentialing Manager or Credentialing Lead will review the audit report and audit analysis that include the following:

- Date of the report
- The name and title of the person who conducted the audit
- The 5% or 50 files auditing methodology
- Auditing period (period reviewed)
- File audit universe size
- Audit sample size calculation and audit sample size used
- Audit date
- Audit log (as a referenced attachment) that includes but not limited to the file indentifier and type of credentialing information audited
- Summary of findings for each file that include a rationale for inappropriate documentation and updates
- The number or percentage and total

inappropriate documentation and updates by type of credentialing information

The Credentialing Manager or Credentialing Lead will provide a completed audit report even if no inappropriate documentation and updates were found.

Qualitative Analysis: The Credentialing Manager at least annually conducts a qualitivte analsis of each instance of inappropriate documentation and updates as indentified in the audit to determine the cause. The qualitative analysis report includes the titles fo the credentialing staff involved in the qualitiative analysis and the cause of each finding.

Improvement Actions: The Credentialing Manager will discuss the findings of the audit and analysis with the Credentialing Committee Chair and the Director of Provider Network Management to determine appropriate corrective actions to address all inappropriate documentation and updates indentified in the audit. Documentation will include the non compliant issues, the reason for non-compliance, and the corrective actions taken or planned including dates of actions. The Credentialing Manager is responsible for implementation of corrective actions.

Measure of Effectiveness Follow-Up Audit: The Credentialing Manager audits the effectiveness of corrective actions on findings in the audit within three to six months of the annual audit and draws conclusions about the actions' overall effectiveness. The audit universe includes practitioner files for all credentialing decisions made, or due to be made three to six months after the annual audit. The Credentialing Manager conducts a qualitative analysis if the Credentialing Manager identifies noncompliance with integrity policies and procedures during the follow-up audit.

The Credentialing Manager will conduct the follow-up audit report and analysis to measure corretive action effectivness that include the following:

- Date of the follow-up audit report
- The name and title of the person who conducted the audit
- Auditing methodology
- Auditing period (period reviewed)
- File review universe size
- Audit sample size calculation and audit sample size used
- Audit date
- Audit log (as a referenced attachment) that includes but not limited to the file indentifier and type of credentialing information audited
- Summary of findings for each file that include a rationale for inappropriate documentation and updates
- The number or percentage and total inappropriate documentation and updates by type of credentialing information
- Qualitative analysis if needed
- Analysis of actions' effectiveness that include the non-compliant issues, the corrective actions completed including date of completion, and conclusion.

At the time that the credentialing files are completed, the Credentialing Coordinator who was responsible for completing the file attests that the information is accurate and complete and is documented on the credentialing tracking sheet. The file is then peer reviewed by another Credentialing Coordinator prior to the Credentialing Meeting to ensure all credentialing is completed according to the credentialing policy and signs the credentialing tracking sheet indicating the name and date of the review.

		Prior to the Credentials Committee meeting, the Credentialing Manager and/or Credentialing Lead will review any applications (initial or recredentialing) that is not considered clean to ensure the file is processed in accordance with existing policies and procedures. For any files that were not approved by the Credentialing Committee the file is reviewed by the Credentialing Manager and/or Credentialing Lead to ensure credentialing decisions were made in accordance with existing policies and procedures. To ensure the integrity and security of the practitioner data contained in the credentialing database, to identify areas of non-compliance and ensure policy adherence, various auditing activities will be performed on an ongoing basis. Reviewing job roles and user access annually to ensure system access is still appropriate for scope of job responsibility. An audit log report identifies the user name, the credentialing data field, the audit date and time, the code, and the field name for all adds, updates and modifications made to the credentialing data. The audit report is reviewed by the Credentialing Manager and Credentialing Lead to ensure all policies and procedures are followed and to identify any unusual or inconsistent activity. An audit of all modifications made to the credentialing data to confirm appropriateness of action. In the event of a discrepancy, appropriate steps shall be taken by the Credentialing Manager. Any evidence of inappropriate modifications or deletions made to the credentialing database or information that is not outlined in the policy, the Credentialing Manager will immediately address and take appropriate actions. In order to maintain an accurate credentialing file, modification to data and documentation may be required. The Credentialing staff will complete updates during credentialing and recredentialing as deemed necessary. The Credentialing staff will also update information between credentialing cycles including, but not limited to: correct erroneous data, update expired verifications, update practitioner demographics due to a change in name, address,

		corporation, specialty, and etc. Modifications made in the credentialing system are electronically listed with the user name with a date and time stamp of when the edit occurred. The credentialing staff will also add a note as to why the information was modified. The credentialing software tracks when the information is modified with an audit log, and how the information is modified, and a monthly audit report that tracks the old value and the new value clearly identifying how the data was modified, and who made the modification. The credentialing system audits the user who made the add, modification or deletion. The Credentialing Manager or Credentialing Lead will conduct a monthly system control audit and present the results to the Credentialing Committee at least once per year or as necessary.
Credentialing Department	F	**Criteria for credentialing and recredentialing:** HAP assures that all practitioners applying for affiliation meet rigorous credentialing standards prior to providing care to members. The provider must submit information and documentation of his/her education, qualification and certification which qualifies them to be identified as a specialist in a particular field of medicine. It is anticipated that the services to HAP members, performed by that credentialed specialist, would be consistent with the medical specialty for which the provider applied for and was evaluated and credentialed by HAP. Credentialed specialists are accordingly expected to provide covered services to HAP members that are within the scope of the specialty credentialed by HAP after review of the providers' application. Practitioners will go through the recredentialing process within 36 months of the previous credentialing decision. The recredentialing process will incorporate recredentialing activities as part of the assessment: • Member appeal and grievances • Quality of Care (QOC) and quality of service events • Medical records review at recredentialing

		and on a continuous basis Recredentialing process incorporates various forms of data, including, but not limited to: • Grievance data • Results of quality reviews • Utilization Management (UM) information • Member satisfaction survey results • Performance indicators obtained through your organizations quality improvement plan (QIP) The recredentialing cycle begins with the date of the initial credentialing decision. HAP counts the 36-month cycle to the month, not to the day. If HAP cannot recredential a practitioner within the 36-month time frame because the practitioner is on active military assignment, maternity leave, or a sabbatical, but the contract between HAP and the practitioner remains in place, HAP will recredential the practitioner upon his or her return. HAP will document the reason for the delay in the practitioner's file. It is acceptable to recredential practitioners on leave. HAP will verify that a practitioner who returns from military assignment, maternity leave or a sabbatical has a valid license to practice before he or she resumes seeing patients. Within 60 days of when the practitioner resumes practice, HAP will complete the recredentialing cycle. If a practitioner is given administrative termination for reason beyond HAP's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, HAP may recredential the practitioner as long as it is documented that the practitioner was terminated for reasons beyond HAP's control and was recredentialed and reinstated within 30 calendar days of termination. HAP will initially credential practitioners if reinstatement is more than 30 calendar days after termination. • Completion of a CAQH application.

- Completion of at least three years of post-graduate training in an approved internship and/or residency program (MD or DO) or DOs with only one-year post-graduate training before 1989 in an approved program and board certification.
- Completion of an accredited physician assistant program with an approved internship/clinical practice requirements and hold a current active certification by the National Commission on Certification of Physician Assistants.
- Completion of an accredited nurse midwife program, nurse practitioner, clinical nurse specialists or CRNA program with an approved internship/ clinical practice requirement.
- Nurse Practitioners and Physician Assistants must submit evidence of collaborative or practice agreement between applicant and a designated HAP credentialed physician.
- Graduate from an optometry program that is accredited by the Accreditation Council on Optometric Education (ACOE) of the American Optometric Association (AOA). Optometrists must complete a four-year post-baccalaureate Doctor of Optometry Degree program.
- Completion of a master's degree in social work (MSW) with a major focus of study in the treatment of Behavioral Medicine or equivalent field, as defined by the Michigan Board of Examiners of Social Work.
- **Acupuncturists:** Current Michigan license to practice as an Acupuncturists.
- **Licensed Professional Counselor:** Current Michigan license to practice as a Licensed Professional Counselor Master's degree from a program approved by the State Board of Counseling.
- **Fully Licensed Psychologist:** Current Michigan license to practice as a

Licensed Psychologist. Doctoral degree in psychology from an institution approved by the State of Michigan Board of Psychology

- **Limited License Psychologist/LLP:** Current Michigan license to practice as a Limited License Psychologist. Master's or doctoral degree in psychology from an institution approved by the Michigan Board of Psychology.
- **Board Certified Behavior Analyst (BCBA):** Possession of a minimum of a bachelor's and a master's degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine, or a field related to behavior analysis and approved by the BACB and must obtain BCBA Certification.
- Board certification in the requested area of practice is recommended. Board certification does not apply to chiropractors or psychologists.
- Recent graduates of residency programs who are not board certified at the time of application are encouraged to **attain board certification within four years of completing the training program.**
- Specialties such as OB/GYN and all surgery related specialties are encouraged to **attain board certification within six years of completing the training program.**
- Non-boarded practitioners see Section 4; Process for making credentialing and recredentialing decisions.
- Unrestricted Licensure in the State of Michigan.
- Unrestricted DEA in the State of Michigan or arrangements with a HAP contracted/ credentialed provider with a valid DEA for required prescriptions will be considered for approval or denial at the discretion of the Credentialing Committee. For initial

practitioners or practitioners who move from another state, they may have a covering practitioner for up to six months until they obtain their DEA.

- Affiliation with a hospital, as applicable. Select specialists including Physical Medicine & Rehab, Dermatology, Ophthalmology and Psychology are not required to have an affiliation with a hospital. All others must have hospital affiliations. For PCPs, hospital affiliation is not required if they are able to identify a credentialed contracted practitioner to oversee the care of their members.
- Current malpractice insurance, with at least $100,000/$300,000 coverage. Verify malpractice coverages and amounts from the CAQH application or obtain a copy of the face sheet from practitioner.
- Federal Torte Coverage - In lieu of malpractice insurance for practitioners delivering care at federal facilities, the file must include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage.
- For practitioners requesting assignment of a dual PCP and specialist, each designation must be assigned to a separate network. The request will be approved by the HAP Credentialing Committee.
- Eligible to participate in Medicare and Medicaid and must not be excluded from participation in any governmental healthcare program to include their employees.
- Participate in Medicare and does not appear on the Medicare Opt-Out List.
- Lack of current sanction and/or suspension from Medicare or Medicaid, or Federal Employees Health Benefits (FEHB). Exclusion or sanctions from a federal health care program shall cause an automatic termination as an affiliated practitioner.

		• Cooperation with Quality Management and Utilization Management programs, including a credentialing site visit and medical record-keeping practices review if requested. • Accept the HAP fee schedule as payment in full. • Accept new patients for all contracted product lines. • Favorable professional liability history including malpractice claims history with no more than $500,000 per claim or no more than 5 claims within the past five years. • Not excluded from System for Award Management (SAMS) Exclusion list. • Lack of present illegal drug use. • Attest to any felony convictions. • No unexplained gaps in work history. • Obtain disclosure of Ownership and control of network provider • Lack of fraud, waste, and abuse documentation from Audit Department or FWA Response Team.
Credentialing Manager, and/or Credentialing Lead and Credentialing Committee Chair	G	**Process for making credentialing and recredentialing decisions:** Decision-making is governed by a majority vote of the Credentialing Committee for practitioners who do not meet minimum HAP standards and is nondiscriminatory. Each decision is based upon information, documents and/or evidence created, collected, maintained, or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies Committee decisions will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee in order to encourage candor and careful assessment necessary to effect peer review and quality assurance. All credentialing activities are in compliance with NCQA, State of Michigan Department of Consumer and Industry Services Bureau of Health Services, and all other

applicable laws and regulatory bodies.
The Credentialing Committee considers all applicants, including those who have been granted waivers in the context of all available information. In the case of waivers, the Committee must weigh the lack of adherence to standards with factors such as:

- Perceived value to HAP which merits approval despite failure to meet the standard, and/or
- Perceived professional qualities, which may not be appropriately reflected in the HAP standard requiring board certification and residency training, including:

a. Demonstrated motivation to participate in HAP and follow managed care procedures
b. Special need for practitioners in the geographic area/network
c. Reputation in the community
d. Prominence in the network's managed care organization
e. Professional experience/Continuing Medical Education experience
f. Partnership with current HAP practitioners of perceived exceptional quality

Board certification waivers are reviewed for **initial** applicants only. To be considered for a board certification waiver, the practitioner must request a board certification waiver. A practitioner may be required to submit a letter of recommendation including network need from their (hospital) department chair or three letters of recommendation from HAP contracted and credentialed practitioners. Board certification waivers will be considered for approval or denial at the discretion of Credentialing Committee.
Board certification extensions are granted to recredentialing applicants who provide proof from the board stating they are scheduled to sit for the

		exam. The Credentialing Committee reserves the right for approval or denial of Board certification extensions. Practitioners certificates that expired and who fail to become re-certified, or those practitioners whose board eligible period expired or lapsed and have no plans of certifying or re-certifying must provide a written explanation to Credentialing Committee to continue their affiliation. The Credentialing Committee reserves the right for approval or denial. • The Credentialing Committee may determine that some applicants who meet minimum HAP standards should not be approved for participation, for example: • Lack of demonstrated motivation to participate cooperatively as a practitioner and follow the managed care/quality management procedures • Lack of perceived need for practitioners in the geographic area/network • Unfavorable reputation in the community • Lack of good standing at affiliated hospital • Perceived lack of quality of medical school/residency experience • Failure to comply with the ethics of the profession
Credentialing Manager, and/or Credentialing Lead and Credentialing Committee Chair	H	**Process for managing credentialing files that meet the organization's established criteria:** All credentialing files that do not meet minimum credentialing standards must be reviewed by the Credentialing Committee. Credentialing files that meet minimum credentialing standards, "clean files," are reviewed and approved by the Chair of the Credentialing Committee or an equally qualified practitioner. Medical Director's Review of Clean Files. • The Medical Director reviews and approves all practitioners that meet minimum requirements.

- Practitioner must meet all the following criteria:
  - Current and active license with no restrictions or limitations;
  - Valid NPI number (Type 1);
  - No sanctions or exclusion (State of Michigan or Ohio License to practice, Medicare, Medicaid, CMS Preclusion, FEHB, Sam or OIG);
  - Current and active DEA liscens with no restrictions or limitations (if applicable);
  - Current malpractice coverage at the required level ($100,000/$300,000);
  - No gaps in work history greater than six (6) months (initial credentialing only);
  - Lack of present illegal drug use;
  - Ability to perform the essential functions of the position, with or without accomodation;
  - No felony or misdemeanor convictions;
  - Any claims settled for an amount less than $500,000 or instance where there have been three (3) or more total claims

		settled with the past five (5) years; ▪ No adverse findings on the NPDB or HIPDB; ▪ No restricted hospital privileges or other disciplinary action; ▪ No adverse actions or disciplinary activity by another health plan; ▪ HAP minimum credentialing guidelines met for education, training and board certification; ▪ No reported complaints or potential quality concerns since the previous recredentialing cycle. • The Medical Director's approval is obtained through a handwritten signature or an electronic identifier. • The list of initial and recredentialing clean files is documented in the meeting minutes and the total number of clean files is presented to the Credentialing Committee.
Credentialing Department	I	**Process for delegating credentialing or recredentialing:** The credentialing process for affiliation with HAP may be delegated to another credentialing body if the potential delegate passes the pre-delegated evaluation, along with the approval from the Credentialing Committee and a signed executed mutually agreed upon delegated agreement. In all cases, HAP retains ultimate authority over the process and engages in oversight activities to ensure that minimum standards are applied (Refer to Delegated Credentialing Policy).

Credentialing Committee, Credentialing Committee Chair	J	**Process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner:** To ensure that all credentialing and/or recredentialing decisions are made in a non-discriminatory manner, all applications will be given a fair and impartial review. The Credentialing Committee does not base credentialing decisions on the applicant's race, ethnicity, nationality/country of origin, gender, age, sexual orientation, or types of procedures or patients cared for by the practitioner, but solely on the criteria and process of the credentialing program. All members and guests of the Credentialing Committee sign a statement of confidentiality and nondiscriminatory decision-making on an annual basis as part of their Committee participation requirements. On an annual basis the Credentialing Committee Chair and Credentialing Manager review a random selection of ten (10) initial credentialing and ten (10) recredentialed practitioners files (approved and denied files) to ensure that there is no pattern of discrimination or evidence of individual discrimination.
Credentialing Department	K	**Process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization:** If the information received varies substantially from the information provided on the application, the credentialing staff requests clarification from the practitioner and provides the practitioner an opportunity to amend the erroneous information. Notification of erroneous information is sent to the provider by mail or secured e-mail with the details of what is being requested, where to send the corrections and the time frame. Information will not be shared that is peer-protected or if federal or state law prohibits. Credentialing will document receipt of corrected in the practitioner's credentialing file.
Credentialing Department	L	**Process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 30 calendar days of the committee's decision:** Practitioners are notified within 30 calendar days of

		the Credentialing Committee's decision. Approval notices for initial credentialing are sent via email by a Credentialing team member to the practitioner notifying the practitioner of the committee's decision. Recredentialing approvals do not require notification. Denial notices for initial and recredentialing, with the reason for the denial are sent by a Credentialing team member to the practitioner via certified mail.
Credentialing Committee Chair	M	**Medical director or other designated physician's direct responsibility and participation in the credentialing program:** The HAP Medical Director is responsible for the Credentialing Committee, chairs the Credentialing Committee meetings, and reviews, modifies as needed, and signs clean files and Credentialing Committee Meeting minutes, Credentialing Policies and Procedures, and correspondence to practitioners. The HAP Medical Director ensures that HAP carries out its credentialing activities in the most efficient, effective way possible and that all credentialing activities are in compliance with the Credentialing Policies, NCQA standards, State of Michigan Department of Consumer and Industry Service Bureau of Health Services, and all other applicable laws and regulations. The Medical Director may approve initial and recredentialing files that meet all credentialing criteria or may determine that additional review is necessary by the Credentialing Committee.
Credentialing Department, Credentialing Committee Chair	N	**Process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law:** The Credentialing Department and all members and guests of the Credentialing Committee sign a statement of confidentiality and nondiscriminatory decision-making on an annual basis. Members and guests of the Credentialing Committee will not discuss or share information that was obtained at this meeting, or in preparation or follow-up to the meeting. Information is to be utilized only as it is originally intended. Information, documents and/or evidence created, collected,

		maintained, or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee in order to encourage candor and careful assessment necessary to effect peer review and quality assurance. Credentialing Committee members and guests will not discuss, share, or use any peer review information for any purpose other than peer review. Access to credentials documents will be restricted to authorized credentialing staff, Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee. Active credentialing files (currently in process) and completed credentialing files may only be accessed by the Credentialing Department to protect the accuracy of information gathered from primary sources and NCQA-approved sources in accordance with existing corporate policies and procedures. All credentialing files are electronic and stored in electronic format on a secure server only accessed by the Credentialing Department, password specific to the user, to prevent unauthorized access, changes to and release of credentialing information in accordance with existing policies. Access to the credentialing database is requested via an on line IT request form and approved by the Credentialing Manager. All Credentialing staff are required to change their passwords every 90 calendar days. For maintaining confidentiality, staff will use strong passwords, avoid writing down their password or share their password; but remember it. User ID's and passwords are unique to each user. The Credentialing Department will follow the Password Management Policy, Network Encryption Standard Policy, Confidentiality, and Information Security Policy of Henry Ford Health System, which includes HAP. Upon the termination of a staff member's employment or transfer to another department within the organization that does not require access

		to the credentialing database the user access shall be inactivated no later than close of the business on the employee's last day of work. The request is sent by the Credentialing Manager to the IT Department to disable immediately. The identity of a person whose condition or treatment has been studied in the Committee is confidential and the Committee shall remove the person's name and address from the record before the Committee releases or publishes a record of its proceedings, or its report, findings, and conclusions. Except as otherwise provided, the record of proceedings and the reports, findings, and conclusions and data collected by or for this Committee are confidential, are not public records, and are not discoverable and shall not be used as evidence in a civil action or administrative proceeding. Disclosure of credentialing information is limited to information needed (i.e., name, address, network, specialty, education and training, board certification status, hospital affiliation) for provider directory, provider assignment or on-line directory. Access to credentialing information maintained in the Credentials Department is limited to staff members who are assigned to fulfill the requirements of the department. Members of the Credentials Committee, the Medical Director/ Credentials Committee Chairman, may view information only in the course of active Credentials Committee reviews.
Credentialing Department	O	**The process for confirming those listings in practitioner directories and other materials for members is consistent with credentialing data.** The HAP Information Technology (IT) Department extracts practitioner-specific information including education and training, board certification status, specialty, hospital affiliation, gender, and language information directly from the Credentialing Department secure credentialing data system that is used for member materials and practitioner directories to ensure consistency with the

		information obtained during the credentialing process. The practitioner directory excludes all practitioners that are not independently contracted and credentialed who practice in an inpatient setting. The directory may differ based on member's benefit level. Once the Credentialing Coordinators or Credentialing Team Leads verify all practitioner-specific information (education and training, board certification status, specialty, hospital affiliation, gender, and language information) according to HAP's Credentialing Policy, the Credentialing Staff enters this information into the credentialing system (known as symplr Provider and in the future will be smyplr Payer).
Credentialing Department	P	**Practitioners Rights** HAP notifies practitioners about their right to: 1. Review information submitted to support their Credentialing application. 2. Correct erroneous information. 3. Receive the status of their Credentialing or Recredentialing application, upon request. Practitioners may submit requests to exercise their rights to HAP via email, ProviderNetwork@hap.org or by mail to HAP Credentialing Department, 1414 East Maple Rd. Troy Michigan 48083. **HAP notifies practitioners about their rights to review information from outside sources to support their credentialing application:** It is the practitioner's right to review information obtained from outside sources (e.g., malpractice insurance carrier, State Licensing Board) to evaluate the practitioners credentialing application, attestation, or CV. Each practitioner has the right to review certain information obtained during the verification process. Practitioners do not have the right to review information such as peer-review protected information, recommendations, references, or other information that is considered to be peer-review protected. The practitioner may review credentialing policies

and procedures upon written request.

Correction of erroneous information:
The practitioner may choose to correct erroneous information anytime before the Credentialing Committee meets to discuss the practitioner's file by contacting HAP by email or by mail at 1414 East Maple Rd. Troy, Michigan 48083. The Credentialing Coordinator documents receipt of corrected information in the practitioner's file.
If the information received varies substantially from the information provided on the application, HAP requests clarification from the practitioner and provides the practitioner an opportunity to amend the erroneous information. Notification of erroneous information is sent to the provider by certified mail or secured e-mail.
The practitioner is asked to respond in writing within 14 calendar days of receipt of the certified letter.
The practitioner mails the response to the Credentialing Team member or the Manager of Credentialing by mail to 1414 East Maple Rd. Troy, Michigan 48083.
If the practitioner chooses to exercise his or her right to correct the erroneous information:

- HAP Credentialing will further investigate the primary source information.
- This information, along with the practitioner's response, is presented to the Credentialing Committee for review and resolution if applicable.
- IF the practitioner is approved, the practitioner will be sent a welcome letter by secure email within 60 days of the credentialing approval. if the practitioner is denied by the Credentialing Committee, the practitioner will be sent a certified letter with the reason and date of denial.
- If the practitioner chooses **not** to exercise his or her right to correct the erroneous information, or does not respond within 14 days:

		• The information is presented to the Credentialing Committee for review and resolution, without input from the practitioner. • The practitioner is notified of the committee decision by certified mail.
Credentialing Department	Q	**Upon request, the practitioner receives the status of their credentialing or recredentialing application:** If the practitioner requests the status of his/her application, HAP provides practitioner with the approximate date when the application will be presented to the Credentialing Committee and any outstanding primary source verification letters either by telephone, email, or written correspondence. Practitioners do not have the right to review information such as recommendations, references, or other information that is considered to be peer-review protected.
Credentialing Department	R	**Notification of Practitioner Rights:** HAP notifies practitoners about their right to 1) review information submitted to support their crdentialing application, 2) correct erroneous information, and 3) receive the status of their credentialing or recredentialing application, upon request. HAP notifies practitioners of their rights on the HAP Website, CareSource Website, HAP and CareSource Provider Manuals, HAP Credentialing Policies and Procedures, email correspondence with Credentialing staff, and other sources. Practitioners are notified of these rights upon their initial request for enrollment and on an ongoing basis. Credentialing policies and procedures are made available to all HAP contracted practitioners on an ongoing basis on the provider portal of the website and practitioners are notified annually and offered hard copies of the policies and procedures if web access is unavailable. HAP notifies practitioners of their right to review information obtained from outside sources such as malpractice insurance carrier and state licensing board to support their credentialing applicaton. HAP does not make available references, recommendations, or peer-review protected

		information. HAP notifies practitoners of their right to correct erroneous information such as actions on a license, malpractice claims history, or board certification. The nofication includes the time frame for making corrections, the format for submitting corrections, and where to submit corrections.The time frame for practitioners to make corrections is intially ten calendar days from notification by secure email and, if HAP does not receive corrections from the practitioner during that time, the practitioner receives a second email notification giving an additional ten calendar days to correct the erroneous information. If no corrected information has been received within the twenty calendar days, HAP sends a certified letter to the practtiioner requesting corrections within fifteen calendar days of the date of the letter and indicating that the practitioner's credentialing process will be discontinued if no response is received; the practitioner may reaply in the future. The practitioner may submit corrections via secure email or by mail to 1414 E. Maple Rd, Troy MI 48083 addressed to the Credentialing Coordinator or Team Lead assigned to the practitioner. The Credentialing Coordinator and Credentialing Team Lead documents corrected information in the practitioner's credentialing file. HAP is not required to reveal the source of information that was not obtained to meet verfication requirements or if federal or state law prohibits disclosure. HAP notifies practitioners of their right to be informed of the status of their application, upon request, the information HAP is allowed to share with practitioners such information obtained from outside sources (e.g., malpractice insurance carriers, state licensing boards), and HAP's process for responding to requests for application status. The procedure for responding to requests for application status includes a secure email from the HAP Credentialing Coordinator to the practitioner indicating at what stage the practitioner's file is in the credentialing process.

MONITORING:

At a minimum, monthly reports are generated from the credentialing system or as needed.

REPORTING:

The policy is reviewed at least annually, or more frequently, for accuracy, quality and as new guidance becomes available. An annual Credentialing department report is submitted to the Clinical Quality Management Committee (CQMC) on credentialing productivity, credentialing audits conducted, changes, and major activities. All updates/changes in the credentialing requirements/processes are reviewed and approved by the Credentialing Committee.

Name of Report	Frequency of Report	Owner	What committee or senior leader(s) receives report
Audit Report and Analysis	Yearly	Credentialing Lead/Manager of Credentialing	Credentialing Committee
Clean File Report	Weekly	Credentialing Lead and/or Credentialing Manager	Credentialing Committee Chair
Recredentialing Due Report	Weekly	Credentialing Lead	Credentialing Team and Credentialing Manager
Credentialing Disenrollment Report	Quarterly	Credentialing Manager	Credentialing Committee Chair

Approval Signatures

Step Description	Approver	Date
Compliance Final Review	Johnathan Randle: Dir-Gov't Programs Compliance	08/2025
Medical Director-HCM	Yvonne Sesi: Medical Director-HCM	08/2025
Compliance Initial Review	Irina Shikin: Compl Monitorng & Overst Audit	08/2025
Document Owner	Janet Krajnovic: Mgr-Credentialing	08/2025

Applicability

Health Alliance Plan

Standards

No standards are associated with this document

Provider Performance Improvement Policy

Status Active PolicyStat ID 16080916

Origination	04/1995
Last Approved	09/2024
Effective	09/2024
Last Revised	09/2024
Next Review	09/2025

Owner	Janet Krajnovic: Mgr-Credentialing
Area	Provider Network Management
Applicability	Health Alliance Plan
Document Types	Policy

Provider Performance Improvement Policy

APPLIES TO:	X	COMMERCIAL:	X	MMP:	X	MEDICARE ADVANTAGE:	X	MEDICAID:	X	OTHER:

Purpose:

The Performance Improvement Process (PIP) is used to improve provider performance, when it has been determined that the provider is not meeting standards.

HEALTH ALLIANCE PLAN and its subsidiaries and HAP CareSource has as a well-defined Performance Improvement Process (PIP) to improve provider performance. Behaviors that may lead to the initiation of the Performance Improvement Process include, but are not limited to, failure to comply with HAP's Policies and Procedures, non-compliance with physician profiling performance improvement plan, violation of provider contract, acting in a manner that jeopardizes the health or safety of an enrollee, fraud, waste and abuse or that affects accreditation or licensure. Failure to correct such behaviors may lead to termination (Refer to Termination Policy). Retains the exclusive right to determine the appropriate corrective action based upon the circumstances of each case.

Policy:

This policy is put into place that HAP will comply with regulatory and accreditation standards in the development and management of Credentialing with the following regulatory provisions

- National Committee for Quality Assurance (NCQA) standards:
  - CR 6 Notification to Authorities and Practitioner Appeal Rights
    - Element A: Actions Against Practitioners
- Centers for Medicare & Medicaid Services (CMS)

- 422.504 (A) (5) To operate a quality assurance and performance improvement program and have an agreement for external quality review.

- The Michigan Department of Health and Human Services (MDHHS) guidelines
  - MCL 500.3528 (1) A health maintenance organization shall establish written policies and procedures for credentialing verification of all health professionals with whom the health maintenance organization contracts. A health maintenance organization shall apply these standards consistently.
  - 42 CFR 438.214 Policies and procedures in place for provider selection.
- Michigan Department of Insurance and Financial Services (DIFS)

Definition:

- CMS: Centers for Medicare & Medicaid Services
- DIFS: Michigan Department of Insurance and Financial Services
- MDHHS: The Michigan Department of Health and Human Services
- NCQA: National Committee for Quality Assurance - CR 1, CR 5, CR 7, CR 8
- NPDB: National Practitioner Data Bank
- Provider(s) includes Physicians, Practitioners and Ancillaries

Procedure:

Responsible Party (Who)	Step	Action Taken (Does What)
Credentialing Department Medical Director or designee Credentialing Committee Chair Peer Review Committee Chair	All	**Provider Performance Improvement Process** 1. Performance Improvement Monitors include but are not limited to: quality, fraud, legal actions, inappropriate behavior, noncompliance with HAP contractual obligations,failure to detect and report actual or suspected non-compliance, technical reasons, and all of HAP's Policies and Procedures. The Performance Improvement Process is overseen by the Peer Review Committee and generally consists of three levels, including an initial verbal notification to the provider, followed by written notification. 2. The Performance Improvement Process is triggered when a provider accumulates three (3) Performance Improvement Monitors covering the period of 24 months. • The Credentialing Committee Chair, Medical Director or designee will issue a letter reminding the provider of the need to comply with HAP Policies and Procedures, contractual requirements and applicable laws. The letter will be sent by

Responsible Party (Who)	Step	Action Taken (Does What)
		certified mail or secured email and requires the provider to submit a performance improvement plan (PIP) within 10 working days. • If the provider is required to follow-up with a HAP Clinical Pharmacist as part of the PIP, the provider must do so within 10 business days of submitting the PIP. Additionally, the provider must respond to any follow-up pharmacy requests within 5 business days of the request. • If, after the initial reminder, another incident occurs, the Medical Director or designee will speak with the provider, which will serve as a First Notification communication. The Medical Director will send written confirmation of this notification and advise the provider that further non-compliance may result in a Second or Third Notification letter and, ultimately, termination, contract termination and reporting to the National Practitioner Data Bank (NPDB). • Second and Third Notifications are formal notices to the provider outlining the behavior that needs to change and advising the provider that additional noncompliance may result in termination, contract termination, and reporting to the NPDB. 3. Termination may occur at any point in the PIP and is not dependent on completing all three (3) levels. 4. During the PIP, the provider may receive copies of HAP's Policies and Procedure's upon request. 5. The Credentialing Committee Chair or HAP designee keeps record of all levels of PIP action and reports monthly to the Peer Review Committee. 6. The Peer Review Committee will review PIP actions and determine when a provider has successfully completed the PIP plan. The Credentialing Committee Chair, Medical Director, or designee will notify the provider in writing within thirty (30) calendar days of the Peer Review Committee's decision. The Credentialing Manager, or designee will place the documentation in the provider's file. 7. If the Credentialing Committee referred the case to a Peer Review Committee, the Credentialing Committee Chair or designee will then also notify the Credentialing Committee of

Responsible Party (Who)	Step	Action Taken (Does What)
		the successful completion of the PIP Plan. 8. If the provider does not respond to the Notifications or comply with the Process Improvement Plan, the Manager or designee brings the case to the Peer Review Committee for disposition. The Peer Review Committee shall recommend termination and will forward the case to the Chair of the Credentialing Committee. Providers who are terminated by the Credentialing Committee may not reapply for a minimum of seven (7) years across all HAP product lines and must show proof of corrected behavior and standards. 9. In the event that inappropriate activity reoccurs with a provider who has already gone through a PIP plan, including, but not limited to, failure to follow-up with a HAP when requested to do so, the Peer Review Committee reserves the right to recommend termination immediately to the Credentialing Committee. 10. Communications with the provider, including PIP Plan and follow up, remains in the provider's file at least seven (7) years.

Monitoring:

Quality Review Monitoring:

Policy is reviewed annually for accuracy and quality

Policy Monitoring:

Provider Network Management's Regulatory Policy review (including standards and regulatory requirements and references) must include review of standards at least annually, or more frequently as new guidance becomes available

Reporting:

Name of Report	Frequency of Report	Owner
No reporting	Quarterly	Manager, Credentialing

ATTACHMENT(S):

n/a

Approval Signatures

Step Description	Approver	Date
Compliance Final Review	Johnathan Randle: Dir-Gov't Programs Compliance	09/2024
Medical Director-HCM	Yvonne Sesi: Medical Director-HCM	09/2024
Compliance Initial Review	Irina Shikin: Compl Monitorng & Overst Audit	09/2024
Document Owner	Janet Krajnovic: Mgr-Credentialing	09/2024

Applicability

Health Alliance Plan

Standards

No standards are associated with this document

Termination of Providers Policy

Status Active PolicyStat ID 16223541

Origination	04/1995
Last Approved	09/2024
Effective	09/2024
Last Revised	09/2024
Next Review	09/2025

Owner	Janet Krajnovic: Mgr-Credentialing
Area	Provider Network Management
Applicability	Health Alliance Plan
Document Types	Policy

Termination of Providers Policy

APPLIES TO:	X	COMMERCIAL:	X	MMP:	X	MEDICARE ADVANTAGE: X	X	MEDICAID:	X	OTHER:

HEALTH ALLIANCE PLAN and its subsidiaries HAP CareSource may terminate the privileges of a HAP provider when HAP determines that the provider has failed to comply with HAP's Credentialing Policies and Procedures, violated his/her contract; or has acted in a manner that jeopardizes the health or safety of HAP members; failure to report instances of non-compliance, failure to assist in the resolution of compliance issues, fraud, waste or abuse; or affects HAP's accreditation or licensure. This policy applies to providers credentialed by HAP or by a delegated credentialing entity.

This policy applies to providers credentialed by HEALTH ALLIANCE PLAN and its subsidiaries HAP CareSource or by a delegated credentialing entity.

Policy: Termination of Providers

This policy is put into place that HAP will comply with regulatory and accreditation standards in the development and management of Credentialing with the following regulatory provisions. Failure to comply with the requirements of this policy may result in disciplinary action, up to and including termination of employment

- National Committee for Quality Assurance (NCQA) standards
  - CR 4 Element A: If the organization does not have the necessary information for recredentialing, it informs the provider/practitioner that this information is needed at least 30 calendar days before the recredentialing deadline and that without this information, the practitioner will be administratively terminated.
  - CR 5 Element A Factor 4: The organization implements interventions based on its

policies and procedures if there is evidence of poor quality that could affect the health and safety of its members.

- CR 6 Element 1: Specify that the organization reviews participation of practitioners whose conduct could adversely affect members' health or welfare, specify the range of actions that may be taken to improve practitioner performance before termination and specify that the organization reports its actions to the appropriate authorizes.
- CR 8: NCQA requires an unbroken string of recredentialing at least every 3 years. If an organization can obtain files from the delegate, it is not required to start over with initial credentialing; it may continue the process begun by the delegate and recredential practitioners when they are due.

- Centers for Medicare & Medicaid Services (CMS) guidelines
  - eCFR :: 42 CFR Part 489 Subpart E – Termination of Agreement and Reinstatement After Termination
- Michigan Department of of Health & Human Services (MDHHS) guidelines
  - SECTION 6 – Denial of Enrollment, Termination, and Suspension

Definition:

- CMS: Centers for Medicare & Medicaid Services
- MDHHS: Michigan Department of Health & Human Services
- NCQA: National Committee for Quality Assurance

Procedure:

Responsible Party (Who)	Step	Action Taken (Does What)
Credentialing Department Medical Director and/or Designee Credentialing Committee Chair Quality Management	All	**Practice/Procedure/Requirements for Compliance:** 1. HAP may terminate a provider at any time upon the decision of the HAP Credentialing Committee. 2. There may be occurrences that necessitate the immediate review of a provider's continued affiliation prior to the regularly scheduled recredentialing review. 3. In cases in which the provider loses his or her license to practice medicine, appears on the Office of the Inspector General's list, Sanction listing or acted in a manner that jeopardizes the health or safety of HAP members, the Chair of Credentialing Committee or Credentialing Manager or designee shall recommend immediate termination of the provider's affiliation. 4. The following situations can result in termination including, but not limited to: **Violation of HAP's Quality Management Standards** (including but not limited to):

Responsible Party (Who)	Step	Action Taken (Does What)
		• Any action or omission to act that results in serious harm to a patient or is below the community or national standard of care (e.g., wrongful surgery, avoidable death) • Any action or omission to act that does not result in serious harm or death to the patient but is regarded by the Credentialing Committee as not meeting the HAP standard of care including, but not limited to: a. Failure to comply with published HAP clinical, preventive and pharmacy guidelines, b. Failure to obtain medical consultation for patients with behavioral problems when indicated, c. Peer review issues, d. Any utilization management issues indicative of quality problems, including pharmacy e. General member complaints, f. Excessive complaints, g. Refusal to allow members to participate in disease management programs for which they qualify, including pharmacy h. Refusal to allow members to participate in case management programs for which they qualify, i. Refusal or failure to participate in quality management programs including case and disease management programs, j. Refusal or failure to implement quality improvement plan(s) requested by a HAP Clinical Pharmacy Specialist within 10 business days of the initial request (as outlined in the Provider Performance Improvement Process policy). This includes, but is not limited to, disease re-assessment and/or adjustment of drug therapy within 10

Responsible Party (Who)	Step	Action Taken (Does What)
		business days of notification of the quality issue, in the event that the provider wishes to resolve the issue without the assistance of Pharmacy Specialists, k. Failure to collect and provide data requested by HAP related to quality investigations, HEDIS, regulatory regulations, and disease management programs, l. Site visit reviews that consistently remain at minimum levels or refusal to submit a corrective action plan to improve site visit scores, m. Refusal to allow a site visit to occur, n. Poor quality charting, o. Failure to provide twenty-four (24) hour, seven (7) days a week availability to members, p. Failure to have back-up coverage by a contracted physician, q. Failure to respond to requests for any information related to UM or QM cases, including requests from HAP Clinical Pharmacists, within 5 business days of the request. 5. Three or more episodes of violation of HAP's Utilization Management Standards (including, but not limited to): • Noncompliance with HAP's authorization process for inpatient admissions, outpatient procedures, referrals, or pharmacy team, or • Refusal to work with managed care coordinators, the transfer team, or case managers regarding coordination of care, • Referral of members to non-contracted providers, or • Refusal or failure to demonstrate participation in utilization management programs. • Failure to show reduced variation related to

Responsible Party (Who)	Step	Action Taken (Does What)
		misuse, overuse, and underuse after HAP Medical Director implement a Performance Improvement Process. 6. Actions related to fraud, waste or abuse, legal sanctions. or unethical behavioral (including, but not limited to): • Intentional misrepresentation of facts, • Inappropriate billing practices including permitting any other provider to bill using the provider's name or inappropriate referral practices, • Violation of any law that affects the ability of the provider or HAP to participate in any state or federal health care program including Medicare and Medicaid, or • Sanction by the Office of the Inspector General. • Termination of Provider Agreement; The Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) • Sanction by Medicare and/or Medicaid • Sanction by CMS Preclusion list • Debarments and Suspensions from the Federal Employees Health Benefits Program (FEHB) 7. Abusive behavior or outrageous conduct (including, but not limited to): • Sexual relations with a patient, patient's family member, patient's caregiver, or • Profane or rude language toward patients or staff, • Unprofessional conduct. 8. Compliance with contractual obligations (including, but not limited to) • Failure to comply with contractual requirements to provide at least ninety (90) calendar days' notice before transferring networks. 9. Administrative Reasons (including, but not limited to): Administrative Terminations is not a professional review action as defined in HAP's Credentialing Policies; there is no

Responsible Party (Who)	Step	Action Taken (Does What)
		opportunity for a peer review appeal process. As a courtesy, HAP will permit appeal of the decision by meeting with Medical Director at a mutually agreed upon date and time. You must request the meeting within 30 days of your receipt of termination letter. • Failure to submit required recredentialing document as requested within thirty days (30) calendar days of the recredentialing due date. • Failure to appear before the Credentialing Committee within sixty (60) calendar days of the date of the written request to appear. 10. The Medical Director, Chair of the Peer Review Committee, or other HAP department staff may refer a case for potential termination to the Chair of the Credentialing Committee who may refer the case to the Peer Review Committee. 11. The Chair of the Credentialing Committee may place the provider on a corrective action plan for a maximum of six (6) months in order to resolve the issue. 12. The Credentialing Committee reserves the right to close the provider's panel to all lines of business during the corrective action period. 13. The Credentialing Committee upon a majority vote can do any of the following: • Recommend termination, • Convene an ad hoc panel of at least three (3) physicians consisting of at least one HAP Medical Director and at least two same-specialty peers who are not economically competitive with the provider and have no personal interest, • Recommend a corrective action plan, see Performance Improvement Process) policy or, • Recommend any other action deemed appropriate by the Committee based on the circumstances of the case. 14. If an ad hoc panel reviews the provider's file, any recommendations of this panel are forwarded to the Credentialing Committee for final determination. 15. If the provider is terminated, the Credentialing Committee

Responsible Party (Who)	Step	Action Taken (Does What)
		notifies the provider in writing by certified mail, of the decision within thirty (30) calendar days of the decision. 16. Provider Contracting gives the provider a ninety (90) calendar day termination notice with consideration of continuity of care (COC) needs (See Policy on Ongoing Course of Treatment) except in cases requiring immediate termination. Member Services to be notified for PCP re-assignment. 17. The letter to the provider or contract holder includes: • Reasons for the action, • Standards and/or the profiling data used to evaluate the provider if used, and • Appeal rights. 18. Clinical Care Management and Referral Management will be notified if the physician termination is due to failure to meet applicable quality standards or fraud for activation of the continuity of care process. 19. The Chair may seek legal advice any time during the corrective action period and/or termination process. After receipt of such advice, the Credentialing Committee will review and make final decision. 20. Providers who are terminated by the Credentialing Committee for reasons other than administrative termination or for not meeting minimal criteria **may not** reapply for a minimum of seven (7) years across all HAP product lines and must show proof of corrected behavior.

Monitoring: The policy is monitored by credentialing data reports, the Credentialing Committee, Medical Director and Peer Review Committee.

Quality Review Monitoring:

Policy is reviewed annually for accuracy and quality

Policy Monitoring:

Provider Network Management's Regulatory Policy review (including standards and regulatory requirements and references) must include review of standards at least annually, or more frequently as new guidance becomes available

Reporting:

Name of Report	Frequency of Report	Owner
Terminated providers	Quarterly	Manager, Credentialing

ATTACHMENT(S):

Credentialing Committee, Credentialing Department Employees are responsible for reporting any observed violations of this policy to the Office of Compliance.

Approval Signatures

Step Description	Approver	Date
Compliance Final Review	Johnathan Randle: Dir-Gov't Programs Compliance	09/2024
Medical Director-HCM	Yvonne Sesi: Medical Director-HCM	09/2024
Compliance Initial Review	Irina Shikin: Compl Monitorng & Overst Audit	09/2024
Document Owner	Janet Krajnovic: Mgr-Credentialing	09/2024

Applicability

Health Alliance Plan

Standards

No standards are associated with this document

Appendix C

State-Mandated Requirements

Providers participating in HAP CareSource MI Coordinated Health must comply with the following provisions as required by the Michigan Department of Health and Human Services (MDHHS) through HAP CareSource's contract with the State:

Provider Responsibilities

- Providers must participate with and submit eligible member data to the Michigan Care Improvement Registry (MCIR). HAP CareSource will offer training and educational materials to provider to facilitate this process.
- Providers must meet MDHHS standards for timely access to care and services under HAP CareSource's contract with the State, including standards identified in Appendices D and N of that contract, and taking into account the urgency of the need for services.
- Providers must not charge eligible members for any Medicaid covered services or Supplemental Services rendered by provider. This includes circumstances in which provider fails to obtain necessary referrals or preauthorization or fails to perform other required administrative functions.
- Providers must comply with all applicable EMTALA obligations and not create any conflicts with hospital actions required to comply with EMTALA.
- PCPs and specialty providers must provide coverage for their respective practices 24 hours a day, 7 days a week, and have a published after hours telephone number; voicemail alone after hours is not acceptable.
- Providers must adhere to the Medicaid Provider Manual.
- Providers acknowledge that MDHHS-OIG has the authority to conduct post-payment evaluations of claims paid by HAP CareSource.
- Providers must follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL §§24.2 et seq. and MCL §§ 24.3 et seq. for post-payment evaluations conducted by MDHHS-OIG.
- Providers must provide MDHHS representatives and authorized federal and State personnel, including but not limited to MDHHS-OIG, the Michigan Department of Attorney General, the U.S. Department of Health and Human Services, the U.S. Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized State or federal agency immediate and complete access to all records pertaining to services provided to Michigan Medicaid members, without first obtaining authorization from the member to disclose such information (42 C.F.R. §§ 455.21 and 431.107).
- Pursuant to 42 C.F.R. § 438.602(b)(1), Providers must enroll with the Michigan Medicaid Program via the State's Medicaid Management Information System.
- Providers must comply with applicable requirements of 42 C.F.R. §§ 422.504, 423.505, 438.3(k), 438.208 and 438.230(b), which are incorporated into this Manual by reference.
- Providers must comply with all applicable Medicare laws, regulations, and CMS instructions.
- Providers must comply with all applicable obligations under HAP CareSource's contract with the State.
- Providers acknowledge that MDHHS or its designee has the right to audit, evaluate, and inspect books, contracts, computers, or other electronic systems, including medical records and documentation of providers.

- Providers acknowledge that MDHHS or its designee has the right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Providers must not to hold an eligible member liable for payment of any fees that are the obligation of HAP CareSource.
- Providers must perform all services and other activities in accordance with HAP CareSource's contractual obligations to CMS and MDHHS.
- Providers acknowledge that HAP CareSource may revoke the delegation activities and reporting requirements or avail itself of other remedies in instances where MDHHS or HAP CareSource determines that providers have not performed satisfactorily.
- Providers acknowledge that their performance will be monitored by HAP CareSource on an ongoing basis and that HAP CareSource may impose corrective action as necessary.
- Providers must safeguard members' privacy and the confidentiality of members' health records.
- Providers must comply with all Federal and State laws, regulations, and MDHHS instructions.
- Any providers delegated for credentialing of medical providers acknowledge that either the credentials of affiliated medical professionals will be reviewed by HAP CareSource, or the credentialing process will be reviewed and approved by HAP CareSource, and HAP CareSource will audit the credentialing process on an ongoing basis.
- Providers acknowledge that HAP CareSource retains the right to approve, suspend, or terminate any arrangement involving the selection of providers.
- Providers acknowledge that neither HAP CareSource nor the provider has the right to terminate a provider contract without cause. Providers must give at least 60 calendar days' notice of termination to HAP CareSource, and providers must assist with transitioning eligible members to new providers, including sharing members' medical records and other relevant member information as directed by HAP CareSource or the member.
- If HAP CareSource terminates a provider's contract, HAP CareSource will issue a written statement to a provider stating the reason or reasons for termination with cause.
- HAP CareSource will pay providers under the terms of the contract between HAP CareSource and such provider. HAP CareSource will comply with prompt payment terms pursuant to the provider contract and this Manual.
- Providers must provide services in a culturally competent manner to all eligible members, including those with limited English proficiency or reading skills and diverse culturally and ethnic backgrounds.
- Providers must abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records and other health and enrollment information.
- Providers must ensure that medical information is released in accordance with applicable Federal or State laws, or pursuant to court orders or subpoenas.
- Providers must maintain enrollee medical records and information in an accurate and timely manner.
- Providers must ensure timely access by members to the records and information that pertain to them.
- Providers acknowledge that eligible members must not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to eligible members.
- Providers, whether or not a PCP, must not close or otherwise limit acceptance of eligible members as patients unless the same limitations apply to all commercially insured members.

- HAP CareSource will not refuse to contract or pay an otherwise eligible provider for the provision of covered services solely because such provider has in good faith:
  - Communicated with or advocated on behalf of one or more of its prospective, current or former patients regarding the provisions, terms or requirements of HAP CareSource's health benefit plans as they relate to the needs of such provider's patients; or
  - Communicated with one or more of its prospective, current, or former patients with respect to the method by which such provider is compensated by HAP CareSource for services provided to the patient.
- Providers are not required to indemnify HAP CareSource for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, or court costs and any associated charges, incurred in connection with any claim or action brought against HAP CareSource based on HAP CareSource's management decisions, utilization review provisions, or other policies, guidelines, or actions.
- Providers must comply with HAP CareSource's requirements for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services.
- HAP CareSource will notify providers in writing of modifications in payments, modifications in covered services, or modifications in HAP CareSource's procedures, documents, or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of provider. Such notice will state the effective date of the modifications and will be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon between HAP CareSource and provider or unless such change is mandated by CMS or MDHHS without 30 calendar days' prior notice.
- Providers must not bill eligible members for charges for covered services other than pharmacy co-payments, if applicable.
- No payment will be made by HAP CareSource to a provider for a provider preventable condition.
- As a condition of payment, provider must comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by HAP CareSource. Provider must comply with such reporting requirements to the extent provider directly furnishes services.
- The agreement between HAP CareSource and a provider will not include incentive plans that include a specific payment to a provider as an inducement to deny, reduce, delay, or limit specific, medical necessary services.
- Providers must not to profit from provision of covered services that are not medically necessary or medically appropriate.
- HAP CareSource will not impose a financial risk on provider for the costs of medical care, services, or equipment provided or authorized by another physician or health care provider, including with respect to the following:
  - Stop-loss protection;
  - Minimum patient population size for a physician or physician group; and
  - Identification of the health care services for which a physician or physician group is at risk.
- For providers that contact with HAP CareSource for laboratory testing sites providing services, such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

H4193_MI-SNP-P-4050176_C