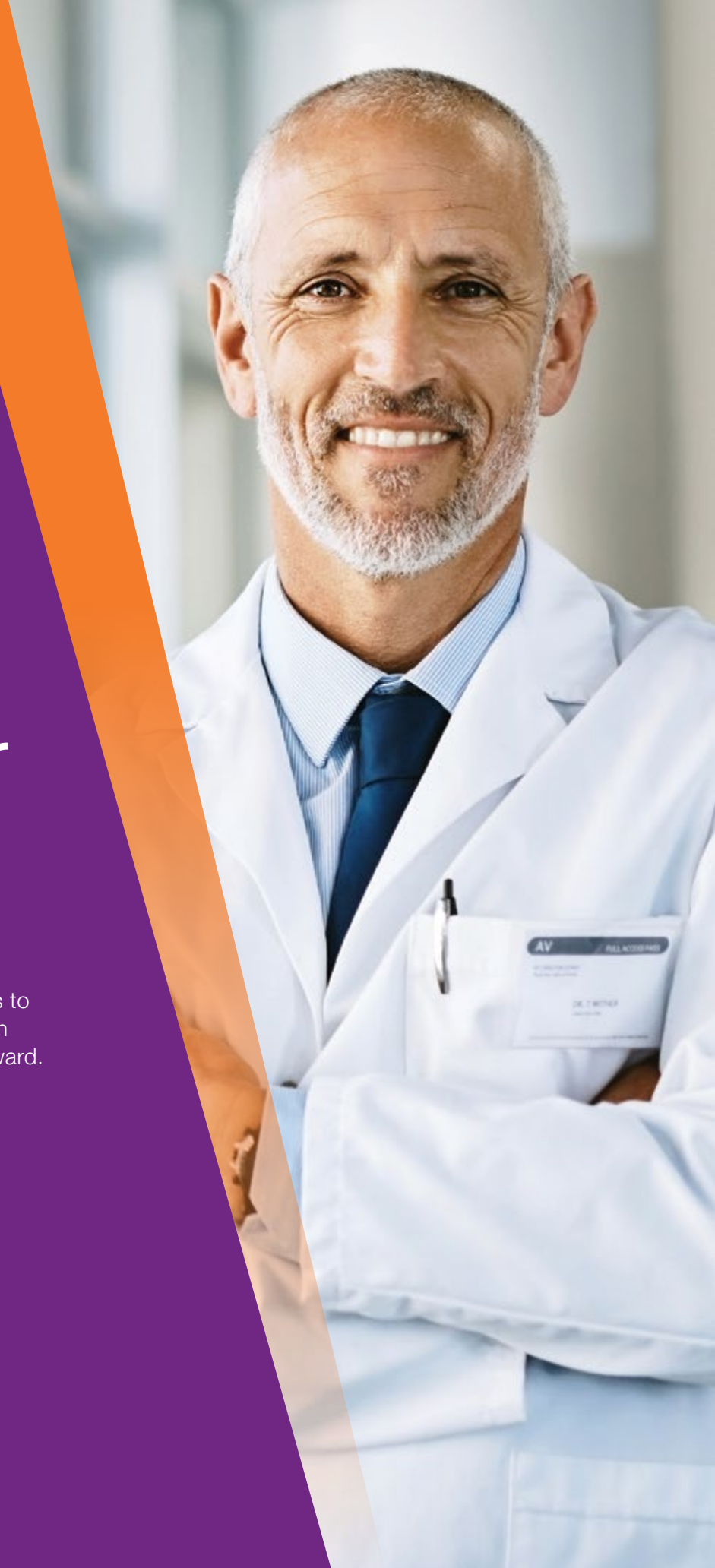
Provider Manual

The material in this manual applies to HAP CareSource Marketplace Plan effective January 1, 2025 and forward.

January 2025

HAP CareSource™



This content has been reviewed; however, changes and/or revisions occur frequently. Providers should check the Provider Manual and Updates & Announcements pages on **HAPCareSource.com** for the most up-to-date information.

Dear HAP CareSource™ Provider,

Thank you for your participation. HAP CareSource™ values our relationships with our providers, and we are actively working to make it easier for you to deliver quality care to our members.

Members enrolled in our Marketplace plans pay any premiums and cost-sharing amounts (deductibles, coinsurance, copayments, etc.) that apply to their coverage based on plan selection and subsidy level. Our Marketplace plans help provide members with stability, peace of mind and affordable health care with heart – allowing members to select the plan which best meets their needs.

This manual is a resource for working with our plan. It communicates policies and programs and outlines key information such as claims submission, reimbursement processes, authorizations, member benefits and more to make it more efficient for you to do business with us. This manual is available on **HAPCareSource.com** > Providers > Tools & Resources > Provider Manual. You may also request a hard copy of the manual by calling **Provider Services at 1-833-230-2101**. Our hours of operation are Monday through Friday from 8 a.m. to 6 p.m. Eastern Time (ET).

HAP CareSource communicates updates to our provider network regularly at **HAPCareSource.com** > Providers > Tools & Resources > Updates & Announcements. You can also find the most up-to-date information on our HAP CareSource Provider Portal at HAPCareSource.com. In an effort to better support our providers and offer an immediate response to questions, concerns and inquiries, we offer claims, policy and appeals assistance through our call center.

To support our providers, we have a dedicated Customer Care team to assist with questions and concerns. Additionally, an external team of specialists are available to provide onsite training and work with our providers in their communities.

We know great health care begins with you. Together, we can help attain better outcomes for our HAP CareSource members.

Sincerely,

HAP CareSource™

HAP CareSource™

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About HAP CareSource

Welcome

Welcome, and thank you for participating with HAP CareSource.

We look forward to working together to ensure that our members – your patients – can improve their health and well-being. Because you're our partner, we strive to make it simple for you to do business with us. This manual directs you to the solutions you need, whether that's through convenient online self-service solutions, fast prior authorizations and/or hassle-free claims payments. Our strong partnership allows us to work together to facilitate a high level of care and a respectful experience for our members.

We are a nonprofit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy.

As a managed health care organization, we improve the health of our members by utilizing a contracted network of high-quality participating providers. Primary care providers (PCPs) within the network provide a range of services to our members and can also coordinate patient care by referring them to specialists when needed, ensuring that members have timely access to health care services and receive all appropriate preventive services.

HAP CareSource distributes the member rights and responsibilities statements to the following groups upon their enrollment and annually thereafter:

- New members
- Existing members
- New providers
- Existing providers

About Us

HAP CareSource was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a nonprofit, we are mission-driven to provide quality care to our members. We offer process efficiencies and value-added benefits for our members and participating providers.

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 and 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 www.hap.org.

About HAP CareSource

HAP CareSource is a nonprofit, nationally recognized managed care organization with over two million members. Headquartered in Dayton, Ohio since its founding in 1989, HAP 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, HAP 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: www.HAPCareSource.com, follow @HAPCareSource on X (formerly Twitter), or like HAP CareSource on Facebook.

Mission Statement

HAP CareSource's Family of Plans, which include Marketplace, Medicaid and MI Health Link, are committed to providing excellence with our product lines for our members through fiscally responsible programs that ensure access to and the delivery of cost-effective and high-quality medical services.

Our Services

- Provider relations
- Provider services
- Member eligibility/Enrollment information
- Claims processing
- Credentialing/Recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory/Compliance
- Special investigations for fraud, waste, and abuse
- Member services, including a member call center with HAP CareSource as well as our benefit managers:
  - Pharmacy: Express Scripts, Inc.

In addition to the functions above, our Care Management programs include the following:

- Low, medium, and high-risk/complex case management – a "no wrong door" referral intake

- Telephonic case management
- Transition of Care Program
- Disease management for
  - Cancer and Cancer prevention
  - Diabetes and Diabetes prevention
  - Depression and Depression prevention
  - HIV, AIDS and HIV prevention
  - Sepsis/Chronic wounds
  - And others based on member needs
- Preventive health and wellness assistance with focused health needs/risk assessment
- Emergency department diversion – high emergency department utilization focus (targeted at members with frequent utilization)
- Maternal and child health
  - Dedicated neonatal intensive care unit (NICU) case management nurses
  - Comprehensive prenatal, postpartum and family planning services
  - Outreach programs in partnership with community agencies to target members at greatest risk for preterm birth or complications
- Behavioral health and substance use disorder (SUD)
- Collaboration with pharmacy and medication therapy management (MTM)

For more information on these programs, see the **"Member Support Services"** chapter of this manual.

Compliance and Ethics

At HAP CareSource, we serve a variety of audiences – members, providers, government regulators, community partners and each other. We serve them best by working together with honesty, respect and integrity. Our Corporate Compliance Plan, along with state and federal regulations, outline the personal, professional, ethical and legal standards we must all follow.

Our Corporate Compliance Plan is an affirmation of HAP CareSource's ongoing commitment to conduct business in a legal and ethical environment. It has been established to:

- Formalize HAP CareSource's commitment to honest communication within the company and within the community
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state and federal laws and regulations
- Implement a system for early detection and reporting of noncompliance with laws, regulations or HAP CareSource policy

This allows us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties, and criminal sanctions.

HAP CareSource's Corporate Compliance Plan is a formal company policy that outlines how everyone who represents HAP CareSource should conduct themselves. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as providers, consultants and vendors. All providers are required to review and comply with HAP CareSource's corporate compliance plan, located at **HAPCareSource.com** > About Us > Legal > Corporate Compliance.

General Compliance And Ethics Expectations Of Providers

- Act according to the compliance standards
- Let us know about suspected violations or misconduct
- Let us know if you have questions

For questions about provider expectations, please call your Provider Engagement Specialist or Provider Services at **1-833-230-2101**.

If you suspect potential violations, misconduct or non-compliant conduct which impacts HAP CareSource or our members, please leverage one of the following methods to communicate the issue to HAP CareSource:

- Ethics and Compliance
- Online: HAP CareSource.ethicspoint.com
- Hotline: 877-LINKCSM (877-546-5276)
- Compliance Officer: 937-487-5110 or Susan.Anderson@HAPCareSource.com

Any issues submitted to the Ethics and Compliance Hotline may be submitted anonymously.

The HAP CareSource Corporate Compliance Plan is posted for your reference on **HAPCareSource.com** > About Us > Legal > Corporate Compliance.

Please let us know if you have questions regarding the HAP CareSource Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

Personally Identifiable Information

In the day-to-day business of patient treatment, payment and health care operations, HAP CareSource 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 that PII be appropriately protected wherever it is stored, processed, and transferred in the course of 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 this content when it is 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, 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.

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 HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located at **HAPCareSource.com** > Provider > Forms.

The 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.

Accreditation

HAP CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our Medicaid and Health Insurance Marketplace plans. NCQA is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency, and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement. Visit www.NCQA.org for more information.

Communicating with HAP CareSource

HAP CareSource communicates with our provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, HAPCareSource.com and network notifications. We encourage you to reach out to your assigned Provider Engagement Representative with any questions.

HAP CareSource Hours of Operation

Provider Services 1-833-230-2101		
HAP CareSource Marketplace Plan	Monday through Friday	8 a.m. to 6 p.m. Eastern Time (ET)

Member Services 1-833-230-2099		
24-Hour Nurse Advice Line (Nurse Advice Line for all plans)	Seven days a week, 365 days a year	24 hours a day
HAP CareSource Marketplace Plan	Monday through Friday	7 a.m. to 7 p.m. ET

Representatives are available by telephone Monday through Friday, except on observed holidays.

Please visit **HAPCareSource.com** > About Us > Contact Us for more information on the holiday hours.

Phone

Our interactive voice response (IVR) system will direct your call to the appropriate professional for assistance. We also provide telephone based self-service applications that allow you to verify member eligibility.

Michigan	
Provider Services	1-833-230-2101
Prior Authorizations	1-833-230-2101
Claim Inquiries	1-833-230-2101
Credentialing	1-833-230-2101
Member Services	1-833-230-2099
Nurse Advice Line	1-833-687-7394
Fraud, Waste and Abuse Hotline	1-844-415-1272
TTY for the Hearing Impaired	711

Fax

Michigan	
Care Management Referral	1-833-230-2064
Fraud, Waste and Abuse	1-800-418-0248
Medical Prior Authorization Form	1-844-676-0372
Outpatient Drugs Covered Under Medical Benefit Prior Authorization Form	1-888-399-0271
Provider Appeals	1-937-531-2398

Other

Michigan	
Credentialing	ProviderNetwork@HAP.org
Contract Implementation	ProviderNetwork@HAP.org
Provider Maintenance	ProviderNetwork@HAP.org

Provider Representative Information

Our goal is to build collaborative and mutually supportive relationships with our network. HAP CareSource's Provider Representatives are dedicated to helping your practice.

You can find your assigned Provider Representative here and by visiting **HAPCareSource.com** > Providers > Provider Overview > Contact Us.

Website

Accessing our website, **HAPCareSource.com**, is quick and easy. On the Provider section of the site, you will find commonly used forms, newsletters, updates and announcements, our provider manual, claims, information, frequently asked questions, clinical guidelines, preventative guidelines, and much more.

Provider Portal

URL: www.CareSource.com/MI/providers/provider-portal

Our secure online Provider Portal allows you instant access to valuable information at any time. You can access the HAP CareSource Provider Portal at **HAPCareSource.com** > Login > Provider in MI. Simply enter your username and password (if you are already a registered user) or fill out your information to become a registered user. Assisting you is one of our top priorities in order to deliver better health outcomes for our members.

Provider Portal Benefits

- Easy access to a secure online (encrypted) tool with time-saving services and critical information
- Available 24 hours a day, 7 days a week
- Secure, convenient access to time-saving services and critical information
- Accessible on any web browser without any additional software

Provider Portal Tools

We encourage you to take advantage of the following time-saving tools:

- **Payment history** – Search for payments by check number or claim number.
- **Claims Features**
  - Submit Claims – Submit claims using online forms or upload a completed claim. Claim submission through the portal is available to traditional providers, community partners, delegates, and health homes. For more information about submitting claims online, please visit the "**Claims Submissions**" chapter of this manual.
  - Claim Status – Search for status of claims.
  - Claims Attachments – Submit documentation needed for claims processing.
  - Rejected Claims – Find claims that may have been rejected so that you can resubmit them.
  - Claim Dispute and Appeals – Submit and search for claim appeals and disputes.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior authorization** – Request authorization for medical and behavioral inpatient/outpatient services, as well as pharmacy authorizations.

- **Eligibility termination dates** – View the member's termination date (if applicable) under the eligibility tab.
- **Benefit limits** – Track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy, speech therapy, and more.
- **Care treatment plans** – View care treatment plans for patients on our Provider Portal.
- **Clinical Practice Registry (CPR)** – Review member gaps in care. View and sort HAP CareSource members into actionable groups for improved focus on preventive care (e.g., well-baby visits, diabetes, asthma and more). Look on the "Member Eligibility" page for alerts to notify you what tests a patient needs.
- **Recovery Letters** – View and download letters.
- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **Member financial status and information** – View member payment responsibilities (such as deductible, copay, and coinsurance) and monthly premium status.
- **Monthly membership lists** – View and download current monthly membership lists.
- **Case management referrals** – Submit automated case management forms on our Provider Portal for efficiency in enrolling members.
- **Information exchange** – Share relevant member information to facilitate better integration of behavioral health and medical care.
- **File Grievance**

Portal Registration

Two Portals, One Simple Sign-On!

CareSource and HAP both offer the benefit of a provider portal. To help streamline your operations, we offer **single sign on** from the HAP Portal to the HAP CareSource™ Provider Portal.

How to Register for the HAP CareSource Provider Portal

It's easy! You will access the HAP CareSource Provider Portal through the HAP Portal. Only one username and password to remember to access both portals.

If you are not registered for the HAP Provider Portal, please self-register by visiting the Michigan Provider Portal and clicking the Login button. Once registered for the HAP Provider Portal, follow the below instructions.

- Log in to the HAP Provider Portal with your HAP username and password
- Once logged in, you can link directly to the HAP CareSource Provider Portal
- The first time you access the HAP CareSource Provider Portal, you will need to set up the Multifactor Authentication* method you would like to use when signing in
- Locate your verification code and enter the code

**Please Note: Multi-factor authentication (MFA) is part of connecting to the HAP CareSource Provider Portal. You may follow the prompts to set up MFA or view the HAP CareSource Provider Portal User Guide*

Forms

Providers may access plan forms at **HAPCareSource.com** > Providers > Tools & Resources > Forms.

Mailing Addresses

General Mailing Address	HAP CareSource P.O. Box 8738 Dayton, OH 45401-8738
Medical Prior Authorization Submission Address	HAP CareSource Attn: Michigan Utilization Management Department P.O. Box 1307 Dayton, OH 45401-1307
Behavioral Health Prior Authorization Submission Address	HAP CareSource Attn: Michigan Behavioral Health Utilization Management Department P.O. Box 1307 Dayton, OH 45401-1307
Medical Claims Submission Mailing Address	HAP CareSource Attn: Claims Department P.O. Box 1186 Dayton, OH 45401-1186
Provider Claims Dispute Mailing Address	HAP CareSource Attn: Claim Disputes PO Box 2008 Dayton, OH 45401
Provider Appeals Mailing Address Please Note: Provider appeals can only be mailed if supporting documentation is above 100 MBs where the Provider Portal will not allow submission.	HAP CareSource Attn: Michigan Provider Appeals P.O. Box 2008 Dayton, OH 45401 Please visit our website for more information on how to submit appeals online.
Provider Clinical Appeals Mailing Address	HAP CareSource Attn: Provider Clinical Appeals PO Box 1947 Dayton, OH 45401 Please visit our website at HAPCareSource.com for more information on how to submit appeals online.
Member Appeals and Grievances Mailing Address	HAP CareSource Attn: Member Appeals P.O. Box 1947 Dayton, OH 45401
Fraud, Waste and Abuse Address	HAP CareSource Attn: Program Integrity P.O. Box 1940 Dayton, OH 45401-1940 Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.

Provider Credentialing Contact Information

Provider Credentialing Contact Information	Email providernetwork@hap.org and include: • "Credentialing status" in the subject line • Type 1 NPI, Type 2 NPI, and TIN • Provider name, address, phone and email"

Provider Communications

Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway at HAP CareSource. We will also share updates to adopted Evidence Based Guidelines through our newsletters.

Network Notifications

We regularly communicate policy and procedure updates to HAP CareSource providers via network notifications. Network notifications are found on our website at **HAPCareSource.com** > Providers > Tools & Resources > Updates & Announcements.

Provider Policies

HAP CareSource maintains medical, pharmacy, reimbursement, and administrative policies on our website. Approved policies may be found at **HAPCareSource.com** > Providers > Tools & Resources > Provider Policies. Policies are regularly reviewed, updated, withdrawn or added, and therefore subject to change. HAP CareSource provides notice to providers regarding a change in policy at least 30 calendar days prior to implementation.

Provider Trainings

HAP CareSource encourages our providers to access our on-demand and scheduled virtual trainings on topics related to your practice. These trainings provide key information for you to do business with us. Providers may access HAP CareSource's trainings and events by visiting **HAPCareSource.com** > Providers > Education > Training & Events.

Providers may also contact their assigned Provider Representative for additional live training support. You can find your assigned Provider Representative by visiting **HAPCareSource.com** > Providers > Provider Overview > Contact Us.

Credentialing and Recredentialing

HAP CareSource credentials and recredentials all licensed independent practitioners including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action. Through credentialing, HAP CareSource checks the qualifications and performance of physicians and other health care practitioners. Our Director, Provider Network Management is responsible for the credentialing and recredentialing program.

Credentialing Process

Council For Affordable Quality Healthcare Application

HAP CareSource is a participating organization with Council for Affordable Quality Healthcare (CAQH). Please make sure that we have access to your provider application prior to submitting your CAQH number.

1. Log onto the CAQH website at www.CAQH.org, utilizing your account information
2. Select the Authorization tab and ensure HAP CareSource is listed as an authorized health plan (if not, please check the Authorized box to add)

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current) or Controlled Substance Registration (CSR)
- Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable
- Standard collaborative care arrangement (if an advanced practice nurse or a physician assistant)

It is essential that all documents are complete and current, or HAP CareSource will discontinue the contracting and credentialing process.

Debarment And Criminal Conviction Attestation

HAP CareSource verifies that its providers and the providers' employees have not been debarred or suspended by any state or federal agency. HAP CareSource also requires that its providers and the providers' employees disclose any criminal convictions related to federal health care programs. "Provider employee" is defined as directors, officers, partners, managing employees or persons with beneficial ownership of more than five percent of the entity's equity.

Providers must offer a list that identifies all of the provider employees, as defined above, along with the employee's tax identification or social security numbers. Providers and their employees must execute the attestation titled, "HAP CareSource Debarment/Criminal Conviction Attestation" (in addition to being subject to and cooperating with HAP CareSource verification activities) as a part of the credentialing and recredentialing process.

HAP CareSource conducts credentialing and recredentialing activities, based on the NCQA standards and the appropriate federal and individual state department of insurance requirements.

Who Is Credentialed

Contracted providers listed in the Provider Directory and the following are credentialed:

- Providers who have an independent relationship with HAP CareSource. This independent relationship is defined through contracting agreements between HAP CareSource and a provider or group of providers and is defined when HAP CareSource selects and directs its members to a specific practitioner or group of providers.
- Providers who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Providers who are hospital-based but see the organization's members as a result of their independent relationship with the organization.
- Dentists who provide care under the organization's medical benefits.
- Non-physician providers who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.
- Covering providers (locum tenens).
- Medical directors of urgent care centers and ambulatory surgical centers.

The following providers listed in the Provider Directory do not need to be credentialed:

- Providers who practice exclusively within the inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting.
- Providers 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 who are not listed separately in the HAP CareSource Provider Directory.
- Pharmacists who work for a pharmacy benefit management (PBM) organization.
- Providers who do not provide care for members in a treatment setting (e.g. board-certified consultants).

Provider Selection Criteria

HAP CareSource is committed to providing the highest level of quality of care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we have developed the following provider selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our providers.

The Institute of Medicine defines quality of care delivery as: *"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."*

HAP CareSource has developed comprehensive care management and quality improvement programs to facilitate this level of quality-of-care delivery, as well as a comprehensive credentialing program to ensure that our providers have the appropriate training and expertise to serve our members from a care delivery and service perspective. HAP CareSource bases selection on quality-of care and service aspects, in addition to business and geographic needs for specific provider types in a nondiscriminatory manner.

The following selection criteria have been put in place and are assessed during the credentialing and recredentialing process in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

Selection Criteria:

- Active and unrestricted license in the state issued by the appropriate licensing board.
- Current DEA certificate (if applicable).
- Successful completion of all required education.
- Successful completion of all training programs pertinent to one's practice.
- For MDs and DOs, successful completion of residency and/or fellowship training pertinent to the requested practice type.
- For dentists and other providers where special training is required or expected for services being requested, successful completion of training.
- Board Certification is not required for primary care specialties. PCPs who are approved by the HAP CareSource Credentialing Committee will appear in HAP CareSource Provider Directories.
- Providers approved by the HAP CareSource Credentialing Committee in non-primary care specialties will be listed in the Provider Directory as specialists if certified by a specialty board, which is recognized by the HAP CareSource Credentialing Committee.
- An advanced practice registered nurse (APRN) may be credentialed as a primary care provider if that APRN maintains compliance with the rules set forth by the Michigan Board of Nursing and Michigan specific codes. The APRN is expected to be familiar with these rules.
- Education, training, work history and experience are current and appropriate to the scope of practice requested.
- Malpractice insurance at specified limits established for all practitioners by the credentialing policy.
- Good standing with Medicaid and Medicare.

- Quality of care and practice history as judged by:
  - Medical malpractice history
  - Hospital medical staff performance
  - Licensure or specialty board actions or other disciplinary actions, medical or civil
  - Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
  - Other quality of care measurements/activities
  - Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
  - Lack of issues on HHS-OIG, SAM/EPLS, or state site for sanctions or terminations (fraud and abuse)
- Signed, accurate credentialing application and contractual documents.
- Participation with Care Management, Quality Improvement and Credentialing programs.
- Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
- Agreement to comply with plan formulary requirements or acceptance of Plan Drug Formulary as administered through the Pharmacy Benefit Manager.
- Agreement to access and availability standards established by the health plan.
- Compliance with service requirements outlined in the provider agreement and HAP CareSource Provider Manual.

Please Note: Any pending and/or suspected fraud, waste and abuse investigation(s) or case(s) against the provider may affect the provider's credentialing application.

Organizational Credentialing and Recredentialing

The following organizational providers are credentialed and recredentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Free-standing Rural Health Center
- Free-standing Inpatient Psychiatry Health Facility
- Outpatient Infusion Center

Additional organizational providers are also credentialed:

- Hospice providers
- Urgent care facilities, free-standing and not part of a hospital campus

- Dialysis centers
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Free-standing facilities that provide outpatient, non-emergent advanced radiology services (including MRI/MRA, CT and PET scans)

In addition to the Ambulatory Surgical Facilities, Opioid Treatment Facilities, Rural Health Centers, Free standing Inpatient Psychiatry Health Facilities and Outpatient infusion Center being credentialed the Vice President Provider Network management is responsible for medical services will be credentialed using the standard, provisional credentialing or recredentialing process. If Medical Director or Senior Physician is denied credentialing the facility will also not be credentialed.

The following elements are assessed for organizational providers:

- Provider is in good standing with state and federal regulatory bodies
- Provider has been reviewed and approved by an accrediting body
- Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body
- Malpractice/Liability insurance coverage is maintained and meets contract minimums
- Clinical Laboratory Improvement Amendments (CLIA) certificates are current (if applicable).
- Completion of a signed and dated application.
- If not approved by an accrediting body must have a CMS Site survey or agree to a site visit.

Providers will be informed of the credentialing committee decision within 60 business days of the committee meeting. Providers will be considered recredentialed unless otherwise notified.

Provider Credentialing Rights

- Practitioners have the right to review information submitted to support their credentialing application upon request to the HAP CareSource Credentialing department. HAP CareSource keeps all submitted information locked and confidential.
- Practitioners 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, HAP CareSource will request that the provider submit written clarification to the Credentialing Department electronically, by e-mail, fax or by certified mail, return receipt requested and the provider will be given five business days to respond. Nonresponse within that time frame will result in discontinuance on the sixth day.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department. An automated email is sent to providers once their application is submitted via the HAP CareSource Provider Portal. This email directs them to contact Provider Services at **1-833-230-2101** to obtain application status updates. Provider service representatives are able to inform providers if their application is complete and they are showing as participating in the HAP CareSource network, or if their application is still in process while referencing state-specific time frames. Practitioners also have the ability to check the status of their application by visiting the HAPCareSource.com website, signing into the provider portal, and entering their application and NPI numbers.

Provider Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. HAP CareSource will initiate immediate action in the event that the participation criteria are no longer met.

Providers are required to inform HAP CareSource of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification, or any event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

Providers are recredentialed a minimum of every three years. As part of the recredentialing process, HAP CareSource considers information regarding performance to include complaints, and safety and quality issues collected through the quality improvement program, in addition to information regarding sanctions collected from the NPDB, Medicare and Medicaid Sanctions and Reinstatement Report, Medicare Opt-Out and the HHS/OIG. Providers will be considered recredentialed unless otherwise notified.

Board Certification Requirements

Effective Jan. 1, 2003, physicians applying to become participating providers must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board, with the exception of general dentists who will have board certification requirements waived in lieu of adequate education and training.

Effective Sept. 10, 2010, PCPs may be exempted from the board certification requirement if they have successfully completed a primary care residency program and their education and training are consistent with their intended scope of practice.

Physicians who are pursuing certification must be certified within the time frame specified by their respective board. Failure to become certified may result in termination as a participating provider.

Physicians whose boards require periodic recertification will be expected but not required to be re-certified, although failed attempts at re-certification may be reason for termination.

To be credentialed as a subspecialist physicians must:

- Complete an approved fellowship training program in the respective subspecialty and
- Be board-certified by a board that is recognized and approved by the HAP CareSource Credentialing Committee. If no subspecialty board exists or the board is not a board recognized and approved by the HAP CareSource Credentialing Committee, then subspecialty recognition will be determined based on education, training and experience requirements of the fellowship training program and/or other suitable board certification recognition.

Delegation of Credentialing/Recredentialing

HAP CareSource will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is NCQA-accredited for these functions, follows NCQA credentialing standards or utilizes an NCQA-accredited credentials verification organization (CVO), and successfully passes a pre-delegation audit demonstrating compliance with NCQA, federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA, and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and Recredentialing Committee meeting minutes from the previous year
- Credentialing and recredentialing provider file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

HAP CareSource may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited CVO. Providers will be notified of this and must adhere to the requests from the chosen CVO.

Reconsideration and Appeals of Credentialing/Recredentialing Decisions

HAP CareSource may decide that an applying or participating provider may pose undue risk to our members and should be denied participation or be removed from HAP CareSource's network. If this happens, the applying or participating provider will be notified in writing. Reconsideration and appeal opportunities are available unless an exception applies. Exceptions are set forth in the Provider Hearing Plan. To submit a request, the following steps apply:

Step 1

Submit to the Vice President Provider Network Management a reconsideration request in writing, along with any other supporting documentation.

HAP CareSource
Attn: Vice President Provider Network Management
P.O. Box 8738
Dayton, OH 45401-8738

All reconsideration requests must be received by HAP CareSource within 30 calendar days of the date the provider is notified of the decision. The request, along with any supporting information, will be presented to the Credentialing Committee for review at the next meeting. The committee will respond within 30 calendar days of that meeting, and the provider will be notified in writing of the committee's decision.

Step 2

If the committee maintains the original decision, an appeal may be made consistent with provisions of the Provider Hearing Plan unless an exception applies. Any appeal request must be submitted in writing and received by HAP CareSource within 30 calendar days of the date the provider is notified of the reconsideration decision.

Appeals May Be Sent To:

HAP CareSource
Attn: Vice President/Senior Medicaid Director
P.O. Box 8738
Dayton, OH 45401-8738

Applying providers may submit additional documents for reconsideration by the credentialing committee to the address above. An application rejection due to the provider's failure to submit a complete application is not subject to reconsideration or appeal.

Provider Disputes

Provider disputes for issues related to quality, professional competency or conduct should be sent to:

HAP CareSource
Attn: Quality Improvement
P.O. Box 8738
Dayton, OH 45401-8738

Provider disputes for issues that are contractual or non-clinical should be sent to:

HAP CareSource
Attn: Provider Relations
P.O. Box 8738
Dayton, OH 45401-8738

Summary Suspensions

HAP CareSource reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating provider who, in the opinion of the HAP CareSource Vice President/Senior Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our members. Any participating provider that is subject to a suspension or termination may dispute the action and request a hearing through the Provider Hearing Plan unless an exception applies. Exceptions are set forth in the Provider Hearing Plan.

Claim Submissions

As with other commercial health plans, HAP CareSource's Marketplace plan members are responsible for copays, coinsurance and deductibles. Providers are responsible for collecting the appropriate payments.

In general, HAP CareSource follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. These can be found at **HAPCareSource.com** > Providers > Provider Policies. For expedited claims processing and payment delivery, please ensure addresses and phone numbers on file with HAP CareSource are up to date. For more information on how to update this information, go to the **Submitting Provider Changes** section of this manual.

Billing Methods

HAP CareSource accepts claims in a variety of formats, including paper and electronic claims. We encourage providers to submit routine claims electronically to take advantage of the following benefits:

- Faster claim processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claims status
- Minimal staff training or cost

Submit Claims Online Through Provider Portal

Providers may submit claims through the secure, online Provider Portal. Online submission saves you money by eliminating the costs associated with printing and mailing paper claims. Using the portal for claims submission also provides additional benefits:

- Improves accuracy by decreasing the opportunities for transcription errors and missing or incorrect data
- Allows tracking and monitoring of claims through a convenient online search tool
- Includes attachments up to 100 MB that may be necessary for claim processing
- Allows uploading of a completed claim
- Allows corrections and re-submissions

Who Can Submit Claims Via The Portal?

HAP CareSource's traditional providers, community partners and delegates, and health homes all may submit claims through the Provider.

What Types Of Claims Can Be Submitted?

- Professional medical office claims (CMS 1500 and 837P)
- Medical/surgical claims
- Institutional claims (UB-04 and 8371)
- Behavioral health claims

Electronic Funds Transfer

HAP CareSource offers electronic funds transfer (EFT) as a payment option. Visit the Provider Portal for additional information about the program and to enroll in EFT. Providers who elect to receive EFT payment may also elect to receive an EDI 835 (Electronic Remittance Advice). Providers can download their Explanation of Payment (EOP) from the Provider Portal or request a hard copy via the mail.

Benefits of EFT:

- **Simple** – Receive fully reconciled remittances electronically; eliminate paper checks and EOPs, which will increase efficiency with payment processing.
- **Convenient** – Available 24 hours a day, seven days a week; free training is also offered for providers.
- **Reliable** – Claim payments electronically deposited into your bank account.
- **Secure** – Access your account through HAP CareSource's secure Provider Portal to view (and print if needed) remittances and transaction details.

Please Note: TPL/Coordination of Benefits (COB) information can be found in loop 2100/segment NM103 when NM101 = PR on the 835 file.

HAP CareSource provides TPL/COB information for EFT. This can be found in segment 2100 Claim Payment Information and loop 2110 Service Payment Information on the 835 file in this format:

- NM1*PR*INSURANCE NAME US HEALTHCARE
- NM1*GB*1*DOE*JOHN

- REF*6P*W212345678
- The NM1*PR (COB carrier), NM1* GB (other subscriber information from other payer) and REF*6P (other insurance group number)

To enroll in EFT, complete the enrollment form, available on **HAPCareSource.com** > Providers > Claims and fax it back to our payment processing vendor, ECHO Health Inc. Providers may also call ECHO support at 1-888-834-3511 for assistance with registration.

Electronic Claim Submission

Electronic data interchange (EDI) is the computer-to-computer exchange of business data in ANSI ASC X12 standard formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). HAP CareSource has invested in an EDI system to enhance our service to participating providers. Our EDI system complies with HIPAA standards for electronic claims submission.

Clearinghouse

HAP CareSource prefers electronic claim submission. To submit claims electronically, providers must work with an electronic claims clearinghouse. HAP CareSource currently accepts electronic claims from Michigan providers through the clearinghouse listed below. Please contact the clearinghouse to begin electronic claims submission.

Clearinghouse	Phone	Website
Availity	1-800-282-4548	www.availity.com

Please provide the clearinghouse with the HAP CareSource payer ID number: **MICS1**

File Format

HAP CareSource accepts electronic claims in the 837 ANSI ASC X12N (005010X ERRATA version) file format for professional and hospital claims.

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This was in preparation to implement ICD-10 CM codes on Oct.1, 2015. The new standard is the HIPAA 5010 format. All trading partners and payers should be 5010 compliant.

Transactions Covered Under the 5010 Requirements

- 837 Health Care Claim/Encounter
- 276/277 Health Care Claim Status Request and Response
- 835 Health Care Claim Payment/Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 278 Health Care Services Review (Prior Authorization Requests)

- 834 Benefit Enrollment and Maintenance
- 820 Group Premium Payment for Insurance Products
- NCPDP Version D.0

Please include the full physical address for billing 5010 transactions. P.O. Boxes are no longer accepted for the billing address. However, a P.O. Box or Lock Box can be used for the Pay-to Address (Loop 2010AB).

Procedure and Diagnosis Codes

HIPAA specifies that the health care industry use the following four code sets when submitting health care claims electronically. HAP CareSource also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. Local or proprietary codes are no longer allowed.

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD- 10- CM). Available from the U.S. Government Printing Office at (202) 512-1800, (202) 512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at www.ama-assn.org/amaone/cpt-current-procedural-terminology.
- HCFA Common Procedure Coding System (HCPCS). Available at https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system?redirect=/MedHCPCSGeninfo/https%3A//www.cms.gov/default.asp
- National Drug Codes (NDC). Available at http://www.fda.gov/.

Procedures That Do Not Have a Corresponding Code

- If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
  - A full, detailed description of the service provided.
  - A report, such as an operative report or a plan of treatment.
  - Any information that would assist in determining the service rendered. For example, 84999 is an unlisted lab code that would require additional explanation.
- Drug injections that do not have specific J code (J3490 thru J3999) and any assigned HCPCS J code that is not listed on the Medicare fee schedule require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report plus any other documentation that will assist in determining reimbursement.
- COB claims require a copy of the EOP from the primary carrier. Claim status is updated daily on our Provider Portal, and you can check claims that were submitted for the previous 24 months.

National Provider Identifier And Tax ID Numbers

Your NPI number and Tax ID are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Please Note: On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering Provider's NPI and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating Provider's NPI and (if applicable) Box 49 for the group NPI

Professional Claims

On 837P professional claims (005010X222A1), the Provider's NPI should be in the following location:

- 2010AA Loop – Billing Provider Name
- 2310B Loop – Rendering Provider Name
- 2010AA Loop – Billing Provider Name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing Provider NPI
- 2310B Loop – Rendering Provider Name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Rendering Provider NPI

The Billing Provider TIN (Tax Identification Number) must be submitted as the secondary Provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

Institutional Claims

On 837I institutional claims (005010223A2), the Billing Provider NPI should be in the following location:

- 2010AA Loop – Billing Provider Name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing Provider NPI

The Billing Provider TIN (Tax Identification Number) must be submitted as the secondary Provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

On all electronic claims, the HAP CareSource Member ID number should go on:

- 2010BA Loop – Subscriber Name
- NM109 = Member ID Number

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

To register for claims payment, complete the ECHO enrollment form located on **HAPCareSource.com** > Provider > Claims and fax, email, or mail it back to ECHO. You may call ECHO Customer Support at **1-888-834-3511** for assistance with your enrollment.

Claims Payment Processing

HAP CareSource has partnered with ECHO Health, Inc. to deliver provider payments. ECHO offers three payment methods you may choose from:

- Electronic funds transfer (EFT) – preferred
- Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
- Paper checks

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

Enroll with ECHO for payment and choose EFT as your payment preference for HAP CareSource. You can also complete the ECHO enrollment form located on **HAPCareSource.com** > Provider > Claims and fax, email or mail it back to ECHO. For questions, call ECHO Customer Support at 1-888-834-3511.

Paper Claim Submissions

For the most efficient processing of your claims, HAP CareSource recommends you submit all claims electronically. For more information on electronic claims, please reference the **"Electronic Claims Submission"** section of this manual.

Paper claim forms are only encouraged for services that require clinical documentation or other forms to process. If T formerly UB92 form for Facilities.

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare and Medicaid Services (CMS), and the National Uniform Claim Committee (NUCC).

We cannot accept handwritten claims or SuperBills. Detailed instructions for completing each form type are available at the websites below:

- CMS 1500 Form Instructions: www.nucc.org
- UB-04 (CMS 1450) Form Instructions: www.nucc.org

Please Note: On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
- UB-04 (CMS 1450): Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

All claims (EDI and paper) must include:

- Patient (member) name
- Patient address
- Insured's ID number – Be sure to provide the complete HAP CareSource member ID number of the patient. For the most efficient processing of your claims, HAP CareSource recommends you submit all claims electronically.

- Patient's birth date – Always include the patient's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service – Use standard CMS (HCFA) location codes
- ICD-10 diagnosis code(s)
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable
- Units, where applicable (anesthesia claims require minutes)
- Date of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain From/To formats. Please enter each date individually.
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information.
- Federal tax ID number or physician social security number – Every provider practice (e.g., legal business entity) has a different tax ID number.
- Signature of physician or supplier – The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

National Drug Code (NDC)

What to include on claims that require National Drug Code:

- NDC and unit of measure (e.g., pill, milliliter (cc), international unit or gram)
- Quantity administered – number of NDC units
- NDC unit price – detail charge divided by quantity administered
- HCPCS codes that will require NDCs on professional claims (submitted on the 837P format)

Instructions for National Drug Code on Paper Claims

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code – F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC, or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

Tips For Submitting Paper Claims

For the most efficient processing of your claims, HAP CareSource recommends you submit all claims electronically.

HAP CareSource uses an optical/intelligent character recognition (OCR/ICR) system to capture claims information, which increases efficiency, improves accuracy and results in faster turnaround time.

To ensure optimal claims processing timelines:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current form version as designated by CMS, NUCC and the ADA.
- No handwritten (including printed claims with any handwritten information) claims or Super Bills will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Fonts should be 10 to 14-point (capital letters preferred) with printing in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- It is recommended that you submit your 12-digit HAP CareSource Provider ID, located in your Welcome Letter, in conjunction with your required NPI number. Please refer to sections for Professional and Institutional claim information.
- Federal Tax ID number or physician SSN is required for all claim submissions. Please send all paper claim forms to the following address:

  HAP CareSource
  Attn: Claims Department
  P.O. Box 1186
  Dayton, OH 45401-1186

No Surprises Act

Effective January 1, 2022, HAP CareSource will comply with new state and federal requirements, in alignment with the No Surprises Act, including how we process claims from certain out-of-network providers. This applies to claims with the date of service starting January 1, 2022.

The No Surprises Act, part of the Consolidated Appropriations Act of 2021, establishes patient protections for members enrolled in Marketplace plans, including protection from out-of-network providers' surprise bills (balance billing) for emergency care and other specified items or services.

HAP CareSource presumes emergency services (including post-stabilization) and services from out-of-network providers at in-network facilities are covered under the No Surprises Act. Post-stabilization services are defined as emergency services needed to evaluate or stabilize an emergency medical condition per citation 42 CFR 438.114. Claims will be processed according to the Consolidated Appropriations Act of 2021 and MCL 333.24502-11 based on criteria below as billed on the claim. Providers are prohibited from balance billing members, aside from patient responsibility for copay, deductible, and coinsurance.

Out-of-network providers are encouraged to submit a new contract request, which can be done online at Becoming a Participating Provider or by working with a contract manager.

How to Bill Claims for Services Covered Under the No Surprises Act

Emergency Services

- Outpatient Facility claims for emergency services should be billed with Revenue Codes 0450-0459, or 0762.
- Inpatient Facility claims for post-stabilization emergency services should be billed with an Admit Type = 1, 2, or 5.
- Air ambulance claims for emergency services should be billed with Current Procedural Terminology (CPT) Codes A0430, A0431, A0435 or A0436 AND an Emergency Indicator of 'E', 'I', 'A' or 'Z' in box 24c on the 1500 form.
- Professional claims for emergency services should be billed with Place of Service (POS) 23, 11, 19, 21-24, 31, 23 or 81; CPT Codes 99217-99220 or 99234-99236 or Emergency Indicator 'E' or 'I' in box 24c on the 1500 form.

Non-Emergency Services

- Boxes 32 and 32a are required to be completed with the appropriate facility information.
- Independent labs performing tests on samples drawn at an inpatient or outpatient department of a hospital should bill the correct POS code per CMS billing guidelines instead of POS 81 (i.e. Inpatient = POS 21, Off-Campus Outpatient = POS 19, On-Campus Outpatient = POS 22, etc.).
- CMS Billing Guidelines: Medicare Claims Processing Manual (cms.gov).

Claims paid in accordance with this Act will be notated in the claim detail section of your Electronic Remittance Advice or Explanation of Payment notice with Remark Code N830. Providers do not need to submit documentation of notice and consent requirements with their claims. Prior authorizations will still be required for services that require medical necessity review.

Claim Submission Timely Filing

For in-network providers, claims must be submitted within 365 days of the date of service or discharge. For out-of-network providers, claims must be submitted within 365 days from the date that the non-participating provider was furnished with the correct name and address of HAP CareSource, if applicable. We will not be able to pay a claim if there is incomplete, incorrect, or unclear information on the claim, as the claim will be denied. If this happens a corrected claim may be submitted with corrected information, but this is still considered an initial claim and must be filed within 45 days from the date of the original denial.

Claim Processing Guidelines

If an initial claim is filed timely and is denied, the provider has the following options:

- If a claim denial is due to a provider's incorrect or inaccurate claim information, the provider may resubmit the claim with corrections.
- For adjudication purposes, a denied claim that is resubmitted with corrected information is considered to be an initial claim and, as such, is subject to the 365-day timely filing limit.
- For adjudication purposes, a denied claim resubmitted without corrected information is considered to be a duplicate claim and will continue to deny for the same reasons. Resubmitted claims with no correction will be subject to the 365-day timely filing limit and will not be accepted as "reasonable and continuous attempts to resolve a claim problem" for consideration to waive or extend the timely filing limit.
- If a claim denial is not due to a provider's incorrect or inaccurate claim information, but the provider disagrees with the denial, the provider should refer to the provider appeal section of this manual for further information.
- If a line item on a claim is denied, that line item should be resubmitted separately, unless the claim details are dependent on one another for payment. For example, all surgical services for the same member, same date and same provider must be submitted on one claim form and cannot be separately processed. To rebill a surgical procedure, a claim adjustment must be requested.

If an initial claim is filed timely and is paid, including claims partially paid, or paid at zero, the provider has the following options:

- If a claim paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider may submit a corrected claim. The corrected claim must be filed within 45 calendar days from the date of receipt of the claim decision notification, also referred to as the explanation of payment (EOP).
- If a claim payment disagreement is not due to a provider's error, refer to the provider appeal section of this manual.
- If a member has other insurance and HAP CareSource is secondary, the provider may submit for secondary payment within 90 calendar days of the primary carrier's EOP.
- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period.
- If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing. When the patient is discharged, the provider will be required to submit a final bill, which includes the entire bill from date admitted to date discharged. HAP CareSource is not able to determine correct payment unless the full, final bill is submitted. The provider will have 6 months from the date of discharge to submit the complete bill. If this information is not submitted within the timely filing guidelines, the claim will be denied, and previous payments will be recouped.

All claims for newborns must be submitted using the newborn's MID. Do not submit newborn claims using the mother's MID; the claim will deny. Claims for newborns must include the birth weight. The same timely filing guidelines apply for newborns. Newborns receiving **retroactive** eligibility are not subject to timely filing requirements.

Claim Status

Provider Portal at **HAPCareSource.com** > Login > Provider in MI, selecting your state.

Claim status is updated daily on our provider portal, and you can check claims that were submitted for the previous 36 months from the data of service (DOS). You can search by Medicaid ID, HAP CareSource Member ID, member name and date of birth, claim number, check number, or patient number.

You can find the following claim information on the provider portal:

- Claim history available up to 36 months from the date of service
- Submission of claim appeals and disputes
- Reason for payment, denial, or adjustment
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date
- Submission of attachments for denied claims
- Easy submission for corrected claim when the claim was submitted online via the portal
- Accessibility to claim recovery letters

Code Editing

HAP CareSource uses clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately and efficiently.

HAP CareSource's code editing software finds any coding conflict or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need for additional information from the provider.

HAP CareSource's code editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Provider Coding and Reimbursement Guidelines

HAP CareSource strives to be consistent with national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims.

Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, ICD-10 and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored as would be any aspect of a provider contract. Generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. HAP CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

HAP CareSource uses coding industry standards, such as the AMA CPT manual, CCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPCS code or modifier usage

HAP CareSource seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that will review, upon request, any claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review will take into consideration all the previously mentioned CCI and national commercial standards when considering the appeal. In order to ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the HAP CareSource appeals team to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current HAP CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Explanation of Payment

An Explanation of Payment (EOP) is a statement of the current statuses of claims that have been submitted to HAP CareSource and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated, depending on your claim submission activity. Providers who receive EFT payments may also elect to receive an Electronic Remittance Advice (ERA) and can access it on the Provider Portal.

Information Included on Explanation of Payment

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA-compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

Checking Claim Status

Please remember that you can track the progress of your submitted claims at any time through our Provider Portal.

HAP CareSource is responsible for resolving any pended claims, not the provider. A Pended Claim Report may be sent to you merely to acknowledge receipt. Please do not resubmit pended claims; this may further delay processing. A Pended Claim Explanation report may be sent on the first and third check write of the month.

Other Coverage

Coordination of Benefits

HAP CareSource collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately.

While we try to maintain information as accurately as possible, we rely on numerous sources of information that are updated periodically, and some information may not always be fully reflected on our Provider Portal. Please ask HAP CareSource members for all health care insurance information at the time of service.

Search Coordination of Benefits on the Provider Portal By:

- Member ID Number
- HAP CareSource case number
- Medicaid number/MMIS number
- Member name and date of birth

You can check COB information for members who have been active with HAP CareSource within the last 12 months.

Claims involving COB will not be paid until an Explanation of Benefits/Payment or EDI payment information has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (zero balance) must still be submitted to HAP CareSource for processing. This is due to regulatory requirements.

Coordination Of Benefits Overpayment

If a provider receives a payment from another carrier after receiving payment from HAP CareSource for the same items or services and it is determined the other carrier is primary, this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the provider, or providers can issue refund checks to HAP CareSource for any overpayments. Providers should not refund any money received from a third party to a member.

Workers' Compensation

Claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The provider will be advised to submit the charges to workers' compensation for reimbursement.

Third-Party Liability/Subrogation

Claims indicating the provided services were the result of an injury will be considered as a case of possible subrogation. Any third-party liability will be determined. HAP CareSource will pay the provider for all covered services. Then, we will pursue recovery from any third parties involved.

Member Financial Liability and Grace Period

Some benefits under a plan may have first dollar coverage while others will require a member to first pay an annual deductible before HAP CareSource contributes payment for the services. In addition to the deductible, copayments or coinsurance are also applicable for many covered services. It is up to the provider to collect these amounts at the time of service. If a member overpays his or her financial liability (e.g. deductible, copay, coinsurance), the provider must refund the overpayment to the member. Please refer to the **"Member Disenrollment"** section of this manual for information on how claims processing and eligibility is affected if premiums aren't paid on time, otherwise known as the grace period.

Explanation of Benefits

HAP CareSource members receive an Explanation of Benefits (EOB) that informs members of their deductible and out-of-pocket status and shows copays and coinsurance they have paid. The EOB outlines the amount the provider billed, the amount HAP CareSource reimbursed and the remaining amount for which the member is responsible.

Referrals and Prior Authorizations

HAP CareSource uses a select network of hospitals, physicians and ancillary providers. Typically, HAP CareSource does not pay for non-network, non-emergent services; however, these may be provided in limited situations with prior authorization (PA) from HAP CareSource's Utilization Management (UM) team. Any participating facility/provider requesting prior authorization for an elective admission must obtain prior authorization (PA) for the use of any out-of-network RAPHL (Radiologist, Anesthesiologist, Pathology, Hospitalist and Laboratory). Please visit the Provider at **HAPCareSource.com** for the most current information on PA and referral requirements.

Referral Information

Generally, HAP CareSource does not require referrals or PA before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, prior authorizations are needed before HAP CareSource will pay for services from out-of-network providers, except in cases of emergency and other scenarios as defined in the Evidence of Coverage (EOC). If you have questions about referrals or PAs, please reference our Prior Authorization Lookup Tool or call our Utilization Management Department at **1-833-230-2101**.

Referral Procedures

Any treating doctor can refer HAP CareSource members to specialists. Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists require prior authorization for any services rendered to HAP CareSource members and scenario must be due to specific criteria.

You can also submit a request on the HAP CareSource Provider Portal at **HAPCareSource.com** > Login > Provider in MI. You can request a prior authorization by calling Provider Services and telling our interactive voice response system (IVR), that you want to request a prior authorization.

If you have difficulty finding a specialist for your HAP CareSource member, please use our online Find a Doctor/ Provider tool at **HAPCareSource.com** > Members > Tools & Resources > Find a Doctor or call Provider Services at **1-833-230-2101**.

How to Make a Referral to a Specialist

Referring doctor – Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

Specialist – Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure. HAP CareSource expects specialists to collaborate on the member's care and inform the member of treatment plan updates.

Standing Referrals – A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral. Treating providers must get prior authorization from our health plan before sending a member to an out-of-network provider.

Referrals to an out-of-plan provider – A member may be referred to out-of-plan provider if the member needs medical care that can only be received from a doctor or other provider who is not participating with our health plan. Treating providers must get prior authorization from our health plan before sending a member to an out-of-plan provider.

Referrals for second opinions – A second opinion is not required for surgery or other medical services. However, providers or members may request a second opinion.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a non-participating provider.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Prior Authorization Information for Utilization Management

Prior Authorization Procedures

The Provider Portal is the preferred method to request prior authorizations for health care services. You get immediate approval or a pending status for some services, and you can also check pending claim status. Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone, fax or mail. If submitted by mail or fax, please use the appropriate prior authorization form. Copies of prior authorization forms can be found on **HAPCareSource.com** > Providers > Forms.

Request Prior Authorization	
Online/Provider Portal* *preferred method	Visit HAPCareSource.com > Login > Provider in MI
Phone	Please call **1-833-230-2101** and tell our IVR that you need to submit an authorization request.
Fax	Please fax the prior authorization form to 844-676-0372. The prior authorization form can be found on HAPCareSource.com > Providers > Tools & Resources > Forms.
Mail – Prior Authorizations	HAP CareSource Attn: Michigan Utilization Management Department P.O. Box 1307 Dayton, OH 45401-1307
Mail – Behavior Health Prior Authorizations	HAP CareSource Attn: Michigan Behavioral Health Utilization Management Department P.O. Box 1307 Dayton, OH 45401

Copies of prior authorization forms can be found on **HAPCareSource.com** > Providers > Forms.

When requesting an authorization, please provide the following information:

- Member/patient name and HAP CareSource Member ID number
- Provider name and NPI/TIN
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity for the service

Prior Authorization Criteria

HAP CareSource requires timely submissions of prior authorization requests for inpatient admissions. If the service is an acute inpatient emergent admission HAP CareSource expects the facility to submit the authorization request within one business day of admission, not including Saturdays, Sundays, or legal holidays. However, if it is a planned admission, HAP CareSource expects that the physician submits a prior authorization request prior to admission.

Please Note: Below is not a comprehensive listing and other criteria may be associated to other items requiring prior authorization.

- *IF THE PROVIDER FAILS TO OBTAIN PRIOR AUTHORIZATION FOR NON-EMERGENCY SERVICES, NEITHER THE PLAN NOR A COVERED PERSON WILL BE REQUIRED TO PAY FOR THOSE NON-EMERGENCY SERVICES.*
- If the request is for **inpatient admission** (whether it is elective, urgent or emergent), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.
- If **inpatient surgery** is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, any appropriate clinical and anticipated discharge needs prior to the planned surgery.
- If the request is for **outpatient surgery**, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs prior to the planned surgery.
- Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and coverage/benefit limitations.
- When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service and adherence to other terms and conditions of the Evidence of Coverage, such as benefit limits. Providers must verify eligibility on the date of service. HAP CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.
- All services that require prior authorization from HAP CareSource should be authorized before the service is delivered. HAP CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the provider. HAP CareSource will notify you of prior authorization determinations via fax to the provider's address on file.
- For standard prior authorization decisions, HAP CareSource provides notice to the provider and member as expeditiously as the member's health condition requires, but no later than seven calendar days following receipt of the request for service.
- Urgent prior authorization decisions are made within 72 hours of receipt of request for service. Please specify if you believe the request is urgent.
- Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. If an authorization is being appealed for medical necessity, a member consent form must also be submitted.

Services That Require Prior Authorization

Please visit **HAPCareSource.com** > Providers > Provider Portal > Prior Authorization > Tools & Resources for the most up-to-date information of services that require prior authorization.

Determination Time Frames

HAP CareSource's time frames to make authorization determinations vary depending upon the member's health condition, completeness of submission of information and state requirements. Please reference the appropriate table below to find determination time frames:

Review Request Category	Timeframe for Making Decision
Urgent Care Requests	72 hours
Non-Urgent Care Requests	Seven calendar days
Initial Inpatient Requests	Three calendar days
Inpatient Continued Stay Requests	Three calendar days
Retrospective Requests	30 calendar days

Billing For Services Denied Prior Authorization

HAP CareSource may permit billing members for services that require authorization, but for which authorization is denied, if certain safeguards are in place and are followed by the provider:

- The provider must establish that authorization has been requested and denied before rendering the service.
- The provider can request HAP CareSource review of the authorization decision. HAP CareSource must inform providers of the contact person, the means for contact, the information required to complete the review and procedures for expedited review, if necessary.
- If HAP CareSource maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that the authorization has been denied.
- The member must be informed of the right to contact HAP CareSource to file an appeal if the member disagrees with the decision to deny authorization.
- The provider must inform members of member responsibility for payment if the member chooses to or insists on receiving the service without authorization.
- If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:
- The waiver is signed only after the member receives the appropriate notification stated in requirements three and four.
- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
- Providers must not use nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.
- The waiver must identify the specific procedure to be performed, and the member must sign the consent before receiving the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that HAP CareSource did not authorize the service.

The waiver must include the right to appeal any denial of payment by HAP CareSource for denial of authorization.

Utilization Management

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to HAP CareSource members. The Utilization Management department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources.

We also monitor the coordination of medical care to ensure its continuity and refer members to HAP CareSource's Care Management department, if needed. HAP CareSource's UM criteria are available in writing by fax, mail and via the website.

	Fax	Mail
Marketplace	844-676-0372	HAP CareSource P.O. Box 1307 Dayton, OH 45401-1307

On an annual basis, HAP CareSource completes an assessment of satisfaction with the UM process and identifies any areas for improvement opportunities.

Criteria

HAP CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. These criteria are designed to assist providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients.

HAP CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. HAP CareSource also has medical policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a HAP CareSource Medical Director for further review and determination. Physician reviewers from HAP CareSource are available to discuss individual cases with attending physicians upon request.

Providers can access HAP CareSource's medical policies online at **HAPCareSource.com** > Provider > Provider Policies.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. HAP CareSource does not reward providers or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

Our members' health is always our number one priority. Upon request, HAP CareSource will provide the clinical rationale or criteria used in making medical necessity determinations when an adverse decision has been rendered. You may request the information by calling or faxing the HAP CareSource Utilization Management Department. If you would like to discuss an adverse decision with a HAP CareSource Clinical Peer Reviewer, please call the Utilization Management Department at **1-833-230-2101** then state "extension" once the automated phone system completes the introduction. Please then ask for extension 1283. This request for the discussion with the Clinical Peer Reviewer needs to occur within five business days of the determination. After this deadline, you must follow the appeals process.

Post-Stabilization Services

Post-stabilization care services are covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition. Prior authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a participating provider.

To request prior authorization for observation services as a non-participating provider or to request authorization for an inpatient admission, please visit the provider portal to request a prior authorization.

You can also request a prior authorization by calling our Provider Services, follow the prompt for post-stabilization. During regular business hours, your call will be answered by our Utilization Management Department. If calling after regular business hours, the call will be answered by our nurse advice line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

If you have questions related to post-stabilization service, please call the Provider Services.

Access to UM Staff

Providers may call our Utilization Department at **1-833-230-2101** with any questions.

Staff Availability

- Staff members are available via the toll-free telephone line or direct dial telephone number Monday through Friday from 8 a.m. to 6 p.m. Eastern Time (ET) for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours. Providers may leave voice mail messages on these telephone lines after business hours, 24 hours a day, seven days a week. A dedicated fax line and Provider Portal for medical necessity determination requests is also available 24 hours a day, seven days a week.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by first name/last initial, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

For the best interest of our members and to promote their positive health care outcomes, HAP CareSource supports and encourages continuity of care and coordination of care between medical care providers as well as between physical care providers and behavioral health providers.

Pharmacy

HAP CareSource is a qualified health plan in the Health Insurance Marketplace that provides prescription drug coverage. This includes the pharmacy benefit which will provide coverage for prescriptions obtained from an in-network retail pharmacy, mail-order pharmacy, or specialty pharmacy. Additionally, some drugs administered in the patient's home or through a provider's office may also be covered under the medical benefit.

Prescription Drug Coverage

HAP CareSource partners with Express Scripts, Inc. to process medication claims at retail pharmacy, mail- order pharmacy, or specialty pharmacy. Express Scripts, Inc. processes pharmacy claims for all HAP CareSource Michigan Marketplace plans to provide continuity for provider offices and HAP CareSource members.

Copayment/Coinsurance Requirements

Members may be required to pay a copayment or coinsurance for covered prescription drugs. Our plans offer lower cost-shares for less costly drugs. For example, there may be a lower charge for a generic drug, a higher copay for a preferred brand-name drug and an even higher copay for a non-preferred drug. A drug's cost-sharewill never exceed the actual cost of the drug itself.

For specialty pharmacy, a coinsurance is applied. Coinsurance is a percentage of the drug's cost. When members pay a percentage, their cost may be higher than expected for many reasons:

- The cost of the drug may be high. For example, assume the coinsurance is 30 percent. In this case, a $250 drug will be more costly than a $25 drug.
- The drug may not be on a preferred tier on the formulary, so the member pays at a higher tier.
- The member may be buying a more expensive brand-name drug when there is a generic equivalent available for lesser cost, if authorized.

Prescribing providers for HAP CareSource's Marketplace plan members must contact the plan for medication prior authorizations.

For a complete list of drugs available, visit **HAPCareSource.com** > Providers > Tools & Resources > Drug Formulary. Members may also confirm coverage and cost of a specific drug using the HAP CareSource Find My Prescriptions tool at **HAPCareSource.com** > Members > Tools & Resources > Find My Prescriptions.

Tiered Medications

Every drug covered on the HAP CareSource Marketplace Drug Formulary is in one of the tiers below. Typically, the higher the cost-sharing tier number, the higher the cost for the drug:

Tier 0: Prescription drugs in this tier are preventive medications. They have no copay or coinsurance.

Tier 1: Prescription drugs in this tier are low-cost generic drugs. The member's cost-share will be the lowest for drugs in this tier.

Tier 2: Prescription drugs in this tier are preferred single- or multi-source brand name drugs. They will have a higher cost-share than drugs in Tier 1.

Tier 3: Prescription drugs in this tier are non-preferred single- or multi-source brand-name drugs. They will have a higher cost-share than drugs in Tier 1 or 2.

Tier 4: Prescription drugs in this tier are specialty drugs. This tier will have the highest cost-share for members.

Drug Formulary

HAP CareSource uses evidence-based guidelines to ensure health care services and medications meet the standards of excellent medical practice and are the lowest cost alternative for the member.

HAP CareSource uses a Drug Formulary of covered drugs. The Drug Formulary contains information about drugs covered, their cost share tiers and limitations of coverage (such as prior authorizations, quantity limits and step therapy protocols). Drugs are listed by therapeutic class and also by alphabetical index so that therapeutic interchanges for most drug classes are easier to compare. To learn more about how to use our pharmaceutical management procedures, **please visit our website's Pharmacy page at HAPCareSource.com** > Provider Overview > Education > Patient Care > Pharmacy.

HAP CareSource updates the Drug Formulary regularly and communicates any updates online on the Drug Formulary Changes pages. The most up-to-date formulary may be found online at **HAPCareSource.com** > Providers > Tools & Resources > Drug Formulary. Drugs not listed on the Drug Formulary are not covered without prior approval.

Quantity, Supply, Duration and Benefit Limits

Quantity limits and dosing limits are based on normal manufacturers' recommended dosing frequencies and long-term safety considerations, diagnosis and best practices. Limits on opioids or other substances of abuse are based upon maximal morphine equivalent dosing limits and/or applicable law. Additionally, benefit limitations may pertain to preventive coverage or as defined by applicable rights to coverage for our members.

Step Therapy

Certain medications on the Drug Formulary are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a first step formulary medication be tried and failed prior to the approval of a second step formulary medication. A reasonable clinical trial of the step one drug is defined to include appropriate use for labeled or compendia-supported indications, titration of the step one drug (where appropriate), and supporting evidence (such as provider notes or lab results) to show the step one drug has failed. Step two drugs are formulary medications which may require the member to pay higher cost share and also may be more costly to the plan. Step therapy is designed to preserve best practice and protect our member's financial medication burden.

Generic Substitution & Therapeutic Exchange

Generic substitution occurs when a pharmacy dispenses a generic drug that is equivalent to the prescribed brand-name drug. Generic drugs are usually priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Members and providers can expect the generic to produce the same effect and have the same safety profile as the brand-name drug.

Additionally, if a non-formulary brand drug is requested instead of the generic equivalent, a prior authorization request would be required. Non-Formulary Medications Policy requires submission of clinical documentation including clinical notes, proper MedWatch form submissions, etc., as explained in the policy. A determination of clinical appropriateness will be made as explained in the Prior Authorizations section below. If approved, members will pay higher copayments. This can be significant for our members.

Prior Authorization

Medications administered under the pharmacy benefit may require prior authorization before they will be covered. Refer to the Formulary to determine which drugs need prior authorization. Exception requests for medications not listed on the Formulary will also be considered (see below).

Prior authorization requests for medications covered under the **pharmacy benefit** may be submitted electronically via the CoverMyMeds or SureScripts prior authorization portals.

Medications to be administered in an outpatient setting by a physician and billed under a member's medical benefit may also require prior authorization.

Prior authorization requests for medications covered under the **medical benefit** may be submitted electronically through the HAP CareSource Provider Portal.

Please note that prior authorization and exception review requests not accompanied by the necessary clinical information might take longer to process and might result in denials.

For all prior authorization decisions (standard or expedited), HAP CareSource provides notice to the provider and member as expeditiously as the member's health condition requires. Please specify if you believe the request is urgent.

Pharmacy prior authorization requests are reviewed and determinations are made within:

Review Type	Decision Turnaround Time
Pharmacy Benefit (Standard)	72 Hours
Pharmacy Benefit (Expedited)	24 Hours
Medical Benefit (Standard)	Seven Business Days
Medical Benefit (Expedited)	72 Hours
Medical Benefit (Retrospective)	30 Business Days

Formulary Drug Exceptions

Exceptions are requests for drugs not covered on the health plan's Drug Formulary. Typically, our formulary includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective or considered a treatment standard of care equal to or better than the drug you are requesting, we will generally not approve your request for an exception.

Clinically appropriate reasons for approving an exception could include lack of available alternatives on our Formulary to treat the member's condition, a severe intolerance or allergy to all formulary drugs causing hospitalization or submission of a MedWatch notice to the FDA, or the member has failed all available formulary options.

As mentioned previously, drugs that are on the formulary may have utilization management applied for reasons of cost, safety, allowances by state laws and more. All documentation to request an exception must establish the necessity of the requested drug over the available drugs covered by the plan as per each policy.

HAP CareSource has an exception process that allows the member, the member's representative, or the prescribing physician to make a request for a formulary coverage exception, or an exception to utilization management. The member, member's representative or prescribing physician may initiate the request by calling Member Services or by filling out a **Member Exception Request Form**. The prescribing physician may also submit electronically via the CoverMyMeds or SureScripts prior authorization portals. If requested by the member or member's representative, HAP CareSource reaches out to the provider to obtain the appropriate clinical documentation.

HAP CareSource will provide a decision no later than 72 hours after the request is received, or within 24 hours if the request is expedited.

If the initial exception request is denied, providers have the right to request an external review by an Independent Review Organization (IRO). The external review process is outlined in the **"Member Grievances and Appeals"** chapter of this manual.

Other Medical Supplies And Durable Medical Equipment

Limited durable medical equipment (DME) may be covered on the Drug Formulary. Please visit our website for the most recent formulary list at **HAPCareSource.com** > Providers > Tools & Resources > Drug Formulary.

Medications Administered in the Provider's Clinical Setting

Medications that are administered in a provider setting, such as a physician's office, hospital outpatient department, clinic, dialysis center or infusion center will be billed to the health plan through the member's medical benefit. Prior authorization requirements now exist for many injectable medications.

Medication Therapy Management Program

HAP CareSource offers a Medication Therapy Management (MTM) program for all members. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs and provide health care to patients in a cost-effective manner. You may be contacted by a pharmacist to discuss your patients' medications. We also encourage members to talk with their pharmacist about their medications, as we want to make sure they are getting the best results from the medications they are taking.

Network Pharmacies

Our Pharmacy Directory gives members a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website for a complete list of network pharmacies at **HAPCareSource.com** > Members > Tools & Resources > Find My Prescriptions > Find A Pharmacy.

Member Enrollment and Eligibility

The Health Insurance Marketplace is responsible for determining whether applicants are eligible for benefits under the plan, the application and enrollment processes and any subsidy level that may apply. Applicants must be lawfully present of the United States and reside in the plan's service area.

Members must enroll in the Marketplace every year. They must inform the Marketplace if they become pregnant, have a baby, change address or phone number, have a change in income or marital status or become eligible for other health care coverage.

Member Eligibility Verification

Providers are expected to verify member eligibility each time a service is rendered.

Providers may use the Provider Portal to verify member eligibility. Upon logging in to the Provider Portal, providers will be able to view member eligibility with:

- 24 months of history
- Member span information
- Multiple member look-up (up to 500)

You can also verify eligibility with HAP CareSource by calling our Provider Services at **1-833-230-2101**.

Member ID Cards

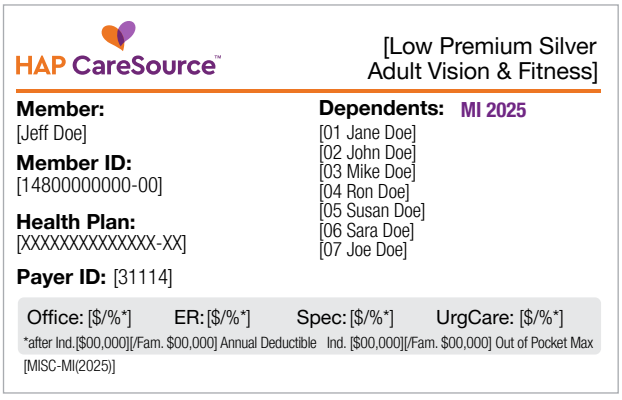
The member ID card is used to identify a HAP CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from HAP CareSource and retain their ID card. Therefore, it is important to verify member eligibility prior to each service rendered.

Providers may use our secure Provider or call Provider Services at **1-833-230-2101** to check member eligibility:

- Click on “Member Eligibility” on the left, which is the first tab. Make sure to enter the full 11-digit member ID number for the person, and if a dependent, include the dependent suffix.

Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification.

Sample Marketplace Member ID Card


HAP CareSource™

[Low Premium Silver Adult Vision & Fitness]

Member:
[Jeff Doe]

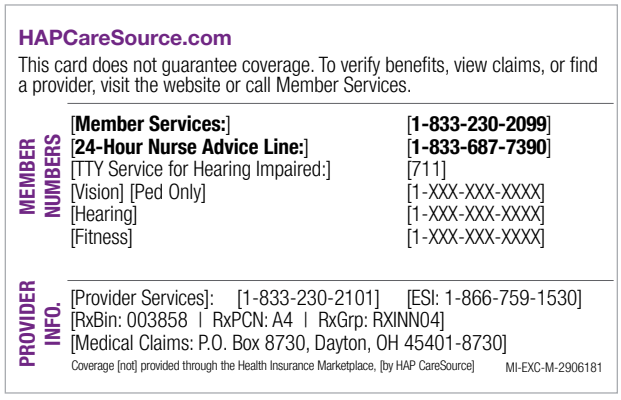
Member ID:
[14800000000-00]

Health Plan:
[XXXXXXXXXXXXX-XX]

Payer ID: [31114]

Dependents: MI 2025
[01 Jane Doe]
[02 John Doe]
[03 Mike Doe]
[04 Ron Doe]
[05 Susan Doe]
[06 Sara Doe]
[07 Joe Doe]

Office: [$/%*] ER: [$/%*] Spec: [$/%*] UrgCare: [$/%*]
*after Ind.[$00,000][/Fam. $00,000] Annual Deductible Ind. [$00,000][/Fam. $00,000] Out of Pocket Max
[MISC-MI(2025)]


HAPCareSource.com
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the website or call Member Services.

MEMBER NUMBERS

[**Member Services:**]	[**1-833-230-2099**]
[**24-Hour Nurse Advice Line:**]	[**1-833-687-7390**]
[TTY Service for Hearing Impaired:]	[711]
[Vision] [Ped Only]	[1-XXX-XXX-XXXX]
[Hearing]	[1-XXX-XXX-XXXX]
[Fitness]	[1-XXX-XXX-XXXX]

PROVIDER INFO.

[Provider Services]: [1-833-230-2101] [ESI: 1-866-759-1530]
[RxBin: 003858 | RxPCN: A4 | RxGrp: RXINN04]
[Medical Claims: P.O. Box 8730, Dayton, OH 45401-8730]
Coverage [not] provided through the Health Insurance Marketplace, [by HAP CareSource] MI-EXC-M-2906181

ID Card Elements

- **Member plan** – Member’s plan choice will be included in this area
- **Member** – This is the name of the plan holder.
- **Member ID** – This is the ID number + suffix for the plan holder.
- **Health plan number**
- **Payer ID number**
- **Copay amounts** – for office, emergency room, specialist and urgent care visits.
- **Dependents** – This is the member specific suffix & name. When checking eligibility and/or submitting claims for dependents, please ensure you replace the subscriber suffix (last 2 digits, usually 00) of the Member ID number with the dependent suffix from the ID card.
- **Member Services phone number**
- **24/7 Nurse Advice Line**
- **Provider Services phone number**

- **Benefit Manager Information** – HAP CareSource partners with several benefit managers to provide our members with the best service possible in specific benefit categories. This section identifies the benefit category, company name and contact number. Please ensure that when referring members for these related services, you are leveraging these resources.
- **Address to submit medical claims**
- **Deductibles and Maximum Out of Pocket (MOOP)** – These are listed as the individual amount for plans with only a single member and the family amount for plans with multiple members. Members will be only responsible for satisfying their individual deductible or MOOP which is half of the family amount.
- **Pharmacy numbers**

New Member Welcome Kits

Once a member has paid to effectuate their coverage, each household receives a new member kit and two or more ID cards that include each family member who has joined HAP CareSource. The new member kits are mailed separately from the ID card.

New Member Welcome Kit Elements

- A welcome letter
- A Member Handbook, which explains plan services and benefits and how to access them
- A quick start guide for how to get started with HAP CareSource
- HAP CareSource's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA)
- Other preventive health education materials and information, including how to select a PCP and how to complete an initial health screening

Finding a Doctor

Members are generally referred to our online Find-a-Doctor directory tool. The online Provider Directory, which lists participating HAP CareSource providers and facilities within a certain radius of the member's residence, provides the latest information on our provider network. A current list of providers can be found at any time on HAP CareSource's website, **HAPCareSource.com** > Members > Tools & Resources > Find a Doctor.

Members will only receive a printed copy of our Provider Directory if they requested one at the time of enrollment or by returning a request postcard included in their new member kits. As the contents of the printed directory are subject to change, we encourage members to call HAP CareSource or to use the online provider directly to confirm they are in network.

Member Disenrollment

Members may disenroll from HAP CareSource for a number of reasons. Disenrollment may be initiated by the member, HAP CareSource or the Health Insurance Marketplace.

Member Grace Period

Members have a federally mandated 90-day grace period if they are receiving advanced premium tax credit (APTC), or a 31-day grace period if they are not receiving APTC in which to make their payment.

- This is not applicable for their initial payment
- For APTC-receiving members, 30 days after their due date HAP CareSource will: flag the member in the eligibility file on the Provider Portal, suspend pharmacy benefits and pend claims rendered
- For non-APTC members, the day after their due date, HAP CareSource will: flag the member in the eligibility file and on the Provider Portal, suspend pharmacy benefits and pend claims rendered

If members bring their account into good standing before the expiration of the grace period, pharmacy benefits will start again and pended claims will be processed.

Member Termination

After the grace period has expired, the member is terminated for non-payment of premium.

- HAP CareSource will retroactively terminate the member to either the last day of the first month of the grace period (APTC) or the last paid date (non-APTC).
- HAP CareSource will then deny claims that are pended during the grace period and reserves the right to recover any amounts paid in this period.

Covered Services and Exclusions

This section describes some of the services and exclusions to benefits that are provided to our HAP CareSource members. HAP CareSource requires all covered service s to be medically necessary. Covered services may require prior authorization. Please visit the Provider Portal at **HAPCareSource.com** > Login > Provider in MI for the most up-to-date list of services that require prior authorization.

Covered Services

HAP CareSource's Marketplace product is compliant with the Affordable Care Act in terms of benefit offerings and cost share applications. See our Evidence of Coverage and Schedules of Benefits at **HAPCareSource.com** > Plans > Plan Documents for more detail. Please refer to our website and the **"Referrals and Prior Authorizations"** chapter of this manual for more information about referral and prior authorization procedures.

Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Provider Services at **1-833-230-2101**.

Any services rendered in excess of the benefit limits will be denied.

Prior Authorizations and Determinations

Some services require Prior Authorization. When request for authorization is submitted, HAP CareSource will notify the provider and member in writing of the determination. If a service cannot be covered, the letter from HAP CareSource will include the reason that the service cannot be covered and how to request an appeal if necessary.

If a service cannot be covered, providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the **"Provider Appeals Procedures"** section on page 79 of this manual for information on how to file an appeal.

Pediatric Vision

All HAP CareSource pediatric members have access to vision benefits. Pediatric vision services are provided exclusively through our Vision Benefits Manager, EyeMed, and the benefit covers eye exams (no cost), eyewear including glasses or contact lenses, as well as other value add services through the relationship such as low vision exams/aids and discounts on a wide array of materials and services.

Routine Hearing Exams and Hearing Aids

All HAP CareSource members have access to no cost routine hearing exams through our vendor, TruHearing. Members must contact TruHearing's member services to establish a relationship with a hearing specialist who will guide them through finding a provider, setting up an appointment, as well as supporting them through any follow up processes to ensure satisfaction.

Optional Adult Vision and Fitness

HAP CareSource's Vision, & Fitness plans provide adult members (19 years and older, except as stated below) the ability to access the following benefits:

Vision – Adult routine vision benefits are available exclusively through our Vision Benefits Manager, EyeMed, and include eye exams (cost share may apply), eyewear including contact lenses, as well as other value add services through the relationship such as low vision exams/aids and discounts on a wide array of materials and services. Eyewear (glasses and contacts) are subject to a $250 allowance each calendar year with no copay/deductible.

Fitness – Available for members age 18 and above, HAP CareSource is proud to offer our adult members access to the Active&Fit® program with no member cost share. The Active&Fit program provides your patient with a no cost access to their network of participating fitness centers and select YMCAs along with access to up to two home fitness kits per benefit year, online tools such as fitness center search, a quarterly online newsletter, online classes and more.

The Active&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit is a trademark of ASH and used with permission herein.

Member Support Services and Benefits

HAP CareSource provides a wide variety of support and educational services to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

HAP CareSource Member Services

Representatives are available by telephone Monday through Friday, except on observed holidays.

Please visit **HAPCareSource.com** > About Us > Contact Us for the holiday schedule or contact Provider Services for more information.

Members access Member Services by calling our Member Services department at **1-833-230-2099** from 7 a.m. to 7 p.m. ET, and telling our interactive voice response (IVR) system what their question is regarding.

24-Hour Nurse Advice Line

Members can call our nurse advice line 24 hours a day, seven days a week. Members have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions.

Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is the "Gold Standard" in telephone triage, offering evidence-based triage protocols and decision support.

Our nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the PCP by explaining the importance of their role in coordinating the member's care. For improved care coordination with PCPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse provided.

Key features of this service include nurses who:

- Assess member symptoms
- Advise of the appropriate level of care
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP-member relationship

Members may access our 24-hour nurse advice line anytime night or day. The phone number is on the member's ID card.

Care Management/Outreach

HAP CareSource provides the services of care management that consists of physical and behavioral health nurses, behavioral health professionals and outreach specialists to provide one-on-one, personal interaction with patients. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team. Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging treatment adherence, reinforcing medical instructions and assessing social and safety needs, as well as educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many conditions.

Direct Access to Case Management referrals and assistance with member needs is available by phone **1-833-230-2064** or by fax 1-844-839-6395. Providers can also make electronic case management referrals on the Provider Portal.

Care Management Services

HAP CareSource's Care Management program is a fully integrated health management program that strives for member understanding of and satisfaction with their medical care. We promote integration of physical and behavioral health to manage the member across the continuum of care with a holistic approach. More importantly, it's designed to support the care and treatment you provide to your patient. We stress the importance of establishment of the medical home, identification of barriers and keeping appointments.

This one-on-one personal interaction with outreach specialists, behavioral health professionals, and nurse care managers provides a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care and education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional community resources, such as housing and food resources. Our Care Management team can also assist members and providers with discharge planning for inpatient stays, or other transitions of care.

We offer individualized education and support for many conditions and needs, including:

- Asthma
- Chronic Kidney Disease (CKD)
- Diabetes
- Heart disease
- Depression
- High blood pressure and cholesterol
- Pregnancy
- Weight loss

HAP CareSource encourages you to take an active role in your patients' care management programs and participate in the development of individualized care plans to help meet their needs. Together, we can make a difference.

MyResources

The MyResources search engine is a social service and community resource search tool. The MyResources Tool connects members with local low-cost and no cost community-based programs and social services. The tool is easy to use and allows our staff and members to search for a wide category of resources like food, housing, transportation, and job training programs by simply entering a zip code from anywhere in the United States.

The search information is provided in real time, including 8 a.m. - 7 p.m. ET, Monday through Friday, distance from the zip code entered, and other locations nearby. More than 100 languages are supported, and resources can be updated and new resources suggested directly from the site. Other features include the ability to send a resource to a friend via email or text.

Health Risk Assessment (HRA)

HAP CareSource asks that all members complete the Health Risk Assessment (HRA). Through a few questions about their health and well-being, HAP CareSource can help identify health, housing, education and employment concerns where we may be able to help.

HAP CareSource wants members to take a Health Risk Assessment (HRA) when they join HAP CareSource and each year after. Members answer questions about their health and habits. This tool helps identify members' health needs. It shows HAP CareSource how they can help members get and stay healthier.

Completing the HRA is simple! Members can complete the HRA in one of the following ways:

- Call our Member Assessment Team at **1-833-230-2011 (TTY: 711)** Monday through Friday, 7 a.m. to 6 p.m. ET
- Visit MyHAPCareSource.com and click on My HAP CareSource account
  - Click on the Health tab at the top of the navigation bar
  - Scroll and click on the 'Health Risk Assessment'
- New members can complete the printed copy of the HRA included with their new member packet. It can be returned in the enclosed self-addressed, postage paid envelope

Tobacco Cessation Program

In an effort to help members maintain a healthy lifestyle, HAP CareSource would like to remind providers of resources available for tobacco cessation. This includes not using tobacco products as well as prevention. The Tobacco Quitline aims to increase members' knowledge of the risks associated with tobacco use and the benefits of cessation. The program provides regular health coaching as well as information on how to obtain pharmacotherapy, from a provider, to assist with quitting. For more information, please contact the Tobacco Quitline at 1-800-QUIT-NOW (800-784-8669).

Mom and Baby Beginnings Team

HAP CareSource has a program for perinatal and neonatal care management utilizing a staff of specialized nurses. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members. This outreach program is offered in partnership with community agencies to target members at greatest risk for preterm birth or complication. The expertise offered by the staff includes a focus on patient education and support and involves direct telephone contact with members and providers. We encourage our prenatal care providers to notify our Care Management department when a member with a high-risk pregnancy has been identified.

Referrals to the Mom and Baby Beginnings program can be made via phone at **1-833-230-2034**, or email at MBB@HAPCareSource.com.

Disease Management Program

Our free Disease Management Program helps our members find a path to better health through information, resources, and support.

We help our members through:

- The MyHealth online program for members 18+ with health education and self-management tools (called Journeys) to help manage chronic conditions and improve their overall health.
- Educational materials with helpful tips and information to manage their disease, promote self-management skills, and provide additional resources.
- Coordination with outreach teams such as wellness advocates and health coaches
- One-to-one care management

Members with specific chronic conditions are identified by criteria or triggers such as emergency room visits, hospital admissions, and the health assessment. All ages (children, teens, and adults) are eligible. These members are automatically mailed quarterly condition-specific newsletters. The materials are available in English and other predominant languages upon request. Any member may self-refer or be referred into the Disease Management Program to receive condition-specific information or outreach. If a member does not wish to receive newsletters or outreach, they can contact HAP CareSource to update their contact preferences.

Disease Management Benefits to Members and Health Partners

Members identified in the Disease Management Program receive help finding the appropriate level of care for their condition, and they are encouraged to actively participate in the patient-provider relationship. The program improves the percentage of HAP CareSource members who receive their recommended screenings.

If you have a patient with asthma, diabetes, or hypertension who you believe would benefit from this program and are not currently enrolled, please call **1-844-438-9498**.

MyHealth Rewards

HAP CareSource offers MyHealth Rewards for members over the age of 18 who actively participate in healthy behaviors. The program encourages the member to complete healthy activities, such as taking their Health Risk Assessment (HRA); having routine exams; and completing screenings for cholesterol, colorectal cancer and more. Members can also participate in a tobacco cessation program to earn rewards.

Members can redeem their rewards through the MyHealth website for a variety of gift cards to national retailers such as iTunes®, Google® Play, TJ Maxx®, Sephora®, Old Navy®, Panera Bread® and more. Members can access MyHealth via the MyHealth option from the Health tab on MyLife.CareSource.com.

Activity	Who's Eligible	Rewards*
Comprehensive diabetes care measures: A1C, Kidney Screening and Retinal Eye Exam	All Adults Diagnosed with Diabetes (Type 1 or 2)	$25 each, once per calendar year
Breast Cancer Screening	Females 50-74 years old	$25 once per calendar year
Colorectal Cancer Screening	Adults ages 45-75 years old	$25 once per calendar year

**The rewards available will vary depending on the member's health care needs. Note that not all reward activities are covered services annually. Members may be responsible for the cost if they do not check with HAP CareSource or their PCP before receiving services.*

To get started with the HAP CareSource online wellness program, members simply login to their personal online My HAP CareSource account, click on the *Health* tab and then select the link for the *MyHealth – Wellness Program.*

Emergency Department Diversion Program

HAP CareSource is committed to making sure our members access the most appropriate health care services at the appropriate time for their needs. Members are informed to call 911 or go to the nearest emergency department (ED) if they feel they have an emergency. HAP CareSource covers all emergency services for our members.

We instruct members to call their PCP or the 24-Hour Nurse Advice Line if they are unsure if they need to go to an ED. HAP CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access.

Member ED utilization is tracked closely. If there is frequent ED utilization, members are referred to our Case Management department for analysis or intervention. Members are contacted via phone or mail. Intervention includes education, as well as assistance with removing any identified health care access barriers. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Interpreter Services

HAP CareSource offers over-the phone language interpreters for members who need assistance to communicate with HAP CareSource. These services are available at no cost to the member.

HAP CareSource requires providers, at their own expense, to offer sign and language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking ability. These services should be available at no cost to the member. You are also required to identify the need for interpreter services for your HAP CareSource patients and offer assistance to them appropriately. We can provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during well-child exams as needed. HAP CareSource endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). This schedule is updated annually and the most current updates are located on **www.aap.org**.

Immunization Codes

Please bill HAP CareSource with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. Please refer to the code tables located on the CMS website at www.cms.gov/medicare/coding-billing/icd-10-codes. You can also get CMS coding guidelines at www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

Health Education

HAP CareSource members receive health information from HAP CareSource through a variety of communication vehicles including brochures, phone calls and personal interaction. HAP CareSource also sends preventive care reminder messages to members via mail and automated outreach messaging.

Member Grievances and Appeals

We want you to be happy with the services you get from HAP CareSource and 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 at **1-833-230-2099 (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 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 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 staff member was rude to you.
- Your provider or a(n) HAP CareSource 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 at **1-833-230-2099 (TTY: 711)**. You can also file your grievance in writing via mail or online at:

Mail:

HAP CareSource
Attn: Grievance & Appeals
P.O. Box 1947
Dayton, OH 45401-1947

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 **1-833-230-2099 (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 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 plan 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 an external review 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 180 calendar days of the date on the Adverse Benefit Determination letter. 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 at **1-833-230-2099 (TTY: 711)**. You can also file your appeal in writing via mail or online at:

Mail:

HAP CareSource
Attn: Grievance & Appeals
P.O. Box 1947
Dayton, OH 45401-1947

Online:

HAPCareSource.com

You have several options for assistance. You may:

- Call Member Services at **1-833-230-2099 (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 HAP CareSource Appointment of Representative form.

You may call and request the form or find this form on our website at **www.CareSource.com/mi/members/tools-resources/forms/marketplace/.**

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 for pre-service, or 60 calendar days of the date we received your appeal request for post-service. HAP CareSource may request an extension up to 10 business 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'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 for pre-service or 60 calendar days for post-service 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 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 at **1-833-230-2099 (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 an External Review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services (DIFS).

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 120 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:

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

Phone: 1-877-999-6442

Fax: 1-517-284-8838

Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

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.

For more information, refer to the member's handbook: HAP CareSource or HAP CareSource MI Health Link.

HAP CareSource Member Rights and Responsibilities

As a HAP CareSource provider, you are required to respect the rights of our members. HAP CareSource members are informed of their rights and responsibilities via their Member Handbook. The list of our members' rights and responsibilities are listed below. All members are encouraged to take an active and participatory role in their own health and the health of their families.

Member Rights and Responsibilities, as Stated in the Member Handbook, are as Follows:

- Receive information about HAP CareSource, our services, our network providers and member rights and responsibilities.
- Be treated with respect and dignity by HAP CareSource personnel, network providers and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive.
- Participate with your doctor in making decisions about your health care.
- Candidly discuss with your doctor the appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about the plan or the care it provides.
- Make recommendations regarding the plan's member rights and responsibilities policy.
- Choose an advance directive to designate the kind of care you wish to receive should you be unable to express your wishes.

Members of HAP CareSource are Also Informed of the Following Responsibilities:

- Supply information needed, to the extent possible, that the organization and its doctors need in order to provide care.
- Follow the plans and instructions for care that you have agreed to with doctors.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Be enrolled and pay any required premiums.
- Pay an annual deductible, copayments and coinsurance.
- Pay the cost of limited and excluded services.
- Choose network providers and network pharmacies.
- Show your ID card to make sure you receive full benefits under the plan.
- Report suspected fraudulent behavior to HAP CareSource.

HIPAA Notice of Privacy Practices

Members are notified of HAP CareSource's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (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. HAP CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members.

As a provider, please remember to follow the same HIPAA regulations as a covered entity and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations. Thank you for your assistance in providing requested information to HAP CareSource in a timely manner.

Please remember that 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.

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 in MI 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 of the patient's health information on the Provider Portal.

Please encourage your HAP CareSource patients who have not consented to complete a 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 & Resources > Forms. The 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.

Americans with Disabilities Act

The Americans with Disabilities Act (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.

Providers are required to comply with ADA standards, including but not limited to:

- Providing waiting room and exam room furniture that meet 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 HAP CareSource provider network must make reasonable accommodations to ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. HAP CareSource and its network providers will comply with the ADA (28 C.F.R. 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 https://www.ada.gov/.

HAP CareSource Health Equity Commitment

At HAP CareSource, we are dedicated to the communities we serve, and to making a positive impact in the lives of our members through the elimination of health disparities, supporting health equity initiatives and partnering with community stakeholders to carry out this work.

We recognize language and cultural differences have a significant impact on member health care experience and outcomes. Consistent with federal mandate 42 CFR 438.206 (c) (2), Access and Cultural Considerations, HAP CareSource Network Partners, LLC and its Affiliates, including HAP CareSource 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 prohibit our providers or partners from refusing to treat, serve or otherwise discriminate against an individual because of race, color, national origin, disability, age, religion, or sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes).

In consideration of cultural differences, including religious beliefs and ethical principles, we will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the United States Department of Health and Human Services (HHS).

Cultural Competency

Cultural competency within HAP CareSource is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population.” It is the use of a system’s perspective which values differences and is responsive to diversity at all levels in an organization.

Cultural competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Participating providers are expected to deliver services in a culturally competent manner, which includes removing all language barriers to service and accommodating the unique ethnic, cultural, and social needs of the member. Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

Providers can address racial and ethnic gaps in health care with an awareness of cultural needs and improving communication with their growing numbers of diverse patients. HAP CareSource recognize cultural differences, including religious beliefs and ethical principles. In accordance with this, providers are not required to perform any treatment or procedure that is contrary to their religious or ethical principles.

CLAS Standards: National Culturally & Linguistically Appropriate Standards

The Office of Minority Health (United States Department of Health & Human Services, 2018), created National Culturally and Linguistically Appropriate Standards (CLAS) to provide a blueprint for implementing culturally and linguistically appropriate services for health and health care organizations to:

- Advance health equity
- Improve quality
- Help eliminate health disparities

HAP CareSource recognizes language and cultural differences have the potential to negatively impact interactions between providers, members, and employees.

HAP CareSource adheres to the National Culturally & Linguistically Appropriate Standards (CLAS), which serve as a blueprint for health care providers and organizations to implement culturally and linguistically appropriate services. CLAS consists of 15 standards that encompass the following topic areas:

- Principal Standard: Provision of effective, equitable, understandable, and respectful quality care and services that are response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs
- Governance, Leadership, and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement & Accountability Network providers must ensure that:
- Members understand that they have access to free medical interpreter services in their native language, including Sign Language. No cost TDD/TTY services are available to facilitate communication with hearing impaired members.
- Health care is provided with consideration of the members' cultural background, encompassing race/ethnicity, language and health beliefs. Cultural considerations may impact/influence member health decisions related to preventable disease or illness.
- The provider office staff makes reasonable attempts to collect race-and language-specific member data. The staff is available to answer questions and explain race/ethnicity categories to a member, to assure accurate identification of race/ethnicity for all family members.
- Treatment plans are developed based on evidence-based clinical practice guidelines with consideration of the member's race, country of origin, native language, social norms, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

HAP CareSource encourages our participating providers to visit the U.S. Department of Health and Human Services Office of Minority Health website. Their Cultural Competency Resources website found at: https://thinkculturalhealth.hhs.gov/ provides toolkits and educational resources. Included on the site is a free 9 credit Continuing Medical Education (CME) course, A Physician's Practical Guide to Culturally Competent Care. This self-directed e-learning program equips providers to better understand and treat diverse populations.

Quality Improvement Program

HAP CareSource is committed to providing evidence-based care in a safe, member-centered, timely, efficient and equitable manner. The scope of our HAP CareSource Quality Improvement (QI) Program is comprehensive and inclusive of both clinical and non-clinical services as well as health, safety and/or welfare concerns. HAP CareSource uses a population health lens to monitor and evaluate the quality of the care and service delivered to our members emphasizing:

- Accessibility and availability to medical, behavioral health and other care
- Equitable delivery of service
- Quality of care and member safety
- Internal monitoring, review, and evaluation of program areas, including but not limited to, Utilization Management, Case Management and Pharmacy

Member and provider satisfaction and health outcomes are monitored through:

- Quality improvement activities
- Routine health plan reporting
- Annual Health Effectiveness Data and Information Set (HEDIS®) measures the quality of our health plan
- Qualified Health Plan (QHP) Enrollee Experience Survey scores
- Member feedback captured via surveys, inclusion in advisory workgroups and collection by member facing employees
- Review of accessibility and availability standards
- Utilization trends

HAP CareSource assesses our performance against goals and objectives that are in keeping with industry standards. Annually, we complete an evaluation of our QI Program. We submit the evaluation which includes identified priority areas for improvement and the degree to which improvement was achieved for each priority year to the appropriate accrediting bodies.

HAP CareSource is a partnership between Health Alliance Plan of Michigan (HAP) and CareSource. It's a nonprofit corporation and accredited by the National Committee on Quality Assurance (NCQA). CareSource is fully accredited by NCQA for our Kentucky, Indiana, Ohio, and West Virginia Marketplace plans. NCQA is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement.

Program Scope

HAP CareSource supports an active, ongoing and comprehensive quality improvement program across the organization. Performance goals are developed to measure the components of our program, including performance against national benchmarks.

HAP CareSource uses HEDIS® as one method to determine the quality of care delivered to members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS data collection and reporting is developed and maintained by NCQA. HEDIS is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence- based research and address significant health priorities in the United States.

HAP CareSource uses the annual member survey, Qualified Health Plan Enrollee Experience (QHPEE) Survey, to capture how a member views the quality of health care received. CAHPS QHPEE is a survey overseen by the United States Department of Health and Human Services. Potential QHPEE survey measures include:

- Helpful and courteous customer service
- Getting care quickly, for example, getting timely care for an illness or an injury
- Ease of access in obtaining needed care
- Providers' ability to communicate and show respect to member
- Ratings of all health care, health plan, personal, doctor, and specialists

The HAP CareSource Quality Improvement Program oversees quality assessment and performance improvement activities for our HAP CareSource Marketplace members to maintain a robust QI Program, our scope includes:

- Advance health equity related issue including reduction of health disparities
- Ensure regulatory and accrediting agency compliance, including:
- Perform HEDIS® compliance audit and performance measurement.
- Ensure compliance with NCQA accreditation standards.
- Establish safe clinical practices throughout our network of providers.
- Provide quality oversight of all clinical services, including addressing all quality-of-care concerns.
- Advocate for members across settings, including review and resolution of quality-of-care concerns.
- Meet member access and availability needs for physical and behavioral health care.

Using interventions for HEDIS overall rate improvement to increase preventive care rates and facilitate support of member acute and chronic health conditions and other complex health, safety, or welfare needs.

- HAP CareSource uses the annual member QHPEE survey and other enrollee experience surveys to assess member perspectives on health care quality and establishes interventions based on results to enrich member and provider experience and satisfaction.
- The use the Institute for Healthcare Improvement (IHI) model for improvement methodologies and Six Sigma, where appropriate, to evaluate initiatives and effect change.
- Ensure HAP CareSource is effectively serving our members with cultural and linguistic needs, as well as identified disparities that may impact member receipt of health care services and achieving positive member outcomes.
- Monitor important aspects of care to ensure the health, safety and welfare of members across healthcare settings Ensure that HAP CareSource is effectively serving members with complex health needs.
- Ongoing assessment of member population health characteristics.

- Regularly assess the geographic availability and accessibility of primary and specialty care providers.
- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings.
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies.
- Conduct regular Provider Satisfaction Survey with results driving improvement initiatives and education development.

Quality Strategy

HAP CareSource seeks to advance a culture of quality and safety that begins with our executive and senior leadership and is cultivated throughout the organization. HAP CareSource utilizes the Institute of Healthcare Improvement (IHI) framework developed to optimize health system performance, as well as the CMS National Quality Strategy, which is a national effort to align public-and private-sector stakeholders to achieve better health and health care.

Institute for Healthcare Improvement Quadruple Aim for Populations

HAP CareSource aligns with the IHI framework to:

- Enhance the experience and outcomes of the member
- Improve the health of populations
- Reduce the per capita cost of health care
- Improve provider satisfaction
- Advance health equity

In addition, HAP CareSource utilizes Six Sigma tools, when indicated, to focus on improving member experience, member safety and ensuring our processes consistently deliver the desired results.

Quality Measures

HAP CareSource adheres to the following quality measures as part of our QI Program:

- Achieve and maintain National Committee for Quality Assurance (NCQA) accreditation
- Assure compliance with NCQA accreditation standards
- Receive scores on Healthcare Effectiveness Data and Information Set (HEDIS) that reflect a high level of performance
- Receive scores on QHPEE Survey that reflect a high level of performance
- Develop and maintain a comprehensive population health management program
- Develop and maintain a comprehensive provider engagement program
- Ensuree HAP CareSource is meeting all federal and state requirements for a quality improvement and management program.

HAP CareSource continually assesses and analyzes the quality of care and services provided to our members, through the use of objective and systematic monitoring and implementation of quality improvement initiatives.

Member Health, Safety & Welfare

HAP CareSource recognizes that patient safety is the cornerstone of high-quality health care, contributing to the overall health and welfare of our members. Our HAP CareSource Patient Safety Program evaluates patient safety trends with the goal of reducing avoidable harm. Our patient safety program is developed in the context of our population health management approach and includes regulatory/accreditation, policies and procedures, training and implementation, continuous monitoring and program evaluation and improvement. Safety events are monitored through retrospective review of quality of care concerns and real-time reporting of claims data. Data analysis of our provider and health system network ensures situational risks can be identified in a timely manner, reviewed, and mitigated by a proactive corrective action, or performance improvement steps.

Clinical Practice Guidelines & Preventive Guidelines

HAP CareSource approves and adopts evidence-based nationally accepted standards and guidelines and promotes them to practitioners and members 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 topics. 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 these guidelines allows HAP CareSource to measure their impact on member health outcomes. Review and approval of the guidelines are completed by the HAP CareSource Provider Advisory Committee (PAC) and Enterprise PAC. The Quality Enterprise Committee (QEC) is notified of guideline approval. Topics for guidelines are identified through analysis of Marketplace plan members. Guidelines may include, but are not limited to:

- Behavioral health (e.g., depression)
- Adult health (e.g., hypertension and diabetes)
- Population health (e.g., obesity and maternity care)

Guidelines may be promoted to practitioners and providers through newsletters, our website, direct mailings, provider manual, and through focused meetings with HAP CareSource Provider Engagement Specialists. Information regarding clinical practice guidelines and other health information may be made available to members via member newsletters, the HAP CareSource member website, or upon request.

If you would like more information on our Quality Management and Improvement Program, please visit **HAPCareSource.com** > Provider Overview > Education > Quality Improvement or call Provider Services at **1-833-230-2101**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Medical Records

Physicians shall prepare, maintain, and retain as confidential the health records of all members receiving health care services and members' other personally identifiable health information received from HAP CareSource, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and provider are subject, and in accordance with accepted practices.

Providers are required to maintain member records on paper or in an electronic format. Member medical records shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review.

Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records and other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the contract. Medical records shall be signed by the provider of service.

The PCP also must maintain a primary medical record for each member that contains sufficient medical information from all providers involved in order to ensure quality of care.

The medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information, on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school name and telephone numbers (if no phone, contact name and number) of emergency contacts, consent forms, identification of language spoken and guardianship information
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions and known allergies noted in a prominent location;
- Past medical history, including serious accidents, operations and illnesses [for children, past medical history includes prenatal care and birth information, operations and childhood illnesses (e.g., documentation of chickenpox)
- Identification of current problems
- The consultation, laboratory and radiology reports in the medical record shall contain the ordering provider's initials or other documentation indicating review
- Documentation of immunizations
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or the Department for Public Health
- Follow-up visits provided and (secondary) reports of emergency room care
- Hospital discharge summaries
- Advance medical directives, for adults
- All written denials of service and the reason for the denial
- Record legibility to at least a peer of the writer (records judged illegible by one reviewer shall be evaluated by another reviewer)

A member's medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's physical/behavioral health, including mental health and substance abuse status

- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services addressed from previous visits
- Plan of treatment including:
  - Medication history, medications prescribed, including the strength, amount, directions for use and refills
  - Therapies and other prescribed regimen
  - Follow-up plans including consultation and referrals and directions, including time to return
- A member's medical record shall include the following minimal detail for hospitals and mental hospitals:
- Identification of the beneficiary
- Physician name
- Reasons and plan for continued stay if applicable
- Other supporting material the committee believes appropriate to include
- For non-mental hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable

Access Standards

HAP CareSource has a comprehensive quality program to help ensure our members receive the best possible health care services. It includes evaluation of the availability, accessibility and acceptability of services rendered to patients by participating providers.

HAP CareSource expects participating providers to have procedures in place to see patients within these time frames and to offer 8 a.m. - 7 p.m. Monday through Friday to their HAP CareSource patients that are no less (in number or scope) than the 8 a.m. - 7 p.m. Monday through Friday offered to non-HAP CareSource members.

Primary Care Providers

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 15 business days

For Primary Care Providers (PCPs) only: Provide 24-hour availability to your HAP CareSource patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PCP or a back-up provider to be triaged for care. **It is not acceptable to use a phone message that does not provide access to you or your back-up provider, and only recommends emergency room use for after hours.**

Non-Primary Care Providers (Specialists)

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine	Not to exceed 30 business days

Behavioral Health

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Non-life-threatening emergency	Not to exceed 6 hours
Urgent care*	Not to exceed 48 hours
Initial visit for routine care	Not to exceed 10 business days
Follow-up routine care	Not to exceed 30 calendar days based off the condition
Follow-up after discharge	Within seven calendar days from the date of discharge (for members engaged with Case Management)

*A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms.

It is expected that if a provider is unable to see the member within the appropriate time frame, HAP CareSource will facilitate an appointment with a participating provider or a non-participating provider, if necessary.

For the best interest of our members and to promote their positive health care outcomes, HAP CareSource supports and encourages continuity of care and coordination of care between medical care providers as well as between physical care providers and behavioral health providers.

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and are critical for claims processing. Additionally, it ensures our directories are up-to-date and reduces unnecessary calls to your practice.

Provider Changes

Providers should submit provider adds, demographic or status changes and terminations via the HAP CareSource™ Provider Change Form. The form is available on our website by visiting **HAPCareSource.com** > Provider > Provider Resources > Provider Maintenance.

Once complete, email the form to providernetwork@hap.org with the subject line Provider Change Form. In the body of the email, be sure to include:

- Type 1 NPI
- Type 2 NPI
- Tax ID

For more information on this process, go the **"Submitting Provider Changes"** section of this manual.

Quality of Care Reviews

HAP CareSource continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

HAP CareSource ensures the provision of safe and quality care to members by investigating and mitigating potential quality of care concerns, that include:

- Inappropriate or inconsistent treatment
- Delay in receipt of care
- Compromising member health, safety or welfare
- Having the potential to limit functional abilities on a permanent or long-term basis

To properly assess quality of care concerns HAP CareSource Enterprise Quality Improvement initiates contact with providers to request medical records using established processes and timelines. As per our policies and provider contracts, we are authorized to ask for protected health information for health care operations, which includes quality issue reviews. Medical record requests are forwarded to providers via mail, e-mail or fax and may be returned to HAP CareSource via these same mechanisms as detailed in the medical record request document.

All providers are expected to return medical record requests related to quality-of-care concerns within 14 days from initial receipt of the request, unless otherwise defined by program guidelines or state or federal law requirements. If a state, federal or regulatory agency, or if the health and safety of a member requires that medical records must be submitted under a shorter time frame, providers are expected to comply with the shorter turnaround time. Providers and facilities that utilize third party health information management vendors are responsible for providing medical records to HAP CareSource or facilitating delivery of medical records to HAP CareSource by the identified contractor. We are legally bound to interact with providers only and HAP CareSource is not subject to any fees charged by health information management companies for medical record retrieval or submission.

Your health partner representative may contact you if medical records are not received within the 14-day time frame to ensure you received the request. In addition, our market Chief Medical Officer may also be in contact to facilitate and ensure receipt of the required medical records to complete the quality-of-care reviews. Providers or facilities who repeatedly fail to return requested medical records are reported to the Credentialing Committee and may face other directed intervention or penalties up to and including contract termination.

Provider Appeals Procedures

If in your capacity as a member's provider you file an appeal on behalf of a member, please refer to the procedures set forth in this manual. Please refer to the applicable plan's **"Member Grievances and Appeals Procedures"** sections for additional details.

Please note: If time frames in this manual differ from the provider agreement, the agreement will be the presiding authority.

Claim Dispute Process

If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file a dispute or appeal.

Claim Dispute Process for Participating and Non-Participating Providers

- Claim disputes must be submitted in writing or by using the HAP CareSource Provider Portal.
- The dispute must be submitted within 90 calendar days from the date the claim is paid.
- If HAP CareSource fails to render a determination for the dispute within 30 days after receipt, an appeal may be submitted.

Appeal of Claim Denials

If you do not agree with the decision of the processed claim or dispute, you will have 365 calendar days from the date of service or discharge, unless otherwise specified in your contract, to file a claim appeal. If the appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied. If the appeal is denied, providers will be notified in writing. If the appeal is approved, payment will show on the provider's Explanation of Payment (EOP).

Please Note: If you believe the claim processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim; you do not need to file an appeal. Providers have 365 calendar days from the date of service or discharge to submit a corrected claim.

How to Submit Appeals

Providers can submit claims through our secure Provider Portal, or in writing:

Online

Visit **HAPCareSource.com** > Login > Provider in MI

Under the Provider Portal from the Claims menu, click on the "Claims Appeals" tab on the left. This is the preferred method of appeal submission.

Writing

Use the "**Appeal and Claims Dispute Form**" located on our website. Please include:

- The member's name and the HAP CareSource member ID number.
- The provider's name and ID number, located in your provider welcome number.
- The code(s) and reason why the determination should be reconsidered.
- If you are submitting a timely filing appeal, you must send proof of origin al receipt of the appeal by fax or electronic data information (EDI) for reconsideration.
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.

HAP CareSource Provider Medical Necessity Appeals

If in your capacity as a member's provider you file an appeal on behalf of a member, please refer to the procedures set forth in this manual. Please refer to the applicable plan's "Member Grievances and Appeals Procedures" sections for additional details.

How to Submit Medical Necessity Post-Service Appeals

There are three ways to submit appeals: through our Provider Portal, by fax or in writing:

Online

Visit **HAPCareSource.com** > Login > Provider in MI

Fax

Standard Appeals/Disputes: 1-937-531-2398

Writing

HAP CareSource
Attn: Provider Appeals – Clinical
P.O. Box 1025
Dayton, OH 45401-1025

Primary Care Providers

Primary Care Provider Concept

All HAP CareSource members may, though are not required, choose a PCP upon enrollment in the plan. PCPs should help facilitate a medical home for members. This means that PCPs will help coordinate health care for the member and provide additional health options to the member for self-care or care from community partners.

Members select a PCP from our online Provider Directory available at **HAPCareSource.com** > Members > Tools & Resources > Find a Doctor. Members have the option to change to another participating PCP as often as needed. Members initiate the change by updating on the Member Portal, or by calling Member Services.

Primary Care Provider Roles and Responsibilities

PCP care coordination responsibilities include the following:

- Assisting with coordination of the member's overall care, as appropriate for the member.
- Serving as the ongoing source of primary and preventive care.
- Recommending referrals to specialists, as necessary.
- Triaging members.
- Participating in the development of case management care treatment plans and notifying HAP CareSource of members who may benefit from case management. Please see the **"Member Support Services"** section of this manual to learn how to refer members for case management.

Primary Care Providers Are Responsible For:

- Treating HAP CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plan and Michigan Department of Community Health (MDCH).
- Providing 30 days of emergency coverage to any HAP CareSource patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by HAP CareSource patients for emergency or urgent care if notified of the visit.
- Use best commercial efforts to collect required copayments for services rendered to applicable members.
- Ensuring demographic and practice information is up to date for directory and member use.
- Reporting suspected fraud and/or abuse.

In addition, HAP CareSource PCPs play an integral part in coordinating health care for our members by providing:

- Availability of a personal health care practitioner to assist with coordination of a member's overall care, as appropriate for the member
- Continuity of the member's total health care
- Early detection and preventive health care services
- Elimination of inappropriate and duplicate services

Prenatal and Postpartum Care Documentation

To ensure accurate documentation of prenatal and postpartum care, please be sure to document the following in patient records:

- Evidence of prenatal teaching – This includes education on infant feeding; Women, Infants and Children (WIC); birth control; prenatal risk factors; dietary/nutrition information and childbirth procedures.
- Components of the postpartum checkup – This includes documenting the pelvic exam, blood pressure, weight, breast exam and abdominal exam.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered as needed. HAP CareSource endorses the same recommended childhood immunization schedule that is recommended by the Center for Disease Control and approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). This schedule is updated annually, and the most current updates can be found at www.aap.org.

Clinical Practice Registry and Member Profile

Quick and easy to access on our secure Provider Portal, the HAP CareSource Clinical Practice Registry helps PCPs improve patient health outcomes efficiently. The primary use of the Registry is to help PCPs manage their patient population.

PCPs can quickly sort their HAP CareSource membership into actionable groups. The HAP CareSource Clinical Practice Registry is a proactive approach to patient care and helps place emphasis on preventive care.

Key Benefits of the Registry

- The registry is color-coded, which provides easy identification of members in need of tests and/or screenings.
- The information can be downloaded as a PDF or in an Excel spreadsheet format (the Excel spreadsheet contains patient contact information).
- It provides direct access to the HAP CareSource Member Profile feature for individual members of interest.

Information Included on the Registry

- Well-baby visits (zero to 15 months)
- Well-care visits (two to 21 months)
- Asthma
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening
- Lead screening
- Diabetes (e.g. cholesterol, eye exam, hematology, kidney)
- Emergency room visits

The HAP CareSource Clinical Practice Registry is located on our secure Provider Portal.

Member Profile

With its comprehensive view of patient medical and pharmacy data, our Member Profile can help you improve health outcomes for your HAP CareSource patients. The Member Profile can also help you determine an accurate diagnosis more efficiently, reduce unnecessary diagnostic tests and minimize emergency room visits.

Key Benefits of the Member Profile

- Provides medical history
- Identifies potential prescription non-adherence or abuse
- Identifies duplication of services
- Introduces disease or care management options

Please Note: The Member Profile tool can be found on the Eligibility and Prior Authorization screens of the Provider Portal.

After-Hours Care

Telephone Arrangements/24-Hour Access

PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services. They must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and reschedule broken and no-show appointments.

- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
  - After hours telephone care for non-emergent, symptomatic issues within 30 minutes.
  - Same day for non-symptomatic concerns.
  - Crisis situations within 15 minutes.
- Schedule continuous availability and accessibility of professional, allied and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method and then transferred to the member's medical record.
- During after-hours calls, a provider must have arrangements for the following:
  - Office phone is answered after hours by an answering machine service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of 30 minutes;
  - Office phone is answered after hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the provider has designated to return the call within a maximum of 30 minutes; and
  - Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of 30 minutes.

Value-Based Purchasing

Your success is important to us. We offer a series of value-based purchasing (VBP) programs for our providers. Check out our website for more information.

CPT Code	Days/Hours	Reimbursement
99050	Monday to Friday 5 p.m. to 10 p.m. ET Weekends and holidays: 8 a.m. to 10 p.m. ET	$16.50, plus office visit rate
99051	Seven days per week 10 p.m. to 8 a.m. ET	$22, plus office visit rate

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. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Provider Responsibilities

- Providing HAP CareSource with advance written notice of any intent to terminate an agreement with us. In terminations without cause, written notice must be done 60 calendar days prior to the date of the intended termination and submitted on your organization's letterhead.
  - **60 calendar days' notice is required if you plan to close your practice to new patients.** If we are not notified within this time period, you will be required to continue accepting HAP CareSource members for a 60 calendar day period following notification.
- **For Primary Care Providers (PCPs) only:** Providing 24-hour availability to your HAP CareSource patients by telephone. Whether through an answering machine or a taped message used after-hours, patients should be given the means to contact their PCP or a back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider and only recommends emergency room use for after hours.
- Submission of claims or corrected claims should be submitted within 365 calendar days of the date of service or discharge.
- Appeals must be filed within the required time frame from the date of service or discharge. Please see the requirements in **"Provider Appeals Procedures"** chapter starting on **page 79**.
- Providers should keep all demographic and practice information up to date.

Examples

- Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.
- Participating providers are expected to treat members with respect. HAP CareSource members should not be treated any differently than patients with any other health care insurance. Please reference member rights in the "Member Support Services" section of this manual.

HAP CareSource Responsibilities

- Paying claims timely.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a HAP CareSource determination regarding claims payment. Our appeal process is outlined in the appeals section of this manual.
- Offering a 24-hour nurse advice line service for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance which involves subtracting the primary payment from the lessor of the primary carrier allowable or the HAP CareSource allowable. If the member's primary insurer pays a provider equal to or more than HAP CareSource's fee schedule for a covered service, HAP CareSource will not pay the additional amount.
- Making available member details on coverage and benefits.

These are just a few of the specific terms of our agreement. In addition, we expect participating providers to follow standard practice procedures even though they may not be spelled out in our provider agreement.

HAP CareSource expects participating providers to verify member eligibility and ask for all of their health care insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other health care insurance coverage that we have on file by logging onto the Provider Portal from the menu options.

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and are critical for claims processing.

Submitting Provider Changes

Type of Change	Notice Required Please notify HAP CareSource of the change prior to the time frames listed below.
New providers or deleting providers	30 calendar days
Providers leave the practice	30 calendar days
Phone number change	30 calendar days
Address change	30 calendar days
Change in capacity to accept members	30 calendar days
Providers intent to terminate	30 calendar days

Why Is It Important to Give Changes to HAP CareSource?

This information is critical to process your claims. In addition, it ensures our Provider Directories are up-to-date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare.

How to Submit Changes to HAP CareSource

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a physician to your practice helps us keep our records current. Your current information is critical for efficient claims processing.

Providers should submit provider adds, demographic or status changes and terminations via the HAP CareSource™ Provider Change Form. The form is available on our website by visiting **HAPCareSource.com**> Provider > Provider Resources > Provider Maintenance.

Once complete, email the form to providernetwork@hap.org with the subject line Provider Change Form. In the body of the email, be sure to include:

- Type 1 NPI
- Type 2 NPI
- Tax ID

Please be sure your office address, phone, fax, etc. are up to date in the National Plan & Provider Enumeration System (NPPES). Pharmacy benefit managers typically use DEA and NPPES systems to send required patient-level notices, such as transition letters and approval or denial letters.

HAP CareSource continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

Please contact our Provider Services team at **1-833-230-2101** if you have any questions.

Provider Directory Information Attestation

State and Federal regulations require Health Plans to validate and update published information regarding their contracted provider network every month. This validation ensures we have the most accurate information for claims payment and provider directories. This information is critical to process your claims. In addition, it ensures our Provider Directories are up to date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare. **Providers are required to attest to directory information every 90 days.**

Accurate provider directory information ensures we can connect the right patients to the right provider.

Quest Analytics & BetterDoctor

BetterDoctor is the Quest Analytics Accuracy solution that outreaches to providers to collect attestations for HAP CareSource. The goal is to improve the quality of provider data. BetterDoctor is performing this outreach for us to providers like you, to ensure our provider directory is as accurate as possible. All outreach efforts are made under the BetterDoctor name.

What Happens If I Do Not Attest to My Information?

CMS requires health plans to verify the accuracy of provider directory information every 90 days. Not attesting to your information and/or providing updated information when applicable can result in claims payment issues and inaccurate provider data in our online and printed directories. With the No Surprises Act in effect as of Jan.1, 2022, providers who do not attest quarterly, risk being suppressed in impacted provider directories.

Americans with Disabilities Act (ADA) Standards

Additionally, providers will remain compliant with Americans with Disabilities Act (ADA) standards, including but not limited to:

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

For more information on these ADA standards and how to be compliant, please see the ADA section of this manual.

Fraud, Waste and Abuse

Health care fraud, waste, and abuse hurts everyone, including members, providers, taxpayers, and HAP CareSource. As a result, HAP CareSource has a comprehensive fraud, waste, and abuse program in our Program Integrity department. Please help us by reporting questionable activities and potential fraud, waste, and abuse situations.

Definition of Terms

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees, or other recipients). 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.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider/member has not knowingly and/or intentionally misrepresented facts to obtain payment.

Improper Payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts. HAP CareSource has the right to recoup improper payments.

Examples of Fraud, Waste and/or Abuse

Examples of Member Fraud, Waste and/or Abuse:

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions – i.e., changing prescription forms to get more than the amount of medication prescribed by their physician
- Non-disclosure of other health insurance coverage
- Obtaining unnecessary equipment and supplies
- Identity theft/sharing ID cards – i.e., member receiving services under someone else's ID, sharing your ID with others, or submitting prescriptions under another person's ID
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Note: This is not an all-inclusive list.

Examples of Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower Medicaid/Medicare reimbursement rates
- Billing for services not provided
- Requiring members to pay for HAP CareSource covered services
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Purchasing drugs from outside the United States
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking member ID numbers, resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using patient lists for the purpose of submitting fraudulent claims
- Billing drugs for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark Law violations
- Not reporting overpayments or overbilling including those made in error by HAP CareSource

- Preventing members from accessing covered services resulting in underutilization of services offered
- Failing to comply with federal and/or state laws

Note: This is not an all-inclusive list.

Examples of Pharmacy Fraud, Waste and/or Abuse:

- Dispensing prescription drugs not dispensed as written inconsistent with the order
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed
- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted, tainted, or illegal drugs
- Billing prescriptions not filled or picked up

Note: This is not an all-inclusive list.

It is also important for you to tell us if a HAP CareSource employee or vendor acts inappropriately.

Examples of Employee Fraud, Waste and/or Abuse:

- Receiving gifts or kickbacks from vendors for goods or services
- Inappropriately marketing our company to potential members
- Behaving in an unethical or dishonest manner while performing company business

Note: This is not an all-inclusive list.

It is important for you to tell us if a HAP CareSource employee acts inappropriately.

Examples of Vendor Fraud, Waste and/or Abuse:

- Falsifying business reports
- Not reporting or taking action on employees that are debarred
- Billing for services not rendered or products not received
- Billing for a more expensive services, but providing a less expensive service

Note: This is not an all-inclusive list.

The Program Integrity department routinely monitors for potential billing discrepancies or potential fraud, waste and abuse. When found, an investigation is initiated and if warranted, corrective action is taken. **It is important for you to tell us if a HAP CareSource vendor acts inappropriately.**

Corrective Actions

The HAP CareSource Program Integrity department routinely monitors for potential fraud, waste, and abuse. We review claims data and medical records to look for billing discrepancies. When found, an investigation is initiated and, if warranted, a corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Contract termination
- Employee disciplinary actions
- Reporting to one or more applicable state and federal agencies
- Legal actions

Refer to your Provider Agreement for specific information on each type of provider termination/suspension. Also, refer to the Provider Participation Plan, for information on the appeal process. The HAP CareSource Provider Participation Plan is available at **HAPCareSource.com** > Provider Overview > Provider Education > Provider Disputes and Appeals. The "Provider Participation Plan" provides information on an appeal process for specific corrective actions.

Network providers are to report and return to HAP CareSource any overpayment within 60 calendar days of identification and notify HAP CareSource in writing of the reason for the overpayment.

The Federal and State False Claims Acts and Other Fraud, Waste and Abuse Laws:

Using the False Claims Act (the Act), you can help reduce fraud against the federal government. The Act allows everyone to bring "whistleblower" lawsuits on behalf of the government — known as "qui tam" suits — against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

The False Claims Act Addresses Those Who:

- Knowingly* presents, or causes to be presented, a false or fraudulent claim for payment or approval
- Knowingly* makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim
- Conspires to commit a violation of any other section of the False Claims Act
- Has possession, custody or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all of that money or property
- Is authorized to make or deliver a document certifying receipt of property used, or to be used by the government, and intending to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true
- Knowingly* buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the armed forces, who lawfully may not sell or pledge property

- Knowingly* makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government

**"Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.*

A violation of the Federal Anti-Kickback Statute constitutes a false and fraudulent claim under the Federal False Claims Act.

An example would be if a provider, such as a hospital or a physician knowingly "upcodes" or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.

The time period for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.

Protection for Reporters of Fraud, Waste or Abuse (Whistleblowers)

In addition, federal and state law and HAP CareSource's policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our Program Integrity department.

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement. Additional information on the False Claims Act and our fraud, waste and abuse policies can be found on **HAPCareSource.com** > Providers > Education > Fraud, Waste & Abuse.

Other Fraud, Waste and Abuse Laws

- Under the federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program. 42 U.S.C. §1320a-7b.
- Under the federal Stark Law, and subject to certain exceptions, providers are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs. 42 U.S.C. §1395(a) and §1903(s).
- As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. 18 U.S.C. §1347.

- The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, HAP CareSource is required to comply with certain provisions of the DRA. One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Acts, and other state laws regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste and abuse when handling HAP CareSource business.

Prohibited Affiliations

HAP CareSource is prohibited from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities, this includes ineligibility to participate in federal programs by the U.S. Department of Health and Human Services (HHS) or another federal agency under 2 CFR 180.970 and exclusion by HHS's Office of the Inspector General or by the General Services Administration under 2 CFR 376.

Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation. If you become aware that your corporate entity, those with more than five percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us **immediately** by emailing Provider Maintenance at ProviderMaintenance@HAPCareSource.com.

Confidentiality

Physicians shall prepare, maintain, and retain as confidential the health records of all members receiving health care services, and members' other personally identifiable health information received from HAP CareSource, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Disclosure of Ownership, Debarment and Criminal Convictions

Before HAP CareSource enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment, proposed for debarment, suspension or declared ineligible status related to federal programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.

You must also notify HAP CareSource of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child or sibling. Please contact us by emailing Provider Maintenance at ProviderMaintenance@HAPCareSource.com.

If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request.

If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations 42 CFR 455.100-106 for more information and definitions of relevant terms.

How to Report Fraud, Waste or Abuse

It is HAP CareSource's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act. Federal and state law and HAP CareSource policy prohibit any retaliation or retribution against persons who report suspected violations. If you have knowledge or information that any such activity may be or has taken place, please contact our Program Integrity department. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options For Reporting Anonymously:

- **Phone:** 1-844-415-1272 and follow the appropriate menu option for reporting fraud
- **Mail:** HAP CareSource
  Attn: Program Integrity
  P.O. Box 1940
  Dayton, OH 45401-1940

Options For Reporting That Are Not Anonymous:

- **Fax:** 1-800-418-0248
- **Email:** Fraud@CareSource.com

Or you may choose to use the Fraud, Waste and Abuse Reporting Form located on **HAPCareSource.com** > Providers > Tools & Resources > Forms.

When you report fraud, waste, or abuse, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law. Thank you for helping HAP CareSource keep fraud, waste and abuse out of health care.

*Most email systems are not protected from third parties. Please do not use email to send confidential information. If you will be sending confidential or health information, please use the form or phone number to report your concerns to help protect your privacy.

Physician Education Materials

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse. This brochure can be found on the Office of Inspector General's website at https://oig.hhs.gov/compliance/physician-education/index.asp.

CMS provides training on their website at https://www.cms.gov/Outreach-and-Education/MLN/WBT/MedicareFraudandAbuse/FraudandAbuse/story.html.

Once you have completed a Fraud, Waste and Abuse training program, please attest to completing this training at **HAPCareSource.com** > Providers > Forms > Provider Education Attestation Form.

Thank you for helping HAP CareSource keep fraud, waste and abuse out of health care.

Frequently Asked Questions

How Can I Reach HAP CareSource?

Call Provider Services at 1-833-230-2101 to reach HAP CareSource. Provider Services is available Monday through Friday from 8 a.m. to 6 p.m. Eastern Time (ET). See the **"Communicating with HAP CareSource"** section for more information.

How Do I Check Member Eligibility?

It is important to verify member eligibility before providing services. Patients must be eligible HAP CareSource members at the time of service in order for services to be covered. HAP CareSource offers several ways to check member eligibility, including by phone or our secure Provider Portal.

How Do I Submit A Claim?

HAP CareSource accepts paper and electronic claims. We encourage you to submit electronic claims for quicker processing. Please see the **"Claim Submission"** section of this manual for more information.

How Do I Optimize My Claim Payment Time Frame?

Claims submitted electronically are typically received and processed more quickly than paper claims. Providers may submit claims electronically through the HAP CareSource Provider Portal or through Electronic Data Interchange (EDI) clearinghouses listed in the **"Claim Submission"** section on of this manual.

For paper claim submissions, we require the most current form versions as designated by the Centers for Medicare & Medicaid Services (CMS), and the National Uniform Billing Committee (NUBC). We cannot accept handwritten claims or superbills.

How Do I File A Claim Appeal?

We hope you will be satisfied with HAP CareSource and the service we provide. However, providers who are unhappy with HAP CareSource's action concerning a medical necessity decision or a claim payment may appeal it. Please see our **"Provider Grievance and Appeals"** section on page 79 for more information.

Can I Bill My HAP CareSource Patients?

Generally, providers enrolled in Marketplace can bill members only under certain condition. See the "Member Billing Policy" section in the **"Claim Submission"** chapter for more information about billing HAP CareSource members.

How Do I Obtain A Prior Authorization?

Utilization Management [UM]

Prior authorizations for health care services can be obtained by contacting the Utilization Management department online, by, phone, fax or mail:

- **Online:** Visit HAPCareSource.com and select the Provider Portal option from the menu
- **Phone:** **1-833-230-2101** and follow the appropriate menu prompts for the authorization requests, depending on your need.
- **Fax:** 844-676-0372

Pharmacy

Prior authorizations for outpatient medications may be submitted electronically through:

- **Medical Benefit:** Electronic (medical benefit): HAP CareSource Provider Portal
- **Pharmacy Benefit:** Prior authorization requests for medications covered under the pharmacy benefit may be submitted electronically via the CoverMyMeds (https://www.covermymeds.com/main/prior-authorization-forms/caresource/) or **SureScripts** (https://providerportal.surescripts.net/ProviderPortal/Caresource/login) **prior authorization portals**

In the event of electronic service failures, we will accept via fax at:

- **Drugs under the Pharmacy Benefit:** 1-866-930-0019
- **Drugs under the Medical Benefit:** 1-888-399-0271

NOTE: All oncology treatment regimens should be submitted to NantHealth Eviti (https://connect.eviti.com/Connect/Account/Login.aspx) for prior authorization consideration.

What Benefits Does HAP CareSource Offer Its Members?

Please visit the HAP CareSource website at **HAPCareSource.com** for information on services, the member's coverage status and other information about obtaining services.

How Do I Make a Referral?

Follow the steps below to make a referral:

Referring Doctor – Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

Specialist – Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure.

Standing Referrals – A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period must be at least one year to be considered a standing referral. Treating providers must get prior authorization from our health plan before sending a member to an out- of-plan provider.

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. In accordance with 42 CFR 438.206(b)(3), HAP CareSource complies with all member requests for a second opinion from a qualified professional. If our network does not include a provider who is qualified to give a second opinion, HAP CareSource shall arrange for the member to obtain a second opinion from a provider outside the network at no cost to the member.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a nonparticipating provider.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

HAP CareSource™

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