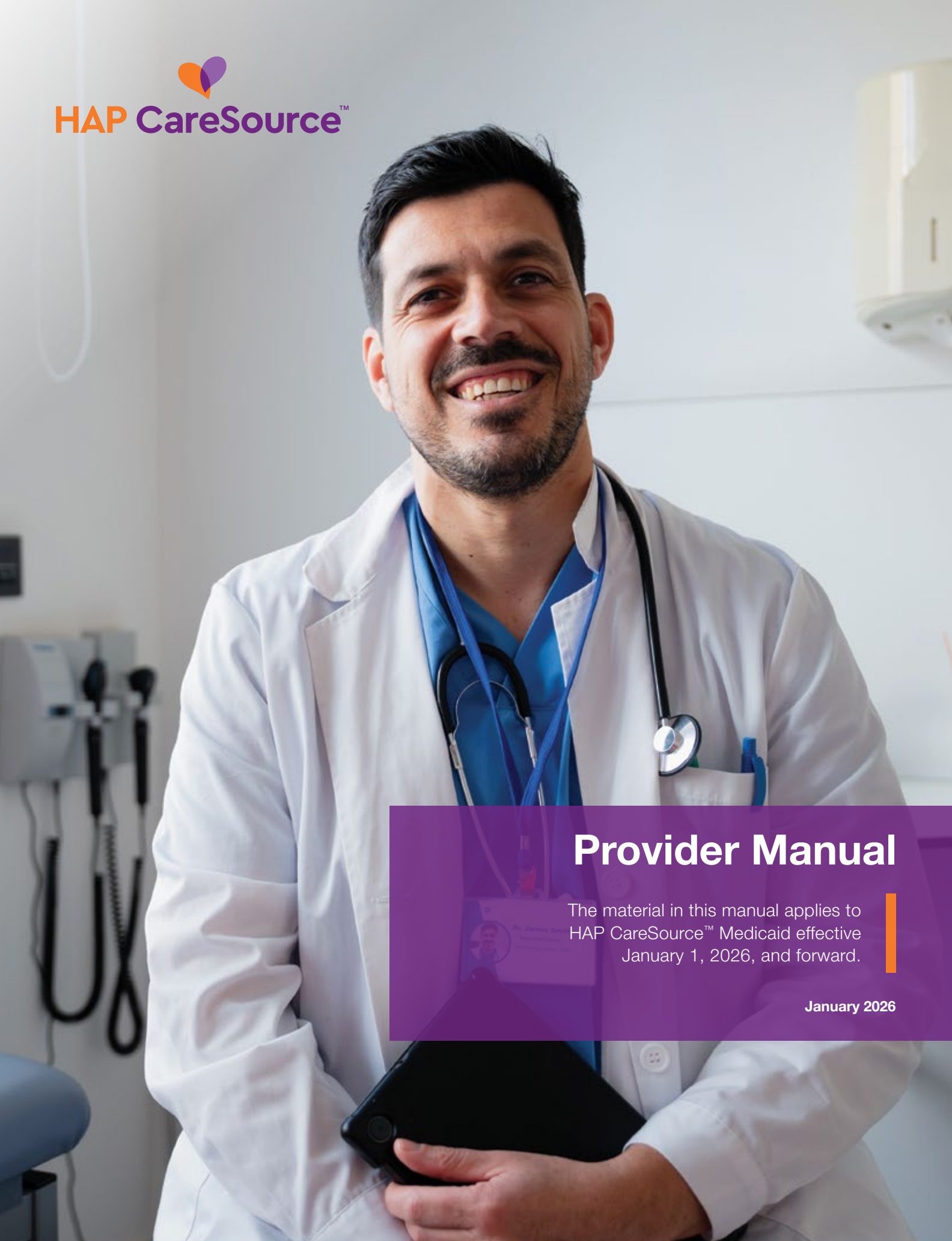
HAP CareSource™



# Provider Manual

The material in this manual applies to HAP CareSource™ Medicaid effective January 1, 2026, and forward.

**January 2026**


MEDICAL CENTER

# Table of Contents

# Section 1: Overview

## Medicaid Plan

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

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

HAP CareSource follows guidelines from the Michigan Department of Health and Human Services (MDHHS) which can be found in the MDHHS Medicaid Provider Manual. The manual contains coverage, billing and reimbursement policies for Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Maternity Outpatient Medical Services (MOMS) and other health care programs administered by the MDHHS.

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

## About Health Alliance Plan

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

## About CareSource

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

## Mission Statement

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

We offer:

- **HAP CareSource** in Clinton, Eaton, Genesee, Hillsdale, Huron, Ingham, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw and Wayne counties

The information below is a high-level overview of the Medicaid program. Detailed information can be found at www.michigan.gov/mdhhs.

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

| Program | Description | Eligibility Criteria |
|---|---|---|
| **Children's Special Health Care Services***<br><br>**Persons with Special Health Care Needs** | It is for children and some adults with special health care needs and their families. | • Qualifying medical condition<br>• Age:<br>- Children must be under the age of 26<br>- Persons 26 and older with cystic fibrosis, sickle cell, or certain hereditary blood coagulation disorders commonly known as hemophilia may also qualify<br>• Citizenship:<br>- A U.S. citizen<br>- A documented non-citizen who has been admitted for permanent residence<br>- A non-citizen legally admitted migrant farm worker (i.e., seasonal agricultural worker)<br>• Must be a Michigan resident<br>• For additional details or to submit a Medical Eligibility Referral Form (MERF) for an individual, please visit Children's Special Health Care Services (michigan.gov) |
| **Healthy Michigan Plan*** | Healthy Michigan is a low-cost program that offers health coverage to adults ages 19-64 who do not qualify for Medicaid or Medicare and whose income is at or below 133% of the federal poverty line. | • Age 19-64 years<br>• Have income at or below 133% of the federal poverty level<br>• Does not qualify for or not enrolled in Medicare<br>• Does not qualify for or not enrolled in other Medicaid programs<br>• Not pregnant at the time of application<br>• Michigan residents<br>• For more information, visit Healthy Michigan Plan |
| **Medicaid** | Comprehensive health care coverage provided by the state for people of all ages with low income at or below the federal poverty level | Determined by the state. Criteria include:<br>• Age<br>• Income<br>• Financial resources<br>• Other information |
| **MIChild** | A health insurance program for the uninsured children of Michigan's working families | • Must be a US citizen (some legal immigrants qualify)<br>• Must live in Michigan<br>• Must be under the age of 19<br>• Family must meet income requirements<br>• Children must not have other insurance coverage |

*See the following pages for more details.

# Healthy Michigan Plan

In 2014, Michigan joined 35 other states in the nation and expanded its Medicaid program to include beneficiaries up to 133% of the federal poverty level, creating the Healthy Michigan Plan. Healthy Michigan Plan (HMP) is a low cost, comprehensive health insurance plan that includes coverage for medical, hearing, vision and dental benefits for qualified residents of Michigan aged 19-64. For more information about who is eligible for this plan, visit www.michigan.gov/healthymiplan.

Prior to services being rendered, providers must verify the member is covered by the Healthy Michigan Plan using the member's mihealth card (Medicaid) and HAP CareSource ID cards.

### What's Covered

The HMP covers all benefits listed in Section 6 of this manual. It also covers additional benefits like the ones listed below.

| | |
|---|---|
| **Dental services** | Includes dental exams, cleanings and extractions (tooth removal). These services are also covered for pregnant women who are members of HAP CareSource:<br>• Routine exams and cleanings every six months<br>• Four bitewing X-rays every year<br>• Full-mouth X-rays once every five years<br>• One filling per tooth every two years<br>• Emergency exams, no more than twice a month<br>The following procedures require prior authorization:<br>• Gum disease-related cleanings<br>• Root canals<br>• Tooth extractions (removal)<br>• Tooth repair if attached to a bridge or partial<br>If members have questions, they can call Delta Dental at 1-866-558-0280 (TTY: 711).<br>If members need a ride to the dentist's office, they can call Member Services at **1-833-230-2053 (TTY: 711)**. |
| **Habilitative services** | These services help a person keep, learn or improve skills and functions and may include speech, physical or occupational therapy. They could also include equipment to help a person walk or move. |
| **Preventive care** | HAP CareSource covers many preventive services. The HMP covers additional preventive care. These services are recommended by organizations like the United States Preventive Services Task Force. |

### Cost Sharing and Copayments

A copayment (sometimes called "copay") is a set dollar amount a member is required to pay as their share of the cost for a medical service or supply. HAP CareSource does not require a member to pay a copayment or other costs for covered services under the Medicaid or Healthy Michigan Plan program.

# Children's Special Health Care Services Program (CSHCS)

Children up to age 26 with a serious chronic medical condition could be eligible for CSHCS—a State of Michigan program that serves children (and some adults) at no cost. Currently there are over 2,700 diagnoses that qualify a member for CSHCS.

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

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

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

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

**The Children with Special Needs Fund (CSN)**

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

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

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

**County Health Departments**

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

- Schools
- Community mental health care
- Respite care
- Financial support
- Childcare
- Early On program
- WIC program

# Section 2: Network Development and Contracting Process

## Joining HAP CareSource

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

## Changes in Existing Provider Information

We have a change form that you can use to update existing provider information such as:

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

You can find it in two places when you visit hap.org:

- *Provider resources; Forms and other information*
- *Contact; I'm a Provider; Demographic changes, training & education*

Simply download the form, complete it and then email it to providernetwork@hap.org. Note: If you are part of a physician organization/physician hospital organization, do not send the form directly to HAP. All changes must be submitted from your PO/PHO organization.

## Changes in Provider Network

HAP CareSource will make a good faith effort to give written notice of termination of a network provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the enrollee will be provided by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice.

## Provider Terminations by HAP CareSource

HAP CareSource may immediately terminate a provider contract, pursuant to the termination provisions set forth in the provider agreement. Grounds for immediate termination include:

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

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

## Network Adequacy

HAP CareSource monitors their provider networks to ensure reasonable availability and accessibility of medical care and services for members. We annually review:

- Mapping of providers and members
- Telephone accessibility and appointment availability of the PCP networks

To ensure network adequacy, the provider Contracting department:

- Follows the standard ratio for travel time to and from network providers
- Reviews the provider network to strategically locate additional primary care and specialist providers within the service area where needed
- Ensures adequate primary care physician to enrollee ratios

We maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served within the Medicaid network.

We monitor the network on a weekly basis and/or by notification of significant no cause network change (per our *Significant No-Cause Provider Terminations* Policy). The monitoring is done through Quest Analytics Cloud services. Any indications of non-compliance are reported to Provider Network Management leadership and Compliance leadership.

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

## Reporting

The Provider Contracting department ensures required reports are provided to regulatory agencies and accrediting bodies in a timely and accurate manner.

## Physician Incentive Disclosure

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

## Our Pledge

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

### Clinical Criteria

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

To discuss a utilization management decision or process with a physician reviewer or health care professional reviewer or to obtain a copy of the criteria used in the decision-making process, practitioners may contact HAP CareSource at **1-833-230-2102**. Please have the member's name and HAP CareSource ID number available to assist in accessing the case. HAP CareSource physician reviewers are board certified and have current Michigan licenses to practice without restriction.


## Section 3: Credentialing

HAP CareSource ensures all practitioners applying for affiliation meet rigorous credentialing standards prior to approval for participation. All credentialing and recredentialing decisions are non-discriminatory and not based on an applicant's race, ethnic or national identity, gender, age or sexual orientation.

- Providers have the right to be informed of their application status throughout the credentialing process.
- Providers have the right to review information submitted to support their credentialing application upon request to the HAP CareSource Credentialing department. HAP CareSource keeps all submitted information locked and confidential. This could include information from outside sources like malpractice insurance carriers, state licensing boards, etc. HAP CareSource is not required to provide information such as references, recommendations and peer-review-protected information.
- Providers have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing department prior to presenting to the Credentialing Committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner will be notified and given the opportunity to correct this information within 30 days or prior to presenting to the Credentialing Committee.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department.

### Primary Care Physicians

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

## Who Is Credentialed and Recredentialed?

We credential and recredential the following practitioners:

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

## Who Is Not Credentialed?

We do not credential:

- Practitioners who practice exclusively within the inpatient setting and provide care for members being directed to the hospital or another inpatient setting
  - Hospitalists
  - Pathologists
  - Radiologists
  - Anesthesiologists
  - Neonatologists
  - Emergency room physicians
  - Critical care medicine providers
- Practitioners who practice exclusively within freestanding facilities
- Practitioners who provide care for members being directed to the facility
- Locum tenens providers
- General dentistry providers
- Certified registered nurse anesthetists

### Verification

All potential candidates must complete a Council for Affordable Quality Healthcare (CAQH) application. HAP CareSource verifies:

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

## Provider Disclosure of Ownership and Control Interest Statement Form Collection Process

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

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

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

The form can be found online. Visit hap.org/providers; then *Join HAP*.

## Credentialing Policy and Process

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

## Ongoing Monitoring

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

**HAP CareSource collects and reviews Medicaid sanctions. We also review information within 30 calendar days of its release by the reporting entity.**

Verifies practitioners' Medicaid and Medicare status from a query of one of the following:

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

**HAP CareSource collects and reviews sanctions or limitation on license and reviews information within 30 calendar days of its release by the reporting entity.**

Reviews physician sanctions or limitations on licensure status from a query of one of the following:

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

**We review non-physician health care practitioner sanctions or limitation on licensure status from a query of one of the following:**

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

**HAP CareSource reviews provider/practitioners self-reporting and individual/employee screening:**

- Providers are required to self-report claim/payment errors immediately to HAP CareSource.
- Providers are required to conduct screening on individuals/employees to be compliant with MDHHS-Office of Inspector General (OIG) guidelines.

## Provider Performance Improvement Policy

The Performance Improvement Process (PIP) is used to improve provider performance when it has been determined that the provider is not meeting standards. HAP CareSource has a well-defined PIP to improve provider performance. Behaviors that may lead to the initiation of the PIP include but are not limited to, failure to comply with HAP CareSource Policies and Procedures, non-compliance with physician profiling performance improvement plan, violation of provider contract, acting in a manner that jeopardizes the health or safety of an enrollee, fraud, waste and abuse or that affects accreditation or licensure. Failure to correct such behaviors may lead to termination. You can find our Provider Performance Policy in Appendix C of this manual.

## Termination of Providers Policy

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

## Background Check

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

# Section 4: Provider Services

## Communicating with Providers

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

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

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

## Member Advocacy

HAP CareSource does not prohibit any participating practitioner or allied health professional from discussing treatment options with members, regardless of benefit coverage, or from advocating on behalf of a member in any grievance, utilization review process or individual authorization process to obtain health care services. Practitioners may freely communicate with patients about their treatment, including medication treatment options, regardless of benefit coverage limitations. Since the member's participation is an integral part of making decisions about their treatment and care, HAP CareSource encourages providers to develop care plans with their patients or their patients' guardians or representatives. The provider may inform enrollees of the provider's affiliation or change in affiliation.

## Primary Care Physician — Coordinator of Care

The PCP is responsible for supervising, coordinating and providing primary care to HAP CareSource members. A PCP is an MD or DO who is listed as a practitioner in family practice, general practice, internal medicine, or pediatrics. The PCP develops a plan of care collaboratively with the member, specialists, social workers, hospitals, rehabilitation clinics, other clinicians and family members.

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

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

## PCP Reporting Requirements

Participating PCPs must submit all encounters with assigned members to HAP CareSource. We are required to submit this information to the MDHHS.

## Payment Structure

**Fee-for-service**

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

## Primary Care Physician Incentive Program

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

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

## PCP Accessibility and Availability

PCPs are required to:

- Provide 24-hour PCP telephone coverage to your HAP CareSource patients.
- Be available to see patients a minimum of 20 hours per location per week.
- Give written prior notice to HAP CareSource of alternative coverage arrangements during times of non-availability. PCPs should encourage their members to contact them whenever possible, prior to seeking health care services outside of their office.
- Be actively enrolled in The Community Health Automated Medicaid Processing System or CHAMPS on date of service. This is the state's online Medicaid enrollment and billing system. It ensures all providers who participate in Medicaid comply with federal screening and enrollment requirements.

## Pharmacy Access Requirements

For HAP CareSource, pharmacy services are available within 10 minutes/5 miles for large metro areas, 15 minutes/10 miles for metro areas, 30 minutes/20 miles for micro and 40 minutes/30 miles for rural and counties with extreme access considerations.

## PCP Request for Member Transfer

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

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

As a result, the PCP may request the member to transfer to another HAP CareSource provider or be removed from the plan. The transfer process is outlined below.

**PCP process**

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

**HAP CareSource process**

1. The Medical Director or designee reviews the documentation and requests clarification or additional information from the PCP as appropriate.
   Note: failure to respond to such requests will result in denial of the transfer or disenrollment.

2. If the request for transfer or disenrollment is approved, HAP CareSource will send the appropriate notice to the member, PCP and the State of Michigan, if necessary. The member must receive 30 days advance notice to allow adequate time to select another provider or make other arrangements for health care services.

For more information, please contact HAP CareSource Provider Services at **1-833-230-2102**.

## Access to Care Standards for Medicaid Plan

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

## Appointment Time Access Standards

### Appointment Lead Time for Primary Care

Provide 24-hour availability to your HAP CareSource patients by telephone. Whether through an answering machine or taped message used after hours, patients should be given the means to contact their PCP or a 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.

| Type of Care | Standard |
|---|---|
| **Emergency Services** | Immediately 24 hours/day, 7 days a week |
| **Urgent Care** | Within 48 hours |
| **Routine Care** | Within 30 business days of request |
| **Non-Urgent Symptomatic Care** | Within 7 business days of request |
| **Specialty Care** | Within 6 weeks of request |
| **Acute Specialty Care** | Within 5 business days of request |
| **Wait time in office: How long before member is seen by provider after checking in at front desk** | Less than 30 minutes |
| **Prenatal Care – Initial prenatal appointment (Medicaid only)**<br><br>Note: Appointment should be with an obstetrician, PCP, certified nurse midwife or other advanced practice registered nurse with experience, training, and demonstrated competence in prenatal care. | • If enrollee is in first or second trimester: within 7 business days of enrollee being identified as pregnant<br>• If enrollee is in third trimester: within 3 business days of enrollee being identified as pregnant.<br>• If there is any indication of the pregnancy being high risk (regardless of trimester): within 3 business days |

### Appointment Lead Time for High-Volume and High-Impact Specialists Including OB/GYN and Oncology

| Type of Care | Standard |
|---|---|
| **Acute Specialty Care** | Within 5 business days of request |
| **Specialty Care** | Within 6 weeks of request |
| **Urgent care** | Within 48 hours |

### Appointment Lead Time for Mental Health

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

### Appointment Lead Time for Dental

Note: Monitoring is conducted by Delta Dental

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

### Monitoring

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

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

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

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

# Section 5: Doula Information

## Enrollment

Since January 1, 2023, Michigan Medicaid has been reimbursing for doula services provided to individuals covered by or eligible for Medicaid insurance. Doula providers seeking reimbursement for their professional services to Medicaid beneficiaries are required to be on the MDHHS Doula Registry and enrolled as a Medicaid provider.

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

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

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

# Doula Reimbursement

Submit claims for doula services to HAP CareSource. Here are the options:

- **Electronic**
  Use Availity clearinghouse CS Payer ID: MIMCDCS1 (Medicaid)
- **Paper Claims**
  Send to:
  HAP CareSource
  P.O. Box 1186
  Dayton, Ohio 45401-1186

Use the pregnant or postpartum member's HAP CareSource ID Number.

Claims must include a primary diagnosis code to support the services billed.

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

**Doula services are to be reported as follows:**

| Visit Type | Procedure Code | Modifier | Primary Diagnosis Codes | Limit per pregnancy | Rate |
|---|---|---|---|---|---|
| Prenatal Visits and Postpartum Visits | S9445 | HD | Prenatal: Z33.1 Postpartum: Z39.2 | Up to 12 visits | $100 each |
| Attendance at Labor and Delivery | T1033 | HD | Z33.1 | 1 visit | $1500 |

# Section 6: Member Services

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

Providers can contact HAP CareSource Provider Services at **1-833-230-2102**, Monday through Friday from 8 a.m. to 6 p.m. ET.

## PCP Assignment

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

## Member Accessibility to PCP Services

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

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

## Member Request for PCP Transfers

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

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

## Member Complaints and Grievance Resolution

HAP CareSource has a centralized process to address, resolve and track all member complaints and grievances. All members receive written information outlining this process in their welcome packet.

The Member Services department receives complaints and grievances. The Grievance and Appeals department investigates, tracks and responds to all member complaints and grievances. A HAP CareSource representative may contact PCP offices during the investigation. A prompt response from the PCP is important and appreciated.

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

## Provider Complaints and Grievance Resolution

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

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

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

## Dental Care

Dental care is an important part of your patient's overall health. On April 1, 2023, the MDHHS expanded dental benefits. Dental services will be covered for:

- Adults age 21 and older
- Healthy Michigan Plan beneficiaries age 19 and older

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

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

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

Members can find a dental provider online through Delta Dental's website. They can also call HAP CareSource Member Services at **1-833-230-2053 (TTY: 711)**.

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

- Monday through Friday from 8 a.m. to 8 p.m. ET (member)
- 8:30 a.m. to 8 p.m. ET, 866-558-0280 (TTY users call 711) for information and billing help. Automated system available 24 hours a day, seven days a week.
- HAP CareSource members may also be eligible for earning a reward upon completion of a dental exam.

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

**Dental Care for Children**

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

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

## Language Interpretation and Services

HAP CareSource is committed to maintaining open lines of communication with all members and providers. We've contracted with vendors to provide language interpretation services and services for communicating with hearing- and speech-impaired members. This is a free service for our members. For more information, members can call the Member Services number on the back of their HAP CareSource member ID card. Providers can call HAP CareSource Provider Services at **1-833-230-2102**.

## HAP CareSource Benefits and Covered Services

It's important that members get the care they need when they need it. There are no counseling or referrals that we would not provide because of moral or religious grounds. We provide all covered services that MDHHS provides. The member's Certificate of Coverage (COC) has a complete list of covered care.

**Services Covered by HAP CareSource**

The following are covered services without copays

- Ambulance and emergency medical transportation
- Bilateral cochlear implantation, mapping and calibration (ages 1-20)
- Blood lead screening and follow-up services (ages 21 and under)
- Care management services
- Certified nurse midwife care
- Certified pediatric and family nurse practitioner care
- Chiropractic care, up to 18 visits per calendar year, limited to specific diagnoses and procedures
- Contraceptive medications and devices
- Durable medical equipment and supplies

- Early and periodic screening, diagnosis and treatment services (EPSDT) (ages 21 and under)
- Emergency care
- End-stage renal disease (ESRD) services
- Family planning services
- Health education and outreach
- Hearing care – hearing exams, supplies, hearing aids and batteries are covered
- Hearing aids are covered for all ages
- Hearing and speech services (ages 21 and under)
- Home health care services and wound care, including medical and surgical supplies
- Hospice services
  - Inpatient hospital services
  - Outpatient hospital services
  - Diagnostic and therapeutic services: diagnostic lab, X-ray and imaging services
- Infusion therapy
- Maternal Infant Health Program (MIHP)
- Maternity
  - Hospital and physician care
  - Certified nurse midwife services
  - Doula services
  - Parenting and birthing classes
  - Doula services – one labor visit and 12pre/postpartum visits
  - Prenatal care
  - Newborn care – for the month of birth
  - Home care services
  - Breast pumps, i.e., hospital-grade electric, personal-use double electric and manual
- Medically necessary weight reduction services
- Mental health services – outpatient
- Psychiatric collaborative care in PCP office
- Podiatry services
- Preventive services required by the Patient Protection and Affordable Care Act
- Prescription drugs
  - Up to a 34-day supply for most drugs on the formulary
  - Up to a 102-day supply for certain maintenance medications (i.e., drugs members take every day)
  - Up to a 12-month supply for oral contraceptives, contraceptive patches and the vaginal ring

- Professional care services by physicians or other health care professionals
  - Certified pediatrics and family nurse practitioner care
  - Preventive care and screenings
  - Routine pediatric and adult immunizations
  - Health education
  - Second opinion from a provider
  - Services of other doctors when referred by the member's PCP
  - Services provided by local health departments
- Prosthetic devices and orthotics
- Radiology examinations and laboratory procedures
- Prevention, diagnosis and treatment of health impairments
- Rehabilitative nursing care – intermittent or short-term restorative or rehabilitative services up to 45 days in a nursing facility
- Restorative or rehabilitative services in a place of service other than a nursing facility
- Services to achieve age-appropriate growth and development
- Screening mammography and breast cancer services
- Skilled nursing facility
- Therapy (physical therapy, occupational therapy, speech therapy)
- Tobacco cessation treatment, including prescription and over-the-counter drugs and support programs
- Treatment for sexually transmitted diseases (STDs)
- Transportation for medically necessary covered services
- Vaccines
- Vision services
- Well-child services (ages 21 and under)

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

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

**Services Not Covered by Medicaid**

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

# Member's Rights and Responsibilities

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

**HAP CareSource Member Handbook**

## HAP CareSource

**You have the right to:**

- Receive information about HAP CareSource, its services, its practitioners and providers, and member rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Receive Culturally and Linguistically Appropriate Services (CLAS).
- Have your personal and medical information kept private.
- Participate in decisions regarding your health care, including the right to refuse treatment and express preferences about treatment options regardless of cost or benefit coverage.
- Voice complaints or appeals about HAP CareSource or the care it provides.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records, and request those be amended or corrected.
- Be furnished with health care services consistent with state and federal regulations.
- Be free to exercise your rights without adversely affecting the way the Contractor, providers, or the State treats you.
- To file a grievance and/or appeal to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act.
- Be free from other discrimination prohibited by state and federal regulations.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand.
- Receive Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services.
- To request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided.
- To request information on the structure and operation of the HAP CareSource.
- To make suggestions about our services and providers.
- To make suggestions about member rights and responsibilities policy.
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

**You have the responsibility to:**

- Review this handbook and HAP CareSource Certificate of Coverage.
- Make and keep appointments with your HAP CareSource doctor.
- Treat doctors and their staff with respect.
- Protect your Medicaid ID cards against misuse.
- Contact us if you suspect fraud, waste, or abuse.
- Give your Health Plan and your doctors as much info about your health as possible in order to provide care.
- Learn about your health status.
- Work with your doctor to set care plans and goals.
- Follow the plans for care that you have agreed upon with your doctor.
- Live a healthy lifestyle.
- Make responsible care decisions.
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior.
- Apply for Medicare or other insurance when you are eligible.
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes.
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes of income or changes to your family size). You can call your local MDHHS office or go to newmibridges.michigan.gov.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

See the HAP CareSource Handbook for details.

## Transportation

We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other Medicaid covered services, whether those services are provided by the Medicaid health plan or through MDHHS directly. In some cases, we may provide bus tokens or if the member has their own vehicle or someone else to drive, they can request mileage reimbursement.

**Emergency Transportation**

- If members need transportation for a life-threatening emergency, they are advised to call 911 for an ambulance.
- If members need same-day transportation for urgent care or care that is not life-threatening, they are advised to call Members Services at **1-833-230-2053 (TTY: 711)**.
- HAP CareSource will cover emergency transportation and hospital-billed ambulance services to and from a nursing facility or member's home.

### Routine (Non-Emergency) Transportation

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

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

Members are reminded to:

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

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

Additional transportation services include the following:

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

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

Medically necessary, non-emergency ambulance transportation to Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) related services.

# Section 7: Member Eligibility and Enrollment

MDHHS determines the beneficiary's eligibility for public assistance.

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

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

## New Members

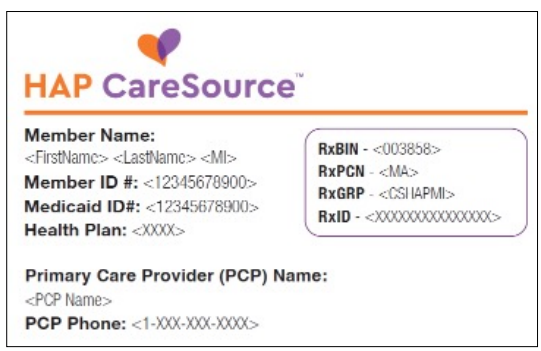
We mail a welcome packet with plan and benefit information to new members within 10 business days from receipt of enrollment data from MDHHS.

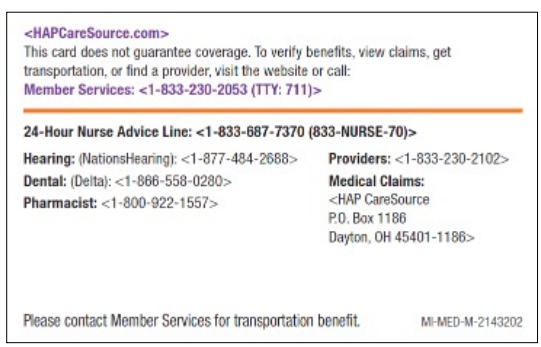
## ID Cards

**HAP CareSource members carry two member ID cards:**

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


**HAP CareSource ID card**
This card is for members enrolled in HAP CareSource, HAP CareSource Children's Special Health Care Services, HAP CareSource MIChild, and HAP CareSource Healthy Michigan Plan.




**Note:**

- Possession of a HAP CareSource ID card does not guarantee member eligibility or coverage.
- Providers must verify eligibility prior to services being rendered to guarantee payment.
- Any member who abuses the enrollment card by allowing others to use it to fraudulently obtain services will be reported to the MDHHS or the CMS for immediate termination from the plan.
- If you suspect a non-eligible person using a member's ID card, please report the occurrence to the HAP CareSource at **1-833-230-2102**.

## Verifying Eligibility

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

| Method | Instructions |
|---|---|
| **HAP CareSource Provider Portal** | • Log in at CareSource.com/mi/providers/provider-portal/medicaid/<br>• Once on the HAP CareSource Provider Portal, select *Member Eligibility* (Note: PCPs can get a list of their assigned members by selecting *Click Here* to *View Member Roster*. The list is updated monthly).<br>• Call HAP CareSource at **1-833-230-2102** |
| **CHAMPS** | • Web portal<br>• Provider support: 1-800-292-2550, option 5, then 2 |
| **Phone options** | • HAP CareSource at **1-833-230-2102**<br>• CHAMPS provider support: 1-800-292-2550, option 5, then 2 |

## Disenrollment from a Plan

### HAP CareSource

The MDHHS allows for disenrollment from Medicaid health plans as outlined below:

- **Enrollment errors by MDHHS**

  If a non-eligible individual or Medicaid member who resides outside the plan's service area is enrolled in a Medicaid plan and the MDHHS is notified within 15 days of enrollment effective date, the MDHHS will retroactively disenroll the individual. If the MDHHS is notified 15 days after the enrollment effective date, the MDHHS will disenroll the enrollee prospectively the first day of the next month.

- **Special disenrollment**

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

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

# Section 8: Referrals and Authorizations

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

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

Referrals and prior authorization for services should be made to in-network providers whenever possible. Contracted providers can be found in our online provider directory through Find a Doc. To refer a member to an out-of-network provider, call our Utilization Management department at **1-833-230-2102**.

Non-contracted providers should call our Utilization Management department at **1-833-230-2102**.

## Submitting a Prior Authorization Request

The member's PCP or the servicing provider (i.e., DME provider, specialist) obtains the prior authorization online by logging into the **HAP CareSource Provider Portal** and selecting Authorizations, or via fax at 844-432-8931.

**Supporting clinical documentation must be included with all requests.**

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

- Delays in processing the request
- Claims denials

## Criteria Used in Decision Making

We use objective and evidenced-based criteria when determining the medical appropriateness of requested health care services. This includes criteria from:

- InterQual/MCG (formerly known as Milliman Care Guidelines)
- The Centers for Medicare & Medicaid Services
- The state of Michigan
- Internally developed and adopted criteria based on industry standards with input and review from participating physicians

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

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

Authorization decisions are communicated to members with approval or denial letters. Providers are notified of determinations via fax, determination letters and through the Provider Portal.

- Authorization decisions are communicated to members with approval or denial letters.
- Denials: a letter that you receive after an appeal is denied, in whole or in part, or if the plan cannot provide a service in a timely basis. The letter will tell you what action was taken, why the action was taken and your rights.

Copies are retained in the member's medical record.

## Medical Necessity Defined

For Enrollees 21 years of age and older, covered services which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. For Enrollees less than 21 years of age, a service that meets the EPSDT standard of Medical Necessity set forth in Section 1905® of the Act and 42 USC Section 1396®(5). Without limitation, medically necessary services for Enrollees less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development; attain, regain, or maintain functional capacity; or improve, support, or maintain the Enrollee's current health condition. The contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

## Peer-to-Peer Review (Medicaid Only)

| For | Instructions |
|---|---|
| **Inpatient medical denials** | Physician or a physician representative can call us at the number below to initiate a same day peer-to-peer review on a denied admission.<br><br>**1-833-230-2168**, option 3; Monday through Friday, 8 a.m. to 5 p.m. ET |
| **Outpatient denials** | Physician or a physician representative can call us at the number below to initiate a same day peer-to-peer review.<br><br>**1-833-230-2168**, option 2; Monday through Friday, 8 a.m. to 5 p.m. ET |

## Prior Authorization Decision Time Frames

*Effective January 1, 2026*

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

## Prior Authorization Requests

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

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

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

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

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

## Skilled Nursing

HAP CareSource members have a skilled nursing benefit as follows:

| Membership | Number of Days Allowed |
|---|---|
| HAP CareSource | Up to 45 days in a nursing facility (Note: If additional time is needed, the member would be disenrolled to state-run Fee for Service Medicaid. The HAP CareSource Health Services department will assist with this process). |

**Important**

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

## Second Opinions

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

## Vision Services

Routine vision services include eye examination (refraction), lenses and frames. Members in HAP CareSource plans can access vision services directly by contacting EyeMed at 1-866-939-3633. Contracted vision providers are in our online provider directory at **findadoctor.CareSource.com**.

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

## Mental Health Care

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

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

HAP CareSource does not cover inpatient mental health admissions, partial hospitalization and other intensive mental health services. Authorization must be granted by the local Prepaid Inpatient Health Plan (PIHP) in the county which member enrolled.

HAP CareSource Care Managers collaborate regularly with PIHP on member care.

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

HAP CareSource utilizes the Medicaid Mental Health Authorization and Payment Responsibility Grid. This grid indicates Medicaid Health Plan (MHP) and PIHP coverage responsibility for mental health services. It should be utilized by MHPs, PIHPs, Community Mental Health Service Programs, providers and other, as applicable, to determine the responsible entity for authorization and payment of mental health services delivered to enrollees.

This grid currently delineates coverage responsibility by the setting in which a service is provided. MDHHS intends to modify this policy and grid so that coverage responsibility for mental health services will be determined by the level of enrollees' needs rather than by the setting in which a service is provided. The grid will be updated in accordance with any change in MDHHS policy. In addition to this grid, all entities should follow Medicaid policy as described in the Medicaid Provider Manual and the entity's contract with the State and as directed by MDHHS.

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

## Mental Health Framework

MDHHS is shifting to a more person-centered approach to serve Michiganders with mental health needs. As part of MIHealthyLife, an initiative that began in 2022 to strengthen the Comprehensive Health Care Program (CHCP), MDHHS is partnering with Medicaid Health Plans (MHPs), Prepaid Inpatient Health Plans (PIHPs) and providers to improve access to and coordination of mental health care across the Medicaid program.

Under the Mental Health Framework, an enrollee's level of mental health need, as determined through a State-identified standardized assessment tool, will more clearly determine which payer is responsible for their mental health coverage and care. Also, MHPs will begin covering additional mental health services for enrollees with lower levels of mental health need, so MHPs are accountable for more of these enrollees' continuum of care.

Beginning in October 2026:

- MHPs will cover most mental health services for CHCP enrollees with lower levels of mental health need, and
- PIHPs will cover all mental health services for CHCP enrollees with higher levels of mental health need. Referrals for mental health care, including those across MHP and PIHP systems, will be standardized to facilitate enrollee access to needed care.

**Impact**

Beginning October 2025, all qualified mental health providers participating in Michigan's Medicaid program and contracted with an MHP and/or PIHP will need to incorporate into their practice:

- Use of standardized tools for assessing the level of mental health need of CHCP enrollees seeking mental health. The State's designated assessment tools are the Michigan Child and Adolescent Needs and Strengths (MichiCANS) Screener for children and youth under 21, and the Level of Care Utilization System (LOCUS) for adults 21 and older. MDHHS will provide more information and access to trainings on these tools.
- Adoption of a standardized referral process for mental health services, including use of a new referral platform accessible to mental health providers, PCPs and Community Mental Health Services Programs (CMHSPs), MHPs and PIHPs.

Beginning October 2026, MHPs will begin covering additional mental health services – including inpatient psychiatric care, crisis residential services, partial hospitalization services and targeted case management – for enrollees with lower levels of mental health need.

Providers of these services should prepare to contract with MHPs and PIHPs for coverage effective October 1, 2026. MDHHS will provide more detailed guidance to facilitate these efforts. MDHHS encourages all mental health providers to send any questions or comments to MDHHSMentalHlthFramework@michigan.gov.

## Case Management

The HAP CareSource case management programs assist members in following the plan of care prescribed by their physician. It helps them regain or maintain optimum health or functional capability in the right setting in a cost-effective manner. Participation in case management is voluntary and members can terminate at any time. Members have the right to refuse active care management activities.

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

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

To initiate an evaluation for case management services, contact the Care Management department at **1-844-217-1357**.

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

## Elective Hospital Admissions

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

- CMS surgical list
- Established HAP CareSource clinical criteria
- InterQual criteria, when contractually obligated
- InterQual surgical list, when contractually obligated
- MCG, when IQ is not contractually obligated

## Emergent Hospital Admissions

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

- CMS surgical list
- Established HAP CareSource clinical criteria
- InterQual criteria, when contractually obligated
- InterQual surgical list, when contractually obligated
- MCG, when IQ is not contractually obligated

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

## Laboratory Services and Genetic Testing

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

# Section 9: Hospital Notification and Review

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

## Urgent/Emergency Care and Inpatient Admissions

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

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

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

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

## Admission Notification Process

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

**Once HAP CareSource is notified:**

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

# Section 10: Billing & Reimbursement

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

We contract with the Centers for Medicare & Medicaid Services and the Michigan Department of Health and Human Services. We follow billing guidelines for claims processing under each contract unless otherwise indicated in this section.

If you have questions or need assistance, please call us at **1-833-230-2102**.

## Community Health Automated Medicaid Processing System (CHAMPS)

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

MDHHS has issued final deadlines for CHAMPS enrollment:

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

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

## Verifying Member Eligibility

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

| Method | Details |
|---|---|
| **CHAMPS online** | Web portal |
| **CHAMPS Provider Support** | **1-800-292-2550, option 5, then 2** |
| **HAP CareSource Provider Portal** | View the **HAP CareSource Provider Portal** webpage to review login instructions |
| **HAP CareSource Provider Services** | Call **1-833-230-2102**, open Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET) |

The HAP CareSource Medicaid plan follows MDHHS for covered services.

## Electronic Funds Transfer (EFT) Registration

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

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

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

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

Simply complete the enrollment form and fax it back to ECHO Health and HAP CareSource's EFT partner at 1-440-835-5656. ECHO Health will work directly with you to complete your enrollment in EFT.

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

## Filing Limitations

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

## Ensure Claims for Your HAP CareSource Patients Get Paid

For dates of service October 1, 2023, and forward, all HAP CareSource claims must be submitted to HAP CareSource as follows:

| How to Submit Claims – HAP CareSource | |
|---|---|
| **Electronic** | Use Availity clearinghouse HAP CareSource Payer ID: **MIMCDCS1** |
| **Provider Portal** | **HAP CareSource Provider Portal** |
| **Paper Claims** | HAP CareSource<br>Attn: Claims<br>P.O. Box 1186<br>Dayton, OH 45401 |
| **Paper Grievance & Appeals** | Please see the Claims Disputes section of this manual for additional information. |

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

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

## Out-of-Network Providers

Out-of-network providers must follow the HAP CareSource referral requirement and claims submission processes. If you have any questions, please contact Provider Services at **1-833-230-2102**.

## Prior Authorization: Out-of-Network Providers

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

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

## Payment Procedure

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

## Provider Capitation Payment

Provider capitation payments are processed around the 15th of every month. Payments are calculated based on assigned membership and the contracted PMPM rates from the Facets system. This process will capture any member retro enrollments or disenrollments dating back to six months. Actual payments are disbursed by ECHO Health.

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

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

**Provider Portal Directions:**

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

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

## Clean Claims

- HAP CareSource pays clean claims in accordance with State and/or Federal Prompt Pay regulations.
- A clean claim will be considered when a written itemization of any documents or other information needed to process the claim has been supplied to HAP CareSource.
- If any mandatory or conditional information is missing, the claim is considered unclean.
- Unclean claims will be returned or rejected within 30 days for HAP CareSource.

## Returned Claims

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

## Resubmission of Rejected Claims

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

## Overpayments

To the extent the provider detects an overpayment from HAP CareSource, the provider will send a written notice of the overpayment to:

- HAP CareSource Provider Portal
- Mail:
  HAP CareSource
  P.O. Box 632128
  Cincinnati, OH 45263-2128

If the parties agree that an overpayment has occurred and agree on the amount, such overpayment will be returned to HAP CareSource within 60 days of identification of the overpayment.

## Checking Claims Status

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

- Log into the **HAP CareSource Provider Portal** and select *Claims*.
  (Note: There's a link to view the date of service (DOS) prior to October 1, 2023 information.)
- Log in to the **HAP CareSource Provider Portal** and select *Remittance Advice*.
  (Note: There is a link to view DOS prior to October 1, 2023 information.)
- Call HAP CareSource Provider Services at **1-833-230-2102**, available Monday through Friday, 8 a.m. to 6 p.m. ET.

## Claim Editing Guidelines for Attending, Ordering or Referring Fields

HAP CareSource follows the Michigan Department of Health and Human Services (MDHHS) claim editing guidelines for attending, ordering or referring fields for all claim types. Please see bulletin, MSA 21-45 on the MDHHS website here, for more details. Listings of allowed attending provider types for inpatient hospitals and outpatient hospital providers can be found under Attending Provider Tips on the MDHHS website.

## Remittance Advice and Explanation Codes

| For | Process |
|---|---|
| **A remittance advice for dates of service October 1, 2023, and forward (HAP CareSource)** | Log in to the **HAP CareSource Provider Portal** and select *Remittance Advice*. |
| **835 files** | If you don't get an 835 from HAP CareSource today, contact your clearing house and give them HAP CareSource's payer ID MIMCDCS1. |

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

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

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

## General Billing Guidelines

- Submit claims for complete episode of care.
- Do not bill future dates of service.
- Do not submit single claim with date span across calendar years except in the case of inpatient facility MS-DRG and APR-DRG billing.
- Submit supporting documentation for unlisted CPT/HCPCS codes.
- Interim billing is not accepted.

- Indicate the appropriate HAP CareSource product name in the upper right corner on CMS-1500 claim form and in field 61 on the CMS-1450 (UB-04) form.
- Claims and encounters must be computer generated or typed and signed by the servicing provider and submitted via:
  - **Paper**: CMS-1500 claim form or CMS-1450 (UB-04) claim form
  - **Electronically**: through the clearing house Availity
- Handwritten entries are not acceptable anywhere on the claim.
- Electronic signatures are acceptable.
- Mandatory items on claim forms must be completed or the claim cannot be processed. Refer to claim form submission guidelines within this section.
- Conditional items, if applicable, on claim forms are required or the claim may not be processed. Refer to claim form submission guidelines within this section.
- Blank items may be left empty and will not affect claims processing. Refer to claim form submission guidelines within this section.
- All claims must contain an NPI number submitted as follows:
  - Field 24 J of CMS-1500 rendering provider is conditional, required when different from billing provider and must be an entity type of one individual
  - FL 56 of the UB-04 form
- Submit the HAP CareSource member ID number using the 11-digit number on the ID card.

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

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

**Legend**

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

| Field Locator | Status | Description |
|---|---|---|
| 1 | Blank | Patient/Insured Information |
| 1a | Mandatory | Insured's ID Number as shown on insured's ID card |
| 2 | Mandatory | Enter the patient's last name, first name and middle initial (if any) in that order |
| 3 | Mandatory | Enter the patient's eight- digit birthdate (MMDDYY) and sex |
| 4 | Conditional | Mandatory if the patient has other insurance primary to Medicaid |
| 5 | Blank | Enter patient's current address |

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

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

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

## UB-04 CMS-1450 Claims Form

For efficient claims processing, please follow the guidelines below.

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

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

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

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

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

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

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

# Ordering, Referring and Attending Providers – Requirements for HAP CareSource Claims

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

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

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

- The following provider types are allowed to be reported as attending providers in addition to the above provider types for Institutional claims by Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Tribal Health Center (THC) providers.

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

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

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

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

- Laboratory services
- Certain mental health and substance abuse children's waiver services
- Certain Maternal Infant Health Program (MIHP) services
- Pharmacy services
- Private duty nursing services
- Certain School based services
- Therapy services [occupational therapy (OT), physical therapy (PT) and speech]
- Certain vision supplies

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

## National Drug Code (NDC) Reporting Requirement for Physician Administered Drugs

Providers and hospitals are required to report the NDC when billing for a physician administered drug on electronic and paper claim formats. This requirement is for HAP CareSource claims.

Billing guidelines can be found in the Michigan Department of Health and Human Services Medicaid Provider Manual. You can find the manual here. Please refer to the following sections:

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

## Nine-Digit ZIP Code Reminder

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

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

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

## National Provider Identifiers (NPIs) on CMS 1500 Claim Submission

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

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

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

- NPI and entity type qualifier combination does not align in National Plan and Provider Enumeration System (NPPES) or is not active in NPPES.

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

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

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

## Taxonomy Codes Required on Professional Claims

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

**On a CMS-1500 claim form**

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

### Electronic submission

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

| | |
|---|---|
| **Billing** | PRV01 = BI<br>PRV02 = PXC<br>PRV03 = taxonomy code |
| **Rendering** | PRV01 = PE<br>PRV02 = PXC<br>PRV03 = taxonomy code |

Claims may deny if the taxonomy is missing or incorrect.

## Specific Claim Coding Requirements

### Coordination of Benefits (COB)

- Medicaid is the payer of last resort.
- Providers must report all other insurance or liability coverage using all other payment resources before submitting a claim to HAP CareSource.
- An explanation of payment or explanation of benefits from the primary carrier must accompany the claim to coordinate benefits.
- Professional, facility and ancillary services not covered by the primary insurance carrier and billed to HAP CareSource must comply with our authorization requirements to be reimbursed. See Referrals and Authorizations section in this manual.
- It's highly recommended to submit COB claims electronically and indicate the primary insurance detail payment lines in loop 2400. COB claims may be submitted on paper with other insurance explanation of payment attached.

### Durable Medical Equipment, Prosthetics and Orthotics

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

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

### Evaluation & Management (E&M) Billing Guidelines

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

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

### Two E&M Services on Same Date of Service

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

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

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

### Emergency Services

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

### Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Tribal Health Centers (THCs)

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

### Long-Term Support Services

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

### Per Diem Services

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

### Modifier N1, N2, N3 for Home Oxygen Use

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

### Urgent Care Services

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

## Michigan Department of Health and Human Services Newborn Recoveries

To avoid upfront EDI rejections from HAP CareSource for timely filing limit, newborn recovery claims with a date of service greater than one year must be:

- Billed within 60 days of MDHHS remittance advice date
- Submitted via paper with supporting remittance advice to:

  HAP CareSource
  P.O. Box 1186
  Dayton, OH 45401-1186

## Telemedicine Services

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

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

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

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

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

## Therapy Services

Therapy services furnished to Medicaid beneficiaries must be billed with the appropriate therapy modifier used to identify physical, occupational, or speech language therapy services. Services should also be reported with the appropriate modifier that represents the nature of the therapy performed. Modifier 96 should be used when habilitative services are rendered. Therapy services submitted without these modifiers may be denied.

## Billing Members

Providers who accept a patient as a Medicaid beneficiary with HAP CareSource cannot bill the beneficiary for:

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

## Balance Billing

- Providers may not balance bill HAP CareSource members.

# Claim Disputes

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

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

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

Providers can dispute claims by following the processes outlined below. All disputes must be submitted in writing to:

HAP CareSource
Attn: Grievance & Appeals
P.O. Box 1025
Dayton, OH 45401-1025
**HAP CareSource Provider Portal**

Claims disputes must include the following claim information:

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

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

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

| Dispute | Process |
|---|---|
| **Level 1** | Submit dispute within 60 days of original claim denial.* |
| **Level 2** | Submit dispute within 60 days of claim dispute. |
| **Account Receivable Reconciliation Group (ARRG)** | For non-contracted hospital providers that have signed the Hospital Access Agreement, disputes will be referred to the AARG. The AARG is comprised of HAP CareSource stakeholders that meet no less than every 90 days to reconcile outstanding bills and payments.<br><br>All appeal decisions will be finalized at the AARG. |
| **Decision** | If the original decision is overturned and the service is approved, the claim will be reprocessed for payment. A letter will be sent to the provider notifying them of the Approval and that payment will be forthcoming within 2-3 weeks. |
| **Unresolved** | Where a disputed claim, or group of similar claims, remains, the hospital or the provider may submit a request to MDHHS for Rapid Dispute Resolution (RDR). |
| **Arbitration/Rapid Dispute Resolution** | • The RDR process can be found in the Medicaid Provider Manual and should be followed for non-contracted hospital providers that have signed the Hospital Access Agreement.<br>• Non-contracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the RDR process.<br>• The Binding Arbitration process can be requested by non-hospital providers or hospital providers that have not signed the Hospital Access Agreement after they have exhausted our internal provider dispute process. |

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

# Denials – When to Submit a Corrected Claim vs. a Dispute

### Corrected claim submission

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

- Follow our process for Claim Corrections in this manual.

### Important!

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

Denials include, but are not limited to:

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

### Disputes

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

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

You can find the appeals process in this manual.

Denials include, but are not limited to:

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

### Missing Modifiers Requiring Appeal and Corrected Claim

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

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

**Important!**

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

## Claim Corrections

To ensure proper payment, please follow the process below.

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

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

## Replacement (xx7)

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

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

**Important**

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

- Contact Provider Services at **1-833-230-2102**, available Monday through Friday, 8 a.m. to 6 p.m. ET
- Follow the online Claims Adjustment Process

## Cancel (xx8)

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

HAP CareSource will use the cancelled claim as the indicator to adjust the original claim in full. This indicates the claim should not have been submitted.

## Post-Payment Review

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

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

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

## Quarterly Claim Audits

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

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

**Process to obtain medical records**

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

**Process for medical records that do not support services**

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

These services cannot be billed to the patients.

# Coding Validation Process

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

Below is an overview of our process.

### Modifiers

We will review the following modifiers:

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

### Resources

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

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

### Prepayment review

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

### Review outcome

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

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

## Enhanced Clinical Editing Processes

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

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

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

- The CMS medical coding guidelines
- AMA CPT coding guidelines
- Local and regional Medicare guidelines
- MDHHS guidelines for HAP CareSource claims

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

| Topic | Description and Guidelines |
|---|---|
| **Add-On Codes** | • Certain procedure codes are commonly performed and billed in addition to the primary procedure.<br>• They should never be reported as a standalone service.<br>• These codes are identified in the American Medical Association (AMA) Current Procedural Terminology (CPT) manual with a plus (+) symbol.<br>• They're also listed in Appendix D of the CPT Manual.<br>• Add-on codes in the HCPCS Level II Manual and the American Dental Association (ADA) Dental Services Manual are identified with "list separately in addition to code for primary procedure" or "each additional" language within the code description.<br>• If an Add-on code is submitted and the primary procedure has not been identified on the same or different claim, HAP CareSource will deny the Add-on code as an inappropriately coded procedure. |

| Topic | Description and Guidelines |
|---|---|
| **Ambulatory Surgery Center Edits** | • The following services will be denied if billed without an approved Ambulatory Surgical Center (ASC) surgical procedure for claims submitted with place of service 24:<br>- Radiology<br>- Drugs and biologicals<br>- Devices<br>- Brachytherapy source |
| **Ambulance Edits** | • If a provider does not submit an origin modifier combined with a destination modifier for ambulance services will be denied.<br>• Ambulance claims submitted with non-covered origin and destination modifiers will be denied.<br>• Advanced Life Support (ALS) emergency services will be denied when billed without a diagnosis that supports ALS emergency services.<br>• ALS or Basic Life Support (BLS) non-emergency services will be denied when billed without a diagnosis that supports ALS/BLS non-emergency services. |
| **Anesthesia Edits** | When more than one anesthesia CPT code (00100 – 01999) can be used for a surgery, then the lower based unit anesthesia code should be billed. If not, the service will be denied to be rebilled correctly. |
| **Assistant Surgeon Edits** | • Reimbursement for an assistant surgeon will be denied when billed by the primary surgeon.<br>• Only one assistant surgeon will be allowed for a surgical procedure. |
| **Bundled Services** | • There are several services or supplies CMS bundles into the payment for other related services. These services are grouped into three categories:<br>1. Not separately payable when billed on the same day as other payable services (Status Indicator P).<br>2. Not payable under any circumstances (Status Indicator B).<br>3. Injection services (Status Indicator T). |
| **Correct Coding Edits** | • When multiple CPT/HCPCS codes are billed together without modifiers to denote different sides, but there is a single code that describes the same procedure/services under one code, the service will be denied and to be rebilled under the correct code.<br>• Nuclear medicine procedure will be denied when billed without a radiopharmaceutical imaging agent on both outpatient and professional claims.<br>• Certain procedures will be limited to one unit per day regardless of appended modifier.<br>• 99441-99443 (Telephone E/M services), G2010 (Remote evaluation of recorded video and/or image), G2012, or G2252 (Brief check in by MD/QHP) will be denied when an E/M service has been billed on the same day, <previous seven days>, or following day with the same primary diagnosis. |

| Topic | Description and Guidelines |
|---|---|
| **Detailed Fetal Anatomical Ultrasound with Evaluation** | According to HAP CareSource policy, which is based on the Society of Maternal Fetal Medicine, a detailed fetal anatomic exam (76811 or 76812) is not intended to be the routine ultrasound performed for all pregnancies. |
| **Device and Supply** | CMS has established a policy regarding the billing of implant devices and implant procedure codes. This policy identifies certain implant procedures that require an implant device to be billed along with the implant procedure, or vice versa. When one is billed without the other and they are required to be billed together, the billed service will be denied.<br><br>Example: 92982 (PTCA) will be denied if billed without C1725 (catheter, transluminal, angioplasty, non-laser) or C1885 (catheter, transluminal, angioplasty, laser). |
| **Diagnosis-Age Rules** | • Certain diagnosis codes are identified as being specific to certain age groups.<br>• All services on a claim billed with one of these codes will deny if:<br>- It's the only diagnosis on the claim.<br>- It doesn't match the age of the patient on the claim for the date of service.<br>• This policy looks at all diagnoses on a claim. |
| **Diagnosis Criteria** | CMS has determined that for certain services, for that procedure to be covered, it must be billed with a diagnosis to indicate the criteria for the service has been met. If the service is billed without one of the requisites diagnoses, the service will be denied. Example: CMS requires a diagnosis of morbid obesity for bariatric surgery procedures. If not billed on claim, then the service will be denied. |
| **Diagnosis Edits** | Ultrasound, abdominal aorta, screening study for abdominal aortic aneurysm [AAA] (CPT 76706) will be denied when the appropriate diagnosis based the patient age and gender is not billed per CMS guidelines. |
| **Diagnosis Requirement** | Effective October 1, 2021, End Stage Renal Disease (ESRD) facilities must submit a principal diagnosis of end stage renal disease (ICD-10 code N18.6) for claims submitted with bill type 0720-072Z (clinic-hospital based or independent renal dialysis center) and a condition code of 84 (dialysis for acute kidney injury).<br><br>Dialysis for Acute Kidney Injury (AKI) is excluded from this policy. |

| Topic | Description and Guidelines |
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| **Drug and Biological Edits** | • When a drug is Food and Drug Administration (FDA) approved, there are criteria required to be met for that drug to be prescribed. Below are some of the edits and HCPCS codes that these edits may be applied to:<br>- J0256, J0257, J9042, J9145, J9176, J9228, J1950, J3380, J1300, J0881, J0882, J0885, J2505, J9035, J9305, J9308, J1745, J9217, J9271, J9306, J9312, J9311, J9315, J9355, J2357, J0178, J2778, J7318, J7320, J7321, J7322, J7323, J7324, J7325, J7326, J7327, J7328, J7329, J2353, J9041, J9044, J1300, J9299<br>- A9513, Q5108, Q5111, Q0138, Q0139, C9257, Q5103, Q5104, Q5109<br>• When an FDA approved indication or an approved off-labeled indication is not present on the claim will be denied. Indications are, but not limited to:<br>- Diagnosis that the drug is to be used for<br>- Dosage and Max Dosage Over Time<br>- Frequency<br>- Route of Administration<br>- Lab Requirements<br>- Age Restrictions<br>- Examples of Indications edits:<br>- J2505, Q5108, or Q5111 will be denied when billed by any provider less than 10 days prior to the administration of a cytotoxic chemotherapy drug.<br>- J1950 will be denied when billed and the patient is greater than 11 years of age, and the patient's gender is female, and the diagnosis on the claim is central precocious puberty.<br>- Limit J1950 to 24 combined units every 48 weeks and the diagnosis on the claim is prostate cancer.<br>• Chemotherapy drug administration code (96401-96450, 96542-96549, G0498, Q0083-Q0085) will be denied when billed with a drug that is administered using non-chemotherapy administration codes and a drug that is administered using chemotherapy codes has not been billed for the same date of service by any provider.<br>• Intravenous push chemotherapy administration (96409, 96411) will be denied when billed with specific drugs codes and no other drug administered by chemotherapy administration has been billed for the same date of service by any provider. |

| Topic | Description and Guidelines |
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| **Drug and Biological Edits** *(Continued)* | • Limit 96415 to one unit when billed with specific drug codes and no other chemotherapy drug administered by IV infusion for greater than one hour has been billed for the same date of service by any provider.<br>• Drug administration services other than for subcutaneous technique (96365-96371, 96373-96379, 96402-96450, 96542, 96549, or G0498) when billed with specifics codes and no other drug has been billed for the same date of service by any provider.<br>• Any code other than a drug code when billed with modifier JW (drug amount discarded/not administered to any patient) will be denied.<br>• A drug when billed with modifier JW (drug amount discarded/not administered to any patient) and another claim line does not exist for the same drug on the same date of service will be denied.<br>• Duplicate drug codes when the same code with the same units has been billed on a different claim by any provider for the same date of service will be denied. |
| **Drugs** | Effective Nov. 1, 2022, for Q5112, Q5113, Q5114, Q5116, or Q5117:<br>• Deny when billed with units representing a multiple of an entire vial (42, 84, or 126 units) and another claim line for the same drug does not exist on the same claim for the same date of service. |
| **Duplicates** | • Any claim submitted by a physician or provider for the same service provided to a single patient on a specified date of service that was included on a previously submitted claim.<br>• When new claims and claim lines are received, they are compared against other claims and claim lines in both history and in the same new claim batch.<br>• Claims for multi-specialty groups operating under the same tax ID and specialty are processed in a slightly different manner.<br>• Additional specific criteria, such as specialty, are used to make the determination to ensure providers within the tax ID do not edit against each other when treating the same member on the same date of service. |
| **Durable Medical Equipment and Supplies Edits** | • Indwelling catheters (A4311-A4313, A4314-A4316, A4338-A4346) will be limited to three units when billed separately or in any combination every three months.<br>• E0935 (CPM device) is limited to one unit per day when billed by any provider within three weeks of the original arthroplasty.<br>• According to national CMS policy, certain items are not payable because they are considered not primarily medical in nature; not medical equipment; a non-reusable supply; or a convenience item. These items will be denied as non-covered items when billed. |

| Topic | Description and Guidelines |
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| **Evaluation and Management (E&M) Services** | • The AMA defines a new patient as "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." Otherwise, the patient is considered an established patient.<br>• Only one E&M code should be billed for a single date of service by the same provider group and specialty regardless of place of service.<br>• When E&M services are billed on the same date as other therapeutic or diagnostic services, they shouldn't be billed unless they're separate and distinct services.<br>• Annual exams or screening services should be billed as new or established patient preventive medicine visits, not as consultations.<br>• Preventive medicine visits may include, but are not limited to, the following:<br>- Gynecologic screening services<br>- Screening Pap Smear (Q0091)<br>- Cervical or vaginal cancer screening; pelvic and clinical breast examination (G0101)<br>- Prostate cancer screening; digital rectal examination (G0102)<br>- Visual screening<br>- Preventive medicine counseling codes<br>• Please refer to AMA guidelines for correct use of E&M services codes and modifiers.<br>• Reimbursement for additional services considered part of the pediatric critical care inter-facility transport codes (99466-99467) and critical care codes (99291-99292) will be denied.<br>• Interprofessional telephone/internet consultation (99446-99449, or 99451) will be denied when billed and any face-to-face service has been billed on the same date or in the previous 14 days. |
| **Global Surgery** | • The global surgery package includes all necessary services normally provided by the surgeon before, during and after a surgical procedure.<br>• The global surgery package only applies to surgical procedures that have global periods of 0, 10 and 90 days.<br>• Global surgery only applies to primary surgeons and co-surgeons.<br>• The following items are included in the global surgery package:<br>- Preoperative and same day E&M visits after the decision is made to operate. |

| Topic | Description and Guidelines |
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| **Global Surgery** *(Continued)* | - All post-operative E&M visits and services for 10-day and 90-day surgeries related to the primary procedure per CMS guidelines.<br>- Anesthesia services billed by the surgeon are not reimbursed separately.<br>- Care management services (99487-99490) or transitional care management services (99495-99496) performed within 90 post-operative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of provider ID and specialty, and the diagnosis is a complication of surgical and medical care, or an aftercare diagnosis will be denied.<br>- Care management services (99487-99490) or transitional care management services (99495-99496) when billed with modifier 24 and a major surgical procedure with the global postoperative period has been billed in the previous 10/90 days and the E&M diagnosis is a complication of surgical and medical care or an aftercare diagnosis will be denied.<br>- Care management services (99487-99490) or transitional care management services (99495-99496) performed within the global postoperative days of a 10/90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of provider ID and specialty, and the diagnosis is a complication of surgical and medical care, or an aftercare diagnosis will be denied.<br>- Evaluation and management services performed within the global postoperative days of a medical or surgical service will be denied when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis.<br>- Evaluation and management services performed within 10 postoperative days of a 10-day medical or surgical service will be denied when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the E&M service has a primary diagnosis associated to the 10-day medical or surgical service.<br>- Evaluation and management services will be denied when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E&M diagnosis is a complication of surgical and medical care or an aftercare diagnosis. Evaluation and management services will be denied when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E&M service has a primary diagnosis associated to the 10-day medical or surgical service. |

| Topic | Description and Guidelines |
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| **ICD-10 Correct Coding** | • In addition to ensuring ICD-10 diagnosis codes are coded to the highest level of specificity, and appropriate diagnosis to age codes are being submitted, there are unique coding attributes of the ICD-10 CM code set and coding conventions that also need to be observed.<br>• Per coding guidelines, principal, primary or the only diagnosis submitted on a claim should never be one of the following:<br>- External causes<br>- Manifestation codes<br>- Sequela codes<br>• "Diagnosis to diagnosis pointer" and "diagnosis to modifier" edits are also new to the editing rules for ICD-10. If a diagnosis code for left side is used in the header, the line pointer or line modifier must match to the left side or service lines may be denied for inappropriate coding.<br>• For many diagnosis codes, laterality has been built into the codes. These edits will look at the service and/or modifier billed to the diagnosis code to make sure they service was billed correctly. These edits also review diagnosis to diagnosis to determine if multiple diagnosis billed for a single service is appropriate. Claims billed inaccurately will be denied and to be rebilled correctly.<br>Example: X-ray of foot 73620 with LT (left) modifier with a diagnosis of pain in right foot M79.671 - This claim would be denied since the modifier of left doesn't match the diagnosis showing right foot.<br>• All services received with a manifestation code billed as the only diagnosis on the claim will be denied.<br>• Any procedure or service received with an ICD-10-CM sequela (7th character "S") code billed as the only diagnosis on the claim will be denied.<br>• Any procedure or service received with an ICD-10-CM sequela (7th character "S") code billed in the primary, first listed or principal diagnosis position will be denied. |
| **Intensity-Modulated Radiation Therapy (IMRT)** | Additional billings of 77301 (IMRT plan) when billed more than one date of service in eight weeks will be denied. |

| Topic | Description and Guidelines |
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| **IMRT with Image-Guide Radiation Therapy (IGRT) Delivery** | Per ASTRO coding guidance:<br>• If a facility bills for the IMRT, with IGRT delivery, they should bill for 77385 or 77386 depending on the complexity of the scan.<br>• The facility should not bill 77014 and should appropriately bill 77385 or 77386 based on the complexity of the scan administer for IMRT with IGRT.<br>• Hospitals should modify their chargemaster to include IGRT within IMRT delivery. However, do not bill or report IGRT Technical Component separately with IMRT.<br>• If a physician bills for IMRT with IGRT delivery they should bill G6001, G6002, G6017 and/or 77014.<br>Note: The provider should be billing CPT 77387 for IGRT related treatment in conjunction with IMRT delivery codes. |
| **Inpatient Only Services** | • CMS has identified certain services that may only be performed in a facility setting due to:<br>- The invasive nature of the procedure.<br>- The need for postoperative care following surgery.<br>- The underlying physical condition of the patient requiring surgery.<br>• When these services are performed in an office setting, they will be denied. |
| **“Incident To” Services** | Per CMS guidelines, “incident to” services are provided as an integral, although incidental, part of the physician's personal, professional services in the course of diagnosis or treatment of an illness or injury.<br>“Incident to” services should not be billed in:<br>• An inpatient hospital.<br>• An outpatient department (including the emergency department).<br>• A military treatment facility setting. |
| **Maximum Allowable Units of Service** | When a provider bills for a quantity of services that exceed the amount the health plan feels is reasonable for a given period of time, the units considered excessive will be denied. Maximum unit settings have been established for different time periods, such as per day, per year, and in some cases other time periods. The maximum allowable unit settings have been defined through a combination of various sources:<br>• Procedure code definitions.<br>• Anatomical site definitions.<br>• Clinical guidelines suggested by specialty societies or physician panelists considered experts in their fields. |

| Topic | Description and Guidelines |
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| **Maximum Allowable Units of Service** *(Continued)* | • CMS' reimbursement limitations and code status indicators<br>• Other analytics and research<br><br>**Example:** Code 97032 is defined as "Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes." If one hour of this type of therapy is allowed per day, then the daily maximum unit for code 97032 would be set at four and any units greater than four per day will be denied. [15min X 4 = 60min (1hour)]<br><br>Note regarding the use of Anatomical Modifiers - Anatomical modifiers E1-E4 (Eyes), FA-F9 (Fingers), and TA-T9 (Toes) have a maximum allowable of one unit per anatomical site. Any service billed with an anatomical modifier for more than one unit of service will be adjusted accordingly. |
| **Modifiers** | HAP CareSource follows CMS usage for modifiers. This includes, but not limited to:<br>• Modifiers used to identify who provided the medical care (QZ, AH, etc.)<br>• Modifiers use to add more information (E1, CA, etc.)<br>• Modifiers use for durable medical equipment or by suppliers (RR, KX, etc.)<br>• ABN specific modifiers (GA, GX, GY, GZ, etc.)<br>• Modifiers which impact the pricing of the code (51, 54, As, etc.) |
| **National Correct Coding** | • The National Correct Coding Initiative or NCCI is a collection of bundling edits created and sponsored by CMS. They are separated into two major categories:<br>1. Column I and Column II procedure code edits (previously referred to as "Comprehensive" and "Component")<br>2. Mutually Exclusive procedure code edits<br>• CCI edits are for services performed by the same provider on the same date of service only. They don't apply to services performed within the global surgical period.<br>• Each CCI code pair edit is associated with a policy as defined in the National Correct Coding Initiative Policy Manual. Effective dates apply to code pairs in CCI and represent the date when CMS added the code pair combination to the CCI edits.<br>• Code combinations are processed based on this effective date.<br>• Termination dates also apply to code pairs in CCI. This date represents the date when CMS removed the code pair combination from the CCI edits.<br>• Code combinations are refreshed quarterly. |

| Topic | Description and Guidelines |
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| **National Coverage Determinations (NCD)** | • According to CMS policy, certain lab services are payable when billed with specific diagnoses.<br>• These services will be denied in the absence of one of the designated covered diagnoses identified in the NCD coding manual which can be found at cms.gov, then select:<br>- Regulations and Guidance<br>- Manuals<br>- Internet-Only Manuals<br>- 100-03 Medicare NCD Manual<br>• Chapter 1 – Coverage Determinations, Part 3, Sections 170-190.34 |
| **National Coverage Edits (CMS)** | • E0748 (electrical osteogenesis stimulator) when billed and a diagnosis of post-surgical arthrodesis status is not present.<br>• E0760 (ultrasonic osteogenesis stimulator) when billed without a required diagnosis with be denied.<br>• Subsequent service, supply or device will be denied when modifier CA (procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission) has been reported in the past for the same patient by any provider.<br>• 77080 or 77085 will be denied when billed without a covered diagnosis based on CMS guidelines and HAP CareSource's BAM.<br>• G0102 or G0103 will be denied when billed and the patient is under 50 years of age.<br>• 84153 (prostate specific antigen [PSA], total) will be denied when billed more than twice in a patient's lifetime by any provider with a diagnosis of carcinoma in situ of the prostate.<br>• Any combination of G0420-G0421 (face-to-face educational services related to the care of chronic kidney disease) if billed for more than 6 units in a patient's lifetime by any provider will be denied.<br>• 99201-99397 or 99420-99499 (evaluation and management service) will be denied when billed with 99406 or 99407 (smoking and tobacco cessation counseling visit) on the same date of service.<br>• G0422 or G0423 (intensive cardiac rehabilitation) when billed in any place of service other than 11 (office), 19 (outpatient hospital-off campus), or 22 (outpatient hospital-on campus) will be denied.<br>• G0438 (annual wellness visit; initial visit) will be denied when billed more than once in a patient's lifetime. |

| Topic | Description and Guidelines |
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| **National Coverage Edits (CMS)** *(Continued)* | • Subsequent service, supply or device will be denied when modifiers PM (post-mortem), P6 (brain dead) or QL (pronounced dead after ambulance called) have been reported in the past for the same patient by any provider.<br>• E/M services and outpatient clinic visits billed without a distinct services modifier when performed with continuous overnight oximetry monitoring (94762) will be denied.<br>• FQHC new patient visit (G0466 or G0469) will be denied when reported for PPS payment and any professional service has been billed in the previous three years. |
| **National Drug Code (NDC) Numbers** | Deny claim lines containing expired NDC numbers.<br><br>According to CMS policy, providers are required to report valid NDC numbers for the given date of service. For example: the NDC number has surpassed the allowed obsolete period of 30 months (913 days) set in the standard NDC reference sources. |
| **Non-Obstetric Transvaginal Ultrasound and Non-Obstetric Transabdominal Ultrasound** | Pelvic ultrasound (76856 or 76857) and transvaginal ultrasound (76830) evaluate the patient for the same conditions at the same session. Therefore, they represent redundant services. HAP CareSource will not pay separately for the pelvic echography unless there are extenuating circumstances as to why both studies had to be performed. |
| **Oxygen** | • Modifier KX should be appended to oxygen and oxygen equipment only when all the coverage criteria have been met.<br>• Modifiers GA, GY and GZ should be appended to oxygen and oxygen equipment when all the coverage criteria have not been met.<br>• The oxygen and oxygen equipment (E0424-E0447, E1390-E1392, E1405-E1406, K0738) will also be denied when modifier KX, GA, GY or GZ are not submitted. (for Commercial and Medicare). |
| **Place of Service** | • Certain codes are allowable only in specific places of service. For example, hospital admission codes, 99221-99223 can only be billed for hospital places of services such as POS 21 inpatient hospital or POS 51 psychiatric inpatient facility.<br>• Medical and surgical supplies and DME when billed with professional fee revenue codes (0960-0989) in an outpatient facility or inpatient facility setting will be denied. (CMS-1450) |

| Topic | Description and Guidelines |
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| **Procedure-Modifier Rules** | • Procedure code modifier combinations are reviewed and validated.<br>• Modifiers that affect reimbursement or show that separate and distinct services occurred may override incidental or mutually exclusive edits.<br>• Appropriate use of modifiers to identify the correct anatomic site is required.<br>• Modifier use may be subject to retrospective review.<br>• Per AMA and CMS code definitions, procedures billed with incorrect modifiers will be denied as inappropriately coded procedures. |
| **Procedure Code Definition** | Throughout the T-4 Manual and CMS HCPCS Manual, the publishers have provided instructions on code usage. MMM has adopted edits that support correct coding based on the definition or nature of a procedure code or combination of procedure codes. These edits will either bundle or re-code procedures based on the appropriateness of the code selection.<br><br>**Example:** CPT code 73510 (X-ray, hip, unilateral complete) billed on one line with modifier LT (left side) and on a second line with modifier RT (right side) will be replaced with 73520 (X-ray, hips, bilateral) |
| **Professional Component and Technical Component** | • Most diagnostic radiology services and some laboratory services are reimbursed based on the concept that these services are divided into the following components:<br>1. **Professional component.** Describes the physician work portion of the procedure. This portion is identified by appending modifier 26 to the appropriate lab or radiology procedure.<br>2. **Technical component.** Describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service. This portion is identified by appending modifier TC to the appropriate lab or radiology procedure.<br>• The CMS Medicare Physician Fee Schedule has certain indicators that note if the professional or technical component concept applies. If the professional or technical component don't apply, it's inappropriate to append modifier 26 or TC.<br><br>**Example:** CPT 90707 (MMR vaccine) is listed as a PC/TC Indicator 9 code. Since a vaccine wouldn't have a professional or technical component, it's inappropriate to append modifier 26 or TC to this service. |
| **Radiation Therapy** | Limit any combination of Treatment devices, simple; intermediate; complex (77332-77334) to seven units in eight weeks by any provider and the diagnosis is not head neck cancer, or prostate cancer, and a complex therapy service has not been billed for the same date of service or within two weeks (before or after). |

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

| Topic | Description and Guidelines |
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| **Same/Similar Services Performed Recently Edits/ Once Per Lifetime Edits** *(Continued)* | • Certain renal services that are performed after a total nephrectomy by any provider will be denied.<br>• Certain services related to the lung that are performed after a total pneumonectomy by any provider will be denied.<br>• Certain services related to the uterus that are performed after a total hysterectomy by any provider will be denied.<br>• Certain thyroid services that are performed after a total thyroidectomy by any provider will be denied. |
| **Self-Administered Drugs** | According to CMS policy, coverage for drugs that are furnished 'incident to' a physician's service is allowed provided that the drugs are not usually self-administered by the patients who take them. When these items are billed, they will be denied. An exception applies when drug J0129 (Injection, abatacept) or J2354 (Injection, octreotide) is reported with modifier JA (Administered intravenously). |
| **Special treatment procedures** | Special treatment procedure (i.e., total body irradiation, hemibody radiation, per oral or endocavitary irradiation) (77470) will be denied when billed by any provider without a qualifying diagnosis on the claim, and a complex therapy service has not been billed for the same date of service or within two weeks (before or after). |
| **Surgical pathology** | • According to the AMA CPT Manual, "A specimen is defined as tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. Service codes 88302 through 88309 describe all other specimens requiring gross and microscopic examination and represent additional ascending levels of physician work. Levels 88302 through 88309 are specifically defined by the assigned specimens."<br>• Our enhanced guidelines will enforce the diagnosis meeting the level of surgical pathology reported. For example, the AMA CPT Manual states CPT 88302 should be used for the examination of:<br>- Appendix, incidental<br>- Fallopian tube, sterilization<br>- Fingers/toes, amputation, traumatic<br>- Foreskin, newborn<br>- Hernia sac, any location<br>- Hydrocele sac<br>- Nerve<br>- Skin, plastic repair<br>- Sympathetic ganglion<br>- Testis, castration<br>- Vaginal mucosa, incidental<br>- Vas deferens, sterilization<br>• 88302 should not be used for examination of specimens not included in this list. |

If you have any questions, please contact Provider Services at **1-833-230-2102.**

## National Correct Coding Initiative

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

Reimbursement methodologies include:

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

Providers may not:

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

## Facility Inpatient Claims Edits

Edits will be applied to claims submitted with:

- Questionable admission-principal diagnosis
- Unacceptable principal diagnosis

This affects all HAP CareSource claims. Please see details below.

**Questionable Admission-Principal Diagnosis**

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

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

Examples from questionable admission-principal diagnosis only list:

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

### Unacceptable Principal Diagnosis

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

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

Examples of unacceptable principal diagnoses:

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

# Section 11: Clinical Appeals

Providers, with written consent from the member, can appeal a utilization management decision made by HAP CareSource. The appeal must be submitted on the **HAP CareSource Provider Portal** or in writing to the address listed below based on the appeal type.

If you disagree with a clinical decision regarding medical necessity, we make it easy for you to be heard. Please see the information below this section about how to submit appeals and disputes.

After receiving a letter from HAP CareSource denying coverage, a provider or member can submit a pre-service or post-service clinical appeal. Clinical appeals are reviewed by nurses and physicians not involved in any prior review. They are also reviewed by practitioners with expertise and knowledge appropriate to the item, service or drug being requested.

**Pre-Service Appeal:** denial of an authorization for a service prior to being completed. Members, providers or the member's representative with member written consent, have 60 calendar days from the date of the receipt of the authorization denial to submit a standard pre-service appeal. This is considered a member appeal. Member appeals will be resolved within 30 days plus any extension, if applicable, for a standard appeal. Member appeals for Children's Special Health Care Services (CSHCS) members are resolved within 10 days plus any extension, if applicable, for a standard appeal. See 'Extending an Appeal" for more information on extensions. Please see 'Expediting Clinical Appeals' for more information on expedited clinical appeals. Members have additional appeal rights through Department of Insurance and Financial Services (DIFS) for an external review or may request a state fair hearing.

HAP The pre-service appeal must be accompanied by a valid consent form. The form is available on our webpage. Please see 'Expediting Clinical Appeals' for more information on expedited clinical appeals. Members may also appeal through DIFS for an external review or request a state fair hearing.

**Post-Service Provider Appeal:** Providers have 60 calendar days from the date of the initial adverse benefit determination to submit a post-service appeal. Post-service provider appeals are resolved within 30 calendar days. Appeals submitted by providers and other representatives on behalf of the member are considered member appeals, will be resolved within 30 days plus any extension, if applicable, for a standard appeal. Appeals for CSHCS members are resolved within 10 days plus any extension, if applicable, for a standard appeal.

| Appeal Type | Address | Fax Number |
|---|---|---|
| **Pre-Service or Pre-Service Expedited** | HAP CareSource<br>Attn: Grievance & Appeals<br>P.O. Box 1025<br>Dayton, OH 45401-1025 | HAP CareSource<br>**Standard Appeals/Disputes:**<br>1-937-396-3492<br>**Expedited Appeals:**<br>1-937-396-3507 |
| **Post-Service** | | N/A |

## Expediting Clinical Appeals

If you feel that the standard appeal time frame of 30 days could seriously jeopardize the life or health of your patient, or their ability to regain maximum function, you may ask us to expedite a clinical appeal. HAP CareSource does not take any punitive action against providers for supporting their patient's expedited request.

Please note - expedited appeals for Michigan Medicaid members must be submitted within 10 calendar days of the adverse determination and require member written consent if submitted by anyone other than the member.

HAP CareSource will review appeals as expeditiously as the member's medical condition requires, and expedited appeals are resolved within 72 hours of receipt, unless the time frame is extended, or the appeal request does not meet expedited criteria. Please see "Denied Expedited Appeals" for more information about what happens if a request for expedited appeal review is denied, and "Extending an Appeal" for more information about extensions. HAP CareSource will make reasonable efforts to provide notice by phone of the appeal resolution to the member or representative in addition to written notification. Providers will also receive notification of the appeal decision.

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

## Denied Expedited Clinical Appeals

If HAP CareSource decides not to expedite the clinical appeal because the criteria for expedited review is not met, HAP CareSource will transfer the request to a standard appeal time frame beginning the day the expedited request was received. The member will be given prompt oral notice of the decision not to expedite. A letter will also be sent to the member or representative notifying of the reason for the decision not to expedite the appeal, notifying that the appeal is being transferred the standard appeal time frame.

## Extending an Appeal

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

## Time Frame Extension

Extending the appeal time frame for 14 calendar days is allowed when additional information is needed to support the member request and, in the member's, best interest.

## Appeal Level

HAP CareSource contracted and non-contracted providers have one appeal level.

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

- Submit a written request along with any supporting documentation.
- Mail request, documentation and Waiver of Liability (if applicable) to:

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

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

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

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

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

## Member Grievances Filed Directly with Provider

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

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

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

# Provider Appeal Process

| Appeal type | Process and Requirements |
|---|---|
| **Pre-Service**<br><br>A request to change the decision on any case or service that must be made in whole or in part in advance of the member obtaining medical care or services | • The provider is notified of their appeal rights and procedure.<br>• Pre-service appeals must be submitted in writing to the address, on the **HAP CareSource Provider Portal** or the fax number above.<br>• If initial denial is issued by a HAP CareSource Medical Director, a physician reviewer not involved in the initial denial reviews the case. The physician reviewer will be the same specialty as the requesting physician with similar credentials and licensure.<br>• Please note – for Medicaid members, HAP CareSource will resolve your clinical appeal within 30 calendar days or 10 calendar days for members enrolled in the CSHCS program date of receipt. |
| **Post-Service**<br><br>A request to change a decision on any review for care or services that have already been received | • The provider is notified of their appeal rights and procedure.<br>• The provider has up to 60 calendar days from the date of the initial denial letter to file an appeal.<br>• Post-service appeals must be submitted in writing to the address, on the **HAP CareSource Provider Portal** or the fax number above.<br>• If initial denial is issued by a HAP CareSource Medical Director, a physician reviewer not involved in the initial denial reviews the case.<br>• The appeal will be resolved within 30 calendar days of the request for appeal. |
| **Expedited (Pre-Service)**<br><br>A request to change an urgent care request where the decision could:<br>• Seriously jeopardize the life or health of the member<br>• Jeopardize the member's ability to regain maximum function<br>• Subject the member to severe pain, not managed without the requested care | • When the HAP CareSource Medical Director denies the request for urgent care, written confirmation of the decision is sent to members and providers within 72 hours of receipt of the request.<br>• The member, or their authorized representative, or their provider with member's written consent may file an expedited appeal for a denied urgent care request.<br>• The member must submit the appeal within 10 calendar days.<br>• With member consent within 10 calendar days.<br>• HAP CareSource will complete the entire expedited appeal process within 72 hours of receipt of the appeal request.<br>• Verbal and written notification is given within 72 hours of receipt of the appeal request |

# Section 12: Pharmacy

## Pharmacy Drug Plan Coverage

We manage prescription drug benefits. We use a pharmacy benefit manager (PBM) to process pharmacy claims.

**Helpful numbers and links for providers**

| For | Contact |
|---|---|
| **Pharmacy Care Management** | Phone: **1-833-230-2102**<br>Monday-Friday, 8 a.m. to 6 p.m. ET |
| **Completed prior authorization forms for HAP CareSource Pharmacy Department** | Fax: 866-930-0019<br>OR submit via CoverMyMeds or SureScripts Prior Authorization portals |
| **Completed prior authorization forms for HAP CareSource Physician Administered Drugs** | Fax: 888-399-0271<br>OR submit electronically through Evicore.com |
| **HAP CareSource Formulary** | https://client.formularynavigator.com/Search.aspx?siteCode=4727604885 |
| **Specialty and Mail Order (Home Delivery) Pharmacy (Pharmacy Advantage)**<br>**Note:** Use of Pharmacy Advantage is optional for members. | **1-800-456-2112**<br>Monday-Friday, 8 a.m. to 6 p.m. ET |

## Drug Formulary

The formulary is a list of covered drugs. Drugs on the formulary may have some restrictions, including:

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

## Formulary and Drug List Changes

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

## Prior Authorization Requirements Removed for Specific Drugs for HAP CareSource

Per State of Michigan Senate Bill No. 412, prior authorization requirements for your HAP CareSource patients have been removed for drugs in the following classes:

- Cancer
- Organ replacement therapy
- Epilepsy or seizure disorder
- Opioid withdrawal symptom management

This applies to drugs administered through the pharmacy benefit and for medical injectable drugs for your HAP CareSource patients.

Claims for drugs in these protected classes will be approved according to reasonable, appropriate payment parameters (i.e., age, diagnosis, amounts, etc.) that align with a drug's U.S. Food and Drug Administration's approved labeled indications to:

- Prevent fraud, waste, and abuse
- Be reasonable, appropriate, and within community standards of practice

For additional details, please see Senate Bill No. 412.

# HAP CareSource

### Formulary

- For Medicaid, Healthy Michigan Plan, MIChild and Children's Special Health Care Services, we administer the State of Michigan Common Formulary (including products on the Single Preferred Drug List [SPDL]). This list of covered drugs is common across all contracted Medicaid health plans and is aligned with Fee-for-Service (FFS) Medicaid. It's developed and maintained by a Pharmacy and Therapeutics Committee with the Michigan Department of Health and Human Services (MDHHS) and Medicaid Health Plans.
- The Common Formulary, required under Section 1806 of Public Act 84 of 2015, was created to streamline drug coverage policies for Medicaid and Healthy Michigan Plan members and providers.
- The Common Formulary includes covered prescription drugs and over-the-counter drugs. The list also contains drugs that are "carved out" and covered under Medicaid FFS, with a status that shows these medications are carved out. Pharmacies know the process for billing the Medicaid Health Plan or FFS Medicaid.
- For medications that fall into categories outside of the Single PDL and Common Formulary, HAP CareSource maintains pharmacy policies to offer guidance on determination of medical necessity coverage of pharmaceutical products.

### Medications Covered Under the Medical Benefit:

- The Common Formulary/SPDL includes drugs covered as a pharmacy benefit only.
- Medications administered under the medical benefit may be subject to a prior authorization before they are covered. Refer to the Procedure Code Lookup Tool for a complete list of medication services that require authorization.
- Medications used in a physician's office may be covered under the medical benefit. For example:
  - Intrauterine devices
  - Physician-administered injectable drugs
  - Some vaccines

### Brand Over Generic Drug List

The State's SPDL includes some drugs where the brand drug is preferred over the generic version of the drug. All Medicaid Health Plans must comply with the State's requirements for preferred drugs. If the pharmacy submits a claim for the generic drug, they receive a rejection and point-of-service message that reminds them to bill the brand drug. The MDHHS maintains the list of these drugs. You can find it online at mi.primetherapeutics.com/provider; select *Documents; Other Drug Information* and *Brand Preferred Over Generic Products List*.

### Federal Medicaid Drug Rebate Program (MDRP)

Medicaid Health Plans can only cover drugs made by manufacturers that participate in the federal Medicaid Drug Rebate Program (MDRP). This includes both prescription drugs and over-the-counter (OTC) drugs. Pharmacies will receive a rejection for claims submitted for a drug made by a manufacturer that does not participate in the federal MDRP. They will be instructed to bill a product from another manufacturer. This may happen with both prescription drug products or OTC products. The Medicaid Health Plan can override this rejection in certain circumstances with supporting documentation for medical necessity.

The HAP CareSource formulary and updates can be found at the website and contains a list of formulary drugs with the tier (including covered, preferred, or non-preferred status), formulary restrictions such as prior authorization criteria, step therapy criteria and other related formulary information.

- Information on the website also includes descriptions about:
  - how to use the formulary
  - formulary restrictions and preferences
  - explanations of limits
  - generic drugs, prior authorization and step therapy
  - how to submit an exception request for a drug that is not on the list

Go here for HAP CareSource Medicaid pharmacy information at the website:

Medicaid | Michigan – HAP CareSource | CareSource

Go here for the HAP CareSource Medicaid drug formulary search tool and related documents.

You can obtain a printed formulary by calling Provider Services at **1-833-230-2102**.

**340B Drug Billing Reminders**

Providers are responsible for accurate reporting of drugs purchased through the 340B program. When billing providers must indicate drugs purchased through the 340B program:

- For institutional and professional claims, use the MDHHS modifier U6
- For pharmacy claims, enter the value 20 in the Submission Clarification Code field

**Prior Authorization or Exception Requests**

Certain drugs on the Michigan Common Formulary, including some preferred SPDL drugs and all non-preferred SPDL drugs, may require prior authorization.

- To prescribe a drug that requires prior authorization, or to request an exception to the formulary for a drug that is not on the list, please complete a Request for Prior Authorization Form. We will accept any similar form.
- For the best patient experience, please review the drug formulary prior to writing a prescription for a new drug. Drugs are listed by category with a drug tier status which makes it easy to view the alternatives. If the drug has restrictions and/or an alternative is not appropriate, please complete a request for prior authorization (by fax or telephone) with supporting documentation.
- If the request is not approved in advance, there may be a delay for the member in obtaining their medication from the pharmacy.

### Contact information for HAP CareSource Pharmacy Prior Authorization

| For | Contact |
|---|---|
| **Prior Authorization/Formulary Exceptions Requests** | Electronic (pharmacy benefit): CoverMyMeds or SureScripts prior authorization portal<br>Fax: 866-930-0019 |
| **Prior Authorization Line** | Phone: 1-833-230-2102, Health Care Provider > Prior Authorization > Pharmacy |
| **Physician Administered Drugs Prior Authorization or Exceptions** | Provider Portal<br>Fax: 888-399-0271 |

### HAP CareSource Drug Utilization Review (DUR) Program

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

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

This program alerts prescribers to potentially life-saving risks as well as opportunities to:

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

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

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

### Prescription Drug Monitoring Program Requirement for Providers

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

As a best practice, Medicaid enrolled pharmacies are encouraged to check MAPS prior to dispensing a controlled substance.

These checks are in place for program integrity, quality and safety as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

### The SUPPORT Act - Medicaid opioid prescribing

DUR provisions for the state fee-for-service Medicaid and managed Medicaid health plans can be found in section 1004 of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act*. This act, also known as the SUPPORT Act, was effective October 1, 2019, and is designed to reduce opioid related fraud, misuse and abuse. The HAP CareSource program monitors claims data for potential fraud and abuse of controlled substances by members, providers and pharmacies.

**Specific claims processing edits for Medicaid pharmacy claims for opioids prospective safety edits.** These are alerts in the claims processing system when the pharmacy is processing the claim. Passive edits **pause** the claim at the pharmacy and send an alert message to the dispensing pharmacist. A soft block **stops** the claim. The dispensing pharmacist can override it after reading the alert. A hard edit requires a patient-level override from the health plan. Types of prospective safety edits include:

- A passive concurrent DUR rule that identifies beneficiaries with a prescription for a long-acting opioid or fentanyl product, but the beneficiary appears to be opioid naïve based on the absence of another opioid in their claims history.
- A passive concurrent DUR rule that identifies beneficiaries with a greater than seven-day supply of a short acting opioid for beneficiaries new to therapy.
- A soft block concurrent DUR rule that identifies beneficiaries using multiple long-acting opioids.
- Quantity limits on acetaminophen-containing combination products, including but not limited to opioids, to prevent unsafe doses of acetaminophen from the use of multiple products (in alignment with the Medicaid Common Formulary/SPDL).

**Prospective safety edits specifically to address Morphine Milligram Equivalents (MME) dose limitations. These edits include:**

- A passive concurrent DUR rule provides information to the dispensing pharmacist if a beneficiary is new to opioid therapy and the opioid prescription has a dosage between 50-90 MME.
- A passive concurrent DUR rule that identifies if a beneficiary is new to opioid therapy and the opioid prescription has a dosage greater than 90 MME.
- A cumulative edit for the previous 30 days of opioid use above 90 MME threshold. This is a hard reject and an override must be manually placed by the health plan, after a review of the beneficiary's claims history and medical conditions and a discussion with the prescriber if necessary.
- Quantity limits on certain opioid products.

We also perform retrospective review of claims data for various scenarios, both at the plan level and by the pharmacy benefit manager. This helps to identify patterns and trends for further review at the beneficiary, pharmacy and provider level.

**Questions or need help with opioid management?**

Visit the CDC website.

## Benefits Monitoring Program (BMP)

We administer a BMP as required by MDHHS to educate and prevent overuse, misuse, or abuse of Medicaid services (medical visits, ER, prescription drugs, etc.). Program enrollment criteria are based on identification of overutilization, misuse or abuse of physician, medical and pharmacy services (with some exclusions based on diagnosis or circumstances).

This is a collaborative program managed by the HAP CareSource Pharmacy and Case Management staff. The teams do a comprehensive review of medical and pharmacy history for beneficiaries who are identified by the State or by the Plan using established criteria. As it relates to pharmacy, criteria include multiple prescription fills for drugs/categories with abuse potential and use of multiple prescribers and pharmacies. A MAPS report that includes all controlled substances fills for a member may be reviewed, if appropriate, to identify/confirm controlled substances prescription activity.

When a member is enrolled in the BMP program, HAP CareSource sends an educational letter/form to notify the beneficiary. The beneficiary has 10 days to discuss the findings with HAP CareSource. If the beneficiary does not return the form, HAP CareSource sends a second notice to the beneficiary that advises that they are enrolled and documents the provider(s) to which they've been assigned as determined by the HAP CareSource Pharmacy and Case Management teams. Providers are also notified/educated about the enrollment.

**Potential Control Mechanisms**

- When a member in BMP is assigned to a pharmacy, they are locked into the use of a specific pharmacy for certain drugs (drugs with potential abuse). Drugs outside of the restricted drugs may be obtained at the same pharmacy or other pharmacies if the member chooses to do so.
- When a member in BMP is assigned to a prescriber (or multiple prescribers), only those specific drugs are restricted to those providers. The provider and other providers may prescribe other drug classes.

If we are reviewing a member for potential enrollment into the program, we may contact your office to request additional information. Thank you in advance for responding with additional information.

## HAP CareSource Transition of Care Policy - Prescriptions

The HAP CareSource transition of care program for prescription drugs ensures continued access to services during a transition from fee-for-service (FFS) Medicaid or from another Medicaid Health Plan (MHP) when a member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

**Prescriptions**

HAP CareSource provides a transition supply of medication without prior authorization if one of the following occur:

- The member is taking a drug that is not covered by HAP CareSource (not on the formulary drug list)
- Formulary rules/restrictions do not cover the amount ordered by the prescriber
- The drug requires prior authorization
- The drug is part of a step therapy restriction

**When does the transition fill apply?**

A transition (temporary) supply applies for maintenance drugs where the member is already on the drug and has received a 30-day supply of the drug in the previous 90 days. Consistent with Medicare, Medicaid Health Plans are required to allow up to a 30-day temporary supply during the member's 90-day transition period. New members are in a transition period for 90 days after enrollment.

**How is the transition policy communicated?**

Our Medicaid transition policy is a quality program and is communicated to members and providers in various ways:

- Member website
- Member Handbook
- Provider education/manual (posted on the website)
- Newsletter articles

In addition, when a transition fill is processed at the pharmacy, transition notices are sent to the member and the prescriber. The notices are sent to the member within three business days and to the provider within five business days. The notices include the following:

- An explanation that the drug is not on the list or requires prior authorization and that this is a temporary/transition fill
- Claim information (member, drug name)
- Instructions for the member/prescriber

**How does the transition process work?**

When a pharmacy processes a claim for a member who is in their 90-day transition period, most drugs will automatically pay in transition if the claim is for a drug or amount that:

- Is not covered
- Requires prior authorization
- Is part of a step therapy restriction

For safety and monitoring reasons, certain drug categories are transitioned through a request from the provider, member or the member's representative.

If you need to request a transition fill to allow continuity of care for one of these drug categories, or any other Medicaid covered drug, you, the member or the member's appointed representative can contact:

- The HAP CareSource Pharmacy team at **1-833-230-2102**. Then select Health Care Provider > Prior Authorization > Pharmacy.
- Customer Service
- The member's Care Manager

# Section 13: Quality Management

## Quality Management Program for HAP CareSource Including HAP CareSource Children's Special Health Care Services (CSHCS) and HAP CareSource Healthy Michigan Plan (HMP)

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

- Promote and improve the delivery of members medical and health care services consistent with our mission and goals.
- Objectively and systematically monitor and evaluate the appropriateness of clinical and nonclinical member care and services.

HAP CareSource pursues opportunities to improve care and services and resolve identified problems. HAP CareSource, PCPs and specialists have a role in monitoring, maintaining and improving the quality of care and services. We partner with network practitioners and providers who agree to cooperate with Quality Improvement activities to improve the quality of care, services and member experience, and allow us to use their performance data for quality improvement activities.

QAPI effectiveness is evaluated annually. You can find a copy of the QAPI program, including progress on our annual goals and the annual evaluation by visiting: https://caresource.com/mi/providers/education/quality-improvement/medicaid.

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

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

## Preventive and Clinical Care Guidelines for HAP CareSource

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

Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management tools. Guidelines are reviewed at least every two years or more often as appropriate and updated as necessary. They may be found at **HAPCareSource.com** > Providers > Education > Patient Care > Health Care Links.

Guidelines are promoted to providers through one or more of the following: newsletters, our website, direct mailings, provider manual and through focused meetings with Provider Engagement Specialists. Information regarding clinical practice guidelines and other health information are made available to members via member newsletters, the member website or upon request.

# Health and Wellness Programs

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

| Program | Description |
|---|---|
| **24-Hour Nurse Advice Line** | HAP CareSource members have access to a 24 hours a day, seven days a week Nurse Advice Line for health information to help with questions about medical care. Nurses are ready to answer questions any time, day or night. The Nurse Advice Line provides trusted, physician-approved information to help guide members' health care decisions. A registered nurse helps with:<br>• Choosing appropriate location for medical care<br>• Finding a doctor or hospital<br>• Understanding treatment options<br>• Achieving a healthy lifestyle<br>• Learning how take medication safely<br>To use the 24-Hour Nurse Advice Line, members can call 1-833-687-7370 **(1-833-NURSE-70)**. |
| **Preventive Health Reminders** | HAP CareSource contacts members who may be due for preventive health services including:<br>• Annual well visits<br>• Blood lead testing<br>• Cervical cancer screening<br>• Child and adolescent vaccines<br>• Colorectal cancer screening<br>• Comprehensive diabetes care<br>• Lead testing<br>• Mammogram screening<br>• Well-child and adolescent visits |
| **Smoking Cessation Program** | The Michigan Tobacco Quitline is a free, phone-based program to help members quit using tobacco. Members will work one-on-one with a health coach to develop a quit plan. Members can enroll in the program by self-referral, PCP referral or health plan referral. To refer a member to the program, call **1-800 QUIT NOW (784-8669)**. For more information, call **1-888-654-2200**. |

| Program | Description |
|---|---|
| **Maternity Program Powered by HAP CareSource Mom & Baby Beginnings** | HAP CareSource 's Maternity Management program, Mom & Baby Beginnings, supports Medicaid-eligible pregnant women to help members have a healthy pregnancy by:<br>• Connecting members with an OB provider<br>• Providing reminders for prenatal and postpartum visits and assisting with scheduling and transportation, if needed<br>• Conducting maternity-specific assessments in order to ensure members are receiving the care that they need<br>• Developing member-centric individualized Care Treatment Plans<br>• Educating on benefits and rewards available while pregnant, including dental services<br>• Connecting members to nurses, doulas, social work, mental health services and lactation support<br>• Referring members to a Maternal Infant Health Program (MIHP). MIHPs offer in home visits to provide education about pregnancy and newborn care.<br>• Checking in after delivery to make sure everyone is doing well<br>For more information or to enroll, members can call **Mom & Baby Beginnings at 1-833-230-2034**. |
| **Maternal Infant Health Program, (MIHP)** | MIHP supports healthy pregnancies and healthy infants. It is open to all Medicaid-eligible pregnant women. It also serves infants with Medicaid. MIHP will:<br>• Visit members during and after their pregnancy to help them take care of themselves and their baby<br>• Nurses who visit will teach about pregnancy, labor and delivery. They also teach members how to care for their baby<br>• Social workers will help with housing, baby supplies and other support<br>• Dietitians will teach about eating healthy during pregnancy. They also teach members how to feed their baby<br>• Connect members to parenting classes<br>• Refer members to local community services, if needed<br>• Refer members to childbirth classes close by<br>• Help members with transportation to services, if needed |

If Medicaid members have questions about MIHP, they should contact HAP CareSource at **1-833-230-2023**.

# Blood Lead Testing Reminder

No safe blood lead level in children exists. Even low levels cause harm. Michigan Medicaid policy requires all Medicaid-enrolled children to be tested for blood lead:

- At 12 and 24 months of age
- Between 24 and 72 months of age if not previously tested

Recently, The Centers for Disease Control and Prevention updated the blood lead reference value (BLRV) from 5 µg/dL to 3.5 µg/dL. The BLRV should be used as a guide to determine follow-up actions.

**Resources**

For more information and resources about blood lead screening and recommendations, visit For Healthcare Providers (michigan.gov).

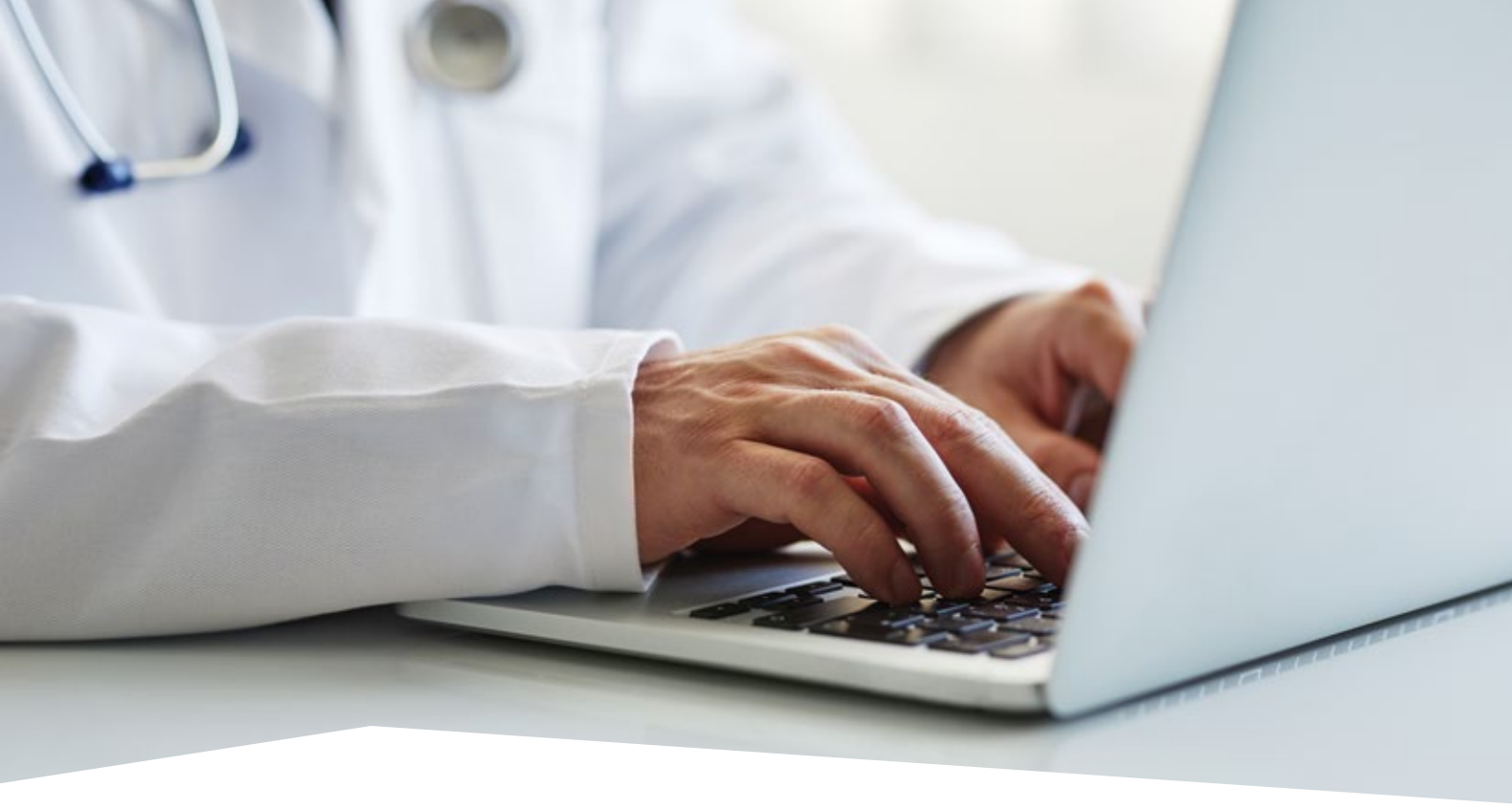
**HAP CareSource PrEP Resources**

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

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

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

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



# Section 14: Member Medical Records

## Requirements

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

For more information regarding medical record requirements, please see Appendix A for provider contract language.

**General**

1. Medical records must be maintained in a manner that is current, detailed and organized to facilitate communication and coordination of care.
2. Medical records must be complete, documented accurately, updated in a timely manner, readily accessible, and permit prompt and systematic retrieval of information.
3. Medical records must be maintained in English, legible and fully disclose and document the extent of services provided to members.
4. Medical records should be in a detailed, comprehensive manner that conforms to good professional medical practice, allows effective professional medical review and medical audit processes, and facilitates a system for follow-up treatment.
5. Practitioners and providers must abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. These laws require providers to fully disclose the extent of the services, care and supplies furnished to our members, as well as support claims billed.

### Content and Organization

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

9. Advanced directives (required for hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, hospices) – whether or not an advance directive has been executed.

**Retention, Confidentiality and Accessibility**

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

**Sharing Medical Record Information**

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

**Mental Health Records**

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

1. Each patient must have an individual treatment plan, completed by the second visit and include:
    a. Strengths and weaknesses
    b. Patient input
    c. Diagnosis
    d. Short and long-term goals
    e. Treatment time frames and reassessment dates
    f. Risk behaviors
    g. Specific treatment modalities
    h. Treatment referrals
    i. A written consent for treatment must be signed by the patient or legally responsible individual

    Note: Records must be revised as clinically appropriate and be individualized to the patient.
2. Progress notes must contain the following:
    a. Entries by mental health professional responsible for care
    b. Entries by Allied Health professionals participating in the patient's treatment

c. Entries documenting each patient encounter

d. Session type identified for each patient encounter

e. Documentation for “no show” appointments

f. Evidence of communication with the PCP as well as a signed Release of Information or refusal

**Provider Office Education and Training**

Here is how we educate provider offices on our medical record requirements.

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

Contact your Provider Engagement Specialist to schedule training or a site visit.

## Medical Records Retrieval Policy

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

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

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

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

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

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

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

Non-compliance with providing medical records to HAP CareSource may result in corrective action including termination from the plan.

## CMS Risk Adjustment Validation Audits

Provider shall include supporting documentation in a Medicare Member's medical record for all diagnosis codes submitted to HAP CareSource for payment. Provider shall complete such documentation in accordance with CMS's coding guidance in effect at the time of completion. Provider shall timely supply HAP CareSource with medical records so that (1) HAP CareSource can comply with a CMS Risk Adjustment Data Validation Audit (RADV) and (2) HAP CareSource can conduct appropriate oversight and risk mitigation as it relates to HAP CareSource risk adjustment processes. Provider shall submit complete and accurate risk adjustment data as requirement by CMS. Provider acknowledges Its obligation to cooperate with HAP CareSource and/or CMS during RADV audits and to timely produce (a) requested medical records in accordance with 42 CFR 422.310(e) and/or (B) any required attestations to correct signature deficiencies in the medical records. [42 CFR 422.310].

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

B. Records must be provided in a format required by law. Medical Records must include:
   - Patient's condition or diagnosis legibly documented
   - Name of patient on each page
   - Date of service the visit took place (include both admit and discharge date for inpatient records
   - Physician legible signature and date
   - Physician credentials

C. Provider will maintain medical records related to covered services rendered by provider for 10 years.
   - Inability to produce a medical record for a covered service will result in the following:
     - **First occurrence:** Written warning and retrieval of paid amount made to the provider
     - **Second occurrence:** Written warning and retrieval of paid amount made to the provider. Incident will be reviewed at Provider Peer Review Committee meeting.
     - **Third occurrence:** Termination of participation with HAP and retrieval of paid amount made to the provider.

# Section 15: Hepatitis C Virus – Frequently Asked Questions for Providers

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

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

## Hepatitis C Facts

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

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

Below are some frequently asked questions about HCV.

## Member Outreach

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

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

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

   Members can call our Member Service team to schedule a ride. They can be reached at 1-833-230-2053 (TTY 711). Information about the transportation benefit can be found:

   - On the HAP CareSource website
   - In the member handbook

## Testing

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

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

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

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

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

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

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

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

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

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

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

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

   Yes. We have the following initiatives:

   - Our Care Management team has developed an outreach plan for:
     - Members needing HCV screening
     - Members diagnosed with HCV
   - We ensure the member is connected with their PCP. We continue to provide ongoing support and follow up.
   - Part of our maternity care program ensures the member gets all recommended screenings. HCV screening is included.
   - Part of the health screening of new members includes HCV screening questions. Our Care Management team will follow up with members who have not completed screening.
   - We added information on hepatitis C screening and treatment to:
     - The welcome packet for new members
     - The member handbook
     - The member newsletter
     - Our website
   - Our Care Management team partners with the following groups to reach out to members:
     - Community-based organizations
     - Homeless shelters
     - Local health departments
     - Federally Qualified Health Centers

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

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

## Treatment

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

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

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

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

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

2. **What are authorization requirements for MAVYRET and other DAAs?**

   For all Michigan Medicaid plans, the preferred drug is MAVYRET and it is available without a prior authorization or quantity limit.

| Preferred DAA | MAVYRET (glecaprevir and pibrentasvir) |
|---|---|
| **Non-Preferred DAAs (prior authorization required)** | • Epclusa<br>• Harvoni<br>• ledipasvir/sofosbuvir (generic for Harvoni)<br>• sofosbuvir/velpatasvir (generic for Epclusa)<br>• Sovaldi<br>• Vosevi<br>• Zepatier |

*These antiviral medications are carved out and billed through the State's PBM for all Michigan Medicaid members.

3. **How does HAP CareSource ensure members with an HCV diagnosis are linked to a provider familiar with HCV treatment?**

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

   If members need transportation for testing or treatment, they can call our Member Services team to schedule a ride. They can be reached at 1-833-230-2053 (TTY 711). Information about the transportation benefit can be found on the HAP CareSource website or in the member handbook.

4. **How does HAP CareSource follow up with members receiving treatment to offer support on medication adherence?**

   Our Pharmacy team reviews pharmacy claims for hepatitis C antivirals and reaches out to the prescriber or pharmacy when appropriate.

| If the MAVYRET Prescription is Filled for | Then |
|---|---|
| **A 28-day supply** | The Pharmacy team contacts the pharmacy to ensure there is a refill allowed on the prescription. Then they contact the member to encourage them to get the refill in a timely manner. |
| **A 56 or 84-day supply** | The member has the full course of therapy. Members being followed by our Care Management team will receive a medication reminder. The Pharmacy team will contact the member as needed. |

Similar activities and outreach occur if a DAA other than MAVYRET is prescribed.

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

- Electronic bulletins to the pharmacy network
- Outreach to individual pharmacies when needed to facilitate medication adherence

5. **Does HAP CareSource track members with an HCV diagnosis and no record of treatment?**

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

# Resources

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

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

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

# Section 16: Vaccines, MCIR & Reporting Communicable Diseases

## Vaccines

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

Being a VFC provider is a sound investment in your practice and your patients. It reduces up-front costs by providing vaccine for your VFC-eligible children. Your patients benefit by not having to go elsewhere for vaccines, and there is no charge to you, the provider.

**Why join VFC?**

- Reduce costs: You won't have to purchase vaccine for eligible patients with your own money.
- Provide all ACIP-recommended vaccines!
- An administration fee may be charged to offset costs of doing business.
- Eligible patients receive vaccine at no cost to them.

**Eligible patients are less than 19 years old and meet one of the following criteria:**

- Medicaid-eligible
- Uninsured
- American Indian or Alaska Native
- Underinsured (i.e., has insurance, but it does not cover all ACIP-recommended vaccines)

**How do I become a VCF provider?**

1. Review Michigan VFC details: www.michigan.gov/vfc
2. Contact your Local Health Department (http://www.michigan.gov/lhdmap) and/or fill out an enrollment request via Michigan Care Improvement Registry (MCIR).
3. Receive a site visit and training from your Local Health Department to review requirements and ensure proper storage and handling of vaccines.
4. Inform your patients that you are now a VFC Provider

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

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

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

## Requirements for Reporting to the Local Health Department

The state and HAP CareSource provider contract require providers to report communicable diseases to the local health department.

## The Immunization Alliance of Michigan (IAM)

IAM was formed in 1994 to focus on a broad spectrum of immunization issues in Michigan. IAM's mission is to promote immunizations across the lifespan through a coalition of health care professionals and agencies.

For vaccine information and resources, visit www.immunizationalliancemi.org/.

# Section 17: Continuity of Care

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

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

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

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

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

- Identify the patient on the list and document the reason for continuing their care.
- Fax the list back to HAP CareSource at **1-248-663-3780**.
- HAP CareSource will send a confirmation letter to the provider that outlines the continued treatment conditions for each member that the provider agrees to continue treating.
- The provider will be allowed to continue treatment as a non-participating provider with appropriate prior authorization for up to 90 calendar days for:
  - Members in active treatment for an acute or chronic medical condition
  - Members through the acute phase of the condition being treated
  - Members through the postpartum period of six weeks postdelivery for women in the second and third trimester of pregnancy
  - A terminally ill member for the remainder of their life
- You must share information regarding the treatment plan with HAP CareSource.
- You must follow the HAP CareSource health utilization management policies and procedures.
- You can’t charge or balance bill the member for services.
- You will be reimbursed at current Medicaid fee-for-service rates.

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

# Section 18: Ensuring Culturally Appropriate Care

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

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

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

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

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

**Cultural Competency Training Resources**

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

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

# Section 19: Philosophy of Care

HAP CareSource providers will deliver services consistent with these philosophies:

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

HAP CareSource providers are accountable for:

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

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

## Confidentiality Policy

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

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

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

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

Health plan associates sign a confidentiality statement upon employment.

## Reporting Fraud, Waste and Abuse

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

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

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

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

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

**Examples:**

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

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

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

**Examples:**

A. A provider ordering excessive diagnostic tests.

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

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

**Examples:**

A. Using the Emergency Room for non-emergency health care.

B. A provider unknowingly misusing codes on a claim.

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

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

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

You may also report your concern to Medicaid, Michigan Department of Health and Human Services, Office of Inspector General by:

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

## Whistleblower Protection

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

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

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

# Appendix A: Other Responsibilities for Providers

The verbiage below is a summary of verbiage from the provider contract. It's general responsibilities for all HAP CareSource providers.

## General Provider Responsibilities

- Provider agrees to provide Medicaid services that are subject to the terms of the provider's agreement, all rules, regulations, policies and procedures of the Medicaid program, HAP CareSource authorization and referral requirements to members enrolled in the HAP CareSource health plan.
- Provider and each individual providing services on its behalf, agree to:
  - Provide covered services
  - Accept eligible members as patients
  - Render care to eligible members consistent with professional medical standards
- Provider and each individual providing services on its behalf, agree to comply with all applicable requirements set forth in the HAP CareSource and HAP CareSource Provider Manuals and the additional requirements for participation in the HAP CareSource provider contract.
- Covered services will be subject to any restrictions or limitations set forth in the HAP CareSource Provider Manual, bulletins, directives and other written information received by HAP CareSource from MDHHS or CMS.
- HAP CareSource will give provider notice of any changes to such restrictions or limitations, as well as of any changes in:
  - Covered services
  - Operational policies and procedures
  - Appeal procedures with respect to the policies
  - Administrative decisions that the provider is required to follow
- Provider and each individual providing services on its behalf, will cooperate with and participate in all aspects of HAP CareSource:
  - Quality assurance
  - Quality improvement
  - Utilization review programs
  - Grievance system
- Provider and each individual providing services on its behalf will participate in and cooperate with the decisions, rules and regulations established by the HAP CareSource utilization review program, including but not limited to:
  - Precertification of elective admissions and procedures
  - Referral processes
  - Reporting of clinical encounter data
  - Other HAP CareSource policies and procedures.

- Provider agrees that HAP CareSource may amend such program, policies and procedures from time to time with fifteen (15) days prior written notice.
- Provider and all individuals providing services hereunder on its behalf agree to allow HAP CareSource to use their performance data.
- Provider and each individual providing services on its behalf shall not discriminate against providing health care services to eligible members on any grounds prohibited by law, including without limitation, on the basis of:
  - Age
  - Ancestry
  - Color
  - Creed
  - Disability
  - Health status
  - Marital status
  - Membership in HAP CareSource
  - National origin
  - Physical or mental handicap
  - Race
  - Religion
  - Gender
  - Sexual orientation
  - Source of payment
- Provider and each individual providing services on its behalf shall accept all eligible members, provide physical access, reasonable accommodations and accessible equipment for eligible members with physical or mental disabilities, and not segregate eligible members in any way or treat them in a location or manner different from other persons receiving health care services.
- Provider and each individual providing services on its behalf shall promote the delivery of services in a culturally responsive manner to all eligible enrollees including those with limited proficiency in English, deaf and hard of hearing, and diverse cultural and ethnic backgrounds.
- Provider and each individual providing services on its behalf shall ensure that eligible members are not denied a covered service or availability of a particular facility or provider.
- Provider and each individual providing services hereunder on its behalf agree that they are prohibited from denying covered services to any eligible member due to his or her inability to pay any applicable co-payment.
- Provider and each individual providing services on its behalf also agree to comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq. and 47 USC 225) and not discriminate against any employee or applicant for privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap or disability.

- Until the expiration of 10 years (or longer to the extent required by applicable law) provider will maintain medical records, required data, reports of services, reports on complaints, grievances, quality or utilization issues and any books, documents and records, electronic or paper, for the purpose of assessing quality of care, conducting medical care evaluations and audits, and determining on a concurrent basis, the medical necessity, appropriateness, nature and extent of care provided to eligible members.
- Providers will allow the representatives below to inspect the provider's premises and equipment and to review and copy records pertaining to the provision of covered services eligible members.
  - HAP CareSource
  - The Michigan Medicaid Program
  - Fraud Control Unit
  - The Secretary of DHHS
  - MDHHS
  - DIFS
  - CMS
  - United States Office of Inspector General
  - Department of Justice
  - MDHHS-OIG
  - Michigan Department of Attorney General
  - Any Regulatory Agency
- Such records will be maintained in:
  - Compliance with applicable state laws and administrative rules and federal laws and regulations related to privacy and confidentiality of medical records.
  - A detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment, and shall be signed and dated.
- Pursuant to MCL § 500.3547, provider agrees that MDHHS and DIFS may require production of any books, papers, computer databases or documents considered to be relevant to the evaluation or inspection of HAP CareSource affairs.

# Appendix B: Appeals and Grievance Information for Members

## HAP CareSource Members

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

## 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 **1-833-230-2053 (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 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 HAP CareSource staff member was rude to you.
- Your provider or a 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 **1-833-230-2053 (TTY: 711**). You can also file your grievance in writing via mail or online at:

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

Online: CareSource.MyLife.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 Member Services at **1-833-230-2053 (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 90 calendar days of submission. We will send you a letter of our decision.

**Appeal Process**

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

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

You may appeal within 60 calendar days 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 Member Services at **1-833-230-2053 (TTY: 711**). You can also file your appeal in writing via mail or online at:

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

Online: CareSource.MyLife.com

**You have several options for assistance. You may:**

- Call Member Services at **1-833-230-2053 (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 Authorized Representation Designation form.

You may call and request the form or find this form on our website at CareSource.com/mi/members/tools-resources/grievance-appeal/medicaid/.

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

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

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

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

### How Can You Withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same available methods as you have for filing the appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. HAP CareSource 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 Member Services at **1-833-230-2053 (TTY: 711**).

### What Happens Next?

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

### State Fair Hearing Process

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

Call HAP CareSource Member Services at **1-833-230-2053 (TTY: 711**) if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

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

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

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

Fax: 1-517-763-0146

### External Review of Appeals

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

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

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

Or call: 1-877-999-6442

Fax: 1-517-284-8838

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

### Dental Grievance and Appeals

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

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

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

Fax: (517) 381-5527

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

# Appendix C

## Credentialing Policy and Process

HAP CareSource ensures that all practitioners applying for affiliation meet rigorous credentialing standards prior to approval for participation. All credentialing and recredentialing decisions are non-discriminatory and not based upon an applicant's race, ethnic/national identity, gender, age or sexual orientation. To view our full credentialing policy, visit hap.org/providers/become-a-provider.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