Provider Manual

The material in this manual applies to HAP Empowered Medicaid and HAP Empowered MI Health link unless otherwise noted.

April 2023

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Section 1: Overview

General overview

HAP Empowered Health Plan, Inc., a Michigan Medicaid Health Plan, is a wholly owned subsidiary of Health Alliance Plan of Michigan (HAP). It's a Michigan nonprofit, taxable corporation and accredited by the National Committee on Quality Assurance. 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 Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola and Wayne counties.

We're contracted with the federal government to administer Medicare benefits to anyone who has both medical assistance from the State, Medicare (Parts A and B) and lives in Wayne or Macomb County.

HAP Empowered follows guidelines from the Michigan Department of Health and Human Services 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 healthcare 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/medicaidproviders**. Select *Policy, Letters & Forms*. You'll find *The Medicaid Provider Manual* and *Michigan Medicaid Approved Policy Bulletins.*

HAP Empowered MI Health Link

HAP Empowered MI Health Link provides high quality, seamless and cost-effective care through coordinated, person-centered services meeting the unique needs of all members who are dual eligible for both Medicare and Medicaid. We work collaboratively with Pre-Paid Inpatient Health Plans, long term support services and primary care physicians and specialists to improve the quality of care while limiting duplication of services and ensuring cost effective plans of care. All services provided are consistent with the Medicare and Medicaid manuals, guidance, memoranda and other related documents.

We contract with primary care and specialty physicians who are licensed in Michigan as either a medical doctor or a doctor of osteopathic medicine. All HAP Empowered physicians must meet credentialing standards and uphold the managed care philosophy of the plan.

Mission statement

HAP Empowered Health Plan 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 two Empowered plans:

- **Medicaid** in Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola and Wayne counties
- **MI Health Link** (Medicaid and Medicare combined) in Macomb and Wayne counties

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

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

Program	Description	Eligibility criteria
Children's Special Health Care Services* Persons with Special Health Care Needs (aged out of CSHCS; still have the needs of CSHCS, over the age of 21)	A health care program for children and some adults with special health care needs	• Qualifying medical condition • Age: – Children must be under the age of 21 – Persons 21 and older with cystic fibrosis, sickle cell, or certain hereditary blood coagulations disorders commonly known as hemophilia may also qualify • Citizenship: – A US citizen. – A documented non-citizen who has been admitted for permanent residence – A non-citizen legally admitted migrant farm worker (i.e., seasonal agricultural worker) • Must be a Michigan resident
Dual eligible	Secondary coverage for cost sharing portion of the fee-for-service Medicare primary coverage	• Persons with both Medicare and full Medicaid eligibility • Have full Medicaid coverage in addition to another Medicare plan
Healthy Michigan Plan*	A health insurance program for Michigan residents at a low cost so that more people can have health care coverage	• Age 19 - 64 years • Have income at or below 133% of the federal poverty level • Does not qualify for or not enrolled in Medicare • Does not qualify for or not enrolled in other Medicaid programs • Not pregnant at the time of application • Michigan residents
Medicaid	Comprehensive health care coverage provided by the state for people of all ages with low income	Determined by the state. Criteria include: • Age • Income • Financial resources • Other information
MIChild	A health insurance program for the uninsured for children of Michigan's working families	• Must be a US citizen (some legal immigrants qualify) • Must live in Michigan • Must be under age 19 • Family must meet income requirements • Children must not have other insurance coverage
MI Health Link	Complete health care coverage for people in specific Michigan counties who are age 21 and over and currently enrolled in both Medicare and Medicaid	• Age 21 and older • Enrolled in both Medicare and Medicaid • Not enrolled in hospice • Live in Macomb or Wayne counties

*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 creating 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 (Medicaid) and HAP Empowered ID cards.

What's Covered

The HMP covers all benefits listed in Section 5 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 Empowered: • Routine exams and cleanings every six months • Four bitewing X-rays every year • Full-mouth X-rays once every five years • One filling per tooth every two years • Emergency exams, no more than twice a month The following procedures require prior authorization: • Gum disease-related cleanings • Root canals • Tooth extractions (removal) • Tooth repair if attached to a bridge or partial If members have questions, they can call Delta Dental at **(866) 696-7441 (TTY: 711)**. If members need a ride to the dentist office, they can call Customer Service at **(888) 654-2200 (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 Empowered covers many preventive services. The HMP covers additional preventive care. These services are recommended by organizations like the United States Preventive Services Task Force.

MI Health Account

Member copays and contributions are managed by MI Health Account, which is a special health care account for all HMP members. The MI Health Account helps the member keep track of their costs and payments. Members receive a MI Health Account Statement that will show:

- The services the member received
- The amount HAP Empowered paid
- The amount the member owes

Healthy Michigan Plan Copays

For covered services, members will pay copay amounts over time through the MI Health Account. For example, if members had $12 in copays for services on the statement, they will pay $4/month for copays. Average co-pay amount is re-calculated every three months to reflect member's current utilization of healthcare services.

The amounts might be as high as shown below. There are ways members can reduce what they owe. Also, some services have no copays.

Healthy Michigan Plan Copays	Copay* Income less than or equal to 100% FPL**	Copay* Income more than 100% FPL**
Physician Office Visits (including freestanding Urgent Care Centers)	$2	$4
Pharmacy	$1 preferred $3 non-preferred	$4 preferred $8 non-preferred
Dental Visits	$3	$4
Vision Visits	$2	$2
Hearing Visits	$3 per aid	$3 per aid
Podiatry Visits (foot doctor)	$2	$4
Chiropractic Visits	$1	$3
Outpatient Hospital Clinic Visits	$2	$4
Emergency Room Visits for Non-Emergencies (no copay for emergency services)	$3	$8
Inpatient Hospital Visits (does not apply to emergency admissions)	$50	$100

* Copay amounts subject to change ** Federal poverty level

These people do **not** pay copayments:

- Beneficiaries under age 21
- People who live in nursing facilities
- People getting hospice care
- Native American Indians and Alaskan Natives consistent with federal regulations at 42 CFR 447.56(a)(1)(x)
- Beneficiaries dually eligible for HMP and Children's Special Health Care Services

There are no copays for:

- Emergency services
- Family planning products or services
- Pregnancy-related products or services for pregnant women
- Services related to preventive care
- Services related to chronic conditions, such as heart disease and diabetes
- Services received at a Federally Qualified Health Center, Rural Health Clinic or Tribal Health Center
- Mental health specialty services and support provided or paid through the Prepaid Inpatient Health Plan or Community Mental Health Services Program
- Mental health services provided through state psychiatric hospitals, the state Developmental Disabilities Center and the Center for Forensic Psychiatry
- Services related to program-specific chronic conditions. A list of these conditions is online at **michigan.gov/healthymiplan**.

Beneficiaries have the opportunity for **contribution reductions** if they complete an annual HMP Health Risk Assessment and agree to maintain healthy behaviors. For more information, see the section with *Healthy Michigan Plan Health Risk Assessment Instructions for Providers* in this manual. Beneficiaries may not be denied care or services based on inability to pay a copayment.

Children's Special Health Care Services Program (CSHCS)

Children with a serious chronic medical condition could be eligible for CSHCS—a State of Michigan program that serves children (and some adults) at no cost. CSHCS works with many agencies to provide resources and services.

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 **(800) 359-3722** available Monday through Friday from 8 a.m. to 5 p.m.
- 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
- Child care
- Early On program
- WIC program

Section 2: Network Development and Contracting Process

Joining HAP Empowered

To join HAP Empowered, email **providernetwork@hap.org.** We'll send the appropriate documents to complete and return. The credentialing department processes completed forms.

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
- Changes to patient accepting status
- Provider type or specialty changes or additions
- Transferring networks

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

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

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

Changes in provider network

HAP Empowered 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 Empowered

HAP Empowered 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 Empowered 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 Empowered monitors its provider network 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 each PCP

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 MI Health Link and Medicaid networks.

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 Empowered does not pay financial incentives to practitioners or providers to withhold any health care or health care related services. HAP Empowered 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 Empowered does not reward practitioners, providers, or other individuals for issuing denials of coverage. HAP Empowered makes decisions on evidence-based criteria and benefits coverage.

Our Pledge

HAP 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 does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. HAP decisions are not based on incentives. HAP does not offer financial incentives to encourage inappropriate underutilization of covered services.

To assist in the continual improvement of health care delivery, practitioners and physicians may obtain clinical criteria or discuss utilization management decisions. (Note: certain clinical criteria or guidelines may be applicable only to governmental programs or only to commercial plans). Criteria used in decision-making may include InterQual, HAP criteria, the HAP Benefit Administration Manual, eviCore healthcare criteria, pharmaceutical clinical criteria, national guidelines, landmark trials, peer-reviewed journal publications, Medicare national and local coverage guidelines, Medicare COMPENDIA such as DrugDex and American Hospital Formulary Service, medical resources such as UpToDate® and, at times, guidelines from other local/national health plans.

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 as outlined in the table below. Please have the member's name and HAP ID number available to assist in accessing the case. HAP physician reviewers are board certified and have current Michigan licenses to practice without restriction.

For	Contact Information
• Outpatient Medical Services (Referral Management Team) – Urgent/emergent requests (determination made within 72 hours - applying the standard timeframe 14 (Medicare)/15 days (Commercial) could seriously jeopardize the life or health of the member or the member's ability to regain maximum function)	**(313) 664-8950** or **(800) 926-3436, option 1**
Provider Appeals	**(313) 664-8950** or **(800) 926-3436, option 2**
• Urgent/emergent requests • Decisions within 24 hours • Inpatient Care Management • Admissions and Transfers • Inpatient Rehab • Skilled Nursing	**(313) 664-8833** or **(800) 288-5959**
Pharmacy	**(313) 664-8940 or (888) 383-2535**
Coordinated Behavioral Health Management	**(800) 444-5755** or visit **hap.org**
eviCore healthcare: cardiology and musculoskeletal programs	**(888) 564-5487** or visit **eviCore.com**
eviCore healthcare: Sleep studies program	Phone: **(855) 736-6284** or Fax: **(888) 693-3210**

Note: You can also obtain a copy of criteria when you log in at **hap.org** and refer to the *Benefit Administration Manual* or the *Procedure Reference Lists*.

Utilization Management Hours of Operation

For utilization management inquiries, please refer to the table below.

For	HAP Department	Contact Information
• Admissions • Inpatient review • Rehab • Skilled nursing facility • Transfers	Admissions Team	**(313) 664-8833 option 3** Monday through Friday 8 a.m. to 5 p.m. On-call nurse available for emergent situations (level of care transfers) during non-business hours
• Outpatient authorizations and elective admissions • Select DME • Speech Therapy • Genetic Testing • Botox for migraines/Headaches • Xiaflex	Referral Management Team	**(313) 664-8950 Option 1** Monday through Friday 8 a.m. to 5 p.m.
• Referral Management • Provider Appeals • Skilled Nursing Facility • Elective Admissions • HAP Empowered inquiries	Intake Call Center	**(313) 664-8950** or **(800) 926-3436 option 2** Monday through Friday 8:00 a.m. to 4:30 p.m.
Pharmacy services	Pharmacy	**(313) 664-8940** Monday through Friday 8:00 a.m. to 4:30 p.m.
Behavioral health services Admissions Concurrent reviews Prior authorization for behavioral health specialty services (review Procedure Reference List to see if authorization required)	Coordinated Behavioral Health Management	 HAP contracted providers can log into the HAP provider portal 24 hours, 7 days per week to enter in a request Non-contracted providers can contact **(800) 444-5755** 24 hours, 7 days per week to request an admission **(800) 444-5755** Monday through Friday 8 a.m. to 5 p.m. Log in at **hap.org**; select *Authorizations*

Section 3: Credentialing

HAP and HAP Empowered ensure 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.

Primary Care Physicians
A PCP is an MD or DO listed as a general practice, family medicine, pediatrician, or internal medicine practitioner. OB-Gyn practitioners and other specialists may be designated as a PCP if they agree to provide care for all medical conditions. PCPs must provide or arrange for coverage of services 24 hours per day, 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
- Certified registered nurse anesthetists
- Chiropractors
- Dentists (only oral and maxillofacial surgeons providing care under medical benefits)
- Fully-licensed psychologists (PhD or PsyD)
- Licensed professional counselors
- Master level psychologists
- Master level social workers
- Nurse practitioners
- Optometrists
- Osteopaths
- Podiatrists
- Physician assistants
- Psychiatric clinical nurse specialists

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

Verification
All potential candidates must complete a Council for Affordable Quality HealthCare application. HAP verifies:

- Board certification
- DEA or CDS certificates
- Education and training
- Hospital affiliations
- Licensure
- Malpractice history
- Work history
- Sanction information

Provider Disclosure of Ownership and Control Interest Statement Form Collection Process

Per regulations 42 CFR 455 Subpart B and 42 CRF §1002.3, 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 Contracting team and Credentialing team 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

Below is our credentialing policy.

Status **Active** PolicyStat ID **10721413**

Origination	04/1995
Last Approved	05/2022
Effective	05/2022
Last Revised	05/2022
Next Review	05/2023

Owner	Janet Krajnovic
Area	Provider Network Management
Applicability	Health Alliance Plan
Document Types	Policy

Credentialing Policy

Department:	Provider Network Management				**Department Head:**			**Richard Trembowicz: Vice-President** Network Management			
Approval Date:	April 2022				**Next Review Date (MM/YYYY):** (12 months from approval date)			April 2023			
Compliance/Executive Approval:											
Name:								**Date (MM/DD/YYYY):**			
APPLIES TO:	X	**COMMERCIAL:**	X	**MMP:**	X	**MEDICARE ADVANTAGE:**	X	**MEDICAID:**	X	**OTHER:**	

HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Empowered.) ensure 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. This policy is put into place that HAP will comply with regulatory and accreditation standards in the development and management of Credentialing with the following regulatory provisions

HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Empowered, Inc.) have a well-defined Credentialing and recredentialing process for evaluating and selecting licensed Independent practitioners to provide care to its members.

Policy:

This policy is put into place that HAP will comply with regulatory and accreditation standards in the

development and management of Credentialing with the following regulatory provisions

- National Committee for Quality Assurance (NCQA) standards - CR 1
- Centers for Medicare & Medicaid Services (CMS) guidelines
- Michigan Department of Community Health (MDHHS) guidelines
- Michigan Department of Insurance and Financial Services (DIFS)

Definition:

- CAQH: The Council for Affordable Quality Healthcare
- CMS: Centers for Medicare & Medicaid Services
- DIFS: Michigan Department of Insurance and Financial Services
- MDHHS: Michigan Department of Health and Human Services
- NCQA: National Committee for Quality Assurance

Procedure: What are the operational processes?

Responsible Party (Who)	Step	Action Taken (Does What)
Manager, Credentialing Department	All	Assessment and Review of Practitioners who provide care to HAP members.
Manager, Credentialing Department		Practitioner Credentialing Guidelines 1. **Types of practitioners to credential and recredential:** This policy applies to practitioners who have an independent relationship including Allopaths (MD), Osteopaths (DO), Dentists (DDS) (only oral and maxillofacial surgeons providing care under medical benefits), Podiatrists (DPM), Chiropractors (DC), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Optometrists (OD), Board Certified Behavior Analysts (BCBA), fully licensed Psychologists (PhD/PsyD), Master Level Psychologists (LLP), and Master Level Social Workers (LMSW). Licensed Professional Counselors (LPC) and Acupuncturists are credentialed as an exception based on the health plan's need. PCP availability; A PCP is described as a MD or DO who is listed as a General Practice, Family Medicine, Pediatrician or Internal Medicine Practitioner. OB/Gyn practitioners and other specialists may be designated as a PCP if they agree to provide care for all medical conditions. PCPs must provide or arrange for coverage of services 24 hours per day, 7 days per week. PCPs must be available to see

Responsible Party (Who)	Step	Action Taken (Does What)
		patients a minimum of 20 hours per practice location per week. Practitioners who do not need to be credentialed are those who practice exclusively within the inpatient setting and provide care for organization members only as a result of members being directed to the hospital or another inpatient setting, Hospitalists, Pathologists, Radiologists, Anesthesiologists, Certified Registered Nurse Anesthetists, Neonatologists and Emergency Department physicians, practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility, locum tenens, and general dentistry. 2. **Credentials System Controls:** Primary source verification (PSV) is documented using a checklist which includes the name of the primary source, the date of verification, the signature or initials of the Credentialing Coordinator who verified the information and the report date, if applicable. If the PSV is obtained via the internet the verification will contain the URL address. The credentialing application which includes PSV documentation, the CAQH application and other documents which complete the file is saved electronically. The credentialing file is saved on a secure drive only accessible by the Credentialing Department. The Credentialing Coordinator is responsible for maintaining the security of the credentialing documents while processing the file. Documents may not be altered. 3. **Primary Source Verification information is received, dated and stored for credentialing and recredentialing:** **Application:** The CAQH application must include a signed current attestation confirming that the application is to be accurate and complete within the required time frame of 180 calendar days prior to the Credentialing Committee's decision. If the signature attestation exceeds 180 calendar days before the credentialing decision, the practitioner must re-attest that the information on the application is current and complete. The CAQH application is received electronically and saved in an electronic format with the

Responsible Party (Who)	Step	Action Taken (Does What)
		date of receipt. The Credentialing Coordinator is responsible for maintaining the security of the document. **The application must also include the following**: • Reasons for inability to perform the essential functions of the position. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage. **Licensure:** HAP verifies a current, valid license to practice and a controlled-substance license as applicable in states where the practitioner provides care to its members is present, is within the prescribed time limit of 180 calendar days and is active at the time of the Credentialing Committee's decision. • Obtains internet verification, oral or written verification directly from the State of Michigan Department of Licensing and Regulatory Affairs (LARA) or certification agency. • Obtains either oral, written, or Internet verification for all other state licenses utilizing the appropriate state-licensing agency. • Review of information of sanctions, licensure, or scope of practice covers the most recent five-year period available through the data source. • Information on state sanctioning activity from the State of Michigan Department of Consumer and Industry Services Bureau of Health Services at the time of license verification. **DEA or CDS Certificates:** HAP verifies a current and valid DEA or CDS certificate with no restrictions or limitations (if applicable) in each state where the practitioner provides care to members through

Responsible Party (Who)	Step	Action Taken (Does What)
		one of the following. Verification is obtained prior to the credentialing decision. Recent graduates, or fellows applying for initial credentialing or practitioners who move from another state, may have a HAP covering practitioner for up to six months until they obtain their DEA. • Confirmation with the state pharmaceutical licensing agency, where applicable • A copy of DEA or CDS certificate • Documented visual inspection of the original certificate • Confirmation with the DEA or CDS agency • Confirmation with the National Technical Information Services (NTIS) database • Confirmation with the American Medical Association (AMA) Physician Master File • The DEA and CDS certificate is not applicable to chiropractors. **Education and Training:** Practitioners must have completed at least three years of post-graduate medical education in an approved internship and/or residency program (MD or DO) or DO's with only one- year post-graduate training before 1989 in an approved program and board certification. Verification of board certification meets the requirement for verification of education and training since medical specialty boards verify both. HAP verifies the highest of the three levels of education and training obtained by the practitioner prior to the credentialing decision. Graduation from medical or professional school, residency, if appropriate, and board certification, if appropriate. The agencies/authorities recognized at the time of this policy are the following: • The Accreditation Council for Graduate Medical Education (ACGME) • American Medical Association (AMA) Physician

Responsible Party (Who)	Step	Action Taken (Does What)
		Master Profile • The American Osteopathic Association (AOA) • Royal College of Physicians and Surgeons of Canada • The American Podiatric Medical Association (AMPA) Council on Podiatric Medical Education • Graduation from a Commission on Dental Accreditation (CODA) accredited training program - Oral Surgeons • Completion of an accredited psychologist program with an approved internship/clinical practice requirement • Completion of an accredited nurse midwife program, nurse practitioner, clinical nurse specialists with an approved internship/clinical practice requirement • Chiropractic College • Graduate from an optometry program that is accredited by the Accreditation Council on Optometric Education (ACOE) of the American Optometric Association (AOA). Optometrists must complete a four-year post-baccalaureate Doctor of Optometry Degree program. • Completion of a master's degree in social work (MSW) with a major focus of study in the treatment of Behavioral Medicine or equivalent field, as defined by the Michigan Board of Examiners of Social Work. • Master's Degree from a program approved by the State of Board of Counseling • Master's or doctoral degree in Psychology (LLP's) • Doctoral degree in Psychology (Psychology) • Possession of a minimum of a bachelor's and a master's degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine or a field related to behavior analysis and approved by the Behavior Analyst Certification Board and must obtain the Board Certified Behavior Analyst

Responsible Party (Who)	Step	Action Taken (Does What)
		Certification. **Board Certification:** HAP verifies board certification and documents the expiration date within the 180- calendar day time limit including lifetime certification status. If the medical board does not provide the expiration date for a practitioner's board certification, verification of the board certification status and date of verification is documented within the practitioners file. Board Certification is verified by one or more of the following HAP recognized agencies/authorities are: • American Board of Medical Specialties (ABMS Certifacts) • American Osteopathic Association (AOA) Physician Profile Report • Royal College of Physicians and Surgeons of Canada • American Board of Addiction Medicine • American Board of Sleep Medicine • American Board of Oral and Maxillofacial Surgery • American Podiatric Medical Association (APMA) • American Board of Foot and Ankle Surgery (ABFAS) • American Board of Lower Extremity Surgery (ABLES) • American Board of Multiple Specialties in Podiatry (ABMSP) • American Board of Podiatric Medicine (ABPM) • American Midwifery Certification Board (AMCB) • National Commission on Certification of Physician Assistants • Nurse Practitioners meet the advanced practice certification standards of one of the following certification organizations: 1. American Nurses Credentialing Center

Responsible Party (Who)	Step	Action Taken (Does What)
		(ANCC) 2. American Academy of Nurse Practitioners 3. National Certification Board of Pediatric Nurse Practitioners and Nurses, Inc. 4. National Certification Corporation (NCC) for obstetric, gynecologic, and neonatal nursing specialties 5. Oncology Nursing certification corporation 6. Pediatric Nursing Certification Board 7. American Association of Critical-Care Nurses **Work History:** HAP obtains a minimum of the most recent five years of relevant work history through the practitioner's application or curriculum vitae within 180 calendar day time limit. Relevant experience includes work as a health professional. If the practitioner has practiced fewer than five years from the date of verification of work history, the time frame starts at the date of initial licensure. The application or curriculum vitae must include the beginning and ending month and year for each position the practitioner's employment experience. If the practitioner has had continuous employment for five years or more with no gaps in work history providing the year is acceptable. • Clarify either verbally or in writing each gap in employment that exceeds six months. • If the gap in work history exceeds one year, the practitioner clarifies the gap in writing. • Document its review of work history, including any gaps, within the credentialing file. • Work history can be documented on the application, CV or checklist. Documentation will include the signature or initials of staff who reviewed work history and the date of review.

Responsible Party (Who)	Step	Action Taken (Does What)
		Malpractice History: HAP obtains confirmation of the past five years of history of malpractice settlements from the malpractice carrier or the National Practitioner Databank (NPDB) within 180 calendar day time limit. The five-year period may include residency or fellowship years. HAP does not need to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship. **Hospital Affiliation:** HAP verifies all current hospital affiliations as attested to on the application. In the event of a "red flag", previous hospitals affiliations are also verified. **Sanction Information:** HAP reviews and evaluates State sanctions, restrictions on licensure, limitations on scope of practice, and Medicare and Medicaid Sanctions prior to making a credentialing/ recredentialing decision. The practitioner's file will contain sufficient documentation to demonstrate that the credentialing information is present at the time of the credentialing decision within the 180 calendar day time limit from the following agencies/sources: • NPDB • State Medicaid agency or intermediary and the Medicare intermediary • List of Excluded Individuals and Entities (maintained by the Office of Inspector General (OIG), available over the Internet • Medicare Exclusion Database • Michigan Department of Health and Human Services (MDHHS) Sanction Provider List, available over the Internet • Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the

Responsible Party (Who)	Step	Action Taken (Does What)
		Inspector General • The System for Award Management (SAM) web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits • The American Medical Association (AMA) Physician Master File entry • Federation of State Medical Board (FSMB) • Centers for Medicare and Medicaid Service (CMS) Preclusion Provider List 4. **Authorization to Modify Information:** The Credentialing staff members in the Credentialing Department are authorized to data enter, review, and modify credentialing data in accordance with existing procedures. The credentialing information is gathered from PSV's, application, and documents to support the credentialing application. Only the Credentialing Manager and/or Credentialing Lead are authorized to delete credentialing information. Deletions are only made once data is reviewed, verified to be incorrect or duplicated. The credentialing software allows which fields can be added, modified, and/or read only according to the user. All requests for access to the credentialing database and/or secured shared drive are reviewed by the Credentialing Manager to evaluate appropriateness and to determine the security group the individual shall be assigned based on job responsibilities. Each user has a unique identifier and password. These ID's and passwords shall not be shared, or the user may be subject to disciplinary action, including possible termination. If access is not granted, the Credentialing Manager will communicate the denial to the requestor, including the reason for the denial. The credentialing software system tracks the adds, modifications and/or changes with an audit log. The audit log identifies the staff member who make the data entry, what change was added, modified, and/or deleted, identifies the time the change was made and date the change was made. The report is run daily. The Credentialing and/or Credentialing Lead review the report regularly. If there is a discrepancy between the information

Responsible Party (Who)	Step	Action Taken (Does What)
		provided by the applicant and the PSV, the Credentialing Coordinator will follow the policy and process for resolving discrepancies in information which may include contacting the applicant and/or the PSV for clarification. Notations may be made in the credentialing file and must contain the date of the entry and the name/initials of the staff member who made the entry. 5. **Credentialing Process Audit** 6. At the time that the credentialing files is completed, the Credentialing Coordinator who was responsible for completing the file attests that the information is accurate and complete and is documented on the credentialing tracking sheet. The file is then reviewed by another Credentialing Coordinator prior to the Credentialing Meeting to ensure all credentialing is completed according to the credentialing policy and signs the credentialing tracking sheet indicating the name and date of the review. 7. Prior to the Credentials Committee meeting, the Credentialing Manager and/or Credentialing Lead will review any applications (initial or recredentialing) that is not considered clean to ensure the file is processed in accordance with existing policies and procedures. For any files that were not approved by the Credentialing Committee the file is reviewed by the Credentialing Manager and/or Credentialing Lead to ensure credentialing decisions were made in accordance with existing policies and procedures. To ensure the integrity and security of the practitioner data contained in the credentialing database, various auditing activities will be performed on an ongoing basis. An audit log report is generated daily, which identifies the username, the credentialing data field, the audit date and time, the code, and the field name for all adds and modifications made to the credentialing data. The audit report is reviewed weekly by the Credentialing and Credentialing Lead to ensure all polices and procedures are followed and to identify any unusual or inconsistent activity. In the event of a discrepancy, appropriate steps shall be taken by the Credentialing Manager. 8. **Criteria for credentialing and recredentialing:** HAP assures that all practitioners applying for affiliation

Responsible Party (Who)	Step	Action Taken (Does What)
		meet rigorous credentialing standards prior to providing care to members. The provider must submit information and documentation of his/her education, qualification and certification which qualities them to be identified as a specialist in a particular field of medicine. It is anticipated that the services to HAP members, performed by that credentialed specialist, would be consistent with the medical specialty for which the provider applied for and was evaluated and credentialed by HAP. Credentialed specialists are accordingly expected to provide covered services to HAP members that are within the scope of the specialty credentialed by HAP after review of the providers' application. Practitioners will go through the recredentialing process within 36 months of the previous credentialing decision. The recredentialing process will include the consideration of practitioner performance indicators obtained through various forms of data, which may include but not limited to results of quality of care reviews, quality of service events, the monitoring of practitioners Appeals and Grievances, U/M information, and member satisfaction surveys. The recredentialing cycle begins with the date of the initial credentialing decision. HAP counts the 36-month cycle to the month, not to the day. If HAP cannot recredential a practitioner within the 36-month time frame because the practitioner is on active military assignment, maternity leave or a sabbatical, but the contract between HAP and the practitioner remains in place, HAP will recredential the practitioner upon his or her return. HAP will document the reason for the delay in the practitioner's file. It is acceptable to recredential practitioners on leave. HAP will verify that a practitioner who returns from military assignment, maternity leave or a sabbatical has a valid license to practice before he or she resumes seeing patients. Within 60 days of when the practitioner resumes practice, HAP will complete the recredentialing cycle. If a practitioner is given administrative termination for reason beyond HAP's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, HAP may recredential the practitioner as long as it is documented that the

Responsible Party (Who)	Step	Action Taken (Does What)
		practitioner was terminated for reasons beyond HAP's control and was recredentialed and reinstated within 30 calendar days of termination. HAP will initially credential practitioners if reinstatement is more than 30 calendar days after termination. • Completion of a CAQH application. • Completion of at least three years of post-graduate training in an approved internship and/or residency program (MD or DO) or DOS with only one-year post-graduate training before 1989 in an approved program and board certification. • Completion of an accredited physician assistant program with an approved internship/clinical practice requirements and hold a current active certification by the National Commission on Certification of Physician Assistants. • Completion of an accredited nurse midwife program, nurse practitioner, clinical nurse specialists or CRNA program with an approved internship/clinical practice requirements. • **Nurse Practitioners and Physician Assistants** must submit evidence of collaborative or practice agreement between applicant and a designated HAP credentialed physician. • Graduate from an optometry program that is accredited by the Accreditation Council on Optometric Education (ACOE) of the American Optometric Association (AOA). Optometrists must complete a four-year post-baccalaureate Doctor of Optometry Degree program. • Completion of a master's degree in social work (MSW) with a major focus of study in the treatment of Behavioral Medicine or equivalent field, as defined by the Michigan Board of Examiners of Social Work. • **Acupuncturists:** Current Michigan license to practice as an Acupuncturists. • **Licensed Professional Counselor:** Current Michigan license to practice as a Licensed Professional Counselor Master's degree from a program approved by the State Board of

Responsible Party (Who)	Step	Action Taken (Does What)
		Counseling. • **Fully Licensed Psychologist:** Current Michigan license to practice as a Licensed Psychologist. Doctoral degree in psychology from an institution approved by the State of Michigan Board of Psychology • **Limited License Psychologist/LLP:** Current Michigan license to practice as a Limited License Psychologist. Master's or doctoral degree in psychology from an institution approved by the Michigan Board of Psychology. • **Board Certified Behavior Analyst (BCBA):** Possession of a minimum of a bachelor's and a master's degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine or a field related to behavior analysis and must obtain BCBA Certification. • Board certification in the requested area of practice is recommended. Board certification does not apply to chiropractors or psychologists. • Recent graduates of residency programs who are not board certified at the time of application are encouraged to **attain board certification within four years of completing the training program.** • Specialties such as OB/GYN and all surgery related specialties are encouraged to **attain board certification within six years of completing the training program.** • Non-boarded practitioners see Section 4; Process for making credentialing and recredentialing decisions. • Unrestricted Licensure in the State of Michigan. • Unrestricted DEA in the State of Michigan or arrangements with a HAP contracted/ credentialed provider with a valid DEA for required prescriptions will be considered for approval or denial at the discretion of the Credentialing Committee. For initial practitioners or practitioners who move from another state, they may have a covering practitioner for up to

Responsible Party (Who)	Step	Action Taken (Does What)
		six months until they obtain their DEA. • Affiliation with a hospital, as applicable. Select specialists including Physical Medicine & Rehab, Dermatology, Ophthalmology and Psychology are not required to have an affiliation with a hospital. All others must have hospital affiliations. For PCPs, hospital affiliation is not required if they are able to identify a credentialed contracted practitioner to oversee the care of their members. • Current malpractice insurance, with at least $100,000/$300,000 coverage. Verify malpractice coverages and amounts from the CAQH application or obtain a copy of the face sheet from practitioner. • Federal Torte Coverage - In lieu of malpractice insurance for practitioners delivering care at federal facilities, the file must include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage. • For practitioners requesting assignment of a dual PCP and specialist, each designation must be assigned to a separate network. • Eligible to participate in Medicare and Medicaid and must not be excluded from participation in any governmental health care program. • Participate in Medicare and does not appear on the Medicare Opt-Out List. • Lack of current sanction and/or suspension from Medicare or Medicaid, or Federal Employees Health Benefits (FEHB). Exclusion or sanctions from a federal health care program shall cause an automatic termination as an affiliated practitioner. • Cooperation with Quality Management and Utilization Management programs, including a credentialing site visit and medical record-keeping practices review if requested. • Accept the HAP fee schedule as payment in full. • Accept new patients for all contracted product lines.

Responsible Party (Who)	Step	Action Taken (Does What)
		• Favorable professional liability history including malpractice claims history with no more than $200,000 per claim or no more than 5 claims within the past five years. • Not excluded from System for Award Management (SAMS) Exclusion list. • Lack of present illegal drug use. • Attest to any felony convictions. • No unexplained gaps in work history. • Obtain disclosure of Ownership and control of network provider • Lack of fraud, waste and abuse documentation from Audit Department or FWA Response Team. 9. **Process for making credentialing and recredentialing decisions:** Decision-making is governed by a majority vote of the Credentialing Committee for practitioners who do not meet minimum HAP standards and is nondiscriminatory. Each decision is based upon information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies Committee decisions will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee in order to encourage candor and careful assessment necessary to effect peer review and quality assurance. All credentialing activities are in compliance with NCQA, State of Michigan Department of Consumer and Industry Services Bureau of Health Services, and all other applicable laws and regulatory bodies. The Credentialing Committee considers all applicants, including those who have been granted waivers in the context of all available information. In the case of waivers, the Committee must weigh the lack of adherence to standards with factors such as: • Perceived value to HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Empowered, Inc.) and/or the membership, which

Responsible Party (Who)	Step	Action Taken (Does What)
		merits approval despite failure to meet the standard, and/or • Perceived professional qualities, which may not be appropriately reflected in the HAP standard requiring board certification and residency training, including: 1. Demonstrated motivation to participate in HAP and follow managed care procedures 2. Special need for practitioners in the geographic area/network 3. Reputation in the community 4. Prominence in the network's managed care organization 5. Professional experience/Continuing Medical Education experience 6. Partnership with current HAP practitioners of perceived exceptional quality • Board certification waivers are reviewed for **initial** applicants only. To be considered for a board certification waiver, the practitioner must submit a letter of recommendation including network need from their (hospital) department chair or three letters of recommendation from HAP contracted and credentialed practitioners. Board certification waivers will be considered for approval or denial at the discretion of Credentialing Committee. • Board certification extensions are granted to recredentialing applicants who provide proof from the board stating they are scheduled to sit for the exam. Credentialing Committee reserve the right for approval or denial of Board certification extensions. • Physician's certificates that expired and who fail to become re-certified, or those physicians whose board eligible period expired or lapsed and have no plans of certifying or recertifying must provide a written explanation to

Responsible Party (Who)	Step	Action Taken (Does What)
		Credentialing Committee to continue their affiliation. Credentialing Committee reserves the right for approval or denial. • The Credentialing Committee may determine that some applicants who meet minimum HAP standards should not be approved for participation for any of the following reasons, but not limited to: 1. Lack of demonstrated motivation to participate cooperatively as a practitioner and follow the utilization management and quality management policies and procedures. 2. Lack of perceived need for practitioners in the geographic area/ network. 3. Unfavorable reputation in the community. 4. Lack of good standing at affiliated hospital. 5. Perceived lack of quality of medical school/residency experience. 6. Failure to comply with the ethics of the profession. 7. Failure to adhere with HAP's Policies and Procedures. 8. Failure to cooperate with HAP's inquiries or investigations. 10. **Process for managing credentialing files that meet the organization's established criteria:** • All credentialing files that do not meet minimum credentialing standards must be reviewed by the Credentialing Committee. • Credentialing files that meet minimum credentialing standards, "clean files", are reviewed and approved by the Chair of the Credentialing Committee or an equally qualified practitioner. • Medical Director's Review of Clean Files.

Responsible Party (Who)	Step	Action Taken (Does What)
		1. The Medical Director reviews and approves all practitioners that meet minimum requirements. 2. The Medical Director's approval is obtained through a handwritten signature. 3. The list of clean files is documented in the Credentialing Committee meeting minutes and the total number of clean files is presented to the Credentialing Committee. 11. **Process for delegating credentialing or recredentialing:** • The credentialing process for affiliation with HAP may be delegated to another credentialing body if the potential delegate passes the pre-delegated evaluation, along with the approval from the Credentialing Committee and a signed executed mutually agreed upon delegated agreement. • In all cases, HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Empowered, Inc.) retains ultimate authority over the process and engage in oversight activities to ensure that minimum standards are applied (Refer to CR 8 Delegated Credentialing). 12. **Process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner:** • The Credentialing Committee does not base credentialing decisions on the applicant's race, ethnicity, nationality/country of origin, gender, age, sexual orientation, or types of procedures or patients cared for by the practitioner. • All members and guests of the Credentialing Committee sign a statement of confidentiality and nondiscriminatory decision-making on an annual basis. • On an annual basis the Credentialing Committee reviews credentialing files (in process, denied and approved files) to ensure that there is no

Responsible Party (Who)	Step	Action Taken (Does What)
		pattern of discrimination or evidence of individual discrimination. 13. **Process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization:** • If the information received varies substantially from the information provided on the application, the credentialing staff requests clarification from the practitioner and provides the practitioner an opportunity to amend the erroneous information. Notification of erroneous information is sent to provider by certified mail or secured email. 14. **Process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision:** Practitioners are notified within 60 calendar days of the committee's decision. • Approval notices are sent by a Credentialing team member to the practitioner notifying the practitioner of the committee's decision. • Denial notices with the reason for the denial are sent by a Credentialing team member to the practitioner via certified mail. 15. **Medical director or other designated physician's direct responsibility and participation in the credentialing program:** • The Medical Director is responsible for the Credentialing Committees. • The Medical Director ensures that HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Empowered, Inc.) carries out its credentialing activities in the most efficient, effective way possible and that all credentialing activities are in compliance with the Credentialing Policies, NCQA standards, State of Michigan Department of Consumer and Industry Service Bureau of Health Services, and all other applicable laws and regulations. The Medical Director may approve initial and recredentialing

Responsible Party (Who)	Step	Action Taken (Does What)
		files that meet all credentialing criteria or may determine that additional review is necessary by the Credentialing Committee. 16. **Process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law:** • All members and guests of the Credentialing and Oversight Committees sign a statement of confidentiality and nondiscriminatory decision-making on an annual basis. • Members and guests of the Credentialing and Oversight Committees will not discuss or share information that was obtained at this meeting, or in preparation or follow-up to the meeting. Information is to be utilized only as it is originally intended. • Information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Oversight Committee in order to encourage candor and careful assessment necessary to effect peer review and quality assurance. • Committee members and guests will not discuss, share or use any peer review information for any purpose other than peer review. • Access to credentials documents will be restricted to authorized staff, Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Oversight Committee. • Active credentialing files (currently in process) and completed credentialing files may only be accessed by password in accordance with existing corporate policies and procedures. All credentialing files are electronic and stored in accordance with existing policies.

Responsible Party (Who)	Step	Action Taken (Does What)
		• Minutes, reports and files of Credentialing Oversight Committee meetings will be maintained in a confidential manner in the physicians file imaging system. The physician file once it has been imaged is transferred offsite in a secure and restricted environment for the duration of seven (7) years. At the end of seven (7) years, the file is shredded/destruction in compliance with Offsite Records Storage, Retrieval, Destruction (Office Services Corporate Policy). • Copies of the minutes will not be allowed to be removed from the site of the Credentialing Committee. All minutes and documentation will be shredded immediately following the meeting. • The identity of a person whose condition or treatment has been studied in the Committee is confidential and the Committee shall remove the person's name and address from the record before the Committee releases or publishes a record of its proceedings, or its report, findings, and conclusions. Except as otherwise provided, the record of proceedings and the reports, findings, and conclusions and data collected by or for this Committee are confidential, are not public records, and are not discoverable and shall not be used as evidence in a civil action or administrative proceeding. • Disclosure of credentialing information is limited to information needed (i.e., name, address, network, specialty, education and training, board certification status, hospital affiliation) for provider directory, provider assignment or on-line directory. • All Credentialing staff is required to change their passwords every 180 calendar days. For maintaining confidentiality, staff will use strong passwords, avoid writing down their password or share their password; but remember it. If a user leaves the credentialing department and/or the organization, a system administrator will delete that person's user account effective immediately. • Physical access to credentialing information

Responsible Party (Who)	Step	Action Taken (Does What)
		maintained in the Credentials Department is limited to staff members who are assigned to fulfill the requirements of the department. Members of the Credentials Committee, the Medical Director/Credentials Committee Chairman, may view information only in the course of active Credentials Committee reviews. 17. **Process for confirming those listings in practitioner directories and other materials for members are consistent with credentialing data.** The practitioner directory excludes all practitioners that are not independently contracted and credentialed who practice in an inpatient setting. The directory may differ based on member's benefit level. • Practitioner-specific information, including education and training, board certification status, specialty, hospital affiliation, gender and language information, that is made available to HAP and its subsidiaries (all products lines) and the general public is derived directly from the Credentialing department's database. • All practitioner-specific information (education and training, board certification status, specialty, hospital affiliation, gender and language information) is verified through the credentialing process and entered into the credentialing database. After the Credentialing Committee's approval, this information is entered into the claims database, where practitioner directories and all practitioner-specific information are derived. • The Credentialing staff is responsible for entering practitioner specific information into the credentialing database. Any discrepancies are validated and corrected within 30 calendar days. • Practitioner-specific information is also validated during the recredentialing process which occurs within 36 months.
Manager, Credentialing Department		Practitioners Rights 1. **HAP notifies practitioners about their rights to review**

Responsible Party (Who)	Step	Action Taken (Does What)
		information submitted to support their credentialing application: • It is the practitioner's right to review information obtained to evaluate the practitioners credentialing application, attestation or CV. • Each practitioner has the right to review certain information obtained during the verification process. Practitioners do not have the right to review information such as peer-review protected information, recommendations or other information that is considered to be peer-review protected. • The practitioner may review credentialing policies and procedures upon written request. 2. **Correction of erroneous information:** • If the information received varies substantially from the information provided on the application, HAP requests clarification from the practitioner and provides the practitioner an opportunity to amend the erroneous information. Notification of erroneous information is sent to provider by certified mail or secured e-mail. • The practitioner is asked to respond in writing within 14 calendar days of receipt of the certified letter or secured e-mail. • The practitioner mails the response to the Manager of Credentialing. • If the practitioner chooses to exercise his or her right to correct the erroneous information: a. HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Empowered, Inc.) further investigate the primary source information. b. This information, along with the practitioner's response, is presented to the Credentialing Committee for review and resolution. c. The practitioner is notified via certified

Responsible Party (Who)	Step	Action Taken (Does What)
		mail within 14 days of the Credentialing Committee's decision. d. If the practitioner chooses **not** to exercise his or her right to correct the erroneous information, or does not respond within 14 days: e. The information is presented to the Credentialing Committee for review and resolution, without input from the practitioner. f. The practitioner is notified of the committee decision by certified mail. 3. **Receive the status of their credentialing or recredentialing application, upon request:** • If the practitioner requests the status of his/her application, HAP provides practitioner with the approximate date when the application will be presented to the Credentialing Committee and any outstanding primary source verification letters either by telephone, email or written correspondence. Practitioners do not have the right to review information such as recommendations, references, or other information that is considered to be peer-review protected. 4. **Notification of Practitioner Rights:** • Practitioners are notified of these rights upon their initial request for a contract and on an ongoing basis. CR1 is sent along with the initial request for a contract. Credentialing policies and procedures are made available to all HAP contracted practitioners on an ongoing basis on the provider portal of the website and practitioners are notified annually and offered hard copies of the policies and procedures if web access is unavailable.

Monitoring:

Quality Review Monitoring:

Policy is reviewed annually for accuracy and quality

Policy Monitoring:

Provider Network Management's Regulatory Policy review (including standards and regulatory requirements and references) must include review of standards at least annually, or more frequently as new guidance becomes available

Reporting: How do you provide reasonable assurance of compliance with policy to the Executive Leadership & Board of Directors (BOD)?

Name of Report	Frequency of Report	Owner
Pending Report Recredentiailng Report Disenrollment Report	Weekly	Manager, Credentialing Credentialing Lead Credentialing Coordinators

ATTACHMENT(S):

Credentialing Committee, Credentialing Department Employees are responsible for reporting any observed violations of this policy to the Office of Compliance.

Approval Signatures

Step Description	Approver	Date
Compliance Final Review	Johnathan Randle: Dir-Gov't Programs Compliance	05/2022
Medical Director-HCM	Yvonne Sesi: Medical Director-HCM	05/2022
Compliance Initial Review	Heidi Angelo: Sr. Compliance Consultant	04/2022
Document Owner	Janet Krajnovic: Mgr-Credentialing	04/2022

Ongoing Monitoring

We conduct ongoing monitoring of practitioner sanctions, complaints and quality and safety issues within 30 days of its release between formal credentialing and takes appropriate actions against practitioners when it identifies an occurrence of poor quality.

Collecting and reviewing Medicare and Medicaid sanctions and reviews 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:

- AMA Physician Master File Entry
- FEHB Program Department Record, published by the Office of Personnel Management, Office of the Inspector General
- NPDB-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

Collecting and reviewing sanctions or limitation on license and reviews information within 30 calendar days of its release by the reporting entity.
Reviews physician sanctions or limitation on licensure status from a query of one of the following:

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

Reviews non-physician healthcare 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

Reviewing provider/practitioners self-reporting and individual/employee screening:

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

Status **Active** PolicyStat ID **10721464**

Origination	04/1995
Last Approved	05/2022
Effective	05/2022
Last Revised	05/2022
Next Review	05/2023

Owner	Janet Krajnovic
Area	Provider Network Management
Applicability	Health Alliance Plan
Document Types	Policy

Provider Performance Improvement Policy

Department: Credentialing			Provider Network Management			**Department Head:** Janet Krajnovic				**Yvonne T. Sesi, MD** Network Management	
Approval Date:			April 2022			**Next Review Date** (12 months from approval date)				April 2023	
Compliance/Executive Approval:											
Name:						**Date (MM/DD/YYYY):**					
APPLIES TO:	X	**COMMERCIAL:**	X	**MMP:**	X	**MEDICARE ADVANTAGE:**	X	**MEDICAID:**	X	**OTHER:**	

Purpose:

The Performance Improvement Process (PIP) is used to improve provider performance, when it has been determined that the provider is not meeting standards.

HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Empowered.) Has a well-defined Performance Improvement Process (PIP) to improve provider performance. Behaviors that may lead to the initiation of the Performance Improvement Process include, but are not limited to, failure to comply with HAP's Policies and Procedures, non-compliance with physician profiling performance improvement plan, violation of provider contract, acting in a manner that jeopardizes the health or safety of an enrollee, fraud, waste and abuse or that affects accreditation or licensure. Failure to correct such behaviors may lead to termination (Policy CR13). Retains the exclusive right to determine the appropriate corrective action based upon the circumstances of each case.

Policy:

This policy is put into place that HAP will comply with regulatory and accreditation standards in the development and management of Credentialing with the following regulatory provisions

- National Committee for Quality Assurance (NCQA) standards
- Centers for Medicare & Medicaid Services (CMS)
- Michigan Department of Community Health (MDCH) guidelines
- Michigan Department of Insurance and Financial Services (DIFS)

Definition:

- CMS: Centers for Medicare & Medicaid Services
- DIFS: Michigan Department of Insurance and Financial Services
- MDCH: Michigan Department of Community Health
- NCQA: National Committee for Quality Assurance - CR 1, CR 5, CR 7, CR 8
- Provider(s) includes Physicians, Practitioners and Ancillaries.

Procedure:

Responsible Party (Who)	Step	Action Taken (Does What)
Credentialing Department	All	**Provider Performance Improvement Process** 1. Performance Improvement Monitors include but are not limited to: quality, fraud, legal actions, inappropriate behavior, noncompliance with HAP contractual obligations,faiure to detect and report actual or suspected non-compliance, technical reasons, and all of HAP's Policies and Procedures. The Performance Improvement Process is overseen by the Peer Review Committee and generally consists of three levels, including an initial verbal notification to the provider, followed by written notification. 2. The Performance Improvement Process is triggered when a provider accumulates three (3) Performance Improvement Monitors covering the period of 24 months. • The Credentialing Committee Chair, Medical Director or designee will issue a letter reminding the provider of the need to comply with HAP Policies and Procedures, contractual requirements and applicable laws. The letter will be sent via confidential fax and requires the provider to submit a performance improvement plan (PIP) within 10 working days. If the provider is required to follow-up with a HAP Clinical

Responsible Party (Who)	Step	Action Taken (Does What)
		Pharmacist as part of the PIP, the provider must do so within 10 business days of submitting the PIP. Additionally, the provider must respond to any follow-up pharmacy requests within 5 business days of the request. • If, after the initial reminder, another incident occurs, the Medical Director or designee will speak with the provider, which will serve as a First Notification communication. The Medical Director will send written confirmation of this notification and advise the provider that further non-compliance may result in a Second or Third Notification letter and, ultimately, termination, contract termination and reporting to the National Practitioner Data Bank (NPDB). • Second and Third Notifications are formal notices to the provider outlining the behavior that needs to change and advising the provider that additional noncompliance may result in termination, contract termination, and reporting to the NPDB. 3. Termination may occur at any point in the PIP and is not dependent on completing all three (3) levels. 4. During the PIP, the provider may receive copies of HAP's Policies and Procedure's upon request. 5. The Credentialing Committee Chair or HAP designee keeps record of all levels of PIP action and reports monthly to the Peer Review Committee. 6. The Peer Review Committee will review PIP actions and determine when a provider has successfully completed the PIP plan. The Credentialing Committee Chair, Medical Director, or designee will notify the provider in writing within thirty (30) calendar days of the Peer Review Committee's decision. The Credentialing Manager, or designee will place the documentation in the provider's file. 7. If the Credentialing Committee referred the case to a Peer Review Committee, the Credentialing Committee Chair or designee will then also notify the Credentialing Committee of the successful completion of the PIP Plan. 8. If the provider does not respond to the Notifications or comply with the Process Improvement Plan, the Manager or designee brings the case to the Peer Review Committee for disposition. The Peer Review Committee shall recommend termination and

Responsible Party (Who)	Step	Action Taken (Does What)
		will forward the case to the Chair of the Credentialing Committee. Providers who are terminated by the Credentialing Committee may not reapply for a minimum of seven (7) years across all HAP product lines and must show proof of corrected behavior and standards. 9. In the event that inappropriate activity reoccurs with a provider who has already gone through a PIP plan, including, but not limited to, failure to follow-up with a HAP Clinical Pharmacist when requested to do so, the Peer Review Committee reserves the right to recommend termination immediately to the Credentialing Committee. 10. Communications with the provider, including PIP Plan and follow up, remains in the provider's file at least seven (7) years.

Monitoring:

Quality Review Monitoring:

Policy is reviewed annually for accuracy and quality

Policy Monitoring:

Provider Network Management's Regulatory Policy review (including standards and regulatory requirements and references) must include review of standards at least annually, or more frequently as new guidance becomes available

Reporting:

Name of Report	Frequency of Report	Owner
No reporting	Quarterly	Manager, Credentialing

ATTACHMENT(S):

n/a

Approval Signatures

Step Description	Approver	Date
Compliance Final Review	Johnathan Randle: Dir-Gov't Programs Compliance	05/2022

Medical Director-HCM	Yvonne Sesi: Medical Director-HCM	04/2022
Compliance Initial Review	Heidi Angelo: Sr. Compliance Consultant	04/2022
Document Owner	Janet Krajnovic: Mgr-Credentialing	04/2022

Status **Active** PolicyStat ID **10721483**

Origination	04/1995
Last Approved	07/2022
Effective	07/2022
Last Revised	07/2022
Next Review	07/2023

Owner	Janet Krajnovic
Area	Provider Network Management
Applicability	Health Alliance Plan
Document Types	Policy

Termination of Providers Policy

Department: Credentialing		Provider Network Management			**Department Head:** Janet Krajnovic			**Yvonne T. Sesi, MD** Provider Network Management			
Approval Date:		April 2022			**Next Review Date** (12 months from approval date)			April 2023			
Compliance/Executive Approval:											
Name:					**Date (MM/DD/YYYY):**						
APPLIES TO:	X	**COMMERCIAL:**	X	**MMP:**	X	**MEDICARE ADVANTAGE:** X	X	**MEDICAID:**	X	**OTHER:**	

HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Empowered) may terminate the privileges of a HAP provider when HAP determines that the provider has failed to comply with HAP's Credentialing Policies and Procedures, violated his/her contract; or has acted in a manner that jeopardizes the health or safety of HAP members; failure to report instances of non-compliance, failure to assist in the resolution of compliance issues, fraud, waste or abuse; or affects HAP's accreditation or licensure. This policy applies to providers credentialed by HAP or by a delegated credentialing entity.

This policy applies to providers credentialed by HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Empowered.) or by a delegated credentialing entity.

Policy:

This policy is put into place that HAP will comply with regulatory and accreditation standards in the

development and management of Credentialing with the following regulatory provisions

- National Committee for Quality Assurance (NCQA) standards - CR 1, CR 5, CR 6, CR 7, CR 8
- Centers for Medicare & Medicaid Services (CMS) guidelines
- Michigan Department of Community Health (MDCH) guidelines
- Michigan Department of Insurance and Financial Services (DIFS)

Definition:

- CMS: Centers for Medicare & Medicaid Services
- DIFS: Michigan Department of Insurance and Financial Services
- MDCH: Michigan Department of Community Health
- NCQA: National Committee for Quality Assurance

Procedure:

Responsible Party (Who)	Step	Action Taken (Does What)
Credentialing Department	All	**Practice/Procedure/Requirements for Compliance:** 1. HAP may terminate a provider at any time upon the decision of the HAP Credentialing Committee. 2. There may be occurrences that necessitate the immediate review of a provider's continued affiliation prior to the regularly scheduled recredentialing review. 3. In cases in which the provider loses his or her license to practice medicine, appears on the Office of the Inspector General's list, Sanction listing or acted in a manner that jeopardizes the health or safety of HAP members, the Chair of Credentialing Committee or Credentialing Manager or designee shall recommend immediate termination of the provider's affiliation. 4. The following situations can result in termination including, but not limited to: **Violation of HAP's Quality Management Standards** (including but not limited to): • Any action or omission to act that results in serious harm to a patient or is below the community or national standard of care (e.g., wrongful surgery, avoidable death) • Any action or omission to act that does not result in serious harm or death to the patient but is regarded by the Credentialing Committee as not meeting the HAP standard of care including, but not limited to: a. Failure to comply with published HAP

Responsible Party (Who)	Step	Action Taken (Does What)
		clinical, preventive and pharmacy guidelines, b. Failure to obtain medical consultation for patients with behavioral problems when indicated, c. Peer review issues, d. Any utilization management issues indicative of quality problems, including pharmacy e. General member complaints, f. Excessive complaints, g. Refusal to allow members to participate in disease management programs for which they qualify, including pharmacy h. Refusal to allow members to participate in case management programs for which they qualify, i. Refusal or failure to participate in quality management programs including case and disease management programs, j. Refusal or failure to implement quality improvement plan(s) requested by a HAP Clinical Pharmacy Specialist within 10 business days of the initial request (as outlined in the Provider Performance Improvement Process CR 12 policy). This includes, but is not limited to, disease re-assessment and/or adjustment of drug therapy within 10 business days of notification of the quality issue, in the event that the provider wishes to resolve the issue without the assistance of Pharmacy Specialists, k. Failure to collect and provide data requested by HAP related to quality investigations, HEDIS, regulatory regulations, and disease management programs, l. Site visit reviews that consistently remain at minimum levels or refusal to submit a

Responsible Party (Who)	Step	Action Taken (Does What)
		corrective action plan to improve site visit scores, m. Refusal to allow a site visit to occur, n. Poor quality charting, o. Failure to provide twenty-four (24) hour, seven (7) days a week availability to members, p. Failure to have back-up coverage by a contracted physician, q. Failure to respond to requests for any information related to UM or QM cases, including requests from HAP Clinical Pharmacists, within 5 business days of the request. 5. Three or more episodes of violation of HAP's Utilization Management Standards (including, but not limited to): • Noncompliance with HAP's authorization process for inpatient admissions, outpatient procedures, referrals, or pharmacy team, or • Refusal to work with managed care coordinators, the transfer team, or case managers regarding coordination of care, • Referral of members to non-contracted providers, or • Refusal or failure to demonstrate participation in utilization management programs. • Failure to show reduced variation related to misuse, overuse, and underuse after HAP Medical Director implement a Performance Improvement Process. 6. Actions related to fraud, waste or abuse, legal sanctions. or unethical behavioral (including, but not limited to): • Intentional misrepresentation of facts, • Inappropriate billing practices including permitting any other provider to bill using the provider's name or inappropriate referral practices, • Violation of any law that affects the ability of the provider or HAP to participate in any state or federal health care program including Medicare and Medicaid, or

Responsible Party (Who)	Step	Action Taken (Does What)
		• Sanction by the Office of the Inspector General. 7. Abusive behavior or outrageous conduct (including, but not limited to): • Sexual relations with a patient, patient's family member, patient's caregiver, or • Profane or rude language toward patients or staff, • Unprofessional conduct. 8. Compliance with contractual obligations (including, but not limited to) • Failure to comply with contractual requirements to provide at least ninety (90) calendar days' notice before transferring networks. 9. Administrative Reasons (including, but not limited to): Administrative Terminations is not a professional review action as defined in HAP's Credentialing Policies; there is no opportunity for a peer review appeal process. As a courtesy, HAP will permit appeal of the decision by meeting with Medical Director at a mutually agreed upon date and time. You must request the meeting within 30 days of your receipt of termination letter. • Failure to submit required recredentialing document as requested within thirty days (30) calendar days of the recredentialing due date. • Failure to appear before the Credentialing Committee within sixty (60) calendar days of the date of the written request to appear. 10. The Chief Medical Officer, any Medical Director, Chair of the Peer Review Committee, or other HAP department staff may refer a case for potential termination to the Chair of the Credentialing Committee who may refer the case to the Peer Review Committee. 11. The Chair of the Credentialing Committee may place the provider on a corrective action plan for a maximum of six (6) months in order to resolve the issue. 12. The Credentialing Committee reserves the right to close the provider's panel to all lines of business during the corrective action period. 13. The Credentialing Committee upon a majority vote can do any

Responsible Party (Who)	Step	Action Taken (Does What)
		of the following: • Recommend termination, • Convene an ad hoc panel of at least three (3) physicians consisting of at least one HAP Medical Director and at least two same-specialty peers who are not economically competitive with the provider and have no personal interest, • Recommend a corrective action plan, see Policy CR12 (Performance Improvement Process), or • Recommend any other action deemed appropriate by the Committee based on the circumstances of the case. 14. If an ad hoc panel reviews the provider's file, any recommendations of this panel are forwarded to the Credentialing Committee for final determination. 15. If the provider is terminated, the Credentialing Committee notifies the provider in writing of the decision within thirty (30) calendar days of the decision. 16. Provider Contracting gives the provider a ninety (90) calendar day termination notice with consideration of continuity of care (COC) needs (See Policy on Ongoing Course of Treatment) except in cases requiring immediate termination. Member Services to be notified for PCP re-assignment. 17. The letter to the provider or contract holder includes: • Reasons for the action, • Standards and/or the profiling data used to evaluate the provider if used, and • Appeal rights. 18. Clinical Care Management and Referral Management will be notified if the physician termination is due to failure to meet applicable quality standards or fraud for activation of the continuity of care process. 19. The Chair may seek legal advice any time during the corrective action period and/or termination process. After receipt of such advice, the Credentialing Committee will review and make final decision. 20. Providers who are terminated by the Credentialing Committee for reasons other than administrative termination or for not meeting minimal criteria **may not** reapply for a minimum of

Responsible Party (Who)	Step	Action Taken (Does What)
		seven (7) years across all HAP product lines and must show proof of corrected behavior.

Monitoring: The policy is monitored by credentialing data reports, the Credentialing Committee, Medical Director and Peer Review Committee.

Quality Review Monitoring:

Policy is reviewed annually for accuracy and quality

Policy Monitoring:

Provider Network Management's Regulatory Policy review (including standards and regulatory requirements and references) must include review of standards at least annually, or more frequently as new guidance becomes available

Reporting:

Name of Report	Frequency of Report	Owner
Terminated providers	Quarterly	Manager, Credentialing

ATTACHMENT(S):

Credentialing Committee, Credentialing Department Employees are responsible for reporting any observed violations of this policy to the Office of Compliance.

Approval Signatures

Step Description	Approver	Date
Compliance Final Review	Johnathan Randle: Dir-Gov't Programs Compliance	07/2022
Medical Director-HCM	Yvonne Sesi: Medical Director-HCM	07/2022
Compliance Initial Review	Irina Shikin: Compl Monitorng & Overst Audit	06/2022
Document Owner	Janet Krajnovic: Mgr-Credentialing	06/2022

Section 4: Provider Services

Communicating with providers

HAP Empowered communicates with its provider network via its website at **hap.org/empoweredproviders.** 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
- 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 **michigan.gov/medicaidproviders**. Select *Policy, Letters & Forms*. You'll find *The Medicaid Provider Manual* and *Michigan Medicaid Approved Policy Bulletins.*

Member advocacy

HAP Empowered 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 Empowered encourages providers to develop care plans with their patients or their patients' guardians or representatives.

Primary care physician—coordinator of care

The PCP is responsible for supervising, coordinating and providing primary care to HAP Empowered 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 Empowered. 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 Empowered 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 Empowered 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 covered services seven days a week, 24 hours per day.
- Be available to see patients a minimum of 20 hours per location per week.
- Give written prior notice to HAP Empowered 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

Pharmacy services are available 25 minutes/25 miles for non-rural and 30 minutes/30 miles for rural.

PCP request for member transfer

Sometimes, a HAP Empowered 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 Empowered provider or be removed from the plan. The transfer process is outlined below.

PCP process

1. Submit a written request to the HAP Empowered Medical Director to transfer or disenroll the member. The letter 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 Empowered to notify the member.

HAP Empowered 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 Empowered will send the appropriate notice to the member, PCP and the State of Michigan. 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 Provider Inquiry at **(866) 766-4661**.

Access to care standards for Medicaid and MI Health Link Plans

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

Appointment Time Access Standards

Appointment Lead Time For Primary Care

For HAP Empowered Medicaid and HAP Empowered MI Health Link Members

Type of Care	Standard
Routine care	Within 30 business days of request
Non-urgent symptomatic care	Within 7 business days of request
Urgent care	Within 48 hours
After-hours care	Physicians or their designee shall be available by telephone 24 hours per day, 7 days per week
Emergency Services	Immediately 24 hours/day, 7 days a week
Wait time in office: How long before member is seen by the provider after checking in with the receptionist	Less than 30 minutes

Appointment Lead Time For High-Volume and High-Impact Specialists Including Ob-Gyn and Oncology

For HAP Empowered Medicaid and HAP Empowered MI Health Link Members

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 Behavioral Health

The standards below are for all HAP Empowered members.

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

Appointment Lead Time for Dental

Note: Monitoring is conducted by Delta Dental.

For HAP Empowered Medicaid members

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

Monitoring

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

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

We also monitor member complaints regarding access issues that are reported to the HAP Appeals and Grievance Team and Customer Service.

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

Site visits

HAP's Provider Network Management (PNM) department conducts site visits at a practitioner/provider office/facility upon notification of every complaint from the Quality Management department or other department of a site deficiency in the office or location where care and services are provided. Site deficiencies include complaints about:

- Cleanliness
- Safety
- Accessible equipment
- Physical accessibility
- Physical appearance
- Adequacy of waiting and exam room space
- Adequacy of medical/treatment record keeping

Within 5 days of notification, PNM reviews the site, using its reviewer guidelines tool, to ensure compliance with all applicable facility and medical records standards (including Americans with Disabilities standards and requirements). Providers not passing the site audit will be placed on a corrective action plan (CAP). The CAP will identify the area for improvement along with the provider's action plan to complete it.

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 Michigan Department of Health and Human Services (MDHHS) Doula Registry and enrolled as a Medicaid provider.

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

1. Visit **hap.org/empoweredproviders**
2. Select *Doula* on the left navigation
3. Complete the *HAP Empowered Doula Enrollment Form*
4. Complete the *HAP Disclosure of Ownership and Control Interest Statement Form*
5. 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 Empowered. Here are the options:

  - **Electronic**
    Use Change Healthcare clearinghouse. HAP Payer ID: 38224

  - **Paper**
    Send to:
    HAP Empowered Claims
    P.O. Box 2578
    Detroit, MI 48202

- Use the pregnant or postpartum member's Medicaid 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	6 total visits	$75
Attendance at labor and delivery	T1033	HD	Z33.1	1 visit	$700

Section 6: Customer Service

The Customer Service department is the first point of contact. Customer Service representatives are trained to respond to all member and provider questions and concerns. Members should refer to their HAP Empowered member ID card. Providers can contact Provider Inquiry at:

(866) 766-4661
Monday through Friday, 8:30 a.m. to noon and 1 to 5 p.m.

PCP assignment

New members enrolled in a HAP Empowered plan via Michigan ENROLLS can select a HAP Empowered PCP at the time of plan selection or HAP Empowered 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 Empowered 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 Empowered 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 Empowered PCPs must be available, make the appropriate coverage available in their absence, for their assigned HAP Empowered members on a 24-hour per day, seven days per week basis, for urgent care and emergency care referrals.

Member request for PCP transfers

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

HAP Empowered 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 Empowered 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 Customer Service department receives complaints and grievances. The Appeals and Grievance department investigates, tracks and responds to all member complaints and grievances. A HAP Empowered 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 Peer Review Committee, Quality Improvement Committee and the Board of Directors. A semi-annual report is submitted to the MDHHS per contractual requirements.

Dental care

Dental care is an important part of your patient's overall health. Dental benefits for your HAP Empowered patients are outlined below. If your HAP Empowered patients have questions about their dental benefits, they can call the customer service number on the back of their HAP Empowered member ID card.

Dental care for pregnant women

Dental services are a covered benefit for pregnant women. The member has to report the pregnancy to an MDDHS caseworker.

Pregnant members will receive a Delta Dental benefit card. They can receive dental services during pregnancy through the last day of the third calendar month after the pregnancy due date.

Members can find a dentist by visiting **hap.org/Medicaid** and selecting *Find a Doctor* from the left navigation, then *Find a Dentist*. They can also call HAP Empowered Customer Service at **(888) 654-2200 (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 users call 711).

- Monday-Friday from 8 a.m. to 8 p.m. (member)
- 8:30 a.m. to 8 p.m. (provider) **866-558-0280** (TTY users call 711) for information and billing help. Automated system is available 24/7.

Covered services include:

• Oral exams (1 in 6 months) • Assessment (1 in 6 months) • X-rays – Bitewing X-rays (1 in 12 months) – Full mouth or panoramic X-rays (1 in 5 years) • Teeth cleaning (1 in 6 months) • Fillings • Sedative filling • Extractions, simple and surgical • Limited other oral surgery	• Emergency treatment of dental pain • IV sedation (when medically necessary) • Complete denture (1 in 5 years) • Partial denture (1 in 5 years) • Denture adjustments and repairs • Denture rebase and reline (1 time in 2 years) • Re-cement crowns and bridges

Dental Care for Children

The State of Michigan's Medicaid program covers dental care for children. 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 Dental deltadentalmi.com/healthy-kids-dental (866) 696-7441

Dental care for Healthy Michigan Plan

The Healthy Michigan Plan covers dental care. This includes dental exams, cleanings and extractions (tooth removal):

• Oral exams (1 in 6 months) • Assessment (1 in 6 months) • X-rays – Bitewing X-rays (1 in 12 months) – Full mouth or panoramic X-rays (1 in 5 years) • Teeth cleaning (1 in 6 months) • Fillings • Sedative filling • Extractions, simple and surgical • Limited other oral surgery	• Emergency treatment of dental pain • IV sedation (when medically necessary) • Complete denture (1 in 5 years) • Partial denture (1 in 5 years) • Denture adjustments and repairs • Denture rebase and reline (1 time in 2 years) • Re-cement crowns and bridges

Members can contact Healthy Michigan Plan customer service for additional questions or billing help Monday-Friday from 8 a.m. to 8 p.m. (member); 8:30 a.m. to 8 p.m. (provider). They can be reached at (**866) 558-0280** (TTY users call 711). Automated system is available 24/7.

Language interpretation and services

HAP Empowered 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 customer service number on the back of their HAP Empowered member ID card. Providers can call Provider Inquiry at **(866) 766-4661**.

HAP Empowered Medicaid 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 Empowered

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
  - Parenting and birthing classes
  - Prenatal care
  - Newborn child 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 month supply for most drugs on the formulary list, a three-month supply for certain maintenance medications (drugs members take every day) and a 12-month supply for oral contraceptives, patches and vaginal rings.
- 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 drug 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)

Services Covered by mihealth
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)
- 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 Empowered 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. Here are the links:
HAP Empowered Medicaid Member Handbook
HAP Empowered MI Health Link Member Handbook

Member's rights and responsibilities – HAP Empowered Medicaid members

Below are the member's rights and responsibilities which are found in the member's handbook.

HAP Empowered members have many rights and responsibilities. These are important to ensure you get quality care. Our staff and providers follow these rights.
You have a right to information:

- Get information about HAP Empowered services and providers
- Get information about practitioners' rights and responsibilities
- Ask for advice from another doctor when you are unsure of the care your doctor suggests
- Ask for a copy of your medical records, including changes or corrections
- Get information about HAP Empowered operations
- Get a second medical opinion from an in-network Provider
- Get a second medical opinion from an out-of-network provider if someone in-network is not available. The plan will arrange for an out-of-network provider. Plan approval is required.
- Request information regarding doctor incentive arrangements, including financial and other types of incentives and whether stop-loss coverage is provided
- Request information on the structure and operation of the HAP Empowered Medicaid Health Plan

You have a right to fair treatment:

- Privacy and confidentiality
- Be treated with respect and dignity
- Get care that meets your health needs
- Work with doctors to make decisions about your health care
- Choose or change your PCP
- Talk about proper or medically necessary treatment for your conditions, regardless of cost or benefit coverage
- Decide what type of care you would like, if critically ill Get medical care through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)
- Help make decisions about your health care, like asking about treatment options or refusing care

You have a right to customer service:

- Get timely Customer Service
- Voice complaints or appeals about HAP Empowered or our care
- Contact Customer Service to file a grievance or appeal
- Ask for an administrative fair hearing with the Michigan Department of Health and Human Services (MDHHS)
- Make suggestions about our services and providers
- Make suggestions about member rights and responsibilities policy
- Be free of restraint or seclusion used to pressure, punish, convenience or retaliate

You have a responsibility to care for yourself:

- Take good care of your health
- Talk to your doctors about regular checkups and screenings
- Understand your health problems
- Understand your medications and why you are taking them
- Participate in your care and ask questions

You have a responsibility to help your doctors:

- Give your medical information to your doctors
- Work with your doctor to develop a care plan you both agree on
- Follow health plans and advice you and your doctor agreed to
- Go to appointments and arrive on time. If you cannot keep your appointment, call your doctor to reschedule.
- Know what to do when your PCP's office is closed

You have a responsibility to follow HAP Empowered guidelines:

- Notify us of life changes. If you have a baby or your family size changes, call your DHS caseworker and let them know. Call HAP Empowered and let us know, too.
- Read your handbook and learn how HAP Empowered works
- Follow HAP Empowered policies for getting health care services
- Choose a PCP
- Show your HAP Empowered and mihealth cards when you need care
- Treat other members, staff and providers with respect
- Make sure no one else uses your HAP Empowered and mihealth cards
- Report suspected fraud and abuse
- Notify us of address or phone number changes. If you move or change your phone number, call us at (888) 654-2200 (TTY: 711). You must also call your caseworker at MDHHS or MI Bridges office.

See the HAP Empowered Medicaid Handbook for details.

Member rights and responsibilities - HAP Empowered MI Health Link members

- Your right to get information in a way that meets your needs
- Our responsibility to treat you with respect, fairness and dignity at all times
- Our responsibility to ensure that you get timely access to covered services and drugs
- Our responsibility to protect your personal health information (PHI)
- How we protect your PHI
- You have a right to see your medical records
- Our responsibility to give you information about the plan, its network providers and your covered services
- Inability of network providers to bill you directly
- Your right to leave the plan

- Your right to make decisions about your health care
  - Your right to know your treatment options and make decisions about your health care
  - Your right to say what you want to happen if you are unable to make health care decisions for yourself
- What to do if your instructions are not followed
- Your right to make complaints and to ask us to reconsider decisions we have made
  - What to do if you believe you are being treated unfairly or your rights are not being respected
- Your responsibilities as a member of the plan
- Information about our quality program

See the HAP Empowered MI Health Link Member Handbook for details.

Transportation

We offer transportation for members to go to medical and dental appointments, the pharmacy or to pick up supplies. We also offer emergency transportation.

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 Customer Service at (888) 654-2200 (TTY: 711)
- HAP Empowered will cover emergency transportation and hospital-billed ambulance services to and from a nursing facility or member's home

Routine (Non-Emergency) Transportation

We give members a ride to the doctor, dentist, or pharmacy if they do not have a way to get there. They're advised to call HAP Empowered Customer Services three business days before the appointment, The number is on the back of their HAP Empowered member ID card.

We provide rides by bus, car, van, or wheelchair van. If they drive themselves, or a family member or guardian drives them, we will reimburse them for mileage or cab services. Family members, guardians, and taxi cab drivers are subject to background checks and sanction screenings prior to reimbursement.

They are reminded to:

- Let us know if they need a wheelchair van or car seat
- Let us know if anyone, such as a caregiver or child, will be going with them
- Have picture ID or their child's HAP Empowered ID card on hand to show the driver
- Be ready one hour before your appointment time

Section 7: Member Eligibility and Enrollment

The Michigan Department of Health and Human Services 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 calendar days from receipt of enrollment data from MDHHS or CMS. The ID card is sent separately by first class mail. The welcome packet is sent by standard mail.

ID Cards

<table>
<tr><td colspan="2">HAP Empowered Medicaid members carry two ID cards:</td></tr>
<tr><td>

- Michigan Medicaid ID Card
This card identifies the member is enrolled in Michigan Medicaid.

- HAP Empowered Medicaid ID Card
This card is for members enrolled in HAP Empowered Medicaid, HAP Empowered Children's Special Health Care Services, and HAP Empowered Health Michigan Plan.

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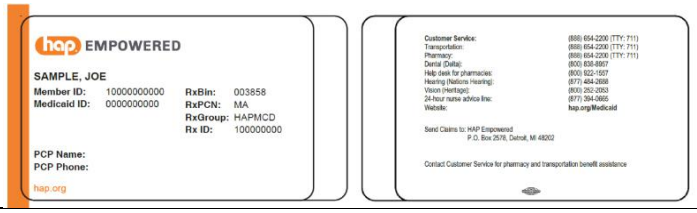


</td></tr>
<tr><td colspan="2">HAP Empowered MI Health Link members:</td></tr>
<tr><td>Carry one ID card</td><td>

</td></tr>
</table>

Note:

- Possession of a HAP Empowered 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 Empowered Compliance Hotline at **(877) 746-2501 (TTY: 711)**. The number is available 24/7.

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 Empowered will not be covered. Providers can verify eligibility by one of the methods below.

HAP provider portal	• Log in at **hap.org**; select *Member Eligibility* (Note: PCPs can get a list of their assigned members by selecting *Click Here to View Member Roster*. The list is updated monthly). • Call **(866) 766-4661**
CHAMPS	Web portal Provider support: **(800) 292-2550, option 5, then 2**

Disenrollment from a plan

HAP Empowered Medicaid

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 Empowered may initiate special disenrollment requests to the MDHHS if the member exhibits any of the following:
  - Violent or threatening behavior involving physical acts of violence
  - Making physical or verbal threats of violence against contracted providers, staff, or the public at HAP Empowered locations
  - Stalking

HAP Empowered MI Health Link

HAP Empowered may never, verbally, in writing or by any other action or inaction, request or encourage a HAP Empowered MI Health Link member to disenroll except when the member:

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

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

Section 8: HAP Medicare Complete Duals (HMO D-SNP) and HAP Empowered MI Health Link Medicare-Medicaid Plan Comparison Guide and Frequently Asked Questions

The following information is specific to the 2023 HAP Medicare Complete Duals (HMO D-SNP) and HAP Empowered MI Health Link plans.

Important!

- D-SNP is a Medicare Advantage plan. The PCP is not required to become a Medicaid participating provider. The member can't be held responsible for the remaining balance that Medicaid would cover. Providers contracted with HAP Medicare plans and open to new patients are required to see our D-SNP members.
- When a HAP Medicare provider sees a D-SNP member, they may not be the HAP Empowered Medicaid PCP on record. The provider only needs to be listed as the HAP Medicare PCP. See Provider Network section in this document for details.
- All MI Health Link PCP's must participate with both Medicare and Medicaid.

General

1. What are these plans?

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
• A dual special needs plan, or D-SNP, is a special type of Medicare Advantage HMO plan that provides health benefits to members who qualify for Medicare and are eligible for Medicaid services in their state. • These members often have special health care needs such as chronic conditions. Most members have an income below the federal poverty line and receive extra help from the government to help pay for their health care costs, including health insurance premiums and prescription drugs. • These members are often transient, meaning they do not have a permanent residence and may stay with family members who can help care for them. Some may live in an institutionalized care facility.	• HAP Empowered MI Health Link is a Medicare-Medicaid Program that combines Medicare and Medicaid benefits, rules and payments into **one coordinated and integrated delivery system**. • The MI Health Link program is a partnership between 3 entities: 1) The Michigan Department of Health and Human Services (MDHHS) 2) The Centers for Medicare & Medicaid Services (CMS) 3) The Integrated Care Organizations (ICOs). Currently, there are 7 ICOs, also known as MI Health Link Plans. In addition to HAP Empowered, they include: Aetna, AmeriHealth, MeridianComplete, Molina Healthcare and Upper Peninsula Health Plan • A 3-way contract between CMS, MDHHS and ICO • The goal is to help dual-eligible beneficiaries live in the setting of their choice for as long as possible by **coordinating** their medical care, coverage and community support services.

Service Area

1. What is the service area?

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
Members must reside in a county where a D-SNP plan is offered by their health plan to be eligible. HAP offers a D-SNP plan in Genesee, Macomb, Oakland and Wayne counties.	Members must reside in a county where a MI Health Link plan is offered by their health plan to be eligible. We offer MI Health Link in Macomb and Wayne counties.

Provider Network

1. What is the provider network?

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
If a provider is contracted for HAP Medicare HMO products, then the provider is participating in our D-SNP network. Members may only see providers in our D-SNP network.	The MI Health Link provider network is comprised of providers who have signed an agreement to participate with the MI Health Link program.

2. Are members required to have a primary care physician?

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
Members must select a PCP to coordinate their care for Medicare services. HAP Empowered will auto-assign a PCP if one is not selected.	Yes, all MI Health Link members must select a PCP. HAP Empowered will auto-assign a PCP if one is not selected.

3. What if the member's PCP is not a Medicaid participating provider?

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
D-SNP is a Medicare Advantage plan. The PCP is not required to become a Medicaid participating provider. Note: The member can't be held responsible for the remaining balance that Medicaid would cover.	All MI Health Link PCP's must participate with both Medicare and Medicaid.
Important! • **Providers contracted with HAP Medicare plans and open to new patients are required to see our D-SNP members.** • MI Health Link providers can see D-SNP members if they participate with the HAP Medicare Advantage D-SNP program. While D-SNP and the MI Health Link program are exclusive of each other, providers can see members within each program if they participate.	

Member Eligibility

1. What are the eligibility requirements to join the plan?

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link

• Must be eligible for Medicare; entitled to Part A and enrolled in Part B; 65 and older or under 65 with certain disabilities, or special needs
• Must be eligible for full Medicaid benefits
  – Note: Members can enroll in the HAP Empowered Medicaid plan or enroll in another carrier's Medicaid plan or have a fee-for-service Medicaid plan with the State
 	
We accept members with these Dual designations:
• FBDE: Full Benefit Dual Eligibles
• SLMB Plus: Specified Low-Income Beneficiaries
• QMB Plus: Qualified Medicare Beneficiary
• Members must reside in 4 county service area: Genesee, Wayne, Oakland or Macomb
	• For Michigan adults, ages 21 or over
	• Who are enrolled in both Medicare and Medicaid
	• Must not be enrolled in hospice
	• People with Medicaid deductibles are not eligible
	• Nursing home residents are eligible, but must continue to pay patient deductible (if applicable)
	• Medigap policy holders are eligible if other eligibility criteria is met
	• Must disenroll from other products to become eligible
	• For HAP Empowered, must reside in:
	  – Region 7- Macomb County
	  – Region 9- Wayne County

2. **When can a member enroll?**

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
D-SNP members have a Special Enrollment Period (SEP) which allow them to enroll, disenroll or switch plans. This is a period of time that may occur due to a qualifying life event at any time of the year. For the full list of qualifying events, you can contact the plan, call Medicare, or visit the Medicare website.	• State can passively enroll eligible members • Sales/Broker model is not available for this plan • Auto assignment and self-selection are key enrollment methods • If eligible for MI Health Link, the state can disenroll a D-SNP member and enroll into MI Health Link – If this occurs, the member would be enrolled into MI Health Link from the same organization (if available) – Member can select another plan, if they choose

3. **What if a member loses eligibility?**

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
If a member loses their Medicaid eligibility, our plan will continue to cover Medicare benefits for a grace period of up to 90 days. This grace period begins the first day of the month after we learn of the loss of eligibility. If, at the end of the 90-day grace period, Medicaid eligibility has not been regained and the member has not enrolled in a different plan, we will disenroll the member from our plan. They will be enrolled back in Original Medicare. We may also contact the member to help them enroll in a HAP Medicare Advantage Prescription Drug Plan with affordable cost shares and premiums.	The member will receive notification from MDHHS regarding their eligibility status. • If it's under review, all services will continue to be covered (Deeming Status) until a determination has been made. • If the member is no longer eligible, the member will receive a letter from MDHHS and be enrolled back into Medicare.

4. **Do D-SNP members have to enroll in HAP Empowered Medicaid?**

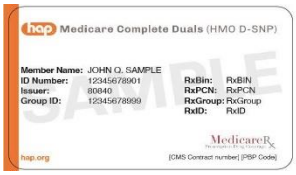
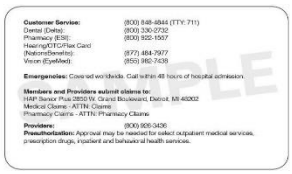
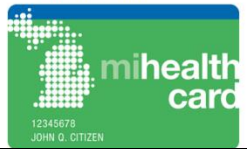
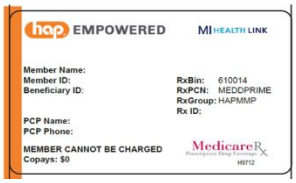
HAP Medicare Complete Duals (HMO D-SNP)
HAP Medicare Complete Duals (HMO D-SNP) members are not required to enroll in HAP Empowered Medicaid. If members also chose HAP Empowered for their Medicaid plan, HAP will coordinate benefits for both plans, and members will receive 2 HAP Empowered ID cards, 1 for each plan.

5. **Do HAP Empowered MI Health Link members have to enroll in Medicare Advantage and HAP Empowered Medicaid?**

HAP Empowered MI Health Link
The program joins Medicare and Medicaid benefits into ONE coordinated and integrated delivery system. MI Health Link is inclusive of Standard Medicare and Medicaid and is not a Medicare Advantage health plan like D-SNP. HAP Empowered MI Health Link members have Standard Medicare and Medicaid.

ID Cards

1. What do ID cards look like?

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
Members carry the HAP Medicare Complete Duals (HMO D-SNP) ID card below. They also have a state-issued Medicaid ID card. They should show both cards each time they visit their doctor or facility.   The mihealth card  	Members will have one card for MI Health link that covers both Medicare and Medicaid. This also including long term supports, services and prescriptions. They must show this card when they get any services or prescriptions.  

Member Benefits

1. What services and benefits are covered?

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link

• All benefits covered under Original Medicare.
• Supplemental benefits vary by plan and can include:
  – Dental
  – Non-emergency transportation
  – Meal programs
  – Over-the-counter (OTC) products
  – Hearing aids
  – Eyewear
  – Emergency response system for eligible members to maintain independence and safety
  – Up to 8 hours of companion care for eligible members
  – Flex Card for Food and Home Safety Modifications
  – Extra help for diabetics
• Members may only see providers in the HAP D-SNP network. No out-of-network benefits exist for this plan except for emergencies, and urgently needed services when the network is not available, and cases in which HAP authorizes use of out-of-network providers.
	• All covered benefits under Medicare
	• All covered benefits under Medicaid
	• $0 cost share
	• No deductible or copayment for in-network doctors or pharmacies
	• No cost prescription drug benefits
	• $75 each quarter for over-the-counter items
	• Nurse line to help you with their health services
	• No cost dental services
	• No cost service upgrade to your SafeLink cell phone
	• No cost non-emergent transportation to and from doctor appointments
	• Personal emergency response system
	• No cost vision benefits
	• No cost home delivered meals post inpatient discharge from a hospital or skilled nursing facility
	• No cost hearing aid(s) and batteries

Billing and Claims

1. Can a provider balance bill a member?

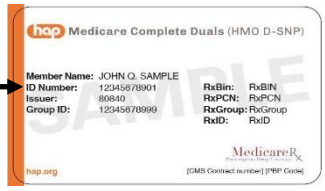
HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
Providers may not balance bill D-SNP members who do not have cost share responsibility (including Qualified Medicare Beneficiary only members). Members who lost their Medicaid eligibility may have a cost share. (D-SNP is a Medicare Advantage plan. The PCP is not required to become a Medicaid participating provider. The member can't be held responsible for the remaining balance that Medicaid would cover).	No. MI Health Link providers cannot balance bill members for services delivered per CMS guidelines. Providers should bill HAP Empowered. Submit a claim to Medicare first and Medicaid as the last resort.

2. **Should a provider bill Medicare or Medicaid first?**

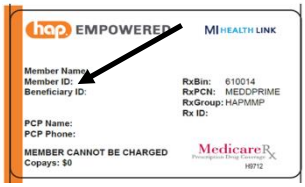
HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
Providers should bill Medicare first. Federal rules dictate that Medicaid is the payer of last resort. For both plans, when Providers receive their HAP Empowered remittance advice, they may bill Medicaid for any remaining balance. Actual payment level depends on the state payment policies. Providers may be required to be enrolled in the state Medicaid program to bill the state Medicaid agency for eligible services. HAP does not coordinate the secondary payment. **Members should never be balanced billed.**	

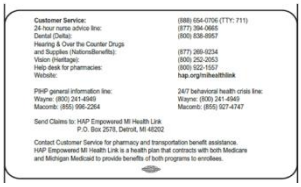
3. **What member ID number should a provider use to submit electronic claims?**

Use the *ID Number* on their HAP Medicare Complete Duals (HMO D-SNP) ID card.



Use the *Member ID* number on their HAP Empowered MI Health Link ID card.





Provider Requirements

1. **Do providers need additional training to see members?**

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
CMS requires D-SNP plans to: • Have an approved Model of Care (MOC) • Conducts initial and annual MOC training for network providers and out-of-network providers seen by beneficiaries on a routine basis • Information on our model of care training can be found here	No additional training is needed. All providers have access to the HAP Empowered Provider Manual.

2. **What information are providers required to submit?**

To support Healthcare Effectiveness Data and Information Set (HEDIS) initiatives, be sure to submit encounter data for the Care for Older Adults (COA) measure. Requirements include Advanced Care Planning (CPTII: 1157F, 1158F); Functional Status Assessment (CPTII: 1170F); Medication Review (CPTII: 1159F and 1160F must both be submitted on the same claim, same day); Pain Screening (CPTII: 1125F, 1126F)

Case Management

1. **Do members receive case management services?**

HAP Medicare Complete Duals (HMO D-SNP)	HAP Empowered MI Health Link
Members enrolled in a D-SNP plan have an Interdisciplinary Care Team (ICT), which includes physicians and care coordinators that work together to help each member receive the most appropriate, highest quality of care. Each member has an Individualized Care Plan (ICP) based on the results of their comprehensive Health Risk Assessment (HRA). The HRA must be performed by a nurse or care coordinator within 90 days of enrolling in a D-SNP and every 365 days thereafter. HAP Medicare Complete Duals (HMO D-SNP) does not include the waiver program assistance which provides home modifications, chore services, adult day care, respite, etc.	The MI Health Link Model is also based on an Integrated Care Team (ICT) which can include the enrollee and/or their representative, Primary Care Physician, Care Coordinator, support services coordinator and others. Medicare behavioral health is handled using Pre-paid Inpatient Health Plans (PIHP). Care coordinators work directly with the member to assist with all aspects of care delivery. This includes initial assessment with member, assistance with scheduling appointments and transportation to get to appointments and coordinating any other support services the member may need. Some members may be eligible for the waiver program assistance which provides home modifications, chore services, adult day care, respite, etc.

Contacts and Resources

Contact Information	
Claims and Reimbursement	
• Claims status and appeals • EFT form	• Call HAP Empowered at **(866) 766-4661** • Log in at **hap.org** and select *Claims*
Fee schedules	• Visit Michigan.gov/mdhhs and search for *Provider Specific Information* • Call HAP Empowered at **(866) 766-4661**
EDI setup	Contact your clearing house and give them our payer ID 38224
Eligibility and Benefits	
Eligibility, benefits copay and deductible information	• Log in at **hap.org** and select *Member Eligibility* • Call HAP Empowered at **(866) 766-4661** • CHAMPS: Visit **milogintp.michigan.gov** Call **(800) 292-2550**, option 5, then 2
Prior Authorizations	
Prior authorization requirements	Log in at **hap.org**; select *Procedure Reference List* under *Quick Links*
Submitting authorization requests and checking status	Log in at **hap.org** and select *Authorizations*
Online Applications	
Access online applications	Visit **hap.org**; select *Log In*, *Register now*, *Provider*
Portal access issues	**Forgot username or password:** Visit **hap.org**; select *Log in*; *Provider*; *Forgot username*; *Forgot password?* Still need help? Email providernetwork@hap.org and include all the information below. • Type 1 and Type 2 NPI • Tax ID • Provider name • Full contact information (address, phone, email)
Changes to existing provider information	
• Billing and office address changes • Tax ID changes • Terminations from HAP • Changes to patient accepting status • Provider type or specialty changes or additions • Transferring networks	Complete the *Provider Change* form. You can find it in two places when you visit **hap.org**: • *I'm a Provider*; *Provider resources*; *Forms and other information* • *Contact; Provider; Demographic changes, training & education; contracting & credentialing* 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 form directly to HAP. All changes must be submitted from your PO/PHO organization
General	
• Contract questions • Credentialing status • Demographic changes • Provider office training • W-9 changes	Email providernetwork@hap.org and include: • Type 1 and Type 2 NPI • Tax ID
Your Network Partners	
For a list of Provider Services Administrators by network: • Log in at **hap.org**; select *Quick Links*, then *Important Contact Information for Providers*	

Section 9: Referrals and Authorizations

HAP Empowered 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. Referrals and 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 at **hap.org**. To refer a member to an out-of-network provider, call our Referral Management department at **(313) 664-8950.**

Non-contracted providers should call our Referral Management department at **(313) 664-8950** for authorization requests.

Submitting a prior authorization request

The member's PCP or the servicing provider (e.g. DME provider, specialist) obtains the prior authorization online by logging in at **hap.org** and selecting *Authorizations*.

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
- Unnecessary delays or cancellations of procedures

Requests for the services below should not be submitted online. Instead, fax the request to **(313) 664-5820**. You can also call **(313) 664-8800.** You can inquire about a request currently being processed for placement or ask questions about the precertification process.

- Inpatient rehabilitation at hospitals
- Long-term care at hospitals
- Skilled nursing facilities
- Subacute rehabilitation

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
- 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 the patient's:

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

Authorization decisions are sent as follows:

- Approvals: We send a letter to the member. We notify providers by fax, phone or through our online application, CareAffiliate.
- Denials: We send letter to member and requesting provider.

Copies are retained in the member's medical record.

Peer to Peer Review

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. **(313) 664-8833**, option 3; Monday through Friday, 8 a.m. to 5 p.m.
Outpatient denials	Physician or a physician representative can call us at the number below to initiate a same day peer to peer review. **(313) 664-8950**, option 2; Monday through Friday, 8 a.m. to 5 p.m.

Prior authorization decision timeframes

Request type	Timeframe
Non-urgent pre-service	A decision will be provided as quickly as the clinical condition warrants, not to exceed 14 calendar days for HAP Empowered Medicaid and HAP Empowered MI Health Link 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; 14 calendar days for HAP Empowered MI Health Link members.

Prior authorization requests

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

- Anesthesia for oral surgery
- Bariatric procedures
- Breast reconstruction
- Breast reduction
- Chemotherapy
- Chiropractic services
- Cosmetic surgery (e.g., scar revision)
- Durable medical equipment
- Genetic testing
- In-office infusion therapy (specific medications)
- Nursing home care (non-custodial)
- Prosthetics and orthotics
- Services with a non-contracted provider
- Speech therapy
- Transplant services

For a complete list of services that require authorization, log in at hap.org and select *Procedure Reference Lists* under *Quick Links*.

The following in-network services do **not** require plan notification:

- Allergy testing
- Obstetrics and gynecology
- Outpatient specialty physician consults and services
- Outpatient diagnostics
- Outpatient mental health visits
- Routine radiology services

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 Empowered:

- 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 Empowered members have a skilled nursing benefit as follows:

Membership	Number of days allowed
HAP Empowered Medicaid	45 days (Note: If additional time is needed, the member would be disenrolled to state run Fee for Service Medicaid. The HAP Empowered Health Services department will assist with this process).
HAP Empowered MI Health Link	100 days
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. • Custodial care is not a covered benefit except for HAP Empowered MI Health Link members.	

Second opinions

HAP Empowered 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

Vision services include eye examination (refraction), lenses and frames. Members in HAP Empowered plans can access vision services directly by contacting Heritage Optical at **(800) 252-2053**. Contracted vision providers are in our online provider directory at **hap.org**.

Behavioral health care

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

HAP Empowered Medicaid 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 Empowered Medicaid does not cover substance abuse services. Members should be referred to the Prepaid Inpatient Health Plan (PIHP) in the county where they live.

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

Case management

The HAP Empowered 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.

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 Empowered, contracted ancillary providers, physicians, hospitals and the member, to ensure timely, effective and medically realistic goals. The program is structured to ensure qualified individuals make medical decisions using nationally recognized criteria and without undue influence of HAP Empowered's fiscal operation.

To initiate an evaluation for case management services, contact the Care Management Department at **(800) 288-2902**.

Elective hospital admissions

Authorization is not required prior to the member's admission to the hospital. **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.org** 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 clinical criteria
- InterQual criteria
- InterQual surgical list

Emergent hospital admissions

- Prior authorization is not required for emergency admissions.
- Providers are not required to call HAP 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.org** 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 clinical criteria
  - InterQual criteria
  - InterQual surgical list

Providers can find approval status online by logging in at **hap.org** and selecting *Authorizations*.

Laboratory services and genetic testing

We provide coverage for laboratory services. Prior authorization is required for genetic testing.

Section 10: Hospital Notification and Review

Below is our policy on specific guidelines surrounding hospital facility notification for members who require hospitalization. This policy pertains to all HAP affiliates, subsidiaries and product lines:

- Health Alliance Plan of Michigan – MA, MAPD
- Alliance Health and Life Insurance Company – MA, MAPD
- HAP Empowered Health Plan, Inc. – Medicaid HMO, MI Health Link

Note: Verbiage not related to HAP Empowered Medicaid and MI Health Link was removed from this section.

Urgent/Emergency Care and Inpatient Admissions

- HAP 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.
- For MI Health Link and Medicaid members, HAP 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 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 ten (10) calendar days of presentation for emergency services. HAP requests notification of emergency inpatient admissions for purposes of care coordination.
  - Post-stabilization care services. After services for Emergency Medical Conditions and urgently needed care, HAP is financially responsible for post-stabilization care services provided by a contracted or non-contracted provider that were pre-approved by HAP; or were not pre-approved by HAP, either because HAP did not respond to a request for pre-approval within 1 hour after being notified or because HAP could not be contacted for pre-approval. HAP remains responsible until the member is discharged from the hospital or is transferred to a contracted facility.
  - HAP is financially responsible for post-stabilization care services that were not pre-approved until:
    - A HAP physician with privileges at the treating hospital assumes responsibility for the member's treatment;
    - A HAP 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.
- For MI Health Link and Medicaid Members: 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 1 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 within 24 hours or the next business day following the elective admission. HAP 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 will accept pre-certification 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 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 provider portal, CareAffiliate, 24 hours per day, seven days per week. The Admission and Transfer team is available to accept standard/concurrent cases Monday through Friday 8 a.m-5 p.m. EST. The Admission and Transfer team will accept an urgent/emergency request for authorization 24 hours a day/7 days a week via phone. The nurse on call can render a determination within one hour of the request if appropriate.
- Pre-service: The HAP Admission department accepts notification of a member's admission by the admitting facility or by the member or members' representative via a telephone call prior to the member being discharged.
- Post-service: The HAP Admission department accepts notification of a member's admission by the admitting facility or by the member or member's representative via telephone call or through receipt of a claim the HAP Claims department.

Once HAP is notified:

- **If HAP is notified prior to the admission**: Once the emergency has been treated and stabilized, HAP will determine whether the admission is appropriate using the standardized clinical criteria.
- If the hospital is non-contracted or out of network, HAP will assess for the appropriateness of a transfer to a contracted or in-network facility.
- **If HAP is notified after the admission, either while the member is still inpatient or after discharge:**
  - Contracted and non-contracted – MI Health Link and Medicaid, HAP 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 Medical Director.

Discharges

- All members who are admitted to an acute care facility (hospital or LTACH) must receive an important message from Medicare about your rights (IM) that is delivered to them by the hospital within two calendar days following a hospital admission. Refer to Hospital Termination of Medicare Services policy for details regarding the requirements and the role of the health plan.
- HAP may deny full or partial coverage for an inpatient admission for the following reasons:
  - Elective admissions, that fall outside the open network model, without a referral to an out of network or out of plan provider (applies to Medicare Advantage HMO members only)
  - Elective admissions without a referral to an out of plan provider.
  - Refusal to transfer
  - Inactive contract
  - Service is not a covered benefit (i.e., dental services)
  - Late notification by a contracted facility (member held harmless)
  - Refusal to leave (medically appropriate for discharge from the inpatient setting)
  - Medically inappropriate - per Interqual criteria and HAP inpatient admission criteria or Medical Director decision

Procedure

Responsible Party (Who)	Step	Action Taken (Does What)
Admission & Transfer Team	A	Receives inquiry regarding requirement for notification and/or pre-approval of emergency medical treatment provided in the ER or other outpatient setting. Informs provider, member or member's authorized representative that notification and pre-approval are not required.
	B	Receives authorization request for a HAP member inpatient emergency admission. Follows guidelines in above policy based on the member's line of business for notification.
	C	Reviews against medical criteria. If request for admission meets inpatient criteria and notification occurs within required timeframes for line of business, approves admission. If case meets inpatient criteria but is not in required timeframes based on line of business, issues administrative denial for late notification.
	D	If case does not meet medical criteria, refers to Medical Director for review.
Medical Director	E	Referencing InterQual criteria and HAP inpatient admission criteria, reviews request that does not meet criteria and assesses the member's history, current medical, behavioral health, and social needs, in combination with medical judgment and considering individual facts of the case, prior to rendering a final approval or denial decision for the inpatient admission.
Admission & Transfer Team	F	Communicates decision to facility/provider verbally and in writing, including notification of opportunity to discuss UM denial decision with a physician reviewer or submit a provider appeal.

Quality Review Monitoring

- Admission Team supervisor reviews ten cases per Admission Team staff member per month for timeliness, appropriate application of criteria, and verbal/written notification. If any deficiencies are noted, staff receives one-on-one coaching and training.
- All member and provider requests for admission are screened for appropriateness and referred to the HAP Medical Director for review.

Definitions

Term/Acronym	Definition
Inpatient	An inpatient is a person who has been formally admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.
Outpatient	When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 48), regardless of the hour they came to the hospital, whether they used a bed and whether they remained in the hospital past midnight.
Medical Necessity	During review of inpatient admissions, medical necessity will be determined based on the medical evidence which was available to the physician at the time of the admission. Does not take into account other information (test results, etc.), which becomes available after the admission.
Services as a result of non-covered inpatient stay	After a member has been discharged from the hospital stay in which they received care for non-covered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior non-covered services may be covered when they are reasonable and necessary in all other respects.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.
Post-Stabilization Care Services	Covered Services related to an Emergency Medical Condition that are provided after the Enrollee's Emergency Medical Condition has been Stabilized to maintain the Stabilized condition and/or under the circumstances described in 42 C.F.R. § 438.114(e)
Prudent Layperson	Person who is without medical training and who draws on practical experience to decide if there is a need to seek emergency medical treatment.

Section 11: 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 **(866) 766-4661.**

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 Jan. 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/medicaidproviders**.

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.

HAP provider portal	• Log in at **hap.org** and select *Member Eligibility* (for dates of service July 1, 2019, forward). • PCPs can obtain a list of assigned members by logging in at **hap.org** and selecting *Member Eligibility*, then *Click Here to View Member Roster*. The list is updated monthly.
HAP Empowered	Call **(866) 766-4661**
CHAMPS online	**Web portal**
CHAMPS Provider Support	**(800) 292-2550, option 5, then 2**

Members in HAP Empowered plans are entitled to all covered services provided by traditional Medicare and Medicaid Managed Care.

EFT registration

- If you're currently set up for EFT with HAP, there is nothing you need to do.
- If you aren't set up for EFT with HAP, please complete an EFT form. Log in at **hap.org**; select *Resources, Working with HAP; Billing Information; Sign Up for Electronic Billing.*

Filing limitations

Type of claim	Filing timeframe
Encounters for capitated services	Submit within 30 days from the date of service
Initial claim for non-capitated services	Submit within 180 days from the date of service
COB claims where other carrier is primary when primary carrier was billed within their filing limits and the carrier's EOP identifies payment or denial of the claim	Submit within 60 days from the notification date of the other carrier EOP. Be sure to attach other carrier's EOP to your claims when submitting to HAP Empowered.
Rejected claims	Resolved within one year from the date of service
Claims appeals	Must be filed within 60 days from the original denial date
Claim complaints or disputes	Must be filed within 60 days from the date of the original remittance advice

Ensure claims for your HAP Empowered patients get paid

Effective December 1, 2020, all HAP Empowered claims, regardless of date of service, must be submitted to HAP Empowered as follows:

- **Electronic**
  - Use Change Healthcare clearinghouse. HAP Payer ID: 38224
- **Paper**
  - Send to:
    HAP Empowered Claims
    P.O. Box 2578
    Detroit, MI 48202

Claims with date of service older than one year must be submitted via paper to the address above.

Out-of-network providers

Out-of-network providers must follow the HAP Empowered referral requirement and claims submission processes. If you have any questions, please contact **(866) 766-4661.**

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, log in at hap.org and select *Procedure Reference Lists* under *Quick Links*.

Payment procedure

- All paper claims and encounters are date stamped on the day received.
- Claims and encounters are processed within 30 days of receipt.
- Payment for all non-capitated, authorized, medically necessary services are paid at current Medicare or Medicaid fee schedules. Note: Contracted rates supersede this statement.
- Providers may not balance bill HAP Empowered Medicaid members or dual eligible members with HAP Empowered MI Health Link for unauthorized services if the enrollee had no prior knowledge of liability for the service.

Clean claims

- HAP Empowered pays clean claims within 30 days.
- If any mandatory or conditional information is missing, the claim is considered unclean. Examples of unclean claims: invalid member ID, provider data discrepancy, NPI and tax ID do not match.
- Unclean claims will be returned or rejected within 60 days for HAP Empowered MI Health Link and 30 days for HAP Empowered Medicaid.

Returned claims

- Paper claims are returned when they can't be entered due to invalid information such as the billing provider not being in system, or the member not being enrolled in a HAP Empowered 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.
- Be sure to review your EDI 277 Health Care Claim status response transactions report for claims RTP (returned to Provider) for correction and resubmission within the timely filing requirements. Resubmission of rejected claims requires a new claim submission claim frequency of (1) original.

Overpayments

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

HAP Empowered
P.O. Box 2578
Detroit, MI 48202
Attention: Claims Department

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

Checking claims status

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

- Log in at **hap.org** and select *Claims*.
  (Note: There's a link to view HAP Empowered historical information**).**
- Log in at **hap.org** and select *Remittance Advice.*
  (Note: There is a link to view HAP Empowered claims historical information**).**
- Call HAP Empowered at **(866) 766-4661**

Claim editing guidelines for attending/ordering/referring fields

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

Remittance advice and explanation codes

For	Process
A remittance advice for dates of service July 1, 2019, and forward	Log in at **hap.org** and select *Remittance Advice.*
A remittance advice for dates of service **prior** to July 1, 2019	1. Log in at **hap.org** 2. Select *Remittance Advice.* 3. Select the link *to view HAP Midwest Remittance Advices.*
835 files	If you don't get an 835 from HAP today, contact your clearing house and give them HAP's payer ID 38224.
MI Health Link Remittance Advice	There will be one line item displaying a combined payment for the Medicare and Medicaid components of the MI Health Link plan.

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

- 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 **hap.org**.

Negative balance on the remittance advice

Following 835 standards, we only report claims that contributed to the negative balance one time.

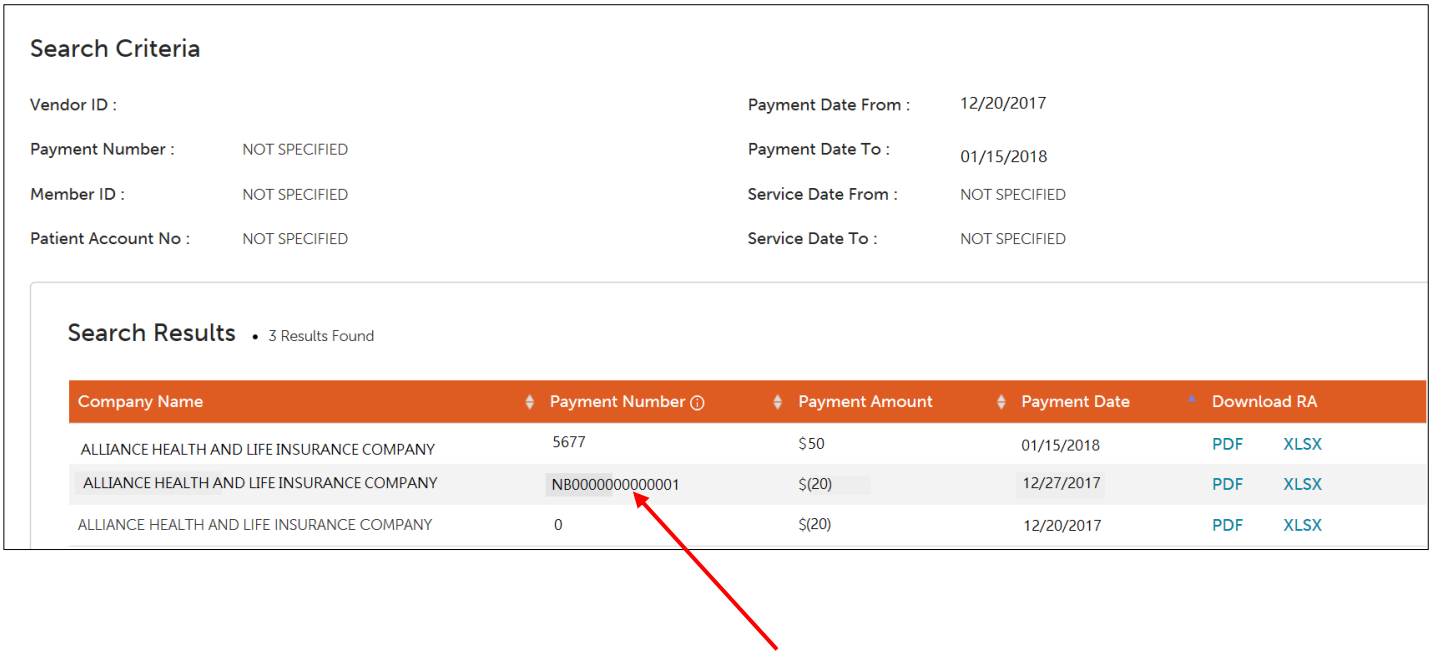
Identifying a Negative Balance on the Remittance Advice

You can access your remittance advice by logging in at **hap.org** and selecting *Remittance Advice*.

Negative balances can be easily identified on the Remittance Advice Summary page by:

- A ***Payment Number* starting with "NB"** (see below)

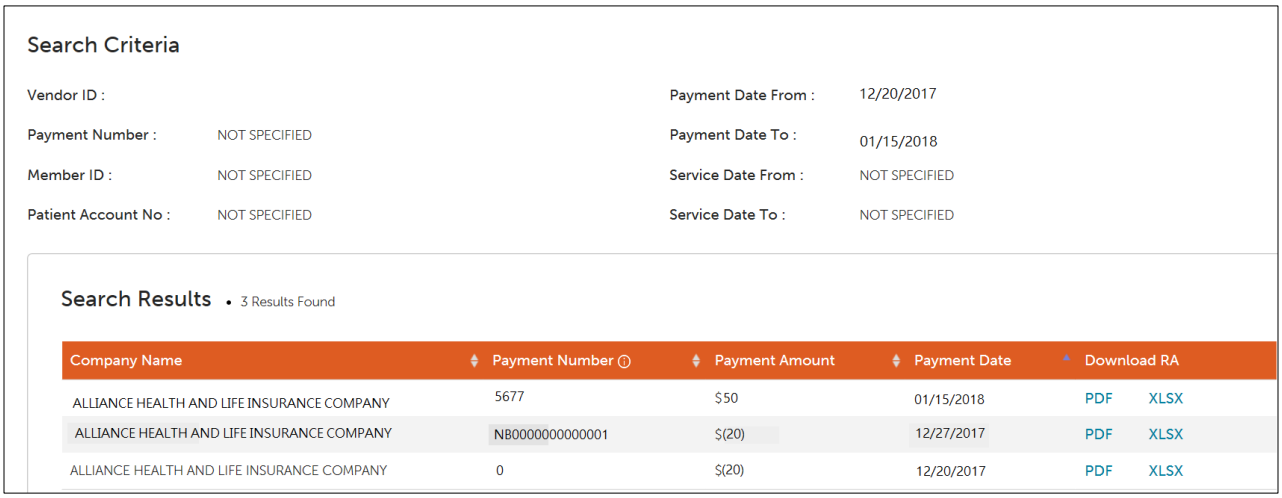
Note: Negative balances are specific to a **line of business** as designated in the ***Company Name*** column (e.g., Alliance Health and Life Insurance Company, HAP Empowered). In the example below, the RA for payment date 12/20/2017 is for Alliance Health and Life Insurance Company (Alliance). The next RA for Alliance is the RA dated 12/27/2017.



For illustration purposes, the examples below follow the Alliance Health and Life Insurance Company.

- Select the PDF or Excel file with the first negative balance from the RA *Search Results* page. In our example, we'll open the RA dated 12/20/2017 with the amount ($20.00) and payment number 0.

Week 1



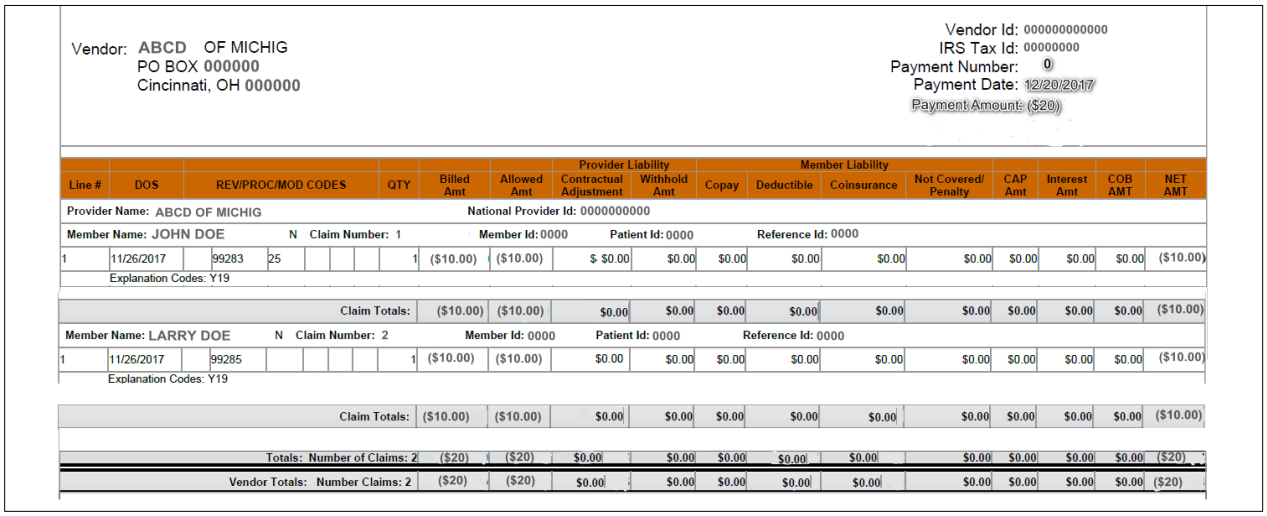
Search Criteria

Vendor ID :		Payment Date From :	12/20/2017
Payment Number :	NOT SPECIFIED	Payment Date To :	01/15/2018
Member ID :	NOT SPECIFIED	Service Date From :	NOT SPECIFIED
Patient Account No :	NOT SPECIFIED	Service Date To :	NOT SPECIFIED

Search Results • 3 Results Found

Company Name	Payment Number	Payment Amount	Payment Date	Download RA
ALLIANCE HEALTH AND LIFE INSURANCE COMPANY	5677	$50	01/15/2018	PDF XLSX
ALLIANCE HEALTH AND LIFE INSURANCE COMPANY	NB0000000000001	$(20)	12/27/2017	PDF XLSX
ALLIANCE HEALTH AND LIFE INSURANCE COMPANY	0	$(20)	12/20/2017	PDF XLSX

- Claims 1 and 2 are causing the negative balance of $20 in week 1.



Vendor: ABCD OF MICHIG
PO BOX 000000
Cincinnati, OH 000000

Vendor Id: 000000000000
IRS Tax Id: 00000000
Payment Number: 0
Payment Date: 12/20/2017
Payment Amount: ($20)

Line #	DOS	REV/PROC/MOD CODES	QTY	Billed Amt	Allowed Amt	Provider Liability: Contractual Adjustment	Provider Liability: Withhold Amt	Member Liability: Copay	Member Liability: Deductible	Member Liability: Coinsurance	Member Liability: Not Covered/ Penalty	CAP Amt	Interest Amt	COB AMT	NET AMT
Provider Name: ABCD OF MICHIG					National Provider Id: 0000000000										
Member Name: JOHN DOE N	Claim Number: 1		Member Id: 0000		Patient Id: 0000		Reference Id: 0000								
1	11/26/2017	99283 25	1	($10.00)	($10.00)	$ $0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Explanation Codes: Y19															
Claim Totals:				($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Member Name: LARRY DOE N	Claim Number: 2		Member Id: 0000		Patient Id: 0000		Reference Id: 0000								
1	11/26/2017	99285	1	($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Explanation Codes: Y19															
Claim Totals:				($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Totals: Number of Claims: 2				($20)	($20)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($20)
Vendor Totals: Number Claims: 2				($20)	($20)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($20)

Week 2

- Claims 3 and 4 are causing further negative balance of $20 in week 2.
- Please note the following fields in the RA header:
  - *Remittance Amount*: This field shows the total NET_AMT of the claims in current Remittance Advice (RA).
  - *Previous Balance*: This field shows the forward balance from previous week (week 1 in this case) for the vendor.
  - *Payment Amount*: Shows the difference between the *Remittance Amount* and the previous Balance

Week 3

Vendor: ABCD OF MICHIG
PO BOX 000000
Cincinnati, OH 000000

Vendor Id: 000000000000
IRS Tax Id: 00000000
Payment Number: NB0000000000001
Payment Date: 12/27/2017
Remittance Amount: ($20)
Previous Balance: ($20)
Payment Amount ($40)

Line #	DOS	REV/PROC/MOD CODES	QTY	Billed Amt	Allowed Amt	Provider Liability: Contractual Adjustment	Provider Liability: Withhold Amt	Member Liability: Copay	Member Liability: Deductible	Member Liability: Coinsurance	Member Liability: Not Covered/ Penalty	CAP Amt	Interest Amt	COB AMT	NET AMT
Provider Name: ABCD OF MICHIG				National Provider Id: 0000000000											
Member Name: JOHN DOE	N	Claim Number: 3		Member Id: 0000		Patient Id: 0000		Reference Id: 0000							
1	11/26/2017	99283 25	1	($10.00)	($10.00)	$ $0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Explanation Codes: Y19															
		Claim Totals:		($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Member Name: LARRY DOE	N	Claim Number: 4		Member Id: 0000		Patient Id: 0000		Reference Id: 0000							
1	11/26/2017	99285	1	($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Explanation Codes: Y19															
		Claim Totals:		($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
		Totals: Number of Claims: 2		($20)	($20)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($20)
		Vendor Totals: Number Claims: 2		($20)	($20)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($20)

- Claim 7 is offsetting the previous negative.

Vendor: ABCD OF MICHIG
PO BOX 000000
Cincinnati, OH 000000

Vendor Id: 000000000000
IRS Tax Id: 00000000

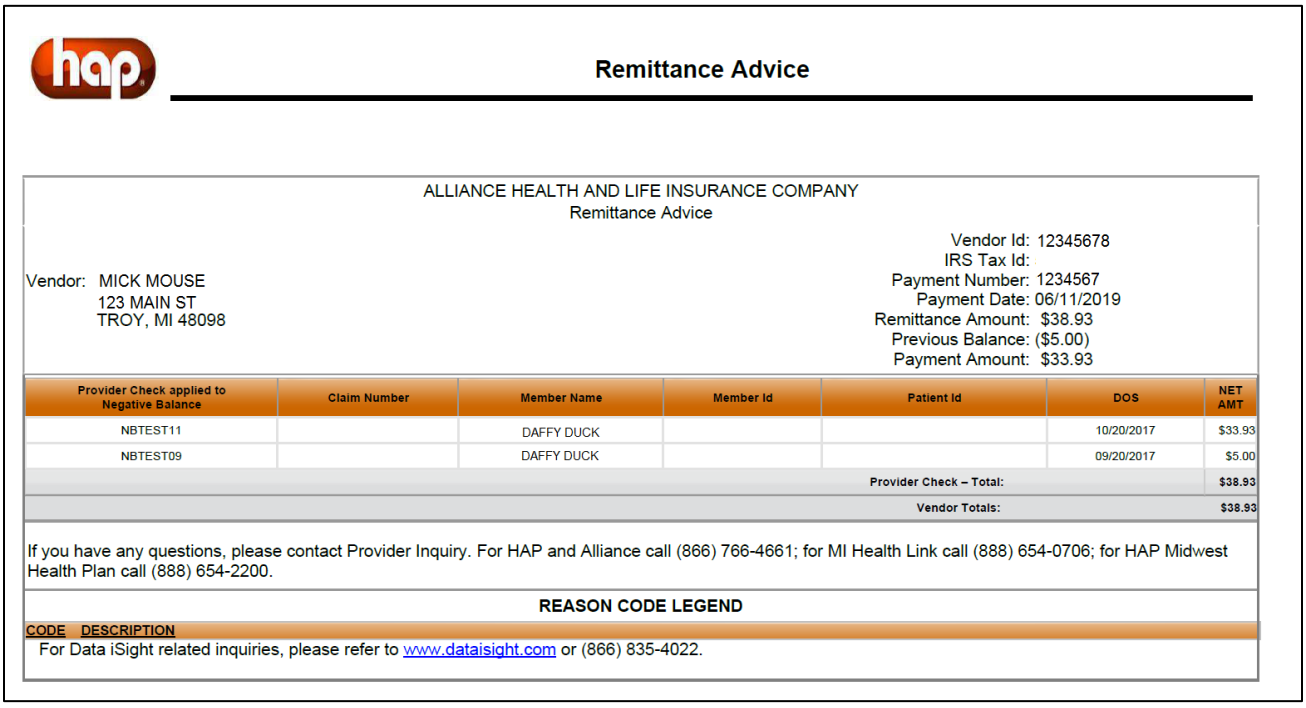
Payment Number: 5677
Payment Date: 01/15/2018
Remittance Amount: $50
Previous Balance : ($40)
Payment Amount : $10

Line #	DOS	REV/PROC/MOD CODES	QTY	Billed Amt	Allowed Amt	Provider Liability: Contractual Adjustment	Provider Liability: Withhold Amt	Member Liability: Copay	Member Liability: Deductible	Member Liability: Coinsurance	Member Liability: Not Covered/ Penalty	CAP Amt	Interest Amt	COB AMT	NET AMT
Provider Name: ABCD OF MICHIG				National Provider Id: 0000000000											
Member Name: Danita J Jones	N	Claim Number: 7		Member Id: 0000		Patient Id: 0000		Reference Id: 0000							
1	12/09/2017	99283 25	1	$50	$50	$ $0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50
Explanation Codes: Y19															
		Totals: Number of Claims: 1		$50	$50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50
		Vendor Totals: Number Claims: 1		$50	$50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50

Negative balance credits

Any payments submitted to HAP that are applied to current negative balances will be displayed in the lower section of the RA. See screen shot below (PHI removed).

The balance will be reduced according to the payment applied. The claim number in this section should be the originating claim(s) that generated the negative balance.



Remittance Advice

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
Remittance Advice

Vendor: MICK MOUSE
123 MAIN ST
TROY, MI 48098

Vendor Id: 12345678
IRS Tax Id:
Payment Number: 1234567
Payment Date: 06/11/2019
Remittance Amount: $38.93
Previous Balance: ($5.00)
Payment Amount: $33.93

Provider Check applied to Negative Balance	Claim Number	Member Name	Member Id	Patient Id	DOS	NET AMT
NBTEST11		DAFFY DUCK			10/20/2017	$33.93
NBTEST09		DAFFY DUCK			09/20/2017	$5.00
				Provider Check – Total:		$38.93
				Vendor Totals:		$38.93

If you have any questions, please contact Provider Inquiry. For HAP and Alliance call (866) 766-4661; for MI Health Link call (888) 654-0706; for HAP Midwest Health Plan call (888) 654-2200.

REASON CODE LEGEND

CODE DESCRIPTION

For Data iSight related inquiries, please refer to www.dataisight.com or (866) 835-4022.

Legend

RA Column	Explanation of values in column
Provider Check applied to Negative Balance	Provider check number submitted to HAP
Claim Number	Claim that initiated the negative balance
Member Name	Member for the claim that initiated the negative balance
Patient ID	Patient ID for the claim that initiated the negative balance
DOS	Date of Service for the claim that initiated the negative balance
NET AMT	Amount from provider check applied to the existing negative balance

You can send payments for negative balances to the appropriate HAP line of business, attention NB Refund Request, 2850 West Grand Blvd., Detroit, MI 48202.

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 Empowered 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 Change HealthCare
- Handwritten entries are not acceptable anywhere on the claim.
- Electronic signatures are acceptable.
- Mandatory items on claim forms must be completed or the claim cannot be processed. Refer to claim form submission guidelines within this section.
- Conditional items, if applicable, on claim forms are required or the claim may not be processed. Refer to claim form submission guidelines within this section.
- Blank items may be left empty and will not affect claims processing. Refer to claim form submission guidelines within this section.
- All claims must contain an NPI number submitted as follows:
  - Field 24 J of CMS-1500 rendering provider is conditional, required when different from billing provider and must be an entity type of (1) individual
  - FL 56 of the UB-04 form
- Submit the member ID number as follows:

Product	Billing ID
HAP Empowered MI Health Link	Use the 11-digit HAP member ID number from the HAP Empowered MI Health Link ID card.
HAP Empowered Medicaid	Use the 11-digit HAP ID number from the HAP Empowered Medicaid 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.
6	Conditional	If item 4 is complete, check the appropriate box, Patient relationship to Insured.

Field locator	Status	Description
7	Conditional	Complete if item 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. 17b: Enter NPI# of referring, ordering or supervising provider.
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 (e.g. 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 Empowered prior authorization number for services requiring an authorization or the 10-digit CLIA number as appropriate. For authorization requirements, log in at **hap.org;** select *Procedure Reference Lists* under *Quick Links*.
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

Field locator	Status	Description
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.
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
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

UB-04 field locator	Field status	Description of field	Information to be included
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 MMDDYYYY
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
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 MMDDYYYY 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.
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	

UB-04 field locator	Field status	Description of field	Information to be included
69	Mandatory	Admitting diagnosis code	The ICD-9CM or ICD-10 diagnosis code describing the patient's diagnosis at the time of inpatient admission
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 Empowered 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
  - Physician Assistant
  - Nurse Practitioner
  - Certified Nurse Midwife
  - Dentist
  - Podiatrist
  - Optometrist
  - Chiropractor (limited to spinal x-rays only)
- Effective for dates of service January 1, 2022, the following provider types are allowed to be reported as attending providers in addition to the above provider types for Institutional claims by FQHC, RHC, THC providers.
  - Clinical Psychologist
  - Clinical Social Workers
  - Clinical Nurse Specialist
  - Marriage and Family Therapists
  - Licensed Psychologists (Doctoral Level)
  - Social Workers (Master's Level)
  - Professional Counselors (Master's Level)
  - 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 (e.g., 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.

NDC Reporting Requirement for Physician Administered Drugs

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

You can also find a list of HCPCS codes that require an NDC.

- Log in at **hap.org**
- Select *Procedure Reference Lists* under *Quick links*
- Select *Codes that require an NDC- HAP Empowered - Excel*

Nine-digit zip code reminder

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

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

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

NPIs on CMS 1500 claim submission

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

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

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

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

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

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

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

Taxonomy codes required on professional claims

Effective January 1, 2020, taxonomy codes are required when submitting professional claims for all HAP and HAP Empowered lines of business. This is consistent with National Uniform Billing Guidelines and is critical for accurate and timely claims processing. Taxonomy codes should be submitted as follows:

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

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

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

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

Claims may deny if the taxonomy is missing or incorrect.

Specific claim coding requirements

Coordination of benefits

- We follow Medicare Secondary Payer Provisions for Medicare and Medicaid dual eligible HAP Empowered MI Health Link members. For more information, visit **cms.gov** and search for *Medicare Secondary Payer (MSP) Manual*.
- 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 Empowered.
- 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 Empowered must comply with our authorization requirements to be reimbursed. See Referrals and Authorizations section in this manual.
- It's highly recommended to submit COB claims electronically and indicate the primary insurance detail payments lines in loop 2400. COB claims may be submitted on paper with other insurance explanation of payment attached.

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

E & M billing guidelines
We follow CMS payment guidelines. HAP Empowered 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 Empowered 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 Empowered members may receive emergency screening and stabilization services without prior authorization.

Federally Qualified Health Centers, Rural Health Clinics and Tribal Health Centers
- For services performed on or after Aug. 1, 2017, FQHC, RHC and TCH can submit claims by one of the methods below.
  - Electronic: Use the ASC X12N 837 5010 institutional format.
  - Paper: Use the National Uniform Billing Code claim form.
- Claims submitted after the date above using the professional claim formats CMS-1500 or 837P will be denied. For more information refer to the Medicaid Policy Bulletin: MSA 17-10. 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
  - HAP Empowered MI Health Link home and community-based services and waiver services for individuals who live in the community and meet nursing facility level of care as determined by the LOCD.
- 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 GA- Pre-service notice of non-coverage was provided by the plan for HAP Empowered MI Health Link only

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

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 requirements, log in at **hap.org** and select *Procedure Reference Lists* under *Quick Links*.

Michigan Department of Health and Human Services newborn recoveries

To avoid upfront EDI rejections from HAP Empowered 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 Empowered
  P.O. Box 2578
  Detroit, MI 48202

Telemedicine services

HAP Empowered Medicaid follows telemedicine billing guidance from the Michigan Department of Health and Human Services. 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 code 02- Telehealth
- GT- interactive telecommunication modifier

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 GT-interactive telecommunication modifier.

Audio only service requires:

- Modifier GT- interactive telecommunication modifier in addition to modifier FQ. When a provider submits modifier FQ for an audio only service, a note is not required in the remarks section stating that the service was provided via telephone.

Telemedicine location patient home requires:

- The comment “patient’s home” in the remarks section and modifier FQ to be appended in addition to modifier GT.

For more information, please refer to the MDHHS policy bulletins MSA 20-09 and 20-13 which can be found here.

Therapy services

Therapy services furnished to Medicaid beneficiaries must be billed with the appropriate discipline 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.

Billing members

Providers who accept a patient as a Medicaid beneficiary with HAP Empowered Medicaid, the beneficiary cannot be billed for:

- Medicaid-covered services, providers must inform the beneficiary before the service is provided if HAP Empowered Medicaid 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 Empowered.

Balance billing

- Providers may not balance bill HAP Empowered Medicaid members or dual eligible members with HAP Empowered MI Health Link for unauthorized services if the enrollee had no prior knowledge of liability for the service.
- Cost-sharing does not apply to dual eligible members in HAP Empowered MI Health Link or HAP Empowered Medicaid dual eligible. For more information, visit **cms.gov**. Select *Outreach & Education*, then, under Find your provider type, select *Health & drug plans*, then *Medical Learning Network® provider compliance*.

Balance billing by provider type – HAP Empowered MI Health Link only

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

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

Qualified Medicare Beneficiary Program

Members in the Qualified Medicare Beneficiary Program (QMB) program are enrolled in both Medicaid and Medicare and receive help paying for:

- Part A or Part B premiums
- Deductibles
- Coinsurance
- Copayments

All providers suppliers, pharmacies and out-of-state providers who render services to dual eligible members are prohibited from billing Medicare cost sharing to members enrolled in the QMB program. For more information, please visit: **cms.gov** and search on SE1128, then select the PDF: *Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program.* Note: cost-sharing does not apply to dual eligible members enrolled in MI Health Link (ICO) program.

Claim Disputes

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

HAP Empowered will make every effort to resolve all disputes as expeditiously as possible. There are two levels of claim disputes within the Plan, Level 1 and Level 2, with Level 2 being the final decision. Any further disputes beyond Level 2 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 sixty (60) days of receipt of original claim rejection or from date of denial of Level 1 dispute from HAP Empowered. 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. There are two levels of disputes. All disputes must be submitted in writing to:

HAP Empowered
P.O. Box 2578
Detroit, MI 48202
Attention: Claims Department

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 are two levels of claim disputes within the Plan, Level 1 and Level 2, with Level 2 being the final decision.

HAP Empowered responds to dispute requests within 60 days of receipt.

Claims disputes for HAP Empowered MI Health Link non-contracted providers

Noncontracted providers have 60 days from the date of the initial organization determination to request a claims payment appeal. HAP Empowered has 30 days to review and respond to the request. Here is the process:

- Submit a written request along with any supporting documentation.
- Include a completed, signed Waiver of Liability form. To find this form, visit **hap.org/empoweredproviders,** select *Forms*, then *Provider – Waiver of Liability (PDF)*
- Mail request, documentation and Waiver of Liability to:

  HAP Empowered Health Plan
  P.O. Box 2578
  Detroit, MI 48202
  Attention: Claims Department

Note: If the Waiver of Liability is incomplete or unsigned the dispute decision will be upheld and HAP Empowered will send a letter to the provider advising of the reason for decision.

Dispute	Process
Level 1	Submit dispute within 60 days of original claim denial. * HAP Empowered reviews the disputes and approves or upholds denial. If denial is upheld, HAP Empowered will send a letter to the provider advising of rights to level 2 appeal.
Level 2	Submit dispute within 60 calendar days from date on level 1 denial letter. * HAP Empowered reviews the dispute and approves or upholds the denial. If denial is upheld, HAP Empowered will send a letter to the provider advising of their right to request a review by our internal Account Receivable Reconciliation Group.
Account Receivable Reconciliation Group (ARRG	Submit appeal within 60 days of level 2 denial. * HAP Empowered stakeholders, identified as the ARR, meet no less than every 90 days to reconcile outstanding bills and payments. All appeal decisions will be finalized at the AARG.
Decision	If the original decision is overturned and the service is approved, the claim will be reprocessed for payment A letter will be sent to the Provider notifying them of the Approval and that payment will be forthcoming within 2-3 weeks
Unresolved	Where a disputed claim, or group of similar claims, remains, the hospital, provider or HAP Empowered may submit a request to (MDHHS) Michigan Department of Health and Human Services for Rapid Dispute Resolution (RDRP)
Arbitration/ Rapid Dispute Resolution Arbitration/ Rapid Dispute Resolution	• The Rapid Dispute Resolution process can be found in the Medicaid Provider Manual and should be followed for non-contracted hospital providers that have signed the Hospital Access Agreement. • Non-contracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the Rapid Dispute Resolution process. • The Binding Arbitration process can be requested by non-hospital providers or hospital • The Rapid Dispute Resolution process can be found in the Medicaid Provider Manual and should be followed for non-contracted hospital providers that have signed the Hospital Access Agreement. • Non-contracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the Rapid Dispute Resolution process • The Binding Arbitration process can be requested by non-hospital providers or hospital providers that have not signed the Hospital Access Agreement after they have exhausted our internal provider dispute process.

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

Denials – When To Submit a Corrected Claim vs. an Appeal

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 (1) year from the date of service to submit a corrected claim.

Denials include, but are not limited to:

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

Appeals
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.

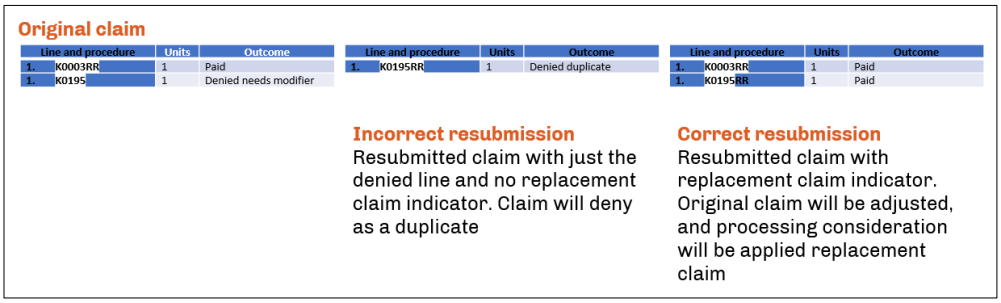
For	Instructions
Paper claims	• Institutional claims enter 7 for replacement or 8 for cancel in box 4 – Type of Bill on the UB-04 with the HAP Empowered claim number to replace in field 64 Document Control Number • Professional claims enter 7 for replacement or 8 for cancel in box 22 on the CMS-1500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

Example



Important

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

- Contact HAP Provider Inquiry at **(866) 766-4661**
- Follow the online Claims Adjustment process (see process in the HAP Empowered Provider Manual)

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 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 Empowered 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 Empowered may require medical records, reports, treatment records, or discharge summaries as appropriate.

Quarterly Claim Audits

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

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

Process to obtain medical records

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

Process for medical records that do not support services

If the medical records submitted do not support the services billed or follow HAP Empowered 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

On September 5, 2022, HAP Empowered implemented a new code validation process to ensure specific modifiers have been used correctly. As you know, claims should always be coded to the level of specificity for the services rendered. Diagnosis codes and modifiers should be appropriately appended so they follow the national guidelines. Reported services should be supported in the patient's medical record.

Below is an overview of our process.

Modifiers

We will review the following modifiers:

Modifier	Definition
25	Indicates a significant, separately identifiable evaluation and management (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 Policy Manual
- 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 new process will improve the accuracy of claims processing.

Enhanced clinical editing processes

Since December 2018, we've been working 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 and HAP Empowered lines of business. Note: For HAP Empowered claims, if an edit doesn't follow the Michigan Department of Health and Human Services (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 Empowered claims

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

Topic	Description and Guidelines
Add-on codes	• Certain procedure codes are commonly performed and billed in addition to the primary procedure. • They should never be reported as a standalone service. • These codes are identified in the AMA CPT manual with a plus (+) symbol. • They're also listed in Appendix D of the CPT Manual. • Add-on codes in the HCPCS Level II Manual and the ADA Dental Services Manual are identified with "list separately in addition to code for primary procedure" or "each additional" language within the code description. • If an Add-on code is submitted and the primary procedure has not been identified on the same or different claim, HAP will deny the Add-on code as an inappropriately coded procedure.
Ambulatory surgery center edits	• The following services will be denied if billed without an approved ASC surgical procedure for claims submitted with place of service 24: – Radiology – Drugs and biologicals – Devices – Brachytherapy source
Ambulance edits	• If a provider does not submit an origin modifier combined with a destination modifier for ambulance services will be denied. • Ambulance claims submitted with non-covered origin and destination modifiers will be denied. • ALS emergency services will be denied when billed without a diagnosis that supports ALS emergency services • ALS or BLS non-emergency services will be denied when billed without a diagnosis that supports ALS/BLS non-emergency services.
Anesthesia edits	When more than one anesthesia CPT code (00100 – 01999) can be used for a surgery, then the lower based unit anesthesia code should be billed. If not, the service will be denied too be rebilled correctly.
Assistant surgeon edits	• Reimbursement for an assistant surgeon will be denied when billed by the primary surgeon • Only one assistant surgeon will be allowed for a surgical procedure
Bundled services	• There are several services or supplies CMS bundles into the payment for other related services. These services are grouped into three categories:

Topic	Description and Guidelines
	1. Not separately payable when billed on the same day as other payable services (Status Indicator P) 2. Not payable under any circumstances (Status Indicator B) 3. Injection services (Status Indicator T)
CMS policy	• According to CMS policy, percutaneous image-guided breast biopsy procedures (19081-19086) are only covered for the evaluation of specific clinical breast conditions such as: abnormal and inconclusive findings on diagnostic imaging of breast, carcinoma in situ of breast, granulomatous mastitis, malignant neoplasm of breast, neoplasm of uncertain behavior of breast, or unspecified lump in breast. If a claim is billed without a diagnosis for a specific clinical breast condition approved by CMS, the service will be denied. • iStent® (0191T) or CyPass® (0474T) will be denied when cataract surgery (66830-66940, 66982-66984, 66987-66988) has not been performed for the same date of service. • Intensity-Modulated Radiation Therapy Plan (IMRT) (77301): The payment for CPT code 77301 includes services that are performed as part of developing an IMRT treatment plan. These services should not be reported in addition to the primary code. The following codes are inclusive to CPT code 77301; and should not be submitted for separate reimbursement and will be denied if done so: 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331 and 77370. • Scanning computerized ophthalmic diagnostic imaging; optic nerve (92133) or scanning computerized ophthalmic diagnostic imaging; retina (92134) when billed more than two units per year when the diagnosis is glaucoma will be denied. (Medicare) • Scanning computerized ophthalmic diagnostic imaging; retina (92134) when billed more than once per month when the diagnosis is retinal disease will be denied. (Medicare) • Scanning computerized ophthalmic diagnostic imaging; optic nerve (92133) when billed more than once per year for any diagnosis other than glaucoma will be denied (Medicare) • Scanning computerized ophthalmic diagnostic imaging; retina (92134) when billed when billed more than once per year for any diagnosis other than glaucoma and retinal disease. (Medicare)
Correct Coding Edits	• When multiple CPT/HCPCS codes are billed together without modifiers to denote different sides, but there is a single code that describes the same procedure/services under one code, the service will be denied and to be rebilled under the correct code. • Nuclear medicine procedure will be denied when billed without a radiopharmaceutical imaging agent on both outpatient and professional claims. • Certain procedures will be limited to one unit per day regardless of appended modifier. • 99441-99443 (Telephone E/M services), G2010 (Remote evaluation of recorded video and/or image), G2012, or G2252 (Brief check in by MD/QHP) will be denied when an E/M service has been billed on the same day, previous seven days, or following day with the same primary diagnosis.
Detailed Fetal Anatomical Ultrasound with Evaluation	According to HAP 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. Effective December 1, 2021, HAP will only consider an indication-driven examination to be reimbursable for fetal abnormalities.
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

Topic	Description and Guidelines
	billed without the other and they are required to be billed together, the billed service will be denied. Example: 92982 (PTCA) will be denied if billed without C1725 (Catheter, transluminal, angioplasty, non-laser) or C1885 (Catheter, transluminal, angioplasty, laser).
Diagnosis-age rules	• Certain diagnosis codes are identified as being specific to certain age groups. • All services on a claim billed with one of these codes will deny if: – It's the only diagnosis on the claim. – It doesn't match the age of the patient on the claim for the date of service. • This policy looks at all diagnoses on a claim.
Diagnosis criteria	CMS has determined that for certain services, for that procedure to be covered, it must be billed with a diagnosis to indicate the criteria for the service has been met. If the service is billed without one of the requisites diagnosis, 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). Dialysis for acute kidney injury (AKI) is excluded from this policy.

Topic	Description and Guidelines
Drug and biological edits	• When a drug is FDA approved, there are criteria required to be met for that drug to be prescribed. Below are some of the edits and HCPCS codes that these edits may be applied to: – J0256, J0257, J9042, J9145, J9176, J9228, J1950, J3380, J1300, J0881, J0882, J0885, J2505, J9035, J9305, J9308, J1745, J9217, J9271, J9306, J9312, J9311, J9315, J9355, J2357, J0178, J2778, J7318, J7320, J7321, J7322, J7323, J7324, J7325, J7326, J7327, J7328, J7329, J2353, J9041, J9044, J1300, J9299 – A9513, Q5108, Q5111, Q0138, Q0139, C9257, Q5103, Q5104, Q5109 • 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: – Diagnosis that the drug is to be used for – Dosage and Max Dosage Over Time – Frequency – Route of Administration – Lab Requirements – Age Restrictions • Examples of Indications edits: – J2505, Q5108, or Q5111 will be denied when billed by any provider less than 10 days prior to the administration of a cytotoxic chemotherapy drug. – J1950 will be denied when billed and the patient is greater than 11 years of age, and the patient's gender is female, and the diagnosis on the claim is central precocious puberty. – Limit J1950 to 24 combined units every 48 weeks and the diagnosis on the claim is prostate cancer. • Chemotherapy drug administration code (96401-96450, 96542-96549, G0498, Q0083-Q0085) will be denied when billed with a drug that is administered using non-chemotherapy administration codes and a drug that is administered using chemotherapy codes has not been billed for the same date of service by any provider. • Intravenous push chemotherapy administration (96409, 96411) will be denied when billed with specific drugs codes and no other drug administered by chemotherapy administration has been billed for the same date of service by any provider. • Limit 96415 to one unit when billed with specific drug codes and no other chemotherapy drug administered by IV infusion for greater than one hour has been billed for the same date of service by any provider. • Drug administration services other than for subcutaneous technique (96365-96371, 96373-96379, 96402-96450, 96542, 96549, or G0498) when billed with specifics codes and no other drug has been billed for the same date of service by any provider. • Any code other than a drug code when billed with modifier JW (drug amount discarded/not administered to any patient) will be denied. • A drug when billed with modifier JW (drug amount discarded/not administered to any patient) and another claim line does not exist for the same drug on the same date of service will be denied. • Duplicate drug codes when the same code with the same units has been billed on a different claim by any provider for the same date of service will be denied.
Drugs	Effective November 1, 2022, for Q5112, Q5113, Q5114, Q5116, or Q5117: • Deny when billed with units representing a multiple of an entire vial (42, 84, or 126 units) and another claim line for the same drug does not exist on the same claim for the same date of service.

Topic	Description and Guidelines
Duplicates	• Any claim submitted by a physician or provider for the same service provided to a single patient on a specified date of service that was included on a previously submitted claim. • When new claims and claim lines are received, they are compared against other claims and claim lines in both history and in the same new claim batch. • Claims for multi-specialty groups operating under the same tax ID and specialty are processed in a slightly different manner. – Additional specific criteria, such as specialty, are used to make the determination to ensure providers within the tax ID do not edit against each other when treating the same member on the same date of service.
Durable Medical Equipment and Supplies Edits	• Indwelling catheters (A4311-A4313, A4314-A4316, A4338-A4346) will be limited to three units when billed separately or in any combination every three months. • E0935 (CPM device) is limited to one unit per day when billed by any provider within three weeks of the original arthroplasty. • According to national CMS policy, certain items are not payable because they are considered not primarily medical in nature; not medical equipment; a non-reusable supply; or a convenience item. These items will be denied as non-covered items when billed. Any non-covered durable medical equipment
Evaluation and Management Services	• The AMA defines a new patient as "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." Otherwise, the patient is considered an established patient. • Only one E/M code should be billed for a single date of service by the same provider group and specialty regardless of place of service. • When E/M services are billed on the same date as other therapeutic or diagnostic services, they shouldn't be billed unless they're separate and distinct services. • Annual exams or screening services should be billed as new or established patient preventive medicine visits, not as consultations. • Preventive medicine visits may include, but are not limited to, the following: – Gynecologic screening services – Screening Pap Smear (Q0091) – Cervical or vaginal cancer screening; pelvic and clinical breast examination (G0101) – Prostate cancer screening; digital rectal examination (G0102) – Visual screening – Preventive medicine counseling codes • Please refer to AMA guidelines for correct use of E/M services codes and modifiers. • Reimbursement for additional services considered part of the pediatric critical care inter-facility transport codes (99466-99467) and critical care codes (99291-99292) will be denied. • Interprofessional telephone/internet consultation (99446-99449, or 99451) will be denied when billed and any face-to-face service has been billed on the same date or in the previous 14 days.

Topic	Description and Guidelines
Global surgery	• The global surgery package includes all necessary services normally provided by the surgeon before, during and after a surgical procedure. • The global surgery package only applies to surgical procedures that have global periods of 0, 10 and 90 days. • Global surgery only applies to primary surgeons and co-surgeons. • The following items are included in the global surgery package: – Preoperative and same day E/M visits after the decision is made to operate. – All post-operative E/M visits and services for 10-day and 90-day surgeries related to the primary procedure per CMS guidelines. – Anesthesia services billed by the surgeon are not reimbursed separately. – Care management services (99487-99490) or transitional care management services (99495-99496) performed within 90 postoperative days of a 90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of provider ID and specialty, and the diagnosis is a complication of surgical and medical care, or an aftercare diagnosis will be denied. – Care management services (99487-99490) or transitional care management services (99495-99496) when billed with modifier 24 and a major surgical procedure with the global postoperative period has been billed in the previous 10/90 days and the E/M diagnosis is a complication of surgical and medical care or an aftercare diagnosis will be denied. – Care management services (99487-99490) or transitional care management services (99495-99496) performed within the global postoperative days of a 10/90-day medical or surgical service when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of provider ID and specialty, and the diagnosis is a complication of surgical and medical care, or an aftercare diagnosis will be denied. – Evaluation and management services performed within the global postoperative days of a medical or surgical service will be denied when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the diagnosis is a complication of surgical and medical care or an aftercare diagnosis. – Evaluation and management services performed within 10 postoperative days of a 10-day medical or surgical service will be denied when billed by a non-physician practitioner (NPP) with the same Tax ID, regardless of Provider ID and Specialty, and the E/M service has a primary diagnosis associated to the 10-day medical or surgical service. – Evaluation and management services will be denied when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E/M diagnosis is a complication of surgical and medical care or an aftercare diagnosis. – Evaluation and management services will be denied when billed with modifier 24 and a minor surgical procedure with a 10-day postoperative period has been billed in the previous 10 days and the E/M service has a primary diagnosis associated to the 10-day medical or surgical service.

Topic	Description and Guidelines
ICD-10 Correct Coding	• In addition to ensuring ICD-10 diagnosis codes are coded to the highest level of specificity, and appropriate diagnosis to age codes are being submitted, there are unique coding attributes of the ICD-10 CM code set and coding conventions that also need to be observed. • Per coding guidelines, principal, primary or the only diagnosis submitted on a claim should never be one of the following: – External causes – Manifestation codes – Sequela codes • "Diagnosis to diagnosis pointer" and "diagnosis to modifier" edits are also new to the editing rules for ICD-10. If a diagnosis code for left side is used in the header, the line pointer or line modifier must match to the left side or service lines may be denied for inappropriate coding. • 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. Example: Xray of foot 73620 with LT (left) modifier with a diagnosis of pain in right foot M79.671 - This claim would be denied since the modifier of left doesn't match the diagnosis showing right foot • All services received with a manifestation code billed as the only diagnosis on the claim will be denied. • Any procedure or service received with an ICD-10-CM sequela (7th character "S") code billed as the only diagnosis on the claim will be denied. • Any procedure or service received with an ICD-10-CM sequela (7th character "S") code billed in the primary, first listed or principal diagnosis position will be denied.
IMRT	Additional billings of 77301 (IMRT plan) when billed more than one date of service in eight weeks will be denied.
IMRT with IGRT delivery	Per ASTRO coding guidance: • If a facility bills for the IMRT, with IGRT delivery, they should bill for 77385 or 77386 depending on the complexity of the scan. • The facility should not bill 77014 and should appropriately bill 77385 or 77386 based on the complexity of the scan administer for IMRT with IGRT. • Hospitals should modify their chargemaster to include IGRT within IMRT delivery. However, do not bill or report IGRT Technical Component separately with IMRT. • If a physician bills for IMRT with IGRT delivery they should bill G6001, G6002, G6017 and/or 77014. Note: The provider should be billing CPT 77387 for IGRT related treatment in conjunction with IMRT delivery codes.
Inpatient only services	• CMS has identified certain services that may only be performed in a facility setting due to: – The invasive nature of the procedure – The need for postoperative care following surgery – The underlying physical condition of the patient requiring surgery • When these services are performed in an office setting, they will be denied.
"Incident To" services	• Per CMS guidelines, "incident to" services are provided as an integral, although incidental, part of the physician's personal, professional services in the course of diagnosis or treatment of an illness or injury. • "Incident to" services should not be billed in: – An inpatient hospital – An outpatient department (including the emergency department) – A military treatment facility setting

Topic	Description and Guidelines
Maximum allowable units of service	When a provider bills for a quantity of services that exceed the amount the health plan feels is reasonable for a given period of time, the units considered excessive will be denied. Maximum unit settings have been established for different time periods, such as per day, per year, and in some cases other time periods. The maximum allowable unit settings have been defined through a combination of various sources: • Procedure code definitions • Anatomical site definitions • Clinical guidelines suggested by specialty societies or physician panelists considered experts in their fields. • CMS' reimbursement limitations and code status indicators • Other analytics and research **Example**: Code 97032 is defined as "Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes." If one hour of this type of therapy is allowed per day, then the daily maximum unit for code 97032 would be set at four and any units greater than four per day will be denied. [15min X 4 = 60min (1hour)] Note regarding the use of Anatomical Modifiers - Anatomical modifiers E1-E4 (Eyes), FA-F9 (Fingers), and TA-T9 (Toes) have a maximum allowable of one unit per anatomical site. Any service billed with an anatomical modifier for more than one unit of service will be adjusted accordingly.
Modifiers	HAP follows CMS usage for modifiers. This includes, but not limited to: • Modifiers used to identify who provided the medical care (QZ, AH, etc.) • Modifiers use to add more information (E1, CA, etc.) • Modifiers use for durable medical equipment or by suppliers (RR, KX, etc.) • ABN specific modifiers (GA, GX, GY, GZ, etc.) • Modifiers which impact the pricing of the code (51, 54, As, etc.)
National Correct Coding	• The National Correct Coding Initiative or NCCI is a collection of bundling edits created and sponsored by CMS. They are separated into two major categories: 1. Column I and Column II procedure code edits (previously referred to as "Comprehensive" and "Component") 2. Mutually Exclusive procedure code edits • CCI edits are for services performed by the same provider on the same date of service only. They don't apply to services performed within the global surgical period. • Each CCI code pair edit is associated with a policy as defined in the National Correct Coding Initiative Policy Manual. Effective dates apply to code pairs in CCI and represent the date when CMS added the code pair combination to the CCI edits. • Code combinations are processed based on this effective date. • Termination dates also apply to code pairs in CCI. This date represents the date when CMS removed the code pair combination from the CCI edits. • Code combinations are refreshed quarterly.
National Coverage Determinations	• According to CMS policy, certain lab services are payable when billed with specific diagnoses. • These services will be denied in the absence of one of the designated covered diagnoses identified in the NCD coding manual which can be found at **cms.gov,** then select: – Regulations and Guidance – Manuals – Internet-Only Manuals – 100-03 Medicare National Coverage Determinations (NCD) Manual • Chapter 1 – Coverage Determinations, Part 3, Sections 170-190.34

Topic	Description and Guidelines
National coverage edits (CMS)	• E0748 (electrical osteogenesis stimulator) when billed and a diagnosis of post-surgical arthrodesis status is not present. • E0760 (ultrasonic osteogenesis stimulator) when billed without a required diagnosis with be denied. • Subsequent service, supply or device will be denied when modifier CA (procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission) has been reported in the past for the same patient by any provider. • 77080 or 77085 will be denied when billed without a covered diagnosis based on CMS guidelines and HAP's BAM. • G0102 or G0103 will be denied when billed and the patient is under 50 years of age. • 84153 (prostate specific antigen [PSA], total) will be denied when billed more than twice in a patient's lifetime by any provider with a diagnosis of carcinoma in situ of the prostate. • Any combination of G0420-G0421 (face-to-face educational services related to the care of chronic kidney disease) if billed for more than 6 units in a patient's lifetime by any provider will be denied. • 99201-99397 or 99420-99499 (evaluation and management service) will be denied when billed with 99406 or 99407 (smoking and tobacco cessation counseling visit) on the same date of service. • G0422 or G0423 (intensive cardiac rehabilitation) when billed in any place of service other than 11 (office), 19 (outpatient hospital-off campus), or 22 (outpatient hospital-on campus) will be denied. • G0438 (annual wellness visit; initial visit) will be denied when billed more than once in a patient's lifetime. • Subsequent service, supply or device will be denied when modifiers PM (post-mortem), P6 (brain dead) or QL (pronounced dead after ambulance called) have been reported in the past for the same patient by any provider. • E/M services and outpatient clinic visits billed without a distinct services modifier when performed with continuous overnight oximetry monitoring (94762) will be denied. • FQHC new patient visit (G0466 or G0469) will be denied when reported for PPS payment and any professional service has been billed in the previous three years.
National Drug Code (NDC) Numbers	Effective November 1, 2022: • Deny claim lines containing expired NDC numbers. Note: 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 will not pay separately for the pelvic echography unless there are extenuating circumstances as to why both studies had to be performed. Effective December 1, 2021, HAP will deny claims for non-obstetric pelvic ultrasounds when billed with transvaginal ultrasounds.
Oxygen	• Modifier KX should be appended to oxygen and oxygen equipment only when all the coverage criteria have been met. • Modifiers GA, GY and GZ should be appended to oxygen and oxygen equipment when all the coverage criteria have not been met. • The oxygen and oxygen equipment (E0424-E0447, E1390-E1392, E1405-E1406, K0738) will also be denied when modifier KX, GA, GY or GZ are not submitted. (for Commercial and Medicare)

Topic	Description and Guidelines
Place of service	• Certain codes are allowable only in specific places of service. For example, hospital admission codes, 99221-99223 can only be billed for hospital places of services such as POS 21 inpatient hospital or POS 51 psychiatric inpatient facility. • Medical and surgical supplies and DME when billed with professional fee revenue codes (0960-0989) in an outpatient facility or inpatient facility setting will be denied. (CMS-1450)
Procedure-modifier rules	• Procedure code modifier combinations are reviewed and validated. • Modifiers that affect reimbursement or show that separate and distinct services occurred may override incidental or mutually exclusive edits. • Appropriate use of modifiers to identify the correct anatomic site is required. • Modifier use may be subject to retrospective review. • Per AMA and CMS code definitions, procedures billed with incorrect modifiers will be denied as inappropriately coded procedures.
Procedure code definition	Throughout the T-4 Manual and CMS HCPCS Manual, the publishers have provided instructions on code usage. MMM has adopted edits that support correct coding based on the definition or nature of a procedure code or combination of procedure codes. These edits will either bundle or re-code procedures based on the appropriateness of the code selection. **Example**: CPT code 73510 (X-ray, hip, unilateral complete) billed on one line with modifier LT (left side) and on a second line with modifier RT (right side) will be replaced with 73520 (X-ray, hips, bilateral)
Professional component and technical component	• Most diagnostic radiology services and some laboratory services are reimbursed based on the concept that these services are divided into the following components: 1. **Professional component.** Describes the physician work portion of the procedure. This portion is identified by appending modifier 26 to the appropriate lab or radiology procedure. 2. **Technical component.** Describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service. This portion is identified by appending modifier TC to the appropriate lab or radiology procedure. • The CMS Medicare Physician Fee Schedule has certain indicators that note if the professional or technical component concept applies. If the professional or technical component don't apply, it's inappropriate to append modifier 26 or TC. **Example**: CPT 90707 (MMR vaccine) is listed as a PC/TC Indicator 9 code. Since a vaccine wouldn't have a professional or technical component, it's inappropriate to append modifier 26 or TC to this service.
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
Revenue code validation	• Revenue codes are 4-digit codes used to classify types of service. They are necessary for accurate hospital outpatient claims processing and are required for processing of all outpatient facility claims. If revenue codes are not present on a claim, the charges will be denied. There are also policies enforcing the appropriate use of revenue codes on outpatient facility claims. • Revenue codes not recognized by CMS will be denied. • The claim line will be denied when the revenue code and the HCPCS code does not match. • Many revenue codes are required to be billed with a CPT/HCPCS code. If these revenue codes are not submitted with a valid CPT/HCPCS code, the charges will be denied. **Example**: Revenue code 0510 (clinic) is required to be billed with a HCPCS code. If billed without one, the charges will be denied. • Alternatively, the CPT/HCPCS codes billed must be appropriate for use with the billed revenue code. If the codes do not match, the charges will be denied. **Example**: If a provider bills 71010 (chest x-ray) and the revenue code associated to the procedure is not 0324 (chest x-ray), then 71010 will be denied as a revenue code/HCPCS code mismatch. • Certain revenue codes are not appropriate for use with outpatient hospital claims billed by facilities. If these revenue codes are billed by facilities for outpatient claims, the claims will be denied. Specifically, room and board revenue codes 010X-021X are intended to be used only in the inpatient hospital setting.
Same/Similar Services Performed Recently Edits/Once Per Lifetime Edits	• Subsequent claims after initial reimbursement are made for once in a lifetime services will be denied. • Claims after two reimbursements are made for once in a lifetime services which can be performed bilaterally will be denied. • Certain ophthalmology services when performed on the same side as a previous eye enucleation, evisceration, or exenteration by any provider will be denied. • Ophthalmology services that are bilateral in nature when billed without modifier 52 (reduced service) following a previous eye enucleation, evisceration, or exenteration by any provider will be denied. • Certain lower limb services when performed on the same side as a lower extremity amputation by any provider will be denied. • Certain gastric services that are performed after a total gastrectomy by any provider will be denied. • Certain upper limb services when performed on the same side as an upper extremity amputation by any provider will be denied. • Certain renal services that are performed after a total nephrectomy by any provider will be denied. • Certain services related to the lung that are performed after a total pneumonectomy by any provider will be denied. • Certain services related to the uterus that are performed after a total hysterectomy by any provider will be denied. • Certain thyroid services that are performed after a total thyroidectomy by any provider will be denied.
Self-Administered Drugs	Effective November 1, 2022: 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).

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

If you have any questions, please contact Provider Inquiry at **(866) 766-4661**.

National Correct Coding Initiative

The HAP Empowered 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 Empowered 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.

Section 12: Clinical Appeals

Providers can appeal a utilization management decision made by HAP Empowered. The appeal must be submitted in writing to the address or fax number listed below based on the appeal type:

Appeal Type	Address	Fax Number
Pre-Service or Pre-Service Expedited	HAP Empowered Health Plan P.O. Box 2578 Detroit, MI 48202	**(313) 664-5866**
Post-Service	HAP Empowered Health Plan Healthcare Management Attention: Denials and Appeals P.O. Box 2578 Detroit, MI 48202	**(313) 664-5904**

Appeal levels

- HAP Empowered Medicaid contracted and noncontracted providers have one appeal level.
- HAP Empowered MI Health Link contracted and noncontracted providers have two appeal levels.

Time frame extension

Extending the appeal time frame is only allowed when the member voluntarily agrees to extend the time to obtain additional information to support the member request.

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

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

Peer-to-Peer Reviews: A chart review is not done. These are conducted when patient is still in hospital and the provider is trying to get authorization.

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

If a full chart review was not done by HAP, 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 Empowered, 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 Empowered. You can send by mail, fax, or email.

Mail: HAP Empowered Health Plan
Appeal & Grievance
P.O. Box 2578
Detroit, MI 48202

Fax: (313) 664-5866

Provider appeal process

Appeal type	Process and Requirements	Applies to
Pre-service A request to change the decision on any case or service that must be made in whole or in part in advance of the member obtaining medical care or services	**Level 1** • The provider is notified of their appeal rights and procedure. • The provider has up to 60 calendar days to file an appeal. • Pre- service appeals must be submitted in writing to the address or fax number above. • If the HAP Empowered Medical Director can't reverse the adverse determination, a physician 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. • The preservice appeal will be resolved within 30 calendar days of the request for appeal. • Procedures for additional levels of appeal are provided to the member when the adverse determination is upheld.	All HAP Empowered plans
	Level 2 • Second-level appeal is sent automatically to the Independent Review Entity for review.	HAP Empowered MI Health Link only
Post service A request to change a decision on any review for care or services that have already been received	**Level 1** • The provider is notified of their appeal rights and procedure. • The provider has up to 60 calendar days to file an appeal. • Post service appeals must be submitted in writing to the address or fax number above. • If the HAP Empowered medical director can't reverse the adverse determination, a physician not involved in the initial denial will review the case. The physician reviewer will be the same specialty as the requesting physician with similar credentials and licensure. • The appeal will be resolved within 60 days of the request for appeal. • Procedures for additional levels of appeal are provided to the provider when the adverse determination is upheld.	All HAP Empowered plans
	Level 2 • When the denial for post service first level appeal is upheld by the HAP Empowered physician reviewer, written confirmation of the decision is sent to members and providers within 60 calendar days of receipt of the request. • Requests for second-level appeal must be submitted in writing and received within 60 days of the first-level appeals decision. • The HAP Empowered medical director reviews the second-level appeal. • If the HAP Empowered medical director can't reverse the adverse determination, the Quality Improvement Committee physicians will convene to review the appeal. • The appeal will be resolved within 60 days of the request for second-level appeal.	HAP Empowered MI Health Link only Contracted providers

Appeal type	Process and Requirements	Applies to
Expedited (preservice) A request to change an urgent care request where the decision could: • Seriously jeopardize the life or health of the member • Jeopardize the member's ability to regain maximum function • Subject the member to severe pain, not managed without the requested care	• When the HAP Empowered 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. • The member, or their authorized representative, may file an expedited appeal for a denied urgent care request. • The member must submit the appeal within 60 days. • HAP Empowered will complete the entire expedited appeal process within 72 hours of receipt of the appeal request. • Verbal notification is given within 72 hours of receipt of the appeal request. • Written notification is given within three calendar days of the appeal request. • Due to the time frame requirements to complete two level reviews, each level will be completed by a HAP Empowered provider in the same or similar specialty, independent of each other (i.e., not partners in the same group).	All HAP Empowered plans

Section 13: Pharmacy

Pharmacy drug plan coverage

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

To request a coverage determination or prior authorization for a medication or for questions related to drug programs, please call HAP Pharmacy Care Management at **(313) 664-8940** and:

- **Select option 1** for HAP Empowered MI Health Link or HAP Medicare Complete Duals (HMO D-SNP)
- **Select option 3** for HAP Empowered Medicaid

Helpful numbers and links for providers

For	Contact
HAP Pharmacy Care Management	**(313) 664-8940** Monday-Friday, 8:00 a.m. to 4:30 p.m.
Specialty and Mail Order (Home Delivery) Pharmacy (Pharmacy Advantage)	**(800) 456-2112** Monday-Friday, 7 a.m. to 7 p.m.
Completed prior authorization forms for HAP Empowered Medicaid	Fax: **(313) 664-5460**
Completed prior authorization forms for: Commercial, Qualified Health Plan, Medicare, HAP Empowered MI Health Link and HAP Medicare Complete Duals (HMO D-SNP)	Fax: **(313) 664-8045**
HAP Empowered MI Health Link Formulary	hap.org/hap-empowered/mi-health-link
HAP Empowered Medicaid Formulary	hap.org/medicaidformulary
Formularies for Commercial, Qualified Health Plan, Medicare and HAP Medicare Complete Duals (HMO D-SNP)	hap.org/prescriptions

Drug Formulary (known as a Drug List for HAP Empowered MI Health Link)

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

- **Prior authorization (PA) criteria:** 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 Empowered Medicaid Patients

Effective June 8, 2022, per State of Michigan Senate Bill No. 412, prior authorization requirements for your HAP Empowered Medicaid 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 Empowered Medicaid patients.

Claims for drugs in these protected classes will be approved according to reasonable, appropriate payment parameters (e.g., 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

Please see Senate Bill No. 412 on the following pages for more details.

Act No. 19
Public Acts of 2022
Approved by the Governor
March 10, 2022
Filed with the Secretary of State
March 10, 2022
EFFECTIVE DATE: June 8, 2022

STATE OF MICHIGAN
101ST LEGISLATURE
REGULAR SESSION OF 2022

Introduced by Senators Hertel, Bullock, Wojno, Santana, Chang, Geiss, Bizon, MacDonald, Irwin, LaSata, Ananich and Schmidt

ENROLLED SENATE BILL No. 412

AN ACT to amend 1939 PA 280, entitled "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act; to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates," by amending section 109h (MCL 400.109h), as added by 2004 PA 248.

The People of the State of Michigan enact:

Sec. 109h. (1) If the department develops a prior authorization process for prescription drugs as part of the pharmaceutical services offered under the medical assistance program administered under this act, the department shall not require prior authorization for the following single source brand name, generic equivalent of a multiple source brand name, or other prescription drugs:

(a) A central nervous system prescription drug that is classified as an anticonvulsant, antidepressant, antipsychotic, or a noncontrolled substance antianxiety drug in a generally accepted standard medical reference.

(b) A prescription drug that is cross-indicated for a central nervous system drug exempted under subdivision (a) as documented in a generally accepted standard medical reference.

(c) Unless the prescription drug is a controlled substance or the prescription drug is being prescribed to treat a condition that is excluded from coverage under this act, a prescription drug that is recognized in a generally accepted standard medical reference as effective in the treatment of conditions specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association, including substance use disorder. The department or the department's agent shall not deny a request for prior authorization of a controlled substance under this subdivision unless the department or the department's agent determines that the controlled substance or the dosage of the controlled substance being prescribed is not consistent with its licensed indications or with generally accepted medical practice as documented in a standard medical reference.

(d) A prescription drug that is recognized in a generally accepted standard medical reference to prevent acquisition of or to treat human immunodeficiency virus infection or complication of the human immunodeficiency virus or acquired immunodeficiency syndrome.

(e) A prescription drug that is recognized in a generally accepted standard medical reference for the treatment of and is being prescribed to a patient for the treatment of any of the following:

(*i*) Cancer.

(*ii*) Organ replacement therapy.

(*iii*) Epilepsy or seizure disorder.

(*iv*) Opioid withdrawal symptom management.

(2) This section applies to drugs being provided under a contract between the department and a health maintenance organization.

(3) This section does not prohibit the department from contracting with a managed care organization for pharmaceutical services offered under the medical assistance program administered under this act as long as the contract complies with the provisions of this section.

(4) As used in this section:

(a) "Controlled substance" means that term as defined in section 7104 of the public health code, 1978 PA 368, MCL 333.7104.

(b) "Cross-indicated" means a drug that is used for a purpose generally held to be reasonable, appropriate, and within community standards of practice even though the use is not included in the United States Food and Drug Administration's approved labeled indications for that drug.

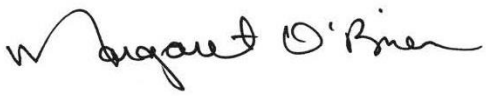
(c) "Prescriber" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(d) "Prescription" or "prescription drug" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(e) "Prior authorization" means a process implemented by the department that conditions, delays, or denies the delivery of particular pharmaceutical services to Medicaid beneficiaries upon application of predetermined criteria by the department or the department's agent for those pharmaceutical services covered by the department on a fee-for-service basis or according to a contract for those services. The process may require a prescriber to verify with the department or the department's agent that the proposed medical use of a prescription drug being prescribed for a patient meets the predetermined criteria for a prescription drug that is otherwise covered under this act or require a prescriber to obtain authorization from the department or the department's agent before prescribing or dispensing a prescription drug that is not included on a preferred drug list or that is subject to special access or reimbursement restrictions.

Enacting section 1. This amendatory act takes effect 90 days after the date it is enacted into law.

This act is ordered to take immediate effect.



Secretary of the Senate

Clerk of the House of Representatives

Approved_____

_____

Governor

HAP Empowered MI Health Link Medicare-Medicaid Program

Drug List

- The current HAP Empowered MI Health Link Drug List can be found here. You can search for drugs alphabetically or by medical use of a drug. The drug list may change annually on January 1 and periodically throughout the year.
- You can obtain a printed drug list by calling Customer Service at **(888) 654-0706**.
- The HAP Empowered MI Health Link Drug List is the same drug list as the HAP Medicare Part D drug formulary with an "**ADD**" file. The ADD file is a list of over-the-counter (OTC) drugs and some other drugs excluded from coverage under Medicare Part D but covered under the Medicaid portion of the HAP Empowered MI Health Link benefit.

Prior authorization or exception request

- To request a coverage determination (for prior authorization or an exception), please complete a Request for Medicare Prescription Drug Coverage Determination Form. It can be found here.
- For the best patient experience, please review the drug list prior to writing a prescription for a new drug. If the drug has restrictions, a prior authorization request must be submitted. HAP now has electronic prior authorization available (ePA) on the CoverMyMeds platform. You may also complete a request form and fax with supporting documentation. You can also call us. See the table below for contact information.
- 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 Empowered MI Health Link Medicare-Medicaid Program:

For	Contact
Requests for prior authorization or exceptions	Fax: **(313) 664 8045**
Provider Prior Authorization Line	Phone: **(313) 664-8940, option 1**

HAP Medicare Complete Duals (HMO D-SNP)

Formulary

- The current HAP Medicare Complete Duals (HMO D-SNP) Drug Formulary can be found at www.hap.org/medicare/member-resources/prescriptions/formulary-drug-list . You can search for drugs alphabetically or by medical use of a drug. The drug formulary may change annually on January 1 and periodically throughout the year.
- You can obtain a printed formulary by calling Customer Service at **(800) 848-4844**.
- The D-SNP formulary is the same drug list as the HAP Medicare Part D drug formulary.
- D-SNP members have an over-the-counter (OTC) drug benefit through their Medicare Advantage medical coverage (Part C). Members may purchase OTC drugs and other products from a catalog using a dollar (money) allowance that is renewed quarterly. The catalog, order form and contact information for the OTC Servicing Center is found on our website https://www.hap.org/medicare/member-resources/over-the-counter-benefit

Prior authorization or exception request

- To request a coverage determination (for prior authorization or an exception), please complete a Request for Medicare Prescription Drug Coverage Determination Form. It can be found here.
- For the best patient experience, please review the drug formulary prior to writing a prescription for a new drug. If the drug has restrictions, a prior authorization request must be submitted. HAP now has electronic prior authorization available (ePA) on the CoverMyMeds platform. You may also complete a request form and fax with supporting documentation. You can also call us. See the table below for contact information.
- 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 Medicare Complete Duals (HMO D-SNP) Program:

For	Contact
Requests for prior authorization or exceptions	Fax: **(313) 664 8045**
Provider Prior Authorization Line	Phone: **(313) 664-8940, option 1**

Biosimilar Policy for Part B Medical Drug Step Therapy

Per our policy, certain biosimilar products are the preferred treatments over reference drug products. This policy includes drugs such as Avastin, Herceptin, Rituxan, Remicade and others. Use the link below to view the complete list. **All** preferred drugs must be tried before the non-preferred product can be authorized.

Depending on the member's plan, prior authorization may be needed for the biosimilar products. Prior authorization is always required for reference drugs. Our *Biosimilar* Products policy applies to HAP Empowered Medicaid and HAP Empowered MI Health link members.

Coverage Policies

Enrollees currently using the branded reference product can continue current therapy until they complete treatment or may switch to the biosimilar product.

You can review the full policy when you log in at **hap.org** and select *Benefit Admin Manual* under *More* and search for biosimilar products.

Find a quick access link to the list of preferred biosimilar drugs at:
www.hap.org/emp/hap-empowered/mi-health-link/prescription

Providers may request prior authorization by following the prior authorization instructions previously described.

Opioid dispensing rules for HAP Empowered MI Health Link and HAP Medicare Complete Duals (HMO D-SNP) members

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

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

Opioid point of sale (POS) pharmacy safety edits

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

2. **Seven-day supply limit for opioid naïve patients**
    - Opioid claims are limited to a seven-day supply when prescribed for opioid-naïve patients, e.g., for acute pain. An opioid naïve patient is identified at the dispensing pharmacy based on the prescription claims history of opioids dispensed. If a beneficiary has not had opioid prescriptions filled in the previous 108 days, the rule set assumes that an opioid is being prescribed to an opioid naïve beneficiary for treatment of acute pain. The pharmacy **cannot** override this edit.
3. **Multiple long-acting opioid medications**
    - If a beneficiary has overlapping prescriptions for two long-acting opioid medications, the new prescription will reject. Pharmacies may override this rejection at the point of sale after confirming with the prescriber that the drug therapy is appropriate.
4. **Concomitant use of benzodiazepines**
    - If a beneficiary has overlapping claims for benzodiazepine and opioid medications, the new prescription will reject. Pharmacies may override this rejection at the point of sale after confirming with the prescriber that concomitant use is appropriate.

Drug Management Program (DMP) for HAP Empowered MI Health Link and HAP Medicare Complete Duals (HMO D-SNP) members

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

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

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

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

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

- Requiring the beneficiary to obtain all prescriptions for opioid medications from one pharmacy
- Requiring the beneficiary to get all prescriptions for opioid medications from one doctor
- Limiting the amount of opioid medications covered in a specified time period

Any Dual Eligible member (HAP Medicare Complete Duals (HMO D-SNP) or HAP Empowered MI Health Link) with a coverage limitation under Part D will have that same drug or quantity restriction under the Medicaid benefit.

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

The dispensing pharmacy or a HAP pharmacist may contact you about a beneficiary's opioid prescription(s) to determine if opioid use is appropriate and medically necessary. During normal business hours, your office will be contacted, or you may be paged. After hours contact will follow your after-hours process as instructed by telephonic recordings or answering services.
For more information on the Part D opioid safety policies please visit *A Prescriber's Guide to Medicare Prescription Drug (Part D) Opioid Policies*.

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

HAP Empowered Medicaid

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. The 2023 HAP Empowered Medicaid formulary and updates can be found here, including the formulary, a list of formulary changes, formulary restrictions such as prior authorization criteria, step therapy criteria and other related drug formulary documents.
- 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

You can obtain a printed formulary by calling Customer Service at **(888) 654-2200**.

Prior authorization or exception requests
Common Formulary drugs, 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*. Visit *hap.org/hap-empowered/medicaid/prescription;* then go to *Formulary and forms.* 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 Empowered Medicaid

For	Contact
Prior authorization or exceptions	Fax: **(313) 664-5460**
Prior Authorization Line	Phone: **(313) 664-8940, option 3**

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 when you visit https://**michigan.magellanrx.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 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 happens mostly with OTC products made by multiple manufacturers. The Medicaid Health Plan can override this rejection in certain circumstances with supporting documentation.

Medications covered under the medical benefit

- The Common Formulary includes drugs covered as a pharmacy benefit only.
- Medications used in a physician's office may be covered under the medical benefit. For example:
  - Intrauterine devices
  - Physician-administered injectable drugs
  - Some vaccines

HAP Empowered Medicaid 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. This program integrates pharmacy claims, medical claims and lab data at the individual patient level, focusing on:

- Adverse drug risk
- Coordination of care opportunities
- Omission of essential care

This program alerts physicians 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 alerts are sent specific to adverse drug-disease.

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 Oct. 1, 2019, and is designed to reduce opioid related fraud, misuse and abuse.
The HAP Empowered Medicaid 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 plan.
Types of prospective safety edits include:

- A passive concurrent DUR rule that identifies beneficiaries who request 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 7-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 MCO 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 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.

We perform claims reviews at least monthly to identify beneficiaries with multiple prescriptions, multiple prescribers and use of multiple pharmacies for opioid medications. We focus on beneficiaries with an average daily MME approaching or above 90. Using prescription claims carve-out data from the State, we review claims data quarterly for concurrently prescribed opioids and benzodiazepines, or opioids and antipsychotic medications. This may result in a reach-out to the provider by letter or telephone to provide and/or discuss treatment alternatives.

Questions or need help with opioid management?
Visit https://www.cdc.gov/opioids/providers/prescribing/index.html

Benefits Monitoring Program (BMP) for HAP Empowered Medicaid

We administer a Benefits Monitoring Program (BMP) as required by MDHHS to 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 Empowered Medicaid Case Management and Pharmacy teams and medical directors. 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. Related to drugs, criteria include multiple prescription fills for drugs/categories with abuse potential and use of multiple prescribers and pharmacies. MAPS reports are reviewed for beneficiaries as appropriate to identify/confirm all controlled substances prescription activity.

When a member is enrolled in the BMP program, HAP Empowered Medicaid sends an educational letter/form to notify the beneficiary. The beneficiary has 10 days to discuss the findings with HAP Empowered. If the beneficiary does not return the form, HAP Empowered sends a second notice to the beneficiary that they will be enrolled and the providers to which they've been assigned. 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 the 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. Other providers may prescribe other drug classes.

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

Medicaid Transition of Care Policy- Prescriptions

The HAP Empowered Medicaid 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 Empowered Medicaid 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 Empowered Medicaid (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 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 3 business days and to the provider within 5 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, including narcotic opioids and specialty drugs, are transitioned through a manual review of claim rejections (for drugs not on the list or with restrictions). The Pharmacy team will:

- Review certain rejected claims from the previous day
- Identify transition-eligible members and claims from these categories
- Reach out to the prescriber to facilitate the transition fill

In addition, for any Medicaid covered drug, the member, his or her appointed representative, or the member's prescriber, may request continuity of care on behalf of the member. If you would like to request a transition fill for a Medicaid covered drug, you can contact:

- The HAP Empowered Medicaid Pharmacy team at **(313) 664-8940 option 3**
- Customer Service
- The member's Care Manager

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

It's also important to update your office information directly with HAP. Please complete our form which can be found in two places on **hap.org**:

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

Section 14: Quality Management

Quality Management Program for HAP Empowered Medicaid including HAP Empowered Children's Special Health Care Services (CSHCS) and HAP Empowered Healthy Michigan Plan (HMP)

HAP Empowered has an ongoing Quality Assessment and Performance Improvement Program (QAPI) for HAP Empowered Medicaid members including HAP Empowered CSHCS and HAP Empowered 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 Empowered pursues opportunities to improve care and services and resolve identified problems. HAP Empowered, PCPs and specialists have a role in monitoring, maintaining and improving the quality of care and services.

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

- Visiting **https://www.hap.org/providers/provider-resources/empowered-providers,** then *Quality programs*.

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
- Consumer and provider surveys
- Medical records
- On-site facility reviews
- Utilization data

Preventive and Clinical Care Guidelines for HAP Empowered Medicaid

HAP Empowered adopts and supports clinical practice or care guidelines for the treatment of a variety of medical and behavioral conditions. Care Guidelines help caregivers provide the right care at the right time using the most current evidence to result in the best outcomes. These guidelines are researched, developed and approved in partnership with the Michigan Quality Improvement Consortium (MQIC)- an organization of health plans focused on the health of our members in Michigan. MQIC is led by physicians and other clinical team members who evaluate scientific data and develop guidelines to help support the work of primary care physicians. MQIC's goal is to standardize these practice guidelines to help all physicians in Michigan; and HAP Empowered is helping these efforts. MQIC reviews the guidelines every two years or as needed. Examples of some of these guidelines include:

- Preventive care from birth to age $\geq$ 50
- Prenatal and postpartum care
- Clinical and chronic care including:
  - Asthma
  - ADHD
  - Depression
  - Diabetes
  - Hypertension
  - Heart Failure
  - Kidney Disease
  - Obesity
  - Tobacco cessation

You can find a link to the guidelines when you visit **www.hap.org/empoweredproviders,** then select *Care guidelines.*

Quality Management Program for HAP Empowered MI Health Link

HAP Empowered has an ongoing Quality Assessment and Performance Improvement Program for HAP Empowered MI Health Link members. The program is designed to:

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

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

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

- Visiting **www.hap.org/empoweredproviders**, then *Quality Programs*.

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

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

Preventive and Clinical Care Guidelines for HAP Empowered MI Health Link

HAP Empowered adopts and supports clinical practice or care guidelines for the treatment of a variety of medical and behavioral conditions. Care Guidelines help caregivers provide the right care at the right time using the most current evidence to result in the best outcomes. These guidelines are researched, developed and approved in partnership with the Michigan Quality Improvement Consortium (MQIC)- an organization of health plans focused on the health of our members in Michigan. MQIC is led by physicians and other clinical team members who evaluate scientific data and develop guidelines to help support the work of primary care physicians. MQIC's goal is to standardize these practice guidelines to help all physicians in Michigan; and HAP Empowered is helping these efforts. MQIC reviews the guidelines every two years or as needed. Examples of some of these guidelines:

- Asthma
- Obesity
- Depression
- Diabetes
- Hypertension
- Preventive care from birth to age $\geq$ 50
- Prenatal and postpartum care
- Heart Failure
- Tobacco cessation

You can find a link to the guidelines when you **www.hap.org/empoweredproviders**, then select *Care guidelines.*

Health and wellness programs

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

Program	Description
24/7 NurseLine	HAP Empowered members have access to a 24/7 health information line to help with questions about medical care. Nurses are ready to answer questions any time, day or night. The NurseLine provides trusted, physician-approved information to help guide members' health care decisions. A registered nurse helps with: • Choosing appropriate medical care • Finding a doctor or hospital • Understanding treatment options • Achieving a healthy lifestyle • Learning how take medication safely To use the NurseLine, members can call **(877) 394-0665.**
iStrive® for Better Health	HAP Empowered members can manage their health with iStrive for Better Health. It's our digital wellness tool powered by WebMD health services. It can help them: • Take an online health assessment. • Learn more about health issues like asthma, being tired all the time, depression and more. • Check their progress with health trackers. • Reach their goals for fitness, weight, healthy eating, stress and quitting tobacco
	• Self-management programs: – Asthma – Back pain – Coronary artery disease – Exercise – Hypertension – Nutrition – Pregnancy – Preventive care – Stress management – Tobacco cessation – Weight management
Preventive health reminders	HAP Empowered outreaches to members that may be due for preventive health services including: • Blood lead testing • Cervical cancer screening • Child and adolescent vaccines • Colorectal cancer screening • Comprehensive diabetes care • Lead testing • Mammogram screening • Well-child and adolescent visits • Annual Well 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 **(888) 654-2200**.

Program	Description
Maternal Infant Health Program, (MIHP)	MIHP supports healthy pregnancies and healthy infants. It is open to all MI Health Link and Medicaid-eligible pregnant women. It also serves infants with Medicaid. MIHP will: • Visit members during and after their pregnancy to help them take care of themselves and their baby • Nurses who visit will teach about pregnancy, labor and delivery. They also teach members how to care for their baby • Social workers will help with housing, baby supplies and other support • Dietitians will teach about eating healthy during pregnancy. They also teach members how to feed their baby • Connect members to parenting classes • Refer members to local community services, if needed • Refer members to childbirth classes close by • Help members with transportation to services, if needed If Medicaid members have questions about MIHP, they should contact ProgenyHealth at **(855) 231-4730.** If MI Health Link members have questions about MIHP, they should contact the HAP Care Management department at **(800) 288-2902.**
Maternity Program powered by ProgenyHealth	HAP's Maternity Management program, powered by ProgenyHealth, supports Medicaid-eligible pregnant women and ensures members have a healthy pregnancy by: • Connecting members with an OB or OB/GYN • Providing reminders for prenatal and postpartum visits and assisting with scheduling if needed • Conducting maternity-specific assessments in order to ensure members are receiving the care they need • Education on benefits available while pregnant, including dental services • Connecting members to nurses or behavioral health services if needed • Referring members to a Maternal Infant Health Program (MIHP). MIHPs offer in home visits to provide education about pregnancy and newborn care. • Checking in after delivery to make sure everyone is doing well • Digital engagement, ongoing education and support through the Ovia Health™ enterprise mobile application For more information or to enroll, members can call ProgenyHealth at **(855) 231-4730.**

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 36 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).

Healthy Michigan Plan Health Risk Assessment Instructions for Providers

$25 Incentive for Primary Care Providers

Healthy Michigan Plan (HMP) is a health care program from the Michigan Department of Health and Human Services. HAP Empowered Healthy Michigan Plan members reside in Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola, and Wayne counties. A key feature of HMP is the Healthy Behaviors Incentive Program which encourages HMP members to maintain and implement healthy behaviors.

Health risk assessment

HAP Empowered Healthy Michigan Plan members are required to complete a health risk assessment (HRA) every year. Within 60 days of enrollment, members are encouraged to schedule an appointment with their primary care provider. They're asked to take the HRA to the appointment. We also partner with Genesee Health Plan to outreach to members and help them complete the form. They also process the HRA.

$25 incentive for providers

HAP Empowered offers a $25 incentive for primary care providers who complete and return an HRA for their HAP Empowered Healthy Michigan Plan patients. Incentives are paid quarterly. Here are the steps for completing the HRA.

- The member completes sections 1-3 of the form.
- The doctor completes section 4 and signs the form.
- The doctor faxes the completed form to HAP at **(844) 225-4602** or to CHAMPS.
- The doctor gives the member a completed, signed copy of the HRA.
- The doctor bills with CPT code 96160. The transaction will appear on the remittance advice and submitted to the Michigan Department of Health and Human Services as an encounter.

Note: During the COVID-19 pandemic, the Michigan Department of Health and Human Services is allowing HAP Empowered staff to complete the HRA with the member. This is a time-limited exception and staff must follow MDHHS guidance until the exception has ended.

Resources

Please see the table below for MDHHS tools that offer quick educational materials about HMP HRA. The videos walk through the HRA completion and submission process. The fact sheets are downloadable PDF's, with screenshots of the HMP HRA process.

Resource Websites	• Healthy Michigan Plan • Health Risk Assessment • Completing the HRA within CHAMPS
HMP HRA Videos	• Completing the HRA • Submitting the HRA • Overview Healthy Behaviors Incentive Program • HMP Healthy Behaviors Incentives Program & COVID-19
HMP HRA Fact Sheets	• HRA – A tool for Patient-Centered Care Fact Sheet • HMP HRA Fact Sheet

For more information:

- Visit michigan.gov/healthymichiganplan
- Call HAP Empowered Customer Service at **(844) 214-0870**

Section 15: Member medical records

Requirements

To promote continuity and quality of member care, HAP Empowered requires all participating providers to maintain their HAP Empowered 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.

1. Providers must maintain medical records of all medical services received by the member. The medical record must include, at a minimum:
    a. A record of outpatient and emergency care
    b. Specialist referrals
    c. Ancillary care
    d. Diagnostic test findings including all laboratory and radiology
        - Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review.
        - If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner.
        - Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow up plans.
        - Working diagnoses are consistent with findings.
    e. Treatment plans
        - Consistent with diagnoses
    f. Prescriptions for medications
    g. Allergies and adverse reactions
        - These are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
    h. Inpatient discharge summaries
    i. Histories and physicals
        - Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
        - Identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
    j. Problem list
        - Includes significant illness and medical conditions
    k. Unresolved problems from previous office visits are addressed in subsequent visits.
    l. Immunization records
        - An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).
    m. Preventive services screenings
        - There is evidence that preventive screening and services are offered in accordance with our practice guidelines
    n. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).

o. Other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided. This could include:
    - Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
    - There is review for under - or overutilization of consultants.
    - If a consultation is requested, there a note from the consultant in the record.
    - There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

p. Advanced Directives
    - Addressed with each adult patient and the completed documents are maintained in the patient record. Advanced care planning recommendation, discussion and appropriate information is provided to the patient and documented in the chart accordingly.

2. Medical records must be maintained 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. Note:
    - Each page in the record contains the patient's name or ID number.
    - Personal biographical data include the address, employer, home and work telephone numbers and marital status.
    - All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
    - The record is legible to someone other than the writer
3. Medical records must be signed and dated.
4. All medical records must be retained for at least 10 years.
5. Maintain medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.
6. Providers must abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information.
7. Providers must comply with applicable State and federal laws regarding privacy and security of medical records and protected health information.
8. When an Enrollee changes PCP, the former PCP must forward the member's medical records or copies of medical records to the new PCP within 10 working days from receipt of a written request.

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

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.

Medical Records Retrieval Policy

Providers shall make records available to HAP and/or State and Federal regulatory agencies when necessary to prove compliance with Federal or State HMO laws, CMS and other federal agency requirements pertaining to Medicare and the Affordable Care Act, or the obligations assumed by HAP 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 members shall be compliant with MDCH and HMO licensing requirements as well as HAP 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 requests medical records for the following reasons:
    - Record content and quality
    - Peer review
    - Grievance review
    - Audit review

CMS Risk Adjustment Validation Audits

Provider shall include supporting documentation in a Medicare Member's medical record for all diagnosis codes submitted to HAP 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 with medical records so that (1) HAP can comply with a CMS Risk Adjustment Data Validation Audit (RADV) and (2) HAP can conduct appropriate oversight and risk mitigation as it relates to HAP's risk adjustment processes. Provider shall submit complete and accurate risk adjustment data as requirement by CMS. Provider acknowledges Its obligation to cooperate with HAP 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 ten (10) years.
    - Inability to produce a medical record for a covered service will result in the following:
        - **First occurrence:** written warning and retrieval of paid amount made to the provider
        - **Second occurrence**: written warning and retrieval of paid amount made to the provider. Incident will be reviewed at Provider Peer Review Committee meeting.
        - **Third occurrence:** Termination of participation with HAP and retrieval of paid amount made to the provider.

Section 16: Hepatitis C Virus – Frequently Asked Questions for Providers

In 2021, the Michigan Department of Health and Human Services 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 actually be as high as 200,000 considering those undiagnosed. Screening, testing and treatment can save and prolong life.

Below are some frequently asked questions about HCV. We will post this information on our website. Visit **www.hap.org\empoweredproviders**.

Member outreach

1. **How do you educate members on hepatitis C?**
   We sent a letter to all HAP Empowered Medicaid members, age 18 and older. The letter had general information about HCV and the importance of testing. We also send a letter to new members that enroll with HAP Empowered. Letters were also sent to all HAP Empowered MI Health Link members, and information on HCV is now included in the New Member Packets.

2. **How do you help members who need transportation for testing or treatment?**
   Members can call our Customer Service team to schedule a ride. They can be reached at **(888) 654-2200 (TTY 711)**. Information about the transportation benefit can be found:
   - On the HAP Empowered website
   - In the member handbook

Testing

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

For	CDC recommendations
Universal hepatitis C screening	• Hepatitis C screening at least once in a lifetime for all adults aged 18 years and older, except in settings where the prevalence of HCV infection (HCV RNA-positivity) is less than 0.1%* • Hepatitis C screening for all pregnant women during each pregnancy, except in settings where the prevalence of HCV infection (HCV RNA-positivity) is <0.1%*
One-time hepatitis C testing regardless of age or setting prevalence among people with recognized conditions or exposures	• People with HIV • People who ever injected drugs and shared needles, syringes, or other drug preparation equipment, including those who injected once or a few times many years ago • People with selected medical conditions, including persons who ever received maintenance hemodialysis and persons with persistently abnormal ALT levels • Prior recipients of transfusions or organ transplants, including people who: – Received clotting factor concentrates produced before 1987 – Received a transfusion of blood or blood components before July 1992 – Received an organ transplant before July 1992 – Were notified that they received blood from a donor who later tested positive for HCV infection – Health care, emergency medical and public safety personnel after needle sticks, sharps, or mucosal exposures to HCV-positive blood – Children born to mothers with HCV infection
Routine periodic testing for people with ongoing risk factors, while risk factors persist	• People who currently inject drugs and share needles, syringes, or other drug preparation equipment • People with selected medical conditions, including people who ever received maintenance hemodialysis
Any person who requests hepatitis C testing	These persons should receive it, regardless of disclosure of risk, because many persons might be reluctant to disclose stigmatizing risks
*Determining prevalence: In the absence of existing data for hepatitis C prevalence, health care providers should initiate universal hepatitis C screening until they establish that the prevalence of HCV RNA positivity in their population is less than 0.1%, at which point universal screening is no longer explicitly recommended but may occur at the provider's discretion. Source: https://www.cdc.gov/hepatitis/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 Empowered 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 Empowered have any initiatives to routinize testing?**
   Yes. We have the following initiatives:
   - Our Care Management team has developed an outreach plan for:
     - Members needing HCV screening
     - Members diagnosed with HCV
   - We ensure the member is connected with their primary care physician. We continue to provide ongoing support and follow up.
   - Part of our maternity care program ensures the member gets all recommended screenings. HCV screening is included.
   - Part of the health screening of new members includes HCV screening questions. Our care management team will follow up with members who have not completed screening.
   - We added information on hepatitis C screening and treatment to:
     - The member handbook
     - The member newsletter
     - Our website
   - Our Care Management team partners with the following groups to outreach to members:
     - Community-based organizations
     - Homeless shelters
     - Local health departments
     - Federally Qualified Health Centers

5. **Does HAP Empowered 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) for Medicaid and Healthy Michigan Plan beneficiaries. MAVYRET is an oral prescription medication. It's used to treat adults and children ages 12 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 and for HAP Empowered MI Health Link MMP, the preferred drug is Mavyret and it is available without a prior authorization or quantity limit.

   Medicaid

Preferred DAA	MAVYRET (glecaprevir and pibrentasvir)
Non-Preferred DAAs (prior authorization required)	Epclusa Harvoni ledipasvir/sofosbuvir(generic for Harvoni) sofosbuvir/velpatasvir (generic for Epclusa) Sovaldi Viekira Pak Vosevi Zepatier

   HAP Empowered MI Health Link

Preferred DAA	MAVYRET (glecaprevir and pibrentasvir)
Non-Preferred DAAs (prior authorization required)	Zepatier

3. **How does HAP Empowered 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.

4. **How does HAP Empowered follow up with members receiving treatment to offer support on medication adherence?**
   Our Pharmacy team gets a weekly report of all pharmacy claims (YTD) for hepatitis C antivirals.

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 reach-out occur if a DAA other than Mavyret is prescribed.

   HAP Empowered also communicates with pharmacy providers related to medication treatment:
   - Electronic bulletins to the pharmacy network
   - Reach-out to individual pharmacies when needed to facilitate medication adherence

5. **Does HAP Empowered track members with an HCV diagnosis and no record of treatment?**
   Yes. A report is shared with Care Management teams monthly to facilitate review and follow up.

Resources

1. **Where can I find helpful resources about HCV?**
   MDHHS has partnered with several organizations for resources to help providers treat HCV patients. Please see the table below.

For	Contact
Consulting line for all health care professionals with questions about HCV treatment	Henry Ford Health **(313) 575-0332** 8 a.m. to 5 p.m. daily
• On-demand webinars • Live training events • Office hours • Other resources for health care professionals on treating HCV	Midwest AIDS Training and Education Center (MATEC) at Wayne State University School of Medicine Division of Infectious Diseases **matecmichigan.com**
Education and case consultation on HCV	**Michigan Opioid Collaborative**
Additional resources	**Michigan.gov/WeTreatHepC**
Notification of new training opportunities and events	Send a request to be added to the listserv: Email **MDHHS-Hepatitis@michigan.gov**

Section 17: Vaccines, MCIR & Reporting Communicable Diseases

Vaccines

State law requires providers who administer vaccines to HAP Empowered Medicaid members to obtain the vaccines through the Vaccines for Children program. This is a federal program that makes vaccines available to immunize children age 18 and under who are Medicaid eligible. Vaccines can be obtained free of charge from local health departments.

- Medicaid covers immunizations for beneficiaries 19 years of age and older.
- Any LHD in the state can be contacted for specifics about the VFC program

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 the HAP Empowered provider contract require providers to report communicable diseases to the local health department.

The Alliance for Immunization in Michigan

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

For vaccine information and resources, visit aimtoolkit.org .

Section 18: Continuity of Care

While in good standing, if a PCP or specialist terminates their contract with HAP Empowered, they may continue to serve their HAP Empowered members to ensure continuity of care. Upon contract termination, HAP Empowered will send the provider a list of their HAP Empowered patients who are:

- In an active course of treatment for an acute episode of chronic illness or an 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 provider has any HAP Empowered 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 Empowered at **(248) 663-3780**.
- HAP Empowered will send a confirmation letter to the provider that outlines the continued treatment conditions for each member that the provider agrees to continue treating.
- The provider will be allowed to continue treatment as a non-par provider with appropriate prior authorization for up to 90 calendar days for:
  - Members in active treatment for an acute or chronic medical condition
  - Members through the acute phase of the condition being treated
  - Members through the postpartum period of six weeks postdelivery for women in the second and third trimester of pregnancy
  - A terminally ill member for the remainder of their life
- You must share information regarding the treatment plan with HAP Empowered.
- You must follow the HAP Empowered 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 Empowered will work with the provider and the member to develop a transition plan to a new PCP or specialist.

Section 19: Long-Term Services and Supports for HAP Empowered MI Health Link Members

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

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

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

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

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

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

The above services require prior authorization.

Section 20: 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
  - A person's cultural background shall be recognized and valued in the decision-making process.
  - Providing culturally competent care by listening and making accommodations for patients' diverse beliefs and practices. Providing 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
  - Health status
  - Marital status
  - Membership in HAP Empowered
  - National origin
  - Physical or mental handicap
  - Race
  - Religion
  - Sex
  - Sexual preferences
  - Source of 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)
- Providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollees with disabilities (both congenital and acquired disabilities), or other special population served by the HAP Empowered. This responsiveness includes the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those with a vision or hearing impairment.
- Providers, including multilingual network providers and understand and comply with their obligations under State or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist network providers to meet these obligations. HAP Empowered MI Health Link Enrollees can call our Customer Service department at (888) 654-0706 (TTY: 711) (found on the back of the member ID card) or their HAP Empowered MI Health Link Care Coordinator for free interpreter assistance.
- Network providers and interpreters/translators are available for HAP Empowered MI Health Link Enrollees who are deaf or vision- or hearing-impaired.
- Providers have a strong understanding of disability, recovery, and resilience cultures and LTSS.

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

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

Section 21: Model of Care – HAP Empowered MI Health Link Only

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

Specially tailored services geared toward the most vulnerable population
HAP Empowered understands how vulnerable the HAP Empowered MI Health Link population is and therefore, has added benefits specific to their known unique needs. These value-added services and benefits include:

- A $0 copay for generic and brand drugs
- Care coordination— A nurse or social worker helps the beneficiary navigate the managed care system and attain optimal health. All beneficiaries get a health risk assessment and inter-disciplinary plan of care.
- Health and Wellness Programs - Includes smoking cessation, preventive health outreach for services due such as vaccinations and colorectal cancer screening and disease management programs for diabetes, asthma and hypertension.
- A 24/7 health information line.
- An emergency response service benefit for high-risk individuals. Persons must meet certain criteria and must be approved by the medical director.
- Podiatry for medically necessary foot care.
- Vision care - One routine eye exam every two years and up to one pair of glasses, including lenses and frames, every two years.
- A hearing test.
- Dental care - includes an oral exam, fluoride treatment, X-rays and cleaning.

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

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

Integrated Care Bridge or Electronic Care Bridge
HAP Empowered maintains an Integrated Care Bridge to facilitate timely and effective information flow between the plan, provider, MiHIN and the PIHPs. The Care Bridge can directly exchange information between all members of the healthcare team for more efficient care.

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

The care coordinator can be a registered nurse or licensed social worker with experience, education and training who interacts with the special-needs population.

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

Care coordinators report to the Manager of Health Services and are responsible for the following:

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

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

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

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

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

The timeframe for reevaluation is individualized based on the member's plan of care. Automatic prompts are displayed in the reminder log in the CareRadius system based on the timeframes identified in the member's care plan. If the member does not meet a goal, the goal is revised, or a new goal is established with the member, based on their input. An annual, comprehensive reevaluation is done after the annual HRA is completed.

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

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

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

Section 22: Philosophy of Care

HAP Empowered health care 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, if not always granted.
  - 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 Empowered health care providers are accountable for:

- Member satisfaction.
- Health care access to comprehensive and quality medical care and preventive services.
- Promoting sharing 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 23: Confidentiality, Notice of Privacy Practices, Fraud, Waste and Abuse, Whistleblower Protection

Confidentiality policy

HAP Empowered Health Plan 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 Empowered Health Plan will only divulge such information with appropriate authorization, by law or as medically or administratively necessary to provide services to our members. HAP Empowered Health Plan does 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 Empowered Health Plan 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 Empowered Health Plan practitioners are required to use a release of information form when members wish to have their records copied or released.

HAP Empowered Health Plan 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 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.

Empowered Health Plan associates sign a confidentiality statement upon employment.

Notice of privacy practices

We're committed to protecting your privacy. Safeguarding information about you and your health is very important to us. This notice tells you how your health information may be used and shared and who can see it.

HAP
Alliance Health and Life Insurance Company®
HAP Empowered Health Plan, Inc.
Effective Oct. 1, 2018

Your protected health information
PHI stands for protected health information. PHI can be used to identify you. It includes information such as your name, age, sex, address and member ID number, as well as your:

- Physical or mental health
- Health care services
- Payment for care

You can ask HAP to give your PHI to people you choose. To do this, fill out our release form.

Your privacy
Keeping your PHI safe is important to HAP. We're required by law to keep your PHI private. We must also tell you about our legal duties and privacy practices. This notice explains:

- How we use information about you
- When we can share it with others
- Your rights related to your PHI
- How you can use your rights

When we use the term "HAP," "we" or "us" in this notice, we're referring to HAP and its subsidiaries. These include Alliance Health and Life Insurance Company and HAP Empowered Health Plan, Inc

How we protect your PHI
We protect your PHI in written, spoken and electronic form. Our employees and others who handle your information must follow our policies on privacy and technology use. Anyone who starts working for HAP must state that they have read these policies. And they must state that they will protect your PHI even after they leave HAP. Our employees and contractors can only use the PHI necessary to do their jobs. And they may not use or share your information except in the ways outlined in this notice.

How we share your PHI
We only share your information with those who must know for:

- Treatment
- Payments
- Business tasks

Treatment
We may share your PHI with your doctors, hospitals, or other providers to help them:

- Provide treatment. For example, if you're in the hospital, we may let them see records from your doctor.
- Manage your health care. For example, we might talk to your doctor to suggest a HAP program that could help improve your health.

Payment
We may use or share your PHI to help us figure out who must pay for your medical bills. We may also use or share your PHI to:

- Collect premiums
- Determine which benefits you can get
- Figure out who pays when you have other insurance

Business tasks
As allowed by law, we may share your PHI with:

- Companies affiliated with HAP
- Other companies that help with HAP's everyday work
- Others who help provide or pay for your health care

We may share your information with others who help us do business. If we do, they must keep your information private and secure. And they must return or destroy it when they no longer need it for our business. It may be used to:

- Evaluate how good care is and how much it improves. This may include provider peer review.
- Make sure health care providers are qualified and have the right credentials.
- Review medical outcomes.
- Review health claims.
- Prevent, find and investigate fraud and abuse.
- Decide what is covered by your policy and how much it will cost. But, we are not allowed to use or share genetic information to do that.
- Do pricing and insurance tasks.
- Help members manage their health care and get help managing their care.
- Communicate with you about treatment options or other health-related benefits and services.
- Do general business tasks, such as quality reviews and customer service.

Other permitted uses

We may also be permitted or required to share your PHI:

With you

- To tell you about medical treatments and programs or health-related products and services that may interest you. For example, we might send you information on how to stop smoking or lose weight.
- For health reminders, such as refilling a prescription or scheduling tests to keep you healthy or find diseases early.
- To contact you, by phone or mail, for surveys. For example, each year we ask our members about their experience with HAP.

With a friend or family member

- With a friend, family member or other person who, by law, may act on your behalf. For example, parents can get information about their children covered by HAP.
- With a friend or family member in an unusual situation, such as a medical emergency, if we think it's in your best interests. For example, if you have an emergency in a foreign country and can't contact us directly. In that case, we may speak with a friend or family member who is acting on your behalf.
- With someone who helps pay for your care. For example, if your spouse contacts us about a claim, we may tell him or her whether the claim has been paid.

With the government

- For public health needs in the case of a health or safety threat such as disease or a disaster.
- For U.S. Food and Drug Administration investigations. These might include probes into harmful events, product defects or product recalls.
- For health oversight activities authorized by law.
- For court proceedings and law enforcement uses.
- With the police or other authority in case of abuse, neglect, or domestic violence.
- With a coroner or medical examiner to identify a body, find out a cause of death or as authorized by law. We may also share member information with funeral directors.
- To comply with workers' compensation laws.

- To report to state and federal agencies that regulate HAP and its subsidiaries. These may include the:
  - U.S. Department of Health and Human Services
  - Michigan Department of Insurance and Financial Services
  - Michigan Department of Health and Human Services
  - Federal Centers for Medicare and Medicaid Services
- To protect the U.S. president.

For research or transplants
- For research purposes that meet privacy standards. For example, researchers want to compare outcomes for patients who took a certain drug and must review a series of medical records.
- To receive, bank or transplant organs, eyes, or tissue.

With your employer or plan sponsor
We may use or share your PHI with an employee benefit plan through which you get health benefits. It is only shared when the employer or plan sponsor needs it to manage your health plan.

Except for enrollment information or summary health information and as otherwise required by law, we only share your PHI with an employer or plan sponsor if they have guaranteed in writing that it will be kept private and won't be used improperly.

To use or share your PHI for any other reason, we must get your written permission. If you give us permission, you may change your mind and cancel it. But it will not apply to information we've already shared.

Organized health care arrangement
HAP and HAP affiliates covered by this Notice of Privacy Practices and Henry Ford Health System and its affiliates are part of an organized health care arrangement. Its goal is to deliver higher quality health care more efficiently and to take part in quality measure programs, such as the Healthcare Effectiveness Data and Information Set. HEDIS is a set of standards used to measure the performance of a health plan. In other words, HEDIS is a report card for managed care plans.

The Henry Ford Health System organized health care arrangement includes:
- HAP
- Alliance Health and Life Insurance Company
- HAP Empowered Health Plan, Inc.
- HAP Preferred, Inc.
- Henry Ford Health System

Henry Ford's organized health care arrangement lets these organizations share PHI. This is only done if allowed by law and when needed for treatment, payment or business tasks relating to the organized health care arrangement.

This list of organizations may be updated. You can access the current list at **hap.org/privacy** or call us at **(800) 422-4641 (TTY: 711)**. When required, we will tell you about any changes in a revised Notice of Privacy Practices.

Your rights
These are your rights with respect to your information. If you would like to exercise any of these rights, please contact us. The contact information is in the "Who to contact" section at the end of this document. You may have to make your requests in writing. You have the following rights:

Right to see your PHI and get a copy
With some exceptions, you have the right to see or get a copy of PHI in records we use to make decisions about your health coverage. This includes our enrollment, payment, claims resolutions and case or medical management notes. If we deny your request, we'll tell you why and whether you have a right to further review.

You may have to fill out a form to get PHI and pay a fee for copies. We'll tell you if there are fees in advance. You may choose to cancel or change your request.

Right to ask us to change your PHI
If we deny your request for changes in PHI, we'll explain why in writing. If you disagree, you may have your disagreement noted in our records. If we accept your request to change the information, we'll make reasonable efforts to tell others of the change, including people you name. In this case, the information you give us must be correct. And we cannot delete any part of a legal record, such as a claim submitted by your doctor.

Right to know about disclosures
You have the right to know about certain disclosures of your PHI. HAP does not have to inform you of all PHI we release. We are not required to tell you about PHI shared or used for treatment, payment and business tasks. And we do not have to tell you about information we shared with you or based on your authorization. But you may request a list of other disclosures made during the six years prior to your request.

Your first list in any 12-month period is free. However, if you ask for another list within 12 months of receiving your free list, we may charge you a fee. We'll tell you if there are fees in advance. You may choose to cancel or change your request.

Right to know about data breaches that compromise your PHI
If there is a breach of your unsecured PHI, we'll tell you about it as required by law or in cases when we deem it appropriate.

Right to ask us to limit how we use or share your PHI
You may ask us to limit how we use or share your PHI for treatment, payment, or business tasks. You also have the right to ask us to limit PHI shared with family members or others involved in your health care or payment for it. We do not have to agree to these limits. But if we do, we'll follow them – unless needed for emergency treatment or the law requires us to share your PHI. In that case, we will tell you that we must end our agreement.

Right to request private communications
If you believe that you would be harmed if we send your PHI to your current mailing address (for example, in a case of domestic dispute or violence), you can ask us to send it another way. We can send it by fax or to another address. We will try to meet any fair requests.

You have a right to get a paper copy of this notice.
See our contact information below.

Changes to the privacy
We have the right to make changes to this notice. If we make changes, the new notice will be effective for all the PHI we have. Once we make changes, we'll send you the new notice by U.S. mail and post it on our website.

Who to contact
If you have any questions about this notice or about how we use or share member information, mail a written request to:

HAP and HAP Empowered Health Plan Information Privacy & Security Office
One Ford Place, 2A
Detroit, MI 48202

You may also call us at **(800) 422-4641 (TTY: 711)**.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us. Contact the Information Privacy & Security Office above or HAP's Compliance Hotline at **(877) 746-2501 (TTY: 711)**. You can stay anonymous. You may also notify the secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Original effective date: April 13, 2003. Revisions: February 2005, November 2007, September 2013, September 2014, March 2015, October 2015, October 2018, January 2019
Reviewed: November 2008, November 2009, October 2011

Reporting Fraud, Waste and Abuse

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

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

Examples:

A. Providing services that are not medically necessary (i.e., unnecessary diagnostic testing).
B. A provider prescribing 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. Going to more than one doctor to get the same prescription.
C. Threatening or offensive behavior at a provider's office, hospital, or pharmacy.

All reported cases of suspected fraud, waste and abuse are monitored and handled by the HAP Office of Compliance and Special Investigations Unit (SIU).

If you suspect any provider, member, employee, or contractor of HAP Empowered of potential fraud, waste or abuse of Medicare or Medicaid assets, please contact us immediately. We have a 24-hour, toll-free compliance 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: **(877) 746-2501**
- Mail: HAP Empowered Health Plan Compliance Officer
  P.O. Box 2578
  Detroit, MI 48220

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.

Medicare Outpatient Observation Notice

Per the Federal Notice of Observation Treatment and Implication for Care Eligibility Act, passed on August 6, 2015, all hospitals and critical access hospitals are required to provide written and oral notification to individuals receiving observation services as outpatients for more than 24 hours.

The MOON is intended to inform members who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients and the reasons for such status. It must be delivered no later than 36 hours after observation services begin. For MOON instructions, frequently asked questions and the final rule, visit:

- **cms.gov**. Click *Medicare*, then, under Medicare – General Information, click on *Beneficiary Notices Initiative (BNI)*, then *Medicare Outpatient Observation Notice (MOON)*.

Appendix A: Other Responsibilities for Providers

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

General Provider Responsibilities

- Provider agrees to provide the health care services Medicaid, Medicare Advantage and MI Health Link program recipients who are enrolled in HAP Empowered Health Plan members.
  - Covered services consists of all services covered by the Medicaid, Medicare Advantage and MI Health Link programs, subject to the terms of the provider's HAP Empowered agreement, all rules, regulations, policies and procedures of the Medicaid, Medicare Advantage and MI Health Link programs, and HAP Empowered authorization and referral requirements
- 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 EHP Administrative Provider Manuals and the additional requirements for participation in the HAP Empowered provider contract.
- Covered services will be subject to any restrictions or limitations set forth in the HAP Empowered Administrative Provider Manuals or provider manuals, bulletins, directives, and other written information received by HAP Empowered from MDHHS or CMS.
- HAP Empowered 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 Empowered:
  - 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 Empowered utilization review program, including but not limited to:
  - Precertification of elective admissions and procedures
  - Referral processes
  - Reporting of clinical encounter data
  - Other HAP EHP policies and procedures.
- Provider agrees that HAP Empowered 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 Empowered 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 Empowered
  - National origin
  - Physical or mental handicap
  - Race
  - Religion
  - Sex
  - Sexual preferences
  - 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 ten (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 Empowered
  - 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 Empowered affairs.

Appendix B: Appeals and Grievance Information for Members

HAP Empowered Medicaid members

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

Grievances and appeals

HAP Empowered wants you to be happy with our service. We comply with applicable federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability or sex.

What Is a Grievance?

A grievance may be any complaint or dispute expressing your dissatisfaction with the quality, access, or delivery of services you received. If you have multiple issues, each instance will be treated separately. We will keep your grievance private.

Grievance examples include:

- Quality of health care services, including safety issues
- Access and availability of care
- Attitude and service of providers, office staff or HAP Empowered staff

What Are the Types of Grievances?

Standard grievance – You can file a grievance under the standard process for the examples listed above. We'll investigate your concerns and mail a final decision as quickly as your health requires but not later than 90 calendar days from the day we receive your grievance.

Expedited grievance – If you're upset that we're taking more time to review your case, you can let us know and we'll respond to you in 24 hours.

We may extend the time frames for standard grievances up to 14 days if (1) you request an extension, or (2) we need more information and determine the delay is in your best interest.

If we extend the time frame, we'll:

- Call and let you know, and
- Mail you a letter reminding you that we're extending our time to investigate your case. If you're not happy that we need to take more time, you can call or write to us and let us know.

How to File a Grievance

You can file a grievance at any time. You can call us, send us a letter or come to our office. With your permission, someone else may file a grievance on your behalf. This person can be a friend, relative, doctor, attorney, or the representative of a deceased enrollee's estate.

If you decide to file a grievance with us, we have someone here to help you. If you need help in a different language, we can help you in the language of your choice.

To file in person, we are located at the following addresses: 2850 West Grand Blvd. Detroit, MI 48202 2050 South Linden Rd. Flint, MI 48532	Or mail or fax us at: Attn: Appeal and Grievance Department HAP Empowered P.O. Box 2578 Detroit, MI 48202 Fax: (313) 664-5866	Or by phone: (888) 654-2200 (TTY: 711)

Adverse Benefit Determination
An adverse benefit determination is a:

- Denial
- Reduction
- failure to provide or make payment, in whole or in part, for a benefit

It includes those based on a determination of:

- eligibility
- application of utilization review
- a failure to provide or make payment, in whole or in part, for a benefit

What's an Appeal?
An appeal is your right to ask us to change our mind about a decision we made to provide a service or medication to you or if you don't agree with how we will pay for something. You have 60 days from the date of our denial to file an appeal.

Examples of appeals include:

- Not approving or paying for a service or item your doctor asks for
- Stopping a service that was approved before

If we decide to reduce or stop a service, you can keep getting the service until we make a final decision on your appeal. You can also keep getting the service while you are waiting for the decision from the State Fair Hearing.

What Are the Types of Appeals?
Standard appeal – must file an appeal within 60 days from the date on the denial letter. We'll mail our decision within 30 calendar days from the time that we receive your request.

Expedited appeal – If you believe that you cannot wait 30 days for a decision, because waiting could cause you harm, you can ask us for an expedited (fast) appeal. If you ask us for an expedited appeal, but your doctor does not send us information about that request, we will decide if it is an emergency. If our doctors decide that you need the service quickly, we will let you know our decision within 72 hours. If our doctors don't think your appeal is urgent, we will process it like a standard appeal. If your doctor asks for an expedited appeal or tells us that your request is urgent, we will let you know our decision within 72 hours.

You may ask us to take an additional 14 calendar days to resolve your case. If we ever need more time to review your appeal, we may take an additional 14 calendar days to make a decision. If we extend the time frame, we will:

- Call and let you know; and
- Send you a letter in the mail reminding you that we are extending our time to investigate your case

Once a decision has been made, we will mail you a letter with our decision. If your appeal was an emergency, we will call and let you know our decision and also send a letter. If we do not completely approve your request during the internal appeal review, the appeal decision letter will explain your further rights for an external review.

If you do not agree with our final appeal decision, you can ask for an external (outside) review from the State of Michigan.

External Appeal
Choose one or both of the following options:

- The State of Michigan Department of Insurance and Financial Services (DIFS). DIFS must receive your appeal within 120 calendar days from the date on our appeal denial letter to you. (Public Act 251, known as the Patient's Right to Independent Review Act (PRIRA) describes this process). You can also appeal to DIFS if we don't make an appeal decision on time. Mail your request, including a copy of the final adverse determination from HAP Empowered the reason(s) why you're appealing the decision and any documentation to support your position to:

  Department of Insurance and Financial Services
  Office of General Counsel/PRIRA – Appeals Section
  P.O. Box 30220
  Lansing, MI 48909-7720
  Phone: (517) 284-8800 or (877) 999-6442
  Fax: (517) 284-8838
  Or submit online at: difs.state.mi.us/Complaints/ExternalReview.aspx

State Fair Hearing
The Michigan Department of Health and Human Services (MDHHS) must receive your appeal within 120 calendar days from the date on our appeal denial letter to you. This process is known as a State Fair Hearing. You will need to call the State of Michigan to have a hearing request form (MDHHS-5617) sent to you.

Michigan Department of Health and Human Services
Michigan Administrative Hearing System
P.O. Box 30763
Lansing, MI 48909
Phone: (517) 335-7519 or (800) 648-3397
Fax: (517) 763-0146

If you asked for your benefit(s) to continue during the internal appeal process and you want them to continue during the State Fair Hearing process, you must ask for the State Fair Hearing. However, you may be required to pay the cost of services provided while the appeal or the State Fair Hearing is pending. The Michigan Administrative Hearing System (MAHS) must also receive your request within 10 calendar days of the date on the Notice of Appeal Decision. If you go to a State Fair Hearing, HAP Empowered can attend the meeting. If someone is deceased, the representative of his/her estate can attend. You may be responsible for the continued coverage cost if the appeal ruling doesn't go in your favor.

How to File an Appeal

Internal Appeals
We have an appeals coordinator to help you. You can call us, send us a letter or come to our office. If you need help in a different language, we can help you in the language of your choice.

With your permission, someone else may ask for an appeal on your behalf. This person can be a friend, relative, doctor, attorney or the representative of a deceased enrollee's estate.

You have the right to submit written comments, documents or other information relevant to the appeal with your request. You or your authorized representative has the right to speak or present information to those reviewing your appeal. This can be done in person or by telephone.

To file in person, visit: 2850 West Grand Blvd. Detroit, MI 48202 2050 South Linden Rd. Flint, MI 48532	Mail or fax us at: Attn: Appeal and Grievance Department HAP Empowered P.O. Box 2578 Detroit, MI 48202 Fax: (313) 664-5866	By phone (888) 654-2200 (TTY: 711)

Expedited External Appeals
After you have filed an expedited appeal with HAP Empowered, you have the right to request an expedited external review. To do so, you must meet the following:

With your permission, someone else may ask for an appeal on your behalf. This person can be a friend, relative, doctor, attorney or the representative of a deceased enrollee's estate.

- Your doctor must tell the Department of Insurance and Financial Services (DIFS), in writing or by phone, that the standard time frame for review of the grievance/appeal would cause serious harm to your health
- You must have already filed a request for an expedited internal appeal with HAP Empowered

The request for external review should be submitted to the DIFS director at:

Department of Insurance and Financial Services, Office of General Counsel–Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Phone: (517) 284-8800 or (877) 999-6442
Fax: (517) 284-8838

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

HAP Empowered MI Health Link Members

Below is the information we provide to members. It's an excerpt from the *HAP Empowered MI Health Link Member Handbook* regarding filing a grievance and appeal.

Important! Any reference to a section and page number throughout this verbiage is to a particular area in the member handbook. The formatting does not match the actual handbook. A copy of the actual handbook can be found here:

What to do if you have a problem
This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Michigan Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.
A1. About the legal terms
There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.
For example, we will say:

- "Making a complaint" rather than "filing a grievance"
- "Coverage decision" rather than "organization determination," "benefit determination," "at-risk determination," or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Where to call for help

B1. Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the MI Health Link Ombudsman

If you need help getting answers to your questions or understanding what to do to handle your problem, you can call the MI Health Link Ombudsman. The MI Health Link Ombudsman is not connected with us or with any insurance company. They can help you understand which process to use. The phone number for the MI Health Link Ombudsman is 1-888-746-6456. The services are free. Refer to Chapter 2 for more information on ombudsman programs.

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call your State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP counselors can answer your questions and help you understand what to do to handle your problem. MMAP is not connected with us or with any insurance company or health plan. MMAP has trained counselors and their services are free. The MMAP phone number is 1-800-803-7174. You can also find information on MMAP's website at mmapinc.org.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website (www.medicare.gov).

Getting help from Michigan Medicaid

You can also call Michigan Medicaid for help with problems. Call the Beneficiary Help Line Monday through Friday from 8:00 AM to 7:00 PM at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800-975-7630 if calling from an internet-based phone service. You can also email beneficiarysupport@michigan.gov.

Which process to use to help with your problem

C1. Using the process for coverage decisions and appeals or for making a complaint

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care, long term supports and services, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care, long term supports and services, or prescription drugs.)	
Yes. My problem is about benefits or coverage. Refer to **Section D: "Coverage decisions and appeals"** on page 149.	**No.** My problem is not about benefits or coverage. Skip ahead to **Section J: "How to make a complaint"** on page 189.

Coverage decisions and appeals

D1. Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

NOTE: Behavioral health services are covered by your Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for information about coverage decisions and appeals on behavioral health services.

- Detroit Wayne Mental Health Authority 1-800-241-4949, TTY: 1-800-630-1044, 24 hours a day, seven days a week
- Macomb County Community Mental Health 1-855-966-2264, TTY: 711, 24 hours a day, seven days a week

What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. We are also making a coverage decision whenever

you ask us to increase or change the amount of a service, item, or drug that you are already receiving. If you or your providers are not sure if a service, item, or drug is covered by Medicare or Michigan Medicaid, either of you can ask for a coverage decision before you get the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our coverage decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is not medically necessary for you. If you or your provider disagree with our decision, you can appeal.

D2. Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call your **Care Coordinator** at 1-888-654-0706.
- Call **Customer Service** at 1-888-654-0706.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Call the **MI Health Link Ombudsman** for free help. The MI Health Link Ombudsman can help you with questions about or problems with MI Health Link or our plan. The MI Health Link Ombudsman is an independent program, and is not connected with this plan. The phone number is 1-888-746-6456.
- Call the **Michigan Medicare/Medicaid Assistance Program (MMAP)** for free help. MMAP is an independent organization. It is not connected with this plan. The phone number is 1-800-803-7174.
- Talk to a **friend or family member** and ask them to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal. Your designated representative will have the same rights as you do in asking for a coverage decision or making an appeal.
    - If you want a friend, relative, or other person to be your representative, call Customer Service and ask for the "Appointment of Representative" form.
    - You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. The form gives the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you choose to have a lawyer, you must pay for those legal services. However, some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
    - However, you do not need a lawyer to ask for any kind of coverage decision or to make an appeal.

D3. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section E on page 152** gives you information if you have problems about services, items, and certain drugs (**not** Part D drugs). For example, use this section if:
    - You are not getting medical care or other supports and services that you want, and you believe our plan covers this care.
    - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered and is medically necessary.
        - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List, with an " ADD" are **not** covered by Part D. Refer to Section F on page 167 for Part D drug appeals.
    - You got medical care or other supports and services you think should be covered, but we are not paying for this care.
    - You got and paid for medical care or other supports and services you thought were covered, and you want to ask us to pay you back.

- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
  - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H on pages 176 and 182.
- Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- **Section F on page 167** gives you information about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on our Drug List.
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior authorization (PA) or approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section G on page 176** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section H on page 182** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call your Care Coordinator at 1-888-654-0706 or Customer Service at 1-888-654-0706 (TTY: 711).
If you need other help or information, please call the MI Health Link Ombudsman at 1-888-746-6456.

Problems about services, items, and drugs (not Part D drugs)

E1. When to use this section

This section is about what to do if you have problems with your benefits for your medical care or other supports and services. You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B drugs. Drugs in the Drug List with an "ADD" are **not** covered by Part D. Use Section F for Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. You think we cover a medical service or other supports and services you need but are not getting.
   What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 153 for information on asking for a coverage decision.
2. We did not approve care your provider wants to give you, and you think we should have.
   What you can do: You can appeal our decision to not approve the care. Refer to Section E3 on page 155 for information on making an appeal.
3. You got services or items that you think we cover, but we will not pay.
   What you can do: You can appeal our decision not to pay. Refer to Section E3 on page 155 for information on making an appeal.
4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.
   What you can do: You can ask us to pay you back. Refer to Section E5 on page 165 for information on asking us for payment.
5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

What you can do: You can appeal our decision to reduce or stop the service. Refer to Section E3 on page 155 for information on making an appeal.
NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections G or H on pages 176 and 182 to find out more.

E2. Asking for a coverage decision

How to ask for a coverage decision to get medical care or long term supports and services (LTSS)
To ask for a coverage decision, call or write us, or ask your representative or doctor to ask us for a decision.

- You can call us at: 1-888-654-0706, TTY: 711
- You can write to us at: HAP Empowered MI Health Link,
  PO Box 2578
  Detroit MI 48202

- **NOTE:** Your Prepaid Inpatient Health Plan (PIHP) will make coverage decisions for behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for more information.
  - Detroit Wayne Mental Health Authority 1-800-241-4949, TTY: 1-800-630-1044, 24 hours a day, seven days a week
  - Macomb County Community Mental Health 1-855-996-2264, TTY: 711, 24 hours a day, seven days a week

How long does it take to get a coverage decision?
It usually takes up to 14 calendar days after you, your representative, or your provider asked unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we don't give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.
Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?
Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).
However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 1-888-654-0706 or fax us at 1-248-663-3771. For details on how to contact us, refer to Chapter 2.
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:
You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision only if you are asking about coverage for services or items you have not yet received. (You cannot ask for a fast coverage decision if your request is about payment for medical care or an item you already got.)
2. You can get a fast coverage decision only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function.
   - If your provider says that you need a fast coverage decision, we will automatically give you one.
   - If you ask for a fast coverage decision without your provider's support, we will decide if you get a fast coverage decision.
     - If we decide that your condition does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.

- This letter will tell you that if your provider asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, refer to Section J on page 189.

How will I find out the plan's answer about my coverage decision?
We will send you a letter telling you whether or not we approved coverage.

If the coverage decision is No, how will I find out?
If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to the Internal Appeals process (read the next section for more information).

E3. Internal Appeal for services, items, and drugs (not Part D drugs)

What is an appeal?
An appeal is a formal way of asking us to review a coverage decision (denial) or any adverse action that we took. If you or your provider disagree with our decision, you can appeal.
NOTE: Your Prepaid Inpatient Health Plan (PIHP) handles appeals about behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for more information.

- Detroit Wayne Mental Health Authority 1-800-241-4949, TTY: 1-800-630-1044, 24 hours a day, seven days a week
- Macomb County Community Mental Health 1-855-996-2264, TTY: 711, 24 hours a day, seven days a week

If you need help during the appeals process, you can call the MI Health Link Ombudsman at 1-888- 746-6456. The MI Health Link Ombudsman is not connected with us or with any insurance company or health plan.

What is an adverse action?
An adverse action is an action, or lack of action, by our plan that you can appeal. This includes:

- We denied or limited a service or item your provider requested;
- We reduced, suspended, or ended coverage that was already approved;
- We did not pay for a service or item that you think is covered;
- We did not resolve your authorization request within the required timeframes;
- You could not get a covered service or item from a provider in our network within a reasonable amount of time; **or**
- We did not act within the timeframes for reviewing a coverage decision and giving you a decision.

What is an Internal Appeal?
An Internal Appeal (also called a Level 1 Appeal) is the first appeal to our plan. We will review your coverage decision to find out if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing and tell you what you can do next if you disagree with the decision.
You must ask for an Internal Appeal before you can ask for an External Appeal under Section E4 below. You can ask for a "standard appeal" or a "fast appeal."

How do I make an Internal Appeal?

- To start your appeal, you, your representative, or your provider must contact us. You can call us at 1-888-654- 0706. For additional details on how to reach us for appeals, refer to Chapter 2.
- You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
  - You can submit a request to the following address:

HAP Empowered MI Health Link,
PO Box 2578
Detroit MI 48202

  - You may also ask for an appeal by calling us at 1-888-654-0706

Can someone else make the appeal for me?
Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you. First, you must complete an Appointment of Representative form. The form gives the other person permission to act for you.
If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
To get an Appointment of Representative form, call Customer Service and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.
We must get the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an Internal Appeal?
You must ask for an Internal Appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you were in the hospital, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.
NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read "Will my benefits continue during Internal Appeals" on page159 for more information.

Can I get a copy of my case file?
Yes. Ask us for a free copy by calling Customer Service at 1-888-654-0706 (TTY: 711).

Can my provider give you more information about my appeal?
Yes. Both you and your provider may give us more information to support your appeal.

How will we make the appeal decision?
We take a careful look at all of the information about your request for coverage of medical care or other supports and services. Then, we check if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.
If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" appeal decision?
We must give you our answer within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your condition requires us to.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 189.
- If we do not give you an answer to your appeal within 30 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Michigan Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, refer to Section E4 on page 159.

If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).
If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we automatically sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Michigan Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, refer to Section E4 on page 159.

When will I hear about a "fast" appeal decision?
If you ask for a fast appeal, we will give you our answer within 72 hours after we get your appeal. We will give you our answer sooner if your condition requires us to do so.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 189.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Michigan Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, refer to Section E4 on page 159.

If our answer is Yes to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.
If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Michigan Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, refer to Section E4 on page 159.

Will my benefits continue during Internal Appeals?
If we decide to change or stop coverage for a service that was previously approved, we will send you a notice before taking the proposed action. If you file your Internal Appeal within 10 calendar days of the date on our notice or prior to the intended effective date of the action, we will continue your benefits for the service while the Internal Appeal is pending.
If you are appealing to get a new service from our plan, then you would not get that service unless your appeal is finished and the decision is that the service is covered.

E4. External Appeal for services, items, and drugs (not Part D drugs)

If the plan says No to the Internal Appeal, what happens next?
You must ask for an Internal Appeal and get a decision from us before you can ask for an External Appeal.
If we say No to part or all of your Internal Appeal, we will send you an appeal denial notice. This notice is called the Notice of Appeal Decision. This notice will tell you if the service or item is usually covered by Medicare and/or Michigan Medicaid.

- If your problem is about a Medicare service or item, you will automatically get an External Appeal with the Independent Review Entity (IRE) as soon as the Internal Appeal is complete.
- If your problem is about a Michigan Medicaid service or item, you can file an External Appeal yourself with the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or a request for an External Review with the Michigan Department of Insurance and Financial Services (DIFS). The Notice of Appeal Decision will tell you how to do this. Information is also on page 163.
- If your problem is about a service or item that could be covered by both Medicare and Michigan Medicaid, you will automatically get an External Appeal with the IRE. You can also ask for an External Appeal with MOAHR and/or External Review with DIFS.
- You may be responsible for the continued coverage cost while the External Reivew with the IRE, MOAHR and/or DIFS is pending. If the decision is "no", you may be responsible for the cost of the services provided while the appeal was in process.

What is an External Appeal?
An External Appeal (also called a Level 2 Appeal) is the second appeal, which is done by an independent organization that is not connected to the plan. Medicare's External Appeal organization is called the Independent Review Entity (IRE). The IRE is an independent organization hired by Medicare. It is not a government agency. Medicare oversees its work.
Michigan Medicaid's External Appeal is a Fair Hearing through the Michigan Office of Administrative

Hearings and Rules (MOAHR). You also have the right to request an External Review of Michigan Medicaid service denials through the Michigan Department of Insurance and Financial Services (DIFS).

My problem is about a Michigan Medicaid covered service or item. How can I make an External Appeal?
There are two ways to make an External Appeal for Michigan Medicaid services and items: (1) Fair Hearing and/or (2) External Review.

Fair Hearing

You have the right to ask for a Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR). A Fair Hearing is an impartial review of a decision made by our plan. You may ask for a Fair Hearing after the Internal Appeal with our plan. In addition, if you do not receive a notice about your appeal, or a decision on your appeal within the time frame the plan has to respond on your appeal, you may ask for a Michigan Medicaid Fair Hearing.

You must ask for a Fair Hearing **within 120 calendar** days from the date on the Notice of Appeal Decision.

NOTE: If you ask for a Fair Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to file your request** if you want to keep getting that service while your Fair Hearing is pending. Read "Will my benefits continue during External Appeals" on page 163 for more information.

To ask for a Fair Hearing from MOAHR, you must complete a Request for Hearing form. We will send you a Request for Hearing form with the Notice of Appeal Decision. You can also get the form by calling the Michigan Medicaid Beneficiary Help Line at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800-975-7630 if calling from an internet-based phone service, Monday through Friday from 8:00 AM to 7:00 PM. Complete the form and send it to:
Michigan Office of Administrative Hearings and Rules (MOAHR)
PO Box 30763
Lansing, MI 48909
FAX: 517-763-0146

You can also start the Fair Hearing by calling 800-648-3397.You can ask for an expedited (fast) Fair Hearing by calling that number or writing to the address or faxing to the number listed above.

After MOAHR gets your Fair Hearing request, you will get a letter telling you the date, time, and place of your hearing. Hearings are usually conducted over the phone, but you can ask that your hearing be conducted in person.

MOAHR must give you an answer in writing within 90 calendar days of when it gets your request for a Fair Hearing. If you qualify for an expedited Fair Hearing, 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.

After you get the MOAHR final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court.

External Review

You also have the right to ask for an External Review through the Michigan Department of Insurance and Financial Services (DIFS). You must complete our Internal Appeals process first before you can ask for this type of External Appeal.

Your request for an External Review must be submitted **within 127 calendar days** of your receipt of our Internal Appeal decision.

NOTE: If you qualified for continuation of benefits during the Internal Appeal and you ask for an External Review **within 10 calendar days** from the date of the Internal Appeal decision, you can continue to get the disputed service during the review. Read "Will my benefits continue during External Appeals" on page 163 for more information.

To ask for an External Review from DIFS, you must complete the Health Care Request for External Review form. We will send you this form with our Notice of Appeal Decision. You can also get a copy of the form by calling DIFS at 517-284-8800. Complete the form and send it with all supporting documentation to:
DIFS Office of Research, Rules, and Appeals – Appeals Section PO
Box 30220
Lansing, MI 48909-7720
FAX: 517-284-8837;
Email: DIFS-HealthAppeal@Michigan.gov
DIFS Consumer Hotline: 1-877-999-6442;

If your request does not involve reviewing medical records, the External Review will be conducted by the Director of DIFS. If your request involves issues of medical necessity or clinical review criteria, it will be sent to a separate Independent Review Organization (IRO). If the review is conducted by the Director and does not require review by an IRO, the Director will issue a decision within 14 calendar days after your request is accepted. If the review is referred to an IRO, the IRO will give its recommendation to DIFS within 14 calendar days after it is assigned the review. The Director will then issue a decision within 7 business days after it receives the IRO's recommendation.
If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited (fast) review. An expedited review is completed within 72 hours after your request. To qualify for an expedited review, you must have your doctor verify that the timeframe for a standard review would jeopardize your life or health.
If you disagree with the External Review decision, you have the right to appeal to Circuit Court in the county where you live or the Michigan Court of Claims within 60 days from the date of the decision.

My problem is about a Medicare covered service or item. What will happen at the External Appeal?
An Independent Review Entity (IRE) will carefully review the Internal Appeal decision and decide whether it should be changed.

- You do not need to ask for the External Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be told when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Customer Service at 1-888-654-0706 (TTY: 711).

The IRE must give you an answer to your External Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

If you had a "fast appeal" at the Internal Appeal, you will automatically have a fast appeal at the External Appeal. The IRE must give you an answer within 72 hours of when it gets your appeal.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

What if my service or item is covered by both Medicare and Michigan Medicaid?
If your problem is about a service or item that could be covered by both Medicare and Michigan Medicaid, we will automatically send your External Appeal to the Independent Review Entity. You can also submit an External Appeal to the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or an External Review to the Michigan Department of Insurance and Financial Services (DIFS). Follow the instructions on page 164.

Will my benefits continue during External Appeals?
If we previously approved coverage for a service but then decided to change or stop the service before the authorization expired, you can continue your benefits during External Appeals in some cases.

- If the service is covered by Medicare and you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the External

Appeal process with the Independent Review Entity (IRE).

- If the service is covered by Michigan Medicaid, your benefits for that service will continue if you qualified for continuation of benefits during your Internal Appeal and you ask for a Fair Hearing from MOAHR or an External Review from DIFS within 10 calendar days from the date of the Notice of Appeal Decision.
- If the service could be covered by both Medicare and Michigan Medicaid and you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the IRE review. You may also qualify for continuation of benefits during MOAHR and/or DIFS review if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: (1) you withdraw the appeal; or (2) all entities that got your appeal (the IRE, MOAHR, and/or DIFS) decide "no" to your request you may be responsible for the continued coverage cost. If any of the entities decide "yes" to your request, your services will continue.

How will I find out about the decision?

If your External Appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, MOAHR will send you a letter explaining its decision.

- If MOAHR says **Yes** to part or all of what you asked for, we must approve the service for you as quickly as your condition requires, but no later than 72 hours from the date we receive MOAHR's decision.
- If MOAHR says **No** to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision" or "turning down your appeal."

If your External Appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, DIFS will send you a letter explaining the Director's decision.

- If DIFS says **Yes** to part or all of what you asked for, we must approve the service for you as quickly as your condition requires.
- If DIFS says **No** to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision" or "turning down your appeal."

If your External Appeal went to the Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for, we must authorize the coverage as quickly as your condition requires, but no later than 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision." It is also called "turning down your appeal."

What if I had different types of External Appeals and they have different decisions?

If any of the External Appeal organizations (MOAHR, DIFS, and/or the IRE) decide **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is No for all or part of what I asked for, can I make another appeal?

If your External Appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, you can appeal the decision within 30 days to the Circuit Court. You may also request a rehearing or reconsideration by MOAHR within 30 days.

If your External Appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, you can appeal to the Circuit Court in the county where you live or the Michigan Court of Claims within 60 days from the date of the decision.

If your External Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount.

The letter you get from the MOAHR, DIFS, or IRE will explain additional appeal rights you may have. Refer to Section I on page 188 for more information on additional levels of appeal.

NOTE: Your benefits for the disputed service will not continue during the additional levels of appeal.

E5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. The only amount you should be asked to pay is any required Patient Pay Amount (PPA) for nursing home care.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: "Asking us to pay a bill you have gotten for covered services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will find out if the service or item you paid for is a covered service or item, and we will check if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for the service or item within 60 calendar days after we get your request. If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section E3 on page 155. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after review by the IRE, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. Refer to Section I on page 188 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Michigan Medicaid, you can ask for a Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) or an External Review from the Michigan Department of Insurance and Financial Services (refer to Section E4 on page 159).

Part D drugs

F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Michigan Medicaid may cover. **This section only applies to Part D drug appeals.**

The Drug List includes some drugs with an "ADD". These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with an "ADD" symbol follow the process in Section E on page 152.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs? Yes.

Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's Drug List

- Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)

- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.
Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section F2** on page 168. Also refer to Sections F3 and F4 on pages 169 and 170.	Skip ahead to **Section F4** on page 170.	Skip ahead to **Section F4** on page 170.	Skip ahead to **Section F5** on page 173.

F2. What an exception is
An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an "exception."
When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.
Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our Drug List.

- If we agree to make an exception and cover a drug that is not on the Drug List, you will not be charged.

2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer to Chapter 5, Section C).

- The extra rules and restrictions on coverage for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "PA.")
  - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - Quantity limits. For some drugs, we limit the amount of the drug you can have.

F3. Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons
Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section F5 on page 173 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-888-654-0706 or fax us at 1- 313-664-8045. Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section D on page 149 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are asking for an exception, provide the "supporting statement." Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the "supporting statement."
- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.

You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.**

If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
    - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 189.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 hours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

F5. Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-888-654-0706.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.
- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Customer Service at 1-888-654-0706 (TTY: 711)

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section F4 on page 170.

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for:
  - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.
  - If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Customer Service at 1-888-654-0706 (TTY: 711).
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.

- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

G1. Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called "An Important Message from Medicare about Your Rights." If you do not get this notice, ask any hospital employee for it. If you need help, please call Customer Service at 1-888-654-0706 (TTY: 711).

You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The "Important Message" tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Customer Service at 1-888-654-0706 (TTY: 711). You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.
- You can also find the notice online at www.cms.gov/Medicare/Medicare-General- Information/BNI/HospitalDischargeAppealNotices.
- If you need help, please call Customer Service or Medicare at the numbers listed above.

G2. Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you.

In Michigan, the Quality Improvement Organization is called Livanta. To make an appeal to change your discharge date, call Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775).

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. "An Important Message from Medicare about Your Rights" contains information on how to reach the Quality Improvement Organization.

- **If you call before you leave**, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead.
  For details, refer to Section G4 on page 180.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service at 1-888-654-0706 (TTY: 711). You can also call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174. You can also get help from the MI Health Link Ombudsman by calling 1-888-746-6456.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775).

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.
If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

G4. What happens if you miss an appeal deadline

You can appeal to us instead

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.
NOTE: Your Prepaid Inpatient Health Plan (PIHP) handles appeals about behavioral health, intellectual/developmental disability, and substance use disorder services and supports. This includes Alternate Appeals for inpatient mental health care. Contact your PIHP for more information.

- Detroit Wayne Mental Health Authority 1-800-241-4949, TTY: 1-800-630-1044, 24 hours a day, seven days a week
- Macomb County Community Mental Health 1-855-966-2264, TTY: 711, 24 hours a day, seven days a week

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a "fast review."
- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
  - If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you got after the planned discharge date.
- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 189 tells how to make a complaint.
During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
    - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
    - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two calendar days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying for your care.

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J on page 189 tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service at 1-888-654-0706 and TTY 711. Or call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524- 9900 (TTY: 1-888-985-8775). Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

What is a Quality Improvement Organization?
It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?
Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, refer to Section H4 on page 186.

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- Within one full day after reviewers have all the information they need, they will tell you their decision. You will get a letter explaining the decision.

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

H3. Level 2 Appeal to continue your care
If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.
During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.
In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775). Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.

- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

H4. What happens if you miss the deadline for making your Level 1 Appeal

You can appeal to us instead

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 189 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

Appeal options after Level 2 or External Appeals

I1. Next steps for Medicare services and items

If you made a Level 1 or Internal Appeal and a Level 2 or External Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can use the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.
If you need assistance at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The phone number is 1-888-746-6456.

I2. Next steps for Michigan Medicaid services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Michigan Medicaid.
If your appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, MOAHR will send you a letter explaining its decision. If you disagree with the MOAHR final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/ reconsideration and/or to file an appeal with the Circuit Court. Please call MOAHR at 1-877- 833-0870 for information about requirements you must meet to qualify for a rehearing/reconsideration.
If your appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, DIFS will send you a letter explaining the Director's decision. If you disagree with the decision, you have the right to appeal to Circuit Court in the county where you live or the Michigan Court of Claims within 60 calendar days from the date of the decision.
If you need help at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The phone number is 1-888-746-6456.

How to make a complaint

J1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- HAP Empowered MI Health Link staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Customer Service or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital, or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
  You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the MI Health Link Ombudsman at 1-888-746-6456.

NOTE: Behavioral health services are covered by your Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for information about internal complaints on behavioral health services.

- Detroit Wayne Mental Health Authority 1-800-241-4949, TTY: 1-800-630-1044, 24 hours a day, seven days a week
- Macomb County Community Mental Health 1-855-966-2264, TTY: 711, 24 hours a day, seven days a week

J2. Internal complaints

To make an internal complaint, call Customer Service at 1-888-654-0706 and TTY 711. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must make it within 60 calendar days after you had the problem you want to complain about.

- If there is anything else you need to do, Customer Service will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- You may file a grievance within 60 calendar days of the date of the circumstance giving rise to the grievance. There is no filing limit for complaints concerning quality of care. Note: The 60-day limit may be extended for good cause. Include in your written request the reason why you could not file within the 60-day timeframe.

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, **we will tell you** and give you our reasons. We will respond whether we agree with the complaint or not.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users can call 1-877-486-2048. The call is free.

You can tell Michigan Medicaid about your complaint
You can also send your complaint to Michigan Medicaid. You can call the Beneficiary Help Line Monday through Friday from 8:00 AM to 7:00 PM at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800- 975-7630 if calling from an internet-based phone service.

You can file a complaint with the Office for Civil Rights
You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights at:
223 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Phone: 1-800-368-1019
Fax: 1-202-619-3818
TTY: 1-800-537-7697
You can also contact the Michigan Department of Civil Rights by phone at 1-800-482-3604 or online at www.michigan.gov/lara/about/contact-us. TTY users should call 1-517-241-1965. You can also email MDCRServiceCenter@michigan.gov or fax 1-517-241-0546.

You may also have rights under the Americans with Disability Act and under Michigan's Persons with Disabilities and Elliott-Larsen Civil Rights Act. You can contact the MI Health Link Ombudsman for assistance. The phone number is 1-888-746-6456.

You can file a complaint with the Quality Improvement Organization
When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us and to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to Chapter 2.
In Michigan, the Quality Improvement Organization is called Livanta. The phone number for Livanta is 1-888-524-9900 (TTY: 1-888-985-8775).

You can tell the MI Health Link Ombudsman about your complaint

The MI Health Link Ombudsman also helps solve problems from a neutral standpoint to make sure that our members get all the covered services that we are required to provide. The MI Health Link Ombudsman is not connected with us or with any insurance company or health plan. The phone number is 1-888-746-6456. The services are free.

You can tell the State of Michigan about your complaint
If you have a problem with HAP Empowered MI Health Link, you can contact the Michigan Department of Insurance and Financial Services (DIFS) at 1-877-999-6442, Monday through Friday from 8:00 AM to 5:00 PM.
The call is free. You can email difs-HICAP@michigan.gov. You can also write to: DIFS –
Office of Consumer Services
P.O. Box 30220
Lansing, MI 48909-7720
For complaints about how your provider follows your wishes, call 517-241-0205, go online at www.michigan.gov/lara/0,4601,7-154-89334_72600_73836---,00 or write to:
Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Enforcement Division
P.O. Box 30670
Lansing, MI 48909
E-mail: BPL-Complaints@Michigan.gov

Send overnight deliveries to:

Department of Licensing and Regulatory
Affairs Mail Services
2407 N. Grand River Avenue
Lansing, MI 48906

You can also call 517-373-9196 or fax 517-241-2389.

To a file a complaint against a licensed nurse, visit: www.michigan.gov/lara/0,4601,7-154-72600_73836---,00

To file a complaint against all other licensed health professionals, visit: www.michigan.gov/documents/lara/lara_ED_200PKT_AllegationPkt_477156_7.pdf