Midwest Health Plan

Provider Newsletter
June 2018

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Contact Information

For	Contact
Claims questions	(888) 654-2200, option 2, 2
Changes in: • Office addresses • Remittance payment addresses • Demographic changes Adding a provider to your office	Robin Owczarzak Phone: (313) 664-8793 Fax: (313) 664-5859 Email: rowczarzak@midwesthealthplan.com Leslie Linares Phone: (313) 664-8529 Fax: (313) 664-5860 Email: llinares@midwesthealthplan.com
Other operational issues	Provider Services • (866) 766-4708 • prelweb1@hap.org
Medicaid eFax	(248) 663-3777
Medicare eFax	(248) 663-3780

Provider Enrollment in CHAMPS Requirement

Per the Michigan Department of Health and Human Services, all providers (in Michigan and out of state) serving Medicaid beneficiaries must be enrolled in the Community Health Automated Medicaid Processing System (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.
Soon, MDHHS will prohibit HAP Midwest from making payments:

- To all typical rendering, referring, ordering, operating, billing, supervising, and attending providers not enrolled in CHAMPS
- For prescription drug claims written by a prescriber who is not enrolled in CHAMPS.

For more information on CHAMPS including deadlines and enrollment, visit:
http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_85441---,00.html

New Medicare ID Cards from the CMS

In April of this year, the Centers for Medicare & Medicaid Services started sending replacement Medicare ID cards. To help prevent identity theft, the new cards won't include Social Security numbers. Instead each person will get a new unique Medicare Beneficiary Identifier or MBI. New cards will be mailed between April 2018 and April 2019. For more information, visit:
https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers-and-office-managers.html

Note: There are no changes in HAP Midwest MI Health Link ID cards.

Billing Medicaid Members

When a provider accepts a patient as a Medicaid beneficiary with HAP Midwest Medicaid, the beneficiary cannot be billed for:

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

Claims

Balance Billing

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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf

Note: cost-sharing does not apply to dual eligible members enrolled in MI Health Link (ICO) program.

Physician Incentive Disclosure

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

HEDIS

Provider Pay for Performance 2018 Reminder

Effective July 1, HAP Midwest will award a $75 bonus to practices for each office visit. To qualify for the bonus, the associated HEDIS® codes must be submitted. This program pays quarterly. For more information, log in at **midwesthealthplan.com** and look for *P4P* under *Quick Links*.

Controlling High Blood Pressure

This HEDIS measure monitors the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Tips

- Don’t round blood pressure readings. Record the exact reading.
- Take the blood pressure twice if the patient has a high BP reading. Try waiting until the end of the visit when the patient is more relaxed.
  - The lowest systolic and lowest diastolic BP results can be used from separate readings.
- Ask your patients if they are taking their prescribed medications. Also remind them of the importance of controlling HTN.

Vaccines for Children (VFC)

As a Medicaid provider, you are required to get your vaccines through the VFC program. The Alliance for Immunization in Michigan (AIM) tool kits include information on VFC and MCIR as well as “catch up schedules”, storage information, vaccine information sheets and more! Contact your local health department if you have questions about the VFC program. The AIM tool kit can be found at **aimtoolkit.org.**

Reporting Communicable Diseases

State law requires providers to report all communicable diseases to the local health department. The AIM Provider Tool Kit includes a helpful brochure titled “Table of Reportable Diseases in Michigan.” Copies of the brochure and other information can be found at **aimtoolkit.org.**

Michigan Care Improvement Registry (MCIR)

Per your contract with HAP Midwest Health Plan and Public Act 91 of 2006, all immunization providers are required to report childhood immunizations to MCIR. This affects immunizations administered to persons born Jan. 1, 1994 to present. If you need information on reporting or access call (888) 217-3903 or visit **mcir.org.** They can also assist you in improving your immunization rates by using MCIR to run batch reports and monthly immunization recall letters.

Healthy Michigan Plan Health Risk Assessment Completion Instructions

HAP Midwest Health Plan offers a $25 incentive for primary care physicians who complete and return the HRA. This incentive payment is part of the Pay for Performance (P4P) bonus program. To be eligible, PCPs must:

- Complete and sign the HRA.
- Give the member a copy.
- Fax the completed HRA to (844) 225-4602.
- Bill with CPT code 96160. It will be processed at a $0.00 fee. The transaction will appear on the remittance advice and submitted to the Michigan Department of Health and Human Services as an encounter.

If you have any questions, please contact (844) 214-0870.

Education on HIV Prophylaxis

The Michigan Department of Health and Human Services has developed guidance documents to assist with education on the use of antiretroviral non-occupational post-exposure prophylaxis (nPEP) medication. nPEP is used in the event of a potential non-occupational exposure to HIV. These documents are attached.

Dental Coverage During Pregnancy

Effective July 1, 2018, the Michigan Department of Health and Human Services (MDHHS) will provide managed care dental services for pregnant beneficiaries who are eligible for the Medicaid dental Fee-for-Service benefit and enrolled in a Medicaid Health Plan (MHP). For more information, visit **michigan.gov/mdhhs**.

Therapy Limits for MI Health Link Members

Medicare has eliminated dollar limits on payment for medically necessary outpatient therapy services per year that includes:

- Physical therapy
- Occupational therapy
- Speech-language pathology therapy

However, additional information is required when therapy services reach certain amounts. Please see the table below for details.

Dollar limits reached	Requirements
$2,010 for PT and SLP services combined $2,010 for OT services	• Therapist will add information to patient's medical record • Therapist will add a modifier KX to therapy claim that confirms: – Therapy services are reasonable and necessary – Medical record includes information explaining why the services are medically necessary
$3,000 for PT and SLP services combined in 2018 $3,000 for OT services in 2018	The therapist or provider can contact HAP Midwest to request an organization determination prior to services being rendered to ensure that services will be approved as medically necessary. They can do this by: • Calling Customer Service at (888) 654-2200, option 2, then 1 If the pre-service organization determination is denied and the member receives the services after receipt of the denial notice, the member may be responsible for payment of the denied services.

Reporting Fraud, Waste and Abuse

HAP Midwest is committed to the prevention, detection, and correction of any criminal conduct. The vision of our company's compliance program is to promote an organizational culture that encourages ethical conduct and compliance with the law. It is our mission to be 100 percent in accordance with federal, state and local mandates.

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

If you suspect any provider, member, employee or contractor of HAP Midwest of potential fraud, waste or abuse of Medicare or Medicaid assets please call us immediately. We offer a 24-hour, toll free Compliance Hotline. The report can be filed anonymously so you are not required to leave your name or any contact information. Contact us at (877)746-2501. Or if you prefer to put your concern in writing, please mail it to the following address:

HAP Midwest Health Plan
2850 W. Grand Blvd
Detroit, MI 48202
Attention: Midwest Information Privacy & Security Office

You may also report to Medicaid, Michigan Department of Health and Human Services, Office of Inspector General (MDHHS-OIG) by calling or sending a letter to:

MDHHS-OIG
PO Box 30062
Lansing, Michigan 48909
Phone: 1-855-MI-FRAUD (643-7283)
Email: mdhhs-oig@michigan.gov or online at: http://michigan.gov/fraud

HAP Midwest Medicaid and MMP Drug Formularies

Looking for information about the drug formularies? This is a reminder that the drug formularies, along with updates and changes, are posted at midwesthealthplan.com. Information includes:

- Restrictions and preferences
- Explanation of limits
- How to use the formulary
- How to submit an exception request
- Generic drugs
- Step therapy
- Prior authorization

You can use the search tool to check the status of a specific drug or look at a drug category. You can also view or print the complete formulary document. A printed copy of the drug formulary and related documents are also available upon request.

Medicare-Medicaid Plan (MMP)
The 2018 HAP Midwest Health Advantage MI Health Link (MMP) formulary is available at the HAP Midwest website at https://www.midwesthealthplan.com/MIHealthLink/CoveredDrugs.aspx. You can search alphabetically or by type of drug. The drug formulary may change on January 1 annually and throughout the year.

Medicaid
HAP Midwest participates in the Michigan Medicaid Health Plan Common Formulary. General information about the common formulary and a history of formulary changes are available at midwesthealthplan.com. To access the 2018 HAP Midwest Medicaid/Healthy Michigan Plan/CSHCS drug formulary, go to https://www.midwesthealthplan.com/Formulary.aspx.

HAP Midwest posts the drug formularies at the website annually, and posts updates about formulary changes throughout the year. Negative changes are changes that result in restrictions or replacements, which may include prior authorization, step therapy, quantity limits or tier level changes. For the MI Health Link MMP formulary, negative changes do not apply during the calendar year. For the Medicaid formulary, negative changes typically apply only to new start members. HAP Midwest notifies members if they are impacted by a negative change. The prescriber is also notified as required.

HAP Midwest Health Plan Access and Availability Standards

Per the HAP Midwest Health Plan contract all providers must follow the Access and Availability Standards as outlined in the table below.

Accessibility of Services: Service will be provided "in the appropriate time frame"	
Appointment lead time: Primary Care	
Preventive (well) care – care provided in asymptomatic situations to prevent the occurrence or progression of conditions.	Within 14 calendar days
Routine care – care provided in symptomatic non-urgent conditions.	Within 14 calendar days
Urgent care – care for serious, but nonemergency injury or illness.	Same or next calendar day (< 48 hours)
After hours care	Physicians or their designee shall be available by telephone twenty-four (24) hours per day, seven (7) days per week.
Wait time in the office – length of time before the member is seen by the provider after checking in with the receptionist.	Less than 30 minutes
Accessibility of Services: Service will be provided "in the appropriate time frame"	
Appointment lead time: High Volume Specialist and High Impact Specialist	
• **Non-Urgent with symptoms**	Within 15 calendar days
• **Routine without symptoms**	Within 60 calendar days
• **Urgent care**–care for serious, but nonemergency injury or illness.	Same or next calendar day (<48 hours)

Questions about HAP Midwest Health Plan?

You can always call us at (888) 654-2200 for more information. We also have the following information posted online at **hap.org/midwest**. If you prefer a hard copy, call the number listed above and we will mail it to you.

- Affirmative statement about UM incentives
- Complex case management
- Coordination of Care between Behavioral Health and Primary Care Providers
- Covered and non-covered benefits
- Credentialing information
- Fraud, Waste and Abuse Information
- Disease management services
- Evaluation of medical technology
- HAP Midwest's policy for making an appropriate practitioner reviewer available to discuss any utilization management denial decision and how to contact a reviewer
- Member rights and responsibilities
- Network limits
- Pharmacy procedures and formularies
- Privacy and HIPAA information
- Utilization management criteria