

# SPECIALIST / PROVIDER HANDBOOK



**2004**

*Midwest Health Plan 5050 Schaefer Road Dearborn, MI.. 48126 1-888-654-2200 Fax (313) 581-2780*

## TABLE OF CONTENTS

**MHP Directory**

**MHP Mission**

**MHP Managed Care Overview**

**Provider Support Services**

**Contracting/Credentialing**

**Prior-Authorization / Referral Procedures**

**Claims Management Program**

**Provider Appeal Process for Claims Payment Decisions**

**Provider Appeal Process for Utilization Management Decisions**

**Pharmacy Overview**

**Member Eligibility / Benefits**

**Member Complaints / Grievances**

**Quality Improvement Program**

**Joint Venture Hospital Laboratories(JVHL)**



- Quality Improvement Activity
- Medical Record Audits

**Health Outreach Department:**

- Preventive Care Programs **Ext. 6068**
- Disease Management
- Health Education

**CREREDENTIALING DEPARTMENT:**

- Credentialing / Recredentialing **Ext. 6062**
- Site Visits

**Claims Management Department:**

- Claims Status **Ext: 6002, 6004**
- General Questions Regarding Claims
- Claims Payment

**Member Services Department:**

- General Member Questions and / or Administrative Concerns
- Complaints and /or Grievances
- Verify Member Eligibility **Ext. 7080**
- Determine Primary Care Physician
- Location Transfer
- Member Benefits

# MIDWEST HEALTH PLAN, INC.

## MISSION STATEMENT

*Midwest Health Plan is committed to providing excellence in managed care product lines to the residents of the State of Michigan, through fiscally responsible programs that assure access to and the delivery of cost effective/quality medical services.*

\*\*\*\*\*

## PHILOSOPHY OF MEMBER CARE / RIGHTS

*Midwest Health Plan is a value focused managed care organization, with a philosophy that emphasizes member's rights, through active partnerships between members and their selected physicians.*

## ***MHP HEALTH CARE PROVIDERS ARE ACCOUNTABLE FOR:***

**M**ember satisfaction

**H**ealth care access to comprehensive & quality medical care / preventative services;

**P**romote sharing of the responsibility of health care decisions with member's and their families

## **General Overview of Midwest Health Plan**

Midwest Health Plan is a for-profit, licensed Health Maintenance Organization (HMO) based in Dearborn, Michigan. Midwest was licensed in 1998 and accredited by the National Committee on Quality Assurance (NCQA) in 2000. Midwest Health Plan holds a contract with the State of Michigan to provide health care services to Medicaid recipients residing in Macomb, Washtenaw and Wayne Counties. Members are entitled to and are provided with the same services, benefits and conditions as traditional Medicaid. Managed Health Care is a system that links a Medicaid recipient to a Primary Care Provider (PCP). The system is effective in improving access to care, promoting preventative services and enhancing the quality of services.

The majority of all ambulatory services are provided directly by the PCP in his/her office and is reimbursed through capitation, while other specialty services remain fee-for-service. Most specialty services require a referral or prior-authorization by the PCP and or Health Plan.

All Providers must be contracted and credentialed to be on the Midwest Health Plan Network. MHP contracts with specialists that are Medical Doctors (MD) or Osteopathic Doctors (DO) licensed in the State of Michigan as well as other ancillary providers.

PROVIDER SERVICES DEPARTMENT

## **PROVIDER SUPPORT SPECIALIST**

Midwest Health Plan (MHP) has a team of **Provider Support and Provider Services Specialists** available to answer any questions and assist its entire network Specialist and Providers.

If you are in need of any assistance with the prior-authorization process, your claim/payments or any other type of provider support needs please contact a **Provider Support Specialist at 1-888-654-220 ext 6055**. If they cannot personally assist you, they will direct you to the appropriate MHP specialist who can assist you.

## **CONTRACTING**

Midwest Health Plan is continuously growing and adding new providers to our network of specialists and specialty services. All requests made to the Plan from interested Providers must be submitted in writing by fax or mail. This request must include background information on the organization. When the Provider Services Department receives the request, it will be reviewed to identify if there is a need for the provider in the existing network. Once a need is found, a contract along with a credentialing application is sent out. If the request does not fit the criteria, a letter will be sent informing the provider of the cause.

A Provider Specialist is available to assist you with provider contracting questions or needs, by contacting our **Provider Services Department at 1-888-654-2200 ext 6055**

## **CREDENTIALING/RE-CREDENTIALING**

All providers must be credentialed/contracted to be in the Midwest Health Plan (MHP) Network. Specialists and Ancillary Providers must complete the credentialing process (if accepted) and when the process is completed, the applicant is notified and added to the network. A provider identification number is issued that allows the provider to bill for his/her services.

This process is repeated every three years as recredentialing. Information will be sent sixty days prior to due date.

**UTILIZATION DEPARTMENT**

**REFERRAL PROCEDURES**

Most services performed outside of the Primary Care Physician’s office require a Midwest Health Plan referral form. The members Primary Care Physician must issue these forms. Midwest Health Plan utilizes its own referral forms. Authorization and reimbursement will be based solely on those services indicated on the referral form.

It is the specialist responsibility to provide documentation of findings, recommendations and treatment plans to the primary care physician. This information must be placed in the member’s permanent record at the PCP office.

**AUTHORIZATIONS AT A GLANCE**

<b>Consultation Request Form issued by Primary Care Physician</b>  <b>(Services Provided Outside the PCP Office)</b>	<b>Services Requiring Plan Authorization and CRF</b>	<b>Vision Authorization</b>  <b>Vision Provider to Contact MHP</b>  <b>1-888-654-2200</b>	<b>No Plan Authorization or CRF Needed</b>
Allergy Testing	<i><b>INPATIENT ADMISSIONS</b></i>  (Includes Hospital, Nursing Home, Inpatient Rehabilitation)		Family Planning Services

	<b>(Plan authorization only)</b>		
	<b>*PCP's cannot provide Plan authorization for inpatient admissions.</b>		
Outpatient Radiology – Not at PCP office	Durable Medical Equipment	Lenses	STD Services
Outpatient Diagnostics – Not at PCP office	Medical Supplies	Frames	Urgent Care Services
Podiatry Referrals	Prosthetics and Orthotics		Emergency Room Services
Ambulatory Surgeries <b>(Outpatient Surgery)</b>	Home Oxygen and related supplies		Well Woman Visits To In- Network Providers
Specialist Referrals	Home Health Care  Hospice		Well Child Visits To In-Network Providers
Chemotherapy	Hearing Aids and Batteries		Laboratory Services – JVHL Providers
Radiation Therapy- Not at PCP office			
Speech Therapy-Not at PCP office	MSS – ISS Services		
Physical Therapy- Not at PCP office			
Outpatient Mental Health Services	Chiropractic Services		
	All Out of Network Services		

## HOSPITAL AUTHORIZATION PROCEDURES

The following procedures should be followed when a Midwest Health Plan member requires hospitalization or outpatient services to insure payment to the facility providing that medical care.

### *ELECTIVE ADMISSIONS AND DIRECT ADMISSIONS FROM PHYSICIANS' OFFICES*

An authorization number issued by Midwest Health Plan must be obtained by telephone on the date of service. If the patient presents himself for admission Monday through Friday between the hours of 8:30 AM and 5:00 PM, please call. Midwest Health Plan's Utilization Management Department at 313-581-3700 and follow the prompted message. For after hours and weekend admissions, please contact the plan the next business day. All elective admissions must be precertified by the Primary Care Physician. Specialists must contact the PCP to arrange inpatient care.

### **EMERGENCY ADMISSIONS - MEDICAL / SURGICAL**

An authorization number issued by Midwest Health Plan must be obtained by telephone within 24 hours of the admission or the next business day. Authorization will be issued based upon Milliman and Robertson Guidelines, clinical judgment, and medical necessity. Authorizations will be given only after medical information is obtained. Authorizations may be obtained by calling Midwest Health Plan's Utilization Management Department at 313-581-3700 and following the prompted message.

### **PSYCHIATRIC ADMISSIONS – ALL**

Midwest Health Plan is a Medicaid only HMO. In-patient psychiatric admissions are benefit exclusion. Please contact the Community Mental Health Board of the county of residence for admission authorization.

### **\*IMPORTANT NOTES\***

\*Specialists must contact the PCP before referring patients for additional services. **Failure to do so may result in nonpayment of those services.** Specialists should also contact the PCP before ordering medications. This will help expedite any prior authorization that might be needed.

\*Midwest Health Plan, Inc. contracts with **Joint Venture Hospital Laboratories (JVHL)** for laboratory services. To locate a patient service center, please contact JVHL at 1-800-445-4979. Members may access a JVHL patient service center without a referral from the PCP. Outpatient laboratory services provided by labs not affiliated with JVHL are not covered by Midwest Health Plan.

\*Elective surgeries must be precertified with the plan's utilization department by the member's primary care physician 72 hours prior to the scheduled date of service.



## CLAIMS MANAGEMENT PROGRAM

In conjunction with the Utilization Management and Review program, Midwest Health Plan's Claims Management department endeavors to assure prompt and accurate claims review and processing. This is accomplished through the development of claims processing systems, policies and procedures that are consistently and appropriately applied.

## MEMBER BENEFITS

As a contracted Qualified Health Plan for the State of Michigan Medicaid program, Midwest Health Plan members are entitled to, at a minimum, all Medicaid covered services. The Plan is responsible for payment of all authorized, covered services except inpatient hospital facility claims for admissions prior to October 1, 2001, which should be submitted directly by the provider to the Michigan Medicaid program for processing. Inpatient facility claims for admissions occurring on or after October 1, 2001 should be sent directly to Midwest Health Plan.

## CLAIMS SUBMISSION REQUIREMENTS

Claims for services rendered to Midwest Health Plan members should be submitted to:

**Midwest Health Plan, Inc.**

**Attention: Claims Management Department**

**5050 Schaefer Road**

**Dearborn, Michigan 48126**

All claims submitted to Midwest Health Plan for services rendered to eligible members must contain the following information to be considered complete:

- **Member's Name**

- **Member's MHP Member ID Number (Medicaid recipient ID number)**
- **Member's Date of Birth and Gender**
- **MHP Authorization Number, if applicable**
- **Date(s) of Service**
- **ICD-9 Diagnostic Coding**
- **MPC Procedure Coding for services prior to August 1, 2001**
- **CPT and HCPCS Procedure Coding for services on or after August 1, 2001**
- **Revenue Coding for Hospital Services**
- **Surgical Procedure Codes as applicable**
- **Place of Service Code**
- **Quantity or Units, if applicable**
- **Billed Charges**
- **Other Insurance Information, if applicable**
- **Indication of Emergency, Accident, or Injury**
- **Provider's Name, Address, and Telephone Number**
- **Provider's Federal Tax ID Number or Social Security Number**
- **Name and Address Where Services Rendered, if different than provider's office**
- **Copy of MHP referral form attached to claim, if applicable.**
- **Copy of emergency room report for ER facility claims.**

Claims must be computer generated or typed and signed by the provider of service. Claims may be submitted on HCFA 1500, or UB-92 as appropriate for the service rendered.

## CLAIMS REVIEW

All claims submitted to Midwest Health Plan are reviewed by experienced claims analysts when necessary to determine completeness of claim, eligibility of member, benefit level for service, prior authorization as indicated, duplication of service, and appropriate billing codes. In cases where the services rendered appear to exceed the customary level of care, MHP will require the submission of medical records, reports, treatment records, and/or discharge summaries as appropriate. All claims submitted for the facility component of emergency services require the submission of the emergency room report. Claims submitted without the necessary records will be returned to the provider for resubmission with requested records.

## PAYMENT PROCEDURE

All claims submitted to MHP are date stamped on day received. MHP processes 'clean' claims within 45 days of receipt.

Payment for all authorized, medically necessary services will be paid according to applicable Medicaid fee screens. Payment to provider is accompanied by a remittance advice, specifying member and claim being paid, along with specific rejection information if applicable.

As Midwest Health Plan members are all Medicaid recipients, **providers cannot bill the members** for the difference between the provider's charge and the Medicaid fee that Midwest Health Plan pays. Providers must accept the Medicaid rates paid by Midwest as payment in full.

Please note that Midwest Health Plan does not 'pend' claims. Claims received are processed in the system and either paid or rejected. The only claims not processed through the system are incomplete claims. If the provider has not received a payment or a rejection within 45 days of receipt of the original claim, the provider is advised to resubmit the claim with all required information.

## CLAIM INQUIRY

All provider inquiries regarding claims should be directed to the claims department at the extensions shown in the telephone directory. Due to the volume of calls received, please limit your inquiry to (3) claims per call. Any large volume of claim inquiries or other claim projects should be handled in a written format. Requests for large or special claim projects should be made in writing.

**Please allow 45 days for processing before inquiring on a claim.**

## **EMERGENCY ROOM CLAIM REVIEW**

Pursuant to the Plan's agreement with the Michigan Department of Community Health, Midwest Health Plan (MHP) provides coverage for emergency services as well as medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 USCS 1395 dd (a)). MHP members may receive emergency screening and stabilization services without prior authorization from the Plan or the PCP.

Midwest Health Plan reviews all facility claims for medical emergency care on a retrospective basis to determine if services rendered meet the definition of a medical emergency (as defined below). If services meet the definition, all appropriately billed services will be paid to provider at applicable fee screens. If service does not meet definition, the claim will be returned to the provider, requesting that they re-bill a screening fee. All ancillary services medically necessary to screen and stabilize the member will be reimbursed.

### **DEFINITION:**

**Medical Emergency:** Those 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) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) 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; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

## **LABORATORY SERVICES**

Midwest Health Plan, Inc. contracts with **Joint Venture Hospital Laboratories (JVHL)** for laboratory services. Outpatient laboratory services provided by labs not affiliated with JVHL are not covered by Midwest Health Plan. Please refer to JVHL List.

# **PROVIDER APPEAL PROCESS**

## **FOR CLAIMS PAYMENT DECISION:**

Midwest Health Plan (MHP) understands that providers may not agree with some or Claims Payment decisions and provides a mechanism to resolve these issues. MHP incorporates a review by the Medical Director, optional Peer Review, and the Quality Improvement Committee for recommendations in the appeals process. The appeals process is as follows:

- A provider has the right to appeal a claims payment decision within 60 days from the date of the payment/denial. The provider must make the appeal in writing to:

**Midwest Health Plan**

**Attention: Director of Operations**

**5050 Schaefer Road**

**Dearborn, Michigan 48126**

- An Appeal must include the claim and documentation justifying the service/decision denied. Resubmission of a claim without written documentation requesting an appeal and without indicating the basis for such appeal is not considered an appeal. Submission of a medical record without additional explanation or a request for appeal is also not acceptable.
- Requests for appeal of a claim payment decision that are received beyond the 60 day time period will have forfeited their right to the appeal process.

- The Medical Director or the Associate Medical Director will review the appeal request and accompanying information.
- The Medical Director/Associate Medical Director may request additional information.
- The Medical/Associate Medical Director may request a Peer Review. Peers with a potential conflict of interest will not be used.
- The Medical Director/Associate Medical Director will make a decision on the appeal no later than 30 days after receipt of the appeal. The provider will be notified of the decision. If the original payment decision is reversed, the provider's claim will be processed for payment adjustment within 30 days of decision of Medical Director/Associate Medical Director.

## PROVIDER APPEAL PROCESS

### **FOR UTILIZATION MANAGEMENT DECISIONS:**

Midwest Health Plan (MHP) understands that a provider may not agree with a utilization management decision and that the provider has the right to appeal. The appeal process is as follows:

- A provider has the right to appeal a utilization management decision and must do so within 30 days of receipt of the denial or the decision. The provider must make the appeal in writing to:
- 

**Midwest Health Plan**

**Attention: Director of Operations**

**5050 Schaefer Road**

**Dearborn, Michigan 48126**

- If there is a specific reason that a provider is unable to supply the additional information within the time allotted (30 days) a 30-day extension will be granted upon written request. The request for extension is postmarked no later than 30 days from the initial denial. The extension will be granted for an additional 30 days from date of receipt.
- An appeal must include new supporting evidence and or documentation. Portions of the medical record may be submitted, however, the submission of the medical record without explanation will not be considered for appeal nor will it constitute a request for an appeal.
- Requests for an appeal of a utilization management decision received after 30 days or beyond the granted extension period will not be considered for an appeal.
- Midwest Health Plan will accept verbal appeals in emergent situations. These are defined as “ health care issues requiring a response from the Medical Director or Associate Medical Director in less than 24 hours.”
- Upon the receipt of the appeal, the Medical Director or Associate Medical Director will review additional information supplied by the provider and gather other information as needed. The Medical Director or Associate Medical director may solicit input from the physicians of the Peer Review Committee (or other group of physicians designated for this purpose) prior to making a decision. No physician may participate in the decision process that could create a conflict of interest.
- The Medical director or Associate Medical director will give the provider an answer in writing within 30 days or less as medical necessity dictates.

- If the provider disagrees with the decision of the Medical Director or Associate Medical Director, the provider has the right to appeal the decision in writing to the peer Review Subcommittee. This appeal must be received within 30 days of the denial of the appeal.
- The Peer Review Subcommittee will review all information, make a determination and inform the provider of its decision within 30 days.
- If the provider disagrees with the peer Review Subcommittee's decision, the provider has the right to appeal in writing to the Quality Improvement Committee. The appeal must be received within 30 days of the denial from the Peer Review Subcommittee.
- The Quality Improvement Committee will review all information and inform the provider of its decision within 30 days of its meeting. The decision of the Quality Improvement committee is the final decision.
- All appeals are tracked and reported to the Quality Improvement Committee. At each level of appeal, the provider is informed of the next step in the appeal process.

## **PHARMACY OVERVIEW**

Midwest Health Plan members have a pharmacy benefit, which closely follows the Michigan Medicaid formulary. However, Midwest Health Plan provides a preferred drug list for its providers. Medications not listed may require a prior authorization from the Plan prior to dispensing. Specialists should contact the Primary Care Physician before ordering medications.

## ***CUSTOMER SERVICE DEPARTMENT***

The customer service staff is trained to handle all member calls and inquires. The goal of the customer service department is to ensure prompt resolution to any of a members problems and concerns. The customer service representative is available to coordinate communications with members and providers acting as a member advocate. The customer service hours of operations are Monday through Friday 8:30 am to 5:30 P.M **Customer Service toll free no. 1 888-654-2200 or 313 581-3700**

## ***MEMBER ELIGIBILITY***

All Midwest Health Plan members will have two medical cards. The state issued Medical card should be for the current month of service. This card is used to confirm state eligibility with the plan. The member should also have a Midwest health plan card along with a referral when seeing a specialist, unless other arrangements have been made prior to the visit. The Midwest card should have the name, address and phone number of the current PCP.

**A member's eligibility or PCP may change from month to month as a result the member may or may not be entitled to the services under the same PCP or health plan. If you have any questions or need a verbal confirmation contact the customer service department. A copy of our participating primary providers is available by contacting the customer service department.**

## ***CUSTOMER SATISFACTION***

Midwest Health Plan (MHP) and its participating providers/physicians are committed to maintaining a consistently high level of Customer satisfaction and will continue to work with both the provider and the member to resolve any problems or concerns that may occur. Participating providers who become aware of a problem or a situation that affects MHP customer satisfaction should contact the Customer Service Department to discuss the concern with a

Customer Service Representative. Midwest Health Plan welcomes any new ideas or suggestions from our providers that would improve customer satisfaction.

## **BENEFITS AND SERVICES**

Midwest Health Plan is a Medicaid HMO that is regulated by the state of Michigan. The State of Michigan requires a contracted health plan to ensure that services provided are as accessible to enrollees as are services to non-enrolled members.

## **MEMBER COMPLAINTS / GRIEVANCES**

Any member may file a verbal or a written complaint/grievance by contacting the Customer Services Department. The complaint will be documented on a Grievance Form. There will be a full investigation of the complaint /grievance, including obtaining all necessary information from the provider to determine a prompt and fair resolution.

Information will be kept confidential and will only be shared with those persons directly involved in resolving the issue.

Members may file a complaint/grievances directly to the Department of Community Health. Members have the right to request a fair hearing with the Department of Community Health simultaneously with or after they have utilized MHP's complaints/grievance procedure. Members with complaints or concerns should be directed to call the Customer Services Department.

## **QUALITY IMPROVEMENT**

### **CONTINUOUS QUALITY IMPROVEMENT PROGRAM**

#### **PURPOSE**

The purpose of the MHP Continuous Quality Improvement Program (CQIP) is to assure the delivery of member care and services consistent with the mission statement and the goals of Midwest Health Plan.

## **AUTHORITY**

MHP's CQIP is commissioned by the MHP Board of Directors and is accountable to the governing body. The Medical Director has been delegated the responsibility and authority for establishing, maintaining, and supporting the CQIP, along with the support of the Associate Medical Director, the Quality Improvement Committee (QIC), and the Quality Improvement Department. The CQIP is evaluated on an annual basis by the CQI, with recommendations forwarded to the MHP Board of Directors.

## **APPROACH**

The MHP CQIP links knowledge, structure and processes together throughout MHP to assess and improve quality of care and services. Sources used to assess and improve care and services include:

- A. MHP Departmental Meeting Minutes**
- B. Staff Surveys**
- C. Member Satisfaction Survey (CAHPS) – performed annually**
- D. Member Complaints/Grievances**
- E. Provider Satisfaction Survey – performed annually**
- F. Committee Reports/Meetings**
  - 1. Credentialing**
  - 2. Utilization Management**
  - 3. Pharmacy, Benefits, & New Technology**

- 4. Infrastructure & Inter-rater Reliability Management Meeting**
- 5. Peer Review/Provider Appeals**
  
- G. Utilization Management Program**
- H. Credentialing Program**
- I. Medical Record Audit (External Quality Review – performed annually)**
- J. MHP Continuous Monitors**
- K. MHP Network Analysis**
- L. PCP After-hour survey – performed annually**
- M. Quality of Care / Health Care Studies**
- N. HEDIS review – performed annually**
- O. Quality of Care / Member Care Indicators**
- P. PCP- Wait Time Survey-performed annually**

#### CONTINUOUS QUALITY IMPROVEMENT PROGRAM

- 1. All PCP's and physician providers are contractually required to participate in the MHP CQI Program.**
  
- 2. All PCP Providers are oriented the CQIP requirements and process during their initial orientation process through on-site orientation and PCP Provider Handbook. **Specialists and other providers are oriented through the MHP Specialist/Provider Handbook.****
  
- 3. A Quality Improvement Work plan is a set of scheduled activities that are consistent with the CQIP. This is reviewed and revised on an annual basis by the MHP QIC.**

**4.** Participating Specialists and Providers may be required to assist MHP in data collection for various reporting requirements. This data would be relevant to the special population they serve and includes Pediatrics (immunizations, well-child visits, EPSDT's) and Obstetrics (prenatal/postpartum care and delivery).

## CONFIDENTIALITY OF RECORDS AND QUALITY IMPROVEMENT DATA

MHP has a confidentiality policy. Any person or persons violating this policy or disclosing information without authorization will be subject to disciplinary action including, when appropriate, immediate termination. A copy of this policy is in the Provider Administrative Manual. Contact MHP if you would like a copy of our policy.

Confidentiality of Member's Medical information or "personal health information" includes medical record information, results of record reviews, claims, benefits, other administrative data that are personally identifiable, and other information MHP obtains from facilities and providers on the health care services received by covered persons. This confidential information is used to administer MHP benefits, payment of claims for health care services and to assure quality care is given to our members. This confidential information includes any of the following:

- 1.** Data, reports, claims, records or other information that explicitly or implicitly identifies an individual patient, provider or reviewer ("implicitly identifies" is defined as data unique or small enough to identify an individual patient, provider, or reviewer);
- 2.** Reports and recommendations relative to Utilization Management, Customer Services or Quality Improvement investigation/study/outcomes.
- 3.** Utilization Management, Customer Services, or Quality Improvement proceedings (discussions and communications authorized by a committee, including review notes, meeting minutes and other records or review matters);
- 4.** All MHP policies and guidelines, or other relevant documents discussed during the UM/QI process.

**This confidential information is not disclosed to anyone except for whom the information was intended. MHP does not release any information that explicitly or implicitly identifies a member.**

## **MEMBER'S RIGHTS AND RESPONSIBILITIES**

To promote effective health care, MHP is committed to maintaining a mutually respectful relationship with our members. Upon member enrollment, members are informed of member's Rights and Responsibilities through the Member Handbook, then periodically through the Member Newsletter. Rights include such things as ability to choose a PCP, access to their medical records, treated with dignity and respect, participate in decision making regarding their health care, receiving a second opinion on treatment, voicing complaints on the care provided. Responsibilities include practicing good health habits, treat others with respect, tell PCP/Specialist about their medical history, keep scheduled appointments, arrive on time, and know what to do when the physician office is closed. MHP has a policy on Member's Rights and Responsibilities and monitors this by annual member and provider satisfactions surveys.

## **CONTINUITY AND COORDINATION OF CARE**

MHP addresses three important aspects of continuity and coordination of care: **(1)** coordination among medical practitioners treating the same member; **(2)** special attention to coordination between medical and behavioral care and **(3)** potential continuity problems caused when a practitioner leaves a network and has members in active treatment.

MHP utilizes the PCP "Gatekeeper" approach in order to manage resource utilization, assure that all necessary and required medical care is provided for each member, and promote the quality and continuity of medical care and services.

- **PCP Referrals:** If it is necessary for the PCP to send the member elsewhere for medical care, a MHP Consultation Request Form (CRF) must be completed and accompany the member to the visit. This is a four-copy form, the member should give one to the specialist for their records and **the other copy should be returned to the PCP with a report from the consulting physician.** A copy of the referral must be sent to MHP to

assure that the claim will not be rejected at the time the claim is examined for payment.  
*All referrals should be mailed to MHP on a weekly basis.*

- **MHP Authorization:** All areas that are Case Managed require an MHP authorization. This is obtained by phoning the Utilization Management Department of MHP. The Case Managed areas are listed below:

**A. All in-patient hospitalization admissions.**

**B. Durable Medical Equipment requests.**

**C. All Home Health Care requests.**

The claims for services shall be sent directly to MHP for payment in accordance with the contract that was signed and executed.

#### ACCESS TO CARE

Every Specialist shall provide MHP their hours of coverage at the time of credentialing and recredentialing. All MHP Specialist's are available to all MHP members, as designated by their contract, for emergency care, urgent care, and routine care (defined as follows):

**Emergency Care:** Life threatening situations

**Urgent Care:** Symptomatic problems

**Routine Care:** Follow-up care, non-urgent problems; or

**Preventive Care:** Appointments for screening, early detection, immunizations, and education (ie. self examination instructions)

Specialist Care/Specialty Ancillary Providers:

- Wait for an **Emergency** appointment: immediately-within 24 hours depending upon nature of request or refer to emergency room
- Wait to get an **Urgent** care appointment: 48 hours from the time of the member request.
- Wait to get a **Routine** appointment: 14 days from the time of the member request.

Waiting time to see the Specialist once they have arrived in office: <30 minutes from the time of their scheduled appointment.