

Midwest Health Plan, Inc.

Provider Newsletter

January 2010



Medical Director's Report Dr. Mark Tucker

PRIOR AUTHORIZATION – TAMIFLU & RELENZA

Effective September 1, 2009, Tamiflu and Relenza will not require a prior authorization. Quantity limits will allow one course of treatment for one individual per Rx for Midwest members.

H1N1 FLU VACCINE

The Michigan Department of Community Health has issued a policy bulletin, MSA 09-50, regarding coverage and reimbursement of the 2009 Influenza A (H1N1) monovalent vaccine. **The bulletin is provided as an attachment to this newsletter for information.**

INTERQUAL CRITERIA

The Health Services Department of Midwest Health Plan utilizes InterQual Care Criteria® for making clinical decisions. The criteria are evidence based and utilized as a guideline. The criteria assist with managing care processes and resources in a way that fosters evidence-based practice and ensures patient safety while controlling medically unnecessary care.

InterQual Care Planning Criteria helps Midwest Health Plan to evaluate the appropriateness of care-related interventions including diagnostic testing and procedures.

InterQual Level of Care Criteria aid in recommending the right level of clinical care or setting for patients—from acute through outpatient treatment.

Using information found in the medical record or supplied by healthcare providers, the Midwest Health Plan reviewer determines whether a patient’s clinical status matches the criteria for a specific intervention or placement at a specific level of care. When there isn’t a match, a reviewer or physician advisor can work with the attending physician to decide on an appropriate course of action.

If you would like to review or discuss the InterQual Criteria, please contact your Provider Services representative or the Director of Health Services.

Copies of specific InterQual Criteria are available upon request.

AUTHORIZATION AND REFERRAL PROCEDURES

MHP has a vast network of specialists and ancillary providers. It is expected that referrals for services are made to in-network providers whenever possible. A list of contracted providers and specialists is available on-line. If there is a question regarding the status of a provider or if it is felt a referral out of network is necessary, the Plan should be contacted. Questions can be directed to your Provider Services Representative or the Health Services Department at 313-586-6072 or toll free at 888-654-2200.

REFERRALS

MHP has redefined the word referral.

A referral can be written on a prescription, a Michigan Health Care Referral Form, or any other form of paperwork. Many PCPs write the referral on a prescription, FAX the signed prescription to the referral specialist and give the original to the patient. A referral may be a verbal statement from the PCP for the member to see a referral specialist. The member’s chart should reflect the PCP’s desire for the member to be seen by a referral specialist.

Referrals are provided by the PCP to the member. Members are still to receive a “referral” from their PCP to seek treatment with a contracted specialist. MHP need not be notified of a referral to a contracted specialist. Only specified procedures require MHP notification and approval (see list of services requiring plan notification**).

MICHIGAN HEALTH CARE REFERRAL FORM

The Michigan Health Care Referral form was developed by the Michigan Association of Health Plans to simplify the PCP’s duties in requesting services from all of the Michigan Health Plans. Midwest Health Plan accepts the Michigan Health Care Referral Form for services requiring plan notification. Midwest Health Plan expects the Referral form to be complete, timely, and legible.

For further information or instructions on completing the referral form contact the Health Services Department at 313-586-6072 or toll free at 888-654-2200.

SERVICES REQUIRING PLAN NOTIFICATION / APPROVAL

(PRIOR AUTHORIZATION)

If there is a question regarding the need for Plan Notification / Approval (prior authorization) please contact the Health Services Department at 313-586-6072 or toll free at 888-654-2200.

Plan notification and approval must occur prior to a member receiving the following services**:

<ul style="list-style-type: none"> • Services with a Non-Contracted Provider 	<ul style="list-style-type: none"> • Home Care
<ul style="list-style-type: none"> • Nursing Home Care (Non-Custodial) 	<ul style="list-style-type: none"> • Hospice Care
<ul style="list-style-type: none"> • Transplant Services 	<ul style="list-style-type: none"> • Oxygen and Related Supplies
<ul style="list-style-type: none"> • Bariatric Procedures 	<ul style="list-style-type: none"> • Anesthesia for Oral Surgery
<ul style="list-style-type: none"> • Cosmetic Surgery (Example: blepharoplasty, scar revision) 	<ul style="list-style-type: none"> • In-Office Infusion Therapy (specific medications)
<ul style="list-style-type: none"> • Prosthetics and Orthotics 	<ul style="list-style-type: none"> • Speech Therapy
<ul style="list-style-type: none"> • Durable Medical Equipment 	<ul style="list-style-type: none"> • Physical Therapy
<ul style="list-style-type: none"> • Occupational Therapy 	<ul style="list-style-type: none"> • Breast Reconstruction or Reduction

Prior Authorization from the Plan for the above services must be obtained by the member’s PCP or the Provider of the service (DME Company/Surgeon). Plan authorizations will be issued directly to the Provider of Service and the PCP. The Plan may contact the Member’s PCP or Specialist for information prior to issuing the authorization.

****See Authorization Grid for Complete List**

ELECTIVE HOSPITAL ADMISSIONS

Elective admissions are reviewed concurrently. Authorization is not required prior to the member’s admission to the hospital. The hospital UR department is responsible for obtaining the authorization the next business day after the admission. Physicians and hospitals are subject to non-payment if procedures are deemed unnecessary.

EMERGENT INPATIENT ADMISSIONS

Emergency admissions require an authorization number from MHP. This number is obtained by the hospital the next business day after the admission. Once MHP is notified and the admission is approved, the PCP is notified of the admission via fax.

AMBULATORY / OUTPATIENT AUTHORIZATIONS

Some elective ambulatory surgeries and invasive procedures must be authorized by MHP. Prior Authorization from the Plan must be obtained by the Member's PCP or the provider of the service. The Plan will communicate the authorization number to both the provider of service and to the PCP.

When the PCP determines medically necessary services for an MHP member require plan approval, the PCP, specialist, or his/her designee must complete the Universal Referral Form. The Referral Form must be faxed to the MHP Health Services Department a minimum of 72 hours prior to the requested service. The Health Services fax number is (313) 586-6045.

It is important that the referral form be timely, completed in its entirety, and legible. The absence of information (services being authorized, codes, length of time for treatment, name of provider) or a form that is unreadable may result in:

- Unauthorized or unplanned services being charged to the PCP
- A delay in the processing of the request
- Denial of claims
- Unnecessary delays or cancellations of procedures

Prior Authorization must occur **PRIOR** to the planned service. Retrospective requests for plan approval will not be authorized.

When the plan has approved the requested service, an authorization number will be provided via fax to the PCP and Provider. A copy of the authorized form should be given to the Member to take to the Provider with a copy retained in the member medical.

Urgent requests may be called into the Health Services Department only if the service being requested is urgent. Calls for urgent requests will not be accepted for convenience of the provider or member.

Due to potential changes in Member eligibility, the approved authorization does not ensure payment. Providers should verify eligibility at every visit. PCP's should verify that a member is assigned to them prior to the issuance of a referral. If a referral is issued for a member not assigned to the PCP, it will be charged to their referral fund.

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

- Outpatient Specialty Physician Consults and Services
- Allergy Testing
- Routine Radiology Services
- Outpatient Diagnostics
- Chemotherapy
- Radiation Therapy
- Chiropractic Services (limited to 18 visits)
- Outpatient Mental Health Visits (limited to 20 visits)
- Obstetrics / Gynecology
- Ophthalmology

Per the terms of the Plan contract with the Michigan Department of Community Health, Members may access any of the following services directly, without prior authorization or referral from the PCP or MHP.

- Emergency Room Services - Facility and Professional Components
- Family Planning Services / OB Services at any provider
- STD Services at any provider
- Well-Women exams with a contracted provider
- Well-Child exams with a contracted Pediatrician
- Emergency Transportation
- Services provided by Federally Qualified Health Centers
- Services provided by Public Health Departments

Fraud, Waste and Abuse CMS Mandated Training in Provider Offices

On December 5, 2007, CMS issued a final rule addressing 42 C.F.R. Part 422 regarding the Medicare Advantage program. Pursuant to this final rule, MA Organizations, such as MHP, are required to:

- Maintain appropriate oversight and attest it will implement a compliance plan that is designed to detect, prevent and correct fraud, waste and abuse and includes effective training and education between the compliance officer, organization employees, contractors, agents and directors. Participation in training programs should be a condition of continued employment and a criterion included in employee evaluations.
- Establish training and communication requirements for first tier, downstream and related entities with which MHP has a contractual relationship. In this respect, the first tier, downstream and related entities with whom MHP contracts must undertake the training required by the regulations and addressed by this memorandum, and must attest to MHP that such training has been completed.
- Obtain training logs and copies of attestations from their first tier, downstream and related entities to comply with this requirement. Accordingly, your organization must submit the required attestation within the designated timeframe to MHP and must maintain internal training logs.

Please refer to the attached memo “CMS Mandated training for Providers, First Tier, Downstream and Related Entities. This memo applies to you and your practice. Please read the memo and complete Exhibit A and return to Midwest by March 31, 2010 as documentation of your compliance with this CMS rule.

If you have any questions, please contact Kathy Harkness at #313-586-6063.

Midwest Health Plan now offers affordable, easy-to-use healthy living benefits!



Midwest Health Plan has teamed up with Weight Watchers® to offer our members a program that more physicians have recommended to their patients than any other weight loss plan. With nearly 1,000 meetings held throughout the franchise area, members will be able to find a meeting that is convenient for them. Midwest members can purchase a 12 week Weight Watchers PASS at \$138 (a 25% savings off the published price) by just showing their Midwest Health Plan Member ID card at participating meeting locations. If you have Midwest patients who would benefit from a weight reduction program, please tell them about this discount opportunity.

For more information or to find a meeting place call 1.888.3Florine or go to www.weightwatchers.com .

OBESITY TOOLKIT RESOURCE GRID



The Institute for Health Care Studies (IHCS) at Michigan State University has compiled a resource grid that contains information and Web site links to various Obesity Toolkits that are available on the internet. To access the “Obesity Toolkits for Providers” grid, please go to: <http://www.ihcs.msu.edu> and click on the grey “Obesity” tab on the home page. If you do not have internet access and would like a printed version of the Obesity resource grid, or if you have any questions, please call the Midwest Health Plan Quality Improvement Department at 313-586-6065.

PAY FOR PERFORMANCE 2010

Midwest has expanded and increased funding for our Pay for Performance (P4P) Bonus program starting January 2010. We have added additional measures that are eligible for bonuses and also included a bonus when your Diabetic member has received all their necessary services and for when a child has received all their necessary vaccines by age 2. Midwest is also continuing our CDPS/ABAD diagnosis reporting and percentage of members seen for visits bonus program in 2010. The Bonus programs for 2010 are attached.

We continue to enhance our “Opportunities Reports” on our website to notify you of the members who are due for bonus payment services so that you can increase your revenue. If you have any questions, please contact your Provider Services Representative:

Linda Abdelghani #313-586-6013
Nehya Moslimani #313-586-6055
Gena Neault #313-586-6039
Brian Flemming #313-586-6069

Exhibit B
Attachment 2

MIDWEST HEALTH PLAN
PAY FOR PERFORMANCE BONUS PROGRAM

Effective 1/1/10

SERVICE	TIME FRAME	LIMITATION	CPT CODES	ICD-9 CODES	BONUS
Childhood Immunization			Additional \$100 bonus for completing all P4P Childhood Immunizations by age 2!		
DTaP	Before age 2	4 doses	90698/ 90700/ 90721/ 90723	99.39	\$10 per vaccine
IPV	Before age 2	3 doses	90698/ 90713/ 90723	99.41	\$10 per vaccine
Hepatitis B	Before age 2	3 doses	90723/ 90740/ 90744/ 90747-90748	070.2/070.3/V02.61	\$10 per vaccine
Hib	Before age 2	2 doses	90645-90648/ 90698/ 90721/ 90748		\$10 per vaccine
MMR	Between age 1 & 2	1 dose	90707/ 90710	99.48	\$10 per vaccine
VZV	Between age 1 & 2	1 dose	90710/ 90716	052/053	\$10 per vaccine
Pneumococcal conjugate	Before age 2	4 doses	90669		\$10 per vaccine
Hepatitis A	Before age 2	2 doses	90633	070.0/070.1	\$10 per vaccine
Rotavirus	Before age 2	2 or 3 doses	2 doses=90681/3 doses=90680		\$10 per vaccine
Influenza	Between 6 mos & 2 yrs	2 doses	90655/90657/90661/90622	99.52	\$10 per vaccine
Lead Screening					
Blood lead test	Before age 2	1 per year	83655/ 83655QW		\$15 per test
Adolescent Immunization					
MCV4	Age 11 - 12	1 dose	90733/90734		\$10 per vaccine
Tdap/ Td	Age 10 - 12	1 dose	90715/90714/90718	99.39	\$10 per vaccine
Tetanus & Diphtheria	Age 10 - 12	1 dose each	90703 & 90719	99.38/99.36	\$10 per vaccine
Testing for Pharyngitis					
Strep test at time of diagnosis	Age 2 - 18	Each event	87070-87071/ 87081/87430/87650-87652/87880/ 87880QW & dx code 462/463/034.0		\$10 per test
Preventive Medicine Services					
	Age 0 - <12 mos	6 visits	99381/99391	V20.2	\$15 per visit
	Age 12 mos – 35 mos	2 per year	99382/99392	V20.2	\$15 per visit
	Age 3 - 11	1 per year	99382/99392/99383/99393	V20.2	\$15 per visit
	Age 12 – 17	1 per year	99384/99394	V20.2	\$15 per visit
	Age 18 - 65+	1 per year	99385-99387/99395-99397	V70.0	\$15 per visit
Woman's Health					
Mammogram screening	Age 38 – 69	1 per year	77055-77057	V76.11/V76.12	\$25 per service
Pap test	Age 18 – 64	1 per year	HCPCS Q0091	V72.32/V76.2	\$25 per service
Chlamydia screening	Age 16 – 24	1 per year	87110/87270/87320/87490-87492/87810		\$25 per service
Diabetic Care (250.xx/648.0)			Additional \$100 bonus for completing all P4P Diabetic Care in CY 2010		
HbA1c	Age 18 - 75	1 per year	83036/83037/ 83036QW/83037QW		\$25 per service
LDL-C	Age 18 - 75	1 per year	80061/83700/83701/83704/83721/ 80061QW/83721QW		\$25 per service
Nephropathy screening	Age 18 - 75	1 per year	82042/82043/82044/84156/ 81002QW/81003QW/82044QW		\$25 per service
Diabetic eye exam	Age 18 - 75	1 per year	92002/92004/92012/92014/92018-92019/92225-92226/92230/92235/92240/92250/ 92260	V72.0	\$25 per service

Bold & Italicized codes will be paid Medicaid FFS rates

Bonus also paid for well care services provided at “sick” visits when billed with above codes

An additional \$100 bonus per eligible member for all immunizations completed by age 2

An additional \$100 bonus per eligible member for all diabetic care performed between 1/1/10 & 12/31/10

Pay For Performance

Aid to the Blind and Disabled (ABAD) Bonus Program --2 Parts to the ABAD/Chronic Disease and Disability Payment System (CDPS) P4P

1. Current Year CDPS Qualifying Diagnosis \$25.00 per Qualifying Diagnosis per ABAD (Ongoing payment as appropriate diagnoses are reported)

There are 19 Diagnoses Categories that the ABAD/CDPS diagnoses fall into. We will pay you for ONE diagnosis per category per member. For example, Member X has a visit in January. You report Diabetes with Renal Manifestations (250.41). We will pay you \$25 because the diagnosis falls into the Diabetes Category. Next month, Member X comes in again and you report Diabetes with Hyperosmolarity (250.23) and Left Heart Failure (428.1). We will pay you \$25 for the new category reported (Cardiovascular) but we already paid you for the Diabetes category. The list of ABAD diagnosis categories is:

ABAD Categories

[AIDS -](#)

[Cancer -](#)

[Cardiovascular -](#)

[Central Nervous System -](#)

[Cerebrovascular -](#)

[Developmentally Disabled](#)

[Diabetes -](#)

[Eye -](#)

[Gastrointestinal -](#)

[HIV -](#)

[Hematological -](#)

[Infectious -](#)

[Metabolic -](#)

[Psychiatric -](#)

[Pulmonary -](#)

[Renal -](#)

[Skeletal -](#)

[Skin](#)

[Substance abuse -](#)

The entire list of diagnoses and categories is found on our website in the secure login section. Remember, we still request that you report EVERY diagnosis the patient has at EVERY visit.

2. Member's Non Visit Percentage*:

Less than 35% \$40 per ABAD Member** (See 65 -74.9 % of your ABAD members during the year)

Less than 25% \$60 per ABAD Member** (See 75-84.9 % of your ABAD members during the year)

Less than 15% \$80 per ABAD Member** (See 85% or more of your ABAD members during the year)

*One payment per year paid at highest possible rate based on member visits to the PCP from 1/1 to 12/31 of the contract year, with claims submission by 1/31 of the following year. Bonus will be paid by the end of the first quarter of the following year.

**Bonus paid for each Member with PCP as of 12/31 of contract year whether or not that member was seen by PCP.

AWARDS AND RECOGNITIONS

NCQA selects Midwest Health Plan for its 2009 *Recognizing Innovation in Multicultural Health Care* Award

Midwest Health Plan is pleased to announce it was one of five managed care plans recognized by the National Committee for Quality Assurance (NCQA), with support from The California Endowment, for its innovative efforts to improve health care access and quality for consumers facing language and cultural barriers that frequently impede their access to life-prolonging care.

The award was presented to Midwest Health Plan at an awards reception and poster session in Washington D.C. on October 15, 2009. Midwest was selected for this national recognition for its efforts to improve use of preventive health screening measures – pap smears, mammograms, and chlamydia screening, as well as pre- and post-natal care services – among its Spanish-speaking, African-American and Arabic (comprising 75% of service-area members) minority populations in Dearborn and Detroit. A concerted effort over two years led to increases from 13% to 42% in members’ timely use of these important preventive health services.



Kathleen Harkness and Dr. Mark Saffer of Midwest Health Plan receiving NCQA’s 2009 “Recognizing Innovation in Multicultural Health Care” Award. Pictured from left to right: Jeffrey S. Kasher of Eli Lilly, Ignatius Bau, J.D., from the California Endowment, Kathleen Harkness, RN, Senior Director of Corporate Quality Midwest Health Plan, Garth Graham, MD, MPH, Deputy Assistant Secretary for Minority Health, Department of Health and Human Services, Dr. Mark Saffer, CEO Midwest Health Plan, and Greg Pawlson, Executive VP of NCQA.

PREFERRED PROVIDERS

Midwest Health Plan is currently transitioning members who have oxygen and related supplies to the preferred provider network. Services which are requested with non preferred providers will be re-directed.

**Please use only Preferred Providers when requesting
DME, P&O, Home Care, or Infusion Care**

To arrange for services, you may contact the providers directly or the Midwest Health Plan Health Services Department at 313-586-6072 or FAX 313-586-6045. All Home Care, Infusion, P&O and DME requests require plan approval. The providers will obtain the required plan authorization.

Also, when requesting Physical Therapy, Occupational Therapy, or Speech Therapy - authorizations will only be approved with contracted providers. Requests to non-contacted providers will be re-directed.

DME Preferred Providers

<u>Name</u>	<u>Phone</u>	<u>Fax</u>
Advanced Medical Solutions <ul style="list-style-type: none"> • Howell Office • Brighton Office • Ann Arbor Office 	800-248-2229 517-548-1443 810-225-7701 734-528-2522	800-552-9443 517-548-1588 810-225-8062 734-528-2312
Motor City Medical	800-929-0160 248-545-4520	800-411-7993 248-414-7352
Oakwood Home Medical Equipment <ul style="list-style-type: none"> • Allen Park Location • Oakwood Hospital Location 	800-752-2273 313-271-3550	313-271-0276 313-271-3755
Phoenix Medical Supply	888-699-4362	248-354-9638
J&B Medical Supply	800-737-0045	800-737-0012
Trudell Pharmacy	313-581-2424	313-581-2193

Home Care Preferred Providers

<u>Name</u>	<u>Phone</u>	<u>Fax</u>
Oakwood Home Care Services	800-757-7711	313-996-3025

Crystal Home Care	313-493-4900	313-493-4904
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Infusion Preferred Provider

<u>Name</u>	<u>Phone</u>	<u>Fax</u>
Complete Infusion	734-425-2550	734-425-2620

Prosthetics and Orthotics Preferred Provider

<u>Name</u>	<u>Phone</u>	<u>Fax</u>
Michigan Orthopedics	734-513-8205	734-513-8219

PATIENT CENTERED MEDICAL HOME (PCMH)

The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

There are many resources and opportunities to help providers learn more about PCMH and begin to take steps towards becoming a certified medical home. A partial list of resources is provided below. If you have questions, please contact the Quality Improvement Department at 313-586-6063.

Resources:

- Registry Examples:
 - Wellcentive : #877-692-6180 Wellcentive is offering many incentives to IPAs and PHOs
 - Cielo: #734-827-1000
- Blue Cross Blue Shield Physician Group Incentive Program (PGIP): <http://www.bcbsm.com> (provider site/value partnerships/PGIP) or call #248-448-3306
- Improving Performance in Practice (IPIP): <http://ipip.aiag.org>
- American College of Physicians: http://www.acponline.org/running_practice/technology/
This site has updated information on the American Recovery and Reinvestment Act of 2009
- National Committee for Quality Assurance (NCQA) Physician Practice Connections® - Patient Centered Medical Home™: <http://www.ncqa.org/tabid/631/Default.aspx>

Miscellaneous:

- Midwest looking at adding PCMH to the bonus program in 2010

- Midwest staff will conduct preliminary PCMH assessments to determine areas of opportunities for improvement (This takes about 2 hours of the PCP and the office staff time and can be conducted in one or two sessions)

E-PRESCRIBING

Electronic prescribing or “E-Prescribing” is the use of computer-based systems to generate, transmit, and fill patient prescriptions, replacing paper and faxed prescriptions. E-prescribing allows health care providers to transmit and renew prescriptions electronically, to check patient benefits information, and to maintain current and accurate medication histories.

OB CODING

Midwest does not accept global OB billing (Global Codes such as 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622). Midwest requires that you “bill individual component codes”. Also, please note that when billing for the prenatal services, please note the from and to dates should be FROM-the first date of service and TO-the last date of service. Please put the individual dates in Box 19. Claims will be rejected if not submitted correctly.

E-Prescribing can benefit your patients and practice by:

- Improving patient safety and quality of care (i.e., eliminating illegibility, drug-drug or drug-allergy interactions)
- Increasing office efficiency (i.e., reducing phone calls, call-backs, and faxing to pharmacies)
- Increasing patient convenience (i.e., automating renewal requests, improving medication compliance, and decreasing patient hassles)

Midwest Health Plan, working with RxAmerica, encourages practitioners to implement E-Prescribing. The types of E-Prescription transactions include:

- **E-Prescribing New Prescriptions** – prescription information is sent directly to the pharmacy’s computer through a secure network.
- **E-Refills** – the pharmacy sends refill requests to the prescriber’s prescribing application, eliminating the need to fax or call.
- **Eligibility Check** – allows the prescriber to electronically check what plan a member is eligible for and what formulary code is attached to the plan. It takes about two seconds to get eligibility information through E-Prescribing.
- **Formulary Download** – allows the prescriber to view health plan formularies to assure minimal impact to the patient when filling a prescription.
- **Medication History** – allows the prescriber to electronically retrieve the patient’s previous medication therapies from the plan or pharmacy. Safeguards are in place to block all sensitive drug information.

To learn more about E-Prescribing refer to the E-Prescribing Fact Sheet provided as an attachment to this newsletter or visit www.GetRxConnected.com or www.RxSuccess.com .

CLINICAL AND PREVENTIVE HEALTH GUIDELINES

MHP’s Clinical and Preventive Health Guidelines include:

- Diabetes
- Asthma

- Tobacco Control
- Substance Use Disorders
- Osteoporosis
- Osteoarthritis
- Hypertension
- Hyperlipidemia
- Heart Failure
- Deep Venous Thrombosis
- Major Depression
- Cancer
- Stroke
- Otitis Media
- Obesity
- Chronic Kidney Disease
- Pharyngitis
- Prenatal/Postpartum Care
- Preventive Health Guidelines from birth to over age 65
- Acute Bronchitis in Adults
- Adults with Systolic Heart Failure
- Acute Low Back Pain
- Prevention of Unintended Pregnancy in Adults
- Office –Based Surgery

These guidelines are found on our website of www.midwesthealthplan.com. Please review these guidelines. These guidelines are developed based on nationally recognized sources—each guideline lists the sources. These guidelines were endorsed by the Medical Directors of the Michigan Quality Improvement Consortium (MQIC) and/or the Michigan Association of Health Plans Medical Directors. You can also find the guidelines along with physician tools on the MQIC website at www.mqic.org. If you would like a hard copy of these guidelines, or have any comments or suggestions for revisions, please contact the Quality Improvement Department at 313-586-6065.

If you have any questions, please contact Kathy Harkness at #313-586-6063.

DISEASE MANAGEMENT

Asthma and Diabetes Disease Management Programs

Diabetes Control Network: When enrolled, members will receive information on how to take care of their diabetes. Call **1-313-586-6071** to refer your patient into this program. After joining, the member will be sent information on what diabetes is, how to control blood sugar, taking medications the right way, exercising, eating right, eye and foot care and other important information.

Asthma Focus: When enrolled, members will receive educational information in the mail. To refer your patient into this program, call **1-313-586-6071**. After joining, the member will be

sent information on asthma triggers, use of medications, peak flow meter use, an asthma action plan to complete with PCP, information on stopping smoking, and much more.

GLAUCOMA SCREENING

Glaucoma is an eye condition that develops when too much fluid pressure builds up inside the eye. This pressure can damage the optic nerve and if left untreated, glaucoma can cause blindness. Because most people with glaucoma have no early symptoms or pain, it is important that persons have a complete eye exam with their ophthalmologist or optometrist regularly. Glaucoma occurs most frequently in adults over age 40. Glaucoma cannot be prevented, but if it is diagnosed and treated early, the disease can be controlled. Please remember to screen your Medicare members (age 67 years or older) each year. Please refer to the *Adult Preventive Services (Ages 50-65+) Guideline*, which can be found on our website at www.midwesthealthplan.com.

CONTROLLING HIGH BLOOD PRESSURE

High blood pressure is a major risk factor for heart and kidney disease, stroke, and heart failure. High blood pressure is especially dangerous because it often gives no warning signs or symptoms. Hypertension can be treated with medication, diet, and exercise. Please review the *Medical Management of Adults with Hypertension Guideline*, which can be found on our website at www.midwesthealthplan.com.

HEALTH OUTREACH

Alliance for Immunization in Michigan (AIM)

The AIM Provider Immunization Toolkit for Children & Adults is a resource guide containing the most current standards of practice, forms, and vaccination methodologies for immunizations in Michigan. To order a hard copy of the kit, visit the AIM website at, www.aimtoolkit.org.

ROSEBUD PREGNANCY EDUCATION PROGRAM

Midwest Health Plan would like to remind you of our telephonic case management and education program for pregnant members and their infants. ROSEBUD® is staffed by nurses who specialize in perinatal care and case management.

The Perinatal Case Management program targets women at risk for complications during pregnancy. The program supports the healthcare providers plan of care as well as provide ongoing education to the expectant mother and her family.

You may refer members to this program, by calling the Health Outreach Department at 313-586-6071. You may also fill out the Notification of Pregnancy form (attached at end of newsletter) and fax it to 313-581-2780, Attention: Andrea Fogarty. Thank you for your help!

SMOKING CESSATION PROGRAM

Midwest Health Plan's "I Can Quit" Smoking Cessation Program can help members quit smoking. This is a telephone health coaching program. The program includes: five proactive phone calls by a dedicated health coach over a 12 month period. Health coaches offer strategies to increase self-efficacy, identify barriers to change, and provide techniques to cope with and overcome barriers. For more information on our "I Can Quit" Smoking Cessation Program or to refer any of your patients to the program, call **1-313-586-6071**.

QUALITY IMPROVEMENT

HEDIS UPDATE

Lead Screening

This is a new hybrid measure for HEDIS that started 1/1/07. It's the percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday. Midwest will reimburse you \$12 for every lead test conducted. Codes to Identify Lead Tests: CPT 83655

GUIDELINE MONITORING

Midwest Health Plan monitors physician adherence to clinical practice guidelines through HEDIS measures and also a number of non-HEDIS measures. Results for two non-HEDIS measures were reported to the December Quality Improvement Committee, including PCP follow-up after hospitalization for asthma and Statin use for Diabetics over the age of 40. Results for these measures is provided below.

Asthma Hospitalization – PCP follow up within 7 days

An analysis of claims and encounters is conducted to identify members discharged from a hospital stay with a primary diagnosis of asthma and determine if those members had a visit to their PCP within 7 days of discharge. The review is based on claims data for the timeframe January 1 through October 31 of the reporting year. All members discharged with a primary diagnosis of asthma are included in the denominator. Two numerators and rates are calculated: the percentage of members who had a follow up visit within 7 days of an asthma discharge, and the percentage of members who had a follow up visit within 14 days of an asthma discharge.

Results and Analysis

Table 1: Results and Comparison Performance Goal

Measure	2006	2007	2008	2009
Follow up within 7 days	38% (75/195)	34% (76/222)	26% (48/185)	26% (44/171)
Follow up within 14 days	NA	NA	32.4% (60/185)	37.4% (64/171)
Goal	90%	90%	90%	90%
Met goal?	No	No	No	No

The Plan established an internal performance goal of 90%. Midwest has not met the goal the past four years. The rate of follow up within 7 days remained constant at 26% from 2008 to 2009; however, there has been an increase in the rate of follow up within 14 days. Midwest moved away from phone calls to members discharged for asthma in 2007 and 2008 to the use of McKesson generated letters to members. Using mail method may result in delays in notifying members may help explain why the 7 day follow up rate has not changed but the 14 day rate has increased and highlights the importance of generating the reminder letters on a daily basis because of the short timeframe for meeting this guideline.

MHP will continue efforts in 2010 to encourage members to follow up with their PCP after an asthma discharge with the following actions:

- Continue to use McKesson CCMS to generate a follow up letter to members upon discharge for Asthma. Monitor the timeliness of letters to ensure members are notified within an adequate timeframe in order to schedule and see their PCP within 7 days of discharge.
- Member health fairs to have discussions on asthma and distribute literature (since 1999)
- Participate in annual World Asthma Day (2005, 2006, 2007, 2008, and 2009)
- Continue with Asthma Disease Management Program

Statin Use for Diabetics over age 40 years

The Michigan Quality Improvement Consortium (MQIC) Diabetes clinical guidelines recommend the use of statin therapy for primary prevention against macrovascular complications in patients with diabetes who are greater than or equal to age 40 or who have an LDL-C greater or equal to 100 mg/dl.

To evaluate physician adherence to this guideline, MHP measured the rate of statin use among diabetic members over the age of 40. Diabetic members are identified based on HEDIS technical specifications. Of the members identified in the Diabetes HEDIS denominator, only those age 40 years or older or those who have an LDL-C level greater or equal to 100 mg/dl (based on lab results and/or HEDIS hybrid chart review) are included in the denominator. Pharmacy claims are then reviewed to determine if a statin prescription was filled for the members during the reporting period.

Table 1: Results and Comparison Performance Goal

Measure	HEDIS 2009 (Baseline measure)
Numerator	848
Denominator	1,595
Rate	53%
Benchmark *	52%
Goal	75%
Met Goal?	No

* Benchmark is based on 2008 MQIC non-HEDIS Medicaid diabetes statin therapy indicator.

The Plan identified a benchmark using MQIC's non-Hedis diabetes statin therapy indicator. Midwest performed above the average rate for MQIC Medicaid plans. The Plan established an internal performance goal of 75% recognizing that not all diabetic members can tolerate statins. Results indicate low adherence to the clinical guidelines for statin therapy for prevention against macrovascular complications in patients with diabetes over age 40 or whose LDL lab values are greater than 100 mg/dl.

Please remember to prescribe a statin for your diabetic patients over the age of 40 or who have LDL lab values greater than 100 mg/dl.

EPSDT/ WELL CHILD VISITS – DEVELOPMENTAL SCREENING

The American Academy of Pediatrics recommends developmental surveillance at every well-child visit and developmental screening using formal, validated tools at **9, 18, and 30** months or whenever a parent or provider concern is expressed. Surveillance and screening activities should be performed and coordinated with tracking and intervention services available in the community

Please be sure to conduct a developmental screening at every EPSDT/ Well Child Visit and code it with **CPT 96110** – Developmental testing, limited with interpretation and report. **Midwest will pay Medicaid fee screens (currently \$10) for developmental screening/testing.** Be sure to code your claims and encounters accurately so you can get paid!

Developmental Surveillance

Surveillance is the process of recognizing children who may be at risk of developmental delays. Developmental surveillance is a flexible, longitudinal, continuous, and cumulative process whereby knowledgeable health care professionals identify children who may have developmental problems. There are 5 components of developmental surveillance:

- Eliciting and attending to the parents' concerns about their child's development
- Documenting and maintaining a developmental history
- Making accurate observations of the child
- Identifying the risk and protective factors
- Maintaining an accurate record and documenting the process and findings

Developmental Screening

Developmental screening is the administration of a brief standardized tool aiding the identification of children at risk of a developmental disorder. Developmental screening that targets the area of concern is indicated whenever a problem is identified during developmental surveillance. For more information please visit:

- Listing of developmental screening tools (American Academy of Pediatrics):
<http://pediatrics.aappublications.org/cgi/content-nw/full/118/1/405/T1>
- Coding Fact Sheet for Primary Care Pediatricians:
<http://www.medicalhomeinfo.org/screening/DevProvider.html>.

Remember to conduct a developmental screening at every EPSDT/ Well Child Visit and code it: CPT 96110 – Developmental testing, limited so you can be paid Medicaid fee screen (currently \$10) for this important screening.

PROVIDER SERVICES

BASICARE NO LONGER PRINTING ID CARDS

Wayne County will no longer be printing ID Cards for BasiCare members. The eligibility lists for BasiCare members is found on our website in the Office Manager section with all your Midwest Product lines eligibility. After checking the eligibility list, if you still have a question about a member's eligibility, please contact Customer Services.

WIN CANDY

Your office will have the chance each month to win a free box of candy. All you have to do is answer the questions on the last page of the newsletter and fax the page to us at 313-581-2780. If your answers are correct, the candy will be mailed to your office. Please refer to our website at www.midwesthealthplan.com for the list of winners. **If you do not answer the questions correctly, you will not receive the candy.** So keep up the good work and keep responding. If you're not participating, you should. It's quick and easy and all you have to do is read the newsletter and answer the questions. Please try it. **Congratulations** to those offices who responded correctly. We hope you are enjoying the candy! The **December** office winners include.

Everingham Clinic, P.C.
Hollywood Pediatric Clinic
My Family Doctor
Park Family Lincoln Park
Kamala Vanaharam, M.D.

**MIDWEST HEALTH PLAN
FLU VACCINE COVERAGE AND BILLING INSTRUCTIONS**

2009/2010 FLU SEASON

PROCEDURE CODES AND CORRESPONDING FEES

Procedure Code	Description	Age <19	AGE ≥19
90669	Pneumococcal Vacc, PED<5 years old	0.00 (VFC* covered code)	Not Applicable
90655	Flu Vaccine no preserv 6-35 months old	0.00 (VFC covered code)	Not Applicable
90656	Flu Vaccine no preserve 3 years and older	0.00 (VFC covered code)	\$15.82
90657	Flu Vaccine, 3 years old IM	0.00 (VFC covered code)	Not Applicable
90658	Flu Vaccine, 3 years and older IM	0.00 (VFC covered code)	\$12.06
90660	Flu Vaccine, Nasal	0.00 (VFC covered code)	\$21.18
90732	Pneumococcal Vacc, age >5 years old	(VFC covered code)	\$27.03

*VFC is Vaccine for Children. If the grid lists “VFC covered code”, that means you must obtain this vaccine from the Vaccines for Children program. VFC is for children less than 19 years old.

For all Primary Care providers an administration charge of \$7.00 can be billed for the administration of any of the above vaccines using the appropriate procedure code for separate reimbursement **except** procedure code 90660-Nasal Flu vaccine.

Answers for December 2009 Candy Contest

1. **True** *Midwest Health Plan has teamed up with Weight Watchers® to offer our members a 25% savings off the published price for a 12 week Weight Watchers PASS.*
2. *Please list the two (2) additional measures that are eligible for bonuses on our enhanced Pay for Performance (P4P) Bonus program starting January 2010.*

Diabetics with all necessary services
Children with all vaccines by age 2

3. *Please list the two (2) bonus measures for the Aid to the Blind and Disabled (ABAD) Medicaid population on our enhanced Pay for Performance (P4P) Bonus program starting January 2010.*

Blood Lead Test
Mammogram Screening

4. *Please list three (3) of the Preferred Providers for Home Care, Infusion, P&O and DME services.*

Crystal Home Care
Compete Infusion
Oakwood Home Medical Equipment

January 2010 Candy Contest

- 1) Which Wayne County program will no longer be printing ID Cards _____

- 2) True or False (circle one) InterQual Care Planning Criteria helps Midwest Health Plan to evaluate the appropriateness of care-related interventions including diagnostic testing and procedures

- 3) Which CPT code is used when conducting a developmental screening at every EPSDT/ Well Child Visit _____

- 4) Name three benefits E-Prescribing can benefit your patients and practice by

Your Name: _____
From the office of Doctor: _____ **PIN** _____
Office Site Name: _____
Phone Number: _____

Please fax this completed sheet to (313) 581-2780



Notification of Pregnancy Form 2010

Phone number:
313-586-6071

Fax number:
313-581-2780

MEMBER DATA

Date		Date of Birth	
Last Name		First Name	
Address		Phone #	
City		Alternate Phone #	
ZIP		Recipient ID	

HEALTHCARE PROVIDER DATA

PCP Name		PCP ID #	
Address		Ste	
Zip		Phone #	
OB Provider		OB Phone #	

PERINATAL INFORMATION

Maternal:			
LMP		Date last Pap test	
EDC		Date Chlamydia screen	

RISK FACTORS / COMMENTS

Midwest Health Plan thanks you for notifying us of members who are pregnant.

Memorandum

To: All providers, first tier, downstream, and related entities

From: Midwest Health Plan

Date: December, 2009

Re: CMS Mandated Training for Providers, First Tier, Downstream and Related Entities

I. INTRODUCTION

It is the practice of Midwest Health Plan (MHP) to conduct its business with the highest degree of ethics and in compliance with all laws. MHP has adopted written policies and procedures to comply with business standards, federal and state laws. MHP has established effective lines of communication and has a dedicated compliance officer to monitor suspected violations, and, when appropriate, to oversee corrective actions to prevent future violations.

Midwest Health Plan (MHP) is a Medicare Advantage (MA) Organization that contracts with the Centers for Medicare & Medicaid Services (CMS) to offer health coverage to eligible enrollees. As an entity that contracts with MHP to provide health and/or administrative services on behalf of our MA beneficiaries, your organization must meet new education and training requirements related to fraud, waste and abuse (FWA).

The purpose of this memorandum is to provide FWA compliance training as required by the federal regulations and Medicare guidance. Specifically, this memorandum includes: an overview of the revised regulations; relevant definitions related to the regulations; education requirements; fraud, waste and abuse training; a sample attestation, training log and resources.

II. REVISED REGULATIONS

On December 5, 2007, CMS issued a final rule addressing 42 C.F.R. Part 422 regarding the Medicare Advantage program. Pursuant to this final rule, MA Organizations, such as MHP, are required to:

- Maintain appropriate oversight and attest it will implement a compliance plan that is designed to detect, prevent and correct fraud, waste and abuse and includes effective training and education between the compliance officer, organization employees, contractors, agents and directors. Participation in training programs should be a condition of continued employment and a criterion included in employee evaluations.

- Establish training and communication requirements for first tier, downstream and related entities with which MHP has a contractual relationship. In this respect, the first tier, downstream and related entities with whom MHP contracts must undertake the training required by the regulations and addressed by this memorandum, and must attest to MHP that such training has been completed.
- Obtain training logs and copies of attestations from their first tier, downstream and related entities to comply with this requirement. Accordingly, your organization must submit the required attestation (**Exhibit A**) within the designated timeframe to MHP and must maintain internal training logs (**Exhibit B**).

III. DEFINITIONS

Plan Sponsor: An entity that has a contract with CMS to offer one or more of the following Medicare products: MA Plans, MA Prescription Drug Plans, Prescription Drug Plans (PDP) and 1876 Cost Plans.

First Tier Entity: Any party that enters into a written arrangement acceptable to CMS with a Sponsor or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA or Part D programs.¹

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a Sponsor and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.²

Related Entity: Any entity that is related to the MA Organization by common ownership or control and (1) performs some of the MA Organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than \$2500 during a contract period.³

Fraud: An intentional act of deception, misrepresentation or concealment in order to gain something of value. Examples of fraud include billing for services not furnished; billing for services at a higher rate than is justified; soliciting, offering or receiving a kickback, bribe or rebate; or violations of the physician self-referral (Stark) prohibition.

Waste: Use or expend carelessly, extravagantly, or to no purpose.

¹ 42 C.F.R. 422.2.

² *Id.*

³ *Id.*

Abuse: May be intentional or unintentional and directly or indirectly results in unnecessary or increased costs to the Medicare program. Examples of abuse include: charging in excess for services or supplies; providing medically unnecessary services; or providing services that do not meet professionally recognized standards.

IV. EDUCATION REQUIREMENTS

According to federal regulations, MHP is ultimately responsible for oversight and monitoring of education and training of first tier, downstream and related entities. As one of these entities, your organization can comply with the FWA education and training requirements by satisfying one of the following three options:

- (1) Provide your own training in accordance with 42 C.F.R. 422.504 (b) (4) (vi) (c) – “Effective training and education between the compliance officer and organization employees, contractors, agents and directors.”
- (2) Take training from another MA Organization.
- (3) Complete the training provided by MHP.

Your organization must submit the required attestation (**Exhibit A**) within the designated timeframe to MHP and must maintain internal training logs (**Exhibit B**).

V. FRAUD, WASTE AND ABUSE TRAINING

A. Documentation Requirements

Your organization is required to complete the attestation attached hereto, which must be signed by an authorized representative. Upon request, your organization may be required to submit copies of training logs demonstrating that your employees received FWA training.

If your organization has contracted with other entities to provide health and/or administrative services on behalf of MHP MA and/or Part D beneficiaries, you will need to obtain attestations from those entities that they have completed FWA training. In addition, those entities will also need to provide your organization with copies of their training logs.

B. Relevant FWA Laws

1. False Claims Act

The False Claims Act prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. When submitting claims data to CMS for payment, MHP and our subcontractors must certify that claims data is true and accurate to the best of their knowledge and belief.

The False Claims Act is enforced against any individual/entity that knowingly submits (or causes another individual/entity to submit) a false claim for payment to the federal government. *** Note, intent to defraud is not necessary to prove that the government was in fact defrauded, as long as it is established that the person acted with “intent to defraud.”⁴

2. *Anti-Kickback Statute*

Section 1128B9b of the Social Security Act provides criminal penalties for individuals and entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicare or other federal health care programs.⁵ For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. Recent kickback cases have involved unlawful referral payments in the form of free office space, free equipment, free drugs or supplies, inflated or sham consulting contracts, and travel and entertainment by physicians by hospitals, pharmaceutical companies and laboratories.

In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in the Medicare and other federal health care programs and subject to civil monetary penalties for violations of the Anti-Kickback Statute.

3. *Self-Referral Prohibition Statute (Stark Law)*

The federal Stark law prohibits physicians from referring Medicare patients to an entity with which the physician or a physician’s immediate family member has a financial relationship, unless an exception applies.⁶

4. *HIPAA*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, applies to covered entities, including health care providers and health plans.

Individuals, organizations, and agencies that meet the definition of a covered entity under HIPAA must comply with statutory and regulatory requirements to protect the privacy of health information and provide individuals with certain rights with respect to their health information.⁷

C. Examples of Potential FWA

1. *Potential FWA committed by a MA Organization and/or Part D Plan Sponsor*⁸

⁴ 42 U.S.C. 1320a-7b.

⁵ 42 U.S.C. 1320a-7b(b).

⁶ 42 U.S.C. 1395nn.

⁷ 45 C.F.R. Part 164.

⁸ Medicare Prescription Drug Benefit Manual, CMS Pub. 100-18, Chapter 9, Section 70.1.1.

Potential FWA committed by a MA Organization and/or Part D Plan Sponsor could include unlawful marketing schemes, such as:

- Unsolicited door-to-door marketing.
- Enrollment of beneficiaries without their knowledge or consent.
- Stating that a marketing agent/broker works for or is contracted with the Social Security Administration or CMS.
- Requires beneficiaries to pay up front premiums.

2. *Potential FWA committed by a Prescriber*⁹

Potential FWA committed by a prescriber could include:

Illegal remuneration schemes – Prescriber is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs, products or services.

Script mills – Prescriber writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs on sale on the black market, and might include improper payments to the prescriber.

Provision of false information – Prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism in order to justify coverage. Prescriber misrepresents the dates, descriptions of prescriptions or other services furnished, or the identity of the individual who furnishes the services.

Theft of provider's DEA number or prescription pad – Prescription pads and/or DEA numbers can be stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications often sold on the black market.

3. *Potential FWA related to billing*¹⁰

Potential FWA committed by a provider could include:

- Billing for items or services not rendered or not provided as claimed;
- Submitting claims for equipment or supplies and services that are not reasonable and necessary;
- Double billing resulting in duplicate payment;
- Billing for non-covered services as if covered;
- Knowing misuse of provider identification numbers, which results in improper billing;

⁹ Medicare Prescription Drug Benefit Manual, CMS Pub. 100-18, Chapter 9, Section 70.1.4.

¹⁰ Medicare Prescription Drug Benefit Manual, CMS Pub. 100-18, Chapter 9, Section 70.1.3.

- Unbundling;
- Failure to properly code using coding modifiers;
- Altering medical records;
- Compensation programs that offer incentives for items or services ordered and revenue generated;
- Inappropriate use of place of service codes;
- Routine waivers of deductibles and coinsurance;
- Clustering; and
- Upcoding the level of service provided.

4. *Potential FWA committed by a Pharmacy Benefit Manager*¹¹

Potential FWA committed by a pharmacy benefit manager could include:

Unlawful remuneration – Pharmacy benefit manager receives unlawful remuneration in order to steer a beneficiary toward a certain plan or drug, or for formulary placement. Includes unlawful remuneration from vendors beyond switching fees.

Failure to Offer Negotiated Prices – Occurs when a pharmacy benefit manager does not offer a beneficiary the negotiated price of a Part D drug.

5. *Potential FWA committed by a Retail Pharmacy*¹²

Potential FWA committed by a retail pharmacy could include:

Bait and Switch Pricing – Occurs when a beneficiary is led to believe that a drug will cost one price, but at the point of sale the beneficiary is charged a higher amount.

Prescription Drug Shorting – Pharmacist provides less than the prescribed quantity and intentionally does not inform the patient or make arrangements to provide the balance, but bills for the fully-prescribed amount.

Prescription Forging or Altering – Where existing prescriptions are altered, by an individual without the prescriber’s permission to increase quantity or number of refills.

6. *Potential FWA committed by a Pharmaceutical Manufacturer*¹³

Illegal Off-label promotion – Illegal promotion of off-label drug usage through marketing, financial incentives, or other promotion campaigns.

¹¹ Medicare Prescription Drug Benefit Manual, CMS Pub. 100-18, Chapter 9, Section 70.1.2.

¹² Medicare Prescription Drug Benefit Manual, CMS Pub. 100-18, Chapter 9, Section 70.1.3.

¹³ Medicare Prescription Drug Benefit Manual, CMS Pub. 100-18, Chapter 9, Section 70.1.5.

Illegal Usage of Free Samples – Providing free samples to physicians knowing and expecting those physicians to bill the federal health care programs for the sample.

7. *Potential FWA committed by a Beneficiary*¹⁴

Potential FWA committed by a beneficiary could include:

Misrepresentation of Status: A Medicare beneficiary misrepresents personal information, such as identity, eligibility, or medical condition in order to illegally receive the drug benefit. Enrollees who are no longer covered under a drug benefit plan may still attempt to use their identity card to obtain prescriptions.

Identity Theft: Perpetrator uses another person’s Medicare card to obtain prescriptions.

Prescription forging or altering: Where prescriptions are altered, by someone other than the prescriber or pharmacist with prescriber approval, to increase quantity or number of refills.

Prescription diversion and inappropriate use: Beneficiaries obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. Also can include the inappropriate consumption or distribution of a beneficiary’s medications by a caregiver or anyone else.

Prescription stockpiling: Beneficiary attempts to “game” their drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against periods of non-coverage (*i.e.*, by purchasing a large amount of prescription drugs and then disenrolling), or for purposes of resale on the black market.

Doctor shopping: Beneficiary or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

D. Reporting and preventing FWA

1. Reporting Potential FWA

Compliance with state and federal laws and regulations and Medicare program requirements is a priority to MHP. If your organization or other downstream entity with which you contract to provide health and/or administrative services on behalf of MA or Part D beneficiaries has questions regarding compliance generally, has questions regarding MHP’s FWA compliance policies or training, or identifies potential FWA, please contact:

- Your organization’s compliance officer or compliance hotline; and/or

¹⁴ Medicare Prescription Drug Benefit Manual, CMS Pub. 100-18, Chapter 9, Section 70.1.7.

- MHP:

Kathleen M. Harkness, RN, MS, CPHQ,
Sr. Director of Corporate Quality
Midwest Health Plan
5050 Schaefer Road
Dearborn, MI 48126
(313) 586-6063;

and/or

- Office of Inspector General:

Office of the Inspector General
HHS TIPS Hotline
P.O. Box 23489
Washington, DC 20026
(800) HHS-TIPS ((800) 447-8477) (phone)
(800) 223-8164 (fax)
hhstips@oig.hhs.gov

When making an inquiry, please provide as much information as possible regarding your question or concern, including the following information:

- Contact information (Name, address, telephone number - *** **Note, you also may report anonymously. Retaliation is prohibited when you report a compliance concern in good faith**);
- Type of item or service involved;
- Place of service;
- Nature of the compliance question or allegation(s) (if applicable);
- Timeframe of the allegation(s) (if applicable).

2. Preventing Potential FWA

CMS has adopted the following strategies to prevent fraud and abuse:

- Effective enrollment procedures and education of physicians, providers, suppliers and beneficiaries.
- Early detection through Medical Review (MR) and data analysis.
- Close coordination with law enforcement and other agency partners.
- Applying fair and firm enforcement policies.

In addition, your organization should establish disciplinary guidelines for non-compliant or fraudulent behavior, which should include mandatory retraining and which may include disciplinary action, including possible termination when behavior is serious, repeated, or when knowledge of a possible violation is not reported.

E. Attestation, Training Log and Resources

Your organization must submit the required attestation (**Exhibit A**) within the designated timeframe to MHP and must maintain internal training logs (**Exhibit B**). A list of FWA resources is also attached as **Exhibit C**.

EXHIBIT A

ATTESTATION

As a first tier, downstream or related entity, _____ attests that it has conducted appropriate education and training to identify, correct and prevent potential fraud, waste and abuse, per the Final Rule published at 72 Fed. Reg. 68700 *et seq.* (December 5, 2007). Please select the method of education and training that your organization chose to comply with the Final Rule requirement:

- Conducted our own education and training per 42 C.F.R. 422.504 (b) (4) (vi) (c).
- Took training and education provided by a MA and/or Part D Sponsor or other organization.
- Took training and education provided by Midwest Health Plan.

Signature attests that your organization has completed appropriate education and training to identify, correct and prevent potential fraud, waste and abuse, and your organization will furnish upon request to Midwest Health Plan training logs to validate that training was completed. In addition, your organization will obtain attestations from other entities that provide health, prescription and/or administrative services on behalf of Midwest Health Plan Medicare Advantage beneficiaries, and upon request obtain training logs to verify that fraud, waste and abuse training was completed by those entities.

_____ (signature)

Name: _____

Title: _____

Date: _____

Please return this completed attestation by March 31, 2010 to:

Kathleen M. Harkness, RN, MS, CPHQ
Sr. Director of Corporate Quality
Midwest Health Plan
5050 Schaefer Road
Dearborn, MI 48126
Fax: 313-581-2780

EXHIBIT B

TRAINING LOG

Employee Name – Print	Employee Signature	Name of Training (e.g., MHP)	Date of Training	Manager's Initials

EXHIBIT C

RESOURCES

The following federal government websites are sources of information regarding fraud, waste and abuse education, detection, correction and prevention:

Department of Health and Human Services, Office of Inspector General

<http://www.oig.hhs.gov/hotline.html>

Centers for Medicare & Medicaid Services

http://www.cms.hhs.gov/MLNProducts/downloads/110107_Medicare_Fraud_and_Abuse_brochure.pdf

<http://www.medicare.gov/FraudAbuse/HowToReport.asp>