



**Midwest
Health Plan**

Administrative Provider Manual
for Medicaid including:
Children's Special Health Care Services (CSHCS)
Healthy Michigan Plan (HMP)

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SECTION 1: GENERAL OVERVIEW

HAP Midwest Health Plan is a for-profit, licensed Health Maintenance Organization (HMO), wholly-owned subsidiary of Health Alliance Plan (HAP) and is based in Detroit, Michigan. HAP Midwest Health Plan was first licensed in 1998 and has been continuously accredited by the National Committee for Quality Assurance (NCQA). HAP Midwest Health Plan offers a Medicaid Managed Care plan in Genesee, Huron, Lapeer, Sanilac, Shiawassee, Tuscola and St. Clair counties; a Medicare Dual-Special Needs Plan (D-SNP) in Wayne, Oakland, Macomb, and Washtenaw counties; and a Medicare-Medicaid Dual Demonstration Project (MMP) in Wayne and Macomb counties.

HAP Midwest Health Plan contracts with a primary care physicians (PCPs) and specialty care physicians (SCPs) who are licensed in the state of Michigan as either a Medical Doctor (MD) or a Doctor of Osteopathic Medicine (DO). PCPs in the plan include Internal Medicine, Family/General Practice, Pediatrics, and OB/GYN physicians. SCPs include cardiologists, gastroenterologists, rheumatologists, endocrinologists, surgeons, etc. All physicians in the HAP Midwest Health Plan program must meet the credentialing standards and uphold the managed care philosophy of the plan.

The PCP performs the majority of ambulatory services in his/her office and is reimbursed through either capitation or fee for service contracts. Services provided by contracted specialists in most cases will not require plan approval. Care provided by non-contracted providers will require the PCP to submit a request for plan approval.

Members are entitled to and are provided with the same services, benefits and conditions as traditional Medicaid. HAP Midwest Health Plan is experienced with managed services for the Medicaid population have been effective in lowering overall healthcare costs, improving access to care, and either maintaining or improving upon the delivery and quality of care.

MISSION STATEMENT

HAP Midwest Health Plan is committed to providing excellence in our managed care product lines for our members, through fiscally responsible programs that assure access to and the delivery of cost efficiency and quality medical services.

HAP Midwest Health Plan

Health care providers are accountable for:

- Member satisfaction
- Health care access to comprehensive and quality medical care / preventative services
- Promote sharing of the responsibility of health care decisions with members and their families, caregivers, etc.

CONTACT INFORMATION

Department	Phone	Fax
Customer Service	(888) 654-2200	(248) 663-3774
Claims	(888) 654-2200, option #2	(248) 663-3783
Compliance/Fraud, Waste & Abuse	(877) 746-2501	
Credentialing	(313) 664-8529	
Health Outreach/Disease Management	(248) 663-3794	(248) 663-3782
HEDIS Activities	(248) 663-3789	(248) 663-3782
Network Development/Contracting	(313) 664-8529 OR (313) 664-8793	(313) 429-5154 OR (313) 429-5209
Quality Management	(248) 663-3789	(248) 663-3782
Utilization Management	(888) 654-2200	(248) 663-3780

SECTION II: PROVIDER SERVICES

PCP AS THE COORDINATOR OF CARE

HAP Midwest Health Plan utilizes the PCP to manage resource utilization, assure that all necessary and required medical care is provided for each member/patient, and promote the quality and continuity of medical care and services. The PCP is responsible for supervising, coordinating, and providing all primary care to each assigned HAP Midwest Health Plan member. A PCP may be a primary specialist in any of the following: family practice, general practice, internal medicine, or pediatrics. There are situations when a SCP, physician assistant or nurse practitioner can act as the PCP for certain chronic conditions or circumstances.

A primary care physician is usually the first medical practitioner contacted by a patient, due to factors as ease of communication, accessible location, familiarity, and increasingly issues of cost and managed care requirements. Ideally, the primary care physician works collaboratively with the member to develop a plan of care with participants of the health care team. These may include referral specialists, social workers, hospitals or rehabilitation clinics, and other clinicians and family members.

COMMUNICATION WITH THE PCP

HAP Midwest Health Plan strives to keep the PCP informed of any changes within HAP Midwest Health Plan and/or the State of Michigan Medicaid Program. Our website provides the most up to date information for Providers. This information includes pertinent policies and procedures, weekly eligibility, financial information (pay for performance information, financial reports, remittance advices, opportunity reports, etc.), clinical guidelines, the entire administrative manual and town hall sessions.

MEMBER ADVOCACY

HAP Midwest Health Plan does not prohibit any Participating Practitioner or Allied Health Professional from discussing treatment options with members, regardless of benefit coverage, or from advocating on behalf of a member in any grievance or utilization review process, or individual authorization process to obtain health care services. Practitioners may freely communicate with patients about their treatment, including medication treatment options, regardless of benefit coverage limitations. HAP Midwest Health Plan encourages the PCP along with all health providers to develop plans of care with their patients (or patient's guardian or representative) since the member's participation is an integral part of the decision making for their treatment and care options.

PCP REPORTING REQUIREMENTS

PCPs participating with HAP Midwest Health Plan are contractually obligated to submit documentation of all encounters (visits) with assigned members. The Plan is mandated to provide encounter information to the Michigan Department of Health and Human Services (MDHHS).

PAYMENT STRUCTURE

FEE FOR SERVICE

The PCP "Fee for Service" contract will make payment for all Primary Care Plan and Referral Services at amounts equal to the current Medicaid fee for service rates.

CAPITATION

The financial reports are located on the HAP Midwest Health Plan website. A separate user ID and password is given to each PCP to log on and review this information. This series of reports consist of all capitation payments and adjustments for both the past month and any prior months that may require additional reconciliation as well as remittance advices.

LABORATORY SERVICES

HAP Midwest Health Plan provides coverage for laboratory services. Genetic testing requires an authorization prior to rendering services.

PCP PERFORMANCE AND PAY FOR PERFORMANCE (P4P) BONUS PROGRAM

HAP Midwest Health Plan will pay providers additional money for increasing the quality of patient care received by enrollees of HAP Midwest Health Plan. Payment is based on quality outcomes for specific measures as outlined by the Plan.

Each year HAP Midwest Health Plan reviews its P4P program and may make revisions to the program based on quality outcomes from the measurement year and goals set for the upcoming year. PCPs are notified of P4P changes through their contract. The P4P criteria, the Opportunity Reports, and remittance advices for these programs are found in the Provider's secure financial section of the website.

HAP Midwest Health Plan reserves the right to use practitioner performance data for quality improvement activities designed to improve quality of care and services and the member's overall experience.

PCP ACCESSIBILITY AND AVAILABILITY

Every PCP site shall provide twenty-four (24) hours per day, seven (7) days per week, and three hundred sixty-five (365) days per year. Every physician contracted as a PCP must be available to see patients a minimum of twenty (20) hours per location/per week. The PCP shall give written prior notice to HAP Midwest Health Plan of alternative coverage arrangements during times of non-availability. PCP's should encourage their members to contact them whenever possible, prior to seeking health care services outside of their office. HAP Midwest Health Plan requires the hours of operation that providers and practitioners offer to Medicaid members be no less than those offered to commercial members and comparable to those for Medicaid Fee-for-Service (FFS) members.

ACCESS TO CARE STANDARDS

All HAP Midwest Health Plan PCPs are available (or will make the appropriate coverage available in their absence) for all HAP Midwest Health Plan members, on a 24-hours per day/7 days per week/365 days per year basis for urgent care and emergency care.

Appointment Type	Standard	Description
Preventive/Routine Care	≤ 14 days of member request	Routine, non-symptomatic care
Urgent Care	≤ 48 hours of member request	Symptomatic problems
Emergency	≤ 24 hours of member request	Life threatening situations
Wait Time in the Office	≤30 minutes	After checking in with the receptionist to being seen by the practitioner

HAP Midwest Health Plan requires 100% of our PCPs meet appointment standards and 90% of Wait-Time standards. Monitoring is accomplished through annual surveys.

HAP Midwest Health Plan requires SCPs to follow the same guidelines for wait times as our PCPs. Pharmacy services are within 30 minutes travel time of all HAP Midwest Health Plan members with availability during evenings and weekends.

PCP REQUEST FOR MEMBER TRANSFER

On occasion, a HAP Midwest Health Plan member may exhibit actions that are inconsistent with Plan membership, including fraud, abuse of the plan, or other intentional misconduct; or the PCP may feel that a member's behavior is such as to make it medically unfeasible for the PCP to safely or prudently render care to the member. If this occurs, the PCP may need to request that a member transfer to another HAP Midwest Health Plan provider or that the member be removed from the plan. Some of the reasons for such requests may be as follows:

- Patient/physician incompatibility
- Violent or Life Threatening Behavior
- Medical Non- Compliance
- Fraud/Misrepresentation
- Forged or altering prescriptions

If this occurs, the member's PCP should request the transfer or Plan disenrollment in writing, addressed to the Medical Director of HAP Midwest Health Plan. The letter must clearly indicate the reason for the request and the specific incident(s) that led to the request. The request should also include supporting documentation such as medical records, police/security report, incident reports, etc.

The Medical Director or designee will review the documentation submitted. The Medical Director or designee may request additional information and/or clarification from the PCP prior to making a determination. Failure to respond to such requests will result in denial of the transfer or disenrollment. If the request for transfer or disenrollment is approved, appropriate notice will be sent to the member, PCP, and the state of Michigan. The member must receive 30 days advance notice to allow the member adequate time to select another provider or make other arrangement for health care services.

The PCP should not send the member a letter before the Medical Director has approved the request. For additional information regarding requests for member transfer or disenrollment, please contact Customer Service at 888-654-2200.

SECTION III: CREDENTIALING

HAP Midwest Health Plan has delegated its credentialing activities to its parent organization, HAP. Any willing provider may request participation in HAP MHP Health Plan's (HAP MHP) programs, but HAP MHP reserves the right to consider any such request on the basis of cost, quality, availability of services, and conformity to HAP MHP's administrative procedures, and other factors relevant to delivery of economical, quality care, including HAP MHP's current provider needs. Providers denied an application will be sent a written response to their request with an explanation as to the reason.

CREDENTIALING PROCESS and CRITERIA

All potential candidates must complete a CAQH application. Providers may contact HAP MHP any time during the credentialing process to inquire on the status of their application.

1. Demographics, training, work history, licensure, certification and liability history. All supporting documents are date stamped and initialed on review by the credentialing coordinator.
2. A statement by the applicant regarding:
 - a. reasons for any inability to perform the functions with or without accommodation
 - b. lack of present illegal drug use
 - c. history of loss of license and/or felony convictions
 - d. history of loss or limitation of privileges or disciplinary activity
 - e. current malpractice insurance coverage.
3. Attention to correctness/completeness [attestation] of the application.
4. Release of Information signed.
5. Practitioners and providers retain the right to review information submitted in support of their credentialing applications.
 - a. If the credentialing process discovers information that is substantially different than information provided by the applicant, the applicant will be notified by certified mail, given ten (10) days to correct any erroneous information submitted by another source.
 - b. The erroneous information submitted by another source may be corrected by the provider, if it is in writing and is received by HAP MHP's Credentialing Department within 10 days of receipt of notice to provider.
 - c. Applicant must provide the following information with the application which is then verified as valid and current at time of credentialing decision. See Procedure 3.01.
 - 1) Current Michigan licenses, including CDS.

- 2) Current DEA or arrangements with a contracted/credentialed provider for necessary prescriptions.
- 3) Board Certification (time limited or Lifetime)
- 4) Medical School, Internship, Residency or Fellowship certificates.
- 5) ECFMG Certificate for International Medical Graduates.
- 6) Curriculum Vitae.
- 7) Supplemental forms describing claims involving and malpractice suits that are settled or had judgments.
- 8) Current Liability Coverage, with limits and coverage dates.
- 9) Hospital privileges or admitting arrangements.
- 10) W-9/ Federal Tax Number.

SECTION IV: NETWORK DEVELOPMENT/CONTRACTING PROCESS

Providers may join the HAP Midwest Health Plan provider network by contacting the Network Development/Contracting department at (313) 664-8529, or online application through the HAP MHP website at www.hap.org/midwest.

- Upon initial contact, the contracting department captures the following demographic information:
 - Name of practice
 - Name(s) of physician(s) in practice
 - Hospital affiliation
 - Street address, city, county and zip code
 - Phone number
 - Contact person
 - Email address
 - Champs number

After the initial contact, the prospective provider will receive following documents for completion:

- The appropriate Medicaid provider agreement (PCP fee for service or specialist)
- Medicare amendment
- MI Health Link addendum
- Race and ethnicity questionnaire
- HAP Midwest Health Plan Provider Information form
- Federal form for equity ownership disclosure

Prospective providers are encouraged to email or fax the completed materials to the provider contracting department. Completed forms are forwarded to the Credentialing Department. The Credentialing Department is responsible for running the CAQH report, performing Primary Source Verification and preparation for presentation to the credentialing committee. Approved providers will receive a signed copy of the fully executed contract along with the effective date.

Certain provider types do not require credentialing. These include:

- Physical, occupational and speech therapy
- Durable Medical Equipment
- Orthotic and Prosthetic Providers
- Urgent Care Facilities

PROVIDER TERMINATIONS

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

- Suspension or exclusion from the state Medicaid program, federal Medicare program or any other governmental public sector program.
- Failure to meet or comply with HAP Midwest Health Plan's credentialing requirements.
- In instances where HAP Midwest Health Plan reasonably believes that the Member's safety or care would be adversely affected by continuation of the contract.
- Conviction of Medicaid or Medicare fraud or any other fraudulent activity.

Upon intent to terminate, the following activities are initiated:

- After agreement with the Chief Medical Officer or Medical Director, the Lead Contract Administrator prepares a letter of termination.
- The letter of termination and the provider agreement is sent to HAP's legal counsel along with any supporting documentation and a Legal Project Request Form.
- Once approved by HAP legal counsel, the Director of Provider Contracting notifies the provider in question by fax and certified mail.
- If the provider is a PCP, members are reassigned to a different PCP.
- The Enrollment Services department notifies members of reassignment to another network PCP.
- Other departments are notified to ensure certain activities are halted, such as claims payment or prior authorization.

DEMOGRAPHIC CHANGES

The Provider is responsible for contacting the Network Development/Contracting department of changes in demographics, including:

- Address changes (additions and deletions)
- Addition of new providers under existing tax ID
- Updating providers who have voluntarily or otherwise terminated their contract.
- Change in Tax IDs, NPI numbers, etc.
- Updates in billing and remittance addresses
- Correction of incorrect provider demographic information

DELIVERABLES

The Network Development/Contracting department works with the Quality Management department to ensure required reports are provided timely and accurately to regulatory agencies and accrediting bodies.

NETWORK ADEQUACY

The Network Development/Contracting departments follows the standard ratio for travel time to and from network providers and reviews the provider network in terms of strategically locating additional primary care and specialist providers within the service area where needed and to assure adequate primary care physician to enrollee ratios. The Provider Contracting Department reviews the provider network in terms of strategically locating additional primary care and specialist providers within the service area where needed and to assure adequate primary care physician to enrollee ratios.

PHYSICIAN INCENTIVE DISCLOSURE

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

SECTION V: HEALTH SERVICES REFERRALS AND AUTHORIZATIONS

HAP Midwest Health Plan 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 online at www.hap.org/midwest. 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 the Health Services Department toll free at (888) 654-2200, option 2 then option 1.

REFERRALS

The Michigan Health Care Referral Form should be used when requesting services requiring HAP Midwest Health Plan notification/approval. In order to provide a timely decision, HAP Midwest Health Plan requests clinical documentation accompany the referral form to support the service being requested. The Michigan Health Care Referral Form or Clear Coverage should be used when requesting services requiring HAP Midwest Health Plan notification/approval. Clear Coverage is our web-based referral platform. For more information on access to Clear Coverage please call 248-663-3859. In order to provide a timely decision, HAP Midwest Health Plan requests clinical documentation accompany the referral form to support the service being requested. 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. HAP Midwest Health Plan does not require a referral to a contracted specialist. Only specified procedures require a referral and approval by HAP Midwest Health Plan. (See list of services below requiring plan notification (referral) and approval/prior authorization).

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. HAP Midwest Health Plan accepts the Michigan Health Care Referral Form for services requiring plan notification. HAP 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 toll free at (888) 654-2200, option 2 then option 1.

SERVICES REQUIRING PLAN NOTIFICATION (REFERRAL)/APPROVAL (PRIOR AUTHORIZATION)

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

- Services with a non-contracted provider
- Nursing home care (non-custodial)
- Transplant services
- Bariatric procedures
- Cosmetic surgery (e.g. blepharoplasty, scar revision)
- Prosthetics and orthotics
- Durable Medical Equipment
- Occupational therapy
- Breast reduction
- Chemotherapy
- Chiropractic services
- Home Health Care
- Hospice Care
- Human organ transplant
- Anesthesia for oral surgery
- In-office infusion therapy (specific medications)
- Oxygen and related supplies
- Speech therapy
- Physical therapy
- Breast reconstruction
- Radiation therapy

Prior Authorization from HAP Midwest Health Plan for the above services must be obtained by the member's PCP or the Provider of the service (DME Company/Surgeon). In order to provide a timely decision, HAP Midwest Health Plan requests supporting clinical information accompany the referral form. 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 at www.hap.org/midwest for a complete list.

APPLICATION OF CRITERIA

HAP MHP applies objective and evidenced-based criteria when determining the medical appropriateness of health care services requested. The application of any criteria is based upon the individual needs of the patients, the accepted local practice of medicine and health delivery system characteristics as well as the age of the patient, co-morbidities, medical complications, progress of current treatment, the psychosocial situation and the home environment, when applicable. In addition to InterQual criteria, HAP MHP uses criteria developed by the State of Michigan (documented in the Medicaid Provider Manual and/or the Medicaid Contract.) HAP MHP also uses internally developed and adopted or adapted criteria to make UM decisions. All internally developed criteria are developed based on industry standards with input and review from participating physicians.

ELECTIVE HOSPITAL ADMISSIONS

Elective admissions are reviewed retrospectively. Authorization is not required prior to the member's admission to the hospital however, the procedure or surgery may require prior approval/authorization. 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. HAP Midwest Health Plan reviews all hospital admissions using InterQual criteria.

EMERGENT HOSPITAL ADMISSIONS

Emergency admissions to a non-contracted provider require an authorization number from HAP Midwest Health Plan. The non-contracted provider is required to notify HAP Midwest Health Plan of the member's disposition within one hour of stabilization of the member. Emergency admissions by contracted providers do not require HAP Midwest Health Plan prior authorization. An authorization number by a contracted provider may be obtained by the hospital the next business day after the admission. Once HAP Midwest Health Plan is notified and the admission is approved, the PCP is notified of the admission via fax. HAP Midwest Health Plan reviews all hospital admissions using InterQual criteria.

AMBULATORY SERVICES/OUTPATIENT AUTHORIZATIONS

Some elective ambulatory surgeries and invasive procedures must be authorized by HAP Midwest Health Plan. 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 HAP Midwest Health Plan member require plan approval, the PCP, specialist, or his/her designee must complete the Universal Referral Form. In order to provide a timely decision, HAP Midwest Health Plan requests supporting clinical documentation accompany the referral form. The Referral Form and supporting clinical documentation must be faxed to the HAP Midwest Health Plan Health Services Department a minimum of three (3) business days prior to the requested service. The Health Services fax number is (248) 663-3780.

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's medical record.

Urgent requests should be marked as urgent on the Michigan Health Care Referral Form and faxed to Health Services. **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
- Outpatient Mental Health Visits (limited to 20 visits)
- Obstetrics / Gynecology

Per the terms of the Plan contract with the Michigan Department of Health and Human Services, members may access any of the following services directly, without prior authorization or referral from the PCP or HAP Midwest Health Plan:

- 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

SKILLED NURSING

Per the State of Michigan contract, all HAP Midwest Health Plan members have a limited skilled nursing benefit. This benefit covers inpatient admissions to physical rehabilitative facilities, not substance abuse rehabilitation facilities. Each request for admission is reviewed by the Medical Director or his / her designee for appropriateness of admission, length of stay, etc. Custodial care is not a covered benefit under HAP Midwest Health Plan. Members needing admission for long-term non-rehabilitative care must be disenrolled to straight Medicaid. The Health Services Department will assist with this process.

SECOND OPINION

HAP Midwest Health Plan covers second opinions. If the HAP Midwest Health Plan provider network does not have a provider available for a second opinion within the network, the enrollee will be allowed to obtain a second opinion from an out-of-network provider with prior authorization from the HAP Midwest Health Plan at no cost to the member.

VISION SERVICES

All HAP Midwest Health Plan members may access vision services directly. Vision services include eye examination (refraction), lenses and frames. Members seeking vision services can contact Heritage Optical at (800) 252-2053. A list of contracted Vision Providers is included in the "Provider Directory" tab on the HAP Midwest Health Plan website.

APPEALS PROCESS

HAP Midwest Health Plan recognizes that participating providers may choose to exercise their right to appeal a utilization management decision. The appeals process is established to

facilitate this right. If a provider disagrees with a utilization management decision the provider may file an appeal. The provider must make the appeal in writing to the HAP Midwest Health Plan Denials and Appeals Department. HAP Midwest Health Plan will accept verbal appeals in emergent situations. These are defined as “where the decision could seriously jeopardize the life or health of the member, could jeopardize the member’s ability to regain maximum function, or would subject the member to severe pain, not managed without the requested care.”

DEFINITIONS

Appeal: a request to change a previous decision made by HAP Midwest Health Plan

Pre-service Appeal: a request to change the decision on any case or service that must be made in whole or in part in advance of the member obtaining medical care or services

Post Service Appeal: a request to change a decision on any review for care or services that have already been received

Expedited Appeal: a request to change an urgent care request where the decision could seriously jeopardize the life or health of the member, could jeopardize the member’s ability to regain maximum function, or would subject the member to severe pain, not managed without the requested care

External Appeal: a request for an independent external review of the final determination made by HAP Midwest Health Plan through the internal appeal process. The Independent Review Entity (IRE) Maximus is an entity contracted to provide review services for HAP Midwest Health Plan.

Independent Review Entity: is an entity that conducts independent external medical reviews of adverse health care treatment decisions. Independent review entity serve a dual role: they advocate for the patient while making sure that each patient only receives what they deserve based upon medical fact. They also focus on eliminating wasteful and unnecessary treatments.

Pre-service Appeal

Level 1 - Pre-service Appeal

- When the request for non-urgent pre-service care is denied by the HAP Midwest Health Plan Medical Director, HAP Midwest Health Plan gives members and practitioners written confirmation of the decisions within 14 calendar days of receipt of the request
- The member (or authorized representative) is notified of their appeal rights and procedure
- The member (or authorized representative) has up to 90 calendar days to file an appeal
- Pre-service appeals are to be in writing to the HAP Midwest Health Plan Medical Director (or designee)
- If the HAP Midwest Health Plan Medical Director cannot reverse the adverse determination, a physician not involved in the initial denial will review the case
- The physician reviewer will be of the same specialty of the requesting physician with similar credentials and licensure
- The appeal will be resolved within 14 calendar days (up to 30 calendar days total for all levels of appeal) of the request for appeal
- Notification in writing to the member and provider will be sent within 2 calendar days of the decision
- Procedures for additional levels of appeal are provided to the member when the adverse determination is upheld

Level 2 – Pre-service Appeal

- When the request for non-urgent pre-service 1st level appeal is upheld by the HAP Midwest Health Plan Physician Reviewer, HAP Midwest Health Plan gives members and practitioners written confirmation of the decisions within 14 calendar days (up to 30 calendar days total for all levels of appeal) of receipt of the request
- Requests for 2nd level appeal must be in writing and must be received within 10 days of the 1st level appeals decision
- The HAP Midwest Health Plan Medical Director will review the 2nd level appeal
- If the HAP Midwest Health Plan Medical Director cannot reverse the adverse determination
- The physician members of the Quality Improvement Committee will convene to review the appeal
- The appeal will be resolved within 14 days (up to 30 calendar days total for all levels of appeal) of the request for 2nd level appeal
- Notification in writing to the member and provider will be sent within 2 calendar days of the decision
- The decision of the Quality Improvement Committee is the final internal decision.
- Members have the right to request an administrative hearing by an administrative law judge for any adverse determination.

Post Service Appeal (for medical necessity review)

Level 1 – Post Service Appeal

- When the request for Post Service care is denied by the HAP Midwest Health Plan Medical Director, HAP Midwest Health Plan gives members and practitioners written confirmation of the decisions within 14 calendar days of receipt of the request
- The member (or authorized representative) is notified of their appeal rights and procedure
- The member (or authorized representative) has up to 90 calendar days to file an appeal
- Post Service appeals are to be in writing to the HAP Midwest Health Plan Medical Director (or designee)

- If the HAP Midwest Health Plan Medical Director cannot reverse the adverse determination
- A physician not involved in the initial denial will review the case
- The physician reviewer will be of the same specialty of the requesting physician with similar credentials and licensure
- The appeal will be resolved within 30 calendar days (up to 60 calendar days total for all levels of appeal) of the request for appeal
- Notification in writing to the member and provider will be sent within 2 calendar days of the decision
- Procedures for additional levels of appeal are provided to the member when the adverse determination is upheld

Level 2 – Post Service Appeal

- When the request for Post Service 1st level appeal is upheld by the HAP Midwest Health Plan Physician Reviewer, HAP Midwest Health Plan gives members and practitioners written confirmation of the decisions within 30 calendar days (up to 60 calendar days total for all levels of appeal) of receipt of the request
- Requests for 2nd level appeal must be in writing and must be received within 10 days of the 1st level appeals decision

- The HAP Midwest Health Plan Medical Director will review the 2nd level appeal
- If the HAP Midwest Health Plan Medical Director cannot reverse the adverse determination
- The physician members of the Quality Improvement Committee will convene to review the appeal
- The appeal will be resolved within 14 days (up to 30 calendar days total for all levels of appeal) of the request for 2nd level appeal
- Notification in writing to the member and provider will be sent within 2 calendar days of the decision
- The decision of the Quality Improvement Committee is the final internal decision.
- Members have the right to request an administrative hearing by an administrative law judge for any adverse determination.

Expedited Appeal (pre service)

- When the request for urgent care is denied by the HAP Midwest Health Plan Medical Director, HAP Midwest Health Plan gives members and practitioners written confirmation of the decisions within 72 hours of receipt of the request
- The member (or authorized representative) may file an expedited appeal for a denied urgent care request
- All requests concerning admissions, continued stay or other emergency service related appeals are considered for expedited appeal
- HAP Midwest Health Plan will complete the entire expedited appeal process within 72 hours of receipt of the appeal request.
- Verbal notification is given within 72 hours of receipt of the appeal request, with written notification within 3 calendar days
- Due to the required time frames required to complete two level reviews, each level will be completed by a HAP Midwest Health Plan practitioner in the same or similar specialty, independent of each other; i.e., not partners in the same specialty group.

External Appeal

- Members may request an independent review of final decisions on medical necessity denials
- The member (or authorized representative) has 180 calendar days from the date of the final internal decision to file a request for an independent review.
- The case will be submitted for review to an Independent Review Entity (IRE)
- The IRE has 30 calendar days to render a decision on non-urgent appeals
- The IRE has 72 hours to render a decision on urgent appeals. The treating physician or HAP Midwest Health Plan may identify an urgent appeal
- External Reviews are logged and tracked. Data is reviewed for patterns of denials which are upheld/overturned. This information is used to improve the quality of clinical decision making
- The IRE is responsible for communicating the decision to the member and to HAP Midwest Health Plan
- If the denial is overturned by the IRE, HAP Midwest Health Plan will communicate to the member when service or payment will be received
- The IRE decision is binding to HAP Midwest Health Plan
- Members have the right to request an administrative hearing by an administrative law judge for any adverse determination.

Extension of Time Frames

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

BEHAVIORAL HEALTH CARE

By our contract with the State of Michigan, HAP Midwest Health Plan members are allowed 20 outpatient mental health visits per calendar year. HAP Midwest Health Plan members requiring Mental Health Services may obtain these services by:

- Obtaining a referral from their Primary Care Physician to a Plan approved psychiatrist or contracted behavioral health provider.
- Direct contact of a contracted behavioral health care provider
- In a crisis, self-referring to the nearest emergency room that provides psychiatric services.

Substance abuse services are not a covered benefit of HAP Midwest Health Plan. Members seeking those services should be referred to the Community Mental Health board of their county of residence.

CASE MANAGEMENT

HAP Midwest Health Plan offers all members the ability to enroll in a Case Management Program. The purpose of the Case Management Program is to help members regain/maintain optimum health or functional capability in the right setting in a cost effective manner.

Case Management is offered to assist members to comply with the plan of care prescribed by their physician. Participation in Case Management is voluntary and can be terminated at any time by the member.

A comprehensive evaluation of the social well-being, mental health, and physical health is done to determine the barriers to adherence to the health plan of care. Goals are set in conjunction with all parties involved which may include: primary care physician, ancillary providers, specialty care physicians, and family members. The program is dependent upon the cooperative participation of the Health Plan, contracted ancillary providers, physicians, hospitals, and the member to ensure timely, effective and medically realistic goals. The program is structured to assure that qualified individuals make medical decisions with the use of nationally recognized criteria, and without undue influence of the Health Plan's fiscal operation.

Contact HAP Midwest Health Plan Health Services Department (888) 654-2200, option 2 then option 1, to initiate an evaluation for case management services.

SECTION VI: PHARMACY BENEFIT PHARMACY DRUG PLAN COVERAGE

HAP Midwest Health Plan utilizes a Pharmacy Benefit Manager (PBM) to manage member pharmacy benefits. The PBM provides HAP Midwest Health Plan with a pharmacy network, pharmacy claims management services, drug formulary and pharmacy claims adjudication.

The PBM provides Provider Support at (888) 274-2031. HAP Midwest Health Plan providers may also speak with a clinical pharmacist regarding any pharmaceutical, medication administration or prescribing issues.

Effective 9/30/2016, HAP Midwest Health Plan's formulary will be aligned with Michigan's Common Drug Formulary. For further information, please refer to the State of Michigan - MCO Common Formulary website. The Drug Formulary can be found on the HAP Midwest Health Plan website at hap.org/midwest. The drug Formulary should be accessible and be referred to when prescribing medications for HAP Midwest Health Plan members. HAP Midwest Health Plan is a mandatory generic plan. In some cases there are established Step Therapy (ST) requirements, Age and Gender limitations, and Quantity Limits (QL). Providers must prescribe from within the drug formulary unless a drug prior authorization is obtained from the PBM.

In accordance with the Michigan Medicaid Provider Manual, drug coverage is not provided for the following categories:

- Agents used for anorexia
- Agents used for weight gain
- Agents used for cosmetic purposes or hair growth
- Agents used for symptomatic relief of cough and colds
- Experimental or investigational drugs
- Agents used to promote fertility
- Agents used to promote smoking cessation not on the MPPL
- Vitamin/Mineral combinations not for prenatal care, end stage renal disease or pediatric fluoride supplementation
- Covered outpatient drugs that the Labeler seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the Labeler or their designee
- Covered outpatient drugs where the Labeler limits distribution
- Proposed less-than-effective (LTE) drugs identified by the Drug Efficacy Study Implementation (DESI) program Over-the-counter drugs not on the MPPL
- Drugs of Labelers not participating in the Rebate Program
- Drugs prescribed for "off label" use if there is no generally accepted medical indication in peer reviewed medical literature (Index Medicus), or listing of such use in standard pharmaceutical references such as Drug Facts and Comparisons, AMA Drug Evaluations, American Hospital Formulary Service Drug Information, or DRUGDEX Information Systems Drugs prescribed specifically for medical studies
- Drugs recalled by Labelers Drugs past CMS termination dates (Refer to the Directory Appendix for CMS website information.)
- Lifestyle agents
- Standard Infant Formulas
- Drugs covered by the Medicare Part D benefit Drugs not FDA approved or licensed for use in the United States Agents used for treatment of sexual or erectile dysfunction

OBTAINING A DRUG PRIOR AUTHORIZATION

If a provider wishes to prescribe a drug that for a Medicaid member that requires Prior Authorization (PA), they must complete a Drug Prior Authorization Request Form (plan or state model). This form must be faxed to the PBM Prior Authorization Fax: (248) 540-9811. The PA Form is available on the plan website.

If a provider wishes to prescribe a drug that for a Medicare beneficiary that requires Prior Authorization (PA), they must complete a "Request for Medicare Prescription Drug Coverage Determination". This form must be faxed to the PBM at (248) 341-8133. The PA Form is available on the plan website.

Drugs not included on the Plan Formularies must be requested in accordance with the HAP Midwest Health Plan Exception Request Process. Exception Request policy and forms are available on the plan website. Exception Request Forms should be faxed to (248) 663-3776 and will be processed by the plan Pharmacy staff.

Prior Authorization requests must be completed and approved before providing the member with a written prescription. If a prior authorization is not obtained in advance, the member will not be able to have the prescription filled at their pharmacy, causing a delay for the member in obtaining their medication.

DIABETIC SUPPLIES

Diabetic supplies are available to members from contracted retail pharmacies. There are established quantity limits for Blood Glucose test strips, needles, and syringes. Glucometer devices are provided free of charge by utilizing the order form found on the plan website.

MEDICAID BENEFIT DRUG COVERAGE

Coverage guidelines have been established for many drugs that are requested and administered through the plan's medical benefit. Prior Authorization (PA) criteria are found on the plan website. Providers should utilize the processes outlined in the Provider Manual section titled AMBULATORY SERVICES / OUTPATIENT AUTHORIZATIONS.

SECTION VII: CLAIMS MANAGEMENT

HAP Midwest Health Plan's Claims department endeavors to assure prompt and accurate claim and encounter review, processing, adjudication and payment. This is accomplished through the development of claims processing systems, prepayment and post-payment audits, policies, and procedures that are consistently and appropriately applied.

For general claims information, please contact the claims department at (888) 654-2200, prompt 2 followed by prompt 2.

Claim Submission Guidelines, Formats and Versions

HAP Midwest Health Plan accepts electronic claim submissions, including secondary claims. Providers are encouraged to submit claims electronically to ensure accuracy which results in faster payment. HAP Midwest Health Plan will no longer accept paper claims from providers who have the capability of submitting claims electronically.

HAP Midwest accepts electronic claims submissions through the following clearing houses:

- Relay Health
- Availity
- Netwerks
- Zirmed

HAP Midwest Health Plan accepts claims submitted in the following formats: EDI Claims Information regarding electronic claims submission:

- First time Submitters: please call Customer Service at (888) 654-2200 press prompt 2.
- Current Submitters: for Assistance in EDI Submission, please note Companion Guide Links
- HAP Midwest Health Plans payor ID is MHP77.

Helpful links

Companion guides for institutional and professional claims can be found at www.midwesthealthplan.com. Select *Providers* and then *Companion Guides* under *Quick Links*.

Paper claims - Claim Formats and Versions

Professional Services, use the CMS-1500 (02-12) form. Institutional services use the UB-04 CMS-1450 form. Handwritten entries are not acceptable anywhere on the claim form except for the signature items.

Guidelines for submitting - UB-04 Claims Form

For efficient processing, please take these steps:

- Refer to NUBC Manual for details on each field Locator data to be submitted.
- Use the red UB-04 Form for paper submission. We strongly encourage electronic submission.
- Type the form or print it from a computer (Handwritten claims are not acceptable, and will be returned).
- Print must be dark enough to read easily

UB-04 FL Field Locator	Field Status	Description of Field	Information to be Included
1	Mandatory	The name and service location of the provider submitting the bill.	Billing provider name, (street address) and telephone number.
2	Mandatory	Pay to name and address	Address where payments are to be sent if different than FL 01.
3a	Mandatory	Patient control number	Patient's unique alphanumeric number assigned to facilitate records and posting of payments.
3b	Conditional	Medical/Health Record Number	The number assigned to the patient's medical/health record by the provider.
4	Mandatory	Type of Bill	A code indicating the specific type of bill. The first digit is a leading zero. Do not include the leading 0 on electronic claims.
5	Mandatory	Federal Tax Number	Number assigned to the provider by the Federal government for tax reporting.
6	Mandatory	Statement Covers Period	The beginning and ending service dates of the period included on this bill. The from date should not be confused with the admission date (FL 12).
7	Blank	Reserved	

UB-04 FL Field Locator	Field Status	Description of Field	Information to be Included
8	Mandatory	Patient name/identifier	Last name, first name and middle initial of the patient and the patient identifier as assigned by the payer.
9	Mandatory	Patient Address	The complete mailing address of the patient.
10	Mandatory	Patient Birth Date	In MMDDYYYY
11	Mandatory	Patient Sex	M, F or U=Unknown
12	Mandatory	Admission/Start of Care date	Start date for episode of care. For inpatient this is the date of the admission.
13	Conditional	Admission Hour	The code referring to the hour during which the patient admitted to the facility.
14	Mandatory	Priority (Type of Visit)	A code indicating the priority of the admission/visit.
15	Mandatory	Source of Referral of Admission/visit	A code indicating the source of the referral of the admission/visit.
16	Mandatory	Discharge Hour	Code indicating the discharge hour of the patient from inpatient care.
17	Mandatory	Patient Discharge Status	A code indicating the disposition of discharge status of the patient at the end service.
18-28	Conditional	Condition Codes	A code used to identify conditions or events relating to this bill that may affect processing. (Alphanumeric sequence)
29	Blank	Reserved	The accident state field contains the two-digit state abbreviation where the accident occurred.
30	Blank	Reserved	
31-34, 35-36	Conditional	Occurrence Codes and Dates	The code and associated date defining a significant event relating to the bill that may affect payer processing. Refer to NUBC Manual for list of codes.
37	Blank	Reserved	
38	Conditional	Responsible Party Name and Address	The name and address of the party to whom the bill is being submitted.
39-41	Conditional	Value Codes and Amounts	A code structure to relate amounts or values to identify data elements necessary to process the claim as qualified by the payer organization.
42	Mandatory	Revenue Code	Code that identify specific accommodation, ancillary services, or unique billing arrangements. (00x)
43	Blank	Revenue Description	The standard abbreviated description of the related revenue code included on the bill.
44	Conditional	HCPCS/Accommodation Rates/HIPPS Rate Codes	The (HCPCS) applicable to ancillary service and outpatient bills, accommodation rate for inpatient bills, HIPPS rate codes.
45	Mandatory	Service Date	The date (MMDDYYYY) the outpatient service was provided.

UB-04 FL Field Locator	Field Status	Description of Field	Information to be Included
46	Mandatory	Service Units	A quantitative measure of services rendered by revenue category to or for the patient.
47	Mandatory	Total Charges	Total charges for the primary payer for both non-covered and covered charges.
48	Conditional	Non-covered Charges	To reflect the non-covered charges for the destination payer as it pertains to the related revenue code.
49	Blank	Reserved	
50	Conditional	Payer Identification	
51	Conditional	Health Plan Identification Number	The number used by the health plan to identify itself.
52	Conditional	Release of Information Certification Indicator	Code indicates whether the provider has on file a signed statement from the patient permitting the provider to release data to another organization.
53	Mandatory	Assignment of Benefits	Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.
54	Conditional	Prior Payments-Payer	The amount the provider has received to date by the health plan toward payment of this bill.
55	Conditional	Estimated Amount Due-Payer	The amount estimated by the provider to be due from the indicated payer.
56	Mandatory	NPI-National Provider Identifier	The unique identification number assigned to the provider submitting the bill.
57	Blank	Other Billing Provider Identifier	A unique identification number assigned to the provider submitting the bill by the health plan.
58	Mandatory	Insured's Name	The name of the individual under whose name the insurance benefit is carried.
59	Mandatory	Patient's Relationship to Insured	Code indicating the relationship of the patient to the identified insured.
60	Mandatory	Insured's Unique Identifier	The unique number assigned by the health plan to the insured.
61	Conditional	Insured's Group Name	The group or plan name through which the insurance is provided to the insured.
62	Conditional	Insured's Group Number	The identification number, control number or code assigned by the carrier to identify the group under which the individual is covered.
63	Conditional	Treatment Authorization Code	A number or other indicator that designates that the treatment indicated on this bill has been authorized by the payer.
64	Conditional	Document Control Number (DCN)	The control number assigned to the original bill by the health plan as a part of internal control.
65	Conditional	Employer Name (of the Insured)	The name of the employer that provides health care coverage for the insured individual in FL 58.

UB-04 FL Field Locator	Field Status	Description of Field	Information to be Included
66	Mandatory	Diagnosis and Procedure Code Qualifier (ICD 9 and ICD-10 Version Indicator)	The qualifier that denotes the version of International Classification of Diseases.
67	Mandatory	Principal Diagnosis Code and Present on Admission Indicator	The ICD-9CM codes or ICD-10 describing the principal diagnosis. POA reporting (y=yes, n=no, u=unknown)
67a-q	Mandatory	Other Diagnosis Code	The ICD-9CM or ICD-10 diagnosis codes that coexist at the time of admission.
68	Blank	Reserved	
69	Mandatory	Admitting Diagnosis Code	The ICD-9CM or ICD-10 diagnosis code describing the patient's diagnosis at the time of inpatient admission.
70a-c	Mandatory	Patient's Reason for Visit	The ICD-9CM or ICD-10 diagnosis codes describing the patient's reason for visit at the time of outpatient registration.
71	Conditional	Prospective Payment System (PPS Code)	The PPS code assigned to the claim to identify the DRG based on the grouper.
72a-c	Conditional	External Cause of Injury (ECI) Code	The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
73	Blank	Reserved	
74	Conditional	Principal Procedure Code and Date	The ICD code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill.
74a-e	Conditional	Other Procedure Codes and Dates	The ICD codes identifying all significant procedures other than the principal procedure.
75	Blank	Reserved	
76	Conditional	Attending Provider Name and Identifiers	The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.
77	Conditional	Operating Physician Name and Identifiers	The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).
78-79	Conditional	Other Provider (Individual) Names and Identifiers	The name and ID number of the individual corresponding to the Provider Type category indicated in this section of the claim.
80	Conditional	Remarks Field	Area to capture additional information necessary to adjudicate the claim.
81	Blank	Code-Code Field	To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

Definition of Mandatory, Conditional, and Blank.

Mandatory items must be filled out. If the item is left blank, the claim cannot be processed.
Conditional items are required, if applicable. Your claim may not be processed if left blank
Blank items may be left empty and will not affect the processing of your claim.

CLEAN CLAIMS SUBMISSION REQUIREMENTS

In general, HAP Midwest Health Plan follows Michigan Medicaid Uniform Billing Guidelines. This section will assist you with the HAP Midwest Health Plan claims submission procedures. If you require further assistance, please call the HAP Midwest Health Plan Claims department at (888) 654-2200, prompt 2 followed by prompt 2.

Indicate the appropriate HAP Midwest Health Plan product name on the claim (upper right corner on a CMS 1500 form and FL61 on a UB-04 form) and on the outside of the mailing envelope; e.g., HAP Midwest Health Plan, Medicare Advantage, etc.

Mail paper claims to:

HAP Midwest Health Plan Claims Department
P.O. Box 2578
Detroit, MI 48202

Member ID numbers

When billing EDI or paper claims, please provide the member ID as follows:

Product	Billing ID
Medicaid	Use the 10-digit Recipient ID number on the HAP Midwest Health Plan ID card
Healthy Michigan Plan	Use the 10-digit Recipient ID number on the HAP Midwest Health Plan ID card
Medicare Advantage	Use the 11-digit ID number from the HAP Midwest Health Plan Medicare Advantage ID card
MI Health Link	Use the 11-digit ID number from the HAP Midwest Health Plan MIHealth Link ID card

Providers must verify member's eligibility and effective dates of Health Plan enrollment before rendering covered services.

As a contracted health plan with the State of Michigan Medicaid, Healthy Michigan Plan, MICHild and MICHild CSHCS programs, HAP Midwest Health Plan members are entitled to all covered services allowed by the Michigan Department of Community Health. Covered services are outlined in the HAP Midwest Health Plan Member Handbook. HAP Midwest Health Plan is responsible for payment to providers for all properly authorized and/or covered services rendered to eligible members.

Claims and encounters must be computer generated or typed and signed by the provider of service. Electronic signatures are acceptable. Claims and encounters may be submitted on CMS 1500, UB-04, or electronically through limited clearinghouses. Par providers, who need information regarding EDI submissions using a clearinghouse, or if you need assistance with claims, non-par providers may contact the claims department at (888) 654-2200, prompt 2 followed by prompt 2.

Series type services provided by a facility can be billed on a monthly basis. All dates of service billed on a UB-04, must be itemized in FL 45. The following services may be billed using series

billing:

- Chemotherapy
- Hemodialysis
- Peritoneal Dialysis
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Radiation Therapy

All claims submitted to HAP Midwest Health Plan must contain the National Provider Identifier (NPI) required in FL 24 J of the CMS-1500 form and FL 56 of the UB-04 form. Please click on the link below to view detail instructions on each field locator of the CMS-1500 (02-12) version and UB-04 CMS-1450 paper claims format to identify the fields that are mandatory, conditional, and/or blank.

[CMS-1500 \(02-12\) Submission Guidelines](#)

[UB-04 submission guidelines](#)

- If any mandatory or conditional information is missing, the claim will be considered unclean. Examples of unclean claims e.g. – invalid member ID, provider data discrepancy NPI and tax ID do not match
- HAP Midwest Health Plan pays clean claims and/or denies defective claims within 45 days. Providers are highly encouraged to status any claims that they have submitted but not received payment or denial after 45 days from submission date.
- Unclean claims are considered “defective” and will be returned or rejected within 45 days. The Department of Insurance and Financial Services (DIFS) requires HAP Midwest Health Plan to report all defective claims on quarterly basis.
- Paper claims are returned when we are not able to enter them in our system due to invalid information. (e.g., billing provider not on system, member not enrolled in HAP Midwest Health Plan). These claims cannot be tracked hence they cannot be statused. This makes it very important for the provider to resubmit those claims appropriately within the filing time limits.
- Claims are rejected when pertinent information is available to enter the claim in the system, yet other information needed to complete the reimbursement adjudication process is missing. Rejections are stored in the system hence, these claims can be statused. We highly encourage your staff to work these rejections from your remittance advice and resubmit with corrections in a timely fashion.

CLAIM CORRECTION AND RESUBMISSION

When to Resubmit a Rejected Claim – (no payment of any service line)

- If all service lines of a claim are rejected and the provider determines that the information can be corrected, the services must be resubmitted as a new claim with the correct information. Facility and professional bills may be submitted as new claims.

When to submit an Adjustment Claim – (partial payment on previously billed claim)

- Examples of claim adjustment that are submitted when:
 - ✓ all or a portion of the claim was under/over paid, or
 - ✓ services are added or deleted to the original submission, or
 - ✓ a third party payment was received after HAP Midwest Health Plan made payment
- It is very important to include all service lines from the original claim not just adjusted line or late charge adjustment.
- When an adjustment claim is received, HAP Midwest Health Plan will reverse the original claim and reenter the newly billed claims to assure total re-adjudication and correct payment.
- Do not submit a claim as an adjustment claim when there has been no payment issued by the original or has not been previously processed by HAP Midwest Health Plan.

HOW TO CHECK CLAIMS STATUS ON THE HAP MIDWEST HEALTH PLAN WEBSITE

All HAP Midwest Health Plan providers can status their own claims 24/7 on the HAP Midwest Health Plan website at www.hap.org/midwest. You can status up to three years of claims data. To status a claim, logon to our HAP Midwest Health Plan secure site:

- Click on the Provider tab to get to the Provider's Home page
- In the Information box click on Claims
- Under Claims Information, click on Search Claims
- Enter your HAP Midwest Website Login Username and Password

You have many options on how to extract the data. For best search results and speed, use "Patient's Account#" with "date of service".

For your convenience, all the pertinent legends for code explanations are located on the same page above the claims link labeled "HAP Midwest Health Plan Remittance Advice Legend". They are the same codes used on the Remittance Advice.

If you are a contracted provider and need assistance to sign on to our website, please contact your Provider Services Representative.

If you are a non-contracted provider and you need assistance to sign on to our website, you may call HAP Midwest Health Plan at (888) 654-2200, prompt 2 followed by prompt 2, to inquire about your access.

PAYMENT PROCEDURE

All paper claims and encounters submitted to HAP Midwest Health Plan are date stamped on the day received. HAP Midwest Health Plan processes claims and encounters within 45 days of receipt.

- Payment for all non-capitated, authorized, medically necessary services are paid at current Medicaid fee screens. Contracted rates supersede this statement.
- HAP Midwest Health Plan's payment of covered services is considered payment in full. It is against Medicaid policy (Medicaid Provider Manual, Section 11), except in certain situations, to balance bill a Medicaid member for covered services.
- Typically, HAP Midwest Health Plan makes payments bi-weekly and a special check run on the last working day of each quarter for quarter ending.
- Checks are mailed within 2 working days from the check date.

- Remittance advices for the payments are available in PDF format on the HAP Midwest Health Plan website for 3 months and can be downloaded for your convenience. The check will communicate the following message “The corresponding remittance advice is available at www.hap.org/midwest. Please use your HAP Midwest Health Plan log on to access the information.”
- If you need further assistance, call the Claims department at (888) 654-2200, prompt 2 followed by prompt 2.
- Remittance advice provides information specifying member and claim (form #) being paid and rejection information if applicable. Encounter data also appears on the remittance advice, but will be flagged with ‘C’ for capitated services and will not generate any payments.

EXPLANATION CODES

Explanation codes indicate the reason a service line was rejected. They also give information about service lines and may point out potential problems. Reviewing the codes printed on your Remittance Advice will provide you with information that can assist you with future claims.

For description of remarks codes used on the remittance advices please click on link below. You may download and print the legends for your convenience. Links to legend codes:

- [HAP Midwest Health Plan Remittance Advice Legend](#)
- [HAP Midwest Health Plan APC Status Indicator Legend](#)

POST PAYMENT REVIEW

- All claims and encounters submitted to HAP Midwest Health Plan are reviewed internally and externally by experienced claims staff as necessary.
- HAP Midwest Health Plan conducts ongoing internal review of claims 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, HAP Midwest Health Plan will require the submission of medical records, reports, treatment records, and/or discharge summaries as appropriate.
- HAP Midwest Health Plan has contracted with VARIS, LLC to conduct random and focused audits and chart reviews of facility inpatient/outpatient claims paid by HAP Midwest Health Plan, to identify DRG/APC overpayments, focused post-payment review and occasionally a prepayment review.
- HAP Midwest Health Plan has contracted with First Recovery, to conduct audits of HAP Midwest Health Plan’s paid claims to identify, pursue and recover payments from TPL.

FILING LIMITATIONS

- Encounters for capitated services must be submitted within 30 days from the date of service
- Initial claim for non-capitated services must be received within 180 days from the date of service.
- Contracted providers should follow the filing terms in their contracts.
- Claims involving COB where other carrier is primary will get an extended filing limit, when Primary carrier was billed within their filing limits, and the carrier’s EOP identifies payment or denial of the claim. Those claims must be submitted within 60 days from the notification date of the other carrier EOP. Attach other carrier's EOP to your claims when submitting to HAP Midwest Health Plan.

- All rejected claims must be followed up and resolved within 1 year from the date of Service.
- All claim appeals must be filed within 60 days from the original denial date. Appeals must be submitted with cover letter providing reason for request and supporting documentation different than submitted with the claim, if any. Any clinical decisions must be appealed by a qualified clinical person.
- HAP Midwest has contracted with OPTimum to conduct post payment audits to identify provider credit balances.

BILLING INSTRUCTIONS

BALANCE BILLING

Providers may not balance bill Medicare and Medicaid dual eligible for Medicare-cost sharing. HAP Midwest Medicaid will reimburse the provider an amount up to Medicare's statement of liability for coinsurance and deductible not to exceed HAP Midwest Medicaid's allowable amount for the service. Claims in which Medicare's reimbursement exceeds the maximum allowed by HAP Midwest Medicaid, will result in a "zero" pay claim. **This claim is considered "paid in full" and the provider may not seek additional payment from the recipient.** Also note, HAP Midwest Medicaid does not necessarily pay the full Medicare deductible and coinsurance on a claim. **Providers may not balance bill in these instances.**

For more information regarding the prohibition on "balance-billing" dual eligible individuals for Medicare cost-sharing, including deductible, coinsurance and copayment please visit:

<https://www.cms.gov/Outreach-and-Education/.../SE1128.pdf>

NEGATIVE BALANCE

It is the policy of HAP Midwest Health Plan to audit claim payment activity to identify payments made to providers in error. Payments made in error will be adjusted on the provider's account and any positive claim payment activity for the account will be used to offset this amount.

COORDINATION OF BENEFITS (COB)

MDHHS contracts with HAP Midwest Health Plan to administer the Medicaid HMO benefits to its enrolled members. Medicaid is considered as payment source of last resort. Some Medicaid members have dual insurance coverage. In this case,

- Other insurance company should be billed first because it is always considered the primary insurance over Medicaid.
- All covered services where the HAP Midwest Health Plan is secondary carrier will not require an authorization from HAP Midwest Health Plan.
- When submitting a claim, an EOP or EOB from the primary carrier must accompany the claim in order to coordinate benefits.
- Professional, facility and ancillary services that are not covered by the primary insurance carrier and are billed to HAP Midwest Health Plan, must comply with HAP Midwest Health Plan's authorization requirements in order to be reimbursed for these services as primary carrier. Click on link below for authorization requirements.
- COB claims can be submitted on paper with other insurance EOP attached. It is highly recommended to submit COB claims electronically, indicating the primary insurance detail payments lines in loop 2400.

DME/PROSTHETICS/ORTHOTICS

When billing for equipment/supplies that have a descriptor reflecting a daily rate or per diem (total number of days used as units); the claims must reflect “span” dates in the “From” and: To” date column.

- For example: S5502 (home infusion therapy catheter care/maintenance implanted access device) per diem. If dates of service are August 1, 2014 through August 30, 2014 report 30 units. Dates on the claim should be reported using the “From” and “To” dates.

E & M SERVICES

E & M Billing tips

Note that HAP Midwest Health Plan follows CMS payment guidelines. The following physical exam codes may be billed only by Primary Care Physicians and contracted OB/GYN providers:
99381-99387
99391-99397

The Medicaid benefit allows for one physical exam per calendar year for members ages ≥ 3 years only (<3 years old up to 8 physical exams).

Two E&M services on same date of service

In an office or other outpatient setting, when (2) E & M procedures are billed for an unrelated problem and could not have been provided during the same encounter both E & M procedures will be paid.

In an Inpatient setting, only (1) E & M is allowed per day, per physician or physician’s in same group or specialty. Note that HAP Midwest Health Plan follows CMS Payment Guidelines. For additional information, see:

http://www.wpsmedicare.com/j5macpartb/resources/provider_types/2010_0301_singleday.shtml

EMERGENCY ROOM

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

HAP 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 All ancillary services medically necessary to screen and stabilize the member will be reimbursed at the current Medicaid fee screen.

“Medical Emergency” is defined as: 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 layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or in the case of pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Tribal Health Centers (THC)

Effective for services performed on or after July 1, 2017, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Tribal Health Centers (THC) must use the ASC X12N 837 5010 institutional format when submitting electronic claims and the National Uniform Billing Code (NUBC) claim form for paper claims. Claims submitted after this date using the professional claim format (CMS-1500 and/or 837P) will be denied.

You may reference the MDHHS Bulletin MSA 17-10 using the link below.
http://www.michigan.gov/documents/mdhhs/MSA_17-10_556190_7.pdf

IMMUNIZATIONS: VACCINES AND TOXOIDS

Immunizations are covered when given according to Advisory Committee on Immunization Practices (ACIP) recommendations.

- For HAP Midwest Health Plan Medicaid children 18 years and younger, the provider should utilize the Vaccine for Children (VFC) program which provides vaccines at no cost to the provider.
- HAP Midwest Health Plan also reimburses at Medicaid Fee-for-Service rates for covered vaccines for Medicaid and MICHild members 19 years of age and older.

An administration fee is covered separately for vaccines given to members, whether the vaccine is free or not, and without regard to other services provided on the same day. Due to MDHHS's HEDIS data reporting requirements and consistency in our claims adjudication process, HAP Midwest Health Plan requires an immunization code to be billed in conjunction with each administration code billed.

NEWBORNS

- Newborn claims cannot be processed until the newborn is enrolled in HAP Midwest Health Plan.
- Newborns must be billed separately from the mother, using the newborn's Medicaid ID number and full name.
- Normal newborn claims do not require a separate authorization and the admission is validated against the mother's inpatient authorization.
- If the newborn is a sick or boarder baby, the claim should still be billed under baby's Medicaid
- I.D. Number and full name.
- The sick newborn inpatient stay MUST have a separate authorization from the mother's authorization. HAP Midwest Health Plan authorization number must be provided in the appropriate field on the CMS 1500, UB-04 or electronic field locators. Authorized Neonatal Intensive Care Unit (NICU) services in the facility are billed with revenue code 0174.

NATIONAL CORRECT CODING INITIATIVE

Effective January 1, 2011, HAP Midwest Health Plan has updated the claims edit system. It incorporates National Correct Coding methodologies for all of our lines of business to be compliant with the Patient Protection and Affordable Care Act (HR 3590) Section 6507. More information can be found at

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

Reimbursement methodologies:

- NCCI procedure-to-procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reason.
- Medically Unlikely Edits (MUE"s), units-of-service edits, that define for each HCPCS/CPT code the number of units of service beyond the reported number of units allowed; and surgical procedure billed that should be considered as a component of the global surgical fee.
- A service denied based on NCCI code pair edits or MUE's may not be billed to HAP Midwest Health Plan.
- Providers cannot utilize ABN (Advance Beneficiary Notice) of Non-coverage to seek payment from members.
- If a provider believes that an incorrect decision has been made, supporting documentation may be submitted through our appeals process.

OB SERVICES

HAP Midwest Health Plan does not accept global OB billing. This process is necessary due to MDHHS's HEDIS data reporting requirements and consistency in our claims adjudication process related to the obstetrical care. Members have open access for OB services. Global codes (59400, 59410, 59510, 59515, 59610, 59614, 59618, and 59622) will be denied with a denial reason code of 66, requesting that you "bill individual component codes." The following must be reported on the CMS 1500 claim form:

Box 14: members' last menstrual period (LMP) Box 19: In remarks Section Initial office visit when pregnancy was confirmed and all subsequent prenatal care dates of service being included in the antepartum procedure code.

Perinatal Care	Description	CPT Code	Units
Antepartum	1 – 3 visits	Appropriate E/M code	1
Antepartum	4 – 6 visits	59425	1
Antepartum	7 or more visits	59426	1
Postpartum	N/A	59430	1

Delivery

Description of Service	Procedure code
Vaginal Delivery	59409
Cesarean Delivery	59514
VBAC Delivery	59612/59620

For electronic billing, providers can submit the information in box 19 using the following w: st="on">NTE segment: 2300 loop, Ref01=ADD, Ref02=Narrative up to 80 characters using the date format as mmddyyyy.

If you require further assistance please contact your Claims department at (888) 654-2200, option 2.

OUT-OF-NETWORK PROVIDERS

Out of network providers must follow the HAP Midwest Health Plan referral requirement and claims submission process. Click on link Referrals and Authorization to review the authorization requirements. Contact the Health Services department at (888) 654-2200, prompt 2 followed by prompt 1.

For Authorization requirements please refer to the authorization grid, under the Authorization/Referral Procedures link.

WELL WOMAN/WELL CHILD VISITS

Female members of HAP Midwest Health Plan are entitled to go to any participating OB/GYN, without referral from their PCP, for well woman care. Participating providers are those who are contracted and credentialed with HAP Midwest Health Plan. HAP Midwest Health Plan has defined well woman care as preventative visits, office visits, and prenatal visits. HAP Midwest Health Plan will pay claims from participating GYN's for these services without requiring authorization from the member's PCP. However, services provided by a non-participating GYN require PCP and/or Plan authorization.

Children enrolled in HAP Midwest Health Plan are entitled to go to any participating pediatrician, without referral from their PCP, for well child care. Participating providers are those who are contracted and credentialed with HAP Midwest Health Plan. HAP Midwest Health Plan has defined well child care as preventative care, office visits, and immunizations.

HAP Midwest Health Plan will pay process claims from participating pediatricians for these services without requiring an authorization from the member's PCP. A non-participating pediatrician's services requires PCP authorization.

RECONSIDERATION OF CLAIMS PAYMENT DECISIONS

HAP Midwest Health Plan understands that Providers may not agree with some of the Claims Payment decisions and provides a mechanism to resolve these issues.

REDETERMINATION REQUEST PROCESS

Providers may request a redetermination of claims that appear to be incorrectly processed, incorrectly underpaid or rejected due to coding or fee payment errors, remittance advice issues, claims not processed within 45 days and rejected unauthorized but you have an authorization number. A request for review of such administrative issues must be submitted within 365 days from date of service with supporting documents. You may submit your request and the additional information to:

HAP Midwest Health Plan
Claims Department – Claims Resubmission
P.O. Box 2578
Detroit MI 48202

PROVIDER APPEALS PROCESS

Providers notified by HAP Midwest Health Plan of claims denial have the right to appeal the decision. The following is a list of denials that can be appealed:

- B5: Not eligible for obs payment
- B6: Provider not payable per HAP Midwest Health Plan policy
- C3: Add-on, missing primary code
- GP: Included in global period
- 08: Diagnosis non-emergent for ambulance
- 23: Not medically indicated, per records
- 45: Day, units, or procedures exceed authorized amount
- 49: Authorization expired
- 52: Exceeds chiropractic 18 visit maximum
- 53: Exceeds benefit limit
- 55: Authorization denied
- 56: Authorization from PCP not on file
- 57: Authorization from PCP/UM not on file
- 90: Not a covered benefit by HAP Midwest Advantage
- 96: No prior plan approval

Providers who appeal the claims denial decision may do so as follows:

- All level 1 claim appeals must be submitted within sixty (60) days of receipt of original claim rejection;
- All level 2 appeals must be submitted within sixty (60) days from the date on the level 1 denial letter sent from HAP Midwest Health Plan;
- All appeals must include a cover letter, indicating the basis for the appeal request, all pertinent member details, additional documentation supporting the appeal, and reference to the previously processed claim (DOS, claim number or a copy of the prior authorization) in order to identify the claim(s) being appealed;
- Resubmission of a denied claim alone does not constitute a request to appeal;
- All appeals will be date-stamped, logged into the appeals tracking log with the reason for rejection or payment;
- If the original decision is overturned at any level, payment/additional payment is typically forthcoming in two to three weeks after the decision has been made.

There are two levels of claim appeal within the Plan, Level 1 and Level 2.

1. Level 1: This is the first line of communication for denied claims. The provider must submit the appeal with all of the appropriate documentation within sixty (60) calendar days from the original rejection in order to be considered for review.
 - If the appeal is received in the required 60 day timeframe, the Claims Appeal Coordinator will review supporting documentation and claims history for the reconsideration process.
 - If the appeal is received after the 60 day timeframe, a letter will be sent to the provider indicating the appeal is untimely and no action will be taken
 - All medical claims appeals requests will be reviewed by the Director of Health Services for decisions; the appeal will either be approved for payment or the original decision will be upheld
 - Administrative claims will be reviewed by the Claims Manager for decisions; the appeal will either be approved for payment or the original decision will be upheld
 - All appeals must be responded to within 30 calendar days from the date of receipt

2. Level 2: This is a level of appeal after the level 1 appeal option has been exhausted.
 - If the appeal is received within the required 60 day timeframe, the Claims Appeal Coordinator will review any new material supporting documentation along with claims history for reconsideration.
 - If the appeal is received after the 60 day timeframe, a letter will be sent to the provider indicating the appeal is untimely and no action will be taken
 - All medical claims appeals requests will reviewed by the Medical Director for decisions; the appeal will either be approved for payment or the original decision will be upheld
 - Administrative claims will be reviewed by the Director of Claims for decisions; the appeal will either be approved for payment or the original decision will be upheld
 - All appeals must be responded to within 30 calendar days from the date of receipt

All appeals related to claim denials are mailed to:
HAP Midwest Health Plan
Attention: Claims Appeals Coordinator
P.O. Box 2578 Detroit MI 48202

All appeals beyond level 2 for contracted and non-contracted providers can request an internal Accounts Receivable Reconciliation Group (ARRG) meeting. If there is no resolution from the ARRG meeting, non- contracted providers may contact DIFS. If needed, non-contracted providers may select the option of Binding Arbitration.

BINDING ARBITRATION PROCESS

Upon receipt of an appeal by a provider (par or non-par), HAP Midwest Health Plan will review the information. This review will be undertaken by the Operations or Health Services Senior Staff. This will be considered a Level 1 appeal. If the provider is not satisfied with the decision reached on the Level 2 appeal, they may request a review by internal Account Receivable Reconciliation Group (AARG). This request must be submitted in writing within 60 days of receipt of the Level 2 decision.

HAP Midwest Health Plan will attempt to resolve all issues at the ARRG; both contracted and non- contracted providers have the right to request binding arbitration. HAP Midwest Health Plan will retain a list of arbitration entities.

RAPID RESOLUTION PROCESS

HAP Midwest Health Plan can provide ARRG to meet with contracted and non-contracted providers who wish to achieve reconciliation solutions for outstanding accounts. The ARRG meets on an ongoing basis with contracted providers. These meetings occur quarterly, or more frequently, if needed. If a non- contracted provider has an issue with outstanding accounts, HAP Midwest Health Plan encourages these providers to request an ARRG meeting by contacting the claims department. HAP Midwest Health Plan ARRG includes the following internal staff: Director of Claims, Claims Manager, Health Services staff, the assigned Provider Services representative, any other internal staff that may be needed as well as representatives from the provider entity. HAP Midwest Health Plan will attempt to resolve all issues at the ARRG.

SECTION VIII: CUSTOMER SERVICE

The Customer Service Department is the entry point of contact for all HAP Midwest Health Plan members. The Department is staffed with Customer Service Representatives who are trained to respond to any and all member questions and concerns. Customer Service Representatives are available to assist members and providers Monday through Friday from 7:30 a.m. to 5:30 p.m. toll free at 888-654-2200. TTY call 711.

Customer Service has a qualified staff of representatives to serve our membership. All languages are interpreted by CQ Fluency while a HAP Midwest Health Plan representative is on line.

TTY for the hearing impaired is available by calling the Michigan Relay Center at 711.

NEW MEMBERS

New members enrolled in HAP Midwest Health Plan via Michigan Enrolls either select a HAP Midwest Health Plan Primary Care Provider (PCP) or HAP Midwest Health Plan assigns one to them as of the first day of enrollment. Assignments of PCP's are based on a comparison of the member's zip code of residence and the PCP's office zip code.

All new members of HAP Midwest Health Plan receive a packet of information within of the first 10 days of enrollment. The packet includes a letter welcoming them to the plan, preventive health guidelines, and a member handbook. The member ID card is sent first class mail within the first five (5) days that HAP Midwest Health Plan is notified of enrollment. A Copy of sample ID cards are found in under the "Member ID" tab and the member handbook is located in "member handbook tab" on the HAP Midwest Health Plan website at hap.org/midwest. The handbook defines the benefits available to the member and gives them information pertaining to their rights and responsibilities as a member of HAP Midwest Health Plan.

HOW TO IDENTIFY A HAP MIDWEST HEALTH PLAN MEMBER



HAP Midwest Health Plan members carry two identification cards:

- Michigan Medicaid "mihealth" card
- HAP Midwest Health Plan identification card

In addition, the PCP office can obtain a list of active members via the provider portal. The eligibility lists are updated on a monthly basis.

The Medicaid card should indicate that the member is enrolled with HAP Midwest Health Plan (Medicaid eligibility and Plan assignment can be verified for any Medicaid member on the front page of HAP Midwest Health Plan website or on the State database "CHAMPS"). The HAP Midwest Health Plan identification card will indicate the name and telephone number of the PCP that the member is assigned to, along with the effective date. PCP's are strongly advised to check the member's mihealth card, the HAP Midwest Health Plan identification card, and the

monthly eligibility list each time a HAP Midwest Health Plan member presents for services. Medicaid recipient's coverage can change on a monthly basis.

NOTE: It is not necessary to contact the Customer Service Department to verify member eligibility. If the member appears on a PCP's monthly enrollment list, the member is considered eligible for that month and assigned to that PCP. For assistance with the provider portal, please contact Claims at 888-654- 2200 option 2.

MEMBER ACCESSIBILITY TO PCP SERVICES

HAP Midwest Health Plan is committed to ensuring accessible and timely medical care and services for all members. Members are assigned to the PCP of their choice for routine medical care and specialty referrals. HAP Midwest Health Plan provides reasonable availability and accessibility to primary care by ensuring that the size of the contracted provider network is adequate and contains providers who are available to members within thirty (30) minutes travel time and/or thirty (30) miles of the member's residence. In addition, all HAP Midwest Health Plan PCPs must be available (or will make the appropriate coverage available in their absence) for all HAP Midwest Health Plan members on a 24-hour per day, seven (7) days per week basis, for urgent care and emergency care referrals.

HAP Midwest Health Plan monitors its current provider network to ensure reasonable availability and accessibility of medical care and services for members. As part of the Quality Improvement Program, mapping of providers and members is reviewed at least annually, and telephone accessibility and appointment availability of each PCP is monitored.

In the event that a member requires a referral to a specialist or specialty service that is not readily available through the current provider network, please contact Customer Service at (888) 654-2200 for assistance.

MEMBERS' RIGHTS AND RESPONSIBILITIES

You have a right to:

- Be treated with respect and your right to privacy and confidentiality
- Get care that meets your health needs
- Get information about HAP Midwest Health Plan's services and providers, practitioners and rights and responsibilities
- Work with doctors in decision making about your health care
- Choose or change your PCP
- A candid talk of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- Decide what type of care you would want if critically ill. This is called Advance Directive
- Get medical care through a Federally Qualified Health Center (FQHC)
- Take part in decisions about your health care including refusing treatment or asking about treatment options
- Ask for advice from another doctor when you are not sure about the care your doctor suggests
- Ask for a copy of your medical records, ask for amendments or corrections
- Get timely service from Customer Service
- Voice complaints or appeals about HAP Midwest Health Plan or the care HAP Midwest Health Plan provides

- Call or visit the Customer Service department to file an oral or a written grievance or appeal
- Ask for an administrative fair hearing with the Department of Health and Human Services
- Ask for your grievance to be reviewed by the Department of Financial and Insurance Services if you are unhappy with the decision made by HAP Midwest Health Plan
- To get information about HAP Midwest Health Plan operations, structure, or make suggestions regarding HAP Midwest Health Plan's services and providers. Make suggestions about HAP Midwest Health Plan member rights and responsibilities
- Be free of any form of restraint or seclusion used as a way to coerce, discipline, convenience or retaliation
- Receive a second medical opinion from an in-network provider
- Receive a second medical opinion from an out of network provider, if an in network provider is not available, the plan will arrange for an out of network provider. Plan approval is required.

You have a responsibility to:

- Keep good health habits
- Learn how HAP Midwest Health Plan works
- Follow HAP Midwest Health Plan policies for getting health care services
- Choose a PCP
- Show your HAP Midwest Health Plan and mihealth cards when you need care
- Make sure no one else uses your HAP Midwest Health Plan and mihealth cards
- Treat other members, HAP Midwest Health Plan staff, and providers with respect
- Give information (to the extent possible) that HAP Midwest Health Plan and your doctors need in order to give you the care you need
- Understand your health problems and work with your doctor to develop care that you both agree on
- Follow plans and advice for care that you have agreed to with your doctor
- Keep scheduled appointments. Arrive on time. If you cannot keep your appointment, call your doctor as soon as you can
- Report any suspected fraud and abuse
- Know what to do when your PCP's office is closed
- If you move or change your phone number, call us at (888) 654-2200 to give us the new address and phone number You must call your caseworker at your local Department of Human Services (DHS) office.
- If you have a baby, or if your family size changes for any reason, call your DHS worker and let them know about the changes. Call HAP Midwest Health Plan and let us know too.

MEMBER REQUEST FOR PCP TRANSFERS

HAP Midwest Health Plan members have the right to request a transfer to another HAP Midwest Health Plan PCP. If a member would like to change their PCP, they may call the HAP Midwest Health Plan Customer Service Department, toll-free, at (888) 654-2200 to request the change. HAP Midwest Health Plan reserves the right to immediately transfer any member to another provider, including PCP, SCP, ancillary provider or hospital, if the member's health or safety is in jeopardy.

MEMBER COMPLAINTS AND GRIEVANCE RESOLUTION

To promote customer satisfaction, HAP Midwest Health Plan has a centralized complaint procedure and a formal grievance procedure to address, resolve, and track all member

complaints and grievances that cannot be resolved on the informal level. At the time of their enrollment, all members receive written information which outlines the simplified process available to assist them with filing a complaint or grievance.

The Customer Service Department is responsible for receiving, investigating, tracking, and responding to all member complaints and grievances, The Customer Service Representatives frequently have to contact PCP offices in the course of investigation of a complaint or grievance. Your prompt response to such contacts by the Customer Service representatives is necessary and appreciated.

All formal complaints and grievances are tracked and reported to the Peer Review Committee, Quality Improvement Committee and the Board of Directors on a monthly and quarterly basis. A semi-annual report is also submitted to the MDHHS per the contractual reporting requirements.

TRANSPORTATION

If a HAP Midwest Health Plan member is unable to obtain transportation for medical services, HAP Midwest Health Plan may provide transportation for them. In order to obtain transportation, the member must declare that there are no resources available to them. The members should be advised to contact HAP Midwest Health Plan Customer Service Department toll-free at (888) 654-2200 at least three (3) business (Monday through Friday) days prior to their scheduled appointment to request transportation services. Wheelchair lift vans are available as needed, and child car seats are available upon request.

For members who need cabs or other specialized transportation for an extended period of time, written documentation substantiating the need for the transportation may be requested from the PCP.

LANGUAGE INTERPRETATION AND SERVICES FOR HEARING AND SPEECH IMPAIRED

HAP Midwest Health Plan is committed to maintaining open lines of communication with all members and providers. To support that goal, HAP Midwest Health Plan has contracted with vendors to provide language interpretation services, as well as services for communicating with hearing and/or speech impaired members, for all HAP Midwest Health Plan members. HAP Midwest Health Plan also has support staff available that can provide interpretation services in Arabic and Spanish.

For more information on using these services, please contact the Customer Service Department at (888) 654-2200.

SECTION IX: QUALITY MANAGEMENT

HAP Midwest Health Plan has an ongoing Quality Assessment and Performance Improvement Program (QAPI). The program is designed to promote and improve upon the delivery of member medical and health care services, which are consistent with the mission statement, and goals of HAP Midwest Health Plan. The QAPI is a program designed to objectively and systematically monitor and evaluate the appropriateness of clinical and non-clinical member care/services. HAP Midwest Health Plan will pursue opportunities to improve upon the care/services, and resolve identified problems. All departments, primary care and high volume specialist providers are involved in monitoring, maintaining and improving the quality of care and

services. The effectiveness of the Quality Improvement (QI) Program is evaluated annually. Our QAPI, progress on our annual goals and the annual evaluation are located on our website and a hard copy can be obtained from HAP Midwest Health Plan by contacting the Quality Management Department at (248) 663-3789.

Ongoing monitoring of care and services is performed through review of medical records, administrative data, complaints and grievances, after hours care surveys, appointment wait time surveys, on site facility reviews, Consumer and Provider surveys, and utilization data. The goals HAP Midwest Health Plan has set for each area monitored are included in the PCP Newsletter.

HAP Midwest Health Plan utilizes the Michigan Quality Improvement Consortium's Guidelines for preventive and clinical care. Some examples of these guidelines are for preventive care from birth through over age 65, prenatal and postpartum care. Clinical care and chronic care guidelines include tobacco cessation, hypertension, depression, otitis media, asthma, diabetes, stroke, and cancer screening. The entire listing of guidelines is found on our website under "Current Guidelines".

MEMBER MEDICAL RECORDS

HAP Midwest Health Plan does not generate, maintain or store medical records. HAP Midwest Health Plan providers are responsible for the patient's medical record. All information in the record is confidential. Members have access to their medical record. HAP Midwest Health Plan does not allow employers to have access to personally identifiable (implicitly or explicitly) health information about their employees without consent or unless mandated by law. Members can review their medical record in the presence of their primary care provider during a mutually convenient appointment time. Since HAP Midwest Health Plan does not maintain the medical record, and therefore is not able to control member access to records, it is up to their PCP to determine the extent to which a member may amend their record. It is noted that a member cannot amend information such as laboratory and x-ray results. The member or guardian must sign consent for release of information when they request their records to be released to another party. If a member is unable to give consent, their legal guardian does so on their behalf. The guardian then has the same rights as the member to request and review the information in the medical record. Medical record information will not be released without appropriate written authorization of the member unless legally mandated.

While safeguarding the confidentiality of the member/patient relationship, HAP Midwest Health Plan and participating providers/physicians shall release information regarding the member/patient to other health care providers can render the necessary medical care in cases of emergency. It is the HAP Midwest Health Plan policy to release information otherwise considered confidential to certain entities for the purpose of protecting the health and safety of the general public whenever such release is required by law.

This confidential information is not disclosed to anyone except for whom the information was intended. HAP Midwest Health Plan does not release explicit or implicit member identifiable information for purposes other than treatment, payment, or health care operations without an explicit authorization from the member. The Quality Improvement Committee is responsible for creating and annually reviewing the application of confidentiality policies and the practices regarding the collection, use, and disclosure of medical information.

MEDICAL RECORD MAINTENANCE REQUIREMENTS

The primary goal of this policy is to assure that the medical care and services provided to the patient are documented appropriately and in a standardized, industry accepted, manner.

To promote continuity and quality of member/patient care, HAP Midwest Health Plan requires that all participating providers maintain their HAP Midwest Health Plan member/patient charts in a manner which assures that the medical record information is organized and readily accessible when needed.

All participating providers are advised of the chart requirements as part of their provider orientation. HAP Midwest Health Plan's goal is to have providers' charts meet at least 90% of the elements audited.

General Medical Record Maintenance Requirements Policy is as follows:

HAP Midwest Health Plan requires participating providers to maintain a single unit record that is a detailed and comprehensive medical record of all services provide by the PCP and the medical services received by its members. These records are maintained in a manner that provide a basis for managing patient care, provide inter- and intra-office communication of patient related data, document total and complete health care, allow patterns to surface that will alert physicians and health care providers of the patient's health care needs, conforms to professional medical practice, permits effective professional review, and facilitates a system for follow-up treatment.

HAP Midwest Health Plan providers have sufficient staff, facilities, and equipment to maintain clinical records that are complete and accurately documented, readily accessible, and organized so as to facilitate the retrieval and compilation of information. Each provider of primary care designates a person with the responsibility for assuring that clinical records are maintained, completed and preserved.

All participating providers are advised of the chart requirements as part of their provider orientation. Providers will conform to their contractual agreement concerning medical record maintenance. Compliance to medical record standards is evaluated by HAP Midwest Health Plan's medical chart audit process. HAP Midwest Health Plan requires periodic audits of member medical records for the purposes of member safety, medical record studies, provider credentialing, and peer review studies.

HAP Midwest Health Plan assures the compliance of its Medical Record policy by including the summary requirements in its provider manual and on the website of hap.org/midwest. Audits are performed to monitor compliance with certain aspects of the guidelines. Feedback is provided to providers on their performance.

Patient files must be kept in a secured area and locked when appropriate personnel are not in attendance. Policies and procedures for must be created and used for privacy, security, business responsibility, and records management as it relates to electronic medical records. HAP Midwest Health Plan providers are expected to follow the Health Insurance Portability and Accountability Act (HIPAA) regarding the use and release of medical records and privacy standards for paper and electronic medical records.

HAP Midwest Health Plan, per its contract with providers, assures the confidentiality of the clinical record is maintained.

Providers maintain a single unit clinical record for each member in accordance with accepted professional standards and practices. Charts should be organized to easily find lab, x-rays, consultations, hospitalizations, and physical/ history records. [Dividers or an organized system]. Medical records shall be organized and stored by the provider in a manner that will assure and maintain confidentiality and facilitate review and retrieval of the clinical information. All entries must be legible. Medical record documentation must be written in the English language ONLY.

Medical Record Content/Organization and Filing Requirements

Providers of HAP Midwest Health Plan are required to meet these guidelines. Each new provider is provided with the chart maintenance requirements as a part of their orientation process. These requirements are also found in their PCP Administrative Manual and on the HAP Midwest Health Plan website.

- Each clinical record must be a single unit record for one (1) individual. Each page within the record must identify the patient by name and a medical record ID/ (Medicaid ID #).
- Each unit clinical record must be organized and each page must be attached to the file.
- Allergies and allergic reactions must be clearly noted in a prominent location on the outside of the chart as well as within the medical record, so that the allergy status is clearly visible during each record entry. Patients should be asked their allergy status and the status updated at each encounter. The abbreviations NKA = No Known
- Allergy and NKDA = No Known Drug Allergy may be used.
- All forms must be completed in their entirety with all blank spaces marked with an N/A (Not Applicable).
- Documentation throughout the clinical record is done in a consistent format.
- Example: SOAP format. Writing must legible and in English.
- The vaccination and immunization status must be documented and complete in each Patient's chart.
- Patient histories (initial and interval) shall include at the minimum:
 - Significant past medical conditions, serious accidents, and illnesses
 - Significant past surgical / invasive procedures
 - Pertinent family history and high risk factors
 - For children and adolescents (18 years and younger) past medical history includes at a minimum prenatal care, birth, operations and childhood illnesses.
- Problem list identifying chronic conditions and major health issues.
- Current medications, including over the counter medications
- Lifestyle habits including the use of cigarettes, alcohol and substances
- Preventive services/ risk screening
- Documentation of each patient encounter shall include at the minimum:
 - Reason for the visit, chief complaint
 - Diagnosis / diagnostic impression
 - Studies or tests ordered and / or performed
 - Therapies or treatments ordered and / or performed
 - Detailed documentation of the patient examination / findings
 - Patient instructions
 - Patient disposition at the end of the encounter and the physician recommendations for further care and / or follow up.
 - Documentation of any prescription or nonprescription medications-prescribed and / or dispensed to the patient (including samples).

- All record entries must be author identified [name & title], dated and signed by the provider of the service.
- The patient identification information (demographics) including name, age / date of birth, sex, marital status, emergency contact person, etc... must be clear and easily located in the clinical record. Demographics such as addresses, phone numbers, employer and employer phone number, and insurance information must be verified and updated at each encounter.
- Clinical records shall contain the results of any appropriate age-specific, sex-specific, or other type-specific screenings (EPSDT).
- Advance Directives shall be displayed in a prominent part of the record, and information as to whether or not the individual has executed an Advance Directive.
- Results of laboratory, diagnostic, ancillary services (home health agencies, nursing home reports, physical therapy, etc.) and consultation reports shall be reviewed by the physician and filed in a timely manner (within 30 days from receipt), and must include the date of the review, the physician's signature, and the appropriate actions noted [progress note]. Note: the PCP must make arrangements with referral physicians to obtain a copy or a summary of care (i. e., OB care, consultant's care, etc.).
- Inpatient health facilities Discharge Summaries must be filed in the chart at least 60 days from the date of discharge, and must be dated and signed by the physician (reviewed).

Confidentiality

All information contained in the record is treated as confidential. The confidentiality of the medical records of enrollees must be maintained. No information is released from a medical record without the written permission of the patient. An appropriate release of medical information must be signed and placed in the medical record at the time of the release of the records. Each provider site shall be responsible for maintaining medical records of enrollees and for the proper release of the medical information. Enrollees can view the information in their records with the PCP at a mutually convenient time. Enrollees can only view their personal records and cannot change any medical information contained therein. If requested, they may put a dated, signed note in the record. Refer to Confidentiality Policy. Patient files must be kept in a secured area and locked when appropriate personnel are not in attendance. The clinical files of the HAP Midwest Health Plan enrollees are confidential, and such; employees and contractors shall protect the privacy of the patient information unless otherwise required by law.

Release of Records

Medical records are to be released only with proper authorization by the patient, parent, legal guardian, or subpoena. An appropriate release of medical information must be signed and placed in the medical record at the time of the release of the records. Medical information will not be released to the patient except through the patient's attending physician. Clinical information is not to be released by telephone except in emergency situations where it is immediately needed by outside physicians to properly care for a patient. In such cases, the information is to be released only by the attending physician. No information is released from a medical record without the written permission of the patient.

Copies of Records

Upon appropriate written request for copies of medical records by an enrollee, or the enrollee's parent or guardian, as appropriate, a photocopy of the requested medical record are sent to the authorized requester. The original copies of all medical records are maintained as required by Federal and State law.

Record Access, Storage and Retrieval

The clinical files of HAP Midwest Health Plan enrollees shall be made available to the Michigan Department of Public Health and / or the Michigan Department of Health and Human Services authorized staff or its designees, and/or the Center for Medicare/Medicaid Services (CMS) at their written request. Per contract, HAP Midwest Health Plan has immediate access to all enrollee records. If copies of charts are requested by HAP Midwest Health Plan, the providers do not receive any additional reimbursement for copying the records. Current records must be maintained in such a manner that there is immediate access. HAP Midwest Health Plan requires that the clinical records must be maintained for seven years for adults, and two years past the age of majority for minors [for a minimum of seven years]. The provider's signature on the contract is acknowledgment and acceptance of the medical record policy requirements. The facility must have a contingency plan for retention of records for the length of time remaining to the seven years after last seeing or for two years past age of majority for minors (for a minimum of seven years) in case of cessation of operations. The medical records of members that change PCP's are forwarded within 10 days of a release of information request.

Purged Records

Records can be purged from charts if they are at least three (3) years old. If a chart becomes too thick to handle (over 1.5 inches) a second volume chart can be started. Purge the older records into the second volume and maintain the most current in the first volume. Purged charts must be identified on the outside cover with their volume number, (i.e., volume 1 of 3). All member identification must be on all volumes of all charts. Purged records that are less than three (3) years old must be maintained in the active filing system or in another area on-site that is readily accessible. Purged records that are less than three (3) years old must be available within 24 hours when requested. Purged records over three (3) years old must be available within 48 hours when requested. Purged records should be logged for quick access. The log should note exactly what records were purged, the date they were last purged, and their exact storage location. When requested, the provider must make these records available to HAP Midwest Health Plan.

Medical Record Evaluations:

As a part of the of the quality assurance and improvement plan, medical record evaluations (medical record audits) are conducted utilizing the criteria from the medical record policy. The goal is to have at least 90% of our records meet the medical record evaluation criteria under review. All new primary care provider sites undergo a medical record evaluation as a part of the initial credentialing/qualifying process. Annual medical record documentation audits are conducted to monitor ongoing provider compliance with standards.

- The HAP Midwest Health Plan audit representative discusses the results of the record audits with the provider to resolve any problems and to assist the provider with their corrective action plan. The corrective action plan is monitored at a minimum of every 6 months to ensure improvement in the provider's performance. Results of the audit and compliance to the corrective action plan are reviewed upon recredentialing at the Credentialing Subcommittee or more often if deemed necessary. Appropriate action will be taken if the provider does not follow the corrective action plan.
- Results of the medical record evaluations are presented to the QI Committee and to the Board of Directors.

CONTINUITY OF CARE

When a PCP or Specialist terminates their contract with HAP Midwest Health Plan, while in good standing, in order to assure continuity of care for our members, PCP's and Specialists are given the opportunity to continue to serve our members. Upon the voluntary termination, you will be sent a list of the members that you are treating that are in an active course of treatment for an acute episode of "chronic illness" or an "acute medical condition", or in the 2nd or 3rd trimester of pregnancy or that are terminally ill. An active course of treatment is one in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. If you have any members who meet the above criteria and you are willing to continue treating this member on a FFS basis, you will be asked to circle their name, document the reason for continuing their care on the form, and fax the form back to HAP Midwest Health Plan at (248) 663-3780. If you agree to continue to treat this member, the following will occur:

- You will be reimbursed at then current Medicaid FFS rates
- HAP Midwest Health Plan will work with you and the member to develop a transition plan to a new PCP or Specialist
- You will be allowed continuation of treatment for up to 90 calendar days for members in active treatment for an acute condition or through the acute phase of the condition being treated and through the postpartum period (six weeks post-delivery) for women in the second and third trimester of pregnancy and for the terminally ill member for the remainder of the member's life
- You will share information regarding the treatment plan with HAP Midwest Health Plan
- You will continue to follow the HAP Midwest Health Plan Utilization Management policies and procedures
- You will not charge or balance bill the member for services
- HAP Midwest Health Plan will send you a confirmation letter that outlines the continued treatment conditions for each of the members you agree to continue to treat

VFC, MCIR AND REPORTING OF COMMUNICABLE DISEASES

All providers who administer vaccines for HAP Midwest Health Plan Medicaid members are required by State law to obtain the vaccines through the Vaccines for Children (VFC) program. The VFC program is a federal program which makes vaccines available to immunize children age 18 and under who are Medicaid eligible. The vaccines are obtained free of charge from the local health departments. The Alliance for Immunization in Michigan (AIM) tool kits include information on VFC and MCIR as well as "catch up schedules", storage information, vaccine information sheets and much more. Contact your local health department if you have questions about the VFC program. The AIM tool kit can be found at www.aimtoolkit.org.

Providers who administer immunizations are also required to report the immunizations to Michigan Care Improvement Registry (MCIR). Data can be entered into this statewide database registry through a computer via modem, batch transfers, and phone/fax or through data forms. If you have any questions, visit the MCIR website at: <http://www.mcir.org/> for resources and technical assistance contact information. MCIR can also assist you in improving your immunization rates by using MCIR to run batch reports and monthly immunization recall letters.

As a reminder, all providers are required by the State and through the contract with HAP Midwest Health Plan to report communicable diseases to the local health department. The Alliance for Immunization in Michigan Provider Tool Kit includes a helpful brochure titled "Table of Reportable Diseases in Michigan." If you need an additional copy of this or any other information found in the AIM kit, it is found on the website at www.aimtoolkit.org.

DISEASE MANAGEMENT PROGRAMS

To refer a member to a disease management program, please call (248) 663-3794.

Diabetes Disease Management Program

When enrolled, members will receive information on how to take care of their diabetes. Enrollees will be sent information on what diabetes is, how to control blood sugar, taking medications the right way, lowering risk factors, exercising, eating right, meal planning, eye and foot care and other important information. Those enrolled will also receive reminders for scheduling important screening tests including: HbA1c, Cholesterol screening, Eye exam, Foot exam and Urine test for protein.

Asthma Disease Management Program

When enrolled, members will receive information on how to manage asthma. Enrollees will be sent information on asthma triggers, symptoms, proper use of medications, an asthma action plan to complete with their doctor, information on quitting smoking, and much more.

Hypertension Disease Management Program

When enrolled, members will receive educational information on how to manage high blood pressure. Enrollees will be sent information on high blood pressure basics, managing medications, a medication log, healthy diet and nutrition, tips to improve blood pressure, and healthy lifestyle resources.

HEALTH OUTREACH

Smoking Cessation Program

The Michigan Tobacco Quitline is a FREE phone-based program to help members quit smoking. Members will work one-on-one with a health coach to develop a quit plan. Members may enroll in the program by: self-referral, PCP referral, or health plan referral. To refer a member to the program, call 1- 800 QUIT NOW (784-8669). For more information, please call (248) 663-3794 or toll free at (888) 654-2200.

ROSEBUD® Pregnancy Program

The ROSEBUD Special Delivery Program is available to help members achieve a healthy pregnancy. The goal of this program is early recognition of potential problems and education on healthy lifestyles. A nurse that specializes in high-risk pregnancy care will contact the member by phone to discuss their pregnancy and general health. The nurse will help determine if there are any risks for early delivery or other pregnancy risks, and provide education and support. For more information about this program or to enroll call (248) 663-3794.

Maternal Infant Health Program (MIHP)

The Maternal Infant Health Program is for pregnant women and their baby up to 1 year of age. This program helps pregnant members and infants get the proper food, support, and transportation for health services. It will also help emphasize the importance of getting prenatal care, well child care, and shots when they are scheduled. To refer a member, please call (248) 663-3794. Services include:

- Prenatal teaching
- Childbirth education classes
- Nutritional support and education
- Newborn baby assessments
- Help with personal problems that may complicate pregnancy
- Referrals to community resources
- Help with transportation to pregnancy related appointments
- Support to quit smoking

Weight Watchers® Discount Program

HAP Midwest Health Plan members can purchase a 12-week Weight Watchers® pass at a discounted rate by just showing their HAP Midwest Health Plan Member ID card at participating meeting locations. For more information or to find a meeting place call 1-888-3Florine or visit the Weight Watchers® website at www.weightwatchers.com.

Preventive Health Reminders

HAP Midwest Health Plan sends out preventive health reminders to members that may be due for services. These reminders include:

- Child Vaccines/Adolescent Vaccines
- Human Papillomavirus (HPV) Vaccines
- Lead Testing
- Well Child Visits/Well Adolescent Visits
- Mammogram and Cervical Cancer Screening
- Colorectal Cancer Screening
- Glaucoma Screening
- Comprehensive Diabetes Care
- Annual Physical Exams

HAP Midwest Health Plan also sends reminder letters to Primary Care Physicians regarding their members with the following chronic conditions: Asthma, Diabetes, and Hypertension.

Health Education Materials

HAP Midwest Health Plan has educational materials available for members on the following topics:

- Asthma
- Diabetes
- High Cholesterol
- High Blood Pressure
- Depression
- Pregnancy
- Well Woman Care
- Colorectal Cancer
- Controlling Weight
- Domestic Violence
- Healthy eating
- Immunizations
- Well Child Care
- Lead Poisoning
- Sexually Transmitted Diseases
- Stroke
- Preventive Health Guidelines

MEMBER FINANCIAL INCENTIVES

Member Incentive Programs:

Members are eligible to receive gift cards after they have obtained the following services:

Service	Criteria
Child Vaccines	Complete all before age 2
Adolescent Vaccines	Complete all before age 13
Adolescent Well Visit	1 well visit each year
Human Papillomavirus (HPV) vaccine	Complete series before age 13
Lead Screening	Complete before age 2
Postpartum depression screening	Return form
Health Risk Assessment	Return form
Breast Cancer Screening	Return form
Cervical Cancer Screening	Return form
Diabetes Services (Dilated eye exam, HbA1c, urine testing for nephropathy, LDL)	Return form

CONFIDENTIALITY POLICY

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

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

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

Information that is held confidential includes "personal health information" (PHI) such as name, date of birth, address, gender, medical record information, claims, benefits and other administrative data that are personally identifiable. This includes all forms of PHI- oral, written,

and electronic forms of member information. If a member is unable to give consent (lack the ability to give consent), the member's legal guardian may authorize the release of personal health information and have access to information about the patient. Midwest Health Plan associates sign a confidentiality statement upon employment.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION THAT IS ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Alliance Health and Life Insurance Company HAP Midwest Health Plan, Inc.
Last Review: October 2015

Your Protected Health Information (PHI)

PHI stands for the words "Protected Health Information." PHI is information about you, such as your name, demographic data and member ID number that can reasonably be used to identify you. This information relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care. Our policies cover protection of your PHI whether it's oral, written or electronic.

Important information about privacy

Safeguarding the privacy of your PHI is important to HAP. We're required by law to protect the privacy of your PHI and to provide you with notice of our legal duties and privacy practices. That's what this notice is for. It explains how we use information about you and when we can share that information with others. It also tells you about your rights with respect to your PHI and how you can use your rights. We're required to comply with the terms set out in this notice.

How we protect your PHI

We protect your PHI, whether it's written, spoken or in electronic form, by requiring employees and others who handle your information to follow specific confidentiality and technology usage policies. When they begin working for HAP, all employees and contractors must acknowledge that they have reviewed HAP's policies and that they will protect your PHI even after they leave HAP. An employee or contractor's use of protected information is limited to the minimum amount of information necessary to perform a legitimate job function. Employees and contractors are also required to comply with this privacy notice and may not use or disclose your information except as described in this notice.

Using and disclosing PHI

These next sections describe how HAP uses and shares your health information. Keep in mind that we share your information only with those who have a "need to know" in order to perform these tasks:

Treatment

We may share your PHI with your doctors, hospitals or other providers to help them provide medical care to you. For example, if you're in the hospital, we may give them access to any medical records sent to us by your doctor.

We may use or share your PHI with others to help manage your health care. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.

Payment

We may use or share your PHI to help us determine who is financially responsible for your medical bills. We may also use or share your PHI to conduct other payment activities, such as obtaining premium payments and determining eligibility for benefits and coordinating benefits with other insurance you may have.

Operations

We share your PHI with affiliated companies as permitted by law, non-affiliated third parties with whom we contract to help us operate HAP and with others who are involved in providing or paying for your health care services. We may also share your information with others who help us conduct our business operations. If we do so, we will require these persons or entities to protect the privacy and security of your information and to return or destroy such information when it's no longer needed for our business operations.

Here are examples of business activities undertaken by HAP:

- Conducting quality assessment and improvement activities, including peer review, credentialing of providers and accreditation
- Performing outcome assessments and health claims analyses
- Preventing, detecting and investigating fraud and abuse
- Underwriting, rating and reinsurance activities, although we're prohibited from using or disclosing any genetic information for underwriting purposes
- Coordinating case and disease management activities
- Communicating with you about treatment alternatives or other health-related benefits and services
- Performing business management and other general administrative activities, including systems management and customer service

We may also disclose your PHI to other providers and health plans that have a relationship with you for certain health care operations. For example, we may disclose your PHI for their quality assessment and improvement activities or for health care fraud and abuse detection.

Other uses and disclosures that are permitted or required

HAP may also use or release your PHI:

- For certain types of public health or disaster relief efforts
- To give you information about alternative medical treatments and programs or about health-related products and services that you may be interested in, such as information we might send you about smoking cessation or weight loss programs
- To give you reminders relating to your health, such as a reminder to refill a prescription, or to schedule recommended health screenings
- For research purposes; For example, a research organization that wishes to compare outcomes of all patients who receive a particular drug and must review a series of medical records. In all cases in which your specific authorization hasn't been obtained, your privacy will be protected by strict confidentiality requirements applied by an institutional review board or a privacy board, that oversees the research, or by representations of the researchers that limit their use and disclosure.

- To report information to state and federal agencies that regulate us, such as the U.S. Department of Health and Human Services, the Michigan Department of Financial and Insurance Services, the Michigan Department of Health and Human Services and the federal Centers for Medicaid and Medicare Services
- When needed by the employer or plan sponsor to administer your health benefit plan
- For certain FDA investigations, such as investigations of harmful events, product defects or for product recalls
- For public health activities if we believe there is a serious health or safety threat
- For health oversight activities authorized by law
- For court proceedings and law enforcement purposes
- To a government authority regarding abuse, neglect or domestic violence
- To a coroner or medical examiner to identify a deceased person, determine a cause of death or as authorized by law (We may also share member information with funeral directors to carry out their duties, as necessary.)
- To comply with workers' compensation laws
- For procurement, banking or transplantation of organs, eyes or tissue
- When permitted to be released to government agencies for protection of the president

We must obtain your written permission to use or disclose your PHI if one of these reasons doesn't apply. If you give us written permission, then change your mind, you may cancel your written permission at any time. Cancellation of your permission will not apply to any information we've already disclosed. We may ask you to complete a form when you make a request.

Other uses and disclosures of PHI

- We may release your PHI to a friend, family member or other individual who is authorized by law to act on your behalf. For example, parents may obtain information about their children covered by HAP, even if the parent isn't covered by HAP.
- We may use or share your PHI with an employee benefit plan through which you receive health benefits. Except for enrollment information or summary health information and as otherwise required by law, we will not share your PHI with an employer or plan sponsor unless the employer or plan sponsor has provided us with written assurances that the information will be kept confidential and won't be used for an improper purpose. Generally, information will only be shared when it's needed by the employer or plan sponsor to administer your health benefit plan.
- We may give a limited amount of PHI to someone who helps pay for your care. For example, if your spouse contacts us about a claim, we may tell him or her whether or not the claim has been paid.
- payment or health care operations relating to the organized health care arrangement unless otherwise limited by law, rule or regulation. This list of entities may be updated to apply to new entities in the future. You can access the most current list at hap We may use your PHI so that we can contact you, either by phone or by mail, in order to conduct surveys, such as the annual member satisfaction survey.
- In certain extraordinary circumstances, such as a medical emergency, we may release your PHI as necessary to a friend or family member who is involved in your care if we determine that the release of information is in your best interest. For example, if you have a medical emergency in a foreign country and are unable to contact us directly, we may speak with a friend or family member who is acting on your behalf.

Organized Health Care Arrangement

HAP and its affiliates covered by this Notice of Privacy Practices participate together with the Henry Ford Health System and its listed affiliates in an organized health care arrangement to improve the quality and efficient delivery of your health care and to participate in applicable quality measure programs, such as HEDIS. The entities that comprise the HFHS OHCA are:

- Health Alliance Plan of Michigan
- Alliance Health and Life Insurance Company
- HAP Midwest Health Plan, Inc.
- HAP Preferred, Inc.
- The Henry Ford Health System

The HFHS Organized Health Care Arrangement permits these separate legal entities, including HAP and its affiliates, to share PHI with each other as necessary to carry out permissible treatment, payment or health care operations relating to the organized health care arrangement unless otherwise limited by law, rule or regulation. This list of entities may be updated to apply to new entities in the future. You can access the most current list at hap.org/privacy or call us at (877) 746-2501 to ask for a list. When required we'll provide you with appropriate notice of such purchase or affiliation in a revised Notice of Privacy Practices.

Your Rights

These are your rights with respect to your member information. If you would like to exercise any of these rights, contact us as described below under "Who to Contact."

- You have the right to ask us to restrict how we use or disclose your PHI for treatment, payment or health care operations. You also have the right to ask us to restrict PHI that we've been asked to give to family members or to others who are involved in your health care or in payment for your health care. We aren't required to agree to these additional restrictions, but if we do, we'll abide by them (except as needed for emergency treatment or as required by law) unless we notify you that we are terminating our agreement.
- You have the right to ask to receive confidential communications of PHI. For example, if you believe that you would be harmed if we send your PHI to your current mailing address (for example, in situations involving domestic disputes or violence); you can ask us to send the information by alternate means, by fax or to an alternate address. We will try to accommodate reasonable requests.
- You have the right to inspect and obtain a copy of PHI that we maintain about you. With certain exceptions, you have the right to look at or receive a copy of your PHI contained in the group of records used by or for us to make decisions about you, including our enrollment, payment, claims adjudication and case or medical management notes. If we deny your request for access, we'll tell you the basis for our decision and whether you have a right to further review. We may require you to complete a form to obtain this information and may charge you a fee for copies. We'll inform you in advance of any fee and provide you with an opportunity to withdraw or modify your request.
- You have the right to ask us to amend PHI we maintain about you. You have the right to request that we amend your PHI in the set of records you're granted access to upon your request. If we deny your request to amend them, we'll provide you with a written explanation. If you disagree, you may have a statement of your disagreement placed in our records. If we accept your request to amend the information, we'll make reasonable efforts to inform others of the amendment, including individuals you name. We'll require that the information you provide be accurate. We are unable to delete any part of a legal record, such as a claim submitted by your doctor.

- You have the right to receive an accounting of certain disclosures of your PHI made by us during the six years prior to your request. HAP is not required to provide you with an accounting of all disclosures we make. For example, we aren't required to provide you with an accounting of PHI disclosed or used for treatment, payment and health care operations purposes; or information disclosed to you or pursuant to your authorization. Your first accounting in any 12-month period is free. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We'll inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.
- You have the right to be informed of any data breaches that compromise your PHI. In the event of a breach of your unsecured PHI, we'll provide you with notification of such a breach as required by law or in cases in which we deem it appropriate.
- You have a right to receive a paper copy of this notice upon request at any time.

Your request to exercise any of these member rights must be in writing and it must be signed by you or your representative. We may ask you to complete a form when making a request.

Changes to this privacy statement

We reserve the right to make periodic changes to the contents of this notice. If we do make changes, the new notice will be effective for all PHI maintained by us. Once we make our revisions, we'll provide the new notice to you by mail and post it on our website.

Who to contact

If you have any questions about this notice or about how we use or share member information, contact the HAP and HAP Midwest Health Plan Office of Compliance by mail at:

Health Alliance Plan
Attn: Office of Compliance
2850 West Grand Boulevard
Detroit, MI 48202

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

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Office of Compliance or by filing a grievance with our Customer Service department. You may also notify the secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Original effective date: April 13, 2003

Revisions: February 2005, November 2007, September 2013, September 2014, March 2015, October 2015

WHISTLEBLOWER PROTECTION

As discussed in more detail in the Compliance Program and the policies, employees are responsible for internally reporting compliance issues including issues that raise false claims concerns, fraudulent activity or noncompliance to the code of conduct. It is the policy of the company that no employee who makes a report of alleged wrongdoing will be subjected to reprisal, harassment, retribution, discipline or discrimination by company or any of its employees or agents based on having made the report. Any employee or agent who engages in any such reprisal, harassment, retribution, discipline or discrimination against a good faith reporter may be subject to disciplinary action as deemed appropriate by the company. The Michigan Whistleblowers' Protection Act also provides protection to employees who report a violation or suspected violation of state, local or federal law. The Michigan Medicaid False Claims Act also provides protection for employees who initiate, assist or participate in a proceeding or court action under this law or who cooperate or assist with investigations conducted under this law. The Federal False Claims Act also contains protections for employees, who are discharged, demoted, suspended or discriminated against in retaliation for their involvement in false claims act cases.

MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

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

The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status, and must be delivered no later than 36 hours after observation services begin.

For MOON instructions, frequently asked questions and the final rule, visit:
<https://www.cms.gov/Medicare/Medicare-General-Information/BNI/>.