Updated
April 2017

UPHP

UPPER PENINSULA HEALTH PLAN

MEDICAID AND MICHILD PROVIDER MANUAL

UPHP
UPPER PENINSULA HEALTH PLAN

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UPPER PENINSULA HEALTH PLAN

INTRODUCTION

Mission

The mission of UPHP is to be an innovative health plan managing the care of our members in the Upper Peninsula guiding them to quality, cost-effective care through our network of providers improving the overall health of the communities we serve.

Core Values

Values

While UPHP's impact on health care in the Upper Peninsula has grown since we began operating in 1998, our inherent values have not changed. These are the values that guide us in our work:

Members First

We believe we are accountable to the residents of the Upper Peninsula. We aspire to be our members' trusted advisor and partner providing access to the highest quality care.

Partnership with Providers

We believe the Upper Peninsula's hospitals and healthcare providers are valuable partners to improve our members' quality of life and promote wellness. The best healthcare solutions come from collaboration with our network of providers.

Valued Employees and Volunteers

Our culture is distinct and essential to our success, and it begins with our team. We seek out bright, engaging people and support their growth to nurture dynamic careers and offer impactful volunteer opportunities.

Connected to Communities

We believe access to resources and information leads to better health. We strive to build healthier communities and empower people to make smarter decisions about their health.

About the Upper Peninsula Health Plan

The Upper Peninsula Health Plan (UPHP), located in Marquette, Michigan, is a managed care organization which operates many different government programs for people who receive healthcare benefits through a Medicare Advantage Plan, Medicare-Medicaid Plan, Medicaid, Children with Special Health Care Services (CSHCS), and Healthy Michigan Plan. UPHP became a health plan for residents of the Upper Peninsula of Michigan on August 1, 1998, when it partnered with 300 medical providers, 15 hospitals, and clinics in every county in the Upper Peninsula. The office staff in Marquette was small, starting with just six employees and managing the health care of 1,900 enrolled members. Today, the network exceeds 1,200 providers, the staff has increased to more than 140 employees, and enrollment has increased to over 45,000 Medicaid, Healthy Michigan Plan, MIChild, Medicare, and MI Health Link members.

CONTACT INFORMATION

The following is a list of contact information to assist you in making the appropriate contact with the Service departments of the Upper Peninsula Health Plan.

Customer Service…….. 800-835-2556, Option 2 then 1

Fax Number……906-225-7690

Pharmacy Related Authorizations / Questions (Magellan Rx Pharmacy Management)...…. 888-274-2031

Eligibility and PCP Verification……...……...800-835-2556, Option 2 then 1

Non-Pharmacy Prior Authorization and Utilization Management Inquiries 800-835-2556, Option 2 then 3

Non-Pharmacy prior authorization fax number……..906-225-9269

Medical Claims Services……...800-835-2556, Option 2 then 2

Provider and member Appeals fax number…….……..906-225-7720

Provider Relations/Contracting……...……....800-835-2556, Option 2 then 4

UP Blue …….....……800-835-2556, Option 2, then 5

Claims Address:
Upper Peninsula Health Plan
853 West Washington Street
Marquette, Michigan 49855

Electronic Claims Code: 38337

UPPER PENINSULA HEALTH PLAN MEMBER RIGHTS AND RESPONSIBILITIES

Members of the Upper Peninsula Health Plan (UPHP) are entitled to specific rights regarding their health care and related services. UPHP also expects its members to be responsible for certain aspects of their health care and related services. As a provider of services to UPHP members, you should be aware of these rights and responsibilities.

If UPHP members have questions about their rights or responsibilities, please refer them to their Member Handbook, the UPHP Website at www.uphp.com, or to UPHP Customer Service at 800-835-2556.

The following rights and responsibilities are given to UPHP members after they enroll:

Member Rights

- To get high-quality health care.
- To be treated with respect.
- To have full discussions with your doctors about your treatment options and decisions, whether covered or costly.
- To work with your doctors to make health care decisions.
- To be told what services are covered by UPHP.
- To say that you do not want certain care.
- To choose or change your primary care provider (PCP).
- To know the names and backgrounds of your health care providers.
- To have your records kept private and your privacy protected.
- To have your medical and financial records kept private, whether in oral, written, or electronic form.
- To have your medical information disclosed only with your consent (except when required by law, when needed for plan management or for studies and medical research).
- To look at your records or those of your minor dependents at the office of your doctor during the doctor's normal work hours.
- To have your problems taken care of quickly by filing a complaint or appeal.
- To have a fair hearing with the State of Michigan if you are a Medicaid member.
- To get your questions answered about your bills.

- To have medical benefits even if you have or had a long-term illness or problems before you enrolled with UPHP.
- To get help with any special disability needs you may have.
- To get help with any special language or cultural needs you may have.
- To get information about how your PCP is paid.
- To get information about doctor incentives.
- To get information about UPHP.
- To get your rights.
- To know what UPHP expects of you.
- To have the UPHP staff and its providers comply with all of your rights and what UPHP expects of you.
- To make suggestions about member rights, UPHP policies, or what UPHP expects of you.

Member Responsibilities

- Be respectful to your doctors, all health care staff, and the UPHP staff.
- Tell your doctors your full health and social history.
- Follow the advice of your doctors.
- Get care if you are pregnant.
- Ask questions about your care.
- Make and keep appointments.
- Cancel your appointments **24 hours ahead of time** if you cannot go.
- Follow UPHP rules.
- Tell your local Department of Health and Human Services (DHHS) office about name, address, and telephone number changes if you are a Medicaid member.
- Always carry your current UPHP identification card.
- Always carry your current mihealth identification card if you are a Medicaid member.
- Call UPHP if your UPHP card is lost or stolen.
- Tell UPHP, Michigan Medicaid and your doctors if you have other insurance. If you have Medicaid, also tell your local DHHS office.
- Work with your primary care provider (PCP) to manage your health.
- Understand your health problems so that you and your doctors can set treatment goals.

- Work with your UPHP Clinical Services nurse to help manage an ongoing health problem.
- Provide information needed by UPHP or your doctors.
- If you have more than one doctor, ask them to communicate about your care.

ENROLLMENT, ELIGIBILITY, AND DISENROLLMENT INFORMATION

Medicaid

Medicaid is a federal program created by Title XIX of the Social Security Act in 1965, which provides necessary medical and health services to those who would not otherwise have the financial resources to obtain them. Eligibility for services is determined by the Department of Health and Human Services (DHHS) and applications should be filled out at the local DHHS office.

Most people who receive Medicaid must join a health plan. Health plans provide Medicaid-covered health care services for an enrolled group of beneficiaries in a defined service area. After a Medicaid case is opened, Michigan ENROLLS (the State's enrollment broker) will contact the member about their health plan choices. For general questions and further information regarding Medicaid, call Michigan ENROLLS at 888-367-6557.

Upper Peninsula Health Plan is notified each month when Medicaid beneficiaries are assigned to the plan. Members will have two cards; the Upper Peninsula Health Plan will send new members a UPHP identification card and the State of Michigan will send a Michigan Medicaid identification card (referred to as a mihealth card). The mihealth card contains information on the member's Medicaid eligibility, and although the member is enrolled in the Upper Peninsula Health Plan, they should present both cards each time they seek health care or services.

Newborns are automatically enrolled with the health plan the mother was enrolled in on the date of delivery. It should be known that the newborn's mihealth card may not reflect the HMO coverage for 30-60 days.

MIChild

MIChild is a Medicaid program for uninsured children of Michigan's working families. Upper Peninsula Health Plan provides coverage to children less than 19 years of age that reside in the Upper Peninsula of Michigan. The cost is $10 a month for the whole family, even if there is more than one child.

To qualify for MIChild benefits, the child/children must be under the age of 19, a U.S. citizen and Michigan resident, and meet the program's monthly family income limits. MIChild applicants may call MIChild/Healthy Kids toll-free at 888-988-6300 or apply online at the Michigan Department of Health and Human Services website.

UPHP ID Card

UPHP
UPPER PENINSULA HEALTH PLAN

www.uphp.com

Member Name:	**JANE DOE**
Member ID:	**0123456789**
Primary Care Provider:	**THOMAS SMITH**
PCP Phone:	**(123) 456-7890**
Pharmacy:	**Magellan Rx (see back of card)**

This card is for identification purposes only. To ensure payment for covered care, providers should use the Michigan Eligibility Verification System.

KEEP THIS CARD WITH YOU AT ALL TIMES.

If you have questions, call the Upper Peninsula Health Plan (UPHP) at 1-800-835-2556, 24 hours a day, 7 days a week. Call your primary care provider (PCP) shown on the front of this card when you need health care or after UPHP hours. If you have an emergency, go to the nearest hospital. Call your PCP for follow-up care.

CLAIMS: Send all claims on CMS-1500 or UB-04 forms within one year of the service date. Mail ***paper claims*** to Upper Peninsula Health Plan, 853 West Washington Street, Marquette, MI 49855. The payer number for ***electronic claims*** is 38337.

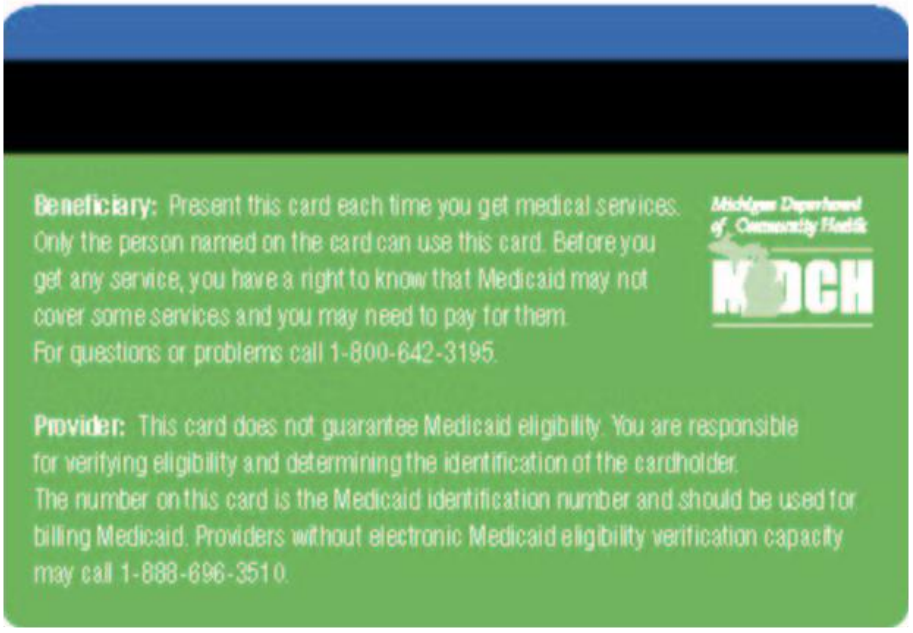
PROVIDERS OUT OF PLAN: You must call UPHP at 1-800-835-2556 before providing care. For emergencies and urgent care, if you call after hours, leave a full message for Customer Service.

HOSPITALS OUT OF PLAN: Covered UPHP members must get approval before admissions that are not for emergencies. Inform UPHP of ***all*** admissions. Call 1-800-835-2556.

PHARMACY BENEFIT MANAGER: Magellan Rx; BIN 017480; PCN 01990000; 1-888-274-2031.

24 HOUR NURSE ADVICE LINE: 1-877-615-2915

mihealth ID Card



Eligibility

A member's eligibility may change monthly; therefore it is the responsibility of all providers rendering services to verify a beneficiary's eligibility at the time of service. Services provided when a member is not enrolled with the Upper Peninsula Health Plan will not be covered.

The following resources should be utilized to check the eligibility status of a member:

CHAMPS Web portal	https://milogintp.michigan.gov
Community Health Automated Medicaid Processing System (CHAMPS)	800-292-2550
UPHP Customer Service Department	800-835-2556, Option 2 then 4

Retroactive Eligibility

Members who are disenrolled from the Upper Peninsula Health Plan due to loss of Medicaid eligibility will be automatically re-enrolled prospectively to UPHP provided that they regain eligibility within two months.

Occasionally, a Medicaid beneficiary may be retroactively determined eligible. Once a beneficiary (other than a newborn) is determined to be Medicaid eligible, enrollment with UPHP will occur on the first day of the next available month following the eligibility determination and enrollment process. UPHP will not be responsible for paying health care services during a period of retroactive eligibility and prior to the date of enrollment in the health plan, with the exception of newborns.

If the beneficiary is in any inpatient hospital setting on the date of enrollment (the first day of the month), UPHP will not be responsible for the inpatient stay or any charges acquired prior to the date of discharge. UPHP will be responsible for all care from the date of discharge forward. On the contrary, if a beneficiary is disenrolled from UPHP and is in any inpatient hospital setting on the date of disenrollment (the last day of the month), UPHP will be responsible for all charges acquired through the date of discharge, with the exception for disenrollment based on CSHCS enrollment.

Direct any questions about a beneficiary who is re-enrolled or gains retroactive eligibility to the UPHP Customer Service Department at 800-835-2556.

Co-Payments

There are no co-payments or deductibles for UPHP covered services for UPHP Medicaid or MIChild members.

Changing a Primary Care Provider

UPHP members will be allowed one Primary Care Provider (PCP) change in a calendar year. Members desiring to change their PCP must call UPHP's Customer Service Department at 800-835-2556. Exceptions to the one change per year rule are:

1. New Members are allowed to change their PCP in the first thirty (30) days of enrollment; thereafter, they are held to the one PCP change per calendar year.
2. Member moves and is more than 30 miles from their current assigned PCP.
3. Practitioner terminates and member has to choose another PCP.
4. Quality of care issues that are substantiated by the Medical Director.
5. Member has a grievance with the PCP or office that cannot be resolved to the satisfaction of the PCP or the member.
6. PCP releases the member from their practice for any reason (i.e. non-compliant behavior).
7. CSHCS members may change their PCP at any time.

If a PCP requests a member to be transferred to a different PCP, the current PCP should inform the member in writing of the reason(s) for terminating the current physician/patient relationship and also inform the member they have thirty (30) days to choose another PCP. The PCP should then send a copy of the correspondence to UPHP at:

Upper Peninsula Health Plan
Customer Service Department
853 West Washington Street
Marquette, MI 49855
Fax: 906-225-7690

When a PCP believes an immediate transfer is necessary, the PCP should contact UPHP's Customer Service Department at 800-835-2556 for assistance.

Disenrollment

UPHP may initiate special disenrollment requests to the Department of Health and Human Services (DHHS) if the member acts in a violent or threatening manner:

Violent/life-threatening situations involve physical acts of violence; physical or verbal threats of violence made against providers, staff, or the public; or stalking situations.

A member may not be disenrolled based on physical or mental health status. If a member's physical or mental health is a factor in the actions conflicting with UPHP membership, UPHP must assist the member in correcting the problem, which includes making the appropriate physical and mental health referrals.

UPHP must make contact with law enforcement when appropriate, before seeking disenrollment of members who exhibit violent or threatening behavior. DHHS may require additional information from UPHP to evaluate the appropriateness of the disenrollment. The effective disenrollment date should be within sixty (60) days from the date DHHS received the complete request. If the member appeals this decision, the effective disenrollment date should be no later than thirty (30) days following the resolution of the appeal.

The PCP should provide UPHP with the following documentation, if applicable, for special disenrollment:

- An Incident Report or summary of member actions.
- A copy of the PCP dismissal letter or correspondence to the member.
- A copy of a police report, including a reference number given by the Police Department.

The documentation should be sent to:

Upper Peninsula Health Plan
Attn: Compliance Officer
853 West Washington Street
Marquette, MI 49855
Fax: 906-225-7690

Benefits Monitoring Program

State and federal regulations require the Michigan Department of Health and Human Services (MDHHS) and Upper Peninsula Health Plan (UPHP) to conduct surveillance and benefits utilization review to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to UPHP members. The Benefits Monitoring Program (BMP) is in place to closely monitor program usage and to identify members who may be potentially over utilizing or misusing their UPHP Medicaid services and benefits.

Enrollment Criteria

The criteria below are used to determine whether a UPHP member may be placed in the BMP. Potential BMP enrollees are identified through a variety of methods such as (but not limited to): data mining activities, medical records reviews, MDHHS BMP-PROM system, and provider referrals. Actual placement in the BMP is determined after review of the member's usage of medical and pharmacy services. Members are enrolled in BMP when UPHP determines any of the following (alone or in combination) criteria apply to an individual:

1. Fraud – the member is suspected, or has been convicted, of fraud for any one or more of the following:
   - Selling or purchasing products/pharmaceuticals obtained through UPHP.
   - Altering prescriptions to obtain medical services, products, or pharmaceuticals.
   - Stealing prescriptions/pads; provider impersonation.
   - Using another individual's identity, or allowing another individual to use the member's identity, to obtain medical services, products, or pharmaceuticals.
2. Misutilization of Emergency Department Services – criteria include, but are not limited to, the following:
   - More than three emergency department visits in one quarter.
   - Repeated emergency department visits with no follow-up with a primary care provider or specialist when appropriate.
   - More than one outpatient hospital emergency department facility used in a quarter.

- Repeated emergency department visits for non-emergent conditions.

3. Misutilization of Pharmacy Services – criteria include, but are not limited to, the following:
   - Utilizing more than three different pharmacies in one quarter.
   - Aberrant utilization patterns for drug categories listed below over a one-year period and/or obtaining more than five (5) prescriptions for the drug categories listed below in one quarter (including emergency prescriptions):
     - Narcotic Analgesics
     - Barbiturates
     - Sedative-Hypnotic, Non-Barbiturates
     - Central Nervous System Stimulants/Anti-Narcoleptics
     - Anti-Anxiety Agents
     - Amphetamines
     - Skeletal Muscle Relaxants

     Utilizing multiple prescribing providers for the drug categories listed above; including when prescribing providers provide services to the member as a private pay patient (i.e. member pays cash for office visits while using the Medicaid pharmacy benefit to obtain prescriptions).

4. Misutilization of Physician Services – criteria include, but are not limited to, the following:
   - Utilizing more than one physician/physician extender in different practices to obtain duplicate or similar services for the same or similar health condition and/or to obtain prescriptions for the drug categories listed above.
   - Utilizing covered services to obtain prescriptions for drugs subject to abuse and paying cash to obtain the drugs.
5. Other:
   - UPHP will review additional criteria as misutilization patterns emerge or are identified by the plan.

BMP Placement Process

All potential BMP candidates are referred to the BMP Committee for review. The BMP Committee verifies that the member meets the minimum BMP criteria. The Clinical Coordinator will then offer care coordination or care management services to the member

to assist with appropriate utilization. If the member fails to work with a Clinical Coordinator and does not improve utilization the BMP committee with complete the UPHP BMP referral form recommending BMP enrollment. If in agreement, the Pharmacy Director, Chief Quality Officer, and Medical Director will sign the form indicating the member is appropriate for BMP placement. Once the Medical Director signs off on the BMP enrollment, a Clinical Coordinator is assigned to the member. The Clinical Coordinator is responsible for sending the notification of enrollment in the BMP to the member's current address on file with the Michigan Department of Health and Human Services (MDHHS). It is the member's responsibility to keep his/her address up-to-date A copy of the letter is also sent to the member's primary care provider (PCP). This notification includes the following:

- Information regarding the utilization patterns and concerns,
- The enrollment effective date, and
- Instructions on the selection of potential providers, which must be approved by UPHP.
    - These providers will coordinate care and provide services for the member. If the member does not respond to the letter and/or does not identify potential providers UPHP will assign providers to the member.

The member is given no less than twelve (12) calendar days to contact UPHP and discuss the findings prior to the BMP enrollment effective date. Enrollment of a UPHP member may be determined by MDHHS or UPHP using approved criteria. Enrollment in the BMP does not constitute a negative action by MDHHS or UPHP. Enrollment of a member in the BMP does not suspend, reduce, discontinue, or terminate any services or assistance that a member is eligible for at the time of that member's enrollment in the BMP.

After the twelve (12) calendar day time period has passed, the assigned Clinical Coordinator informs the UPHP Enrollment Coordinator via a route noted in the Plexis Claims Manager (PCM) that outlines all provider and/or pharmacy restrictions (if applicable) for the member. The Clinical Coordinator also submits the request to MDHHS via the Program Monitoring (PROM) application system. Once the BMP enrollment is in place, UPHP will identify the member as a "special handle member" in its PCM system. All medical claims will be manually reviewed before payment is issued. Notification is also sent to UPHP's Pharmacy Benefit Manager (PBM) to implement prescribing and/or pharmacy restrictions as determined by UPHP.

If a member is restricted to certain providers and/or pharmacies, the Clinical Coordinator will send the member a second letter after the BMP enrollment that lists their BMP assigned providers with the effective date no less than 12 days later. The member is given the opportunity to participate in the provider assignment process in the initial BMP notification letter. If the member does not respond to the first BMP letter and/or does not identify potential providers, UPHP will assign providers to the member. Assigned providers are identified through collaboration with the member's last PCP and review of member utilization patterns. Qualification of assigned providers includes: acceptance of treating BMP member, assisting BMP member with utilization, and following UPHP BMP procedures (i.e. referrals to other providers).

If UPHP has reason to suspect that a selected provider will not contribute to a reduction in utilization, the selection may be denied. UPHP reserves the right to end/terminate provider authorization for a BMP member at any time. A replacement provider will be assigned following such an action. Instances will be determined on a case by case basis following periodic review, and must meet at least one of the following criteria:

- A review of utilization reveals that the provider is not contributing to a reduction in service utilization (including use of drugs subject to abuse) as defined by the BMP,
- The BMP Authorized Provider becomes a sanctioned provider, or
  The BMP Authorized Provider makes referrals to the emergency department for non-emergent conditions.

If the member does not agree with the action to be placed with the selected provider(s), they can ask for a hearing within ninety (90) days of the date of the letter. A Hearing Request form is enclosed with the letter. Members may also request a State Fair Hearing form by calling the UPHP Customer Service Department at 800-835-2556 or by writing to:

State Office of Administrative Hearings and Rules
For the Department of Health and Human Services
P.O. Box 30763
Lansing, MI 48909-9951

Any written notice of a negative action shall include reference to the member's right to appeal. UPHP is the respondent in BMP-related hearing pertaining to actions taken by UPHP for its members.

BMP Control Mechanisms

The BMP has a variety of control mechanisms available to assist the UPHP in managing the BMP members:

- Obtaining drugs subject to abuse
  - Members in the BMP are prevented from filling or refilling prescribed medications in the drug categories (item # 3 under "Enrollment Criteria") until 90 percent of the medication quantity limits would have been consumed in compliance with the prescribed dose, amount, frequency, and time intervals as ordered by the prescribing provider, and consistent with Medicaid limits.
- Assigned Providers – the BMP may assign members to providers through which covered services can be obtained. BMP authorized providers that may be assigned include, but are not limited to, the following:
  - Specific primary care provider (PCP)
  - Specific pharmacy
  - Specific outpatient hospital
  - Specific specialist physician(s)
  - Specific group practice
  - Provider assignments may be used singularly or in combination of any or all of the above as deemed appropriate by the UPHP and/or MDHHS.
- Restricting Benefits
  - In some cases, UPHP may find that a restriction of optional benefits (i.e. pharmacy) is an appropriate intervention. In the event of continued misutilization (as defined in the Benefits Monitoring Program section of the Medicaid Provider Manual), optional benefits may be reduced in accordance with federal and state regulations. Members subject to a benefit restriction will receive written notice of action, the effective and end dates applicable, and appeal information.
- Exempt Services – the following services are exempt from the BMP control mechanisms:
  - Emergency services
  - Dental services
  - DME Services
  - Services rendered by a nursing facility provider
  - Services rendered in an inpatient hospital
  - Hospice services

- Vision services
- Services rendered at Local Health Departments (LDHs)
- Hearing services
- Podiatry services
- Chiropractic services
- Services rendered by a non-prescribing Mental Health provider (i.e. MSW's, PhDs, professional counselors, etc.)
- Sexually Transmitted Infections (STIs) screening/treatment, family planning, and related services

Provider Responsibilities

All providers MUST verify eligibility before providing service(s). BMP members are indicated on the CHAMPS Eligibility Inquiry Response as additional information. If the BMP Provider Restriction Indicator is "Y", the hyperlink will be activated. The hyperlink will open the BMP restrictions page, which contains the BMP authorized provider information. If there is no provider listed, the member is restricted only by the pharmaceutical refill tolerance for that date of service.

It is the responsibility of the PCP to coordinate all prescribed drugs, specialty care, and ancillary services for BMP members. Reimbursement for any ambulatory service will not be made unless the service was provided, referred, prescribed, or ordered by the PCP and/or (if applicable) an approved UPHP BMP notification number is in place.

The PCP **must** complete the UPHP Prior Authorization & Notification Form, with the BMP indicator checked, to notify UPHP of the need to authorize care by other physicians (MD, DO), medical clinics, and outpatient hospitals. This form must be completed and submitted to UPHP **prior** to services being rendered. UPHP will issue a UPHP BMP Notification Number to be billed on all claims provided by the referred provider(s) for the BMP member. This request by the PCP does not replace any prior authorization (PA) required by UPHP (i.e. out-of-network services, cosmetic surgery). All PA requests must follow UPHP Policy # 300-005 Utilization Management Process.

Only a provider listed on the member's BMP Authorized Provider list or having an approved UPHP BMP Notification Number will be reimbursed by UPHP. If a provider already has an approved UPHP BMP Notification Number in place and wishes to order any restricted services and/or restricted medications, or feels referral to another physician is needed, these activities must be coordinated with the member's PCP. The referred

provider or the PCP must either contact the Clinical Coordinator or submit a UPHP PA Form with the BMP indicator checked for the additional requested services **prior** to those services being rendered. This will allow UPHP to issue a UPHP BMP Notification Number for the services or identify the referred provider as an authorized prescriber of a restricted medication.

Monitoring and Evaluating BMP Members

Members are placed in the BMP for a minimum of 24 months. The Clinical Coordinator will gather member information using a collaborative approach, involving the member, PCP, and other appropriate parties as necessary to assess member needs. BMP members will either be placed into UPHP's Care Coordination Program or Complex Case Management Program depending on the needs of the member. See *UPHP Policy #300-001 Complex Case Management* and *UPHP Policy #300-002 Care Coordination* for details on these processes. Interventions are implemented as appropriate and evaluated for effectiveness including education regarding correct utilization of services, assistance with removal of barriers to correct utilization of services, and referral to behavioral health and substance use disorder providers when appropriate. The utilization of medical services and drugs are routinely monitored and cases are discussed at CM meetings to determine if care management, care coordination, BMP, and education have modified behavior. A member enrolled in the BMP will remain in the BMP for the minimum time period, regardless of any change in enrollment status (i.e. change from Fee-for-Service to managed care; break in eligibility, incarceration, etc.) When a member in the BMP has a change in enrollment, responsibility for monitoring the member transfers from UPHP to a different Medicaid Health Plan (MHP) and/or Fee-for-Service Medicaid.

After 24 months of enrollment in BMP each member is reviewed to determine if goals and guidelines have been met and to determine appropriateness of removal from BMP. If a member remains in BMP for over 24 months, the BMP member is reviewed every 3 months for possible BMP disenrollment.

TRANSPORTATION

Non-Emergent Transportation

If patients or clients are Medicaid members of the Upper Peninsula Health Plan (UPHP) and have difficulty obtaining services because of transportation, you may direct them to UPHP for transportation assistance.

UPHP does not provide transportation assistance for the following services:

- Community Mental Health (CMH)
- Medicaid Dental (transportation is provided for Healthy Michigan Plan Dental)
- Substance abuse

Non-emergent transportation may be provided by the most cost-effective means for UPHP members who have no other means of transportation to medically necessary appointments- especially when failure to receive necessary medical services would be detrimental to the members' health.

Members ***must*** contact UPHP's Transportation Department at least ***five business days*** before the date when transportation is needed. To reach the Transportation Department, call 800-835-2556, option 1 then 2.

Emergent Transportation

Emergency transportation is a covered benefit when medically necessary. All emergency transports are subject to retrospective review. UPHP does not schedule, arrange, or coordinate emergency transportation.

QUALITY ASSESSMENT AND IMPROVEMENT AND UTILIZATION MANAGEMENT PROGRAM

The objective of the Quality Assessment and Improvement (QAI) and Utilization Management (UM) program is to facilitate safe, efficient, effective, and economical delivery of services throughout the Upper Peninsula Health Plan (UPHP) network. The QAI/UM program processes incorporate functions to examine the multi-faceted components of health care delivery; to make recommendations where problems are identified; and to implement interventions to improve the quality and safety of health care in accordance with the requirements of federal, state, and accrediting agency standards. The UPHP QAI/UM program promotes an integrated approach to evaluate and improve the quality and safety of medical and behavioral health care and services delivered to members, to manage health care resources, and to improve the processes and outcomes of care provided to members. This program is designed to support a comprehensive approach to identify any sources of variation in outcomes and to implement corrective action when necessary.

Many programs and initiatives are offered by our Utilization Management (UM) Department at Upper Peninsula Health Plan (UPHP). The objective of the UM Program at UPHP is to assure appropriate, timely, and efficient utilization of services in accordance with the requirements of federal, state, and accrediting agency standards.

Who Are We and What Do We Do?

The UPHP Management Committee delegates authority to the Medical Director and the Chief Executive Officer (CEO) of UPHP to ensure the QAI/UM program has the needed resources to meet its goals and to evaluate the program's progress towards goals.

The following committees are integral components to the QAI/UM program:

- UPHP Pharmacy Clinical Advisory Committee (PCAC)
    - Membership is comprised of UPHP Medical Director (chairperson), UPHP Pharmacy Director, Pharmacy Benefit Manager (PBM) representative(s), UPHP network physician members, and a representative from a contracted network pharmacy.

  - Meets on a quarterly basis to review and update policies for pharmaceutical management, discuss drug utilization activities; review fraud, waste, and abuse monitoring reports, and oversees all issues relating to pharmaceutical management.
- UPHP Credentialing Committee
  - Consists of the UPHP Medical Director, and a minimum of four but up to six UPHP primary care or specialist licensed practitioners who routinely provide care to UPHP members.
  - Meets bi-monthly to discuss credential files for providers; Medical Director directs files needing further discussion to the UPHP Clinical Advisory Committee (CAC).
- Clinical Advisory Committee (CAC)
  - Chaired by the UPHP Medical Director and consists of at least six participating physicians who broadly represent the composition of the UPHP provider network, two behavioral health care practitioners (one psychiatrist and one outpatient psychologist – both of which serve as advisors in the development and oversight of all daily behavioral health related quality improvement activities), UPHP CEO, UPHP Chief Quality Officer, UPHP Director of Pharmacy, and other UPHP and/or practitioner representatives as required.
  - Meets at least four times a year (or more frequent if urgent situations transpire) to discuss approval and oversight of the clinical services components of the QAI/UM Work Plan and activities, and related policies and procedures for all UPHP members; reviews pharmacy management issues forwarded from the UPHP PCAC as well as identified practitioner and provider issues forwarded from the UPHP Credentialing Committee.
- Service Advisory Committee (SAC)
  - Chaired by Chief Operations Officer and consists of the staff members from the Provider Relations, Information Systems, Customer Service, Claims, Pharmacy, and Clinical Services departments.
  - Meets on a quarterly basis to discuss goals related to service quality, member satisfaction, access and availability, and to oversee all activities related to service quality for improvement for members.
  - Recommends policy decisions; analyzes and evaluates results of service QAI activities; institutes needed action and assures follow-up as appropriate; educates members about both kinds of benefits for which they are eligible.

UPHP Quality Assessment and Improvement (QAI) Functions and Activities

The UPHP QAI/UM program collects, integrates, analyzes, documents, and reports data necessary to implement the QAI functions and activities by utilizing multiple sources (such as medical record audits, disease management programs, and chronic care improvement programs). The QAI/UM program evaluation analyzes the quality, safety, and appropriateness of services and care for UPHP members and helps identify the most vulnerable members of the population for which it can design quality improvement activities.

UPHP selects, prioritizes, and conducts quality improvement projects relevant to its members designed to achieve—through ongoing measurement and intervention—beneficial effects on health outcomes and member satisfaction. Examples of quality improvement projects are: evaluation of service and benefit utilization rates, timeliness of referrals or treatment, quality of life indicators, and chronic disease outcomes.

UPHP continually monitors its own performance on a variety of dimensions of care and services for members, identifying areas for potential improvement, implementing individual projects with system interventions to improve care, and monitoring the effectiveness of the interventions.

To provide for overall quality functioning as a managed care plan, UPHP continuously monitors important aspects of care. The following components are integral to the QAI/UM program:

- *Behavioral Health Services*: UPHP coordinates care between medical and behavioral health care practitioners for appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.
- *Patient Safety*: UPHP fosters a supportive environment for practitioners and providers to improve the safety of the services delivered in their practice through member and network provider/practitioner education and program activities.
    - *Population Health Management and Health Equity:* To assure equal distribution of health outcomes across the entire UPHP membership, UPHP maintains a Population Health Management Program. This program analyzes data to determine areas for improvement and evaluates strategies implemented to achieve equitable outcomes within the UPHP membership. Health Equity based on race,

ethnicity, gender, age, linguistics (primary language), and disability including deafness/difficulty hearing, geographic location or income level; social determinants such as food security housing stability education, family needs, utility stability; and complex medical conditions are key focus areas of the program.

- *Health Services Contracting*: UPHP contracts with individual practitioners and providers, and those making UM decisions specify that contractors cooperate with the UPHP QAI/UM program, and include an affirmative action statement that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations. Contracted providers must cooperate with QAI activities and allow UPHP access to medical records to the extent permitted by state and federal law, and must maintain the confidentiality of member information and records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) requirements and privacy laws.
- *Availability of Practitioners*: Provider availability standards are delineated in UPHP Provider Availability policies which ensure that the number and geographic distribution of primary care providers (PCP), specialty care providers, and the cultural, ethnic, and linguistic needs of the member population are being met.
- *Accessibility of Services*: Accessibility of services standards are delineated in UPHP Access for Primary Care Provider and Behavioral Health Care policies to be sure performance on access standards for preventative, routine, and urgent care appointments, and after hours care are in accordance with policy standards. Member complaints and grievances are used to assess the adequacy of the network for provider member access.
- *Member Satisfaction*: The performance of UPHP providers and services is monitored through an annual CAHPS member satisfaction survey which assesses member satisfaction with their health plan's health care quality and performance and is completed in conjunction with the Centers for Medicare and Medicaid Services (CMS) and Michigan Department of Health and Human Services (MDHHS).
- *Member Grievances*: Member complaints, grievances, and appeals reports are tracked according to UPHP policy, CMS requirements, MDHHS contract requirements, Department of Insurance and Financial Services (DIFS) regulations, and National Committee for Quality Assurance (NCQA) standards. The data is analyzed to identify opportunities for improvement, implement improvement efforts, and evaluate the effectiveness of the interventions.

- *Disease Management*: Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies population with, or at risk for, chronic medical conditions. Disease management supports the practitioner-patient relationship and plan of care, emphasizing the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies (such as self-management). It continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health. UPHP's disease management program currently addresses the needs of members with diabetes and childhood obesity. UPHP works with both practitioners and members to manage such issues as comorbid conditions, lifestyle, and medications. For more information, contact Clinical Services.
- *Care Management*: Complex case management is the coordination of care and services provided to members who have experienced a critical event or have complex needs, such as individuals with physical or developmental disabilities, multiple chronic conditions, and severe mental illness that requires the extensive use of resources and who need help navigating the system to facilitate appropriate deliver of care and services. A collaborative person-centered approach involving the member, provider, and other Care Team members is used to develop an individualized care plan, which is updated annually, or as the member's health status changes. Providers are encouraged to refer members for care management services.
- *Care Coordination*: The entire UPHP organization assists in coordinating services provided to members, who require minimal use of resources, to facilitate appropriate delivery of care and services. The goal of care coordination is to help members regain (or maintain) optimum health in the right setting in a cost effective manner, but does not require comprehensive assessment plans, monitoring, and follow-up. Providers are encourages to refer members for care coordination services.
- *Interdisciplinary/Holistic Clinical Practice Guidelines and Protocols*: Clinical Practice Guidelines (CPG) are based on scientific data and expert opinion and developed and/or approved by the UPHP CAC and appropriate UPHP contracted providers. Information on the guidelines is communicated and made available to all appropriate practitioners in the UPHP network through new practitioner orientation packets, newsletters, UPHP website, and upon request through UPHP Customer Service. The CPG's are used as the basis for development and implementation of the UPHP disease management and case management programs.
- *HEDIS*: These performance measures are used to identify opportunities for improvement and to demonstrate performance in important clinical areas. These

measures include (but are not limited to) preventive care, chronic care, acute care, and care management services. The results of these performance measures are used to evaluate the QAI/UM program. Data from these measures are also helpful for monitoring disease management and chronic care improvement programs.

- *Service Quality Improvement*: CAHPS surveys measures are used to identify opportunities for improvement and to demonstrate improvement in important health care service areas. The results of service quality improvement activities are incorporated into the UPHP QAI/UM Work Plan as opportunities for improvement and are identified by the UPHP SAC and as required by regulatory and accrediting standards.
- *Medical Record Documentation Standards*: Per the UPHP Network Provider Medical Record Documentation Standards policy 300-026, medical records must be maintained in a manner that is complete, current, detailed, organized, comprehensive and which permits effective and confidential patient care and reporting of clinical information for each member. This policy is available to providers on the UPHP website or by calling the UPHP Customer Service Department. UPHP assesses compliance with medical record standards and develops action plans with providers not meeting requirements.
- *External Quality Review (EQR) Findings*: MDHHS arranges for an annual, external independent review of the quality, timeliness, and accessibility to services provided by UPHP providers. The findings from the review are addressed through the UPHP QAI program and are compared to other data gathered by the QAI program. Results from the EQR are included as appropriate in the annual UPHP QAI/UM Work Plan as opportunities for improvement are identified by the UPHP CAC and as required by MDHHS requirements.

UPHP Utilization Management (UM) Functions and Activities

The UPHP Medical Director is responsible for oversight of the UM program activities and integration with quality improvement, peer review, credentialing, and other clinical services functions, to ensure optimal efficiency and effectiveness as it relates to provider clinical practice patterns and the quality of care members receive.

UM involves the evaluation of medical necessity and cost effectiveness of health care services delivered to members, using accepted, standardized UM criteria and methodologies to determine benefits coverage and medical necessity in accordance with regulatory and accrediting standards, MDHHS/CMS requirements, and UPHP policies.

UM activities are incorporated into QAI processes to the extent possible. UM is considered integral to the quality of care and services in the respect that UM decisions must be congruent with optimal quality of care and services for UPHP members. The following components are integral to the UM program:

- *Clinical Criteria, Timelines, Information, and Communication for Decisions and Appeals*: For detailed information on the UM decision making process, refer to UPHP policy 300-005 Utilization Management Process, which is also outlined later in this chapter. For detailed information on the clinical appeals processes, refer to UPHP policy 300-024 Member Appeals Related to Utilization Management Adverse Determinations.
- *Evaluation of New Technology:* UPHP evaluates new health care services to ensure members have equitable access to safe and effective care using a systematic process to evaluate the inclusion of new medical technologies and the new application of existing technologies in the care of members; this includes medical and behavioral health procedures, pharmaceuticals, and devices. The communication and oversight of this process is in accordance with UPHP policy 300-021 Review of New Medical Technology.
- *Assessing Experience with the UM Process :* UPHP collects and analyzes data regarding member and annually to identify any improvement opportunities and take any action to improve member and provider experiences with the UPHP UM department.
- *Emergency Services:* Emergency services are provided without the requirement of pre-authorization, for both in-plan and out-of-plan providers acknowledging the "prudent layperson" standard. Members are not held financially liable for emergency room services, and service claims are not reviewed for medical necessity. All emergency services claims are paid in accordance with UPHP policy 300-022 Emergency Services.
- *Procedures for Pharmaceutical Management:* The UPHP PCAC develops and maintains updates of the procedures for pharmaceutical management, which include the criteria used for decisions about classes of pharmaceuticals and criteria within classes (which are based on clinical evidence from appropriate external organizations.) These procedures address how to use the pharmaceutical management system; explanations of any limits or quotas; explanations of how prescribing practitioners must provide information in support of exception requires;

and the process for generic substitution, therapeutic interchange, and step therapy protocols.

- *Affirmative Statement about Incentives:* UPHP informs members, providers, practitioners, and UPHP employees' that UM decision making is based only on appropriateness of care and service and existence of coverage. UPHP does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. UPHP does not provide financial incentives for UM decision makers to encourage decisions that result in underutilization.
- *Behavioral Health Care:* Behavioral health is carved out by the State of Michigan for its Medicaid members with the exception of 20 outpatient behavioral health visits per calendar year. UPHP does not have a centralized triage and referral process for behavioral health services; UPHP does not review for medical necessity, and thus does not deny benefit coverage within the 20-visit benefit for Medicaid members. UPHP will review for availability of services in-plan if there is a request for a member to see an out-of-plan provider.
- *Peer Review:* Practitioner peer review is used to determine provider performance against UPHP CAC approved standards of care. Some aspects of the review involve: service site and access, use of diagnostic procedures, and coordination of transfers or changes in service sites when other sites/services are more appropriate. Peer review activities are considered confidential and subject to protection. *Data Integrity Evaluation:* This refers to the process that identifies the data sources to be used in QAI and UM activities and ensures that the data received is accurate, timely, complete, and reliable. UPHP collects and integrates data from all components of its network in order to develop a comprehensive picture of a member's needs and utilization, including changes over time, so that it may improve patient care. UPHP complies with all HIPAA requirements and privacy laws in regard to the collection, maintenance, and reporting of data.
- *Provider Credentialing Profiles:* UPHP's Clinical Services provides input to the credentialing/contract monitoring function in accordance with UPHP policy 200-002 Credentialing and Recredentialing. Pertinent clinical information is provided to the Credentialing Committee to ensure that all network providers meet and maintain established standards in accordance with CMS requirements and regulatory and accrediting standards.
- *Annual QAI/UM Program Evaluation:* The QAI/UM program is evaluated annually by the UPHP CAC and the UPHP SAC to determine program effectiveness, compare activities to the program goals and objectives, and to evaluate the improvements in

the quality of clinical care and service to the members. The evaluations include evidence that program activities have contributed to meaningful improvements, using quantifiable measurements, to determine the impact of the program in the quality of clinical care and of service provided to members and providers. The reports provide a basis for the program revisions and the work plan for the following year.

- *Annual QAI/UM Work Plan:* The QAI/UM work plan identifies the specific annual quality and utilization goals and objectives, including the following information relative to the activities planned to reach each objective: current performance and target goals, planned interventions, project dates, and responsible individuals. The work plan includes planned monitoring of previously identified issues as delineated in the annual program evaluation and provides a mechanism to track issues for closure and timeliness.
- *Confidentiality of Program Information:* Use of member information is restricted to purposes directly related to the administration of the services required under the contract, or release required by law. This is further described in related UPHP policies 104-007 Confidentiality of Member Information and 104-015 Disposal of Protected Health Information. Information required to study behavioral health shall be protected as is required by law. Information required to study and evaluate the quality of care and services, including cost-effectiveness, is made available only to those on a need to know basis that are active participants in the review process.
- *Communication of Program Results:* UPHP notifies practitioners and members at least annually about the availability of the QAI/UM program results upon request. There is ongoing communication of relevant quality and utilization evaluation findings to the practitioners, providers, and members, which identifies variation compared to the established standards and provides discussion of clinical standards and expectations of UPHP.
- *Delegation and Coordination of Quality and Utilization Activities:* UPHP may delegate and/or coordinate QAI and/or UM activities with another health care entity that is part of the UPHP network through the use of a mutually agreed upon document which describes the roles and responsibilities of UPHP and the delegated/coordinating organization. Prior to delegation, UPHP will evaluate the agency's capacity to perform the activities. The agency must submit its QAI and/or UM program description and work plan annually.

Complex Care Management

The Upper Peninsula Health Plan's (UPHP) complex case management (CCM) program is designed to help providers manage the care of their members who have diabetes, congestive heart failure, high-risk pregnancy, hypertension, uncontrolled asthma, chronic pain, or other complex conditions. The program's objective is to help members with chronic and complex conditions obtain access to care and obtain services needed to help them self-manage their disease.

CCM Clinical Coordinators help to identify members and provide support and interventions. They complement the primary care provider's (PCP) plan of care to help members to better manage their individual complex disease.

Clinical Coordinators' interventions include:

- Care coordination between providers.
- Individualized plans of care with short-term and long-term goals.
- Care coordination between providers and community organizations.
- Transportation help when needed.
- Telephone calls to members.

The role of the CCM Clinical Coordinator is to support the plan of care set by providers. This program supplements that plan of care to help members achieve the best outcomes possible.

Providers who care for a member they feel would benefit from care management can call Clinical Services at 1-906-225-7921 or 1-800-835-2556. To refer a member, you may also complete the Clinical Services Care Coordination/Case Management Referral Form and fax it to our office. The form is available for download on the UPHP website at www.uphp.com or by calling the UPHP Clinical Services Department.

Utilization Management Prior Authorization and Notification Process

The Upper Peninsula Health Plan (UPHP) uses an integrated approach to coordinate and promote optimal utilization of health care resources, make utilization decisions that affect the healthcare of members in a fair, impartial, and consistent manner, and assist with transition to alternative care when benefits end, should a member no longer be eligible for UPHP benefits.

UPHP Utilization Management contact information:

Telephone	1-800-835-2556 (option 2 then press option 3)
Fax	1-906-225-9269

Prior Authorization

Prior authorization decisions are made upon determination of compliance with appropriate criteria. *Prior* ***authorization is required in order to receive payment for services***.

The following services require ***prior authorization*** from the Upper Peninsula Health Plan Clinical Services:

- **Out-of-Plan Services**
  - Elective inpatient admission
  - Practitioner services
  - Facility services
  - Durable medical equipment and supplies
- **Medically Necessary Weight-Reduction Services**
- **Medically Necessary Reconstructive Surgery**
- **Chiropractic Visits exceeding 18-visit limit**
- **Durable medical equipment/medical supplies listed on the UPHP website**
- **Durable Medical Equipment and Medical Supplies Not Meeting Medicaid Guidelines (except for home infusion S codes based on diagnosis)**
- **Physical and Occupation therapy exceeding the 144 Units of initial therapy**
- **Speech therapy exceeding 36 visits of initial therapy**
- **Medical services not meeting the Michigan Medicaid provider manual standards of coverage**

- **Outpatient hospital services for dental care requiring anesthesia.**

Notification

Notification is required in order to receive payment for services; however, notification does not involve the application of clinical criteria for an authorization decision. Notification is required to trigger necessary care-coordination and care-management activities on the part of UPHP. Services that require notification to UPHP Clinical Services include, but are not limited to, the following:

- **Urgent/Emergent Inpatient Admissions-** ***within one business day of admission***
- **Urgent/Emergent Observation Services –** *within one business day of admission*
- **Skilled nursing facility admissions-**within one business day of admission
- **Swing bed admission-**within one business day of admission

The process for prior authorization or notification is as follows:

Provider verifies:

- **Member is currently a UPHP member**
- **Requested service is a covered benefit**
- **Requested service requires prior authorization or notification**
- Prior authorization requests are to be done by the PCP or in-plan specialist
- UPHP will accept prior authorization (PA) requests from Out-of-Plan (OOP) providers under the following circumstances:
    - Emergency Department (ED) follow-up visits to OOP Specialist
    - Hospitalized follow-up to OOP Specialists
    - OOP Provider has current PA on file
    - Prior Authorizations that have been approved by the Michigan Department of Health and Human Services for members who were previously on Fee for Service Medicaid until the member is able to safely transition to UPHP in-network providers.
    - Newly eligible UPHP members who are in active course of treatment with OOP provider
    - UPHP member has moved out of the UPHP provider area and not disenrolled from UPHP.

- Provider submits required documents by fax (preferred) or mail. Requests by phone are taken only in urgent/emergent situations. Required documents include:
  - Appropriate prior authorization/notification request form. UPHP forms are available from Customer Service or the UPHP Website at http://www.uphp.com/providers/forms-links/
  - Clinical information to support the request as indicated on the form

Prior authorization must be obtained **before** services are provided. Retrospective requestswill be administratively denied for not following UPHP UM polices and procedures. Authorization does not guarantee payment. Benefit determinations are subject to diagnosis eligibility, member eligibility, and plan benefits at the time when a service is provided.

For more information on UPHP utilization management and prior authorization policies and procedures go to http://www.uphp.com/providers/utilization-management/. You may also call the UPHP UM department at 906-225-7774.

CLAIMS

Electronic Claims Submission

UPHP accepts and encourages all providers to submit claims electronically, including secondary claims. Electronic claims will be submitted using the following information:

National Electronic Insurance Code (N.E.I.C.) # **38337**

UPHP has a secure provider portal, which can be used to status claims and email questions. For access, visit the UPHP website at www.uphp.com and select "Login" in the upper right hand corner. For EDI claim submission issues, please contact the UPHP Claims Department at 800-835-2556.

Billing Address

Upper Peninsula Health Plan
853 West Washington Street
Marquette, MI 49855

Please contact the UPHP Claims Department for claims questions at 800-835-2556, Monday – Friday, 8 a.m. – 5 p.m. EST. Please have the Member ID, Date of Service, charge amount, and/or Claim Number ready when calling to ensure timely assistance. If you have multiple claim issues, please feel free to fax or email a list for our review. Please include the member ID #, date of service, and charge amount. UPHP's fax number is 906-225-7690 and you may email UPHP's Claims Services at claimservices@uphp.com.

Provider Registration

All ordering/referring and attending providers must be enrolled and active in the Michigan Medicaid program on the date the claim is adjudicated. All plan providers are required to register in CHAMPS. Visit the Michigan Department of Health and Human Services website for more information and instructions on registering in CHAMPS:

http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-145006--,00.html

Failure to register in the Michigan Medicaid CHAMPS system may result in claim denials.

Claims for services rendered as a result of an order or referral must contain the name and individual National Provider Identifier (NPI) of the practitioner who ordered or referred the items or services. All practitioners who order/refer services for Michigan Medicaid beneficiaries must be enrolled/registered in the Michigan Medicaid program. In addition, for all institutional claims, the attending physician must be Medicaid-enrolled.

Claims Submission Guidelines

Filing Limit

- Claims must be sent to UPHP within 365 days from the date of service.
- If a claim is submitted to Medicaid or another HMO in error prior to the claim being submitted to UPHP, the submission limit is not extended. Eligibility must be verified prior to rendering services.
- UPHP responds to claims within State processing guidelines. The Claims determination will be reported to the provider on an Explanation of Payment (EOP) / Remittance Advice (RA).
- If no response is received within 45 days on a submitted claim, please call the UPHP Claims Department at 800-835-2556.
- All claims received after the filing limit will be denied and members may not be billed.

Claim Forms

- Professional charges must be submitted on a CMS 1500 02-12 version form
- Facility charges on a UB-04 Form

Paper Claim Submission Guidelines

- Must use original forms – faxed copies will not be accepted.
- Must be typewritten or computer generated – handwritten forms will not be accepted.
- Do not use highlighters, white-out, or any other markers on the claim.
- Avoid script, slanted, or italicized type. 12 point type is preferred.
- Do not use an imprinter to complete any portion of the claim form.
- Do not use punctuation marks or special characters.

- Use a 6 digit format with no spaces or punctuation for all dates (i.e. May 1, 2013 would be 050113).

Claims Policies

Adjudication

UPHP adjudicates claims according to the State of Michigan Medical Services Administration (MSA) policies and procedures. Reference the Uniform Billing Guidelines, ICD-10Diagnosis Code Book, CPT Code Book, HCPCS and Michigan Department of Health and Human Services (MDHHS) website at www.michigan.gov when submitting a claim.

Payment

Contracted and non-contracted providers will be paid for **covered services** according to the MDHHS Medicaid Fees in effect at the time of service, or the billed charges, whichever is less, unless other arrangements have been made.

Corrected Claims

- Providers may resubmit claims with correction(s) and/or change(s), either electronically or paper.
- To avoid rejection of duplicate submissions submit your entire corrected claim, not just the line items that were corrected.
- For electronic HCFA 1500 claims, enter claim frequency type code in the 2300 loop, enter the original claim number in the 2300 loop in the REF*F8 and add a note explaining the reason for the resubmission in loop 2300 NTE (segment) ADD (Qualifier).
- For paper claims, complete box 22 to include a 7 and the original claim number and add a note to indicate the reason for the resubmission.
- For Paper CMS 1500 claim form: Enter “RESUBMISSION” or “CORRECTED CLAIM” in box 19.
- For Paper UB04 claim form: Type of bill must be indicated on the form. Enter “RESUBMISSION” or “CORRECTED CLAIM” in box 80.

Newborn Care

Newborn care must be submitted on the appropriate claim form using the newborn's Medicaid ID number. The mother's Medicaid ID number may **not** be used to bill for services provided to a newborn.

National Drug Code (NDC)

Per the MSA 10-15 and MSA 10-26 Bulletins regarding the billing of drug codes along with the appropriate NDC code for reimbursement, submitting claims with a missing or invalid NDC drug code will result in delay of payment or denied claim. For additional direction regarding appropriate codes, reference the newest NDC coding guidelines. For further information on how to bill accordingly, reference Michigan Department of Health and Human Services (MDHHS) bulletins MSA -7-33 and MSA 07-61 from 2007 and 2008.

This requirement is mandated to ensure MDHHS compliance with the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148.

Provider National Identification Number (NPI)

Upper Peninsula Health Plan Required Fields:

CMS 1500	Required?	Field Location
Billing Provider NPI	Yes	Box 33a
Rendering Provider NPI	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a
Taxonomy Code	No	Boxes 24j, 33b, and 32b
UB04	**Required?**	**Field Location**
Billing Provider NPI	Yes	Box 56
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77j
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79
Taxonomy Code	No	Boxes 57, 76, 77, 78, and 79

Coordination of Benefits

As a contracted provider treating members of the Upper Peninsula Health Plan (UPHP), your cooperation in notifying UPHP when any other coverage exists is appreciated. This includes other health care plans or any other permitted methods of third party payment. The Michigan Medicaid program is always the payer of last resort.

- Claims with coordination of benefits with primary insurance carriers should be received by UPHP within 365 days from the date of service.
- If UPHP reimburses a provider and then discovers other coverage is primary, UPHP will recover the amount paid by UPHP.
- Regardless of the primary payer's reimbursement, UPHP should be billed as the payer of last resort for all services rendered. A copy of the primary payer's EOB showing payment or denial must be attached to the claim when submitting on paper, or the claim can be submitted electronically for secondary consideration.
- UPHP will only make a payment if the primary insurance payment is less than the Medicaid fee up to the charge amount, whichever is less.
- UPHP members must not be billed for any outstanding balance after UPHP makes payment.
- UPHP Medicaid members do not have deductibles, copayments or co-insurance.

Interim Billing

UPHP does accept claims billed with an interim bill type of outpatient services, containing a 2, 3, 4, etc. in the forth position of the type of bill. All claims must be billed with the admit through discharge information. In the case of continuing or repetitive care, such as physical therapy, facilities must bill on a monthly basis with service dates listed per line.

Billing Tools

The following list includes helpful tools that are highly recommended for each biller/coder to use on a daily basis:

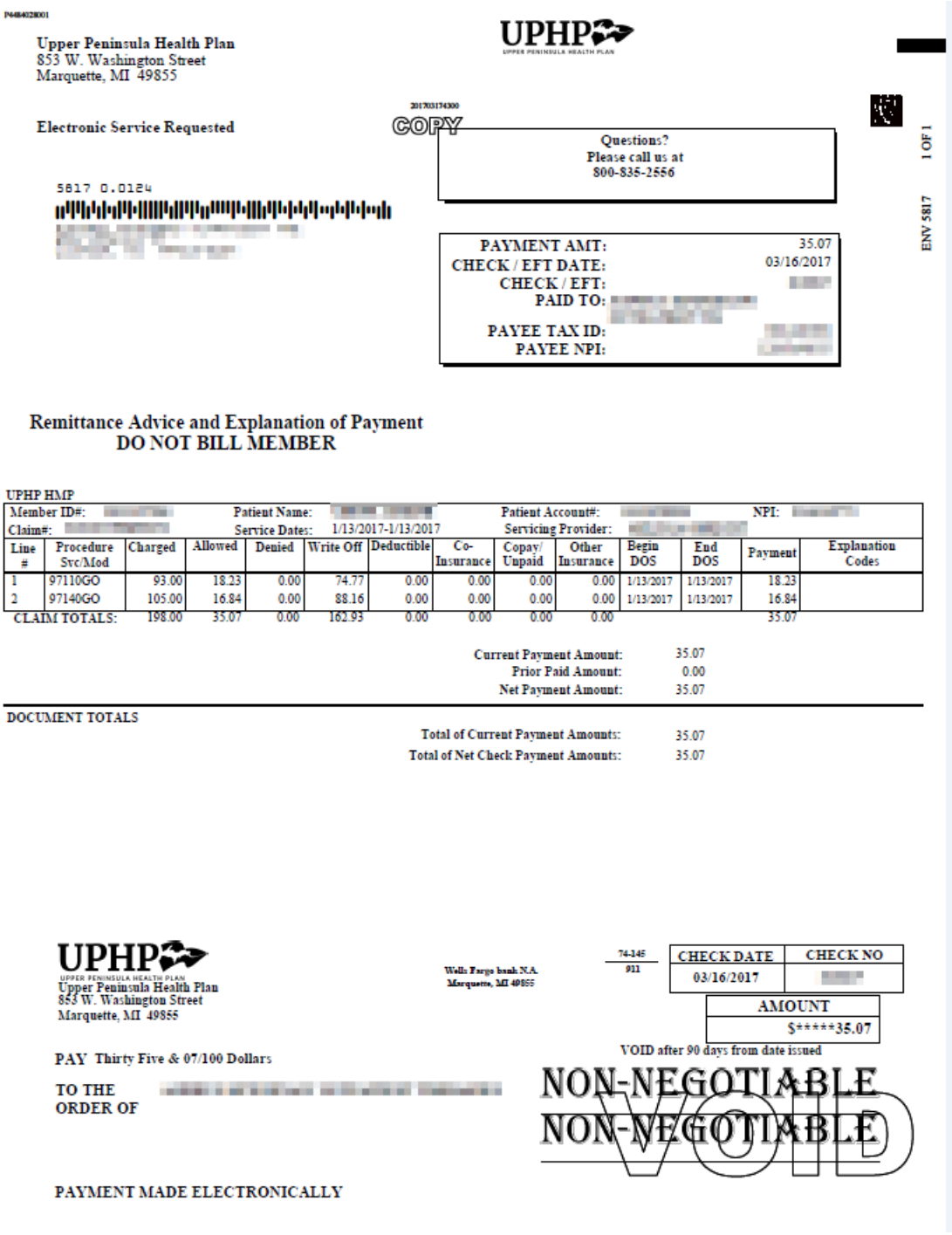
- *Michigan Medicaid Provider Manual* – This manual gives detailed instructions on Michigan Medicaid benefits.

- *CHAMPS – Medicaid Code and Rate Reference* – This tool contains the most current fees with diagnosis and unit limits as well as billing guidelines. It should be checked regularly for changes, updates, and revisions.
- *Medical Services Administration (MSA) Bulletin Updates* – these updates indicate benefit, procedural, or reimbursement changes.

Billing Reminders

- Do not continue to bill if you are unclear why an initial claim was rejected. Contact the UPHP Claims Department for clarification.
- Facility billing must match physician billing.
- UPHP will only research claims for one year after the date of service.

Sample Remittance Advice (RA)



P4484028001

Upper Peninsula Health Plan
853 W. Washington Street
Marquette, MI 49855

UPHP
UPPER PENINSULA HEALTH PLAN

Electronic Service Requested

20170317A300
COPY

Questions?
Please call us at
800-835-2556

5817 0.0124

[redacted]

PAYMENT AMT: 35.07
CHECK / EFT DATE: 03/16/2017
CHECK / EFT: [redacted]
PAID TO: [redacted]
PAYEE TAX ID: [redacted]
PAYEE NPI: [redacted]

ENV 5817 1 OF 1

Remittance Advice and Explanation of Payment
DO NOT BILL MEMBER

UPHP HMP

Member ID#: [redacted] Patient Name: [redacted] Patient Account#: [redacted] NPI: [redacted]
Claim#: [redacted] Service Dates: 1/13/2017-1/13/2017 Servicing Provider: [redacted]

Line #	Procedure Svc/Mod	Charged	Allowed	Denied	Write Off	Deductible	Co-Insurance	Copay/ Unpaid	Other Insurance	Begin DOS	End DOS	Payment	Explanation Codes
1	97110GO	93.00	18.23	0.00	74.77	0.00	0.00	0.00	0.00	1/13/2017	1/13/2017	18.23	
2	97140GO	105.00	16.84	0.00	88.16	0.00	0.00	0.00	0.00	1/13/2017	1/13/2017	16.84	
CLAIM TOTALS:		198.00	35.07	0.00	162.93	0.00	0.00	0.00	0.00			35.07	

Current Payment Amount: 35.07
Prior Paid Amount: 0.00
Net Payment Amount: 35.07

DOCUMENT TOTALS

Total of Current Payment Amounts: 35.07
Total of Net Check Payment Amounts: 35.07

UPHP
UPPER PENINSULA HEALTH PLAN
Upper Peninsula Health Plan
853 W. Washington Street
Marquette, MI 49855

Wells Fargo bank N.A.
Marquette, MI 49855

74-145
911

CHECK DATE	CHECK NO
03/16/2017	[redacted]

AMOUNT
$*****35.07

VOID after 90 days from date issued

PAY Thirty Five & 07/100 Dollars

TO THE ORDER OF [redacted]

NON-NEGOTIABLE
NON-NEGOTIABLE
VOID

PAYMENT MADE ELECTRONICALLY

PROVIDER APPEALS

When a provider disagrees with a determination made by UPHP regarding payment for Medicaid covered services, they may file an appeal in writing to UPHP, 60 calendar days from the remittance notification date. UPHP may allow more time to file the appeal if the provider provides good reason for missing the timeframe. UPHP will issue its reconsidered determination in writing and mail the determination no later than 60 calendar days from the date UPHP received the request for payment reconsideration. UPHP designates persons who were not involved in the making of the initial organization determination when to review reconsiderations. If the denial is based on lack of medical necessity, the reconsideration is reviewed by a physician with the expertise in the field of medicine that is appropriate for the services at issue. An inquiry is not subject to the appeals process.

To file an appeal, the provider must have submitted a claim for the service and/or supplies in question, and received a denial or reduction in payment from UPHP. The provider must submit a written request explaining the basis for the appeal to UPHP which includes the following:

- Member name
- Member identification number
- Remittance notification showing the denial
- Supporting documentation such as proof of timely filing, medical records, reason for not obtaining authorization, or other information that supports the appeal or is pertinent to the appeal.
- The name, address, and telephone number of the person responsible for filing the appeal

All provider appeal requests are to be mailed or faxed to:

Upper Peninsula Health Plan
Attn: Review and Appeals Coordinator
853 W. Washington Street
Marquette, MI 49855
Fax: 906-225-7720

If UPHP does not receive the required documentation within 60 calendar days of UPHP receipt of appeal request, the request for appeal will be dismissed. UPHP will send written notification of the dismissal. UPHP will outreach via phone and in writing to the appealing party to obtain the needed information prior to dismissal.

UPHP will process the reconsideration request and provide a written response within 60 calendar days. This is the final reconsideration from UPHP.

If a hospital disagrees with the UPHP reconsideration, they may submit a request to MDHHS for Rapid Dispute Resolution. UPHP must comply with the Hospital Access Agreement for any non-contracted hospital providers. This applies solely to disputes with non-contracted hospital providers that have signed the Hospital Access Agreement. Non-contracted hospital providers that have not signed the Hospital Access Agreement do not have access to the Rapid Dispute Resolution process.

When a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement requests arbitration, UPHP will participate in a binding arbitration process. Providers must exhaust the UPHP internal provider appeal process before requesting arbitration.

MDHHS will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These arbitrators will have the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid. The party found to be liable will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

Member Appeals Related to Utilization Management Adverse Determination

When an adverse determination is made, a written statement is provided in easily understandable language containing the reason for the adverse determination. Members will be informed of their appeal rights, including the UPHP appeal process and the State Fair Hearing process and will be provided with a copy of any and all applicable appeal forms (Request for Hearing form DCH-0092 and/or FIS-0018 form) in a culturally and linguistically appropriate manner. Members may file an appeal with any UPHP

employee and have 90 days from the date of the notification of an adverse determination to file an appeal with UPHP.

Members will be offered assistance completing appeal forms and with the appeals process. Interpreter services will be offered and TTY/TDD toll free number will be provided.

A member may designate an authorized representative to act on their behalf using the Authorized Representative for Appeal Form (ARAF). An appeal request submitted by someone other than the member, including a provider, is not considered received without an ARAP. The ARAF must be submitted within the 90 day appeal time frame. The UPHP response time frame will begin on the date the ARAF is received. The ARAF is provided in the denial notice.

UPHP members who are beneficiaries of Michigan Medicaid have the right to request a State Fair Hearing with the State Office of Administrative Hearings and Rules within 90 days of notice of the adverse determination. Members do not have to be in the appeal process with UPHP to file a hearing request with MDHHS. UPHP members who are not Michigan Medicaid beneficiaries are not eligible to request a State Fair Hearing. UPHP will describe the State Fair Hearing process in any adverse action notices to members. Members must complete all levels of internal appeal process before seeking external review with DIFS.

UPHP must continue member benefits during the appeal process if all of the following conditions apply:

- The appeal is filed timely, meaning on or before the later of the following:
    - Within 10 days of UPHP mailing the notice of action
    - The intended effective date of UPHP's proposed action
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The authorization period has not expired
- The member requests extension of benefits

UPHP may recover the related costs if:

- The decision to deny service is upheld.
- The member withdraws the appeal
- The member fails to attend the hearing.

Member Preservice Appeal Process (expedited appeal will follow the same process with appropriate time frames):

A member appeal may be initiated by writing or calling:

Upper Peninsula Health Plan
Member Appeal Coordinator
853 West Washington St.
Marquette, MI 49855
Phone: 906-225-7500 or Toll Free: 888-904-7526
Fax: 906-225-7720

A panel comprised of two or more individuals not involved in the initial determination and not subordinate to any person involved in the initial determination will review the appeal. For medical necessity appeals, this panel will include (at minimum) the Chief Quality Officer and a practitioner of same or similar specialty having appropriate clinical expertise in treating the member's condition or disease and not subordinate to a prior deciding practitioner.

In reviewing appeals for UPHP CSHCS members, UPHP will utilize an appropriate pediatric subspecialist provider to review decisions to deny, suspend, terminate, or limit pediatric subspecialist provider services. The member will be notified of the determination of the panel within the time frames defined in this policy.

The member has the right to attend a meeting, or participate via phone, and address the panel during this review. If a meeting is requested, the Member UM Appeals Coordinator will communicate to the member via phone and/or mail the date, time, and location of the panel review at least five (5) business days before the scheduled meeting. All materials necessary for the panel to review must be sent by the member and received at UPHP at least two (2) business days prior to the meeting.

The member will be notified of the determination of the panel referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based and include a list of titles and qualifications, including specialties, of individuals participating in the appeal review in a culturally and linguistically appropriate manner within the time frames defined in this policy.

This is the final level of internal appeal. Upon notification of an adverse appeal decision, the member will be notified about further appeal rights.

Upon request, the member can obtain a copy of the actual benefit provision and guideline or criteria on which the appeal decision was based free of charge. The member is also entitled to receive, upon request, reasonable access to and copies of all documents relevant to the member's appeal free of charge.

UPHP members who participate in Michigan Medicaid may request a State Fair Hearing within 90 days of the notice of the adverse determination, by calling Michigan Enrolls at 888-367-6557 or by writing (UPHP will provide the appropriate form) to:

State Office of Administrative Hearings and Rules
For the Department of Community Health
P.O Box 30763
Lansing, MI 48909-9951

If the member is dissatisfied with the final determination made by UPHP, they may seek an independent (external) review with the Michigan Department of Insurance and Financial Services (DIFS) under the Patient's Right of Independent Review Act (PRIRA). The member has 120 days from the date of final appeal determination notification and may contact them by calling 877-999-6442 or writing (UPHP will provide the appropriate form) to:

Department of Insurance and Financial Services
Office of General Counsel
Healthcare Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Standard Appeal Time Frames:

Extension – 10 Business Days: The length of time an appeal can be extended if the enrollee requests or when UPHP has not received previously requested information and can demonstrate that the delay is in the member's interest. If UPHP uses the extension the member will be given written notice of the reason for the delay.

Independent Review (External) –
120 Calendar Days: The length of time, after receipt of final adverse determination notice, the member has to seek an independent review with DIFS under the PRIRA after they have exhausted UPHP's internal appeal process.

Internal Appeal – 90 Calendar Days: The length of time a member has to file a standard or expedited appeal with UPHP after receipt of an initial adverse determination notice.

Pre Service – 30 Calendar Days: The length of time UPHP or its authorized representative(s) have to provide a final written determination after a formal appeal has been received.

Post Service – 30 Calendar Days: The length of time UPHP or its authorized representative(s) have to provide a final written determination after a formal appeal has been received.

Notice of Receipt of Appeal – 5 Calendar Days: The length of time in which UPHP will notify the member of receipt of appeal request.

State Medicaid Appeal Process – 90 Calendar Days: The length of time after receipt of an initial adverse determination notice the member has to seek a State Fair Hearing with MDHHS.

Expedited Appeals:

72 Hours: The length of time UPHP or its authorized representative(s) have to provide an initial determination after receipt of an expedited appeal. The state law does not allow an extension in the case of an expedited appeal. If a request for extension is submitted, UPHP will transfer the appeal to the standard appeal decision time frame of 30 calendar days and give the member written notice of the transfer within 2 calendar days.

2 Calendar Days: The length of time, after verbal notification, UPHP has to provide written notice of the denial of an expedited appeal.

10 Calendar Days: The length of time an appellant has to file for an expedited external review with DIFS after receiving a denial of request for an expedited appeal from UPHP.

PHARMACY

The prescription benefit is an important component of our member's comprehensive treatment program. The goal of the Upper Peninsula Health Plan (UPHP) is to provide our members rational, clinically appropriate, and cost effective pharmaceutical care. The UPHP formulary is a listing of covered drug therapy.

Formulary

The UPHP formulary is aligned with the MDHHS (Michigan Department of Health and Human Services) Common Formulary for all contracted health plans in the State of Michigan per the Comprehensive Health Plan contract. An MCO Common Formulary Workgroup of representatives from contracted health plans provides recommendations to MDHHS on drugs to be included on the MDHHS Common Formulary. MDHHS has final approval authority for MDHHS Common Formulary coverage. UPHP's formulary cannot be more restrictive than the coverage parameters of the MDHHS Common Formulary, but may be less restrictive in some instances.

UPHP through its Pharmacy Clinical Advisory Committee (PCAC) reviews clinical literature, expert opinions, clinical practice guidelines, relevant findings of Government agencies, medical associations, nation commission, peer-reviewed journals, and other relevant sources to assist determining less restrictive utilization edits. UPHP's PCAC also utilizes the STEPS (Safety, Tolerability, Efficacy, Pricing, and Simplicity) philosophy for review of medications and in making formulary recommendations and decisions.

Formulary Information
The UPHP formulary can be found on the UPHP website at www.uphp.com at Pharmacy/Formulary Information. Information about the MDHHS Common Formulary is also available on the MDHHS website.

UPHP maintains a searchable formulary on its website at www.uphp.com. This document lists covered medications and coverage limitations:, step-therapy, therapy over time, quantity over time, or dose over time edits as well as prior authorization criteria.

Epocrates®
As a service to providers, UPHP partners with Epocrates®. Formulary information is available through Epocrates® drug reference software at www.epocrates.com. The basic

Epocrates® product is free and is how providers can access the UPHP formulary. Epocrates® also offers expanded products for a fee which can also be found on their website.

Formulary Categories

The MDHHS Common Formulary and UPHP's Formulary include drug utilization management tools such as prior authorization criteria and step therapies. Also coverage limitations for age edits and gender edits, and quantity limits are designated in the formulary listing.

The goal of the utilization management edits are to ensure that drugs are utilized in a medically necessary, clinically appropriate, safe and cost effective manner. Brand products are not generally covered if a generic equivalent is available, or in some cases, if a generic therapeutic equivalent is available.

1. **Formulary Medications**
   Medications in this category do not require prior authorization (PA).

2. **Step Therapy**: Requires the use of a drug or drug class prior to utilization of these medications.

3. **Formulary Medications with Prior Authorization (PA)**: These medications may require the use of first line or preferred medications before they are approved. Procedures to request a PA are included in this document.

4. **Non-Formulary Medications**: Some medications can be considered for exception when formulary medications are not appropriate for a particular patient or formulary alternatives have been proven ineffective. A prior authorization, along with clinical evidence, must be provided and is taken into account when evaluating the request to determine medical necessity.

   With the exception of products that are carved out, MHPs must have a process to approve provider requests for any prescribed medically appropriate product identified on the Medicaid Pharmaceutical Product List (MPPL), found at **Michigan.fhsc.com >> Providers >> Drug Information >> MPPL and Coverage Information.** Products that are listed on the MPPL but are not listed on the MDHHS Common

Formulary are available for coverage consideration through a non-formulary prior authorization process.

5. **Drugs available but not covered by UPHP (Carve-outs)**:
   These medications are referred to as "carve-out" drugs because they are a covered benefit, but carved out of health plan coverage. They are reimbursed through Fee-For-Service.

   Examples are behavioral health drugs and drugs used to treat HIV/AIDS.

   Questions and PA requests for these medications should be submitted directly to the MDHHS Pharmacy Benefit Manager (PBM) at https://michigan.fhsc.com. The most up-to-date carve-out medication list can also be found at Michigan.fhsc.com>>Providers>> **Drug Information >> Medicaid Health Plan Carve out.**

6. **Medications not covered by Medicaid**: Certain medications are not covered under the Medicaid benefit and therefore are excluded from coverage. Examples are drugs used in the treatment of fertility or for cosmetic purposes. These exclusions are determined by the MDHHS.

Medically Accepted Indications

Medically accepted indications will also be considered for approval. Medically accepted indications include any use of a drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in the compendia listed in Section 1927(g)(I)(B)(i) of the Social Security Act.

Products Covered As a Medical Benefit

The MDHHS Common Formulary includes drugs that are covered as a pharmacy benefit. The following are examples of products that are not identified on the MDHHS Common Formulary because a MHP may cover it as a medical benefit:

- •Physician-administered injectable drugs
- •Vaccines
- •Intrauterine Devices

Providers should check the UPHP formulary and website to determine how these products are covered. UPHP requires authorization for specific medications billed under the medical benefit.

Pharmacy Procedures

Information on pharmacy management procedures are described in detail in this provider manual and can also be found on the UPHP website at www.uphp.com. These policies and procedures are reviewed annually. To request a hard copy of the procedures, you may call the UPHP Customer Service Department at 800-835-2556. Providers not having access to the website may request that the information be mailed or faxed to them by calling the UPHP Customer Service Department.

Copayments

Medicaid members have no copayments for medications. Healthy Michigan Plan (HMP) members have no co-payments at the point of sale; they are reconciled through the HMP MI Health Account.

Additional Documents and Prescribing Information

Current updates to the UPHP formulary, as well as prescribing tools, are available on the UPHP website at www.uphp.com.

Important Pharmacy Contact Numbers

UPHP uses Magellan Rx (formerly Magellan Rx Pharmacy Management) as a pharmacy benefit manager (PBM). For specific questions regarding pharmacy benefits, contact Magellan Rx.

Customer Service at Magellan Rx

Phone: **888-274-2031 or 248-540-6686**

For prior authorizations contact Magellan Rx Pharmacy Management:

Phone: **248-540-6686**

Fax: **248-341-8133**

For general questions regarding a member's benefit, call the UPHP Customer Service Department at 800-835-2556.

Prior Authorization

UPHP encourages providers to prescribe within UPHP's formulary.

Prior authorization (PA) is generated at the prescriber level. The "Request for Prior Authorization" form is available on the UPHP website at www.uphp.com. A provider not having access to the website may request that the form be mailed or faxed to them by calling the UPHP Customer Service Department.

PA is required for the following medications:

- Medications prescribed outside of quantity limits, time limits, and/or age restrictions
- Medications prescribed outside of step therapy or preferred status
- Non-formulary medications
- DAW (Dispense as Written) prescriptions when a generic equivalent is available

Prior Authorization Procedure

1. Primary Care Provider (PCP), specialist, or their designated agent completes the UPHP "Request for Prior Authorization" form. Prescribing physician and beneficiary information must be complete, as well as the drug name, strength, administration schedule, length of therapy, and quantity requested. The prescriber may complete the remaining information by submitting a dictation, clinic notes, or a letter that contains the relevant information.

2. **The form is faxed to the pharmacy benefit manager (PBM) at the number listed on the "Request for Prior Authorization" form**. Forms are accepted by mail. Prescribers may contact the PBM by telephone during regular business hours and verbally complete the "Request for Prior Authorization" form if the situation is urgent or an emergency. A written form must follow. Any urgent requests will be processed as soon as possible. Every effort will be made to ensure urgent requests are answered on the same day of the request.

3. Upon receipt, the PBM will review the "Request for Prior Authorization" form. The request for PA is then processed by the PBM in one of three ways:

Approved: If the request meets with approved criteria as set forth by the PCAC, an approval is entered into the pharmacy claim system to allow the claim to process. If criteria are not met, the PBM may redirect the prescriber to formulary alternatives. If the practitioner agrees, this is considered redirection and the member may receive the agreed upon formulary medication. The provider is notified via fax by the PBM of all redirections and/or approvals.

Pending: Requests will pend if more information is needed. The PBM will contact the prescriber to obtain further complete information.

Forward the Request to UPHP: If the authorization or redirection cannot be authorized after the PBM review, the "Request for Prior Authorization" form is forwarded to UPHP along with appropriate notes, drug information support, claims history, and any provider documentation provided.

4. When the "Request for Authorization" form is received at UPHP, it is reviewed by an appropriate professional. If a prescriber does not accept redirection to formulary alternatives and wishes to pursue the request, it is processed based on a medical necessity determination along with supporting documentation using some or all of, but not limited to, the following criteria:
   - UPHP formulary guidelines
   - FDA approved indications for the medication requests
   - The member's diagnosis and/or the indication for use
   - Previous drug treatment for the member's diagnosis
   - Compliance with previous drug treatment(s)
   - Previous therapy failure using formulary alternatives

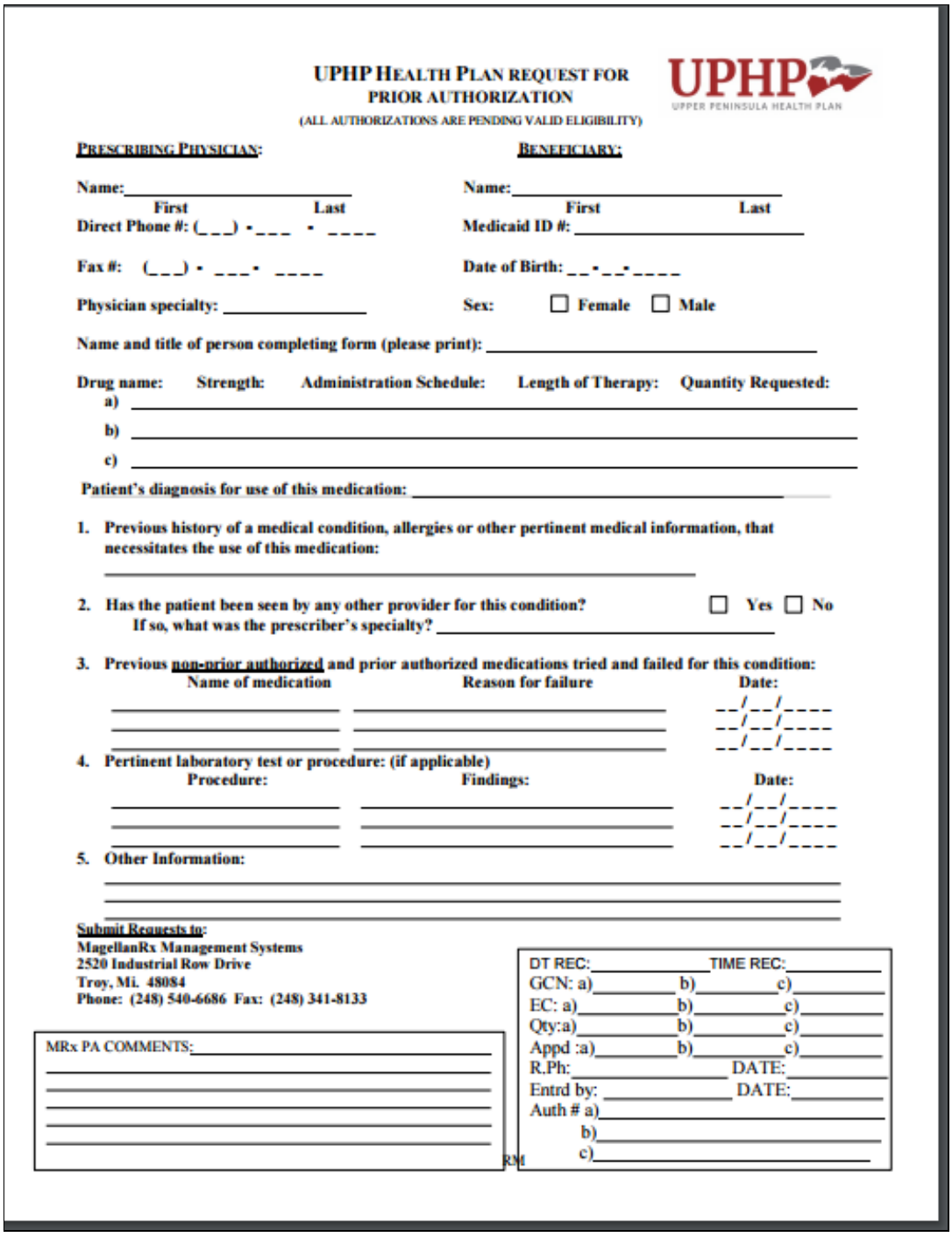
5. If after review by the appropriate UPHP professional, a request is approved, notification is sent to the PBM via secure email to the PA department.

Requests for PA and medical necessity requests that are denied are processed in accordance with the UPHP Policy 300-005 Utilization Management (UM) Process, Policy 300-024 Member Appeals Related to UM Adverse Determinations, and NCQA and MDHHS Standards for timeliness and notification.

Standard Prior Authorization Form

A standard prior authorization form, FIS 2288, was created to simplify the process of requesting prior authorization for prescription drugs. The form is available at **Michigan.gov/difs >> Forms >> Insurance and uphp.com may also be used.**

Request for Prior Authorization (PA) Form



UPHP HEALTH PLAN REQUEST FOR PRIOR AUTHORIZATION

(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

UPHP UPPER PENINSULA HEALTH PLAN

PRESCRIBING PHYSICIAN:

Name: _____
First Last

Direct Phone #: (___) ___ - ____

Fax #: (___) ___ - ____

Physician specialty: _____

BENEFICIARY:

Name: _____
First Last

Medicaid ID #: _____

Date of Birth: __-__-____

Sex: ☐ Female ☐ Male

Name and title of person completing form (please print): _____

Drug name: Strength: Administration Schedule: Length of Therapy: Quantity Requested:

a) _____

b) _____

c) _____

Patient's diagnosis for use of this medication: _____

1. Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:
   _____

2. Has the patient been seen by any other provider for this condition? ☐ Yes ☐ No
   If so, what was the prescriber's specialty? _____

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication	Reason for failure	Date:
_____	_____	__/__/____
_____	_____	__/__/____
_____	_____	__/__/____

4. Pertinent laboratory test or procedure: (if applicable)

Procedure:	Findings:	Date:
_____	_____	__/__/____
_____	_____	__/__/____
_____	_____	__/__/____

5. Other Information:
   _____
   _____
   _____

Submit Requests to:
MagellanRx Management Systems
2520 Industrial Row Drive
Troy, Mi. 48084
Phone: (248) 540-6686 Fax: (248) 341-8133

MRx PA COMMENTS: _____

DT REC: _____ TIME REC: _____
GCN: a) _____ b) _____ c) _____
EC: a) _____ b) _____ c) _____
Qty:a) _____ b) _____ c) _____
Appd :a) _____ b) _____ c) _____
R.Ph: _____ DATE: _____
Entrd by: _____ DATE: _____
Auth # a) _____
b) _____
c) _____

RM

CREDENTIALING

The Upper Peninsula Health Plan's (UPHP) credentialing process is based on standards set forth by the National Committee for Quality Assurance (NCQA). Applications for membership to UPHP's provider network shall be provided to Medical Practitioners and Behavioral Health Practitioners with whom it contracts or employs and who treat members outside the inpatient setting and who fall within its scope of authority and action. Locum providers are not generally credentialed, but must be if the provider will be providing services for a group or facility outside of an inpatient setting for more than 60 days or if the group or facility does not have another provider under which to bill the locum's claims. If an eligible provider is being credentialed, but is not within the list of outlined provider types, the provider must be credentialed in accordance with NCQA verification requirements and the company's policy.

Only those applicants who satisfy UPHP's credentialing criteria by providing a complete application, including supporting documentation and by cooperating with the Credentialing Committee through full and timely responses to all reasonable inquiries and investigations shall be eligible to participate in the company's provider network.

All UPHP network providers must cooperate with UPHP's quality improvement activities to improve quality of care, services and member experience. Cooperation may include, but is not limited to, the collection and evaluation of data and participation in UPHP's quality improvement programs. UPHP may use provider performance data for quality improvement activities.

Credentialing Application

Upon request to the company, applicants will be given an application for appointment, a letter detailing requirements for completion of the application, and the appropriate Participation Agreement if a direct agreement is required. The application will contain a statement advising the applicant of his or her right to review certain information obtained during the credentialing process, the right to correct erroneous information, the right to be informed of the application status, and the right to appeal any adverse decision of the Credentialing Committee regarding appointment or reappointment to the company's provider network. In order to consider an application complete, the following documentation is necessary:

1. A completed, signed application and Participation Agreement if required, as well as the signed release form.

2. A valid Drug Enforcement Administration (DEA) certificate. If an applicant has a pending DEA certificate, he or she may be approved by the Credentialing/Recredentialing Committee with the stipulation that he or she not write prescriptions. The provider must designate a practitioner with a valid DEA certificate who will write all prescriptions that require a DEA number until the practitioner has a valid DEA certificate. The newly appointed practitioner will be informed that he or she must submit a copy of the DEA certificate to the company as soon as they receive it. The company does not require ODs, CRNAs or Pathologists to have a DEA certificate.

3. Statement of Michigan license status.

4. Physicians must give a statement of board status, i.e., board certified or not board certified. If not board certified in the board of their practice specialty, must prove that boards are in process and he/she must also sign a Request for Temporary Board Certification Waiver, which states that he/she will become board certified within six years from the applicable Residency or Fellowship completion or within two years of appointment, whichever is longer. If an applicant is not board certified or eligible due to completion of Residency outside of the United States, he/she must submit a Request for Time-Unlimited Waiver of Board Certification, which must be reviewed along with applicant's CV by the CEO and Medical Director, prior to application processing. The applicant can only be considered for the Time Unlimited Waiver if he/she will be working in a Medically Underserved Area, as deemed by the Health Resources and Services Administration (HRSA).

5. Applicable education and training
6. Chronological work history covering at least the past five years as is documented in the application and/or detailed curriculum vitae. Work history must include the beginning and ending month and year for each position in the practitioner's employment experience. Any gaps exceeding six months should be reviewed and clarified either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file by documenting the date and details of the

conversation. A gap in work history that exceeds 1 year must be clarified in writing.

7. Documentation of current malpractice insurance coverage and documentation of the previous 10 years of professional liability claims history that resulted in settlements or judgments paid by or on behalf of that practitioner.

8. Statement of management and criminal history information, as outlined in CMS's 42 CFR 455.101 through 455.106. The applicant must disclose the name and Social Security Number of their employer's managing employee. The applicant must also disclose any person with ownership or control interest in the provider or who is an agent or managing employee of the provider who has ever been convicted of a criminal offense related to a Medicare or Medicaid program or Title XX services program since the inception of those programs.

9. NPI number.

10. Medicare number.

11. Language(s) spoken (optional).

12. Ethnicity (optional, but must at least check off, "Choose not to disclose".)

13. PCP applicants must list their Covering Providers as well as their 24-hour medical coverage, their admitting arrangements and hospitalized patient care, per CMS requirements.

    In addition, all applicants must be enrolled in CHAMPS, which is the State of Michigan Community Health Automated Medicaid Processing System.

Disciplinary Action

Noncompliance with policy, procedure, contract, or addenda may be investigated and reviewed by Provider Relations or Compliance staff. Disciplinary and adverse action(s) may be progressively severe depending upon the nature and seriousness of the infraction(s). Actions and recommendations from the Medical Director for adverse action(s) regarding major/severe issues, which involve restriction, suspension, or termination, will be forwarded to the Credentialing/Recredentialing Committee for review. Adverse action taken by the Credentialing/Recredentialing Committee, against a provider, shall be approved by the Management Committee.

Network providers of the Upper Peninsula Health Plan (UPHP) are expected to promote quality of care and ensure compliance with regulatory standards and UPHP's contracts, addenda, policy, procedures, competency standards and conduct standards. In the event that UPHP takes adverse action against a provider, the network provider has an opportunity to appeal this recommendation. The provider must notify UPHP, in writing, of the intent to appeal the adverse action within thirty (30) days of written notification from UPHP to provider of UPHP's recommendation to take such adverse action.

Disciplinary or Adverse Action Levels:

- *Level I*: The Medical Director reviews complaints, conduct and competence issue(s) and all related information. If it is found, through review, that there is no evidence of infraction(s), no further action is warranted.
- *Level II – Verbal/Written Warning*: The Medical Director reviews complaints, conduct and competence issue(s), and all related information. If a minor infraction is identified, a letter detailing the action(s) to be taken will be sent to the affected provider. The provider will be invited to respond in writing to the issue(s) under review. This level of disciplinary action is not considered an adverse action and is for minor infractions including, but not limited to:
    - Inappropriate behavior toward UPHP members and/or staff
    - Noncompliance with Policy and Procedures
    - Noncompliance with contract or addenda
- *Level III – Restriction/Suspension/Termination*: The Medical Director reviews complaints, conduct and competence issue(s), and all related information. If a major

or significant infraction is identified, the Medical Director may immediately restrict or suspend the provider's participation in the provider network and/or any committee membership and will forward his/her recommendations and the provider's credential file to the Credentialing/Recredentialing Committee. The Credentialing/Recredentialing Committee will determine whether the provider's professional conduct or competence or the provider's non-compliance with policies, procedures, contract, or addenda warrants continued restriction or suspension, or whether termination is appropriate. The provider will be notified of all adverse actions via a certified, written letter stating the infraction(s) identified and the decision to restrict, suspend, and/or terminate the provider's participation with UPHP. The Provider Relations staff or Credentialing Supervisor may make an administrative restriction, suspension, or termination due to noncompliance with policy, procedure, contract, or addenda. This level of disciplinary action is considered to be adverse action and is for major or significant issues, including, but not limited to:

- Inappropriate behavior toward UPHP members and/or staff
- Noncompliance with policy and procedures
- Noncompliance with contract or addenda
- Noncompliance with interventions or disciplinary actions that resulted in written or verbal warnings
- Fraud
- Medical intervention(s) resulting in serious injury or death of a member
- Medical neglect resulting in serious injury or death of a member

Provider Hearings and Appeals

If an adverse action is taken against a network provider—based upon the provider's professional competence, conduct, or if the provider's participation agreement is terminated by UPHP with or without cause—the provider has the right to an appeal hearing. In UPHP's sole discretion, UPHP may also offer an appeal to those providers who UPHP takes adverse action against for reasons that are not related to the provider's professional conduct or competence.

Notice of Action

When UPHP recommends taking adverse action against a provider for reasons based upon the provider's professional conduct or competence, the provider has the right to appeal UPHP's recommendation before such adverse action becomes final.

Notification by UPHP to Provider of Recommendation to Take Adverse Action: UPHP shall provide provider with certified written notification of UPHP's intent to take adverse action against provider. Such notification shall clearly state the reasons for UPHP's recommendation.

The notice of adverse action must contain:

1. A concise statement of the provider's alleged acts or omissions that caused UPHP to recommend adverse action.

2. A list by number of any specific or representative patient/member records in question.

3. Any other reasons or issues that formed the basis of the recommendation to take adverse action.

The notification shall explain that the recommendation shall not become final until provider has either (1) exercised his or her appeal rights, or (2) effectively waived his or her appeal rights. The letter shall also advise provider that provider has the right to appeal UPHP's recommendation within thirty (30) days from the date of the notification described in this paragraph. The provider shall also be advised of his or her right to be represented by counsel or any other person of the provider's choice at the hearing.

Request for a Hearing

A provider has thirty (30) days after receiving written notification from UPHP of its recommendation to take adverse action against the provider to file a written request to appeal the decision via a fair hearing. The request must be delivered to the UPHP Medical Director either in person or by certified or registered mail. If the provider wishes to be represented by an attorney at the hearing, the request for the hearing must state this wish. Likewise, the UPHP will notify the provider if counsel will represent them.

A disciplined provider who fails to request a hearing in writing within thirty (30) days effectively waives the right to any hearing or appellate review to which the provider might otherwise have been entitled. A waiver constitutes acceptance of the recommendation and such recommendation shall become final and effective on the date the provider has waived the appeal. UPHP shall communicate this in writing to the provider, and as required by law, notify state agencies and data banks.

PRIMARY CARE PROVIDER RESPONSIBILITES

Access to Care Standards

Upper Peninsula Health Plan (UPHP) defines a primary care provider (PCP) as a medical practitioner responsible for supervising, coordinating, and providing all primary care services to members. The PCP is also responsible for initiating referrals for specialty care, continuity of a member's health care, and maintaining the member's medical records, which includes documentation of all services provided by the PCP as well as any specialty services.

Providers who may serve as PCPs are family/general practice physicians, OB/GYN physicians, internal medicine physicians, and pediatricians, nurse practitioners, physician assistants, and other physician specialists when appropriate for a member's health condition.

A PCP must be accessible 24 hours a day, seven days a week, either personally or through coverage arrangements with a designated contracted primary care provider. After hours coverage must meet the following requirements:

- Provides instructions for an emergency situation
- Provides instructions on how to obtain after-hours care

As applicable, primary care providers contracted with UPHP must meet or exceed the following standards for access by patients:

1. *Office Hours:* Primary care providers must be available at least 20 hours per week. Routine physician and office visits must be available during regular and scheduled

office hours.

2. *Emergent Appointments:* Emergencies must be handled immediately or the member should be referred to a hospital emergency room.

3. *Urgent Appointments:* Appointments regarding non-life-threatening conditions requiring urgent care must be scheduled within 48 hours or the member should be referred to an urgent care facility.

4. *Routine Appointments:* Prevention and primary care for non-urgent conditions (such as well-care exams, tests, and immunizations) should be scheduled within four (4) weeks for children ages 0-17 and within five (5) weeks for adults 18 and older.

5. *After-Hours Care*: When a PCP office is closed, the PCP must provide member access and availability to physician services, 24 hours a day, seven days a week for urgent care for symptomatic conditions.

Immunizations

Upper Peninsula Health Plan providers are required to participate in the State of Michigan Immunization Initiatives, including documenting the administration of vaccines in the Michigan Care Improvement Registry (MCIR). Providers are also required to cooperate in an annual review of participation in initiative programs and to provide immunizations that should be given in conjunction with well-child and EPSDT care when possible. Every office visit should provide an opportunity to assess immunization needs and vaccinate when appropriate. Medicaid providers are encouraged to participate in the Vaccines for Children Programs, VFC and MI-VFC.

Provider Change Notification Requirements

Providers must notify Upper Peninsula Health Plan in writing at least 60 days prior to changes in physician staffing, practice location changes, and billing address and tax ID changes. To submit changes, locate the "Information Update Form" found on the Upper Peninsula Health Plan website at www.uphp.com / Providers / Forms / Information Update Form.

Completed forms should be mailed or faxed to:

Upper Peninsula Health Plan
Attn: Provider Relations
853 West Washington St.
Marquette, MI 49855
Fax: 906-225-7776

For further information about updating provider information, please call the UPHP Provider Relations department at 800-835-2556.

COMPLIANCE

Upper Peninsula Health Plan Policies and Procedures

Upper Peninsula Health Plan (UPHP) is committed to comply with all applicable laws and regulations. UPHP has policies and procedures in place to ensure compliance and regulatory standards are met. Policies and procedures are updated as needed to incorporate changes in regulation and reviewed at least annually. UPHP must comply with all provisions of the federal and Michigan Medicaid False Claims Act. This includes establishing and maintaining written policies for employees, contractors and agents of the Upper Peninsula Health Plan regarding detection and prevention of fraud, waste and abuse and whistleblower protections. These policies and other resources are available on the UPHP website at Resources/Fraud, Waste, and Abuse. Additional information is included later in this chapter.

Definitions

Practices that are inconsistent with sound fiscal, business, or medical practices, that result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care are considered fraud, waste and abuse. Specifically:

***Fraud*:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under the applicable Federal or State law. 42 CFR 455.2

Waste: Overutilization of services (not caused by criminally negligent actions) and the misuse of resources.

***Abuse*:** Excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. Abuse refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss.

Examples of Fraud, Waste and Abuse:

By a Member	By a Provider
Identity Theft	Billing for services, procedures and supplies that have not been rendered
Doctor shopping	Billing for unnecessary items or services
Altering or forging a prescription	Unbundling and/or Upcoding
Prescription diversion	Kickbacks
Misrepresentation of personal information to receive benefits	Charging in excess for services or supplies

Preventing Fraud and Abuse

Upper Peninsula Health Plan and other State and Federal agencies collaborate to prevent fraud. Here are ways you can help prevent healthcare fraud and abuse:

- Verify eligibility at each member visit.
- Keep a copy of a photo ID in the member's medical records.
- Bill according to standard billing guidelines.

Reporting Fraud and Abuse

Suspected cases of fraud and abuse should be reported to UPHP's Compliance Officer. You have the right to report your concerns anonymously to UPHP or the Michigan Department of Health and Human Services Program Investigation Section. When reporting an issue, please provide as much information as possible. The more information provided the better chance the situation will be successfully reviewed and resolved. Remember to include the following information when reporting suspected fraud or abuse:

- The nature of the complaint

- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number, and any other identifying information

  To report possible Fraud, Waste or Abuse you may report directly to UPHP by contacting:

- **UPHP Compliance Officer**
  853 West Washington Street
  Marquette, MI 49855
  Call Toll-Free at 800-835-2556

- UPHP Compliance Hotline 906-225-5081
  You may remain anonymous

- **Michigan Department of Health and Human Services Office of Inspector General**
  PO Box 30062
  Lansing, MI 48909
  1-855-MI-Fraud (1-855-643-7283) (toll-free)
  www.michigan.gove/fraud
  You may remain anonymous

Deficit Reduction Act

On February 8, 2006, President George W. Bush signed the Deficit Reduction Act of 2005 into law. The Deficit Reduction Act contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending.

The Upper Peninsula Health Plan (UPHP) is a participant in the State of Michigan Comprehensive Health Care Program and receives reimbursement from Medicaid for health care services provided to Medicaid beneficiaries, including dispensing of prescription medications. As an entity that receives payments from Medicaid, which meet the requirements under Section 6032 of the Deficit Reduction Act of 2005, UPHP is required to comply with certain provisions of the Deficit Reduction Act.

Under the Deficit Reduction Act, UPHP is required by law to establish certain policies and provide all employees with information regarding: (1) the federal False Claims Act and similar state laws, (2) an employee's right to be protected as a whistleblower, and (3) UPHP's policies and procedures for detecting and preventing fraud, waste, and abuse in state and federal health care programs. Further, contractors, subcontractors, agents, and other persons that or who, on behalf of UPHP, furnish or otherwise authorize the furnishing of Medicaid health care items or services, perform billing or coding functions, or are involved in the monitoring of health care provided by UPHP are required to adopt these policies and procedures to continue to do business with UPHP.

This document sets forth UPHP policies and contains information required by law under the Deficit Reduction Act. Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. UPHP will take steps to monitor UPHP contracted providers to ensure compliance with the law.

False Claims Acts

One of the primary purposes of false claims laws is to combat fraud and abuse in government health care programs. False claims laws do this by making it possible for a government to bring civil action to recover damages and penalties when health care providers submit false claims. Upper Peninsula Health Plan (UPHP) must comply with these laws; contracted providers and their staff has the same obligation to report any actual or suspected cases of fraud, waste, or abuse.

Both the Federal False Claims Act and the Michigan Medicaid False Claims Act laws often permit Qui Tam suits, often referred to as "whistleblower" provisions, which are lawsuits filed by laypeople, typically employees or former employees of health care providers that submit false claims, on the government's behalf. The government may decide to take over the case, but if it declines to do so, the whistleblower may still pursue the suit. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government, as well as attorney fees and costs.

The Federal False Claims Act and Michigan Medicaid False Claims Act contain some overlapping language related to personal liability. For example, the Medicaid False Claims Act has the following triggers:

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it;
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use;
- Knowing makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program;
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in furthering a false claim are entitled to:

- Employment reinstatement at the same level of seniority;

- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

HIPAA REQUIREMENTS AND INFORMATION

HIPAA (The Health Insurance Portability and Accountability Act)

Upper Peninsula Health Plan's Commitment to Patient Privacy

Upper Peninsula Health Plan (UPHP) protects the confidentiality, integrity, and availability of electronically transmitted and maintained member information, medical records, research information, and business operations; and shall comply with applicable federal and state laws regarding the privacy and security of members' protected health information (PHI).

Provider/Practitioner Responsibilities

UPHP expects that all contracted Providers/Practitioners will respect the privacy of UPHP members and comply with all applicable laws and regulations concerning the privacy of patient and member PHI.

Applicable Laws

Provider/Practitioners must comprehend all state and federal healthcare privacy laws applicable to their practice and organization. There are various laws that Providers/Practitioners must comply with; most of Michigan's healthcare Providers/Practitioners are subject to laws and regulations pertaining to privacy of health information including, but not limited to:

- Federal Laws and Regulations
  - HIPAA
  - Medicare and Medicaid laws
- Michigan Medical Privacy Laws and Regulations

While HIPAA provides a base for patient privacy, state laws should be followed in certain situations, particularly if the state law is more stringent than HIPAA. Providers/Practitioners should consult with their own legal counsel to address their specific situation.

Patient Rights

Patients have various rights under HIPAA regarding medical information. UPHP Providers/Practitioners must allow patients to exercise any of the following rights that apply to the Provider/Practitioner's practice:

1. *Notice of Privacy Practices.* Providers/Practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explain the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider/Practitioner should obtain a written acknowledgement that the patient received the notice of privacy practices.
2. *Right to Request Restriction on Uses and Disclosures of PHI.* Patients may request that a healthcare Provider/Practitioner restrict its uses and disclosures of PHI.
3. *Right to Request Confidential Communications.* Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.
4. *Right to Request Patient Access to PHI.* Patients have the right to access their own PHI within a Provider/Practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider/Practitioner contains the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.
5. *Right to Request Amendment of PHI.* Patients have the right to request that the Provider/Practitioner amend information in their designated record set.
6. *Right to Request Accounting of PHI Disclosures.* Patients may request an accounting of disclosures of PHI unrelated to healthcare, treatment, payment, or operations, made by the Provider/Practitioner within the past six (6) year period.

HIPAA Security

The Upper Peninsula Health Plan (UPHP) has adopted this General HIPAA Security Regulations Policy to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Department of Health and Human Services (DHHS) security and privacy regulations as well as our duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements.

UPHP shall strive to protect and maintain the confidentiality, integrity and availability of electronically transmitted and maintained member information, medical records, research information and business operations; and shall strive to comply with applicable laws and regulations.

In doing so, Upper Peninsula Health Plan will take steps:

1. To ensure the confidentiality, integrity and availability of all EPHI that it creates, receives, maintains or transmits;
2. To protect against any reasonably anticipated threats or hazards to the security or integrity of EPHI;
3. To protect against any reasonably anticipated uses or disclosures of EPHI that are not permitted or required under the Upper Peninsula Health Plan policies related to privacy of PHI; and
4. To ensure that workforce members comply with Upper Peninsula Health Plan security policies.

The HIPAA security policies are in addition to all other UPHP Information Systems policies and privacy policies for all electronically held information and for information systems and devices that transmit or store EPHI.

HIPAA Transactions and Code Sets

UPHP strongly supports the use of electronic transactions and providers are encouraged to submit claims and other transactions to UPHP using electronic formats. UPHP is committed to complying with all HIPAA Transaction and Code Sets standard requirements.