Updated
April 2018

UPHP

UPPER PENINSULA HEALTH PLAN

MEDICARE
PROVIDER MANUAL

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INTRODUCTION

Welcome

Welcome to the Upper Peninsula Health Plan! Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining the UPHP network, you are helping us serve the residents of the Upper Peninsula that need us the most.

Mission Statement

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.

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 provider 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 to people who receive healthcare benefits through a Medicare Advantage Plan (HMO), Medicaid, Healthy Michigan Plan, Children with Special Health Care Needs (CSHCS), MIChild and a Medicare-Medicaid Plan called MI Health Link. 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 and 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 900 providers, the staff has increased to more than 130 employees, and enrollment has increased to more than 40,000 members.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the plan and provider contract, including all requirements described in this manual, in addition to all federal and state regulations governing the plan and the provider. Upper Peninsula Health Plan (UPHP) may or may not specifically communicate such terms in forms other than the contract and this provider manual. Providers are required to fully understand and apply Michigan Medicaid Health Care Program and CMS requirements.

Annual Notice of Change

UPHP plan benefits are subject to change annually. Members are provided with written notice regarding the annual changes by the date specified by CMS. The CMS Annual Election Period begins on October 15 each year for enrollees and ends on December 7. Providers can access the UPHP website (http://www.uphp.com/medicare) on or around October 15 for information on the individual plan and benefits that will be available for the following calendar year.

Centers for Medicare & Medicaid Services (CMS) Website Links

UPHP administers the plan in accordance with the contractual obligations, requirements, and guidelines established by the CMS. There are several manuals on the CMS website that may be referred to for additional information. The CMS online manuals most used are listed below:

Medicare Managed Care Manual:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

Medicare Prescription Drug Manual:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS050485.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

Medicare Claims Processing Manual:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

Medicare Coverages

Part A – Hospital insurance; pays for inpatient care, skilled nursing facility care, hospice and home health care.

Part B – Medical insurance; pays for doctor's services and outpatient care such as lab tests, medical equipment, supplies, some preventive care, and some prescription drugs.

Part C – Medicare Advantage Plans (MA); combines Part A and B health benefits through managed care organizations; most plans include a Part D (MAPD plans).

Part D – Medicare Prescription Drug Plan; helps pay for prescription drugs and certain vaccines and medical supplies (such as needles and syringes for insulin).

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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 .....877-349-9324 (TTY 711)

Fax Number 906-225-7690

Magellan Customer Service / Pharmacy Questions 844-827-0182

Pharmacy Related Authorizations 866-508-0237

Eligibility and PCP Verification 877-349-9324

Utilization Management and Prior Authorization Inquiry 877-349-9324

Fax Number 906-225-9269

Medical Claims Services 877-349-9324

Claims Appeals Fax Number 906-226-4284

Credentialing Services 877-349-9324

Clinical Services 877-349-9324

Clinical Appeals Fax Number 906-225-7720

Provider Relations/Contracting 877-349-9324

Fraud and Abuse Prevention 888-904-7526

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 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/medicare or to UPHP Customer Service Department at 877-349-9324 (TTY 711).

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 dignity and 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 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 on 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.
- Call Customer Service as soon as you know that 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.
- Always carry your current UPHP identification card.
- Call UPHP if your card is lost or stolen.
- Tell UPHP and your doctors if you have other insurance.
- 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 problem.
- Provide information needed by UPHP or your doctors.
- If you have more than one doctor, ask them to communicate about your care.

ELIGIBILITY AND ENROLLMENT, INFORMATION

Medicare is a health insurance program run by the government for people over age 65 and people under 65 with certain disabilities. The Upper Peninsula Health Plan (UPHP) operates two Medicare Advantage Plans with Prescription Drug coverage: UPHP Advantage (H2161-002) and UPHP Choice (H2161-003). These plans are available to anyone who is:

- Entitled to Medicare Part A
- Enrolled in Medicare Part B,
- Does not have End Stage Renal Disease (ESRD)
- And lives in the Upper Peninsula Health Plan service area.

Enrollment

An individual (or their legal representative) interested in enrolling in either UPHP Advantage or UPHP Choice must complete an enrollment request via one of the following ways:

- A paper enrollment for that is submitted to UPHP via email, facsimile, or through a sales agent;
- Online internet enrollment form on the UPHP website (www.uphp.com/medicare);
- The 1-800-MEDICARE Call Center; or
- Telephone enrollment through UPHP (877-349-9324).

UPHP will use the Centers for Medicare and Medicaid Service's (CMS) model enrollment forms for Medicare Advantage (MA) coordinated care plans. With the exception of forms that are faxed to UPHP, individuals should submit original, not photocopied, forms.

UPHP will utilize a secure internet website that complies with CMS internet security standards and will capture the same data as required on the CMS model enrollment form.

All materials and web pages will have CMS approval. If a legal representative is completing the enrollment request, they must have proof of this authority which is to be made available upon request by UPHP or CMS.

UPHP will accept enrollment requests via incoming telephone calls to a plan representative or agent and will follow a CMS approved Enrollment Script. Requests can only be accepted through in-bound calls from beneficiaries or their legal representative.

Enrollment requests received through the internet or telephone do not need to have a pen and ink signature; instead, the individual indicates their intent to enroll by completing the online process or verifying on the telephone. Upon receiving an enrollment request, UPHP will provide the individual with one of the following notices within ten (10) calendar days:

- Acknowledgement notice as prescribed by CMS;
- Request for additional information;
- Notice of denial.

For an enrollment form to be considered complete it must have: beneficiary name; date of birth; sex; permanent residence address; Medicare number; response to ESRD question; beneficiary signature or authorized representative signature; authorized representative contact information.

If UPHP receives an incomplete enrollment request, the individual or legal representative will be notified within ten (10) days either orally or in writing that additional information is needed. The individual or legal representative will have 21 calendar days to submit the additional information or the enrollment will be denied.

If an individual is not eligible to elect UPHP, UPHP must deny the enrollment and send a notice of denial, including an explanation of the reason for denial, within ten (10) calendar days of receiving the enrollment.

Individuals who have been medically determined to have ESRD are not eligible to enroll into UPHP unless UPHP is made aware that the individual requesting enrollment no longer requires regular dialysis or has received a kidney transplant. UPHP will request

supporting medical documentation from the individual (such as a letter from a physician that documents that the individual no longer requires dialysis to maintain life or the individual had a kidney transplant.)

In cases of mistaken enrollment made by an individual, the individual may cancel the enrollment by contacting UPHP prior to the effective date of enrollment. If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary.

When an enrollment request is canceled, UPHP will send a letter, within ten (10) calendar days of receipt of the request, to the individual that states the cancellation is being processed. The letter will also inform the individual that the cancellation should result in the individual remaining enrolled in the health plan in which they were originally enrolled, so long as the individual is eligible to be enrolled in that health plan.

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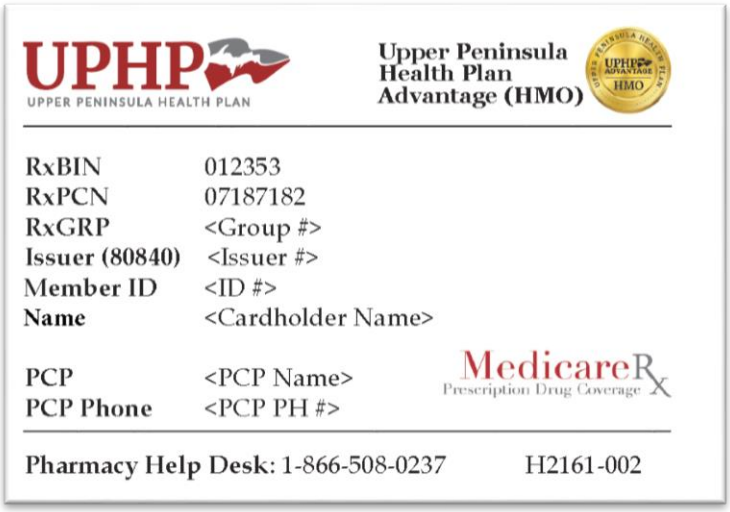
UPHP Member ID Card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Upper Peninsula Health Plan Advantage (HMO)

RxBIN 012353
RxPCN 07187182
RxGRP <Group #>
Issuer (80840) <Issuer #>
Member ID <ID #>
Name <Cardholder Name>

PCP <PCP Name>
PCP Phone <PCP PH #>

MedicareRx Prescription Drug Coverage

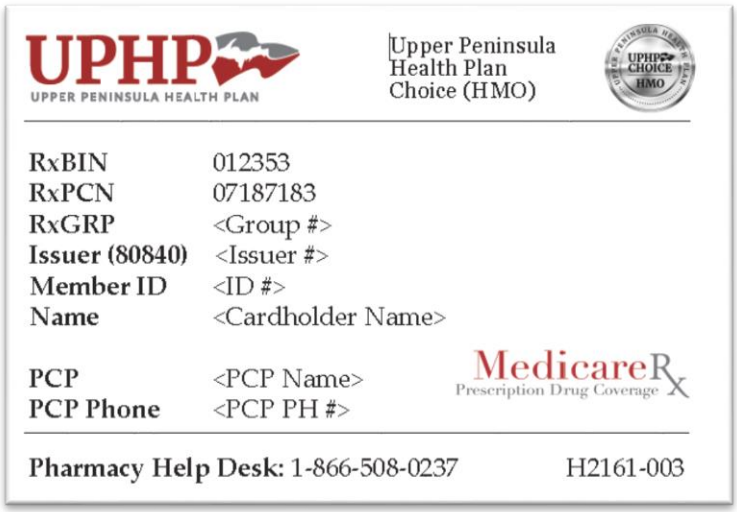
Pharmacy Help Desk: 1-866-508-0237 H2161-002


Submit Claims to:
Upper Peninsula Health Plan
853 West Washington Street
Marquette, MI 49855

The payer number for *electronic claims* is 38337.

Non-Pharmacy Customer Service:
1-877-349-9324
(TTY: 711)
www.uphp.com/medicare

Pharmacy Customer Service:
1-844-827-0182
(TTY: 711)
www.magellanrx.com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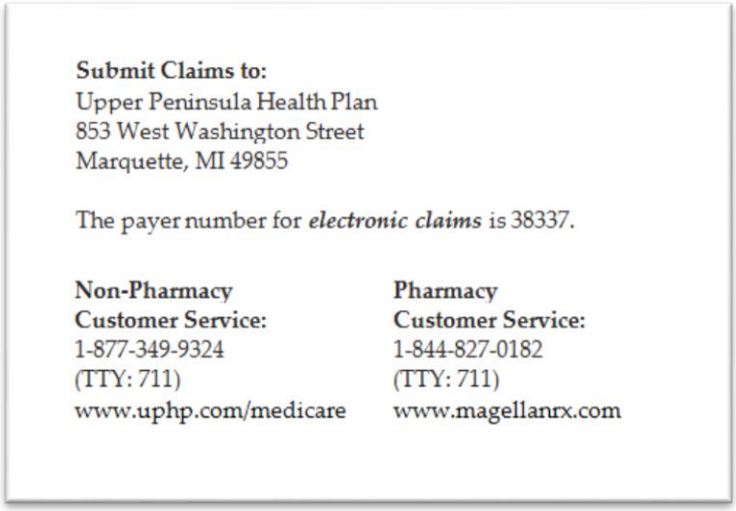
Upper Peninsula Health Plan Choice (HMO)

RxBIN 012353
RxPCN 07187183
RxGRP <Group #>
Issuer (80840) <Issuer #>
Member ID <ID #>
Name <Cardholder Name>

PCP <PCP Name>
PCP Phone <PCP PH #>

MedicareRx Prescription Drug Coverage

Pharmacy Help Desk: 1-866-508-0237 H2161-003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(TTY: 711)
www.magellanrx.com

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 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, to improve the processes and outcomes of care provided to members, and to assure appropriate, timely, and efficient utilization of services. This program is designed to support a comprehensive approach to identify any sources of variation in outcomes and to implement corrective action when necessary, and meet the requirements of federal, state and accrediting agency standards.

Upon enrollment, beneficiaries are entered into the UPHP care management system which allows for the collection and storage of data on individual beneficiaries and the identification and monitoring of the most vulnerable members of the population. Quality improvement activities are aimed at addressing the needs of the beneficiary; examples of interventions are educating the beneficiary on needed care or disease process, coordinating needed care, or enrollment into the Disease Management Program.

The QAI/UM Program is an ongoing and continuous process that involves the collection, analysis, reporting, and reassessment of data relative to quality indices or indicators at the plan level. Supporting documentation for all quality activities is maintained electronically, or in hard copy if documents cannot be maintained in an electronic format.

The QAI/UM Program for UPHP Medicare members at a minimum includes the following:

- A health information system to collect, analyze, and report accurate and complete data
- One or more chronic care improvement program(s) relevant to the population

- One or more quality improvement projects that can be expected to have a favorable effect on health outcomes and enrollee satisfaction, focusing on clinical and non-clinical areas
- Encouragement of providers to participate in Centers for Medicare and Medicaid Services (CMS) and Health and Human Services (HHS) quality improvement initiatives
- Internal quality improvement activities
- Collection and reporting of National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) measures
- Participation in NCQA Health Outcomes Survey (HOS) when enrollment meets required threshold
- Participation in Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey when enrollment meets threshold
- Collection and reporting of Part C Reporting Elements
- Collection and reporting of Part D Reporting Elements
- Medication Therapy Management with qualifying members

QAI/UM Program Structure

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 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, UPHP CEO, and six UPHP primary care or specialist licensed practitioners who routinely provide care to UPHP members.
    - Meets bi-monthly via videoconference to discuss credentialing files for providers; Medical Director directs files needing further discussion to the UPHP Clinical Advisory Committee.
- UPHP 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 inpatient and outpatient doctoral-level 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 practitioner representatives as required.
    - Meets at least four times a year (or more frequent if urgent situations transpire) to provide approval and oversight of the clinical services components of the QAI/UM Work Plan and activities, and related policies and procedures for all UPHP product lines including Medicare Advantage; reviews pharmacy management issues forwarded from the UPHP PCAC as well as identified practitioner and provider issues forwarded from the UPHP Credentialing Committee.
- UPHP Service Advisory Committee (SAC)
    - Chaired by the Government Programs Supervisor and consists of the staff members from the Provider Relations, Information Systems, Pharmacy, Claims, 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 improvement for members.
    - Recommends policy decisions; analyzes and evaluates results of service QAI activities; institutes needed action and assures follow-up as appropriate; oversees service coordination for Medicare SNP program by assuring members access to network providers that participate in the Medicare program.

UPHP 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 including Health Risk Assessments (HRAs), medical record audits, disease management programs, and chronic care improvement programs. This data also determines the quality, safety, and appropriateness of services and care for UPHP members and helps identify the most vulnerable members of the population.

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, depression scales, and chronic disease outcomes. For each quality improvement project, performance is assessed using quality indicators that have:

- Clearly defined objectives based on current clinical knowledge or health services research
- Quality indices and health outcomes written as measurable outcomes
- Interventions that are designed for the targeted population to achieve demonstrable improvement

Systematic and periodic follow-up is conducted using the same methodology to assure improvements are sustained. If improvement is not sustained, additional interventions are implemented.

To assure the overall quality of its 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.
- *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 provider education.

- *Member Cultural and Linguistic Needs and Preferences*: UPHP annually assesses the populations it serves for any particular racial, ethnic, cultural, or linguistic needs by using enrollment data, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results, member and provider grievances and appeals, health risk assessments, and Healthcare Effectiveness Data and Information Set (HEDIS®) measures.
- *Health Services Contracting*: UPHP contracts with individual practitioners and providers, and those making UM decisions, which cooperate with the UPHP QAI/UM program processes. Contracts include an affirmative action statement that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations. Contracted providers must 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 to assure 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 preventive, 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 and Health Outcomes*: 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). UPHP participates in the Medicare HOS survey that solicits self-reported information from a sample of Medicare beneficiaries, when SNP enrollment meets the minimum threshold. The Medicare HOS provides valid and reliable health status data for use in quality improvement activities, plan accountability, public reporting, and improving health. These data are considered when analyzing areas for improvement within the QAI/UM program; UPHP will develop interventions

based on areas in the HOS where UPHP scores are significantly lower than the reported national average.

- *Member Grievances*: Member complains, grievances, and appeals are tracked according to UPHP policy and, CMS requirements. Complaint and grievance data for the Medicare population are collected and reported related to at least the following categories: fraud and abuse; enrollment/disenrollment/access/benefits package; marketing; confidentiality and privacy; quality of care; expedited grievances; and other. The data is analyzed to identify opportunities for improvement, implement improvement efforts, and evaluate the effectiveness of the interventions.
- *Chronic Care Improvement Programs (CCIP) and Disease Management*: Criteria are established for participation in the CCIP and disease management programs and methods are developed and implemented to identify and monitor members with multiple or sufficiently severe chronic conditions who meet the criteria for participation in either program. The programs and methods must adhere to the Medicare Chronic Care Improvement Program (CCIP) requirements.
- CMS requirements, and HEDIS® measurements, as appropriate.
- *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. Information on the guidelines is communicated and made available to all appropriate practitioners in the UPHP network through new practitioner orientation packets, newsletters, website, and upon request through UPHP Customer Service. The CPG are the basis for development and implementation of the UPHP disease management and care management programs.
- *Care Management*: The entire UPHP organization assists in coordinating services provided to members to facilitate appropriate delivery of care and services. Care management is a more robust process to help members regain or maintain optimum health in the right setting in a cost effective manner. Care Management activities include:
    - Health Risk Assessment (HRA) the comprehensive HRA focuses on the following areas:
        - Social functioning
        - Health condition and preventative health measures
        - Informal support services
        - Nutritional and hydrations status

        - Environment assessment
        - Dental and vision status
        - Cognitive patterns
        - Medications
        - Communication and hearing
        - Skin condition
        - Mood and behavior patterns
        - Functional status
        - Disease, diagnosis, and disabilities
        - Service utilization
    - *Individualized Care Plan (ICP)*: Care plan goals are established by the UPHP Care Management Clinical Coordinator (CM), the member, and any other member allies, using a person-centered process. The ICP reflects a coordination of services to improve transitions of care across healthcare settings and providers, appropriate utilization, and cost- effective service delivery. The following objectives are utilized when assisting members to develop ICP's:
        - Improving self-management and independence
        - Improving mobility and functional status
        - Improving pain management
        - Improving medication management or coordination of pharmacy services
        - Improving quality of life and satisfaction with health status and health services
        - Reducing hospitalizations and Skilled Nursing Facility placements
- *HEDIS*®: These performance measures are used to identify opportunities for improvement and to demonstrate improvement in important clinical areas. These measures include screenings, medication reconciliation, care transition, and specific chronic condition management such as diabetes. This data is also used to evaluate the 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, medical records must be maintained in a manner that is current, detailed, and organized, and which permits effective and confidential patient care and quality review. Providers are notified of this policy via new practitioner orientation packets, the Provider Manual, and the UPHP website. Providers many also request a copy by calling the UPHP Customer Service Department.

UPHP 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 screen for benefits coverage and medical necessity in accordance with regulatory and accrediting standards, 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 our 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 for UPHP Medicare, refer to UPHP policy 600-305 Utilization Management Process for Medicare, which is outlined later in this chapter. For detailed information on the clinical appeals processes, refer to UPHP Medicare policy 600-324 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 systemic 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.

- *Satisfaction with the UM Process*: UPHP assesses both provider and member satisfaction annually to identify potential problems and/or unfavorable effects of the process as it relates to a member seeking care and a provider requesting care. After gathering information that specifically addresses member and provider satisfaction regarding the UM process, UPHP identifies opportunities for improvement and takes appropriate and immediate actions for effecting change.
- *Emergency Services*: Emergency services are provided without the requirement of pre-authorization, 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 updates 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.
    - *Medication Therapy Management Reporting*: UPHP's Medication Therapy Management (MTM) Program is maintained by Magellan Rx and is designed to ensure that covered Part D drugs that are prescribed to targeted beneficiaries are used to optimize therapeutic outcomes through improved medication use, and is intended to reduce the risk of adverse events, including adverse drug interactions, for targeted beneficiaries. The program includes prescriber interventions to promote coordinated care, an interactive comprehensive medication review and discussion with the beneficiary to assess their medication therapies and the creation of medication action plans, which includes frequent monitoring and follow-up of the beneficiaries' medication therapies.
- *Ensuring Appropriate Utilization*: To ensure the delivery of appropriate care to members, UPHP informs members, practitioners, providers, and UPHP employees that there are no incentives to encourage barriers to care and service.

- UPHP also performs utilization analysis to identify potential under- and over-utilization issues and implements a plan of action that identifies opportunities for improvement.
- *Affirmative Statement about Incentives*: 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. There are no financial incentives for UM decision makers to encourage decisions that result in underutilization.
- *Behavioral Health Care*: UPHP Medicare provides benefit coverage of in-plan inpatient and outpatient behavioral health services for its Medicare members consistent with Medicare requirements.
- *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 under the Michigan Peer Review Entities Act (MCLA Section 331.531 et seq.)
- *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 upon request of the QAI/UM program evaluation. There is ongoing communication of relevant quality and utilization 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. Prior to delegation, UPHP will evaluate the agency's capacity to perform the activities and develop a mutually agree upon document which describes the roles and responsibilities of UPHP and the delegated organization.

Care Management

The Upper Peninsula Health Plan's (UPHP) Care Management (CM) program is designed to help providers engage their patients in the management of their chronic conditions and achievement of their self-management goals utilizing a person-centered process.

Clinical Coordinators – Care Management complement the primary care provider's plan of care to help members to maintain or improve their health care status.

Clinical Coordinator – CM interventions include:

- Care coordination between providers.
- Individualized plans of care with short-term and long-term goals.
- Care coordination with community organizations.
- Member education.
- Assistance during Transitions of Care.

Providers can call Clinical Services at 1-906-225-7921 or 1-877-349-9324 if assistance is needed to reach a member's Care Manager.

UM Process

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

Upper Peninsula Health Plan Clinical Services contact information:

Telephone: 1-877-349-9324
Fax: 1-906-225-9269

Providers must verify:

- Eligibility
- Requested service is a covered benefit
- Requested service requires prior authorization or notification

Authorization

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

Services that require prior authorization from our plan include:

- Hearing Aids (UPHP Advantage benefit only)
- Medically necessary weight reduction services
- Home Health Services
- Molecular Pathology testing Code 81479
- Out of Network Services
    - Provider services
    - Facility services (outpatient)
    - Labs
    - Durable Medical Equipment (DME) supplies
    - Planned inpatient admissions
- Medically necessary reconstructive surgery
- Medical pharmacy benefit services listed on the UPHP website
- DME medical supplies not meeting Medicare guidelines as well as the following items:
    - CPAP
    - BiPAP
    - TENS
    - Negative pressure wound therapy o Pneumatic compression devices o Hospital Beds – semi-electric
    - Powered wheelchairs and accessories
    - Powered air floatation bed
    - Non-powered advanced pressure reducing mattress and overlay for mattress

- Powered air overlay for mattress
- Powered pressure-reducing air mattress
- Lightweight wheelchairs
- Ventilators
- Wearable Cardio-Defibrillators
- Osteogenic bone stimulators
- Transcutaneous Electrical Nerve Stimulation Devices
- Miscellaneous DME items
- Orthotics and Prosthetic Devices over $500

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 case-management activities on the part of the Upper Peninsula Health Plan. Services that require notification to the Upper Peninsula Health Plan Clinical Services include, but are not limited to, the following:

- **Urgent/Emergent Inpatient Admissions and Observation Services**– *within one business day of admission*
- **Pre scheduled in-network inpatient admissions** – *prior to admission*
- **Skilled Nursing facility admissions** – *within one business day of admission*
- **Swing bed admissions** – *within one business day of admission*

Prior Authorization Requests

- Authorization requests are to be done by the PCP or in-plan specialist.
- An out-of-plan specialist under the following circumstances can request prior authorization:
- Emergency Department(ED) follow-up visits
  - Hospitalization follow-up
  - Out-of-Plan Provider has a current authorization on file
  - Newly eligible UPHP members who are in active course of treatment with an out-of-plan provider

  - UPHP member has moved out of the UPHP provider area and not disenrolled from UPHP
- Prior Authorization forms can be found on the UPHP website at www.uphp.com, or by contacting the Customer Service Department at 1-877-349-9324.
- Completed forms are sent by fax or by mail to the number/address on the form (urgent requests may be phoned in).
- Pertinent clinical documentation should accompany the request.
- Medical pharmacy benefit service prior authorization requests are submitted to Magellan Rx Management from the rendering provider at www.ih.magellanrx.com.

Authorization must be obtained **before** services are provided. Retrospective requests will not be reviewed. 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.

The Upper Peninsula Health Plan's complete Utilization Management policies and procedures are available on the UPHP website at www.uphp.com/medicare. For any questions, please contact the Customer Service Department at 1-877-349-9324.

CLAIMS

The Upper Peninsula Health Plan (UPHP) ensures accurate and timely claims processing in compliance with Medicare Managed Care requirements. Please submit claims for UPHP Medicare to:

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 that can be used to submit claims directly to UPHP via direct claim entry or 837 claim file upload. You can also use the portal 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 877-349-9324.

Billing Address:

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

Please contact the UPHP Claims Department for claims questions at 877-349-9324, Monday – Friday 8 a.m. – 5 p.m. EST. Please have the member ID number, date of service, charge amount, and/or claim number ready when calling to ensure timely assistance.

Claim Submission Guidelines

Filing Limit

- Claims must be sent to UPHP within 365 days from the date of service.
- UPHP responds to claims within the Federal processing guidelines. The claims determination will be reported to the provider on an Explanation of Payment (EOP) / Remittance Advice (RA).
- 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 08-05 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 Submission Guidelines for Dual Eligible Members

Services provided to patients who are covered by both UPHP Medicare and UPHP Medicaid should follow these guidelines:

- Submit claims with the UPHP Medicare member ID number.
- Submit one authorization request with the UPHP Medicare member ID number – UPHP will coordinate authorization requirements, benefits, and services between the two products.
- Submit one claim to UPHP – upon receipt of the claim, we will process under UPHP Medicare then UPHP Medicaid. It is not necessary to submit two claims.
- Claims processing information will be reported on two Remittance Advice (RA) forms:
    - The first RA will come from UPHP indicating how the claim was processed and informing you that the claim was forwarded to UPHP Medicaid for secondary processing.
    - The second RA will illustrate how the claim was processed for UPHP Medicaid.

Claims Policies

Adjudication

UPHP adjudicates claims according to the Medicare claim payment rules and regulations. Reference the Uniform Billing Guidelines, ICD-9 Diagnosis Code Book, CPT Code Book, and HCPCS when submitting a claim.

Payment

Contracted and non-contracted providers will be paid for covered services according to the Original Medicare Fee Schedule or the Medicaid Fee Schedule, whichever is

applicable, 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.

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	No	Boxes 57, 76, 77, 78, and 79

Coordination of Benefits

When a member has other insurance, there are rules set by Medicare that decide whether UPHP or the other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If the member has retiree coverage, Medicare pays first.
- If the member's group health plan coverage is based on their or a family member's current employment, who pays first depends on their age, the size of the employer, and whether they have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
    - If the member is under 65 and disabled and they or their family member is still working, the employer plan pays first if the employer has 100 or more

employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If the member is over 65 and they or their spouse is still working, the employer plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If the member has Medicare because of ESRD, the group health plan will pay first for the first 30 months after the member has become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for the Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

UPHP members should inform their providers, hospitals, and pharmacies of other insurance coverage and should update their other insurance information with UPHP. Any questions should be directed to the UPHP Claims Department at 877-349-9324.

Interim Billing

UPHP does accept claims billed with an interim bill type of outpatient services, containing a 2, 3, 4, etc. in the fourth 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 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.
- Bill modifiers per C.P.T. and HCPCS guidelines.

PROVIDER APPEALS

When a provider disagrees with a determination made by Upper Peninsula Health Plan (UPHP) regarding payment for Medicare covered services, they may file an appeal in writing to UPHP 60 calendars 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 it 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 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/or 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
- Signed Waiver of Liability form (non-contract providers)
- 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 signed provider Waiver of Liability (WOL) from a non-contract provider and/or other 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 for UPHP contracted providers.

For non-contracted providers, if UPHP continues to deny payment in whole or in part, UPHP will send the complete case file to the Independent Review Entity (IRE) contracted by CMS by mail or overnight delivery service at its designated address. For requests for payment, UPHP must forward the case file to the IRE no later than 60 calendar days from the date UPHP receives the request for reconsideration.

UPHP maintains its appeal case files in an appeals software system. The case file sent to the IRE will include:

- An Appeal Transmittal Cover Sheet on top of the case file, so that the IRE can clearly differentiate new cases from other incoming materials;
- Reconsideration Background Data Form, which is a standard data collection document with supplementary narrative description and attachments;
- Case Narrative
- Copy of Organizational Determination Notices;
- Copy of the reconsideration request;
- Copy of information used to make the health plan internal reconsideration decision, including supporting documentation such as medical records; and
- Evidence of Coverage on a CD

When the IRE completes its reconsidered determination, it is responsible for notifying the involved parties of the reconsidered determination and informs parties, other than the health plan of their right to an administrative law judge (ALJ) hearing if the amount in controversy meets the appropriate threshold requirement and the decision is adverse. The IRE will describe the procedures that the parties must follow to obtain an ALJ.

If the amount in controversy meets the monetary threshold of the reconsideration, the provider may request an ALJ hearing within 60 days of receipt of the reconsideration

decision. This is the third appeal level. The IRE is responsible for compiling the reconsideration file and forwarding it to the appropriate ALJ hearing office. The provider must send a copy of the ALJ hearing request to all other parties to the reconsideration. Hearing preparation procedures are set by the ALJ. UPHP may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and the parties to the hearing. The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons including, but not limited to the case being escalated from the reconsideration level, the submission of additional evidence not included with the hearing request, the request for an in-person hearing, the provider's failure to send notice of the hearing request to other parties, and the initiation of discovery if CMS is a party. If the ALJ does not issue a decision within the applicable timeframe, the provider may ask the ALJ to escalate the case to the Appeals Council level.

If the provider to the ALJ hearing is dissatisfied with the ALJ's decision, the provider may request a review by the Medicare Appeals Council (MAC), which is the fourth level of appeal. A minimum monetary threshold is not required to request Appeals Council review. The request must be submitted in writing within 60 days of receipt of the ALJ's decision or dismissal, and must specify the issues and findings that are being contested. In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable timeframe, the provider may ask the Appeals Council to escalate the case to the Judicial Review level.

If the MAC adopted, modified, or reversed the ALJ decision and the amount in controversy meets the appropriate threshold the provider may request judicial review in federal district court. This is the fifth and final level of appeal.

Member Appeals Related to Utilization Management Adverse Determination

When an adverse determination is made, a written notice 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 (reconsideration), and if necessary, an independent review entity, a hearing before the Administrative Law Judges (ALJ), review by the Medicare Appeals Council (MAC), and

judicial review. The member will be provided with a copy of any and all applicable appeal forms.

Members may file an appeal (also called "reconsideration") with any UPHP employee. Members have sixty (60) calendar days from the date of the notification of an adverse determination to file an appeal with UPHP.

If a member shows good cause, UPHP may extend the time frame for filing an appeal. The member requesting the good-cause extension may file the request with UPHP in writing including the reason why the request was not filed timely. The beneficiary may file a grievance with UPHP if the request for good cause extension is denied.

Members are offered assistance in completing appeal forms and with the appeal process. Interpreter services are offered and TTY toll free numbers are provided. Members may designate an authorized representative to act on their behalf using the Appointment of Representative Form (ARF – CMS-1696). An appeal request submitted by someone other than the member, is not considered received without an ARF. The ARF must be submitted within the sixty (60) day appeal time frame. A representative appointed by a member, unless revoked, is considered valid for one year from the date that the appointment is signed by both the member and the representative. The UPHP response time frame will begin on the date the ARF is received.

A member's physician may appeal without a completed representative form in the following circumstances:

- The request comes from the member's in-network primary care physician
- The request comes from either an in-network physician or non-contract physician, and the member's records indicate he or she visited this physician at least once before

If a physician appeals and it appears to be the first contact between the requesting physician and member, UPHP will need to confirm the physician has given the member appropriate notice.

Members may continue to receive the disputed services during the appeal/reconsideration processes. UPHP may recover the related costs if:

- The decision to deny service is upheld
- The member withdraws the request

For further information on adverse determination, please see UPHP policy #600-324 Member Appeals Related to UM Adverse Determination.

Standard 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 Review and Appeal Coordinator
853 West Washington St.
Marquette, MI 49855

Phone: 1-906-225-4481 or **Toll Free:** 1-877-349-9324
TTY users: 711
Fax: 906-225-7720

The member may submit comments, documentation, or other supportive information relative to the appeal.

A panel comprised of two or more individuals not involved in the initial determination and not the 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 beneficiary's condition or disease and not subordinate to a prior deciding practitioner.

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 will be notified 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.

A thorough investigation of all information, including any aspects of clinical care involved, shall be made before a determination is rendered. The investigation shall include all of those persons identified in the appeal with a complete record of each person's description of the appeal and any actions taken. The member appeal is considered resolved if at any point in the appeal process the member acknowledges satisfaction, verbally or in writing, with the initial determination.

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 in a culturally linguistic and appropriate manner per the timeframes listed below.

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.

Standard Appeal Time Frames:

- **Extension – 14 Calendar Days:** The length of time an appeal can be extended only if the member 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.
- **Internal Appeal – 60 Calendar Days**: The length of time a member has to file a standard or expedited appeal ("reconsideration") with UPHP after receipt of an initial adverse determination notice.
- **Pre Service Appeal – 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 Appeal –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.
- **Request for Payment Appeal – 60 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.

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.
- **14 Calendar Days**: The length of time for an extension of an expedited appeal if the member requests the extension or if UPHP can justify a need for additional information and documents how the extensions is in the interest of the member.
- **3 Calendar Days**: The length of time, after verbal notification, UPHP has to provide written notice of the denial of an expedited appeal after oral notification of the denial expedited request.

If UPHP affirms the adverse determination (in whole or in part) in the appeal process the case file will automatically be submitted to an Independent Review Entity (IRE) for further reconsideration.

UPHP will send the member a Notice of Appeal Status indicating the case has been forwarded to the IRE for reconsideration. This notice will include information on the beneficiary's right to submit additional pertinent evidence to the IRE and information on how to contact the IRE. For standard reconsideration, UPHP will forward the member's case to the IRE no later than 30 days for standard reconsiderations. For expedited reconsiderations, UPHP will forward the case no later than within 24 hours. For payment requests, UPHP will forward the member's case file to the IRE no later than 60 calendar days from the date it receives the request. The member will be notified of the IRE decision within 30 calendar days for a standard reconsideration or within 72 hours for an expedited reconsideration. This is the second level of appeal. The IRE will provide further appeal rights to the member if their findings are not fully favorable to the member.

PHARMACY

The prescription benefit is an important component of our enrollee's comprehensive treatment program. The goal of the Upper Peninsula Health Plan (UPHP) is to provide enrollees rational, clinically appropriate, and cost effective pharmaceutical care.

Formulary

The UPHP Medicare formulary is a list of covered drugs selected by UPHP Plan in consultation with a team of healthcare providers, which represent the prescription

therapies believed to be a necessary part of a quality treatment program. Both UPHP Advantage and UPHP Choice have a five tier formulary. Preferred generics are Tier 1, Non-Preferred generics are Tier 2, Preferred Brands are Tier 3, Non-Preferred Brands are Tier 4 and Tier 5 is Specialty.

UPHP contracts with Magellan Rx, a pharmacy benefit manager, to manage the UPHP Choice and UPHP Advantage formularies and our pharmacy network. The formulary may change from time to time throughout the year and on January 1 of each year. Current UPHP Choice and UPHP Advantage formulary information can be **found on the UPHP website www.uphp.com/medicare**.

Limitations and restrictions for coverage may apply. For example, prior approval (or prior authorization), quantity limits and step therapies are listed for some drugs on the formulary. For prior authorization medications approval must be obtained before a prescription will process. Step therapy requirements require that certain drugs must be tried in order for another drug to be covered.

Enrollees receive detailed information regarding their UPHP Choice and UPHP Advantage pharmacy benefits. If you have questions, you may contact UPHP Customer Service or 4D Pharmacy Management, UPHP's Pharmacy Benefit Manager (PBM) at the following numbers:

Magellan Rx Prior Authorization Help Desk: 888-274-2031
Magellan Rx PA Fax Line: 248-341-8133
UPHP Customer Service Department: 877-349-9324

Covered Drugs

The drugs on the drugs covered by UPHP Choice and UPHP Advantage can be found on the UPHP website at www.uphp.com/medicare. UPHP Choice and UPHP Advantage will cover all medically necessary drugs on the formulary when they have been prescribed by the enrollee's provider. These drugs are available at pharmacies within our network. A pharmacy is in our network if we have an agreement with them to work with us and provides services. We refer to these pharmacies as "network pharmacies."

The formulary on our website is searchable. You can search alphabetically by generic or brand (trade) name or by therapeutic class of the medication. Use the alphabetical list to

search by the first letter of a medication. Search by typing part of the generic or brand (trade) name. A search by therapeutic class of the medication is also available. The search function can be used to determine coverage.

Specific covered drugs billed under the Medical Pharmacy Benefit Program need to be submitted to Magellan Rx Management www.ih.magellanrx.com or by calling 800-424-8241 for a prior authorization. The codes that require a prior authorization can be found on the UPHP website.

Drug Formulary Exceptions/Coverage Determination Process

An exception to our coverage rules can be requested. An exception can be requested to cover a drug that is not on our formulary, to ask for an initial coverage decision for a formulary, tiering or utilization restrictions exception, to waive coverage restriction or limits on a drug, or to provide a higher level of coverage for a drug.

You can contact Magellan Rx Customer Services at 844-827-0182 or you can access appropriate forms on our website www.uphp.com/medicare. The website provides a detailed description of the Medicare Prescription Drug Coverage Determination and Exceptions process.

The enrollee, their appointed representative, or a provider/prescriber can submit a request for a coverage determination orally or by using the Request for Prescription Drug Coverage Determination form. The necessary information should be completed on the form. It may be mailed or faxed to Magellan Rx at the addresses listed on the form or Magellan Rx may be contacted directly at the toll-free number indicated on the form.

UPHP Choice and UPHP Advantage Medicare enrollees have the right to request a coverage determination concerning their rights with regard to the prescription drug coverage. An adverse coverage determination constitutes any unfavorable decision made by or on behalf of Upper Peninsula Health Plan Choice or Upper Peninsula Health Plan Advantage regarding coverage or payment for prescription drug benefits an enrollee believes he or she is entitled to receive.

A decision by UPHP Choice or UPHP Advantage concerning an exception request constitutes a coverage determination; therefore all of the applicable coverage determination requirements and timeframes apply. When an exception request is

received, it can be pended until a provider submits the medical reason(s) for the drug exception. Providers may mail or fax the information or provide the information on the phone and follow up by faxing or mailing a written statement if necessary.

For more information about the coverage determination process, you can find the Evidence of Coverage online at www.uphp.com/medicare.

The following actions are considered adverse coverage determinations:

- A decision not to provide coverage for a prescription drug (which includes a decision not to pay because the drug is not on the plan's formulary, determined to be not medically necessary, the drug is furnished by an out of network pharmacy, or the UPHP Choice and UPHP Advantage determines the drug is otherwise excluded under the CMS regulations that the enrollee believes should be covered.
- The failure to provide a coverage determination in a timely manner when a delay would adversely affect the health of the enrollee.
- A decision concerning an exception to a plan's tiered cost-sharing structure.
- A decision concerning an exception request involving a non-formulary drug.
- A decision concerning an exception request to lift restrictions such as prior authorization, step therapy, and quantity limits.
- A decision on the amount of cost sharing for a drug.

UPHP Choice and UPHP Advantage have both a standard and expedited procedure in place for making coverage determinations. Generally, we a request for an exception will only be approved if the alternative drugs included on the plan's formulary, or additional utilization restrictions would not be as effective in treating a condition and/or would cause adverse medical effects. Enrollees or their authorized representative may ask UPHP for a formulary or utilization restriction exception with a statement from you supporting their request. Generally we must make a decision with 72 hours of receiving the prescriber supporting statement. An expedited exception can be requested if it is believed that the enrollee's health could be seriously harmed by waiting up to 72 hours for a decision. If an expedited request is granted, a decision must be provided to the enrollee no later than 24 hours after getting the prescribing physician's supporting statement.

Upon receipt of a standard coverage determination request, UPHP Choice and UPHP Advantage will review the request and make the determination. The determination will

be conducted using applicable timeframes and the enrollee, their appointed representative and provider will be notified of the decision.

The website www.uphp.com/medicare provides a detail description of the Medicare Prescription Drug Coverage Determination and Exceptions process.

Transition Supplies

New enrollees may be taking drugs that are not on our formulary. UPHP covers transition supplies of drugs. Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy cannot be used to buy a non-Part D drug or a drug out of network.

You can assist the enrollee in switching to a similar, appropriate drug that we cover or request a formulary exception. During the first 90 days an enrollee is in the UPHP Choice or UPHP Advantage plan, we may cover certain drugs. UPHP will cover a maximum of a 30-day supply (unless you have a prescription written for fewer days) at network pharmacies.

If the enrollee is a resident of a long-term care facility, we will allow a refill of a prescription until we have provided a 91 day transition supply, consistent with the dispensing increment, (unless you have a prescription is written for fewer days). We will cover more than one refill of these drugs for the first 90 days.

Enrollees receive detailed information about our UPHP Choice or UPHP Advantage prescription drug coverage, in their Evidence of Coverage and other plan materials.

The UPHP Choice and UPHP Advantage formulary may change during the year. Generally, it will only change if:

- A cheaper drug comes along that works as well as a drug on the Drug List now

or

- We learn that a drug is not safe

We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior approval for a drug
- Add or change the amount of a drug an enrollee can receive
- Add or change step therapy restrictions on a drug

UPHP informs enrollees at least 60 days prior when a drug they are taking is removed from the formulary or if we add prior approval, quantity limits and/or step therapy restrictions. The current up to date UPHP Choice and UPHP Advantage formulary can be found on our website at www.uphp.com/medicare.

Medication Therapy Management Program

UPHP Choice and UPHP Advantage enrollees who have multiple chronic diseases take many medications regularly and have an expensive drug therapy regimen may need some help managing their medications. UPHP has developed a Medication Therapy Management Program unique for these enrollees. The program is administered by a team of health care professionals, including clinical pharmacists, registered nurses, case workers, and support staff.

The Centers for Medicare and Medicaid Services (CMS) requires companies that offer Part D benefits to also offer a Medication Therapy Management Program. Enrollees who meet the three criteria listed above are automatically enrolled in the program, but have the ability to opt out of participation. This is a free service to eligible enrollees. This program is not considered a benefit.

Upper Peninsula Health Plan and the Pharmacy Benefit Manager (PBM) will manage the MTM program (MTMP). The MTMP offered to beneficiaries and prescribers is structured to meet both CMS compliance and the spirit of the CMS MTMP providing value-driven healthcare for Medicare Part D beneficiaries.

This program is not considered a benefit; it is part of the services for all enrollees. This is a free service for eligible beneficiaries. If an enrollee does not wish to participate and stop participation in the program, the enrollee must opt out. This is done by contacting Customer Services at the number listed below. UPHP Customer Service personnel will be prepared to answer questions about the MTM Program.

Upon identification of a MTMP eligible enrollee, the Pharmacy Benefit Manager begins enrollee outreach. In accordance with CMS requirements, targeted beneficiaries will be enrolled into the MTMP using an opt-out only method. A welcome letter is sent to a

MTMP eligible enrollee within 60 days of identification. The welcome letter provides details of the program, an offer to schedule a Comprehensive Medication Review (CMR), and a description of MTMP options (i.e., level of participation, including option to opt out). Within 60 days of identification, the Pharmacy Benefit Manager will also provide telephonic outreach to MTMP eligible enrollees.

Long-term care (LTC) beneficiaries are offered the same services as non-LTC enrollees. LTC enrollees receive a welcome letter and telephonic outreach to promote CMR participation. Quarterly Targeted Medication Reviews (TMRs) are performed for all active LTC and non-LTC enrollees. CMRs are performed at least annually for LTC and non-LTC enrollees, if the patient, caregiver, or other authorized individual elects to participate in the interactive review.

UPHP Medication Therapy Management Program (MTMP) targets beneficiaries who are enrollees in the sponsor's Part D plan who: Have specific chronic diseases, Dyslipidemia, Hypertension, Diabetes, Chronic Heart Failure (CHF), Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD) - A beneficiary must have 2 out of the chronic diseases listed above, AND

- Are taking multiple (at least 6) Part D drugs, AND
- Are likely to incur one-fourth of specified annual cost threshold ($3,967) in previous 3 months

The MTMP includes an Annual Comprehensive Medication Review (CMR) and interventions in accordance with the CMS expectations that every MTMP will have both enrollee and prescriber-based interventions. Following a CMR, the CMS standardized written format including standard Cover Letter, Personal Medication List, and Medication Action Plan is mailed to all participating enrollees. The prescriber of the eligible member will receive a faxed Physician CMR recommendation letter, which will include patient-specific subjective and objective clinical data, as well as Pharmacist-identified intervention recommendations(s) from the CMR.

Interventions are sent to patients based on their level of participation in the MTMP and severity of the identified drug related problem. When recommendations exist,

prescribers receive a faxed CMR Recommendation letter, regardless of the level of interaction by the patient. At the discretion of the CSS Pharmacist, the prescriber(s) may be contacted directly by telephone, in addition to receiving faxed information.

Identified MTMP eligible enrollees who choose not to participate in the CMR are provided a TMR. TMRs are performed quarterly for all active MTMP eligible enrollees, evaluating any inputs that are part of the MTM program.

Additional Information

Additional information about UPHP's MTMP program is available on UPHP's website at www.uphp.com/medicare or by calling UPHP Customer Service at 1-877-349-9324 or our Pharmacy Benefit Manager, Magellan Rx's Medication Therapy Management Department directly at 1-855-552-6425 (TTY 711) between the hours of 8 a.m. to 6 p.m. Eastern time, Monday through Friday.

Important Pharmacy Contact Numbers

UPHP uses Magellan Rx as a pharmacy benefit manager (PBM). For specific questions regarding pharmacy benefits, contact Magellan Rx. For general questions regarding an enrollee's benefit, call the UPHP Customer Service Department.

Magellan Rx System Prior Authorization Help Desk: 888-274-2031
Magellan Rx System PA Fax Line: 248-341-8133
UPHP Customer Service Department: 877-349-9324

If you have questions about UPHP Choice or UPHP Advantage formulary you may contact us. If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week or visit http://www.medicare.gov.

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 Providers and Behavioral Health Providers such as MDs, DOs, PhDs, DDSs (who provide care under the medical benefit program such as oral surgeons, endodontists, and periodontists), DPMs, DCs, PAs, NPs, MSWs, LLPs, PsyDs, PTs, OTs, and SLPs 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 UPHP's policy.

All providers must cooperate with UPHP's quality improvement activities, including allowing UPHP to collect performance measurement data and assisting UPHP in improving clinical and service measures.

Only those applicants/ providers 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 UPHP's provider network.

Credentialing Application

Upon request to UPHP, 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 UPHP's provider network.

Upon request, the Credentialing staff will inform a practitioner of the status of his or her application. The status may be given either verbally or in writing, within 5 business days of the request. Written notice may include returning application or contracts via mail or fax, recommendation to review Provider Manual or other distributed materials, or by directing the practitioner to the appropriate web site. Credentialing personnel may give the status on actions on a license, malpractice claims history, board-certification history, affiliation history, or if the application has missing documentation, and/or erroneous/conflicting information.

In the event a practitioner's or organization's license actions, malpractice claims history, school or residency completion, work history, board certification, accreditation or government survey or affiliation history obtained during the credentialing process varies substantially from the information provided on the application, or if there is cause to believe that any information was omitted, the practitioner or organization will be notified in writing and will be given 30 days to correct the erroneous information by responding in writing to the Credentialer who requested it.

All practitioners have a right to review the information obtained by UPHP used to evaluate the practitioner's credentialing application. This includes malpractice claims history, school or residency completion, license actions, board certification or affiliation history. The applicant does not have the right to review references, recommendations, peer-review information, information that is collected which is not obtained to meet verification requirements or any information in which the law prohibits it and shall never be revealed to the applicant. The practitioner may call or write the Credentialing Supervisor or the Medical Director to make an appointment to review his or her credentialing information.

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. Physicians must give a copy of a valid Drug Enforcement Administration (DEA) certificate. If an applicant has a pending DEA certificate, he or she may be approved by the Credentialing Committee with the stipulation that he or she not write prescriptions. The applicant must designate another in-network provider with a valid DEA certificate who will write all prescriptions that require a DEA number until the provider has a valid DEA certificate. The newly appointed

provider must submit a copy of the DEA certificate to UPHP as soon as they receive it. UPHP does not require certain provider types such as Optometrists, Physician Assistants, Nurse Practitioners, Podiatrists, Pathologists or Radiologist to have a DEA certificate, but if one is helped by a provider, a copy must be provided to UPHP.

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 by the ABMS or AOA in the board of their practice specialty, the physician 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 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 provider's employment experience. Any gaps exceeding six months should be reviewed and clarified either verbally or in writing. 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 provider.
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. All applicants must be enrolled in Medicare.

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.
14. Additional information that may be required by UPHP.

Disciplinary Action

Noncompliance with policy, procedure, contract, or addenda may be investigated and reviewed by Provider Relations, Credentialing, 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 Committee for review. Adverse action taken by the Credentialing 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.

- *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 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 RESPONSIBILITIES

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.

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 means of reaching an on-call physician

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: Credentialing/Provider Relations
853 West Washington St.
Marquette, MI 49855
Fax: 1-906-225-7776

For further information about updating provider information, please call the UPHP Credentialing/Provider Relations department at 1-877-349-9324.

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 Medicare 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, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather a misuse of resources.

Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples of Fraud and Abuse

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

Preventing Fraud and Abuse

Upper Peninsula Health Plan and other State and Federal agencies are collaborating to help 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 must be reported to UPHP's Compliance Officer. UPHP has adopted and enforces policies prohibit retaliation against anyone who in good faith reports suspected fraud, waste and abuse. 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, ID number, and any other identifying information

You may report possible fraud and abuse to:

UPHP Compliance Officer
853 West Washington Street
Marquette, MI 49855
Toll-Free: 800-835-2556
UPHP Compliance Hotline: 906-225-5081

U.S. Department of Health and Human Services Office of Inspector General
Attn: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026
OIG Hotline: 1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950
www.oig.hhs.gov/fraud/report-fraud

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;

- Knowingly 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) strives 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 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 strictly regulated 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. The Provider/Practitioner is not required to agree to any such request for restrictions.
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.