Updated November 2018

UPHP

UPPER PENINSULA HEALTH PLAN

MI HEALTH LINK PROVIDER MANUAL

UPHP
UPPER PENINSULA HEALTH PLAN

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INTRODUCTION

Welcome

Welcome to the Upper Peninsula Health Plan (UPHP)! 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 health care providers are valuable partners to improve our members' quality of life and promote wellness. The best health care 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 UPHP

UPHP, located in Marquette, MI, 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 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 1,700 providers, the staff has increased to more than 150 employees, and enrollment has increased to more than 50,000 members.

CONTACT INFORMATION

The following is a list of contact information to assist you in making the appropriate contact with the service departments of UPHP.

Customer Service 877-349-9324

Fax Number 906-225-7690

Pharmacy Related Authorizations/Questions (Magellan Rx Customer Service) 888-274-2031

24-hour Nurse Line 844-411-3695

Behavioral Health Services (PIHP/NorthCare Customer Service) 888-333-8030

Eligibility and PCP Verification 877-349-9324

Utilization Management and Prior Authorization Inquiry Fax Number 906-225-9269

Medical Claims Services 877-349-9324

Claims Appeals Fax Number 906-225-7690

Credentialing Services 877-349-9324

Clinical Services 877-349-9324

Clinical Appeals Fax Number 906-225-7720

Provider Relations/Contracting 877-349-9324

Transportation 877-349-9324

Fraud and Abuse Prevention 888-904-7526

Claims Address:

Upper Peninsula Health Plan
P.O. Box 190
853 W. Washington Street
Marquette, Michigan 49855

Electronic Claims Code: 38337

UPHP MEMBER RIGHTS AND RESPONSIBILITIES

Members of UPHP are entitled to specific rights and responsibilities regarding 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 and responsibilities, please refer them to their Member Handbook (Evidence of Coverage), the UPHP website at www.uphp.com/medicare, or to UPHP Customer Service at 877-349-9324 (TTY: 711).

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

Member Rights and Responsibilities

- A right to receive information about UPHP, its services, its practitioners and providers, and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and right to privacy.

- A right to participate with practitioners in making decisions about their health care, including the right to refuse treatment.
- A right to candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- A right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- A right to request and receive a copy of his/her medical records and request that they be amended or corrected.
- A right to be furnished health care services consistent with the MDHHS contract, state and federal regulations.
- A right to be free to exercise his/her rights without adversely affecting the way UPHP, providers or the State treats them.
- A right to be free from other discrimination prohibited by State and Federal regulations due to (includes but not limited to):
    - Medical condition (including physical and mental illness)
    - Claims experience
    - Receipt of health care
    - Medical history
    - Genetic information
    - Evidence of insurability
    - Disability
    - Age
    - Sexual Orientation
    - Religion
- A right to request and be provided with reasonable accommodations.
- A right not to be balance billed by a provider for the cost of any covered services, which includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part.
- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.

- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ENROLLEE INFORMATION

MI Health Link Program Eligible Population

The MI Health Link Program will be available to individuals who meet all of the following criteria:

- Age 21 or older at the time of enrollment;
- Eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, and receiving full Medicaid benefits. (This includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a nursing facility and have a monthly patient pay amount.); and
- Reside in a demonstration region.

The following populations will be excluded from enrollment in the MI Health Link Program:

- Individuals under the age of 21
- Individuals previously disenrolled due to special disenrollment from Medicaid managed care
- Individuals not living in a demonstration region
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI)
- Individuals without full Medicaid coverage (spend downs or deductibles)
- Individuals with Medicaid who reside in a state psychiatric hospital
- Individuals with commercial HMO coverage
- Individuals with elected hospice services

Enrollment and Disenrollment Process

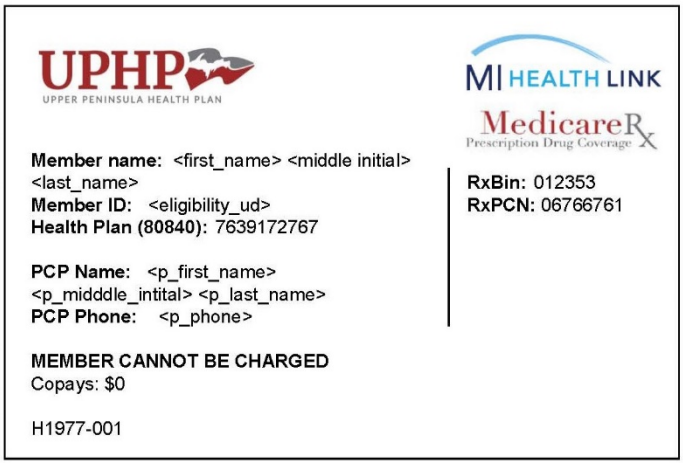
The MI Health Link Program will begin with an opt-in period during which the enrollment will only be among those individuals who choose to participate. Eligible individuals will be notified of their right to select among contracted integrated care organizations (ICOs) no fewer than 30 days prior to the first effective date of

enrollment. For eligible individuals who do not participate in the opt-in period – either by choosing an ICO or expressing a preference not to participate in the MI Health Link Program – enrollment into an ICO may be conducted using a seamless, passive enrollment process. Individuals eligible for passive enrollment will be notified no fewer than 60 days prior to the enrollment effective date of plan assignment, the opportunity to choose among ICOs, choose not to participate in the MI Health Link Program, or choose to disenroll from an ICO at any time after enrollment.

Prior to the effective date of their enrollment, beneficiaries who would be passively enrolled will have the opportunity to opt out until the last day of the month, and will receive sufficient notice and information with which to do so. Disenrollment from ICOs and enrollment from one ICO to a different ICO shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month.

The Centers for Medicare and Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS) will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations, CMS policies, and for the purposes of identifying any inappropriate or illegal marketing practices. ICO enrollments, including enrollments from one ICO to a different ICO, and opt-outs shall become effective on the same day for both Medicare and Medicaid (the first day of the following month). For those who lose Medicaid eligibility during the month, coverage and federal financial participation will continue through the end of that month.

UPHP MI Health Link Program Card


UPHP
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MI HEALTH LINK
MedicareRx
Prescription Drug Coverage

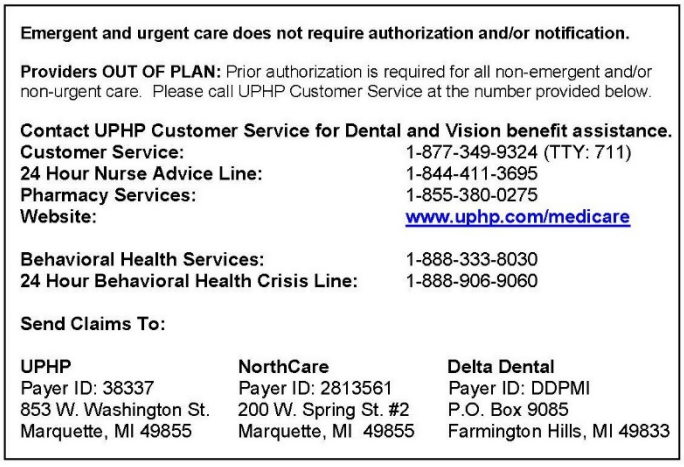
Member name: <first_name> <middle initial> <last_name>
Member ID: <eligibility_ud>
Health Plan (80840): 7639172767

PCP Name: <p_first_name> <p_midddle_intital> <p_last_name>
PCP Phone: <p_phone>

MEMBER CANNOT BE CHARGED
Copays: $0

H1977-001

RxBin: 012353
RxPCN: 06766761


Emergent and urgent care does not require authorization and/or notification.

Providers OUT OF PLAN: Prior authorization is required for all non-emergent and/or non-urgent care. Please call UPHP Customer Service at the number provided below.

Contact UPHP Customer Service for Dental and Vision benefit assistance.

Customer Service:	1-877-349-9324 (TTY: 711)
24 Hour Nurse Advice Line:	1-844-411-3695
Pharmacy Services:	1-855-380-0275
Website:	www.uphp.com/medicare
Behavioral Health Services:	1-888-333-8030
24 Hour Behavioral Health Crisis Line:	1-888-906-9060

Send Claims To:

UPHP	**NorthCare**	**Delta Dental**
Payer ID: 38337	Payer ID: 2813561	Payer ID: DDPMI
853 W. Washington St.	200 W. Spring St. #2	P.O. Box 9085
Marquette, MI 49855	Marquette, MI 49855	Farmington Hills, MI 49833

Eligibility

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

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

CHAMPS Web portal
https://milogintp.michigan.gov

Community Health Automated Medicaid Processing System (CHAMPS)
800-292-2550

UPHP Customer Service Department
877-349-9324

Additional eligibility verification options are identified in the Michigan Medicaid Provider Manual/Directory Appendix/Eligibility Verification. The manual can be found the MDHHS website at http://www.michigan.gov/mdhhs.

Please note: The UPHP Provider Web Portal system should not be used to verify eligibility.

Copayments

There are no copayments for MI Health Link Program covered services.

Changing a Primary Care Provider

UPHP members can change their Primary Care Provider (PCP) at any time. Members desiring to change their PCP must call UPHP's Customer Service Department at 877-349-9324 (TTY: 711).

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

The PCP should then send a copy of the correspondence to UPHP at:

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

When a PCP believes an immediate transfer is necessary, the PCP should contact UPHP's Customer Service Department at 877-349-9324 (TTY: 711) for assistance.

Accessing Language Line Services

UPHP can arrange for an interpreter to speak to a member in any language, free of charge. A member may call Customer Service at 877-349-9324 to inquire about interpretive services. If a member is hearing or speech impaired, TTY services are available by calling 711. Many doctors in UPHP's network speak multiple languages. A member can find out if a provider speaks their preferred language by calling Customer Service at 877-349-9324 or by utilizing the UPHP Provider Search tool, available online at www.uphp.com/medicare.

The Michigan Relay Center makes it possible for hearing-impaired and/or speech-impaired persons to call UPHP. They can be reached 24 hours a day, seven days a week by calling 711.

Special Disenrollment Requests

UPHP may initiate special disenrollment requests to the MDHHS if the member acts in a violent or threatening manner. Violent/life-threatening situations involve physical acts of violence; physical or verbal threats of violence made against providers, staff, or the public; or stalking situations.

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

UPHP must make contact with law enforcement when appropriate, before seeking disenrollment of members who exhibit violent or threatening behavior. MDHHS may

require additional information from UPHP to evaluate the appropriateness of the disenrollment. The effective disenrollment date should be within 60 days from the date MDHHS received the complete request. If the member appeals this decision, the effective disenrollment date should be no later than 30 days following the resolution of the appeal.

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

- An incident report or summary of member actions
- A copy of the PCP dismissal letter or correspondence to the member
- A copy of a police report, including a reference number given by the police department

The documentation should be sent to:

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

MI HEALTH LINK PROGRAM BENEFITS AND SERVICES

Member Benefits and Services

UPHP has a comprehensive benefit package available to all UPHP members that are eligible for The MI Health Link Program. Services for members are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care.

The following is a list of medical services covered by UPHP:

- Acute care services
    - Anesthesia
    - Certified nurse midwife services
    - Childbirth and parenting classes
    - Chiropractic services

  - Diagnostic lab x-ray and other imaging services
  - Emergency services
  - End-stage renal disease services
  - Family planning services
  - Health education
  - Hearing and speech services *(effective 9/1/2018)*
  - Home health services
  - Immunizations
  - Inpatient and outpatient hospital services
  - Medically necessary weight reduction services
  - Occupational therapy
  - Organ & bone marrow transplant services
  - Pharmacy services
  - Physical therapy
  - Podiatry services
  - Practitioners' services
  - Preventive care and screening
  - Respiratory care
  - Restorative or rehabilitative services
  - Telemedicine
  - Therapy evaluation
  - Tobacco cessation treatment
  - Transplants and immunosuppressive drugs
  - Treatment for sexually transmitted disease (STD)
  - Vision services
  - Wellness services
- Durable medical equipment (DME), supplies orthotics, and prosthetics
- Dental services
  - Preventive dental
    - Covered services: oral exams, prophylaxis, and dental x-rays
    - Excluded services: fluoride treatment
  - Restorative dental
    - Covered Services: restorative services, prosthodontics, oral, and oral/maxillofacial surgery
    - Excluded Services: non-routine services, diagnostic services, and endodontics
- Transportation
  - Ambulance and other emergency medical transportation

- Non-emergent medical transportation
- Long-term supports and services (LTSS), including services in nursing facilities as well as home- and community-based services. Members must meet the nursing facility level of care to be eligible for services.
- Nursing facility services
  - Intermittent or short-term restorative or rehabilitative services in a nursing facility
  - Medicaid-covered nursing facility services (including hospital and therapeutic leave days)
- Home- and Community-based Services – An assessment tool will be used to determine the amount, scope and duration of the services required for the individual to live in the community and use person-centered planning in determining how the services will be delivered.
  - State plan personal care services
  - Adaptive/enhanced DME and supplies
  - Chore services
  - Community living supports
  - Community transition services
  - Environmental modifications
  - Fiscal intermediary services
  - Medication reconciliation
  - Preventive nursing services
  - Personal emergency response system (PERS)
  - Training and counseling
  - Adult day program
  - Assistive technology/vehicle modifications
  - Environmental modifications
  - Home-delivered meals
  - Non-medical transportation
  - Private duty nursing
  - Respite

Services Covered Outside UPHP Benefit:

- Hospice services

Non-covered UPHP MI Health Link Program Services (services prohibited or excluded under the MI Health Link Program):

- Elective abortions and related services
- Experimental/investigational drugs procedures, or equipment
- Elective cosmetic surgery
- Services for treatment of infertility

Services Provided by the Regional Prepaid Inpatient Health Plan (PIHP) for Behavioral Health Services:

All behavioral health services will be provided through the regional PIHP, including those traditionally covered by Medicare. This does not include medications; medications will be covered by UPHP.

- Outpatient visits – for members with mild, moderate and severe behavioral health needs
- Other Medicaid behavioral health Services – for members with specialized needs related to the behavioral health and/or intellectual or developmental disability beyond covered acute care services
    - Assertive community treatment
    - Assessments
    - Assistive technology
    - Behavior treatment review
    - Clubhouse psychosocial rehabilitation programs
    - Community living supports
    - Crisis interventions
    - Crisis observation care
    - Crisis residential services
    - Enhanced pharmacy
    - Environmental modifications
    - Family support and training
    - Family therapy
    - Fiscal intermediary services
    - Health services
    - Home-based services
    - Housing assistance
    - Individual/Group therapy
    - Inpatient psychiatric hospital admissions

- Intensive crisis stabilization services
- Medication administration
- Medication review
- Nursing facility mental health monitoring
- Occupational therapy
- Outpatient partial hospitalization services
- Peer-delivered or operated support services
- Personal care in licensed specialized residential setting
- Physical therapy
- Prevention direct service model
- Skill-building assistance
- Speech, hearing and language
- Substance abuse
- Support and service coordination
- Targeted care management
- Telemedicine
- Transportation
- Treatment planning

TRANSPORTATION

Non-Emergent Transportation

If UPHP MI Health Link members have difficulty obtaining services because of transportation, you may direct them to UPHP for transportation assistance.

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

Members must contact UPHP's Transportation Department at least five business days before the date when a ride is needed or at least three business days before the date when a reimbursement form is needed. To reach the Transportation Department, call 877-349-9324 (TTY: 711). You may also request assistance online at www.uphp.com/transportation.

Emergent Transportation

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

QUALITY ASSESSMENT AND IMPROVEMENT AND UTILIZATION MANAGEMENT PROGRAM

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

Many programs and initiatives are offered by the UPHP UM Department. The objective of the UM program at UPHP is to assure appropriate, timely, and efficient utilization of services in accordance with the requirements of federal, state, and accrediting agency standards.

Responsible Staff and Committees

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

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

- UPHP Pharmacy Clinical Advisory Committee (PCAC)

  - Membership is comprised of the UPHP Medical Director (chairperson), UPHP Pharmacy Director, Pharmacy Benefit Manager (PBM) representative(s), UPHP network physicians, 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 oversee all issues relating to pharmaceutical management.
- UPHP Credentialing Committee
  - Consists of the UPHP Medical Director, UPHP CEO, and a minimum of four (but up to six) UPHP primary care/specialist licensed practitioners who routinely provide care to UPHP members.
  - Meets bimonthly via videoconference to discuss credential files for providers; UPHP Medical Director directs files needing further discussion to the UPHP Clinical Advisory Committee (CAC).
- 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), the UPHP CEO, UPHP Chief Quality Officer, UPHP Director of Pharmacy, and other UPHP and/or practitioner representatives as required.
  - Meets at least four times a year (or more frequent if urgent situations transpire) to discuss approval and oversight of the clinical services components of the QAI/UM work plan and activities, and related policies and procedures for all UPHP members; and reviews pharmacy management issues forwarded from the UPHP PCAC as well as identified practitioner and provider issues forwarded from the UPHP Credentialing Committee.
- Service Advisory Committee (SAC)
  - Chaired by the UPHP Government Programs Manager and consists of the staff members from the UPHP Provider Relations, Information Systems, Government Programs, Pharmacy, and Clinical Services Departments.

- Meets on a quarterly basis to discuss goals related to service quality, member satisfaction, access and availability, and to oversee all activities related to service quality 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 government programs by assuring members' access to network providers that participate in the applicable program; educates providers about coordinating benefits for which members are eligible; and educates members about benefits for which they are eligible.

UPHP QAI Functions and Activities

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

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

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

- Behavioral Health Services: UPHP coordinates care between medical and behavioral health care practitioners for appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.
- Patient Safety: UPHP fosters a supportive environment for practitioners and providers to improve the safety of the services delivered in their practice through member and network provider/practitioner education and program activities.

- Member Cultural and Linguistic Needs and Preferences: UPHP annually assesses the population(s) it serves for any particular racial, ethnic, cultural, or linguistic needs 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, providers, and those making UM decisions specify that contractors cooperate with the UPHP QAI/UM program, and include an affirmative action statement that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations. Contracted providers must cooperate with QAI/UM activities and allow UPHP access to medical records to the extent permitted by state and federal law, and must maintain the confidentiality of member information and records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) requirements and privacy laws.
- Availability of Practitioners: Provider availability standards are delineated in UPHP provider availability policies which ensure that the number and geographic distribution of PCPs, 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 policies to be sure performance on access standards for preventative, routine, and urgent care appointments, and after hours care are in accordance with policy standards. Member complaints and grievances are used to assess the adequacy of the network for provider member access.
- Member Satisfaction: The performance of UPHP providers and services is monitored through an annual CAHPS® member satisfaction survey which assesses member satisfaction with their health plan's health care quality and performance and is completed in conjunction with CMS and MDHHS.
- Member Grievances: Member complaints, grievances, and appeals are tracked according to UPHP policy, CMS requirements, MDHHS contract requirements, Department of Insurance and Financial Services (DIFS) regulations, and National Committee for Quality Assurance (NCQA) standards. The data is analyzed to identify opportunities for improvement, implement improvement efforts, and evaluate the effectiveness of the interventions.
- Disease Management: Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management supports

the practitioner-patient relationship and plan of care, emphasizing the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies (such as self-management). The UPHP disease management program currently addresses the needs of members with diabetes and childhood obesity. UPHP works with both practitioners and members to manage such issues as comorbid conditions, lifestyle, and medications. For more information, contact UPHP Clinical Services.

- Care Management: Every MI Health Link program member is assigned a care coordinator who is responsible for assisting the member in the management of their care and services. All members are offered an initial screening, Level I Assessment and a Level II Assessment if LTSS, behavioral health and/or intellectual or developmental disability (I/DD) needs are identified. The care coordinator leads a person-centered planning process involving the member, provider, and other members of the Integrated Care Team (ICT) which is used to develop the Individual Integrated Care and Supports Plan (IICSP) for each member. The IICSP is updated annually, or as the member's health status changes. Providers are encouraged to contact the member's care coordinator as needed.
- Interdisciplinary/Holistic Clinical Practice Guidelines and Protocols: Clinical Practice Guidelines (CPG) are based on scientific data and expert opinion and developed and/or approved by the UPHP CAC and appropriate UPHP contracted providers. Information on the guidelines is communicated and made available to all appropriate practitioners in the UPHP network through new practitioner orientation packets, newsletters, website, and upon request through UPHP Customer Service. The CPG's are used as the basis for development and implementation of the UPHP disease management and care management program activities.
- HEDIS®, Stars, and Core Metrics: These performance measures are used to identify opportunities for improvement and to demonstrate performance in important clinical areas, such as preventive care, chronic care, acute care, service utilization and medication management. The results of these performance measures are used to evaluate the QAI/UM program.
- Service Quality Improvement: CAHPS® survey 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 are identified by the UPHP SAC and as required by regulatory and accrediting standards.

- Medical Record Documentation Standards: Per the UPHP Network Provider Medical Record Documentation Standards Policy 300-026, medical records must be maintained in a manner that is complete, current, detailed, organized, and comprehensive enough to fully disclose the quantity, quality, appropriateness and timeliness of services provided and which permit effective and confidential patient care for each member. This policy is available to providers on the UPHP website or by calling the UPHP Customer Service Department. UPHP assesses compliance with medical record standards and develops action plans with providers not meeting requirements.

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 UPHP members. The following components are integral to the UM program:

- Clinical Criteria, Timelines, Information, and Communication for Decisions and Appeals: For detailed information on the UM decision-making process, refer to UPHP Policy 800-305 Utilization Management Process, which is also outlined later in this chapter. For detailed information on the clinical appeals processes, refer to UPHP Policy 800-324 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 systematic process to evaluate the inclusion of new medical technologies and the new application of existing technologies in the care of members; this includes medical and behavioral health procedures, pharmaceuticals, and devices. The

communication and oversight of this process is in accordance with UPHP Policy 300-021 Review of New Medical Technology.

- Satisfaction with the UM Process: Annually, UPHP assesses both provider and member satisfaction with the UM processes and the UM Department to identify and act upon any opportunities for improvement.
- 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 department services, and service claims are not reviewed for medical necessity.
- Procedures for Pharmaceutical Management: The UPHP PCAC develops, maintains, 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 requests; and the process for generic substitution, therapeutic interchange, and step therapy protocols.
- 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. There are no financial incentives for UM decision-makers to encourage decisions that result in underutilization.
- 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 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 assure improvements in the quality and safety of clinical care and services to the members. The report provides the basis for the revisions to the QAI/UM program and the work plan for the following year.
- Annual QAI/UM Work Plan: The QAI/UM work plan identifies specific annual quality and utilization goals and objectives, including the following information relative to the activities planned to reach each objective: target goals, planned interventions, time frames, and responsible individuals. The work plan includes planned monitoring of previously identified issues as delineated in the annual program evaluation and provides a mechanism to track issues for closure and timeliness.
- Confidentiality of Program Information: Use of member information is restricted to purposes directly related to the administration of the services required under the contract, or release required by law. This is further described in related UPHP policies 104-007 Confidentiality of Member Information and 104-015 Disposal of Protected Health Information. Information required to study behavioral health shall be protected as is required by law. Information required to study and evaluate the quality of care and services, including cost-effectiveness, is made available only to those on a need-to-know basis that are active participants in the review process.
- Communication of Program Results: UPHP notifies practitioners and members at least annually about the availability of the QAI/UM program results upon request. There is ongoing communication of relevant quality and utilization

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 through the use of a mutually agreed upon document which describes the roles and responsibilities of UPHP and the delegated and/or coordinating organization. Prior to delegation, UPHP evaluates the agency's capacity to perform the activities, assigns responsibilities, determines methods of semi-annual reporting and performance monitoring, and the consequences of failure to perform according to the agreement.

Providing Culturally, Linguistically, and Disability-Competent Care

UPHP MI Health Link participating providers must complete cultural competency, linguistics, physical accessibility ADA and disability training. The goal of cultural competency is to improve the quality of services and health outcomes for all cultural groups and to reduce the disparities that occur when cultures deviate from the majority or mainstream. Awareness of personal prejudices is the first step in providing cultural competent services. An individual must be aware of their biases in order to make sure they do not affect the care provided to enrollees.

Linguistic competency is the capacity of a provider and their staff to communicate effectively, and convey information in a manner that is easily understood by a diverse population of enrollees that include persons with limited or no English proficiency, those who have limited or no literacy skills, individuals with disabilities, and those who are deaf or hard of hearing. Providers must find appropriate ways to communicate effectively with enrollees. Various aids and services such as interpreters, written notes, readers, large print or Braille can be used depending on the enrollee need.

Accessibility of a provider's office is essential in providing medical care to enrollees with disabilities. Due to barriers, enrollees with disabilities are less likely to get care. Accessibility is not only legally required, it is important that minor problems are detected and addressed before turning into major problems.

Additional resources, links, and training materials related to providing culturally, linguistically, and disability-competent care is available on the UPHP website at https://uphp.com/providers/provider-resources.

MI HEALTH LINK CARE COORDINATION PROGRAM

The UPHP MI Health Link Care Coordination Program is designed to meet the comprehensive medical, behavior health and psychosocial needs of UPHP MI Health Link members while promoting quality and cost-effective outcomes. The Care Coordination Program is based on a collaborative process of assessing, planning, facilitating, coordinating, evaluating and advocating for options and services for UPHP MI Health Link members. The goal of care coordination is to help members maintain or regain optimum health or improved functional capability in the least restrictive setting in a cost-effective manner utilizing a person-centered process.

UPHP honors member choice about their level of participation in assessments, care coordination activities, and care plan development. This care coordination process also respects member determinations related to the appropriate involvement of their care givers and allies in accordance with HIPAA, and for substance use disorder (SUD) treatment, CFR 42, Part 2.

Assessments

Initial Screening

New MI Health Link members will be identified on enrollment files received from MDHHS. At a minimum, UPHP will use the information received from the initial screening conducted by the Michigan Enrollment Broker at the time of enrollment, as well as other assessments, referrals and program level data (MDHHS MMIS system, CHAMPS), and utilization data (MDHHS Data Warehouse) within 15 calendar days of enrollment to prioritize members with immediate needs for Level I assessments.

If initial screening results are not available, UPHP will conduct the initial screening via telephone or in person within 15 calendar days of enrollment. The initial screening and a Level I Assessment may be conducted during the same contact. All outreach efforts to the member or service providers to complete the initial screening are documented in the care management program software.

Level I Assessments

The Care Coordinator conducts the Level I Assessment within 45 calendar days of enrollment. MI Health Link members identified with immediate needs or at high risk have these assessments completed in person and earlier than 45 days, following the prioritization process.

The Level I Assessment is completed in collaboration with the PIHP Supports Coordinator, LTSS Supports Coordinator, or nursing facility when the member is active in the PIHP or receiving LTSS in the last 12 months. This assessment is also completed in collaboration with family members or other individuals as desired by the member.

UPHP coordinates with the appropriate PCP to ensure that any member with complex medical needs identified in the Level I Assessment receives further follow-up relevant to those needs.

Based on the findings from the Level I Assessment, UPHP also collaborates with the PIHP to ensure that the Level II Assessment is conducted for members identified as having behavioral health, I/DD or SUD needs. UPHP ensures that the Level II Assessment is conducted for members demonstrating LTSS needs. If a member is identified as needing a Level II Assessment and is not currently involved with the PIHP, LTSS, or nursing facility, the UPHP Care Coordinator will arrange with the appropriate agency to complete the Level II Assessment with the member. UPHP screens all members to identify mild to moderate behavioral health needs using the DSM 5 screening tool in the Level I Assessment and refers members with mild to moderate behavioral health needs to the PIHP.

Level II Assessments

Level II Assessments are conducted in-person within 15 days of completion of the Level I Assessment and are performed by professionally knowledgeable and trained individuals with experience working with the respective population. LTSS Supports Coordinators (Michigan licensed social workers, registered nurses, nurse practitioners, physician assistants) or assigned PIHP Supports Coordinators/Case Managers, complete the Level II Assessment for identified members.

Integrated Care Team

All UPHP MI Health Link members are assigned a UPHP Care Coordinator. The Care Coordinator facilitates the development of the member's Integrated Care Team (ICT) and is responsible for assuring ICT activities are conducted and documented in the Integrated Care Bridge Record (ICBR). UPHP ensures ICT members and other providers communicate with members in a manner that accommodates their individual needs such as interpreter services, toll-free TTY/TDD, and preferred communication methods for members with cognitive limitations.

UPHP ensures that the composition of the ICT includes:

1. The member and member-chosen allies (friends, family, caregivers)
2. The UPHP Care Coordinator
3. The PCP or nurse practitioner/physician assistant
4. LTSS Supports Coordinator, as applicable
5. PIHP Supports Coordinator, as applicable
6. Other persons as needed and available (i.e. family caregivers and natural supports, primary care nurse care manager, specialty providers, paid supports, hospital discharge planner, nursing facility representative)

Individual Integrated Care and Supports Plan (IICSP)

In consultation with the member and the member's ICT, the Care Coordinator develops an IICSP that focuses on supporting member achievement of personally-defined goals in the most integrated setting. Person-centered planning, that identifies and honors each member's preferences and choices regarding services, is used. The ICT will provide the member with all necessary information regarding treatment and service options to make informed choices. The IICSP is completed and entered in the ICBR for all members within 90 days of enrollment.

Transitions Between Care Settings

UPHP provides a Transitions of Care (TOC) program which facilitates timely and smooth transitions between care settings and between different providers of the same service. Staff providing TOC services inform the member of his or her right to live in the most integrated setting; inform the member of the availability of services necessary to support his or her choices, and record the home and community-based options and settings considered by the member.

The TOC program offers immediate and continuous discharge planning including, electronic and verbal communication with the member and ICT following a member's admission to a hospital or nursing facility. This program strives to make certain that necessary care, services, and supports are in place when the member is discharged. This includes scheduling outpatient appointments; ensuring the enrollee has all necessary medical equipment, medical supplies, medications, or prescriptions upon discharge; and conducting follow-up with the enrollee and/or caregiver.

UTILIZATION MANAGEMENT PROCESS

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

UPHP Clinical Services contact information:

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

Providers must verify:

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

Authorization

The below services and items require prior authorization (PA) from UPHP Clinical Services. Authorization decisions are made upon determination of compliance with appropriate criteria.

1. Out-of-plan services:
    a. Practitioner services
    b. Facility services
    c. Laboratory services
    d. Durable medical equipment and supplies
    e. Planned inpatient admissions
2. Medically necessary weight reduction services
3. Medically necessary reconstructive surgery

4. Durable medical equipment/medical supplies not meeting CMS/MDHHS guidelines
5. The following durable medical equipment/medical supplies:
    - Orthotics and prosthetic devices (L codes)-PA required on items >$1000.00 per Medicare or Medicaid fee schedule
    - Powered air floatation bed
    - Powered pressure-reducing air mattress
    - Non-powered advanced pressure reducing overlay for mattress
    - Powered air overlay for mattress
    - Non-powered advanced pressure reducing mattress
    - Miscellaneous durable medical equipment codes
    - Negative pressure wound therapy
    - Wearable cardioverter-defibrillators
    - Bi-PAP/CPAP
    - Power wheelchairs/accessories
    - Lightweight wheelchair
    - Hospital bed semi-electric with mattress
    - Pneumatic compression
    - Osteogenic bone stimulator
    - TENS unit
    - Ventilator
6. Home health services
7. Molecular pathology testing code 81479
8. Medicare Part B Drugs listed at www.uphp.com/pharmacy-prior-authorization
9. Specific medications billed under the Medical Pharmacy Benefit Program need to be submitted to Magellan Rx Management www.ih.magellanrx.com for a prior authorization. The codes that require a prior authorization can be found on the UPHP website.

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 management activities on the part of UPHP. Services that require notification to UPHP Clinical Services include but are not limited to:

1. In-plan elective inpatient admissions – prior to admission

2. In-plan and out-of-plan urgent/emergent inpatient admissions – within one business day of admission
3. In-plan and out-of-plan urgent/emergent observation services – within one business day of admission
4. Skilled nursing facility admissions – within one business day of admission
5. Swing bed admissions – within one business day of admission
6. Long-term care admissions – within one business day of admission

Referral Requests

- Referral requests are to be done by the PCP or in-plan specialist.
- An out-of-plan provider can send in a request under the following circumstances:
    - Emergency department follow-up visit
    - Out-of-plan provider has a current PA on file
    - Out-of-plan provider meets continuity of care requirements
    - Hospitalization follow-up visit
- The forms can be found on the UPHP website at www.uphp.com, or by contacting the UPHP 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.

Authorization must be obtained before services are provided. Retrospective requests will not be reviewed. Authorization does not guarantee payment. All authorized services are subject to review for medical necessity, member eligibility, member plan benefits and provider eligibility for payment at the time of service.

UPHP's complete utilization management policies and procedures are available on the UPHP website at www.uphp.com. For any questions, please contact the UPHP Utilization Management Department at 1-877-349-9324.

CLAIMS

Electronic Claims Submission

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

- National Electronic Insurance Code (NEIC) **# 38337**

UPHP has a secure Provider Claims Portal, which can be used to status claims, email questions and enter claims directly. For Provider Claims Portal 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 1-877-349-9324.

If you are unable to bill electronically you can use our billing address:

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

Please contact the UPHP Claims Department for claims questions at 1-877-349-9324 Monday through Friday from 8 a.m. to 5 p.m. Eastern time. Please have the member ID, date of service, charge amount, and/or claim number ready when calling to ensure timely assistance.

Claims Submission Guidelines

Filing Limit

- Claims must be sent to UPHP within 365 days from the date of service.
- UPHP responds to claims within federal and state processing guidelines. The claims determination will be reported to the provider on an Explanation of Payment (EOP)/Remittance Advice (RA).
- If no response is received within 45 days on a submitted claim, please call the UPHP Claims Department at 1-877-349-9324, or use the Provider Claims Portal to status the claim(s).
- All claims received after the filing limit will be denied and members may not be billed.

Claim Forms

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

Paper Claim Submission Guidelines

- Must use original forms – faxed copies will not be accepted
- Must be typewritten or computer generated – handwritten forms will not be accepted
- Do not use highlighters, white-out, or any other markers on the claim
- Avoid script, slanted, or italicized type; 12-point type is preferred
- Do not use an imprinter to complete any portion of the claim form
- Do not use punctuation marks or special characters
- Use a six-digit format with no spaces or punctuation for all dates (i.e. May 1, 2013 would be 050113).

Claims Policies

Adjudication

UPHP adjudicates claims according to CMS) policies and procedures and State of Michigan Medical Services Administration (MSA) policies and procedures. Reference the Uniform Billing Guidelines, ICD Diagnosis Codes, CPT Codes, and HCPCS codes when submitting a claim.

Payment

Contracted and non-contracted providers will be paid for covered services according to the published CMS Medicare and the MDHHS Medicaid reimbursement methodologies 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 a correction(s) and/or a 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 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)

UPHP Required Fields:

CMS 1500	Required?	Field Location
Billing Provider NPI	Yes	Box 33a
Rendering Provider NPI	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a
Taxonomy Code	No	Boxes 24j, 33b, and 32b

UB04	Required?	Field Location
Billing Provider NPI	Yes	Box 56
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77j
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79
Taxonomy Code	No	Boxes 57, 76, 77, 78, and 79

Coordination of Benefits

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

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

Interim Billing

UPHP does accept claims billed with an interim bill type for 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 UPHP regarding payment for Medicare- and/or Medicaid-covered services, they may file an appeal in writing to UPHP within 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 the determination no later than 60 calendar days from the date UPHP received the request for payment reconsideration. UPHP uses designated persons who were not involved in the making of the initial organization determination when reviewing reconsiderations. If the denial is based on lack of medical necessity, the reconsideration is reviewed by a physician with expertise in the field of medicine that is appropriate for the services at issue. An inquiry is not subject to the appeals process.

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

- Member name
- Member identification number
- Remittance notification showing the denial
- 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 Waiver of Liability from a non-contract provider and/or other required documentation within 60 calendar days of UPHP receipt of the 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. For Medicare-covered services, this is the final reconsideration process for UPHP-contracted providers.

For non-contracted providers, if UPHP continues to deny payment in whole or in part for Medicare-covered services, UPHP will send the complete case file to the Independent Review Entity (IRE) contracted by CMS via mail, overnight delivery, or electronic transmission 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. If the IRE continues to uphold the denial, the IRE will provide information on further appeal rights.

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

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

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

Member Appeals Related to Utilization Management Adverse Determination

When an adverse benefit determination is made, a written notice is provided in easily understandable language containing the reason for the adverse benefit determination specific to the service or item type in question, notifying the member of all their Medicare and Medicaid appeal rights (known as an Integrated Denial Notice). The member will be provided with a copy of any and all applicable appeal forms. UPHP will assist in sending forms to the appropriate review entity. Members, providers, estate representatives, or their authorized representatives may file an appeal with any UPHP employee. They have 60 calendar days from the date of notification of an adverse benefit determination to file an appeal with UPHP.

All UPHP MI Health Link members have full access to the Medicare and Medicaid appeals process when a notice of adverse benefit determination is made. Initial appeals for Medicare service denials, reductions and terminations will be made to UPHP; sustained decisions will be auto-forwarded to the Medicare IRE. Members will be able to request a hearing before an Office of Medicare Hearings and Appeals (OMHA) administrative law judge for decisions sustained by the IRE. If the adverse benefit determination involves a Medicaid service or benefit, members have the right to file an appeal through UPHP, the Medicaid Fair Hearings process, and the right to file an external review (PRIRA) with the Department of Insurance and Financial Services (DIFS). Members must exhaust UPHP's internal appeal process prior to filing an appeal with the Michigan Administrative Hearing System (MAHS) State Fair Hearing process or the IDFS PRIRA process. The Medicaid Fair Hearing and/or external review with DIFS must be requested within 120 days from the date of the notice of resolution. For services that may be eligible for both Medicare and Medicaid coverage, individuals may file an appeal through either the Medicaid or Medicare appeals processes or both. In case of a decision where the MAHS, DIFS and the Medicare IRE issue a ruling, UPHP shall be bound by the ruling that is most favorable to the member.

UPHP MI Health Link members who obtain Medicare and/or Medicaid benefits provided by the PIHP will appeal through the PIHP.

UPHP MI Health Link members are afforded the opportunity to have the appeals process explained to them or their representative and, if needed, assistance in completing appeal forms. Beneficiaries will be informed of the availability of the

Enrollee Ombudsman to assist with the appeals process. Interpreter services will be offered and TTY/TDD toll-free numbers will be provided.

UPHP MI Health Link 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 60 day appeal time frame. The UPHP response timeframe will begin on the date the ARF is received. If appeals are submitted without a representative form or with a defective representative form, UPHP informs the member and purported representative, in writing, that the reconsideration request will not be considered until the appropriate documentation is provided.

UPHP Internal (Standard) Appeal Process (expedited appeals will follow the same process with appropriate time frames):

A UPHP MI Health Link member appeal may be initiated by writing or calling:

Upper Peninsula Health Plan
Review and Appeals Coordinator
853 West Washington Street
Marquette, MI 49855

Phone (Toll Free): 1-877-349-9324
TTY users: 711
Fax: 906-225-7720

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 UM Appeals Coordinator will communicate to the member via phone and/or mail the date, time, and location of the panel review at least five 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 business days prior to the meeting.

UPHP will provide the member, provider, or authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony, and make legal and factual arguments. UPHP will inform the member of the limited time available for this in advance of the resolution timeframe for appeals in the case of expedited

appeals. The member, provider, or authorized representative 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 subordinate to any person involved in the initial determination will review the appeal. For medical necessity appeals or an appeal that involves clinical issues, this panel will include (at minimum) the UPHP 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 will be notified of the determination of the panel referencing the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision is based and include a list of titles and qualifications, including specialties, of individuals participating in the appeal review in a culturally linguistic and appropriate manner within 30 calendar days for a standard appeal (within 72 hours for an expedited appeal or as expeditiously as the member's condition requires). UPHP may extend the time frame up to 14 calendar days if the member requests the extension or if UPHP shows that there is need for additional information and how the delay is in the member's interest.

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.

This is the final level of internal appeal. There are additional levels of external appeal available. Please contact UPHP Utilization Management for a copy of the UPHP Appeal Policy# 800-324. The complete policy is also available on the UPHP website at www.uphp.com/medicare.

PHARMACY

The prescription benefit is an important component of our enrollees' comprehensive treatment program. The goal of UPHP is to provide enrollees rational, clinically-appropriate, and cost-effective pharmaceutical care.

Formulary

The UPHP MI Health Link formulary is a list of covered drugs. The MI Health Link formulary combines both Medicare and Michigan Medicaid benefits to enrollees. The UPHP MI Health Link formulary is a two tier formulary. Generics drugs are Tier 1 and brand (trade) drugs are Tier 2. UPHP MI Health Link covers some over-the-counter (OTC) drugs when they are written as prescriptions by a provider. UPHP MI Health Link enrollees have no copays for prescription and covered OTC drugs.

UPHP contracts Magellan Rx, a pharmacy benefit manager (PBM), to manage the UPHP MI Health Link formulary and our pharmacy network. The formulary may change from time to time throughout the year and Jan. 1 of each year. Current UPHP MI Health Link 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 MI Health Link pharmacy benefits. If you have questions, you may contact UPHP MI Health Link Customer Service or Magellan Rx, UPHP's PBM, at the following numbers:

Magellan Rx Prior Authorization Help Desk: 1-888-274-2031
Magellan Rx PA Fax Line: 248-341-8133
UPHP Customer Service Department: 1-877-349-9324

Covered Drugs

The drugs on the drug list covered by UPHP MI Health Link can be found on the UPHP website at www.uphp.com/medicare. UPHP MI Health Link 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 or alternative coverage.

Specific medications billed under the Medical Pharmacy Benefit Program need to be submitted to Magellan Rx Management at www.ih.magellanrx.com or by calling 1-800-424-8241 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 1-855-380-0275 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 Pharmacy Management at the addresses listed on the form or Magellan Rx may be contacted directly at the toll-free number indicated on the form.

UPHP MI Health Link 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 UPHP MI Health Link regarding coverage or payment for prescription drug benefits an enrollee believes he or she is entitled to receive.

A decision by UPHP MI Health Link 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, review the UPHP MI Health Link 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 UPHP MI Health Link determines the drug is otherwise excluded under 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 MI Health Link has both a standard and expedited procedure in place for making coverage determinations. Generally, we will only approve a request for an exception 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's 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 Health Link 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.

UPHP's Medicare website (www.uphp.com/medicare) provides a detailed 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 MI Health Link 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 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 MI Health prescription drug coverage in their Evidence of Coverage and other plan materials.

The UPHP MI Health Link 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 MI Health Link formulary can be found on our website at www.uphp.com/medicare.

Medication Therapy Management

UPHP MI Health Link 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 (MTMP) 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.

CMS requires companies that offer Part D benefits to also offer a MTMP. 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.

UPHP and our PBM will manage the MTMP. The calendar year (CY) 2018 MTMP offered to beneficiaries and prescribers is structured to meet both CMS compliance and the spirit of the CMS MTMP, providing value-driven health care 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 wants to stop participation in the program, the enrollee must opt out. This is done by contacting UPHP Customer Service at 1-877-349-9324 (TTY: 711). UPHP Customer Service personnel will be prepared to answer questions about the MTMP.

Upon identification of a MTMP-eligible enrollee, CSS 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 MTMP-eligible enrollees 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 the option to opt out). Within 60 days of identification, the PBM 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.

The UPHP MTMP targets beneficiaries who are enrollees in the sponsor's Part D plan who:

- Have at least two of the following specific chronic diseases: dyslipidemia, hypertension, diabetes, chronic heart failure (CHF), respiratory disease-chronic obstructive pulmonary disease (COPD), AND
- Are taking multiple (at least six) Part D drugs, AND
- Are likely to incur one-fourth of specified annual cost threshold ($3,967) in previous three months.

The UPHP MTMP includes an Annual 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 recommendation(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 targeted medication review (TMR). TMRs are performed quarterly for all active MTMP-eligible enrollees, evaluating any inputs that are part of the MTMP.

Additional Information

Additional information about UPHP's MTMP is available on UPHP's website at

www.uphp.com/medicare, or by calling UPHP Customer Service at 1-877-349-9324 (TTY: 711) or our PBM, Magellan Rx Medication Therapy Management Department, directly at 1-855-552-6425 (TTY: 711) between the hours of 9 a.m. to 6 p.m. Eastern time, Monday through Friday.

Important Pharmacy Contact Numbers

UPHP uses Magellan Rx as a 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 Prior Authorization Help Desk: 1-888-274-2031
Magellan Rx PA Fax Line: 248-341-8133
UPHP Customer Service Department: 1-877-349-9324

If you have questions about the UPHP MI Health Link 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, seven days a week, or visit http://www.medicare.gov.

CREDENTIALING

UPHP's 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 UPHP's policy.

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

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

Credentialing Application

Upon request to 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.

Upon request, UPHP 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 five business days of the request. Written notice may include returning the application or contracts via mail or fax, recommendation to review the UPHP Provider Manual or other distributed materials, or by directing the practitioner to the appropriate website. 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 UPHP Credentialing Supervisor or the UPHP 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 is 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/Recredentialing 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 the company as soon as they receive it. UPHP does not require certain provider types such as optometrists, physician assistants, nurse practitioners, podiatrists, pathologists, or radiologists to have a DEA certificate, but if one is held 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 in the board of their practice specialty, must prove that boards are in process and he/she must also sign a Request for Temporary Board Certification Waiver, which states that he/she will become board certified within six years from the applicable residency or fellowship completion or within two years of appointment, whichever is longer. If an applicant is not board certified or eligible due to completion of residency outside of the United States, he/she must submit a Request for Time-Unlimited Waiver of Board Certification, which must be reviewed along with applicant's CV by the CEO and Medical Director, prior to application processing. The applicant can only be considered for the Time Unlimited Waiver if he/she will be working in a Medically Underserved Area, as deemed by the Health Resources and Services Administration (HRSA).
5. Applicable education and training.
6. Chronological work history covering at least the past five years as is documented in the application and/or detailed curriculum vitae. Work history must include

the beginning and ending month and year for each position in the 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 one year must be clarified in writing.

7. Documentation of current malpractice insurance coverage and documentation of the previous 10 years of professional liability claims history that resulted in settlements or judgments paid by or on behalf of that practitioner.
8. Statement of management 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 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. 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 UPHP 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 UPHP Medical Director for adverse action(s) regarding major/severe issues, which involve restriction, suspension, or termination, will be forwarded to the Credentialing/Recredentialing Committee for review. Adverse action taken by the Credentialing/Recredentialing Committee, against a provider, shall be approved by the Management Committee.

Network providers of the Upper Peninsula Health Plan (UPHP) are expected to promote quality of care and ensure compliance with regulatory standards and UPHP's contracts, addenda, policy, procedures, competency standards and conduct standards. In the event that UPHP takes adverse action against a provider, the network provider has an

opportunity to appeal this recommendation. The provider must notify UPHP, in writing, of the intent to appeal the adverse action within 30 days of written notification from UPHP to provider of UPHP's recommendation to take such adverse action.

Disciplinary or Adverse Action Levels:

- *Level I:* The UPHP 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 UPHP 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 UPHP Medical Director reviews complaints, conduct and competence issue(s), and all related information. If a major or significant infraction is identified, the Medical Director may immediately restrict or suspend the provider's participation in the provider network and/or any committee membership and will forward his/her recommendations and the provider's credential file to the Credentialing/Recredentialing Committee. The Credentialing/Recredentialing Committee will determine whether the provider's professional conduct or competence, or the provider's noncompliance 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 UPHP 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 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 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, UPHP will notify the provider if counsel will represent them.

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

PRIMARY CARE PROVIDER RESPONSIBILITES

Access to Care Standards

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 PCP. After hours coverage must meet the following requirements:

- Provides instructions for an emergency situation

- Provides means of reaching an on-call physician

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

1. *Office Hours:* PCPs 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 weeks for children ages 0-17 and within five 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.

Provider Change Notification Requirements

Providers must notify UPHP 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 UPHP website at www.uphp.com / Providers / Forms and Links / 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: 906-225-7776

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

COMPLIANCE

UPHP Policies and Procedures

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 UPHP 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 and Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care are considered fraud, waste and abuse. Specifically:

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

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

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid (or other applicable) program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid (or other applicable) program. 42 CFR 455.2

Examples of Fraud and Abuse

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

Preventing Fraud and Abuse

UPHP and other State and Federal agencies collaborate to help prevent fraud. Here are ways you can help prevent health care 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

Any employee, enrollee/family member, provider, first tier, downstream, or related entity of UPHP who suspects an improper or illegal activity associated with the UPHP is required to report such suspicion to the UPHP Compliance Officer. You can report anonymously. Any employee, enrollee/family member, first tier, downstream, or related entity who reports such matters shall not be subjected to retaliation or harassment in any manner and any employee of the UPHP engaging in such conduct will be subject to discipline up to and including termination.

Suspected cases of fraud and abuse should be reported to UPHP's Compliance Officer. You have the right to report your concerns anonymously to UPHP, the State of Michigan Office of Inspector General (OIG), and/or the OIG at the Department of Health and Human Services (DHHS). When reporting an issue, please provide as much information as possible, as this will increase the likelihood of a successful review and resolution. Remember to include the following information when reporting suspected fraud or abuse:

- The nature of the complaint

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

You may report possible fraud and abuse to:

UPHP Compliance Officer
835 W. Washington Street
Marquette, MI 49855
Toll-Free: 800-835-2556

Michigan Department of Health and Human Services Office of Inspector General
P.O. Box 30062
Lansing, MI 48909
Toll Free: 1-855-MI-Fraud (1-855-643-7283)
www.michigan.gov/fraud
You may remain anonymous

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.

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. UPHP must comply with these laws; contracted providers and their staff have 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)

UPHP's Commitment to Patient Privacy

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

Providers/practitioners must comprehend all state and federal health care privacy laws applicable to their practice and organization. There are various laws that providers/practitioners must comply with; most of Michigan's health care 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 explains 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 health care 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 health care 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 health care, treatment, payment, or operations, made by the provider/practitioner within the past six-year period.

HIPAA Security

UPHP has adopted this General HIPAA Security Regulations Policy to comply with the HIPAA and the 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, UPHP will take steps:

1. To ensure the confidentiality, integrity and availability of all electronic PHI (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 UPHP policies related to privacy of PHI; and

4. To ensure that workforce members comply with UPHP 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.