



TOTALLY THERE FOR YOU

PROVIDER MANUAL

for

Medicaid

Healthy Michigan

Commercial

Marketplace

MISSION STATEMENT

Total Health Care strives to be the industry leader in providing quality, cost-effective healthcare for our subscribers.

Effective 1/1/2018; revised 9/1/2018; revised 9/12/2018

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TOTALLY THERE FOR YOU

General Information

The Total Health Care Provider Manual is a resource to assist providers and staff in understanding the network structure, products and the policies and procedures of the Plan. The policies and procedures referenced herein are subject to change as Federal or State regulations (CMS and/or Medicaid), practice patterns, and/or Total Health Care administrative/medical policy dictate. Providers will be notified of changes via newsletters or faxed bulletins. Total Health Care (THC) has produced this document in accordance with current Medicaid guidelines, policies and procedures, statutes, and regulations and in compliance with the Medicaid Provider Manual. ***If the provisions stated in the Medicaid Provider Manual conflict with the THC Provider Manual, the Medicaid Provider Manual shall control.*** To ensure you are following the most up-to-date policies and procedures, please refer to our Web site at www.THCmi.com. You may also contact the Provider Relations staff at 844-THC-DOCS to assist you with any policy questions or to request a hard copy. The manual is an extension of our provider contracts. Nothing in it is intended or should be understood to modify any requirement of your provider contract. This Manual has a companion document, **Claims Provider Manual**, to address all your questions related to our claims policies and procedures.

TELEPHONE DIRECTORY

313-871-2000

800-826-2862

844-842-3627 (844-THC-DOCS) – Provider Only Line

Listen to prompts for Claims, Customer Service, Utilization Management, Provider Relations.

PRODUCTS

Total Health Care offers a network of primary care physicians, specialists and hospitals who are duly licensed by the State of Michigan and authorized to provide Medicaid health care services within our service area of Wayne, Oakland and Macomb Counties. We extend our coverage for commercial members to additionally include Genesee County. . Providers must be in good standing with CMS in order to participate with our Commercial contract.

For purposes of simplification, in this manual “Total Health Care” represents Total Health Care, Inc. and Total Health Care, USA, covering the following product lines:

- HMO comprised of the following groups:
 - Commercial
 - Employer sponsored Large and Small Groups

- Healthcare.gov Insurance Marketplace Plans including group and individual coverage
 - Medicaid, including Healthy Michigan Plan, MiChild and Children’s Special Healthcare Services (CSHCS)
 - Dual Eligible (Medicare primary, THC secondary)
 - Point of Service Product - Total Select USA

SAMPLE MEMBER ID CARDS

Commercial

(Front)

(Back)

TOTAL HEALTH CARE USA HMO
 3011 W. Grand Blvd., Suite 1600
 Detroit, MI 48202

Member Name:
 Member #:
 Group #:
 Employer Name:

PCP Name:
 PCP Phone#:
 PCP #:

To obtain instructions for billing, eligibility and benefit information (including behavioral health/substance abuse): Contact THC at 800-826-2862 or visit www.THCMi.com

| | | | |
|--|--|---|---|
| Send Medical claims: | Cofinity Providers | Behavioral Health | Pharmacy Providers |
| Total Health Care PO Box 21486 Eagan, MN 55121-0486 EDI Payer ID: 38201 | Cofinity* PO Box 2720 Bin # 610473 Farmington Hills, MI 48333 EDI Payer ID: 38335 | Value Options PO Box 930321 Wixom, MI 48393-0321 Provider Connect at valueoptions.com | Catamaran PO Box 930321 Wixom, MI 48393-0321 BIN 005947, PCN CLAIMCR, RNGROUP TOTAL |

*All services other than for an emergency must be obtained through a THC contracted provider. If you are unsure if you are a contracted THC provider, please call THC at 800-826-2862 or visit our web site at www.THCMi.com. Providers must look solely to THC for payment of covered services except for applicable copayments, deductibles and coinsurance.

Certain services require prior authorization. Call 800-826-2862 or visit our web site for a complete list. All inpatient admissions require notification within 24 hours or next business day.

Medicaid

(Front)

(Back)

TOTAL HEALTH CARE, INC.
 3011 W. Grand Blvd., Suite 1600
 Detroit, MI 48202

Member Name:
SAMPLE MEDICAID

Member ID: 000032428 01 \$0 copay

Group: M1500

PCP: AZRA HASHMI RxBIN: 610342

Phone: (313) 846-8800 RxPCN: ROIRX

Recipient ID: 123456789

To obtain instructions for billing, eligibility and benefit information: Contact Total Health Care (THC) at 1-800-826-2862 or visit www.THCMi.com.

| | | |
|--|---|--|
| Medical Claims | Pharmacy Provider | Behavioral Health |
| Total Health Care PO Box 21486 Eagan, MN 55121-0486 EDI Payer ID: 38201 | ENVISION OPTIONAL 1-844-222-5084 BIN: 610342 PCN: ROIRX RxGRP: TOTAL | Beacon Health Options PO Box 930321 Wixom, MI 48393-0321 beaconhealthoptions.com |

All services, other than for an emergency, must be obtained through a THC contracted provider. To verify your participation status, call THC. Certain services require prior authorization, call THC or visit our website for a complete list.

All inpatient admissions, including transfers, (except routine OB deliveries) require authorization by THC, call 1-844-THC-DOCS. We are available 24/7. Claims will be paid at Medicaid or the contracted rate.

- PCP Assignment – Commercial HMO and Medicaid members may choose or are assigned to a Primary Care Physician who is responsible for their overall care. Each member’s PCP is identified on the ID card.

Point of Service

(Front)

TOTAL HEALTH CARE USA POS
3011 W. Grand Blvd., Suite 1600
Detroit, MI 48202

Member Name:
Member ID: RxBIN:
Group: RxPCN:
Employer Name:

(Back)

To obtain instructions for billing, eligibility and benefit information (including behavioral health/substance abuse): Contact THC at 800-826-2862 or visit www.THCMi.com

Send Medical claims: Cofinity Providers Behavioral Health Pharmacy Providers
Total Health Care Cofinity* Value Options Catamaran
PO Box 21486 PO Box 2720 Bin # 610473 PO Box 930321
Eagan, MN 55121-0486 Farmington Hills, MI 48333 Wixom, MI 48393-0321 877-634-9202
EDI Payer ID: 38201 EDI Payer ID: 38335 Provider Connect at BIN 005947, PCN CLAIMCK,
valueoptions.com RxGROUP TOTAL

*All services other than for an emergency must be obtained through a THC contracted provider. If you are unsure if you are a contracted THC provider, please call THC at 800-826-2862 or visit our web site at www.THCMi.com. Providers must look solely to THC for payment of covered services except for applicable copayments, deductibles and coinsurance.

Certain services require prior authorization. Call 800-826-2862 or visit our web site for a complete list. All inpatient admissions require notification within 24 hours or next business day.

- POS members are not required to choose a PCP. They are allowed to receive services outside of the THC network.

Members will receive an ID card within 5 business days of joining the plan. A separate ID card will be issued for each Medicaid member. For Commercial enrollees, one ID card will be issued to the Subscriber.

PCP ROLE & RESPONSIBILITIES

Every HMO member is required to select a Primary Care Physician (PCP). The PCP acts as “gatekeeper” to coordinate all the health care needs of the member, including providing the necessary plan referrals. If a Medicaid member does not select a PCP, the member will be assigned one through an auto-assignment process. Commercial members are not auto-assigned to a PCP.

PCPs are required to make themselves available to their members 24 hours a day/ 7 days a week. They are also required to work a minimum of 20 hours per week at any location where they have assigned membership.

SPECIALTY CARE PHYSICIAN ROLE & RESPONSIBILITIES

Specialty physicians are essential in the care continuum and need to work closely with members’ PCPs to ensure information and treatment plans are shared and aligned. Specialty physician responsibilities include:

- Rendering only those services requested by the PCP
- Requesting prior authorization before rendering any additional service not specified on the original referral.
- Sending consultation reports to the PCP within 60 days of the consult.
- Ordering Labs and radiology from in-network providers, avoiding duplication of services performed by the PCP.
- Coordinating all care outside of the office with the PCP.
- Obtaining necessary prior authorizations from THC.

HOSPITAL ROLE & RESPONSIBILITIES

Hospitals are essential in the care continuum. Hospital responsibilities include:

- Coordinating discharge planning with THC staff
- Coordinating behavioral health services with the appropriate county agency for Medicaid or Beacon Health Options for commercial
- Obtain any necessary prior authorizations prior to rendering services
- Participate with Patient Ping in providing ADT messages related to ER and inpatient admissions
- Obtain prior authorization prior to transferring a patient to another facility
- Communicate hospital admissions within one business day to THC Utilization Management

ANCILLARY PROVIDER ROLE & RESPONSIBILITIES

Ancillary providers are essential in the care continuum. Responsibilities include:

- Providing only those services that are covered under referral
- Verifying eligibility and benefits prior to rendering services
- Obtain any necessary prior authorization before rendering services
- Communicate any necessary information to the member's PCP

Member Services

800-826-2862

The Member Services Department is available 8:00 am to 5:30 pm to assist with the following:

- Eligibility verification
- Benefits
- PCP assignments or changes
- Member responsibility amounts, such as copays, deductibles or coinsurance
- Complaints or grievances
- Authorization verification

After hours representatives are available to assist with:

- Eligibility
- Benefits
- Authorizations
- Inpatient Admissions
- Nurse Advice Line

A. Eligibility Verification

Member eligibility can be verified by calling Customer Service at 800-826-2862 or through the Provider Portal online at www.thcmi.com. To obtain access to the Portal, contact Provider Relations at 844-THC-DOCS, ext 5. PCPs can review their monthly eligibility roster through the provider portal.

B. Changing PCPs

- Members may initiate a PCP change at any time. The PCP change can be made immediately effective in most cases; however, requests received after the 25th of the month will be processed and effective the first of the following month.
- Physicians may also initiate a change in PCP assignment, under the following circumstances:
 - Threatening behavior, including verbal or physical abuse. Transfer will be immediately effective under these circumstances.
 - Failure to pay copayments. Member must have received two written notifications and been given opportunities to work out a payment arrangement. Request to transfer must provide documentation of written correspondence.
 - Excessive no-shows. After 3 consecutive no-show appointments, the practice must notify the member in writing that continued no-shows can result in discharge. Then, upon the next consecutive no-show, the physician may request and must provide appropriate documentation.
 - Non-compliance. This is reviewed on a case by case basis. Patients cannot be discharged for non-compliance for services that do not jeopardize their immediate health and wellbeing.

C. Complaints, Grievances, Appeals

Total Health Care is committed to excellence in the delivery of health care and member satisfaction. However, there may be situations when a member becomes dissatisfied with these services. A grievance is the member's expression of dissatisfaction (including complaints) about any matter other than an appealable action. Members can contact THC regarding any issue with their health care provider by calling Customer Service at 800-826-2862. THC will respond to the grievance within 90 days. Many grievances can be resolved informally, often over the telephone. However, members can file a formal grievance if they are not happy with an outcome. Members have the right to voice complaints or write to THC to file a written complaint about any of the following:

- Benefits
- Eligibility
- Recalling of Coverage
- Payment of claims
- Delivery, coordination and/or quality of health care services
- Contracts with Providers
- Availability of care or Providers
- Adverse Benefit Determination, including services which were denied, reduced or terminated.

Each office must develop policies/procedures to address member complaints. For any significant issues, you must inform Total Health Care's Grievance Coordinator. At a minimum, your policy should include:

- Appropriate interaction with the member.
- Documentation of the member concerns.
- Steps to follow toward resolution.
- Quality management/peer review of pertinent findings.
- Response to the member regarding findings.

When a member contacts Total Health Care either verbally or in writing, the issue will be investigated and you will be contacted if it is your member. Total Health Care is required to perform bi-annual reporting of grievances to the State and will review patterns and trends of grievances per provider on a regular basis. If patterns of member dissatisfaction are identified, improvement interventions will be initiated. Member grievances are also reviewed as part of the provider recredentialing process.

D. Interpretive Services

Total Health Care can arrange for interpretative services for any member who has a limited understanding of the English language or who is hearing impaired at no cost to the member or to contracted providers. It is important to understand that family members should not be used as an interpreter for the comfort of the member. Document any language assistance provided to a member in the member's medical record. If you do not speak the member's language, refer to the Provider Directory at www.thcmi.com, to find a provider that speaks a preferred language. Contact Total Health Care's Customer Services Department for assistance at (313) 871-2000 or (800) 826-2862.

E. Member Rights and Responsibilities

The following are the rights and responsibilities for persons enrolled in Total Health Care.

You have the right:

- To get information about Total Health Care, its services, its providers and member rights and responsibilities.
- To make recommendations regarding Total Health Care's member rights and responsibilities policy.
- To be treated with respect and dignity by others.
- To have privacy while you receive care.
- To take part with your doctors in decision-making about your health care. Including the right to refuse treatment.

- To talk openly about your treatment options regardless of cost or benefit coverage. You have a right to get these explained to you in words that you understand.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To be free to exercise your rights without adversely affecting the way Total Health Care or our providers treat you.
- To be free from other discriminations prohibited by State and Federal regulations.
- To receive healthcare services consistent with your contract, State and Federal regulations.
- To voice your complaints or grievance/appeals about Total Health Care or the care provided.

You have the responsibility:

- To receive all your health care services through Total Health Care.
- To understand your healthcare benefits.
- To provide Total Health Care and its providers with the information needed to care for you.
- To help your doctor decide what treatment will work best for you.
- To follow the plans and instructions for care that you have agreed to with your doctor.
- To respect the rights of other patients, doctors and staff of Total Health Care.
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

Total Health Care's staff and providers will comply with all regulations concerning your rights.

F. Women's Health

Members 16 years and older may self-refer to any THC in-network Ob/Gyn provider for a routine annual exam and screening (pap smear, chlamydia and mammogram). Member may also refer to the in-network Ob/Gyn of her choice for prenatal/perinatal care.

G. Pediatric Care for Children

Members 18 years and younger may seek Total Health Care encourages its members to select a pediatrician as a PCP for their children. You can also encourage this, but it is not required. However, in accordance with the Public Health Code, members may access a network pediatrician for routine pediatric services without a referral or prior authorization. A referral authorization must be issued for routine pediatric services to an out-of-network pediatrician.

H. Covered Benefits and Services

Total Health Care offers a variety of commercial benefit plans to best meet the needs of its members. The core benefits are the same across all commercial plans, however, the member out of pocket expense will vary. Copayments are printed on the Member I.D. card.

Deductible, co-insurance and copayments can be verified online at www.thcmi.com or by contacting the Customer Service Department at (313) 871-2000 or (800) 826-2862. Medicaid members have no out of pocket copayments.

The following is a list of medical services available to all THC members (regardless of Plan) unless otherwise noted:

- Access to a Federally Qualified Health Center (FQHC) or Tribal Health Center (THC) – *Medicaid only*
- Ambulance or other emergency medical transportation
- After Hours / Urgent Care
- Behavioral Health Outpatient Services
- Blood Lead testing in accordance with EPSDT policy
- Certified Midwife Services
- Certified Pediatric and Family Nurse Practitioner Services
- Child and Adolescent Health Center (CAHC) Program
- Chiropractic Services – visit limits apply based on product
- Diagnostic Lab, x-ray and other imaging Services
- Durable Medical Equipment
- Emergency Services
- End State Renal Disease services (ESRD)
- Family Planning Services
- Health Education
- Hearing Aids*
- Home Health Services
- Hospice Services
- Immunizations
- Inpatient and Outpatient Hospital Services
- Intermittent or short-term Restorative or Rehabilitative Services (in a skilled nursing facility)* up to 45 days
- Mammography
- Maternal Infant Health Program – *Medicaid only*
- Medically necessary Weight Reduction Services
- Parenting and birthing classes -
- Pharmacy Services*
- Podiatry Services
- Physician office visits
- Prosthetics & Orthotics
- Pre/Postnatal Services
- Preventive Health Services
- Surgeries (with prior authorization)
- Therapies, such as Speech/Language, Physical or Occupational Therapy
- Tobacco Cessation Treatment
- Transportation for medically necessary covered services - *Medicaid only*

- Treatment for Sexually Transmitted Diseases (STDs)
- Vision Services*
- Well Child/EPDST for persons up to age 21

Medicaid Only – if new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated or otherwise changed, THC will implement the changes consistent with the dates specified by MDHHS.

*Commercial services may require a THC Rider. Contact 800-826-2862 to confirm benefit and coverage.

I. Non-Covered Services

The following services are excluded or prohibited:

- Elective abortions
- Experimental or investigational drugs, procedures or equipment
- Elective cosmetic surgery
- Services for treatment of infertility and medication for erectile dysfunction
- Out of country services – ***Medicaid only***
- Elective, non-emergency out of network services without a prior authorization

PROVIDER ADMINISTRATIVE RESPONSIBILITIES

A. Advanced Directives

The Patient Self Determination Act 1990 allows competent adults the right to make decisions concerning medical care, including the right to accept or refuse any medical or surgical treatment and the right to formulate Advance Directives. Advance Directives are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity.

There are two types of Advance Directives; Living Will and Durable Power of Attorney for Health Care. Each primary care physician is asked to encourage members, as appropriate, to plan for medical care in the event of loss of decision-making ability by developing a Living Will or Durable Power of Attorney for Health Care. A copy of the directive should be maintained in the patient's medical record, as well as the patient should keep a copy in a safe place.

A copy of the Advance Directive Michigan Notice to Patient can be found at www.thcmi.com; Members; More Options, or contact the Provider Relations Department.

B. Confidentiality

The medical office is required to have policies/procedures that ensure the confidentiality of all member information. All information regarding a patient, their health status, and care is considered confidential and cannot be disclosed without a specific signed and executed release. However, an exception is that Providers **must** notify MHDDS immediately if there is a Medicaid member death related to alleged abuse, neglect or exploitation. The following elements are essential to the success of the Confidentiality policy:

Employee Confidentiality Agreement

Upon employment, your employees are required to sign an agreement that all patient/member information is considered confidential and cannot be disclosed without a signed and executed release from the member or their responsible person.

Confidentiality of Patient Information

Total Health Care requires that protected health information in oral, written and electronic form be protected from unauthorized or inappropriate use in accordance with HIPAA privacy laws. You must have policies and procedures to ensure:

- Any record that contains clinical, social, financial, or other data on a patient is treated as confidential and is protected against loss, tampering, alteration, destruction, or unauthorized or inadvertent disclosure.

- Records are released only when appropriately authorized in accordance with applicable state laws.
- Strict confidentiality against unauthorized or inadvertent disclosure regarding psychotherapeutic services provided to members with such coverage.
- All disclosures of information to outside parties not related to the care of the patient will be restricted to purposes directly related to administration of services and will be subject to written consent requirements.
- Upon termination as a participating physician with Total Health Care, your medical records will be made accessible to Total Health Care and the member. You may contact the Provider Relations Representatives to obtain the procedure.

Medical Record Protection

Medical records must be stored in a location that is safe from patient and public access and requires patient consent prior to medical information release in accordance with HIPAA laws.

C. Continuing Medical Education

It is Total Health Care's expectation that physicians and nurses who participate in the Plan will meet or exceed the requirements for continuing medical education (CME) as defined by the State of Michigan, County Medical Associations, and the Bureau of Professional Regulations.

D. False Claims Act

The False Claim Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state healthcare system. Knowingly includes having actual knowledge that a claim is false or acting with "reckless disregard" as to whether a claim is false.

In addition to the federal law, the state has adopted similar laws under the Michigan Medicaid False Claims Act (MMFCA). The MMFCA is designed to prevent fraud, kickbacks and conspiracies in connection with the Medicaid program.

Examples of false claims include billing for services not provided, billing for the same service more than once or making false statements to obtain payment for services.

Penalties Under the False Claims Act

Violations under the federal False Claims Act can result in significant fines and penalties. Financial penalties to the person or organization includes recovery of three times the amount of the false claim(s), plus an additional penalty of \$5,500.00 to \$11,000.00 per claim.

Violation of the MMFCA constitutes a felony punishable by imprisonment, or a fine of \$50,000 or less, or both, for each violation. A person who receives a benefit, by reason of fraud; makes a fraudulent statement; or knowingly conceals a material fact is liable to the state for a civil penalty equal to the full amount received plus triple damages. Providers who file false claims or fraudulent claims can be suspended from participating in the Medicaid program and as a result will be removed from participation with Total Health Care.

Whistleblower Protection Under the False Claims Act

The federal False Claims Act protects employees who report a violation under the False Claims Act from discrimination, harassment, suspension or termination of employment as a result of reporting possible fraud. Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement of their position without loss of seniority and (3) compensation for any costs or damages they incurred

Qui Tam Plaintiff/Relator

An individual (called a qui tam plaintiff or relator) who is an original source of information can sue for violations of the False Claims Act. Under both the federal False Claims Act and the MMFCA, a qui tam plaintiff can receive between 15-25% of the total amount recovered if the government prosecutes and 25-30% if litigated by the qui tam plaintiff.

Regulations

Public Law 109-171 (Deficit Reduction Act of 2005)

- (1) The Federal Civil False Claims Act, Section 1902(a)(68) of the Social Security Act
- (2) The Federal Civil False Claims Act, Section 3279 through 3733 of title 31 of the United States Code.
- (3) The Michigan Medicaid False Claims Act, Public Act 72 of 1977

E. Fraud, Waste and Abuse

Total Health Care recognizes combating healthcare fraud is a system wide challenge. It will take a collaborative effort with providers and members to improve the detection of fraudulent and abusive activities within our Plan. Combating fraud and abuse begins with knowledge and awareness of what is fraud and abuse.

DEFINITIONS:

Fraud means 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 applicable Federal or State law (42 CFR §455.2).

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards

for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR §455.2).

Examples of member fraud include:

- Loaning or using another's ID
- Changing or forging an order or prescription
- Selling prescription drugs or supplies obtained under healthcare benefits
- Providing false information when applying for benefits or services

Examples of provider fraud include:

- Billing for services not provided
- Billing for services not rendered
- Billing for additional, unnecessary treatment
- Billing for duplicate payments
- Unbundling procedures

If you have any information about fraud and abuse, please contact Total Health Care. It is not required that you give us your name. Notification of suspected fraud and abuse can be made anonymously. Reports can be made by calling, writing, or emailing Total Health Care at:

Mail: **Total Health Care
Fraud and Abuse Dept.
3011 W. Grand Blvd., Suite 1600
Detroit, MI 48202**

Call: (800)826-2862 or (313)871-2000

Email: eliminatefwa@thcmi.com

You can also report suspected Medicaid fraud and abuse, directly, with or without giving your name, to:

**Medicaid Department of Health & Human Services
Office of Inspector General
PO Box 30062
Lansing, MI 48909
855-MI-FRAUD (643-7283)
Online: <https://www.michigan.gov/fraud>.**

Total Health Care handles recovery of overpayments ("take-back") based on the situation that created the overpayment and the time frame between when the payment was made and

when the overpayment was identified. Below are situational examples of overpayment and recovery:

- Inaccurate payments due to system or adjudication error, incorrect benefit set up, duplicate payment or paying the wrong provider. Take-backs will be limited to a 12 month time period from date of payment
- Fraud and abuse. Take-backs or recovery of funds will be done within the statute of limitations for such occurrences.
- Medical record audits. Take-backs or recovery will be done within a 12 month look back period.

It is important to note that **no time limits** apply to initiation of overpayment recovery efforts by the State or federal agencies for suspected fraud or misrepresentation.

F. OSHA Requirements

Each provider is required to comply with OSHA regulations in their offices. All office personnel must be periodically instructed regarding these regulations. Appropriate posters and signs should be posted within the offices to ensure adherence to OSHA regulations.

I. Patient Safety

The office must:

- Develop a written safety/fire/emergency plan covering the following:
 - Medical emergency procedures
 - 9-1-1 calling
 - Obtaining emergency equipment
 - Disaster emergency procedures
 - Escape plans for fire, flood, and other natural disasters
 - Evacuation plan for patients including handicapped patients
- Provide comprehensive fraud, waste and abuse education and training programs for all staff

J. Physician Changes in Office

Changes for Physicians

The office must provide Total Health Care information on all new physicians and/or changes to current physician status as they occur, including the loss of hospital privileges. This is important for patient assignment, continuity of care, and credentialing purposes. Physician changes must include:

- Address

- Tax identification number
- Open/closed status to enrollment
- Product participation
- Required credentialing information
- Loss / change of hospital privileges

Termination of Physicians

The office must immediately notify Total Health Care, in writing, of any physician resignation/termination. Physician resignations/ terminations require the following protocols:

Notification consistent with Total Health Care Service Agreement language:

- Reason for resignation/termination
- Effective date of resignation/termination
- Direction for reassignment of members
- Total Health Care product participation

You may contact the Provider Relations Department at (313) 871-7809 to report a termination or use the Provider Change Form located under Section A.

K. Physician Restrictions

Total Health Care has prohibits a primary care physician from treating him/herself as a patient as well as any family member. Therefore, a PCP may not be assigned as his/her own physician nor be assigned a PCP for a family member through Total Health Care.

L. Reporting Requirements

Encounter/Claim Submission

Primary care physicians are required to submit an EDI or hard copy CMS-1500 claim for all services provided for both capitated and fee-for-service contracts. The Proprietary Total Health Care Encounter form is no longer accepted.

The encounter data is required for statutory reporting, HEDIS and claim analysis. In addition, bill-above and Pay-for-Performance (P4P) payments are generated from claim data. The timely submission of a clean claim is valuable to both parties.

Total Health Care requires providers follow industry and national coding guidelines in the assignment of ICD-9-CM, CPT and HCPCS codes. In compliance with the Michigan Department of Community Health, the diagnostic coding of chronic diseases treated on an ongoing basis may be coded and reported as many times as the member receives treatment and care for the condition(s). All conditions that coexist at the time of the encounter and

require or affect patient care, treatment or management, may be coded and reported. Conditions that were previously treated and no longer exist may not be reported. Refer to the Claims section for claim submission guidelines.

Physician Negative Actions

The office is required to immediately notify Total Health Care's Provider Relations Department, in writing, of any of the following actions taken by or against a physician:

- Surrounding, revocation, or suspension of a license or current DEA registration.
- Filing pursuant to Section 805 of the National Practitioner Data Bank.
- Filing of any malpractice claim of more than \$50,000
- Change in hospital staff status or hospital clinical privileges, including any restrictions or limitations.

Communicable Disease Reporting

Providers are required to report communicable diseases and other health indicators to the local health departments when they are identified. Total Health Care will monitor physician compliance with this requirement on an on-going basis.

MCIR

Physicians are required to report all immunizations on their members to the Michigan Care Immunization Registry (MCIR) in accordance with State law. MCIR provides educational assistance to providers and their staff on how to access and report to MCIR. Total Health Care will monitor providers' compliance with this requirement. For additional information, contact Total Health Care's Provider Relations Department at (313) 871-7809.

PRACTICE GUIDELINES AND STANDARDS

A. Access and Availability

To maintain member health, access to and availability of health care is essential. Total Health Care relies on participating physicians to ensure members have access to medical care as the severity of their health condition warrants. Total Health Care monitors the ease with which members can access services based on the following timeframe expectations:

| Primary Care Practitioner | Response Standards |
|---|---|
| Regular and Routine Care Appointments (i.e. preventive/well-care, routine non-symptomatic, physical, annual GYN exam) | Within thirty (30) days |
| Routine Non-Urgent (i.e. symptomatic) | Within seven (7) days |
| Urgent Care Appointments (i.e. persistent diarrhea/vomiting, high fever) | Within twenty-four (24) hours |
| Emergency Care (i.e. life-threatening conditions) | Twenty-four (24) hours/ seven (7) days a week at any hospital in or out of plan |
| Office Visit Wait Time for Scheduled Appointments | Within 15 minutes members should be taken to the exam room. |
| | Within 30 minutes members should be seen by their doctor |

| Behavioral Health Care | Response Standards |
|--------------------------|-------------------------------|
| Urgent Care appointments | Within forty-eight (48) hours |
| Routine office visit | Within ten (10) business days |

B. Patient Discharge Process

We require primary care providers (PCPs) to follow the following steps to discharge a member from their practice.

Note: You may not contact members about discharge until Total Health Care has approved the discharge.

1. Document the reason(s) for requesting discharge within the member's practice record.
2. Document all resolution attempts within the member's practice record.
3. Consider referring member to Beacon Options for assessment of potential behavioral health issues, if appropriate.
4. Request discharge by sending THC a Member Discharge Form (below).
5. Attach copies of your documentation from the member's record indicating reason for request and resolution attempts.
6. THC will review your request and documentation promptly.
7. You will receive an approval or denial for each request.
8. Notify the member that he or she has been discharged from your practice. You may want to use the sample format letter provided below.
9. You must offer 30 days of urgent/emergent care to the member following the discharge date.
10. THC will reassign members to a new PCP. Typically, the new PCP assignment is effective on the first day of the first month after the 30-day discharge period.

Acceptable reasons for discharge:

Discharge requests are approved for the following reasons, which are listed on the PCP Member Discharge Form:

- Unpaid copayments or deductibles, with a minimum of a 90-day collection period. Collection attempts must be documented.
- Persistent non-compliance with a documented care plan which results in unnecessary utilization of health care resources. Non-compliance and steps to educate the member on appropriate use of primary care must be documented.
- Repeated "no-shows" for scheduled appointments. This is defined as three or more visits missed in a twelve month period. Dates of no-shows must be documented.
- Threatening behavior displayed toward practice staff. Behavior and practice response must be documented.
- Members previously discharged from the practice, prior to coverage with a THC.
- "Doctor-shopping" to obtain prescriptions. Details of this activity should be documented including dates of visit or contact with the member.
- Failed drug screen, in violation of practice illegal drug-free policy. Date of drug screen and policy must be documented.
- Fraudulent behavior, with the case documented in the member's record.

C. EPSDT/Well Child Guidelines

Well-child care and immunizations are an important component of a preventive care program. Total Health Care supports EPSDT Guidelines and requires that providers schedule the required well-child visits and administer immunizations. Total Health Care participating physicians must administer immunizations that are part of the capitation. Immunizations must be appropriately documented in the medical record and reported to the Michigan Care Immunization Registry (MCIR) as required by State law. Vaccines are available through the State of Michigan's Vaccine for Children's Program for those who qualify. For more information, the Immunization Standards are located on our website at www.thcmi.com; Providers.

C. Preventive Health Guidelines

To encourage the appropriate delivery and use of preventive services at appropriate intervals, Total Health Care has adopted and implemented preventive health guidelines for prevention and early detection of illnesses. These guidelines are provided on our website: www.thcmi.com; Members; Total Health Care Guidelines. Total Health Care also provides these guidelines to our members.

The use of preventive health guidelines is an essential component of the goals of managed care. The provision of preventive care services can reduce the incidence of illness, disease, and accidents. Early detection of potentially serious illnesses may reduce the impact of illness on the member and associated health care costs. Additionally, use of preventive health guidelines has the potential to reduce unwanted variation in health care outcomes. Total Health Care will annually measure compliance to these guidelines and associated outcomes.

D. Clinical Practice Guidelines

Total Health Care adopts Clinical Practice Guidelines that are appropriate to its membership and organization. Clinical Practice Guidelines are adopted either from evidence-based, nationally recognized organizations such as MQIC (Michigan Quality Improvement Collaborative) that have developed guidelines based on scientific literature, or internally developed by Total Health Care and based on scientific literature and reasonable medical evidence. All Clinical Practice Guidelines are updated, revised and disseminated to all Plan practitioners least every two (2) years. Annually, Total Health Care monitors practitioners' adherence.

These guidelines serve as the basis of all disease management programs. They are used to assist practitioners/providers in maintaining consistency for provisions of acute, chronic and behavioral health care. They are not developed to replace clinical judgment, or to be all-

inclusive. It remains the responsibility of the practitioner to assess the health status of each patient individually, and develop the best plan of action to meet the patient's health care needs. Guidelines are to be used by the health care practitioners and members collectively, to ensure the best outcome for the members.

MEDICAL RECORD DOCUMENTATION

Well-documented, maintained, and organized medical records facilitate communication, coordination, continuity of care, and promote the efficiency and effectiveness of treatment. Total Health Care requires all practitioners maintain a system for collection, processing, maintenance, storage, retrieval, and distribution of all patient medical records as may be required by accreditation bodies and state agencies. Primary Care Physicians may be required to submit to periodic medical record documentation reviews as a component of credentialing and recredentialing and as part of focused quality studies.

A. Medical Record Management

Total Health Care requires all paper and electronic medical records meet minimum standards including but not limited to: are appropriately maintained and protected as follows: . :

- Confidentiality, security, and physical safety of records;
- Timely retrieval of individual records upon request;
- The unique identification of each patient's medical record;
- The supervision of the collection, processing, maintenance, storage, retrieval, and distribution of records; and
- The maintenance of a predetermined, secured, and organized record format.

B. Medical Record Content

As a legal document, all participating providers are required to comply with the following minimum standards regarding documentation within the medical record:

1. Every encounter with the patient will be documented in the medical record and include sufficient information to identify the member and the diagnosis for which the treatment was provided.
2. Each page of the record contains the member's name or consistently uses an identification number.
3. Personal biographical data contained in the medical record includes the member's address, employer (if applicable), home and work telephone numbers, and marital status (if applicable)
4. All entries into the medical record contain author identification, which may be stamped, handwritten, or electronic.
5. All entries into the medical record are dated.

6. The medical record is legible by someone other than the writer.
7. *Significant illnesses and medical conditions are documented on the “problem list.”
8. *Medication allergies and adverse reactions are prominently documented in the medical record. If the member does not have any known allergies or history of adverse reactions, this is noted in the medical record.
9. *Past medical history (for members seen three or more times by the PCP) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years or younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
10. For members 14 years and older, there is an appropriate notation concerning the use of cigarettes, alcohol, and substances (for members seen three or more times.)
11. The history and physical exam records appropriate subjective and objective information pertinent to the member’s presenting complaints.
12. Orders for and results of laboratory and other studies are contained in the record and initialed by the practitioner to signify review. Abnormal labs or results of other studies have an explicit notation in the record of follow-up plans.
13. Significant medical advice or education provided to the patient by telephone or in person is documented into the medical record.
14. Discussions with the patient concerning the necessity, appropriateness, and risks of proposed surgery, as well as discussions of treatment alternatives, are incorporated into the patient’s medical record.
15. Required follow-up care, calls, or visits are documented with the specific time of return noted in weeks, months, or as needed.
16. Unresolved problems from a previous office visit are documented as addressed in subsequent visits.
17. Appropriate use of consultants is documented.
18. Consultant documentation is contained in the member’s medical record.
19. Consultation reports are present in the medical record and initialed by the practitioner to signify review. Follow-up plans are explicitly documented if abnormal results are reported.
20. An immunization record, consistent with immunizations required by Total Health Care for children is up to date, or an appropriate history has been made in the medical record for adults.
21. Preventive screening and services required by Total Health Care are offered and documented.
22. *The working diagnosis is documented and is consistent with the clinical findings.
23. *The treatment plans are documented and consistent with diagnosis.
24. *There is no evidence in the record that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.

*Six critical elements as identified by NCQA

C. Medical Record Organization

Total Health Care requires that medical record documentation is meaningful and all medical records are arranged in an efficient and effective format. You must have policies and procedures to ensure:

- An individual clinical record is established for each person receiving care
- All clinical information relevant to a patient is readily available to authorized health care practitioners anytime the Center is open to patients.
- Documentation in the medical record will be accurate, complete, and concise to ensure valid decisions are made.
- Uniform content and format of clinical records, including sequencing of information.
- Timely review and incorporation into the medical record of reports, histories and physicals, progress notes, lab and x-ray reports, consultations, and summaries or records of patients treated elsewhere (when necessary for ensuring continuity of care).

D. Storage, Security, and Retrieval

Total Health Care ensures that medical and patient information will be protected against theft, destruction, loss, or unapproved access while being readily retrievable for patient care management and oversight purposes. You must ensure that all patient records are maintained in a physically secure area, are available for patient care anytime the facility is open to patients, and, when in use, are kept in a secure area at all times. You must also ensure that medical records are available within a reasonable time, no more than 30 days, for review by Total Health Care, accreditation bodies, and state agencies upon request. Records must be retained for a minimum of ten (10) years per the Michigan Public Health Code Act 368 of 1978, Section 333.16213.

E. Medical Record Release

Uses and disclosures of Protected Health Information that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

J. HIPAA

Total Health Care issues a Privacy Notice in accordance with HIPAA to all Total Health Care members that provides the right to exchange health information in a form necessary to coordinate care.

CLAIMS

Refer to separate CLAIMS MANUAL for complete information related to claims.

A. Submitting Claims

Billing Requirements:

- Provider Tax Identification Number
- Individual NPI and Group NPI (if applicable)
- Standard ICD-10, CPT, revenue and HCPCS codes
- Double digit Place of Service codes
- Claims must be submitted EDI or on a standard CMS-1500 or UB-04
- Handwritten claims are not accepted

*Clearinghouse Information

| Name | Customer Support | Transaction Type/Format | Payer ID |
|------------------------------|------------------|---|-----------|
| Emdeon / ChangeHealthcare | 800-845-6592 | HCFA 1500 - Professional (837P) UB 04 - Institutional (837I) | 382010001 |
| Optum | 800-765-6713 | HCFA 1500 - Professional (837P) UB 04 - Institutional (837I) | 38201 |

****Effective 1/1/2019, THC will use ChangeHealthcare as our exclusive clearinghouse. We will no longer support Ingenix or Netwerkes after 1/1/2019.***

For EDI Support, contact the Information Technology Department at (313)871-7889.

Claim Mailing Address: **Total Health Care, Inc.,
PO Box 21486
Eagan, MN 55121-0486**

Filing Limit: Claims must be submitted within one year from the date of service. Appeals must be received within 180 days from the claim denial.

Claim Status:

Providers may status claims online, by fax or phone.

Electronic: www.thcmi.com; Providers; Claim Status

Fax: (313)871-6407

Phone: (313)871-2000 or (800)826-2862

Overpayments / Payment in Error:

Providers need to report overpayments to THC immediately upon becoming aware of the issue unless the overpayment can be addressed through a claim or it is not practical to claim adjust. Overpayments need to be recouped within 90 days of notice. Out of State providers MUST repay funds by check.

APPEALS

Any provider who has rendered service to a Total Health Care member has the right to submit an appeal to resolve issues or disputes in a timely and reasonable manner. Providers must follow established procedures and processes. Appeals may involve claims, credentialing or recredentialing, or adverse determinations (denials). If you believe you have a dispute, you have the right to submit an appeal to Total Health Care. For all questions on appeals, please contact the Medical Director at (313)871-7801 or Provider Relations at 844-THC-DOCS (844) 842-3627.

PROCEDURE:

Types of Appeals

There are generally 3 types of appeals that providers may have:

1. Claims Appeals

Providers who do not receive payment within required time frames have the right to request an appeal to Total Health Care.

If a provider believes that he/she has not received a payment to which he/she is entitled, an appeal may be submitted to either the Provider Relations Department or the Claims Department at Total Health Care. This request can be in writing or verbally. Total Health Care must process the appeal in a timely manner, which will always be within 30 days.

- **Medicaid Only Claims Disputes:** If the appeal decision is not acceptable to you as a non-contracted hospital and you have signed the Hospital Access Agreement with CMS you can request for Rapid Dispute Resolution. Upon receipt of the request, Total Health Care will follow the Rapid Dispute Resolution Guidelines in the Medicaid Provider Manual.

If the appeal decision is not acceptable to you as a provider, you have the right to participate in a binding arbitration process with regard to Medicaid members only. The Department of Community Health will provide a listing of neutral arbitrators who resolve billing disputes that Total Health Care will use to resolve the issue.

To submit an appeal either write to Total Health Care or call:

Medical Director: (313) 871-7801

Provider Relations Department: 844-THC-DOCS (844) 842-3627

2. Credentialing/Recredentialing Decision Appeals

As a provider, you may not agree with a credentialing or recredentialing decision rendered by the Credentialing Committee of Total Health Care and you have the right to appeal. This process is outlined in detail in the Credentialing and Recredentialing Section.

3. Adverse Determination Appeals (denials, authorizations)

If an authorization or request for inpatient, continued stay, or other care for a member is denied, you as the provider have a right to appeal the denial. You may serve on behalf of a member or may appeal the decision yourself. It is important you submit your request in a timely manner to avoid any unnecessary problems for the member. If a provider appeals on behalf of the member, the member timeframes will be followed and not the provider timeframes (P&P AD 19-1, AD 19-2). Expedited appeals are available for circumstances when waiting would be expected to jeopardize the well-being of the member.

Your appeal should include the necessary medical documentation for the inpatient, continued stay, or other care that you are requesting. This is one level for the appeal process. Total Health Care will review your appeal and render a decision within 30 days of receipt of the oral or written appeal for first level appeals. Expedited appeals decisions will be rendered within 72 hours of receipt of the request for appeal. Appeals of this type should be submitted to the attention of either the Medical Director or the Utilization Management Department either in writing or verbally.

The telephone numbers are as follows:

| | |
|------------------------------------|----------------|
| Medical Director: | (313) 871-7801 |
| Utilization Management Department: | (313) 871-7883 |
| | (313) 871-7884 |
| | (313) 871-7855 |

Arbitration Option to Settle Medicaid Claims Disputes

If the appeal decision is not acceptable to you as a provider you have the right to participate in a binding arbitration process with regards to Medicaid members only. The Department of Community Health will provide a listing of neutral arbitrators who resolve billing disputes that will be used by you and Total Health Care to resolve the issue.

To submit an appeal either write to Total Health Care or call:

| | |
|--------------------------------|-----------------------------|
| Medical Director: | (313) 871-7801 |
| Provider Relations Department: | 844-THC-DOCS (844) 842-3627 |

HEALTH AND WELLNESS

A. Disease Management

Total Health Care offers disease management programs for eligible members who have been identified as having the following chronic diseases:

- Asthma
- Chronic Obstructive Pulmonary Disease
- Diabetes
- Hypertension and
- Heart Disease

Total Health Care's disease management programs are a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. The programs support the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidenced-based practice guidelines and patient empowerment strategies such as self-management. There is a continuous evaluation of clinical and economic outcomes with the goal of improving overall health.

Total Health Care members are automatically enrolled in programs based on disease identification through claims or encounter data; pharmacy data; health appraisal results; laboratory results; data collected from utilization management and case management processes; data from health and wellness programs, and member and practitioner referrals.

If you have a Total Health Care member who is eligible for a program, please contact our Disease Management Department by phone at (313) 871-5254, fax to (313) 871-6623, or via email at www.thcmi.com; Contact.

B. Preventive Health

Preventive Health Care is about ensuring patients remain healthy and educated about potential health risks. Total Health Care offers numerous resources to teach members about healthy life practices and specific conditions. It's our way to help you help your patients take a proactive stance on their health care. Current Programs include:

- Children's Health (birth to 11 years)
- Adolescent Health (12 to 21 years)
- Women's Health
- Men's Health
- Weight Management
- Tobacco Cessation

If you have a Total Health Care member who would like more information on these programs, please contact our Quality Management Department by phone at (313) 871-5254 or via email at www.THCmi.com; Contact.

QUALITY IMPROVEMENT

Quality Overview

Total Health Care's quality improvement program is structured to ensure that its members have access to and receive high quality health care and preventive services that promote wellness. Total Health Care is committed to the continuous quality improvement of services provided to its members and optimal health care outcomes.

The Board of Directors is accountable for the integrity and success of the quality improvement program. The program is designed to permit central coordination by the Plan over health care activities while permitting responsibility within the IPAs, PHOs, and medical groups. The Board delegates the responsibility for the conduct of the quality improvement activities to the Quality Improvement Committee who works closely with the Medical Director.

The Quality Improvement Committee is an interdisciplinary committee composed of Total Health Care participating physicians and administrative staff who are involved in the quality improvement activities. The Plan Medical Director chairs the Committee that meets at least quarterly. The purpose of the Quality Improvement Committee is to oversee and direct a comprehensive, planned, and systematic process of monitoring and evaluating the quality of care and services provided to Plan members.

Opportunities for improvement are identified by objectively and systematically monitoring and evaluating the available data, quality and the appropriateness of all managed care services, identifying opportunities for improving patient care, and resolving identified problems.

To ensure that the Quality Improvement Committee addresses member needs, the following core activities are integrated into the quality improvement program:

- Medical Record Documentation Reviews and Studies
- Member and Provider Satisfaction Surveys
- Clinical Studies
- Access and Availability Studies
- Complaint and Grievance/Appeal Analysis
- Credentialing and Recredentialing
- Utilization Management
- Delegated Activity Monitoring

- Practice and Clinical Guideline Development
- Preventive Care Guideline Development
- Risk Management
- Medication Usage

The Quality Improvement Committee is authorized to delegate quality improvement activities and monitoring to subcommittees. The Utilization Management and Credentialing Committees are subcommittees that are paneled with network physicians and report directly to the Quality Improvement Committee.

Upon request, Total Health Care will provide information to practitioners about the QI Program, including a description of the Program, and a report on the Plan's progress toward achievement of annual goals. For a copy the current year's QI Program document, contact the QI Manager at (313) 871-5254.

RISK MANAGEMENT

Total Health Care is dedicated to delivering quality health care to the public through its membership. Total Health Care's risk management program is a vital part of the delivery system and Total Health Care believes that member, visitor, employee, and provider safety is a top priority and that potentially compensable events can be prevented. Every provider has an affirmative duty to report incidents to the Risk Manager of Total Health Care. The Board of Directors oversees and fully supports a risk management program dedicated to safety and quality of patient care. Providers must recognize that the reporting of incidents is extremely important.

A. Incident Reporting Requirements

Any unusual incident, adverse reaction, negative response, or untoward event involving a member of Total Health Care, or any deviation from an approved policy/procedure or adopted standard which could or did result in injury, should be documented by completing an Incident Report Form (see form under Section C). If an incident involving a Total Health Care member occurs in your facility while the member is under your care, please follow these steps:

- Render care to the patient.
- Document in the chart carefully and completely.
- Complete a Total Health Care Incident Report Form.
- Fax and mail the Incident Report to the Risk Manager without delay.
- Contact Total Health Care's Risk Manager within 24 hours to discuss the incident, action to be taken and appropriate documentation.

If you require assistance completing this form, contact the Total Health Care Risk Manager at: (313) 871-7875.

Total Health Care, Inc.

Risk Manager
3011 W. Grand Blvd Suite 1600
Detroit, Michigan 48202

All Incident Reports will be reviewed, upon receipt, and appropriate action initiated. This action can include measures to minimize risk and control the loss. Total Health Care's objective in working with you is to prevent a claim from being filed against you. In the event that a claim is filed against you, the actions that we have taken may assist in reduction of your exposure.

Providers are expected to comply with the Michigan statutes, OSHA regulations, and community standards.

MEDICAL MANAGEMENT

Contracted physicians (primary care and specialists) are expected to cooperate fully with Total Health Care's utilization management program and share clinical information concerning members under their care. Physicians must understand the utilization management principles of managed care and practice preventive medicine in the management of their patients. The physicians must be willing to work collaboratively with Total Health Care in the delivery of health care and understand the need for utilization management activities. As a participating provider, your utilization management responsibilities include, but are not limited to, the following:

- Adherence to Total Health Care's policies/procedures regarding acute inpatient, skilled nursing facility, outpatient surgery, and emergency services.
- Cooperating and assisting Total Health Care in case management, disease management, and discharge planning activities.
- Responding promptly to concerns raised either concurrently or retrospectively as a result of the utilization management process.

Total Health Care references Interqual criteria length of stay (LOS) Guidelines for assistance in determination of medical necessary, outpatient care approaches, continued stay, and discharge planning.

A. After Hours Services

Total Health Care provides an afterhours service to assist members, physicians, and hospitals in obtaining emergency authorization when the Total Health Care office is closed. The service is available at (313) 871-2000 or toll-free at 1 (800) 826-2862. Please note that this service does NOT replace your requirement to maintain 24-hours/7 day per week availability for your members.

If one of your Total Health Care members is in the emergency room and requires admission after normal business hours, the after hours service will contact you. It is necessary that Total Health Care's Utilization Management Department be notified of all inpatient admissions within 48 hours. Total Health Care requests notification of inpatient hospitalizations prior to admission.

B. Referrals

The primary care physician is responsible for initiating and coordinating the referral process. A Referral must be completed when directing a member for services outside of the practice. The Referral establishes the requested service(s) and provider to render the service. The Referral is not a guarantee of payment. Total Health Care reimburses providers for authorized services rendered, within the scope of the member's benefits and coverage.

Certain services do not require a Referral, including urgent and emergency care. Referrals are not required to participating providers for an annual well-woman care, routine pre/post natal care, screening mammograms and routine well-child services.

Referrals are entered online through the provider portal. The electronic Referral allows for retrieval for the treating provider, member and Total Health Care. If the member or provider does not have online access, a copy of the Referral must be provided.

For provider portal registration, contact Provider Relations at 826-2862, ext 5. Specific services noted below require prior authorization by the Utilization Management Department at Total Health Care.

Services Requiring Prior Authorization: Fax Clinical Information to 313-748-1312

Abortion - *(Medicaid only)*

Admissions:

- Inpatient Hospital – acute, emergent, elective
- Long Term Acute Care Admission
- Skilled Nursing Facility
- Acute & Sub-Acute Rehabilitation
- *Excluding* Observation Stay (no auth required)

Surgeries:

- Abdominoplasty/ Panneculectomy
- Bariatric (*excluding lap band adjustments*)
- Blepharoplasty
- Breast Reduction / Augmentation
- Bunionectomy
- Cosmetic Surgeries not otherwise listed
- Foot - all
- Hammertoe
- Hysterectomy (need form only)
- Transplant, Organ, Tissue, Bone Marrow
- Nasal / Sinus Endoscopy Balloon Dilation
- Rhinoplasty / Septoplasty
- Scar Revision / Keloid Removal
- Surgery to Treat Varicose Veins

Device Implants- *including, not limited to:*

- Insulin pumps, continuous glucose monitors
- Interstim therapy
- Penile Implant
- Vagus nerve/bone growth stimulators
- Implantable Loop Records (cardiac)

Anti-emetic Drugs

Apheresis
Genetic Testing
Cochlear Implants / Auditory Osseointegrated Device
Home Health Care / Hospice
Infusion Therapy
Laser Treatment for Skin Diseases
Specialty Medication Injections (*see separate list*)
Out of Network Services (*excludes Select POS*)
Prosthetics/Orthotics- > \$200
Sterilization-Male/Female
Temporomandibular Joint (TMJ) Procedures
PT/OT/ST Treatment (*excludes Select POS*)
Behavioral Health / Substance Abuse Services
Power/motorized wheel chairs
Experimental & Investigational Services
Non-emergent ambulance transportation
Cardiac LifeVest
Contact Lenses, Prosthetic Eyes, Low Vision Aids

The following services require a PCP initiated Referral:

All procedures/surgeries in an ASC (Ambulatory Surgical Center) or Outpatient Hospital :

- Excluding procedures noted as requiring prior authorization

The following procedures when performed in POS 22 or Outpatient:

Biofeedback Therapy
Cardiac Catheterization
Cardioversion Tilt-table, TEE
Cardiac Rehabilitation
Hyperbaric Oxygen Therapy

Endoscopy procedures in **an outpatient setting**:

- GI Tract – excluding colonoscopy, sigmoidoscopy, proctoscopy
 - Capsule endoscopy
 - EGD
 - ERCP
 - Gastroscopy
 - Laryngoscopy
- Respiratory Tract:
 - Bronchoscopy
- Laparoscopy
- Arthroscopy
- Female Reproductive System:
 - Hysteroscopy
- **Nasal/sinus endoscopy – Prior authorization required**

High-tech radiology exams:

- CT Scans
- MRIs, MRAs

- PET Scans
- Nuclear Studies
 - Cardiac Stress Test
 - MUGA
 - HIDA Scan

Infertility Testing

Podiatry Visits and Treatment

Photochemotherapy – UV Light Treatment

PT/OT/ST- *initial evaluation only*

Sleep Studies

Wound care/ debridement

Chiropractic Visits and Treatment

C. Case Management

Case management is important to the overall management of health care, optimal outcomes, and the conservation of resources. Total Health Care has case managers who are available to assist with this process. Please notify our Quality Management Department of all members who could benefit from case management and assistance with the management of medical care and continuity of care for members with a complex and/or high cost resource medical condition will be coordinated.

The following provides examples of cases that can be significantly impacted by case management:

Targeted Diagnoses

- Cancer (requiring multiple therapy)
- Burns (3rd degree)
- Coma
- Cerebral vascular accidents
- Respiratory problems (e.g., ventilator dependent)
- Transplants
- Multiple trauma
- Premature infants
- AIDs
- Spinal cord injuries
- Head trauma
- High risk pregnancies

Any debilitation or progressive disease with a life expectancy of less than 2 years & with the potential to consume significant amounts of resources.

Situational Criteria

- Patients requiring long-term care outside the hospital setting
- Any member identified by “stop loss”
- Non-compliant members
- Patients identified by repeated admissions
- Any member re-admitted within 30 days of discharge

D. Concurrent Review and Discharge Planning

Concurrent review is conducted on all inpatient stays in accordance with criteria based on the diagnosis. The reviews are initiated by Total Health Care’s Utilization Management staff, under the direction of the Medical Director. This process also includes a focus on discharge planning of the member. Total Health Care maintains the final authority regarding decisions on concurrent review and discharge planning.

Telephonic or on-site reviews are conducted on a daily basis or according to the medical condition from admission to discharge. The Total Health Care Utilization Management staff will determine the type of review.

Inpatient stays are evaluated and reviewed for:

- Appropriate level of care;
- Continued medical necessity of inpatient care;
- Identification of need for discharges, planning and the development of a relevant and adequate discharge plan;
- Non-duplication of physician and ancillary services;
- Case management needs

The clinical evaluation includes the following:

- Physical findings including vital signs;
- Subjective reports;
- Laboratory and radiology reports;
- Scheduled surgical or diagnostic procedures;
- Specialty care needs, ICU, CCU, SICU;
- Care plan including monitoring, treatments, and medication

Interqual Criteria Guidelines are used to evaluate the level of care and length of stay needed but not as a final determination of discharge. The facility is notified of the next expected review date.

If the continued inpatient stay cannot be determined as medically necessary in accordance with the guidelines and clinical evaluation, Total Health Care will contact the attending

physician for additional information. If the continued stay cannot be substantiated as medically necessary, the case will be referred to the Medical Director for evaluation who will render a final decision within 1 business day.

The attending physician and the facility will be notified immediately of the denial and with a denial letter.

E. Retrospective Review

Retrospective review is performed on all unauthorized admissions (as required) of those members who are discharged prior to an initial decision. Specific retrospective review may be required for problematic or quality of care issues.

The retrospective review analyzes the appropriateness of medical services utilizing the same criteria and guidelines as in concurrent review and discharge planning and the most common categories of review are:

- Elective and emergent admissions without authorizations
- Out-of-area admissions for non-emergency care

Medical records are requested as appropriate for review and the Medical Director is consulted, if appropriate, to determine medical necessity and appropriateness of care. If services are denied, you, the attending physician, member, and facility will be notified in writing within 5 business days.

F. Appeals

Providers may request an appeal of a utilization decision in accordance with the procedure outline in the Appeals Process Section.

PHARMACY

Total Health Care is contracted with Envision Rx, a pharmacy benefits manager (PBM), to assist in administering the pharmacy benefit. Envision Rx manages the pharmacy network, pharmacy claim adjudication and management services, in addition to the drug formulary.

For provider support, contact the Pharmacy Department at (800) 826-2862, (313) 871-2000.

A. Prescription Drug Plan Coverage

Total Health Care's drug formularies and Preferred Drug lists are available on the website under the Pharmacy tab. Formularies for the commercial, Medicaid and MIChild line of business vary to meet the membership's different benefit. Please refer to the formularies when prescribing a medication.

Total Health Care supports a modified broad formulary program designed to cover the vast majority of therapeutic drug conditions. Selected drugs are subject to review procedures and prior authorization protocols by Total Health Care's Pharmacy Department. Total Health Care mandates the use of generic drugs that have U. S. Food and Drug Administration approved generic equivalents. The Preferred Therapeutic Drug list was developed to assist physicians in selecting clinically appropriate and cost effective products for our members.

B. Prior Authorization Procedure

Total Health Care asks that you prescribe within the drug formulary. In the event that a certain medication does not have a formulary alternative or requires prior authorization, the following procedure must be followed:

1. The prescriber must complete the Prior Authorization form and fax to the Plan's Pharmacy Benefit Manager. The Prior Authorization form is available at www.thcmi.com ; Providers; Pharmacy- Prior Auth Forms. The fax number is listed on the form.
2. Additional clinical information may be requested to support need for the medication.
3. After the request is reviewed, the prescriber will be notified of the decision via fax. If the medication is approved, the authorization information is entered into the claims processing system for dispensing at a participating pharmacy network provider.

C. Electronic Prescribing (e-prescribing)

Total Health Care encourages electronic prescribing. E-prescribing provides increased medication safety, efficiency, formulary adherence, prescriber and member convenience and improved patient satisfaction. In conjunction with our Pharmacy Benefit Manager, Total Health Care offers e-prescribing through Sure Scripts. There is no transaction cost to the prescriber, as long as they have an appropriate electronic medical record system or e-prescribing system. The system allows for member eligibility check, formulary downloads, and medication history retrieval.

CREDENTIALING

It is Total Health Care's responsibility to ensure the quality of health care delivery to its members. As outlined by the National Committee for Quality Assurance (NCQA), providers who participate in the health services delivery system must be properly credentialed with appropriate records of this activity maintained.

Total Health Care utilizes Professional Credentialing Verification Organization (PCVS), a credentials verification organization (CVO) to conduct primary source verification in compliance with the standards of the National Committee for Quality Assurance (NCQA) to provide credentialing and recredentialing functions for its providers. At no time does THC require PCVS to provide member information.

At any time, providers may contact the Plan to obtain a status on the credentialing process. Providers are also notified that they must self-report to Total Health Care any changes to their licensure, hospital privileges or practice patterns

A. Initial Credentialing

Total Health Care has established minimum standards for participation in the provider network. The following are components of the credentialing process:

1. Physician Credentialing Application

All providers (MD/DO/DDS/DPM/DC) are required to submit a completed Physician Credentialing Application prior to consideration for inclusion in the provider network.

2. The following documents that are subject to primary source verification are required to be submitted with the completed and signed application:

- Copy of current State of Michigan license to practice medicine
- Copy of current malpractice insurance certificate (declaration page). If you do not carry malpractice insurance, a copy of the CPR certificate of financial responsibility, a notarized letter of credit, or an escrow account is required
- Copy of a current DEA certificate with all schedules (2, 2N, 3, 3N, 4, & 5)
- Curriculum Vitae with work history for the past 5 years, with explanations for any gaps in work history
- Copy of Board Certification

Providers cannot be on the Medicare Opt-Out list to participate. Provider must be registered in CHAMPS to participate in Medicaid.

3. Office Site Visits

All providers must have an office site visit conducted after completion of the application and receipt of the required documentation. The office site review conducted by the Provider Relations Representatives will assess the following:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examination room space
- Availability of appointments
- Adequacy of medical record keeping
- Fire & emergency protocols

Provider sites must comply with the Facility Standards. Site visits are conducted at the time of initial credentialing and are performed ad hoc or as a follow up based on a member complaint.

4. National Practitioner Data Bank

A query will be made to the National Practitioner Data Bank for all practitioners.

5. Healthcare Integrity and Protection Data Bank

A query will be made to the Healthcare Integrity and Protection Data Bank for all practitioners.

6. Credentialing Committee

All applications, required documents, and the outcome of the site visit are reviewed by Total Health Care's Credentialing Committee comprised of participating physicians.

B. Recredentialing

Providers are required to be recredentialled every 3 years. The following documentation that is subject to primary source verification is required with recredentialing:

- Completed and signed Recredentialing documents (release of information & reaffirmation statement)
- Updated copies of current license, DEA certificate, and malpractice insurance coverage
- Query to the National Practitioner Data Bank
- Review of quality of care evaluations, medical record reviews and studies, member complaints and grievances, and general compliance with administrative procedures will be conducted
- Review by the Credentialing Committee

C. Reduction, Suspension, Or Termination of Privileges

The Credentialing Committee of Total Health Care has the authority to reduce, suspend, or terminate the privileges of a participating provider. The Committee will evaluate reports from the QI Committee, or other sources within Total Health Care regarding serious quality of care

deficiencies or other problems, which could adversely impact the quality of health care delivery. The Committee may render an expedited review regarding a provider's privileges and provide such in writing. The Committee activity will always include a practicing physician who does not represent a conflict of interest.

D. Appeals

All health care providers have the right to appeal a decision resulting in the reduction, suspension, or termination of privileges within 30 days of receipt of the written notice from Total Health Care. Failure to request an appeal within the 30-day period shall be deemed a waiver of the provider's right to a hearing.

Upon receipt of a request for appeal, the Credentialing Committee shall provide the provider with written notice stating the time, place, and date of the appeals hearing. The date shall not be less than 10 days, or more than 30 days if the provider has been suspended or terminated, or 60 days if the provider has not been suspended or terminated, after the date of the provider's request for appeal. At least two other practicing physicians, not previously involved in the decision, will be part of the Credentialing Committee that hears the appeal and renders the final decision.

The provider shall attend the appeal hearing and have the right to present testimony and other information supporting his or her position. Failure of the provider to attend shall be deemed an automatic waiver of the provider's right to an appeal hearing. Neither Total Health Care nor the provider shall have the right to legal counsel at any such hearing and the rules of evidence shall not apply in this situation.

Following the appeal hearing, a written summary of the hearing and the recommendation regarding reduction, suspension, or termination of privileges shall be completed outlining conclusions and the final recommendation and then forwarded to the Total Health Care Board of Directors. The Board shall vote to determine whether to adopt the final recommendation of the Credentialing Committee. The vote of the Board of Directors regarding reduction, suspension, or termination of the provider privileges shall be final. The provider shall have no right to request review or appeal of the decision of the Board of Directors in any form, including, but not limited to, a court of law.

Any member of the Credentialing Committee who has been directly involved in the decision to recommend reduction, suspension, or termination of privileges shall not participate in the vote of the Board of Directors following the formal appeals hearing.

E. Temporary Privileges

In exceptional and emergency situations, it may be necessary to grant temporary privileges to a physician to ensure optimal health care delivery for a member(s). The Medical Director of Total Health Care has the authority to grant temporary privileges to those physicians who have completed the following:

- License to practice in the State of Michigan verified
- Malpractice coverage with applicable dates (copy of declaration page)
- Application with work history (5 years)
- On-site visit to office conducted (PCPs only)

Revisions:

| Date | Change | Page # | Responsible Party |
|-----------|--|--------|-------------------|
| 9/1/2018 | Updated address to report Fraud Waste Abuse, and office of Inspector General | 18 | S Ryan |
| 9/12/2018 | Added information about time limit to report overpayments and reimburse overpayments | 28 | S Ryan |
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