Healthy Michigan Plan is Here!
Effective April 1, 2014, Medicaid expansion went into effect in the State of Michigan, known as Healthy Michigan Plan. The program includes eligible individuals who meet the following criteria:

- 19 - 64 years of age
- Adjusted gross income at or below 133% of the federal poverty level (FPL)
- Do not qualify for or are not enrolled in Medicare
- Do not qualify for or are not enrolled in other Medicaid programs
- Are not pregnant at the time of application
- Are a resident of the State of Michigan
- Are not incarcerated

Enrollees may change health plans within the first 90-days of enrollment; thereafter, they will be locked in to the health plan for the remainder of the year. Beneficiaries must re-qualify yearly.

Unique Attributes of Healthy Michigan Plan

- **Health Risk Assessment (HRA).** Enrollees are required to complete an HRA annually that collects information to identify risk factors, provides individualized feedback and links the person with at least one intervention to promote health, sustain function and/or prevent disease. The HRA must be reviewed and signed by the PCP. PCPs will be required to bill 99420 and fax the signed HRA to our vendor, Health Integrated. (see more details on Page 3).

- **Initial PCP Visit.** Within the first 60 days of enrollment, all Healthy Michigan enrollees must schedule an appointment with their PCP and be seen within the first 150 days of enrollment.

- **MI Health Account.** The MI Health Account is a unique health care savings vehicle that includes copayments and additional contributions.

- **Cost-sharing.** The premise of Healthy Michigan is that enrollees would participate in the cost of healthcare. Copayments and additional contributions to a HSA Account cannot exceed 5% of the beneficiary's annual income. Beneficiaries cannot be disenrolled for failure to pay their cost-share amount.

- **Copayments** are applied after the first 6 months of enrollment, but are not collected at the point of care. Total Health Care is responsible for collecting copayments and contributions.

**What you need to know**

As Medicaid expansion begins, providers will have access to new patients without the burden of collecting co-pays, coinsurance or deductibles. Primary Care Physicians will be reimbursed for E&M visits up to the Medicare fee schedule for 2014 as per the Affordable Care Act. Therefore, for physicians with closed panels, it may be worthwhile to consider opening your practice to new patients or expanding to take on the Medicaid product. It is projected that by the year 2020, one quarter of the State’s population will be enrolled in Medicaid. At the same time, commercial utilization is declining due to cost-share demands on this population. Contact Provider Relations at 313-871-2000, Option 4 if you wish to enroll or open your panel.

Our Mission:
To be the industry leader in providing quality, cost effective health care for our members
Qualifying Enrollees

The first wave of enrollees into the program are those who were previously enrolled in the Adult Medical Benefit Program, also known as the Adult Benefits Waiver or ABW. Additional beneficiaries will be added in coordination and partnership with CMS, seeking out applications originally submitted through the federal Health Insurance Marketplace that preliminarily met Healthy Michigan Plan guidelines. The State will also identify all applications submitted after October 1, 2013 that received a denial for Medicaid. Both of these cohorts will be reprocessed through Michigan’s Modified Adjusted Gross Income rules to determine eligibility for Healthy Michigan Plan. A continuous Open Enrollment period will allow new enrollees throughout the year.

Medical Benefits

- Preventive Services
- Habilitative Services
- Hearing Aids
- Dental care—Total Health Care plans to work with Dental to administer this benefit

Carve-Out Benefits

- Behavioral Health
  - Inpatient
  - Substance Abuse
  - Outpatient Mental Health - after 20 visits, thru Community Mental Health
- Maternity Infant Health Program. Pregnant members can choose to disenroll into the Plan First program or remain in Healthy Michigan. However, these services are available through Medicaid fee-for-service.

Incentives for Healthy Behaviors

All beneficiaries are eligible for cost-share reductions if certain healthy behaviors are attained or maintained. In order to determine a potential reduction in copayments and cost-sharing, each beneficiary must complete an annual HRA to identify the following unhealthy characteristics:

- Tobacco Use
- Alcohol Use
- Immunization deficiencies
- Substance Use Disorder
- Obesity

The Michigan Department of Community Health will design innovative, evidence-based incentives to address the health status of the chronically ill as well as healthy individuals.

How to Identify a THC Healthy Michigan Plan Enrollee:

Group #: M1001
M1501

Plan #: 111

Eligibility Date: Various
Health Risk Assessment (HRA) Process ~ How it will Work

THC wants to make it easy for our members and physicians to complete the required HRA for Healthy Michigan Plan Enrollees. We have partnered with Health Integrated to work with enrollees to complete Sections I, II & III of the HRA prior to their PCP visit. Here’s how the process will work:

**What THC/Health Integrated Does:**

- THC provides Health Integrated with an eligibility list of all Healthy Michigan Plan new enrollees.
- Health Integrated contacts each member to telephonically complete the HRA, which includes nine questions. This process is expected to take approximately 10 minutes.
- Upon completion of the HRA and within 60 days of enrollment, arrange for the initial PCP appointment to be completed within 150 days of enrollment.
- Arrange transportation, as needed.
- Fax completed HRA to PCP office.
- THC will also make the HRA form available through the Provider Portal.
- Reimburse PCP for completion of HRA.
- Incentivize member for HRA completion.

**What the PCP Does:**

- Educate office staff about the requirements of Healthy Michigan Plan.
- Accommodate appointment requests for Healthy Michigan Plan members. Providers should leave open slots to accommodate timely visits.
- Arrange for the faxed HRA to be available for a patient’s appointment.
- Complete Section IV of HRA and review in detail with patient, discussing appropriate interventions.
- Sign HRA form and fax to Health Integrated.
- Bill 99420 on a HCFA 1500 claim to report completion of the HRA within 30 days of completion.

---

**PCP Visit Requirement**

Days 1-60: The enrollee is expected to schedule a PCP visit within 60 days of enrollment into the health plan. HRA process begins.

Days 1-150: The initial appointment should occur within 150 days of enrollment.

Finalize the Health Risk Assessment during the PCP visit.

Opportunity for an enrollee incentive, reduced MI Health Account contribution and improved health.
Healthy Behaviors can reduce Healthy Michigan Plan Enrollees Contributions

In addition to cost-sharing and premium contributions from enrollees, Healthy Michigan Plan is innovative in its approach to incentivizing healthy behaviors for the following:

- **Emergency Room Use**
- **Inpatient Hospitalization rates**
- **Use of preventive services, including health & wellness programs**

PCPs can support efforts to use health care resources appropriately by referring members to contracted urgent care sites in lieu of the emergency room. THC also offers assistance with tobacco cessation, weight loss services and case management. Contact us to find out how we can help you help our members.

Clinical Practice Guidelines

The following CPGs developed by MQIC (Michigan Quality Improvement Consortium) were approved for use at the February meeting of Total Health Care’s Quality Improvement Committee:

- **Advance Care Planning**
  - Primary Care Diagnosis and Management of Adults with Depression
  - Management and Prevention of Osteoporosis

Visit the THC Website at www.THCmi.com for more information.

BRCA Testing

Total Health Care has contracted Quest Diagnostics to be our sole provider for BRCA testing. Please make a note that all other providers are out-of-network for this service. BRCA testing requires prior authorization. Please fax all requests for BRCA testing to 313-748-1312.

**Appeal Process**

Please note that Total Health Care will accept clinical and claim denial appeals within 180 days from the original denial date. THC allows **one level** of claim appeal.
Cerumen Removal

CPT code 69210, removal impacted cerumen (separate procedure) one or both ears, has been updated for 2014. The code description for 2014 is as follows: Removal impacted cerumen requiring instrumentation, unilateral.

As indicated in the 2014 CPT book, removal of cerumen that is not impacted or does not require instrumentation, e.g., by irrigation, softening drops, cerumen spoons, is not a separately payable procedure even if performed by a physician or midlevel provider. In this situation, it is part of an office visit.

This clarification is not new. In the July 2005 CPT assistant “... mere wax removal (e.g., via lavage) does not warrant the reporting of CPT code 69210. Rather, that work would appropriately be captured by an evaluation and management code regardless of how it is removed.”

Billing Guidelines for CPT 69210

CPT has recognized the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) definition of cerumen impaction.

Cerumen should be considered impacted if one or more of the following are present:

Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane or middle ear condition.

Qualitative considerations: Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.

Inflammatory considerations: Associated with foul odor, infection or dermatitis.

Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills.

Instrumentation is defined as the use of an otoscope and other instruments such as wax curettes and wire loops, or an operating microscope and suction plus specific ear instruments (e.g., cup forceps)

Documentation in the medical record should include the exam findings, time, effort, and the equipment used to provide the service.

If you perform the procedure bilaterally, apply a 50 modifier to the CPT code.

In Summary

Cerumen removals that do not meet the above criteria are not billable. Cerumen removal by lavage is not a separately billable procedure. Report CPT 69210 only when the above criteria are met.

Coding Tips

When Diagnosis Coding ~ In an office setting....

- The first diagnosis listed should reflect the diagnosis, condition, problem or other reason for the visit.
- Don’t code any rule out or suspected illnesses, code to the signs and symptoms instead.
- Code any chronic condition treated.
- Code all conditions (even chronic ones) that effect the patient treatment.
- Do not code conditions that no longer exist. Instead, look to see if there are “history of” codes to report.
Meet our new staff member, Michelle Solomon, serving in the role as Manager of Data Analytics & Physician Education. Michelle has over 25 years experience in physician auditing, coding, compliance and education. Look to Michelle as your resource for questions concerning appropriate billing, coding, ICD-10 and quality measure reporting.

Michelle’s contact information is 313-871-6587 or msolomon@THCmi.com.

Michelle has developed several resource tools which will soon be available on our website, www.THCmi.com, Provider > Physician Education.

Please take the time to review the following documents to help you maximize your pay for performance and quality scores:

* Quality Rules for Adults
* Quality Rules for Children

2013 Provider Survey Results

Thank you to the provider offices that participated in our 2013 Provider Satisfaction Survey. THC is pleased to announce the results of our 2013 Provider Survey, the results of which show an improvement in Overall Satisfaction from prior years:

- **82% overall Satisfaction**
- 40% more satisfied when compared to other HMOs
- 46% indicated plan performance was “better” than last year

Timeliness of claims payments showed improvement and received the second highest score, with 78% of responses indicating “satisfied.” We also received favorable comments in response to the question, “What do you like best about THC”. These responses related to helpfulness of the Provider Relations staff, as well as the ease of our Referral/Authorization processes.

THC is committed to improvement in the areas of Case Management coordination and our contact with the provider community. Your feedback is very helpful to us to formulate action plans to address your needs.

**THANK YOU**
Eligibility Verification

How to Verify Eligibility

Provider Only Line 844-THC-DOCS available April 7, 2014

THC offers several different health plans and products. Our providers are contracted to accept Commercial and/or Medicaid membership in our HMO products, as well as Commercial POS and Medicare. Here is a breakdown:

**HMO:**

* Commercial membership thru small, mid-size and large employer groups
* Healthcare Insurance Marketplace products that cover both individuals and small groups, including:
  ♦ Totally You, HMO Standard, Total Gold, Total Value Plus, Total Value Complete, Saver Plus, Saver Complete, Total Platinum Ultimate, Signature, Premier and Complete, Total Signature Premier and Complete
* Healthy Michigan Plan—Medicaid Expansion
* Medicaid

**POS Products:**

* Total Select
* Health Insurance Marketplace products, including Total Platinum, Signature, Complete, Premier

The Health Insurance marketplace products have cost-share amounts with assorted copayments, deductibles and co-insurance.

Therefore, it is more important than ever to recognize the health plans in which you participate, as well as to verify eligibility to ensure coverage and appropriate cost-share amounts that you can collect at the point of service.

Verify eligibility through the Provider Portal:

* Log in thru secure Portal:
  * Click on Member Inquiry > ‘Eligibility’ or ‘My Members’
  * Search eligibility by using a member’s THC or Medicaid ID number or Member Demographics, including Name, Date of Birth, Gender
  * PCPs may export their entire patient roster by selecting the My Members tab and choosing Roster Export
* Call THC at 800-828-2862 or 844-THC-DOCS, Prompt 4 for eligibility and deductible/coinsurance information. Remember, members through the Healthcare Insurance Marketplace have a grace period so you will want to call to obtain eligibility status.
Member ID Cards

HMO Exchange ID Card:

- Member Name: [Redacted]
- Member #: 727814 01
- Plan #: T324
- Group #: M60183
- Eligibility Date: 09/01/2011
- PCP Name:
- PCP Phone#:
- Employer Name:

Card for Individual exchange members excludes Employer Name

POS Exchange ID Card:

- Member Name: [Redacted]
- Co-Payments:
  - Rx Copay: $10/540
  - Office Visit: $15/540/DC
  - After Hours: $25/560/DC
  - ER: $125/$125/$125
  - Copay: THC/Copay/Out of Network

HMO Commercial Group - non-exchange

- Member Name: SAMPLE A SAMPLE
- DOB: 01/09/1988
- Member #: 727814 01
- Emergency Room: $40
- Inpatient Conserv: $250
- OP Hosp. Consrv: $100
- Rx Copay: $10/540
- PCP Name:
- PCP Phone#: (313)386-1500
- Employer Name:

Medicaid HMO

- Member Name: [Redacted]
- DOB: 09/09/1999
- Group #: M1000
- Plan #: 103
- Eligibility Date: 01/01/2001
- Doctor #: 010702 (999)999-9999
- Covered Benefit: $0 Copay

Total Select POS - non-exchange

- Member Name: [Redacted]
- Co-Payments:
  - Rx Copay: $10/540
  - Office Visit: $15/540/DC
  - ER: $125/$125/$125
  - Copay: THC/Copay/Out of Network

MIChild

- Member Name: SAMPLE A SAMPLE
- DOB: 01/22/1994
- Member #: 3797635 01
- Plan #: 801
- Eligibility Date: 09/01/2011
- PCP #: 0120661 (586)573-0100
- Covered Benefit: $0 Copay

Employer Name:
Referral & Authorization Changes

**Referrals and Authorization Updates**

THC is in the process of updating our referral / authorization guidelines to include CPT codes for easier user. In the interim, please note the following changes:

**Prior Authorization Needed:**
* Laser treatment for inflammatory skin disease  
  Codes 96920-96922
* All miscellaneous codes ending in “99”

**Referral Required:**
* Photochemotherapy / UVL treatment  
  Codes 96910—96913

---

**Guidelines for collecting cost-share amounts at the point of care**
(excludes Health Michigan Plan)

- Providers may collect cost-sharing amounts, such as copayments, deductible and/or co-insurance at the time of service, as long as the amount does not exceed the patient’s liability for that visit.
- If the member overpays due to other outstanding claims, refunds must be promptly returned to the member.
- Cost share amounts should never be waived.
- Call Total Health Care directly to determine current status of deductible and co-insurance payments.
- Credit card information to pay for potential future liabilities may be collected with member consent, but cannot be required for services.

---

**Elective Inpatient Admissions**

THC requires prior authorization for elective inpatient surgeries. PCPs must fax clinical information to THC for review within 15 business days of the scheduled surgery. Hospitals may verify authorization prior to the patient being admitted for services via the Provider Portal. THC will no longer waive the requirement to review prior to admission.
Pharmacy Lockout ~ Does Your Patient Qualify?

Pharmacy Lockouts allow providers to manage their patients’ medication use by controlling prescription duplications, drug seeking behavior and cost, while additionally helping to prevent fraud and/or abuse. A Provider may request THC to place a pharmacy lockout on a patient’s prescription file for the following circumstances:

- Patient seeks controlled substances from multiple providers
- Fraud on prescription drugs

The pharmacy lockout enables only specific named providers to prescribe medications to a patient; thereby locking out all other providers from whom the member may seek unnecessary or duplicate medication.

THC can implement a pharmacy lockout for all medications or target the lockout to a specific therapeutic drug class. This option allows any provider to prescribe medications except for the designated drug class exclusion. For example, the Primary Care Physician may choose to be the sole prescriber of controlled substances for their member.

To initiate a pharmacy lockout, THC requires the NPI number of the provider(s) you wish to include. Multiple NPI numbers can be entered for a lockout. Call the Pharmacy Department 313-871-2000, extension 300 for questions or to implement a pharmacy lockout.

Pharmaceutical Management Procedures

Please visit THC’s web site at www.THCmi.com to view the Drug Formularies specific to the following members:

- Commercial
- Health Insurance Marketplace
- Medicaid
- CSHCS
- MIChild

Each formulary includes information regarding pharmaceutical management procedures regarding generic substitution, step therapy, quantity limits, age limits and prior authorization requirement.

If you would like a copy of the formularies or pharmaceutical management procedures, you may call the Pharmacy Department at 313-871-2000, and press extension 300.

Drug Prior Authorization Criteria

Prior Authorization Criteria for prescription drugs is available upon request by contacting the Pharmacy Department in writing or call 313-871-2000, and press extension 300.
Drug Formulary Updates ~ Effective April 2014

Total Health Care’s (THC) Pharmacy and Therapeutics Committee met in March 2014 and made the following Formulary updates:

- **Zegerid OTC** has been added to all formularies.

- **Nasacort OTC** has been added to all formularies.

- **Pantoprazole 40mg** - The quantity limit (QL) has been increased from one tablet per day to two tablets per day for all formularies.

- **Novolin R (Relion)** has been added to all formularies.

- **Aptiom (eslicarbazepine acetate)** is a carve out medication that will be processed through the member’s State of Michigan coverage for Medicaid & CSHCS formularies. The drug will be excluded from our Commercial, MICoS, MICoCSHCS and Exchange formularies.
  - Evaluate members for alternative drug coverage to include lamotrigine, gabapentin, carbamazepine, topiramate, levetiracetam, oxcarbazepine, phynoytoin, and valproic acid.

- **Anoro Ellipta (umeclidinium and vilanterol)** will be subject to a Prior Authorization for the diagnosis of COPD.

- **Estradiol/norethindrone (Activella)** will be added to the Medicaid & Commercial drug formularies.
<table>
<thead>
<tr>
<th>Medication</th>
<th>Code</th>
<th>Medical Authorization from UM Dept.</th>
<th>Pharmacy Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adcirca (Tadalafil)</td>
<td>J1792</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Advate (factor viii)</td>
<td>J2469</td>
<td>X</td>
<td>Excluded Benefit</td>
</tr>
<tr>
<td>Aloxi</td>
<td>J2469</td>
<td>Excluded Benefit</td>
<td></td>
</tr>
<tr>
<td>Aranesp (Darbepoetin)</td>
<td>J0881</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Avonex</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Betaseron (Extavia)</td>
<td>J1830</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Boniva injectable</td>
<td>J1740</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Botox, onabotulinumtoxinA</td>
<td>J0585</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cimzia</td>
<td>J0718</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Copaxone</td>
<td>J1595</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eligard</td>
<td>J9217 (IM), J1950 (SC)</td>
<td>IM</td>
<td>SC</td>
</tr>
<tr>
<td>Emend Injection</td>
<td>J1453</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Enbrel</td>
<td>J1438</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gleevec</td>
<td>S0088</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Humira Pen</td>
<td>J0135</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Infed Infusion</td>
<td>J1750</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Infergen</td>
<td>J9212</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Invanz IV Infusion</td>
<td>J1335</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lucentis</td>
<td>J2778</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lupron Injection</td>
<td>J1950</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Mifepristone</td>
<td>S0190</td>
<td>X - Commercial Only</td>
<td></td>
</tr>
<tr>
<td>Misoprostol</td>
<td>S0191</td>
<td>X - Commercial Only</td>
<td></td>
</tr>
<tr>
<td>Naltrexone Injection</td>
<td>J2315</td>
<td>X - Commercial Only</td>
<td></td>
</tr>
<tr>
<td>Neulasta</td>
<td>J2505</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Neupogen Injection</td>
<td>J1441, J1440</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Orencia</td>
<td>J0129</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Peg-Intron</td>
<td>S0145</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Procrit Injection (Epogen)</td>
<td>J0885, J0886</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Progesterone</td>
<td>S9560</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prolia</td>
<td>J0897</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Reclast</td>
<td>J3488</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Remicade Infusion</td>
<td>J1745</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Revlimid</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Revatio (sildenafil)</td>
<td>S0090</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>RhoGAM</td>
<td>J2792</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ribasphere (ribavirin)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sensipar (cinacalcet)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Synagis Injectable</td>
<td>J3490, C9003</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tarceva (erlotinib)</td>
<td></td>
<td>X - Commercial Only</td>
<td></td>
</tr>
</tbody>
</table>
Specialty Medications for Prior Authorization, continued

<table>
<thead>
<tr>
<th>Medication</th>
<th>Code</th>
<th>Medical Authorization from UM Dept.</th>
<th>Pharmacy Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasigna (nilotinib)</td>
<td>J9328 (IV), J8700 (O)</td>
<td>IV</td>
<td>X - Commercial Only</td>
</tr>
<tr>
<td>Temodar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thalomid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tygacil</td>
<td>J3243</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tysabri</td>
<td>J2323</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Venofer</td>
<td>J1756</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Vivaglobin</td>
<td>J1562</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Xeloda</td>
<td>J8520, J8521</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Xyntha</td>
<td>J7192</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Note the updates from the last publication, highlighted in yellow.

**Pharmacy Prior Authorization**

To obtain prior authorization, complete a specialty prior authorization form and fax to Catamaran at 888-852-1832 with supporting medical documentation. The form is available on THC’s website at [www.THCmi.com](http://www.THCmi.com): Select Providers, scroll down to the Pharmacy-Prior Authorization Forms. THC’s specialty medications are provided by CVS/Caremark and will be processed to ship to the member or the provider. If you have any questions, you may reach THC’s pharmacy department at 313-871-2000, opt. 2 or 800-826-2862, opt. 2, Catamaran at 877-634-9202 or CVS/Caremark 800-753-2777.

**UM Department Prior Authorization**

To obtain prior authorization, fax a letter of medical necessity including clinical information with diagnosis and procedures codes to 313-748-1312. If you have any questions, you may reach the UM Department at 313-871-2000 or 800-826-2862.
ALERT: Medicare Advantage and Part D Providers

As you know, CMS (Centers for Medicare and Medicaid Services) requires providers associated with the administration of any Medicare Advantage and Prescription Drug line of business to complete certain regulatory compliance requirements. Accordingly, the following actions must be completed within 30 days of receiving this alert and may be audited for compliance. Those provider actions/obligations include but are not limited to the following:

- Receive Compliance Training
- Provide Total Health Care with Compliance Training Attestations upon request
- Receive Model of Care Training
- Provide Total Health Care with Offshore Subcontracting Attestations Associated with the Protection of Beneficiary PHI (Protected Health Information)

Total Health Care’s Medicare Advantage and Prescription Drug internet site contains the training links and forms that support your obligations bulleted above. Our website address is:

[www.TotalMedicarePlus.com](http://www.TotalMedicarePlus.com)

Click on the “Providers” link on the main page (top of page). Next, click on the “Provider In Service” link along the left margin of the page. Click each of the three (3) following links in turn to complete this process. The links are identified as:

- Model of Care Training
- Compliance and FWA Training
- Offshore Subcontracting

Call 313-871-7886 with questions. Thank you for your cooperation.