Total Health Care Begins its Second Year on the Health Insurance Marketplace

Open enrollment on the Health Insurance Marketplace continues through February 15. THC continues to offer POS plans, and HMO plans both on and off the exchange to commercial groups and individuals. Please make sure that your office staff is familiar with our products and your participation to avoid confusion and accurately answer questions from patients. Here is a summary:

HMO Products (Employer Sponsored HMO, Individual & Families HMO):

- Total Gold Complete
- Total Gold Premier
- Total Gold Signature
- Totally You
- Total Platinum Complete
- Total Platinum Premier
- Total Platinum Signature
- Total Platinum Ultimate
- Total Saver Complete
- Total Saver Plus
- Total Value Complete
- Total Value Plus
- Total HMO Standard

POS Products (Employer Sponsored POS):

- Total Select Platinum Complete
- Total Select Platinum Premier
- Total Select Platinum Signature

<table>
<thead>
<tr>
<th>ID Card</th>
<th>Commercial</th>
<th>Medicaid/Healthy Michigan/ MiChild</th>
<th>POS Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO on front of ID card</td>
<td>No product identification</td>
<td>POS on front of ID card</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Numbers</th>
<th>Commercial</th>
<th>Medicaid/Healthy Michigan/ MiChild</th>
<th>POS Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>M6XXXX</td>
<td>M1000, M1500 - Medicaid</td>
<td>M1001, M1501 – Healthy MI</td>
<td></td>
</tr>
<tr>
<td>M7XXXX</td>
<td>M2000, M2500 – Dual Eligible</td>
<td>M3000, M3500 - CSHCS</td>
<td></td>
</tr>
<tr>
<td>XGXXXX</td>
<td>M8000, M8002 - MiChild</td>
<td>M7XXX</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Co-pays, Co-Insurance, Deductibles</th>
<th>Commercial</th>
<th>Medicaid/Healthy Michigan/ MiChild</th>
<th>POS Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vary by product</td>
<td>No out of pocket costs to be collected at point of service</td>
<td>Vary by product</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THC Network</th>
<th>Commercial</th>
<th>Medicaid/Healthy Michigan/ MiChild</th>
<th>POS Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>No in-network restrictions; no out-of-network benefits</td>
<td>No in-network restrictions; no out-of-network benefits</td>
<td>Ability to access care outside of THC network using Cofinity network; higher out of pocket costs apply</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals</th>
<th>Commercial</th>
<th>Medicaid/Healthy Michigan/ MiChild</th>
<th>POS Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to Authorization Grid</td>
<td>Refer to Authorization Grid</td>
<td>Refer to Authorization Grid</td>
<td></td>
</tr>
</tbody>
</table>

To verify your participation, check your listing on THC’s online Provider Directory: www.THCmi.com > Find a Doctor.

Our Mission:
To be the industry leader in providing quality, cost effective health care for our members
Utilization Management Process
THC’s Utilization Management (UM) program ensures medical services provided to members are medically necessary and appropriate. Under the direction of the Medical Director, UM case managers consistently apply Total Health Care written criteria when making benefit and medical necessity determinations. This criteria is available to providers upon request by calling the UM department. All utilization review decisions are made in a timely manner. Coverage denials are made by a board certified physician.

Inpatient Admissions
THC’s Utilization Management program provides 24 hour access for members requiring hospitalization. In- and out-of-network inpatient hospital admissions require prior authorization. Contact THC during normal business hours (8:00am – 5:00pm) at 313-871-2000 or after hours at 800-826-2862. Fax clinical documentation to the Inpatient Hospital Admissions Line: 313-748-1319.

Other Services
All prior authorization requests, including elective surgery, skilled nursing, acute & sub-acute rehabilitation, discharge planning and home care requests must be faxed to: Outpatient Services Request Line 313-748-1312.

Prior Authorizations
Some covered services require prior approval by THC’s Medical Director. These services are not covered unless a comprehensive review of supportive documentation, provided at time of the request, is performed and the service is determined to be medically necessary. Please consider the following:
- Standard prior authorization requests may take up to 14 calendar days for review and determination.
- Urgent requests may take up to 3 calendar days for review and determination.

For a list of services that require prior authorization, please access the THC Prior Authorization Grid located on the Provider Page at www.THCmi.com.

All UM decisions are based on benefit coverage and appropriateness of care and service. Total Health Care does not reward any practitioner or other medical personnel for denying services or care. Persons making UM decisions do not receive any reward for decisions that limit care.

Referrals
THC’s primary care providers (PCPs) have access to THC’s Provider Portal at www.THCmi.com to authorize referrals. This process was designed to support coordination of care by the primary care physicians, while ensuring THC’s members receive the right care in the right location at the right time.

Case Management/Disease Management Services
As part of the discharge plan, our UM case managers facilitate transition of care activities to promote smooth transitions between levels of care/care settings in order to reduce hospital readmissions and avoid ER visits. THC also offers Case Management and Disease Management programs to support patients with case management challenges or patients with a history of chronic conditions who would benefit from self-management strategies. You can access our Disease Management/Case Management program by either submitting a request via www.THCmi.com under the Health & Wellness tab or by calling THC Customer Service.
While we agree with Thomas Jefferson, Total Health Care also believes in rewarding our physicians who promote quality of care through our Pay for Performance program. To align with our goals to meet NCQA standards for performance on HEDIS® measures, we are revamping our program for 2015. THC will continue to support physicians for efforts to promote prevention and healthy outcomes. Visit our website in the next month for specific details, but here is a general overview:

**Participation Prerequisite:** All PCPs must submit a claim for Preventive Wellness Visit for 75% of members assigned during the calendar year. Membership will be frozen on November 30, 2015 to establish the denominator for eligibility.

Preventive Wellness codes that meet the measure include:

99381 - 99397

PCPs who meet the above criteria will be eligible for P4P program, which will be based on Total Quality Score as indicated on your ProHEDIS report card.

**Exceptions:**
- PCPs must have an open patient panel.
- PCPs with less than 50 members (another program is in development).

**Total Reward$ Incentive Program 2014**

In an effort to support physicians and improve HEDIS scores for 2014, THC initiated a special incentive program, Total Reward$. For the months of October, November and December. For every 25 CPT II codes reported for specific measures, physicians names were entered in a monthly drawing for $5000. Approximately 4000 qualifying codes were reported each month! Congratulations to our lucky winners:

**OCTOBER**
Dr. Ghanem Sharabi, Paramount Medical Group and Pamela Long, THC PR

**NOVEMBER**
Dr. Nancy Treece, Riverview Pediatrics and Office Mgr Marlene Jones

**DECEMBER**
Dr. Ronald Barnett, Shores Primary Care and Pamela Long, THC PR
### Pharmacy Formulary Updates

#### THC Pharmacy and Therapeutics Committee Updates
**Effective January 1, 2015**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Action</th>
<th>Formulary</th>
<th>Alternative Formulary Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol 2 mg</td>
<td>Removed</td>
<td>All Formularies</td>
<td>Albuterol 2mg/5mL syrup, Albuterol inhalation via nebulizer, Ventolin HFA</td>
</tr>
<tr>
<td>Albuterol 4 mg</td>
<td>Removed</td>
<td>All Formularies</td>
<td></td>
</tr>
</tbody>
</table>

### Therapy Class

#### Urinary Antispasmodics

<table>
<thead>
<tr>
<th>Therapy Class</th>
<th>Formulary</th>
<th>First Line / Second Line / Third Line</th>
<th>Step Therapy Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxybutynin, Oxybutynin Syrup, Oxytrol OTC</td>
<td>Medicaid &amp; MiChild</td>
<td>Oxybutynin ER, Tolterodine, Tolterodine ER, Trospium</td>
<td>Prior use of Oxytrol OTC, Oxybutynin or Oxybutynin Syrup in the last 90 days.</td>
</tr>
<tr>
<td>Oxybutynin, Oxybutynin Syrup, Oxytrol OTC</td>
<td>Commercial &amp; Qualified Health Plans</td>
<td>Tolterodine ER, Trospium</td>
<td>Second Line: Prior use of Oxytrol OTC, Oxybutynin, Oxybutynin ER or Oxybutynin Syrup in the last 90 days.</td>
</tr>
<tr>
<td>Enablex, Toviaz, Trospium ER, Vesicare</td>
<td></td>
<td></td>
<td>Third Line: Prior use of Tolterodine, Tolterodine ER or Trospium in the last 90 days.</td>
</tr>
</tbody>
</table>

Visit THC’s website at [www.THCmi.com](http://www.THCmi.com) to view the Drug Formularies specific to the following members:
- Commercial
- Qualified Health Plan (Health Insurance Marketplace)
- Healthy Michigan Plan
- Medicaid
- MIChild

Each formulary includes information regarding pharmaceutical management procedures on generic substitution, step therapy, quantity limits, age limits and prior authorization requirements. Contact the THC Pharmacy Department for a copy of the formularies or pharmaceutical management procedures.

**Envision Pharmacy Help Desk:** 844-222-5584  
**Mail Order Pharmacy:** 866-909-5170  
**Diplomat Specialty Pharmacy:** 877-977-9118  
**J&B Medical Supply (Diabetic supplies):** 844-236-7933  
**THC Pharmacy Dept:** 313-871-2000, ext 3300
Healthy Michigan Plan Co-Pays

The Michigan Department of Community Health (MDCH) requires service providers to notify Healthy Michigan beneficiaries of potential co-pay requirements at the point of service. **Providers are not required to collect co-payments**; collection of co-pays for covered services is the responsibility of the health plan through the MI Health account. To assist providers in the notification effort, MDCH provides a printable copy of a document entitled "Information About Healthy Michigan Plan Copays" on its website, [www.michigan.gov](http://www.michigan.gov) that can be distributed to patients.

Co-payment exceptions:
- Certain chronic conditions are exempted from co-payments
- Certain drug classes for treatment of chronic conditions
- Non-covered services are not eligible for payment through the MI Health account

**Co-pay Reductions** - Healthy Michigan members who complete an HRA with their PCP and agree to healthy behaviors may qualify for a reduction in their contribution into the MI Health account.

For specific information related to co-payment exemptions, visit the Michigan.gov website noted above, but here are some general guidelines.

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-Pay Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit (excluding preventive visits)</td>
<td>$2</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$2</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$3 for non-emergent services</td>
</tr>
<tr>
<td>Inpatient hospital stay</td>
<td>$50</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>$1</td>
</tr>
<tr>
<td>Podiatry Visits</td>
<td>$2</td>
</tr>
</tbody>
</table>

Healthy Michigan Requirements

2015 is the second year of participation for Healthy Michigan members. PCPs with HMP members need to be aware of the following special requirements for this population:

- Beneficiaries are eligible for a yearly incentive (reduction in their cost sharing) based on completion of the HRA (Health Risk Appraisal). For year two, members must choose a Healthy Behavior, and PCP must complete Section IV of the HRA within 11-15 months of the completion date of the first HRA.
- Complete Section IV of HRA annually and review in detail with patient, discussing appropriate interventions. Sign HRA form and fax to Total Health Care at 313-748-1358.
- Bill 99420 on a HCFA 1500/837P with corresponding office visit to report completion of the HRA within 30 days of completion. Providers will be reimbursed $25 each for the initial and subsequent HRA.
- Accommodate appointment requests for Healthy Michigan Plan members. Providers should leave open slots to accommodate timely visits.
- Order, perform and address these 4X4 initiatives on a yearly basis on all HMP members:
  - BMI
  - Blood Pressure Check
  - Glucose Screening
  - Cholesterol Screening
Quality Improvement Program

**Clinical Practice Guidelines**

Total Health Care’s Quality Improvement Committee is continually focused on offering evidence-based recommendations to improve positive health outcomes. The following CPGs developed by MQIC (Michigan Quality Improvement Consortium) have been approved for use by our Quality Improvement Committee:

- Adolescent/Young Adult Health Risk Behavior Assessment
- General Principles for the Diagnosis and Management of Asthma
- Management of Acute Low Back Pain in Adults
- Management of Diabetes Mellitus
- Management of Uncomplicated Acute Bronchitis in Adults
- Prevention and Identification of Childhood Overweight and Obesity
- Prevention of Pregnancy in Adolescents 12-17 years
- Routine Prenatal and Postnatal Care
- Treatment of Childhood Overweight and Obesity
- Acute Pharyngitis in Children 2-18 Years Old
- Adults with Systolic Heart Failure

Access to these MQIC Guidelines is available on the THC website, [wwwTHCmi.com](http://wwwTHCmi.com) > Provider page > Clinical Resources.

**Quality Improvement Initiatives**

In addition to the use of evidence-based clinical guidelines, the Quality Improvement Committee supports physicians through outreach interventions directly to members. These include member incentive programs, member telephone reminders and mailings, as well as educational materials related to specific chronic conditions. If you would like a copy of any of these materials, contact your Provider Relations representative.

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**Network Updates**

THC has partnered with CVS MinuteClinics to provide access to urgent care. CVS MinuteClinics are available for common family illnesses such as strep throat, pink eye, treatment of minor wounds and other similar conditions. CVS MinuteClinics can support physicians in keeping patients from inappropriate use of the emergency room. Visit our website to find urgent care locations near your practice to refer patients for after hours care.
National Correct Coding Initiative (NCCI)

In 1996, the Centers for Medicare and Medicaid Services (CMS) developed the Medicare National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to monitor for incorrect payments. The policy was based on coding conventions defined in the American Medical Association’s CPT Manual, national and local policies and edits, coding guidelines developed by national societies and analysis of standard medical and surgical practices. It is updated quarterly and found on the CMS website at the following link:

http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS developed code pair tables that indicate HCPCS/CPT codes that should not be reported together. There are separate tables for outpatient facility claims and physician claims. Code pairs are listed in Column 1 and Column 2 of the table. CMS will pay the code in Column 1 and deny payment for the code in Column 2 unless an appropriate modifier is present as listed in the Modifier column. These denials are referred to as “CCI Edits” and are automatically denied upon adjudication of the claim. The NCCI methodology has been adopted by most health insurance companies, including Total Health Care, with slight differences as defined by each company’s payment rules.

Codes denied in Column 2 of the code pair table include those that are inclusive of a more comprehensive code or are mutually exclusive. A mutually exclusive code is one that could not be performed at the same encounter because their similarity cancels the other out i.e., a repair of an organ by two different methods. Only one method can be reported at the same encounter.

In addition to the NCCI tables, CMS provides an NCCI Policy Manual for Medicare Services. It can be found using the link listed above. The policy manual provides detail about appropriate coding practices.

Medically Unlikely Edits (MUEs)

In addition to the NCCI edits, CMS developed a list of Medically Unlikely Edits (MUEs) and Add-on Code Edits. This information is also found at the link above.

Medically Unlikely Edits (MUEs) were established in January 2007. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single patient on a single date of service. All HCPCS/CPT codes do not have an MUE. CMS publishes most MUE values but some values are confidential. It is updated quarterly and there are separate tables for Physicians, Facilities and DME.

The MUE table includes the HCPCS/CPT Code, the number of maximum units, a MUE Adjudication Indicator and MUE Rationale. In July 2014, CMS added the MUE Adjudication Indicator and MUE Rationale and changed many of the MUEs into a per day edit vs. a line item edit. This is due to findings by the OIG of overcharging units for bilateral procedures. See MLN Matters SE1422 for more information.

Add-on Code Edits

Add-on Code Edits are a list of codes that must be reported with the appropriate primary procedure code performed on the same encounter. Add-on codes billed without the primary code will be denied for payment. If the primary procedure is not payable, the Add-on code is not payable. CMS has three categories of Add-on Code edits:

Type 1 – Add-on Code is linked to one or more primary procedure codes and is payable if the primary procedure code is paid.

Type 2 – Add-on Code is not linked to a primary procedure code. Payment is defined by the Medicare Administrative Contractor.

Type 3 – Add-on Code has some primary procedure codes linked to it and others that are not linked and are defined by the Medicare Administrative Contractor.

Total Health Care’s claims adjudication system incorporates the NCCI, MUE and Add-on Code edits established by CMS.
CPT 2015 Changes

There were approximately 540 updates to the CPT 2015 manual including dozens of new parenthetical instructions to help resolve bundling issues and to explain proper code application. Codes are more specific. Many codes have been re-sequenced.

Preparation for Coding Changes

- Providers should look at the coding changes for their specialty and also get a copy of the CPT 2015 Errata (written errors) which can usually be found on the Internet.
- Compare 2015 revised codes to the 2014 codes to understand the changes made in the description.
- Carefully read the descriptions and highlight specific words that will help select the appropriate code.
- Verify that the electronic health record application has been updated with the 2015 coding updates and adjust the standard encounter forms with any changes.
- Review the RVUs and reimbursement associated with the new codes.
- Attend a webinar about the updates.

We are always here to help. Contact your Provider Relations representative or Amy Farr, Coding Specialist for questions or assistance. See phone numbers on Page 12.

ProHEDIS ~ Online HEDIS reporting Tool

ProHEDIS allows PCPs to view gaps in care reports, report measures by uploading documentation and view an overall report card showing a score for each HEDIS measure.

ProHEDIS will continue to be updated through March 2015 with any claim information regarding services due in 2014. ProHEDIS 2015 will be available in April.

If you are having trouble accessing your information, including the PCP report card, contact your Provider Representative. THC continues to work with our vendor to enhance the product and troubleshoot issues. ProHEDIS will be extremely important in 2015 for our revamped PCP Pay for Performance program. Get to know the tool!

Performance Data

THC receives electronic data of lab results from Quest, LabCorp and contracted hospital labs thru JVHL.

To maximize your Pay for Performance scores, please make certain that you are sending lab specimens drawn in your office to one of these lab providers; if you do lab testing in office, it is critical that you share results data with us through CPT II reporting.
Credentialing Process
Total Health Care has established minimum standards for participation in its contracted provider network. Providers (which includes MDs, DOs, DCs, NPs, PAs, DDS, DPM, CNM) are required to sign a contract, submit a completed Physician Credentialing Application and/or allow THC to access the CAQH application online. Upon primary source verification of required documents, an office site visit will be conducted to assess minimum office requirements, including safety and record keeping. Additional inquiries will be made to the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank, OIG/SAM and Medicare Opt Out lists. All of the aforementioned information is then reviewed by the Credentialing Committee. Upon approval by the Committee, which is comprised of participating physicians, providers receive a Welcome Letter and effective date with the Plan.

Because CAQH is the primary source of information in the credentialing process, it is critical that physicians attest to the accuracy of the CAQH information every 120 days. CAQH is undergoing an upgrade to CAQH ProView™ effective February 23, 2015. The system will be unavailable from 8 pm February 17 though Monday morning February 23rd. Please plan to complete applications or re-attest in the UPD in advance of the scheduled downtime so your plan participation will not be affected. Your current application will automatically migrate into the CAQH ProView.

Grievance and Appeal Rights

Health Coverage Grievance and Appeal Rights
THC adheres to the Department of Insurance and Financial Services (DIFS) internal and external grievance and appeal processes. Patients have the right to an independent review when an adverse determination has been denied through the internal grievance process with Total Health Care. The PRIRA (Patient’s Right to Independent Review Act) provides for an external review through DIFS, and members can authorize a representative, such as a physician, to represent them in the process. For more information about this process, visit www.michigan.gov > Consumers > Health Insurance Information. You can also find our Appeal Process outlines online at www.THCmi.com.
Provider Satisfaction Survey Results

Thank you to our provider offices that participated in our 2014 Provider Satisfaction Survey. We appreciate your feedback and will continue to work on process improvement to serve your needs. Here are the survey highlights:

**Overall Satisfaction**
- 96% rated THC as either Very Satisfied or Somewhat Satisfied
- 68% gave top box score of Very Satisfied

**In Comparison with other HMOs**
- 55% rated Top Box Score of More Satisfied with THC

**Overall Performance in Last 12 Months**
- 76% rated THC as Much or Somewhat Better

Thanks to all participants. You can let us know how we’re doing at any time. Contact your Provider Relations Representative with any questions or concerns you may have.
Total Health Care Team

Clinical Operations
Robyn Arrington, MD  Medical Director  313-871-7801
Linda Alexander, RN  Chief Clinical Officer  313-293-6460
Valeon Waller, RN  Manager, Case Management  313-293-6416
Anita Nesby-Flowers, RN  Clinical Coordinator  313-871-7817
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Kyle Hill  Performance Improvement Administrator  313-293-6418

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Claims
LaDawn Wyatt  Claims Manager  313-871-7877

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Anita Wallace  Provider Relations Representatives  313-871-7809
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- UOP
- Independent Physicians A-M
- Monroe Allied Physicians

Pamela Long  Provider Relations Representatives  313-293-6440
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- St John Providence
- United Physicians
- OPNS
- PMC

Shelley Clark  Provider Relations Representatives  313-293-6413
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- Greater Macomb
- Olympia
- OSP
- Wayne State University Physicians Group
- Independent Physicians N-Z

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Maryanne Adam  Network Analyst  313-871-7808
Gary Francis  Network Development  313-871-7805