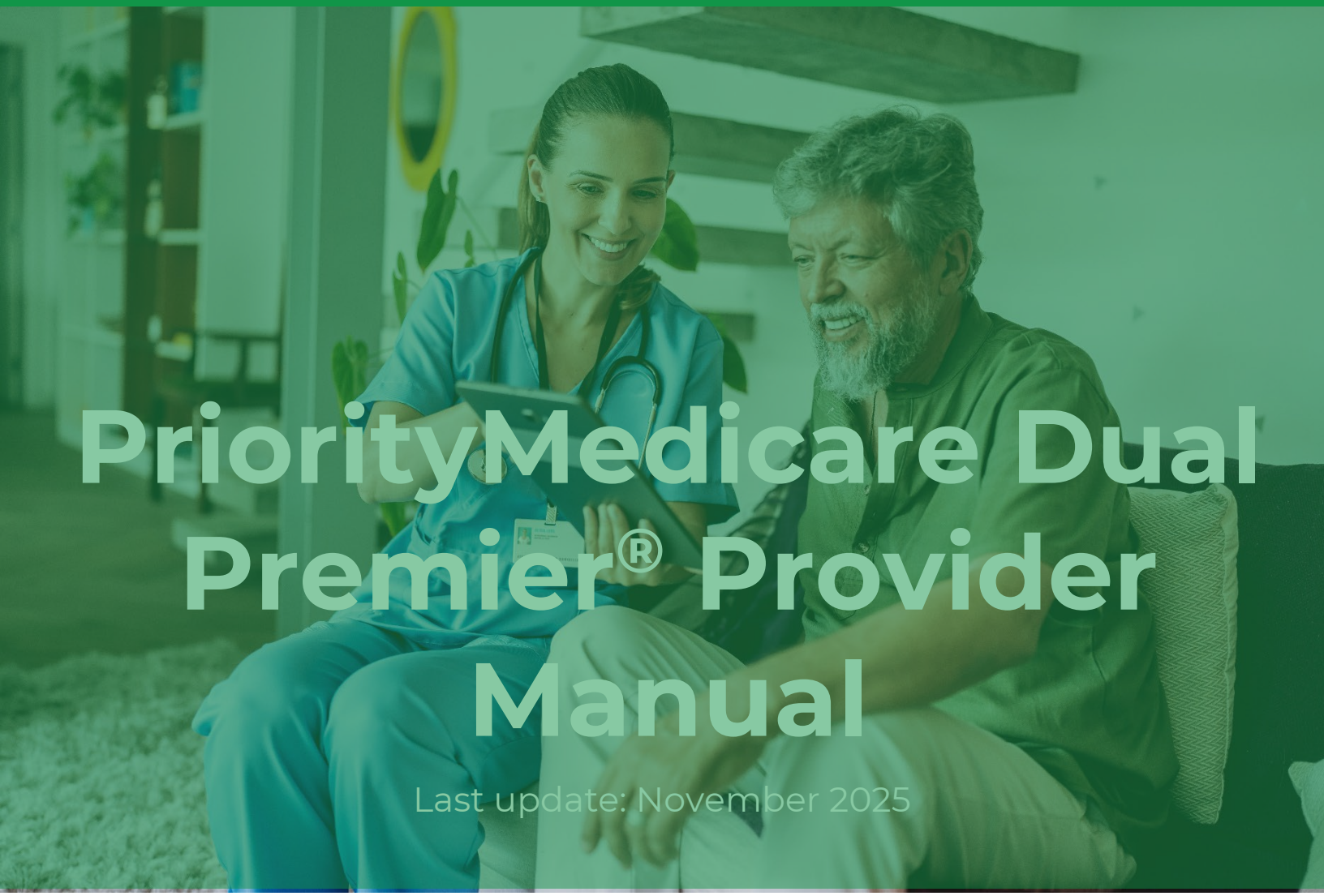
Priority Health



PriorityMedicare Dual Premier® Provider Manual

Last update: November 2025

In this Provider Manual for our highly integrated dual-eligible special needs plan (HIDE-SNP), PriorityMedicare Dual Premier® (HMO D-SNP), you'll find information, instructions and policies specifically for providers caring for Priority Health's HIDE-SNP members. This document is updated annually. For the most current information, instructions and policies, we encourage you to explore our **online Provider Manual** which is updated constantly as changes or new information become available.

What's inside this manual

Online resources

prism, our online provider portal

Through your prism account, you can:

- Manage claims and appeals
- Enroll a provider and make provider changes
- Access our digital navigation assistant
- Submit questions to our teams
- And more

Log into your prism account

Create a prism account

Visit the complete online Provider Manual

Get forms, drug information, plan information, education and training – across all lines of business.

Go to our online Provider Manual

Contact

Contact our Provider Helpline at **800.942.4765**, available Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday from 9 a.m. to 5 p.m.

Use the following extensions:

1 – Claims

2 – Eligibility and benefits

3 – Authorizations

4 – Pharmacy

5 – prism account help

6 – Behavioral health

7 – All other calls

Get your questions answered

Use our **Get your questions answered help guide** to direct all of your claims, credentialing, enrollment and general portal questions. Using the proper channels will help you to hear from us quickly.

Additional provider contact information is **available online**.

PriorityMedicare Dual Premier program information for providers

What is HIDE-SNP?

HIDE-SNP stands for Highly Integrated Dual-Eligible Special Needs Plan. It combines Medicare, Medicaid and Long-Term Services & Supports (LTSS) into one plan for an integrated member and provider experience.

The Priority Health HIDE-SNP is called PriorityMedicare Dual Premier (HMO D-SNP). MDHHS refers to the HIDE-SNP program as the Michigan Coordinated Health plan, or MICH (replacing MI Health Link).

Is this different from D-SNP?

HIDE-SNP is replacing D-SNP in certain Michigan regions in 2026 (then *all* Michigan regions in 2027). D-SNP is coordination-only—so members could have Medicare and Medicaid plans from different payers. Now it will be one plan, with one payer. Providers will now have one health plan to interact with for each member, rather than two. This applies to member eligibility, claims, appeals and grievances, inquiries, etc.

How do I participate with PriorityMedicare Dual Premier?

If you're not yet a participating provider with Priority Health, please join our networks. If you are a participating provider but aren't currently contracted with our Medicare or Medicaid product, submit a new enrollment request in prism. While you only need to be enrolled in one of these to be in-network for PriorityMedicare Dual Premier, we encourage you to enroll in both. Also, to be fully reimbursed, you must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS). Finally, if you're participating but your practice is closed to new patients, consider opening to new patients.

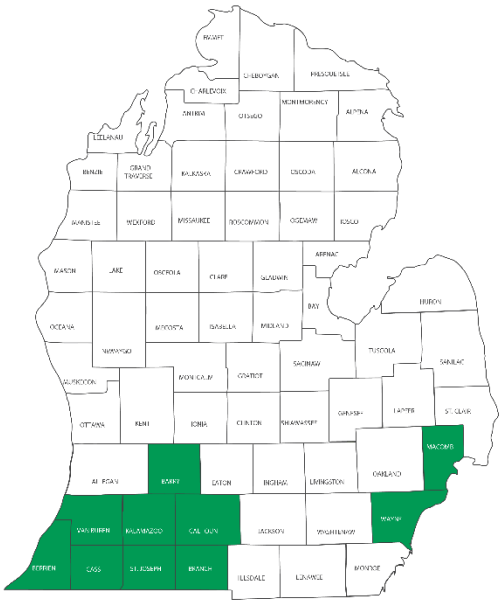
Member eligibility requirements

HIDE-SNP ELIGIBLE POPULATIONS

The HIDE-SNP will be available to individuals who meet all of the following criteria:

- Age 21 or older at the time of enrollment, including individuals age 21 and older served by the Children's Specialized Health Care Services (CSHCS) program

- Entitled to Medicare Part A, Medicare Part B and Medicare Part D
- Receiving full Medicaid benefits (this includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915 (c) waiver or who reside in a Nursing Facility, including those who have a monthly Patient Pay Amount (PPA)
- Reside in a covered Service Area as defined in the map below.



Eligible counties include Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren and Wayne. In 2027, PriorityMedicare Dual Premier will be offered in all regions of Michigan's Lower Peninsula. D-SNP will no longer be offered as of Jan. 1, 2027.

HIDE-SNP EXCLUDED POPULATION

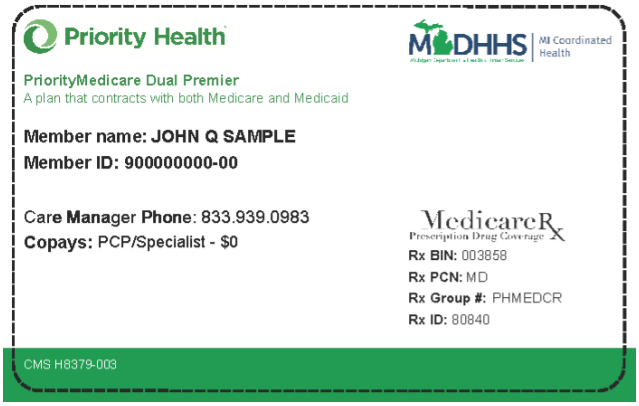
The following individuals are excluded from enrollment

- Individuals under the age of 21
- Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 C.F.R. § 438.56
- Individuals not living in a HIDE-SNP Service Area
- Individuals who are eligible for partial Medicaid coverage through the following eligibility groups: Additional Low Income Medicare Beneficiary (ALMB), Qualified Individual (QI), Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) or Qualified Disabled and Working Individuals (QDWI)
- Individuals without full Medicaid coverage (including those with spend downs or deductibles)

- Individuals with Medicaid who reside in a State psychiatric hospital
- Individuals with other comprehensive health coverage including commercial HMO coverage
- Individuals who elected hospice services prior to HIDE-SNP enrollment
    - If an existing HIDE-SNP Enrollee elects to receive hospice services, the Enrollee may remain enrolled in the HIDE-SNP and will only be disenrolled at the Enrollee's request.
- Individuals who are incarcerated
- Individuals with presumptive eligibility
- Individuals not eligible for Medicaid due to divestment
- Individuals residing in designated State sanctioned Veterans' Homes

Identifying PriorityMedicare Dual Premier members

ID cards: See below for a sample member ID card image:



Member Inquiry: In the prism Member Inquiry tool, PriorityMedicare Dual Premier members will be identified under "plan type" as "PriorityMedicare Dual Premier."

Billing

Providers submit a single claim for services rendered and will receive benefit consideration for both the member's Medicare and Medicaid coverage. The Medicare portion of the plan processes the claim first. If any cost-sharing remains after Medicare adjudication, the Medicaid benefit may cover the balance, subject to payment policy exceptions and/or limitations.

If a provider is out-of-network for either the Medicare or Medicaid portion of the plan, reimbursement will follow an applicable out-of-network fee schedule for that segment of the claim.

Federal law prohibits all Medicare providers and suppliers from billing dual-eligible beneficiaries (also referred to as Qualified Medicare Beneficiaries or QMBs) directly for Medicare Part A and Part B cost-sharing. This includes deductibles, coinsurance, and copayments. Any Medicare cost-sharing obligations will be covered by the member's Medicaid. QMB enrollees bear no financial responsibility for Medicare Part A or Part B cost-sharing. Providers who attempt to bill QMB individuals for these costs are in violation of their Medicare Provider Agreement and may face enforcement actions or sanctions.

Member cost share

PriorityMedicare Dual Premier members will have no costs from deductibles, premiums, coinsurance, copayments and cost sharing of any kind, with the exceptions of the amount an enrollee must pay toward Medicaid Nursing Facility Care, which is known as PPA, or certain medication copays. Providers cannot balance-bill PriorityMedicare Dual Premier members, even if considered out-of-network.

LTSS

Long-term services and supports (LTSS) encompass the variety of **health, health-related and social services that assist individuals with functional limitations** due to physical, cognitive or mental conditions and disabilities. Long Term Supports and Services (LTSS) include:

- Nursing facility services
- State Plan Personal Care Services (PCS)
- MICH Home and Community-Based Services (HCBS) Waiver services for Enrollees who live in the community and meet nursing facility level of care as determined by the level of care determination (LOCD)

Examples include:

- Adaptive medical equipment and supplies
- Adult day programs
- Assistive technology
- Chore services
- Community transition services
- Environmental modifications
- Expanded community living supports
- Fiscal intermediary services

- Home delivered meals
- Michigan Home and Community-Based Services (HCBS) Waiver services for enrollees who live in the community and meet nursing facility level of care as determined by the level of care determination (LOCD)
- Non-medical transportation
- Nursing facility services
- Private duty nursing
- Respite
- State Plan Personal Care Services (PCS)
- Vehicle modifications

LTSS are delivered in both institutional (e.g., nursing homes) settings, community-based settings and member homes.

Under HIDE-SNP, members who meet specific eligibility requirements will receive LTSS that will be provided through Priority Health's partnership with the Michigan and Detroit Area Agencies on Aging (AAAs). The AAAs will manage most administration (i.e. assessments, claims, etc.) using their network.

Members will either be identified by MDHHS as LTSS-eligible or by our Care Management team.

PriorityMedicare Dual Premier benefits

HIDE-SNP coordinates care and coverage between Medicaid and Medicare. HIDE-SNP offers the following services:

- Medicare covered services, including pharmacy
- Medicaid State Plan services, including personal care services, hearing aid coverage and Medicaid drugs
- Dental services, equivalent to the Medicaid adult dental benefit as described in the Dental Chapter of the Medicaid Provider Manual
- Long Term Supports and Services (LTSS), nursing facility services, State Plan Personal Care Services (PCS), MICH Home and Community-Based Services (HCBS), waiver services for Enrollees who live in the community and meet nursing facility level of care as determined by the level of care determination (LOCD)
- Services provided through Prepaid Inpatient Health Plans (PIHPs) for an Enrollee's needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

When services are covered by both Medicare and Medicaid, the member's cost share will be $0. These plans also offer benefits beyond Medicaid and Medicare benefits, including:

- Pharmacy coverage
- Preventive and comprehensive dental coverage
- Routine vision and hearing coverage
- $200 allowance for non-Medicare/Medicaid covered eyewear through EyeMed (every year)
- $0 TruHearing® Advanced brand hearing aids (one per ear, every three years)
- Personal care services
- PriorityFlex card that covers OTC, healthy food and produce*, meal delivery*, pest control services*, select utilities*, household supplies and personal care items ($70-96 per month)
- Unlimited caregiver support through Carallel®
- Digital fitness access and at-home workout kits provided by One Pass®
- $0 copay for CogniFit®, online brain training to help improve memory and focus
- Long Term Supports and Services (LTSS)

- Services provided through Prepaid Inpatient Health Plans (PIHPs) for an Enrollee's needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

**If SSBCI-eligible*

PriorityMedicare Dual Premier (HIDE-SNP) shares the same formulary and authorization requirements as our other Medicare Advantage plans.

For a full list of benefits, see the PriorityMedicare Dual Premier Member Handbook.

Check patient eligibility

Use our Member Inquiry tool

Once you have an online account with us, you can use our **Member Inquiry tool** (login required) to:

- ✓ Check eligibility and contract history
- ✓ Check address and phone
- ✓ Update COB information
- ✓ See out-of-pocket limits
- ✓ See deductible balance(s)
- ✓ See copays and coinsurance
- ✓ See many benefits/coverages, such as DME, home health care, maternity, prosthetic/orthotic

Call our Provider Helpline

Alternatively, you can also call our Provider Helpline at **800.942.4765** (option 1) to confirm that a patient is a current Priority Health plan member.

Covered services

A service must be medically necessary and covered by the member's contract to be paid by the plan. The plan determines whether services are medically necessary as defined either by the member's summary plan description, certificate of insurance or member handbook. The full array of benefits and supportive services under include, Medicare (including inpatient, outpatient, hospice, durable medical equipment, nursing homes, home health, and pharmacy) and Medicaid (including behavioral health, long-term institutional and community-based long-term supports and services).

To verify covered or excluded services, check benefits in **Patient Profile** (login required) or call the PriorityMedicare Customer Care team at the number listed on the back of the member ID card (**833.939.0983)**

All services may be subject to applicable copayments, deductibles and coinsurance. Priority Health uses the current, nationally approved criteria for any medical necessity reviews required. For commercial plans, Priority Health has developed its own medical/pharmacy coverage policies.

Emergency services

For all covered emergency room (ER) visits and associated emergency medical services, the member financial responsibility is $0. Emergency services do not require prior authorization.

Coverage limits

For information on limits for covered services, see individual policies on the **medical policies** page of our online Provider Manual.

Clinical practice guidelines

The purpose of a clinical practice guideline is to help you engage your patients in discussions of goals, preferences and priorities, and to provide you with information on the most effective methods of screening, diagnosis and treatment.

For a list of all Priority Health-recommended Clinical Practice Guideline documents by topic, visit our **Clinical practice guidelines list** page in our online Provider Manual.

Model of Care

Our Model of Care (MOC) delivers a highly integrated model of care designed to improve health outcomes for dual-eligible members by aligning Medicaid and Medicare services and addressing the diverse and complex needs of our members who are covered under both programs. The integrated model of care addresses the needs of enrollees who are often frail, elderly or coping with disabilities, and have compromised daily living activities, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions and/or end-of-life care issues.

The MOC includes four elements, which are required by the Centers for Medicare and Medicaid Services (CMS):

- **MOC Element 1** is the description of the D-SNP and HIDE-SNP populations. Providers need to understand the characteristics, conditions and range of medical, behavioral health, long-term services and support and social needs of the population.
- **MOC Element 2** is care coordination. Providers need to understand the range of tools that are used to address the goals of our MOC including the Health Risk Assessment (HRA), the Individualized Care Plan (ICP) and their role as part of the Interdisciplinary Care Team (ICT).
    - The Health Risk Assessment (HRA) is an important part of the member's care coordination, helping us identify members with the most urgent needs.
    - Within 90 days of enrollment, our care management team will conduct a telephonic HRA. HRAs are repeated within 365 days. The HRA helps us collect information about the member's medical, behavioral health, cognitive and functional needs. It also helps identify medical and behavioral health history. We use this information to create the member's individualized care plan (ICP).
- **MOC Element 3** is the provider network. Providers need to understand training requirements and guidelines.

- **MOC Element 4** is quality measurement and improvement. Providers need to understand the goals and desired outcomes for members and how they can help to improve quality. This information is used to intervene with the most vulnerable enrollees in a timely fashion.

MODEL OF CARE TRAINING IS REQUIRED ANNUALLY FOR ALL PRIORITYMEDICARE DUAL PREMIER NETWORK PROVIDERS.
See our online Provider Manual for up-to-date training information.

Provider enrollment & participation

Credentialing is the process of obtaining and reviewing documentation to determine participation status in a health plan. The documentation may include, but isn't limited to, the applicant's education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history and professional competence.

You shouldn't see Priority Health members until you get your network effective date from us. When we receive your complete credentialing information, it'll take us **up to 80 calendar days** to process your request.

Our credentialing policies and procedures, including credentialing criteria by provider type, are **available online**.

Our review of your enrollment application

We review your application and supporting documents for completeness and verify your information. As detailed above, this process takes 80 calendar days.

Your application is complete when we've received, verified and/or completed the following:

- **Completed application and signed attestation and release**, including copies of professional liability insurance (minimum limits of $100,000/ $300,000)
- **Professional liability claims history**, verified directly with the National Practitioner Data Bank
- **Applicable state and controlled substance licenses**, verified through the state departments of licensing
- **Federal DEA license verified**, registered in Michigan
- **Graduation from medical school**, verified directly with the medical school or state licensure
- **Residency and fellowship (if applicable)** verified directly with the training program or by the American Board of Medical Specialists (ABMS) or American Osteopathic Association (AOA) listings
- **Board certification**, verified with the ABMS, AOA, American Board of Podiatric Surgery, American Board of Podiatric Orthopedics and Primary Podiatric Medicine, American Board of Oral Surgery, American Board of Sleep Medicine, or American Board of Addiction Medicine listings (see individual criteria for

exceptions)

- **Current and previous hospital memberships**
- **CHAMPS enrollment verified**
- **Medicare Opt-out Report**
- **National Practitioner Data Bank (NPDB)**, queried online to verify any disciplinary actions, malpractice payments and Medicare/ Medicaid sanctions
- **MDCH - Medical Services Administration Sanctioned Providers**
- **Office of Inspector General Sanctioned Provider Exclusion Database**
- **System for Award Management (SAM)**
- **Letters of recommendation**, if requested, from physicians who are familiar with your clinical skills

Background checks

All providers have background checks completed as part of the credentialing and regular re-credentialing processes. For requirements by provider type, see our Provider Manual.

Provider responsibilities

Primary Care Provider responsibilities

See our **Determination of Practitioners for Primary Care Practitioner Status** policy.

Other provider/subcontractors' responsibilities

Full details on all provider or subcontractor responsibilities are available in the **Requirements & responsibilities** section of our online Provider Manual.

Michigan Care Improvement Registry (MCIR)

Michigan providers must participate with and submit Enrollee data to the Michigan Care Improvement Registry (MCIR). See below for more information on MCIR, including training and educational materials:

- Information on MCIR from the State of Michigan
- mcir.org/providers

Requirements for treating HIDE-SNP patients

Providers who treat HIDE-SNP patients are required to comply with state and federal regulations related to patient/enrollee rights.

HIDE-SNP enrollee rights include the right to:

- Receive information on beneficiary and plan information
- Be treated with respect and with due consideration for his or dignity and privacy
- Receive culturally and linguistically appropriate services (see below)
- Confidentiality
- Participate in decisions regarding his or her health care, including the right to refuse treatment and express preferences about treatment options
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Request and receive a copy of his or her medical records, and request those be amended or corrected
- Be furnished health care services consistent with the provider contract with Priority Health and State and federal regulations
- Be free to exercise his or her rights without adversely affecting the way the contractor, providers, or the State treats the enrollee
- Be free from other discrimination prohibited by State and federal regulations
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to

understand

CULTURAL/LINGUISTIC NON-DISCRIMINATION

The Michigan Department of Health and Human Services requires that Priority Health providers offer services in a culturally competent manner to all members, including those with limited English proficiency or reading skills.

The federal Office of Minority Health (OMH) offers information on providing culturally competent services on their website, **thinkculturalhealth.hhs.gov**. CMS has also developed an online **Health Care Language Services Implementation Guide** to help your office meet this important standard.

PROVIDER ADHERENCE TO THE PRIORITY HEALTH PROVIDER MANUAL

Priority Health HIDE-SNP network providers must adhere to the Medicaid Provider Manual and the Priority Health Provider Manual.

Priority Health HIDE-SNP network providers must agree that Michigan Dept. of Health and Human Services – Office of Inspector General (MDHHS-OIG) has the authority to conduct post payment evaluations of their claims paid by Priority Health.

Priority Health must agree to follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306 for post payment evaluations conducted by MDHHS-OIG.

Reporting provider changes

To notify us of changes in your address, staff, tax ID number, or if you're opening or closing to new patients, you must notify us 60 days ahead of the change.

The name and information you provide us must be up-to-date. For example, the name you provide us for your practice must match the name you use when you answer patient phone calls.

When you submit your practice name and other details—like your location—during the enrollment process, we use this information in our **Find a Doctor** tool. This tool helps our members—and prospective patients for you—find the care they need. The Centers for Medicare and Medicaid Services (CMS) requires that this information is up-to-date.

For example, if you answer the phone as “ABC Family Medicine” your name in Find a Doctor should be “ABC Family Medicine.”

NEED TO MAKE AN UPDATE?

1. **Log in to your prism account**.
2. Click on **Enrollments & Changes**
3. Select either **Change Individual Provider** or **Change Provider Organization** and follow the steps to submit your change.

CHECK THE STATUS OF YOUR REQUEST

Once you submit your request, our team will receive an inquiry. You can check the status of your request and view comments from our team any time in prism by clicking on Enrollments & Changes and selecting the Inquiry ID. When your request is completed, you'll receive a comment from our team. Any time our team posts a comment, you'll receive an email notification.

REPORTING RETIREMENT/TERMINATION

At least 90 days prior to your retirement or termination of contract with Priority Health, notify us of the change. **Learn how.**

VALIDATE YOUR PROVIDER DIRECTORY INFORMATION WITH OUR BETTERDOCTOR ATTESTATION PROCESS

We partner with BetterDoctor to maintain your Provider Directory (a.k.a., Find A Doctor) information, to ensure our members get the care they need when they needed.

Find more information about BetterDoctor in our online Provider Manual.

Extension of care

Priority Health ensures continuity and coordination of care to its members by:

- Notifying members of the pending terminations of practitioners or practice sites
- Assisting members with selecting a new practitioner
- Offering patients of terminating providers extension of care when appropriate
- Providers have contractual obligations following termination of contracts

PROVIDERS WILL COOPERATE WITH EXTENSION OF CARE

Providers will cooperate with a continuation of treatment based on the provider participation agreement.

- PCPs and specialists who are terminating their contract will cooperate with a continuation of treatment base on the provider participation agreement
- Extension of care may be necessary for patients in active treatment, such as pregnant patients past their first trimester
- Priority Health shall compensate physician for such service in accordance with their previously contracted fee schedule

WHEN PRIORITY HEALTH OFFERS EXTENSION OF CARE TO MEMBERS

- The primary care physician or specialist chooses to terminate their contract with Priority Health and is willing to participate in extension of care
- Priority Health terminates the contract and approves the primary care physician or specialist to participate in extension of care

Priority Health will notify members about extension of care, if it is offered. Whenever possible, this will occur at least 30 calendar days prior to a provider termination. In addition, extension of care applies for both primary care physicians and specialists if the patient is in active treatment.

TIMELINE OF EXTENSION OF CARE PERIOD

Access to care is granted through the current period of active treatment or for up to 90 calendar days.

When the member is in the second or third trimester of pregnancy, access is granted through the postpartum period.

WHEN EXTENSION OF CARE DOES NOT APPLY

- A professional review action has occurred
- The primary care physician or specialist fails to meet applicable quality or licensure standards according to Michigan State Law.
- Medicare has sanctioned the primary care physician or specialist
- The primary care physician or specialist is staying in the service area and can still be selected as a participating primary care physician or specialist. The member can choose to stay with the provider and follow them to their new office location

- The practitioner does not agree to the terms of the extension of care based on the provider participation agreement

Self-reporting overpayments

You have four options for letting us know you are returning an overpayment:

- Complete a refund form, explaining the reason for the return
    - Print a refund form
- Copy the overpayment letter from Priority Health
- Copy the remittance advice and highlight the member and reason for return
- Send a letter with:
    - member name
    - member ID number and claim number
    - date of service
    - reason for return

Mail any one of the above documents with your refund check to:

Priority Health

Attn: Overpayment Refunds

1705 Reliable Parkway

Chicago, IL 60686

Network adequacy

Priority Health has provided supporting documentation to MDHHS that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS's standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). This includes:

- Offering an appropriate range of preventive, primary care, specialty services, behavioral health services, other specialty services and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area
- Maintaining a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of and expected utilization of services for the anticipated number of members in the service area, including:
    - The number of network providers who are not accepting new patients
    - The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for members with disabilities
    - The communication needs of members
    - The cultural and ethnic diversity and demographic characteristics of members

Maximum time, distance and ratio standards

Time is measured in minutes and distance is measured in miles.											
	Large Metro		**Metro**		**Micro**		**Rural**		**Counties with Extreme Access Conside-rations**		**All**
Medicaid Service Type	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**	**Minimum Provider to Enrollees Ratio**
Dentistry: General Dentist	30	15	30	30	30	30	40	40	120	120	Kalkaska [1:692] Missaukee [1:873] Schoolcraft [1:806] All other counties [1:650]

Dentistry: Endodontics	30	15	60	60	60	60	120	120	120	120
Dentistry: Oral Surgery	30	15	60	60	60	60	120	120	120	120
Dentistry: Periodontics	30	15	60	60	60	60	120	120	120	120
Dentistry: Prosthodontics	30	15	60	60	60	60	120	120	120	120
Audiology Services - Examinations	30	15	30	30	30	30	40	40	120	120
Audiology Services - Hearing Aids	30	15	30	30	30	30	40	40	120	120
Vision Services - Eye Examinations	30	15	30	30	30	30	40	40	120	120
Vision Services - Eye Wear	30	15	30	30	30	30	40	40	120	120
Adult Day Care	30	30	30	30	30	30	40	40	60	60
Skilled Nursing Facility	20	10	45	30	80	60	75	60	95	85

To be counted in the General Dentistry calculation, a provider must be enrolled in Medicaid and must be at least full-time (i.e., minimum of 20 hours per week per practice location).

LTSS timely access standards

Timely Access is measured in calendar Days.					
LTSS Provider & Service Type	**Length of Time from Authorization to Initiation of Service**				
	Large Metro	**Metro**	**Micro**	**Rural**	**Counties with Extreme Access Considerations**
Adaptive/Enhanced Durable Medical Equipment and Supplies	21			28	

Assistive Technology Devices	21	28
Chore Services	14	21
Community Living Supports	7	14
Home Delivered Meals	14	21
Personal Care Services - Non-Waiver	7	14
Personal Emergency Response System	30	30
Preventive Nursing Services (non-agency and agency)	7	14
Private Duty Nursing (non-agency and agency)	7	14
Respite	7	14
Respite - Non-waiver (provided in the home)	7	14
Vehicle Modifications	90	120

Specialty care (including vision, dental and hearing) timely access standards

Type of Care/Appointment	**Length of Time**
Specialty Care, such as Vision & Hearing	Within six (6) weeks of request
Acute Specialty Care, such as Vision & Hearing	Within five (5) Business Days of request
Emergency Dental Services	Immediately 24 hours/day 7 Days per week
Urgent Dental Care	Within 48 hours
Routine Dental Care	Within twenty-one (21) Business Days of request
Preventive Dental Services	Within six (6) weeks of request
Initial Dental Appointment	Within eight (8) weeks of request

Billing

Participation

If you are not currently contracted with the Medicare or Medicaid component of the HIDE-SNP plan, you may still be eligible for reimbursement. Covered services will be reimbursed according to the applicable Michigan Medicaid fee schedule or Medicare out-of-network rates, depending on which side of the plan adjudicates the claim.

To be fully reimbursed, you must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS). Enrolling in CHAMPS will ensure you are reimbursed for the Medicaid portion of the HIDE-SNP claim.

Prior authorization may be required for certain services. Please refer to the Authorizations section of this guide for instructions on submitting requests for both in-network and out-of-network services under the HIDE-SNP program.

Providers may not balance-bill HIDE-SNP members for any Medicare Part A or Part B cost-sharing amounts, including copayments, coinsurance, or deductibles. This prohibition applies to all Qualified Medicare Beneficiaries (QMBs), in accordance with federal law.

Home and community-based services (HCBS) codes
The MDHHS Provider Manual for the Michigan Coordinated Health Program for HCBS members provides the HCBS codes.

Nursing Facility Billing Guidance
For the most up-to-date guidance with regards to nursing facility billing for HIDE-SNP, please refer to the MDHHS Provider Manual for the Michigan Coordinated Health Program.

Read more here about Michigan's Expansion to the Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP).

Claim requirements

If a HIDE-SNP member has other insurance (e.g., employer-sponsored coverage, commercial insurance, liability insurance), those payers must be billed before Medicare and Medicaid. The member's HIDE-SNP coverage is secondary to all other member coverage.

The Michigan Department of Health and Human Services (MDHHS) does require that other payers be properly identified on the claim. This ensures accurate coordination of benefits and prevents improper billing to Medicare or Medicaid when another payer is primarily responsible.

Providers must include all known third-party coverage information when submitting claims for HIDE-SNP members. Failure to do so can result in claim denials or recoupments.

Claims submission should follow ASC X12N TR3 (Technical Report Type 3) for 837P transactions guide which defines the structure and required/situational data elements for electronic healthcare claims and detailed specifications for loops like 2320 (Other Subscriber Info), 2330A (Other Subscriber Name), and 2330B (Other Payer Name).

The Michigan Department of Health and Human Services (MDHHS) also publishes HIPAA Companion Guides that align with the national TR3 but include Michigan-specific requirements, available at HIPAA - Companion Guides. These guides clarify which data elements are required, situational, or optional for Michigan Medicaid and HIDE-SNP claims. Additional guidance for submitting claims through CHAMPS may be found within the Electronic Submission Manual (ESM).

Other claim requirements include:

- ✓ **All claims must be electronic or typed on paper.** Priority Health will not accept hand-written claims.
- ✓ **Do not fax or email claims, original or corrected.** Send claims only electronically or, for paper claims, through the U.S. Mail.
- ✓ **Use the member ID number to identify the patient.** Don't use a Social Security number. We reject electronic and paper claims submitted without a valid subscriber ID (with two-digit suffix) or Medicaid recipient ID number.
- ✓ **Total charges should appear only on the last page.** Omit the total charges until the final page of multi-page paper claims.
- ✓ **Secondary claims must be billed with primary EOB.** Billed charges must match the amount shown as billed on the EOB. If they don't, your claim will be rejected as "Inappropriate EOB - does not match claim." You will then have to rebill the claim. If a claim denies for needing the primary EOB, you must resubmit the claim with the EOB attached via electronic or paper claim submission. We do not accept EOBs via fax or email.
- ✓ **National Uniform Billing Committee (NUBC) standard code sets.** Valid ICD-10, CPT and HCPCS codes only. Claims containing invalid codes will be denied upfront, and we will notify you within 48 hours of the denial. See the Diagnosis coding guidelines in this section.
- ✓ **Use Place of Service codes.** See the Medicare Claims Processing Manual, Chapter 26, sections 10.5 and 10.6.
- ✓ **Use the modifier FB.** When you received a drug or item at no cost and are billing that charge for informational purposes, not for reimbursement, use the modifier FB.

HOW TO SUBMIT ELECTRONIC CLAIMS

Learn how to set up HIPAA-compliant electronic (EDI) claim files.

WHERE TO MAIL PAPER CLAIMS

Priority Health Claims
P.O. Box 232
Grand Rapids, MI 49501

Vaccine billing

Medicare Part D vaccines administered in a provider office should be billed to TransactRx rather than Priority Health. Part D vaccines administered in a provider office that are billed to Priority Health will be denied to provider liability, and Priority Health will subsequently direct the provider to TransactRx for claim submission.

Additional billing guidelines

For additional billing guidelines, including the following, visit the **Billing & payments** page in our online Provider Manual:

Service-specific billing, including:

- Preventive health
- Behavioral health
- Medical & surgical
- Vision services
- Services not covered
- Drugs

Billing information, including:

- Behavioral health provider billing
- Facility billing
- Balance billing
- Advanced practice professional billing
- Professional billing
- Ambulatory surgery center billing
- Medicaid billing
- Office-based procedures billing
- Split billing
- Billing policies

Payment information, including:

- Setting up EDI funds transfers
- Setting up electronic claims / RAs
- ACA non-payment grace period
- Clinical edits
- Edits Checker tool guide
- Check reissue procedure
- Correcting overpayments and underpayments
- Diagnosis coding
- Coordination of benefits
- D-SNP billing

- Front-end rejections
- Gender-specific services
- Modifiers
- NDC numbers on drug claims
- Payment integrity
- Risk adjustment

Authorizations

We require prior authorization for certain services and procedures. In these cases, providers will submit clinical documentation and medical records demonstrating that the service or procedure is medically necessary.

How to request an authorization

IN-NETWORK PROVIDERS

Submit authorizations through our Authorizations Request tool. Turnaround times vary by plan requirements, but in all cases are 14 days or less.

Request an authorization (login required)
Check authorization status (login required)

Exceptions

Use the forms linked below to request authorizations for the following procedures:

- **Solid organ transplant prior authorization form**
- **Bone marrow/stem cell transplant prior authorization form**
- **NICU/sick newborn prior authorization form**
- **Inpatient PMU Medicaid medical consent request form**

About our Authorization Request tool

Our Authorization Request tool has two portals – Guiding Care and eviCore. The tool will automatically select the correct portal based on your authorization type:

GuidingCare authorization types

- Post-acute facilities
- Behavioral health
- Durable medical equipment (DME)
- Inpatient
- Outpatient
- Home health care (In home infusions)
- Planned surgeries and procedures

EviCore authorization types

- High-tech imaging
- Lab and genetic services
- Radiation oncology

TurningPoint authorization types

- Cardiology
- MSK, spine and joint surgery

Services not included in our Authorization Request tool

- **Drug authorizations** not related to an inpatient stay or home infusions. Use our drug authorization request forms.
- **Medicare non-coverage notices**
- **Services not covered by our plans**

OUT-OF-NETWORK PROVIDERS

Use the forms below to request prior authorization for medical services. Always use a specific service form when available. Turnaround times vary by plan requirements, but all cases are 7 days or less.

Cardiac & MSK services managed by TurningPoint

TurningPoint manages certain cardiac, MSK, joint and spine procedures and services on behalf of our members.

If requesting a procedure or service managed by TurningPoint, use the following form:

- TurningPoint prior authorization form

Outpatient, elective/planned inpatient admissions

Medical prior authorization form

New form: Use this form for medical prior authorization requests. Effective Apr. 7, 2025, we'll only accept this new form. Old forms will be returned via fax as they don't have all the necessary information. Before using this form, review the prior authorization forms below to determine whether there's a specific service form available for your request.

Clinical trials prior authorization form

DME/P&O prior authorization form

Hospital and other facility

Acute Rehab/LTACH/SNF/SAR prior authorization/review form

Bone marrow/peripheral stem cell or other blood cell transplant prior authorization form

Emergent inpatient prior authorization form

A request is considered emergent if delaying treatment would put the patient's life in serious danger, interfere with full recovery or delay treatment for severe pain. Don't use this form for elective/planned inpatient admissions, instead use the **Medical Prior Authorization Form**. If we determine your request doesn't meet the definition of an emergent authorization, it will be processed according to standard timelines. All emergent cases are reviewed in 72 hours or less.

NICU/sick newborn prior authorization form

Solid organ transplant prior authorization form

Behavioral health

Applied Behavioral Health (ABA) therapy prior authorization form

Behavioral health prior authorization form
Use this form for psychiatric inpatient, outpatient psychotherapy (mental health and substance abuse), detoxification, residential treatment and other behavioral health services.

Transcranial Magnetic Stimulation (TMS) for depression prior authorization form

Home health care services

Home health care services prior authorization form

Home health care IV infusion services prior authorization form

HOW TO CHECK YOUR AUTHORIZATION STATUS

1. Log into your **prism** account
2. Open the Authorizations menu
3. Click Check Auth Status

Don't have a prism account? Contact our Provider Helpline for help checking the status of your authorization request.

Urgent or after-hours prior authorization requests

A request is considered urgent if delaying treatment would:

- Put the patient's life in serious danger
- Interfere with full recovery
- Delay treatment for severe pain

No authorization needed in emergency room or observation setting.
Services that generally require prior authorization, such as advanced diagnostic imaging, don't require prior authorization in an emergency room or observation setting.

URGENT/EMERGENT HOSPITAL ADMISSIONS

Participating hospitals must use our Auth Request tool to notify us of urgent/emergent admissions, deliveries and continuing stays through GuidingCare. Go to Auth Request (login required).

Utilization Review staff review authorization requests with clinical documentation using InterQual® medical necessity criteria to issue a coverage decision.

Non-participating hospitals can fax an emergent inpatient prior authorization form.

Providers outside of Michigan that don't participate with Priority Health: The MultiPlan Network is our preferred network for out-of-state coverage. Please refer to the member's ID card for authorization instructions.

URGENT/EMERGENT BEHAVIORAL HEALTH SERVICES

See the **behavioral health section** of our online Provider Manual.

URGENT/EMERGENT AUTHORIZATIONS AVAILABLE THROUGH EVICORE

Call EviCore toll-free at 844.303.8456. They'll respond to after-hours requests within 72 hours.

- Genetic testing
- Advanced diagnostic imaging: CT/CTA, MRI, MRA, nuclear cardiac studies and PET scans

Their office hours are Monday through Friday, 7 a.m. to 7 p.m. Eastern Time. EviCore is closed on January 1, Memorial Day, July 4, Labor Day, Thanksgiving and the Friday after, and Christmas day.

Urgent/emergent authorizations available through TurningPoint

Call TurningPoint toll-free at **855.253.1100**. They'll respond to after-hours requests within 72 hours.

- Musculoskeletal surgeries and procedures
- Cardiology surgeries and diagnostics

Their office hours are Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. TurningPoint is closed on January 1, Memorial Day, July 4, Labor Day, Thanksgiving and the Friday after, and Christmas Day.

AFTER-HOURS URGENT/EMERGENT AUTHORIZATIONS

- Participating providers must use our Auth request tool (login required) for all authorization requests.
- Non-Participating providers and facilities with urgent, after-hours authorization requests may call us at **800.269.1260**. Leave a message along with a phone number and our on-call nurse care manager will return your call within 30 minutes.

Medical necessity criteria for authorizations

Priority Health uses the criteria below to help us determine medical necessity when we receive requests for services or equipment. In most cases, Priority Health staff perform InterQual® reviews independent from reviews submitted by providers.

Priority Health also recognizes that the criteria can never address all the issues; criteria cannot apply to every patient in every situation. Use of the criteria never replaces clinical judgment.

Read our policy on **establishing medical necessity criteria**.

HIDE-SNP MEDICAL CRITERIA

For HIDE-SNP members, Priority Health follows:

- **InterQual® guidelines** - to see criteria use to review elective procedures, durable medical equipment (DME), home health services, post-acute levels of care and behavioral health services, log into prism and use the Authorization Criteria Lookup under the Authorizations menu.
- **State and Federal laws** and guidelines regarding coverage and benefits
- **EviCore clinical criteria** are available online for genetic testing, high tech radiology and radiation oncology.
- **TurningPoint clinical criteria** – used to review MSK, spine, joint and cardiac procedures – are available here. Alternatively, you may log into prism and use the Authorization Criteria Lookup under the Authorizations menu to access the criteria within TurningPoint's provider portal.

The medical policies listed above are reviewed annually or more frequently if necessary and approved by the Medical Affairs Committee.

Authorization resources

Follow the links below to access additional information and resources to support your authorization requests:

- **Authorization quick reference list**
- **Make authorization changes**
- **Retrospective authorizations**
- **Behavioral health authorizations**
- **Medicare non-coverage**
- **Musculoskeletal and spine services authorizations**
- **Authorization news**

Reviews & appeals

For the most part, reviews and appeals under HIDE-SNP follow our process for commercial plan reviews and appeals, with the addition of the binding arbitration process.

Informal reviews

You must wait 45 days after submitting a claim to request a review.

COMPLEX CLAIM REVIEWS

For the fastest response, use this process.

1. Log into your **prism** account
2. On the Claims tab (medical), find the claim on the claims listing page. Click on the **claim ID** link.
3. On the Claims Detail page, click **Contact us**. Choose “Other related claims questions" in “What is your message about”.
4. Your inquiry will appear within the General Request list page upon submission.
5. A provider operations analyst will respond to your inquiry via comments within 15 calendar days. You’ll receive an automated email notification when a comment has been entered on your inquiry.
6. If your inquiry requires investigation by another department, we'll notify you via comments within 15 calendar days.
7. If you have not received a response within 15 calendar days send an email to ***exceedsprocessingtime@priorityhealth.com*** and include your inquiry number.
8. If you're not satisfied with the outcome of the informal review, you can file a **Level I appeal**.

For details on coding or clinical edit question reviews, third party liability (TPL) and coordination of benefits (COB), **visit our online Provider Manual**.

Level 1 appeals

DEFINITION OF A LEVEL I APPEAL

A Level I appeal is a formal request by a provider for Priority Health to re-examine its initial adverse determination of a claim or authorization after the initial claim review process is completed. If you haven't completed an initial claim review, we won't process your appeal.

An appeal must include additional documentation to support services rendered or payment expected.

LEVEL I APPEAL PROCESS

Deadlines:

- Pre-claim: Within 30 days of the denial
- Post-claim: Within 180 days of the remittance advice

How to submit a Level I appeal

Visit the **Appeals** page in prism. We won't accept appeals from providers that did not perform the service.

For non-participating provider and pre-claim appeals, the servicing provider must either complete the **Level I appeal form** or submit an appeal letter.

Pre-claim appeals (appeals not related to an existing claim)

Use this option when you want to appeal your denied authorization.

1. Log into your prism account
2. Click **New Pre-Claim Appeal**
3. Choose the appropriate Request Type:

Appeal, pre-claim inpatient emergent: utilize when acute inpatient authorization (admitted through ED or conversion from outpatient surgery) has been denied and no claim has been submitted.

Appeal, pre-claim inpatient elective: utilize when Elective Inpatient authorizations have been denied preservice and no claim has been submitted. **Do not submit acute or emergent inpatient admissions here.

Appeal, pre-claim outpatient: utilize when outpatient medical authorizations have been denied preservice and no claim has been submitted.

1. Complete the required fields and attach your supporting documentation
2. Your inquiry will appear within the Appeals list page upon submission

Post-claim appeals (appeals related to an existing claim)

If you haven't completed an **initial claim review**, we don't process your appeal.

1. Log into your **prism** account
2. Click **New Claim Appeal**, then click on the claim number you wish to appeal
3. On the Claims Detail screen, click **Contact us**
4. In the drop-down menu, select **Appeals**
5. Enter your name, phone number, message and attachments
6. Include supporting documentation for your request, related to the appeal. Don't include corrected claims or new claims to be processed
7. Your inquiry will appear within the Appeals list page upon submission

AFTER THE LEVEL I APPEAL IS SUBMITTED

Qualified Priority Health specialists will review the contractual, benefit claims and medical record information.

We'll inform you of the outcome of the review either by remittance advice or by adverse determination letter within 30 calendar days of the submission. If we uphold a pre-claim denial, you'll be informed of the process for filing a Level II appeal.

WHAT ITEMS ARE NECESSARY FOR A MEDICAL APPEAL?

- **Level I appeal form** (for pre-claim appeals or non-participating providers, only)
- Provider appeal letter
- Supporting clinical documentation including: admission summary, physician, documentation, medical testing and a discharge summary, if applicable
- Priority Health denial letter (recommended)

Level II appeals

Level II appeals are available for pre-claim only. If we deny your Level I appeal, you can follow this process to file a Level II appeal.

Deadline: Within one year of the date of service

HOW TO SUBMIT A LEVEL II APPEAL

1. Log into your **prism** account
2. **Click New Pre-Claim Appeal**
3. Choose the appropriate Request Type:

Appeal, pre-claim inpatient emergent: utilize when acute inpatient authorization (admitted through ED or conversion from outpatient surgery) has been denied and no claim has been submitted.

Appeal, pre-claim inpatient elective: utilize when Elective Inpatient authorizations have been denied preservice and no claim has been submitted. **Do not submit acute or emergent inpatient admissions here.

Appeal, pre-claim outpatient: utilize when outpatient medical authorizations have been denied preservice and no claim has been submitted.

1. Complete the required fields and attach your supporting documentation.
2. Your inquiry will appear within the General Request list page upon submission

We won't accept appeals from providers who didn't perform the service.

The servicing provider must complete a **Level II appeal form** or submit an appeal letter.

AFTER THE LEVEL II APPEAL IS SUBMITTED

Priority Health staff and/or third-party consultants will make a decision on your Level II appeal within 30 days of receipt.

We'll inform you of the outcome of the review either by remittance advice or by adverse determination letter within five business days of the decision.

WHAT ITEMS ARE NECESSARY FOR A MEDICAL APPEAL?

- **Level II appeal form** (for pre-claim appeals only)
- Appeal level letter (outlining what you are appealing and why we should reconsider our decision)
- New pertinent supporting documentation to support your appeal

Binding arbitration process

The binding arbitration process below is used when a **non-participating hospital or other non-contracted provider** wishes to dispute the outcome of a **Level I appeal** for a HIDE-SNP claim.

Language taken from the contract that Priority Health (the "Contractor") has with Medicaid:

> Non-contracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the Rapid Dispute Resolution Process.
>
> When a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement requests arbitration, the Contractor is required to participate in a binding arbitration process. Providers must exhaust the Contractor's internal provider appeal process before requesting arbitration.
>
> The Department of Community Health (DCH) will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These arbitrators will have the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid.
>
> The party found to be liable will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

Expedited appeals

Expedited appeal requests are for situations where applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function. The decision time for expedited appeals is 72 hours.

If Priority Health Medicare renders a partial or fully adverse decision, we automatically send your appeal to MAXIMUS Federal Services. This is Medicare's Independent Review Entity (IRE). You will receive a correspondence by mail regarding their decision. If the IRE renders a favorable decision for you, Priority Health Medicare must effectuate and comply with the IRE's decision.

Please note this reminder about an expedited appeal, or what is also referred to as “fast appeal.” Based on CMS guidelines, the expedited appeal process timeframe can be applied to cases where a physician (treating or prescribing for Part C) or other prescriber (Part D) makes a request (or supports a patient’s request) for an expedited appeal. The physician or prescriber (only Part D) should explain why applying the standard timeframe could seriously jeopardize the life or health of your patient or your patient’s ability to regain maximum function. Vague requests only labeled as “fast appeal, urgent, ASAP, etc.” without a physician statement may be evaluated by a Priority Health Medical Director and may be moved to the standard 30-day timeframe. Submitting appeals that don't meet CMS expedited criteria should be avoided.

Member appeals

The information above is for providers submitting appeals on behalf of members. Members should visit our site at priorityhealth.com/member/contact-us/filing-a-complaint/medicare-process/appeals for information on submitting appeals directly.

Important note: Punitive action is *never* taken by Priority Health against a provider who requests an expedited resolution or supports a member’s appeal.

Grievances

When you let us know that you have a problem with us or with our network of doctors, hospitals, pharmacies or other health care providers, it is called "filing a grievance."

How to file a grievance

Call the Provider Helpline (800.942.4765), or have your patient call our Customer Care team (833.939.0983) first. We will try to resolve any complaint that you or your patient might have over the phone. If you ask for a written answer to your phone complaint, we will answer you in writing.

If you prefer, you may send us your grievance in writing to:

Priority Health Medicare Grievances
1231 East Beltline NE, MS 1150
Grand Rapids, MI 49525

You can also deliver it in person, or fax it to us at **616.942.0995**.

REMEMBER TO FILE AN APPEAL IF YOU ARE DISPUTING A PARTICULAR CLAIM OR AUTHORIZATION DECISION.

Practitioner office documentation

Consistent and complete documentation in the medical record is essential for high-quality patient care. In addition to compliance with basic and sound principles of complete record keeping, records must document a process of medical care and patient education.

View the complete documentation review standard for the requirements for medical records and procedure/surgical notes.

Systems for handling and keeping medical records

- The practitioner office must maintain separate medical records for each member seen.
- The medical record must be part of an organized medical record-keeping system and easily retrievable for review.
- Medical records must be retained for a minimum of 10 years in accordance with state and federal law.
- Medical records will be made available to Priority Health as indicated in the provider contract.
- When a member changes his/her Primary Care Practitioner, his/her medical records or copies must be forwarded to the new Primary Care Practitioner within 10 working days from receipt of the request.
- Medical records must be stored away from patient care areas.

Confidentiality

- Each practitioner must maintain a Notice of Privacy Practice in order to maintain HIPAA compliance.
- Employees must protect computer-processed patient or provider care information with the same diligence as the original health record (e.g., identification of authorized users; use of security codes; and location of computer facility in a limited access area).
- The office must maintain back-up files for all current information system data off-site or in a separate secure geographic location.
- As applicable, the office must obtain written agreements from the computer vendors involved with patient or practitioner health care data that mandate the security of computerized data classified as confidential and specify the methods by which employees are to handle and transport such information.

- Medical records must be stored away from patient care areas, in a place where persons other than staff cannot view them.

- Employees must maintain confidentiality at all points: during collection of the information, when and where it is stored with limited access and disclosure including eventual disposal.

These guidelines encompass standards from:

- National Committee for Quality Assurance

- Michigan Department of Insurance and Financial Services (DIFS)

- Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria

Visit the **Practitioner office documentation** page in our online Provider Manual for further information on documentation requirements for:

- ✓ Health status conditions
- ✓ Signature requirements
- ✓ Signature logs
- ✓ Documentation closing in EMRs

Compliance policy

Compliance program and Code of Excellence

Our reputation for excellence and integrity is built on the hard work and responsible conduct of thousands who've worked with and for us for many years. Our **Compliance Program** and **Code of Excellence** shape this culture of compliance. They apply to you as an important business partner.

We require all parties that work with us to comply with all laws and regulations. We've communicated this expectation to providers, vendors and contractors per their individual contracts.

COMPLIANCE TRAINING

We recognize our providers have already made an investment in general compliance and fraud waste and abuse training for the teams that meet regulatory requirements, and these will be considered sufficient. However, as a resource, below are links to the Medicare General Compliance and FWA training.

Download and review the **Medicare Parts C & D General Compliance training** and then go to **Medicare Parts C & D Fraud, Waste and Abuse training**.

HOW TO REPORT COMPLIANCE CONCERNS

You can report potential compliance concerns to us anonymously here:

Priority Health Integrity Helpline
800.560.7013

Compliance Program MS 3230
1231 East Beltline NE
Grand Rapids, MI 49525

PH-compliance@priorityhealth.com

Fraud, Waste and Abuse (FWA)

We're committed to the detection, prevention, investigation and correction of potential health care fraud, waste and abuse. The mission of our program is to ensure that we're proactively protecting our members, providers, government programs, business partners and stakeholders as well as protecting the compliance and financial interests.

LAWS RELATED TO FRAUD, WASTE AND ABUSE

We require all parties that work with us to comply with all laws and regulations. This policy ensures that providers, contractors and vendors are aware of applicable federal and state laws designed to prevent and detect fraud, waste and abuse. In addition, this policy provides information about whistleblower protections. For more information on FWA laws, how to report your concerns and other requirements, please review the information below:

Priority Health policy: Federal and state laws related to FWA

Federal and State False Claims Acts
As required by the federal and state False Claims Acts, all providers, contractors and vendors are prohibited from knowingly presenting (or causing to be presented) to the federal or state government a false or fraudulent claim for payment or approval. The acts define "knowingly" to mean a person that has actual knowledge of the false claim, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. All individuals are prohibited from knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal or state government or its agents. The False Claims Acts are enforced against any individual/entity that knowingly submits (or causes another individual/entity to submit) a false claim for payment to the federal or state government. Violation of the Federal False Claims Acts can result in civil penalties from $5,000* to $10,000* per claim. In addition, an individual or entity may be excluded from participating in federal health care programs. Priority Health monitors the compliance of our contractors and subcontractors to the False Claims Acts.

The federal and state False Claims Acts permit individuals with knowledge of fraud against the federal or state government to file a lawsuit on behalf of the government against the individual/entity that committed the fraud. If the lawsuit is successful, the individual is entitled to a portion of the government's recovery. The False Claims Acts provide a "whistleblower" protection.

Whistleblower
The federal and state False Claims Acts include specific provisions to protect whistleblowers from retaliation by their employers. Any private party who initiates or assists with a False Claims Act case against his/her employer is protected from discharge, demotion, suspension, threats, harassment and discrimination in the terms and condition of his or her employment if the employer's actions are taken in response to the employees efforts on the case. A private party who does suffer retaliation for his or her assistance with a case against his/her employer is entitled to reinstatement, two times the amount of back pay, interest and compensation for special damages including attorney's fees.

Anti-Kickback Statute
As required by the Anti-Kickback Statute, individuals are prohibited from knowingly or willfully offering, paying, soliciting or receiving remuneration (the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind) in order to induce and reward business payable (or reimbursable) under the Medicare or other federal health care programs. A criminal sanction may place those in violation of the law in jail for up to 5 years, assess a $25,000* fine and impose mandatory exclusion from the participation in any government funded health care programs. On the civil side, the monetary penalty of $50,000* per violation and treble damages that equal three times the dollar amount the government is defrauded may apply.

There are three objectives behind the federal anti-kickback law.

1. To prevent over-utilization of health care programs
2. To limit patient steering
3. To promote market competition

The Program Fraud Civil Remedies Act
The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against any person who makes, or causes to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. The Program Fraud Civil Remedies Act addresses lower dollar fraud and generally applies to claims of $150,000 or less.

Stark Law
The Stark law pertains to physician referrals under both Medicare and Medicaid and states that a physician cannot refer patients to an entity for the purpose of furnishing certain designated health services if the physician or an immediate family member has a financial relationship with that entity. The entity cannot bill for improperly referred services unless an exception or safe harbor applies. It is essential to realize that the Stark law has no state-of-mind requirement. The intention and motives of the parties involved are irrelevant. If statutory requirements are met, there is a violation, unless an exception or safe harbor applies.

The Stark law is targeted against over-utilization and improper patient steering and is intended to increase market competition. Sanctions and fines are civil and criminal penalties do not apply. Under the civil penalty, the entity that did the billing must refund the payments for improperly referred services. There is also a civil monetary penalty of up to $15,000* for any person who presents or causes a claim for improperly referred designated health services as long as they know that the claim is improper.

Exclusions
Under the Exclusion Statute, the Office of Inspector General (OIG) must exclude from participation in all federal health care programs providers and suppliers convicted of:

- Medicare fraud
- Patient abuse or neglect
- Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service; or
- Felony convictions for unlawful manufacture, distribution, prescription or dispensing of controlled substances.

The OIG also has the discretion to impose exclusions on a number of other grounds.

Excluded providers cannot participate in federal health care programs for a designated period. An excluded provider may not bill federal health care programs (including but not limited to Medicare, Medicaid and State Children's Health Insurance Programs (SCHIP) for services he or she order or performs. At the end of an exclusion period, an excluded provider must affirmatively seek reinstatement. The

OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE) on the OIG website.

** Amounts adjusted annually for inflation as provided under the 2015 Inflation Adjustment Act*

How to report FWA concerns

You may report any potential case of fraud, waste or abuse related to Priority Health programs directly to Priority Health or to the government. See details below.

Reporting directly to Priority Health
Report any potential case of fraud, waste or abuse related to Priority Health programs, including Priority Medicare and Priority Medicaid, to:

- Customer Care at **833.939.0983**
- Priority Health Compliance Helpline at 800.560.7013 (available 24 hours a day)

Submit the Fraud, Waste and Abuse Report forms by mail, fax or email

- Mail forms to: Priority Health Fraud, Waste and Abuse Program
  Special Investigations Unit (SIU) – Mail Stop 3175
  1231 East Beltline NE
  Grand Rapids, MI 49525-4501
- Fax to Priority Health Special Investigation Unit at 616.942.7916
- Submit the fraud, waste and abuse form online
  Online form / **Printable form**

You do not have to give your name. You may remain anonymous.

Reporting fraud
You may also report suspected cases of fraud related to Priority Health HIDE-SNP directly to the MDHHS OIG through any of these contact methods:

- Call the MDHHS OIG toll-free at 855.MI-Fraud (855.643.7283) (toll-free). Office hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. Voicemail is available for after hours.
- Use the online complaint form at **michigan.gov/fraud**
- Write to: Office of the Inspector General
  P.O. Box 30062
  Lansing, MI 48909

You do not have to give your name. You may remain anonymous.

Reporting Medicare fraud to Office of Inspector General
Report suspected cases of Medicare fraud to the Office of Inspector General at:

- Call 800.447.8477 (toll-free)
- Write to: Office of the Inspector General
  Department of Health and Human Services
  P.O. Box 23489
  Washington, DC 20026

You do not have to give your name. You may remain anonymous.

Exclusion screenings and notification requirements

Federal health care programs, including Medicare and Medicaid, are generally prohibited from paying for any items or services furnished, ordered or prescribed by excluded individuals or entities. Priority Health has adopted these guidelines across all lines of business.

In accordance with OIG requirements, you should conduct monthly screening of your employees against their List of Excluded Individuals and Entities (LEIE), the System of Award Management at Sam.gov, and all other federal and state exclusion lists. In addition to the monthly screening of employees, don't forget to screen owners/managing partners if they have direct or indirect ownership of 5% or more or are a managing an employee (a general manager, business manager, administrator or director) who exercises operational or managerial control or who directly or indirectly conducts day to day operational or managerial control or conducts day-to-day operations.

When to notify Priority Health
In addition to screening for excluded individuals and entities, as a participating provider you agree to provide us timely notice if your office receives the following notifications:

- Any malpractice suit, arbitration or settlement arising out of your professional services, causes of action, indictment or criminal conviction
- Any notices of exclusion (pending or final) from Medicare or any state or federal health care programs
- Any changes in licensure
- Any changes in the status of provider's privileges at any hospital.

We know you share our commitment to combating fraud and abuse and we look forward to our continued collaboration as we strengthen our efforts to identify excluded parties. If you have questions about our Fraud, Waste and Abuse (FWA) program, email us at ***SIU@priorityhealth.com*** or call us at 616.464.8152.

Confidentiality standards

Each practitioner must maintain a Notice of Privacy Practice in order to maintain HIPAA compliance.

Employees must protect computer-processed patient information and provider care information, using the same diligence as he/she would with the original health record. Examples of safeguards include:

- Identification of authorized users
- Use of security codes
- Location of computer facility in a limited-access area

The office must maintain back-up files for all current information system data off-site or in a separate secure geographic location.

As applicable, the office must obtain written agreements from the computer vendors involved with patient or practitioner health care data that mandate the security of computerized data classified as confidential and specify the methods by which employees are to handle and transport such information.

Medical records must be stored away from patient care areas, in a place where persons other than staff cannot view them.

Employees must maintain confidentiality at all points: during collection of the information, when and where it is stored (and in a location with limited access and disclosure), and during the eventual disposal of the information.

Employees must receive periodic training on member information confidentiality policies and procedures.