Priority Health

Medicaid Provider Manual

Last update: October 2024

In this Medicaid Provider Manual, you'll find information, instructions and policies specifically for providers caring for Priority Health's Medicaid 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 a wealth of resources updated constantly as changes or new information become available.

What's inside this manual

Virtual Office Advisory (VOA) webinars

Spend your lunch hour with us in these educational webinars, which we produce several times a year to connect you with Priority Health experts and help your practice maximize its effectiveness.

Register now for upcoming webinars

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

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, benefits, eligibility
2 – Pharmacy
3 – Authorizations, health management status
4 – Behavioral Health
5 – Password help
6 – Connect to 5-digit staff extension
7 – Contracting, credentialing

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**.

Medicaid program information for providers

Participation in the Healthy Michigan Plan and Medicaid

If you aren't currently contracted with our Medicaid product (which includes the Healthy Michigan Plan, MIChild and Children's Special Healthcare Services), **contact our Contracting team** to become a participating provider. If you're participating but your practice is closed, consider opening to new members. To be reimbursed by the Medicaid program, providers must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS).

Compare Medicaid plans

Here's a brief comparison of Medicaid (Priority Health Choice MCD) and the Healthy Michigan Plan (Priority Health Choice HMI).

	Medicaid	Health Michigan Plan
Plan name	ID card will read: Priority Health Choice MDC	ID card will read: Priority Health Choice HMI
Reimbursement	**Medicaid fee schedule** (login required)	
Eligible for PCP Incentive Program (PIP)	Yes, if meeting continuous enrollment criteria	
Member eligibility	Income-based; Ages 0-64	Income based, but don't qualify for Medicaid; Ages 19-64
Member enrollment	Facilitated through the MIBridges online application or local MDHHS office	
PCP	Member chooses at the time of enrollment. If not selected, one will be auto-assigned immediately.	
Health Risk Assessment (HRA)	N/A	PCPs are encouraged to complete HRA forms. **Learn more.**
Copays	No copays apply	
Authorization requirements	See our **authorization reference list**	
Member authorization letters	Use both Medicaid and Priority Health ID numbers	Use both Healthy Michigan Plan and Priority Health ID numbers
Medical policies	See our **medical policies**	
Formulary	See our **approved drug list**	
Provider forms	Marked "all plans" and "Medicaid"	Marked "all plans" and "Medicaid" and "Healthy Michigan Plan"
Behavioral health benefits	Yes	
Habilitative benefits	See **medical policy**	
Dental benefits	Adults: Delta Dental. Ancillary services covered for children only (18 and under): Anesthesia, facility charges only	Delta Dental

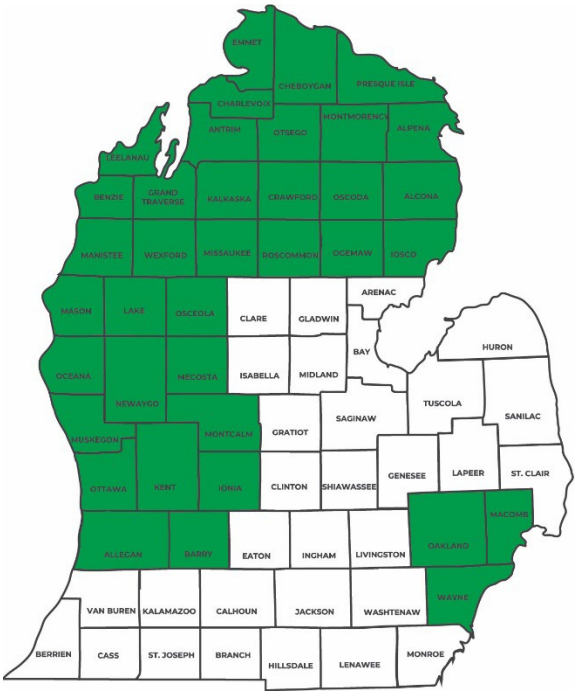
Healthy Michigan Plan information for providers

Priority Health, in accordance with the regulations of the State of Michigan, offers the health care benefits of the Healthy Michigan Plan. Learn more about the Healthy Michigan Plan on **michigan.gov**.

Participation in the Healthy Michigan Plan

If your practice is in one of our approved counties and you're not currently contracted with our Medicaid product (which includes the Healthy Michigan Plan), **contact our Contracting team** to become a participating provider. If you're participating but your practice is closed, consider opening to new members.

To open to new Medicaid/Healthy Michigan Plan members, complete the Provider information form. We will open your practice effective on the date we receive your request.



Approved counties

Eligibility and enrollment

Note that not all Healthy Michigan members will be new to your practice. Your current patients may find that they are eligible for the Healthy Michigan Plan.

Per state regulation, the Healthy Michigan Plan will cover people who are:

- Ages 19-64
- Earning up to 133% of the Federal Poverty Level, approximately $15,000 for single person or $34,000 for a family of four
- Residents of Michigan
- Not currently eligible for Medicaid
- Not eligible for or enrolled in Medicare
- Not pregnant when applying for the Healthy Michigan Plan

Enrollment period: Eligible members will join this plan every month. There's no set enrollment period.

Effective date: The member's effective date will always be on the first of a month.

Identifying members of Healthy Michigan Plan vs. Medicaid
ID cards: The State of Michigan doesn't allow us to indicate "Healthy Michigan Plan" on member ID cards. Therefore, Priority Health ID cards will show the plan as Priority Health Choice HMI.

Member Inquiry: These members share the Medicaid group number 10001. We identify them in the Member Inquiry tool as Healthy Michigan Plan/Priority Health Choice HMI members.

Annual visit

The goal of the Healthy Michigan Plan is to help members get healthy and stay healthy. Therefore, members are encouraged to contact their PCP to schedule an "annual visit." The purpose of the annual visit is to review and complete a health risk assessment (HRA) with the provider and assist the member in selecting a healthy behavior.

The PCP can be either a physician or a mid-level primary care provider (NP/PA).

Submit HRA forms through CHAMPS or to Priority Health via fax to 616.942.0616. To learn more about the Healthy Michigan Plan form submission methods, visit the **Healthy Michigan Plan form submission page**.

Medicaid, MIChild and CSHCS patients

Priority Health is a Qualified Health Plan for West Michigan. Medicaid pays for medical assistance for individuals and families with low income and resources.

ID cards show Priority Health Choice MDC

The State has instructed us not to use the word "Medicaid" on member ID cards. Therefore, our ID cards show the plan name as Priority Health Choice MDC.

Authorizations

To see what services require prior authorization, see the **authorization reference list** in our online Provider Manual.

Billing for services for Medicaid patients

You must use the subscriber ID (including the two-digit suffix), NOT the Social Security number, to identify the patient on both electronic and paper claims. Claims submitted without a valid subscriber ID or Medicaid ID number will be rejected. For more information, see the **Medicaid billing** section of this guide.

Eligibility & enrollment

Medicaid eligibility is determined at the local Department of Health & Human Services (DHHS) office. A DHHS worker reviews the beneficiary's financial and non-financial information (e.g., disability, age, etc.) and determines type of assistance for which beneficiary is eligible. Once eligibility is established, data from DHHS is available via the CHAMPS Eligibility Inquiry and a mihealth card is issued for new beneficiaries.

Enrollment is "rolling." The last digit of the case/contract number indicates the open enrollment month for the beneficiary: 2 = February, for example. Coverage usually is effective the first day of the month in which the beneficiary becomes eligible. Exceptions:

- Coverage may begin the actual day the beneficiary becomes eligible
- Beneficiary may be retroactive up to 3 months prior to the month of application if all eligibility requirements for the specific health care program were met and medical services were rendered.

If the individual doesn't voluntarily choose a managed Medicaid plan within 30 days, they'll automatically be assigned by the State to a managed Medicaid plan available in the person's county of residence.

New Medicaid managed enrollees have 90 days from the date of enrollment to the initial managed Medicaid plan to switch to another plan. Barring this, they're considered "locked-in" until the next open enrollment period.

Access real-time eligibility
Apply for access to real time eligibility online or call MI Enrolls at **888.367.6557**.

CSHCS beneficiaries
Children's Special Health Care Services program beneficiaries are now required to enroll in a Medicaid health plan to receive medical benefits.

- If a member doesn't select a Medicaid plan, they're automatically enrolled in one.
- Members of Medicaid health plans who become eligible for CSHCS will no longer be retroactively disenrolled from their Medicaid plan.
- Members have 90 days to change plans. After 90 days, beneficiaries are locked in until their open enrollment month.
- CSHCS members have no copayments, even if they're over 21 years old.

Newborns

- Newborns may be eligible for Medicaid enrollment for the month of their birth.
- The mother is required to notify the local DHHS office of the birth of the newborn within 10 days of the birth. OR the mother can go to **www.michigan.gov/mibridges** to add their baby to their case online.
- Newborns aren't automatically enrolled onto the mother's plan. The mother must select a plan for the newborn through Michigan Enrolls.
- If the mother doesn't choose a plan, the newborn will be assigned to a plan listed in their county.
- The plan is responsible for all covered services for newborn unless the child is placed in foster care or enrolled in CSHCS.

Reimbursement
We pay Medicaid fees. Go to the **Medicaid fee schedules** (login required).

Specialty network access
Michigan Medicaid has developed a process and funding for referring patients in need of specialty care access to providers at "public entities" including MSU, Wayne State, Hurley Hospital and the University of Michigan.

Our Medical Authorization department has fully implemented the SNAF process. All staff members have been trained in how the process works for the use of the Public Entities for Specialty Care. The process is:

1. All providers referring for specialty care must first exhaust all efforts to find an in-network provider for the member's care.

2. If no care is available in-network, or the timeline to receive care is too long and the member's need is critical, and if the in-network provider cannot accommodate the member's need, we allow them to use the SNAF process and contact the public entity.

3. The PCP completes our **standard out-of-network referral form** and sends it to Priority Health.

4. Our Health Management team determines where the referral will go and provides an authorization number to the PCP. MSU subspecialists are generally the first choice due to their central location and business agreement with Priority Health. MSU specialists are listed on the access form.

5. The PCP completes the access form and forwards it to the appropriate public entity. **MSU specialty care access form** / **U of M specialty care access form**

Medicaid benefits

The Michigan Department of Health and Human Services (MDHHS) website gives you detailed information on covered procedure codes, fee screens and other information related to billing and reimbursement for services to Medicaid, CSHCS, ABW, Healthy Michigan and MOMS beneficiaries.

Go to the MDHHS information now.

Children's coverage and programs

Vaccines for Children Program (VFC): This federally funded program provides vaccines at no cost to children who might not otherwise be vaccinated. Doctors participating in the VFC program also have the right to charge an administrative fee for giving a child a shot.

- Go to the **vaccine coverage list** in our online Provider Manual.
- Go to the VFC program information on the **michigan.gov** website.

Children's Healthcare Access Program (CHAP) in Kent and Kalamazoo County: The primary goal of the Children's Healthcare Access Program is to improve health outcomes among children and adults on Medicaid while better utilizing existing resources and decreasing costs.

Children's Special Health Care Services (CSHCS): This program of the Michigan Department of Health and Human Services provides certain approved medical service coverage to some children and adults with special health care needs, including:

- Persons up to the age of 26 with one or more qualifying medical diagnoses.
- Persons aged 21 and older with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Members who qualify for Children's Special Health Care Services must choose a Medicaid health plan in their county. They have the same benefits as Medicaid and may also be eligible for additional benefits through their local Health Department, Children's with Special Needs Fund and Family Resources.

Chiropractic

Check the fee schedules page for **Medicaid fee schedules** (login required), which include chiropractic services.

Dental

- Adult Medicaid members (age 21 and older) and Healthy Michigan members (age 19 and older) have dental coverage through Delta Dental.
- Child Priority Health Medicaid members can have dental coverage through Healthy Kids dental program (administered by BCBS or Delta Dental) through the age of 20.

Mental health and substance abuse services

We'll arrange for outpatient short-term treatment for mental health.

The State of Michigan has contracted with local Community Mental Health agencies to provide the following services to Medicaid recipients:

- Services to persons with developmental disabilities
- Substance use disorder services
- Inpatient and outpatient hospital mental health services
- Treatment for severe mental illness and severe emotional disturbances

To obtain services, contact the local Community Mental Health agency. If you need assistance in reaching this agency, you may contact the Priority Health Behavioral Health Department at **616.464.8500** or toll-free at **800.673.8043**.

Prescription drug program

Priority Health uses a medication formulary. The formulary includes many kinds of drugs, but not every medicine is covered. Some drugs that aren't covered are:

- Brand-name drugs when the Food and Drug Administration (FDA) has approved a generic medicine that can be used instead
- Appetite control drugs
- Drugs that are not prescribed by a doctor

Go to the formulary lookup tool.
Go to the drug prior authorization forms.

Vision

See **Medicaid vision benefits** in our online Provider Manual.

Hepatitis C (HCV) Testing and Treatment

- The Michigan Department of Health and Human Services (MDHHS) launched a We Treat Hep C Initiative in an effort to eliminate Hepatitis C in Michigan by expanding testing and access to treatment.

- The CDC recommends all adults be screened for HCV at least once per lifetime and pregnant women during each pregnancy.

- Prior authorization is no longer required for Mavyret® which allows any providers with prescriptive authority the ability to prescribe Hepatitis C treatment to beneficiaries with HCV.

- Providers may enroll patients receiving treatment in the MAVYRET Nurse Ambassador program. To learn more visit **MAVYRET Nurse Ambassadors Provide Support and Education**

- See **We Treat Hep C** for additional resources on Hep C.

Services covered by State of Michigan Medicaid

The following services are covered and/or arranged by the State of Michigan Medicaid program. If you have any questions about these services, contact the State of Michigan Beneficiary Hotline at **800.642.3195**.

- Custodial care in a nursing facility
- Personal care or home help services
- Home and community-based waiver program services

Check patient eligibility

Use our Member Inquiry tool

Through prism, our online provider portal, 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 evidence of coverage. To verify covered or excluded services, check benefits in **Patient Profile** (login required) or call Priority Health's customer service team at the number listed on the back of the member ID card.

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.

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.

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 who are seeking in-network care from Priority Health providers until you receive notice from us that your request for network participation is complete, along with a network effective date. When we receive your complete credentialing information, it'll take us **up to 90 calendar days** to process your request.

Our credentialing policies and procedures 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 90 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**
- **Graduation from medical school**, verified directly with the medical school or by the American Board of Medical Specialists (ABMS) or American Osteopathic Association (AOA) listings
- **Residency and fellowship (if applicable)** verified directly with the training program or by the ABMS or 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**, verified by mail, fax and/ or phone

- **CHAMPS enrollment verified**, Medicaid only
- **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 and who aren't employed with or partners of your prospective physician group

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.

Requirements for treating Medicaid patients

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

Medicaid 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 Medicaid's network providers must adhere to the Priority Health Provider Manual. Additionally, our Medicaid network providers must adhere to the **Medicaid Provider Manual**.

Priority Health Medicaid's 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 Medicaid.

Priority Health Medicaid 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, follow these steps 60 days or more before the change takes effect:

1. **Log in to your prism account**.
2. Click on **Enrollments & Changes**
3. Select either **Change Individual Provider** or **Change Provider Organization**
4. Follow the directions as indicated. For individual requests, submit a Provider Change Form. For multiple requests, submit a Provider Change Template.

The form must contain:

- What's changing
- The effective date of the change
- Entity or tax ID number (EIN or TIN)
- W-9, as applicable
- NPI number and taxonomy designation (specialty type) that you'll be using for billing
- If your request is to change the group information for a provider group, include the Type 1 NPIs of the impacted practitioners

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.**

Medicaid billing

Medicaid participation

If you're not currently contracted with the Priority Health Medicaid product, Priority Health will reimburse you at the Michigan Medicaid fee schedule for covered services. Prior authorization may be required. See the **authorizations section** of this guide for instructions on how to request in-network and out of network authorizations. You may not balance-bill the member.

Go to the Michigan Medicaid fee schedule on the State of Michigan website.

Medicaid claim requirements

Medicaid is always the payer of last resort. When a Medicaid member is also covered by another payer, the Michigan Department of Health and Human Services (MDHHS) requires other payers be:

- Billed first
- Identified properly on the claim (see details below)

How to ensure your claims get paid

1. Ensure that ALL applicable Other Insurances are listed on the claim. You can find this information in CHAMPS.
2. Ensure that all required data elements are present for each Other Insurance listed on the claim.

Below in **bold** are the required data elements by loop. Elements identified with an * are situational and only required in certain circumstances.

Loop ID - 2320 - Other Subscriber Information

- SBR - Other Subscriber Information*
- CAS - Claim Level Adjustments*
- AMT - Coordination of Benefits (COB) Payer Paid Amount*
- AMT - Remaining Patient Liability*
- AMT - Coordination of Benefits (COB) Total Non-Covered Amount*
- **OI - Other Insurance Coverage Information**
  Claim Filing Indicator Code
  Yes/No Condition or Response Code
  Release of Information Code
- MIA - Inpatient Adjudication Information*
- MOA - Outpatient Adjudication Information*

Loop ID - 2330A - Other Subscriber Name

- **NM1 - Other Subscriber Name**
- N3 - Other Subscriber Address*
- **N4 - Other Subscriber City, State, ZIP Code**
- REF - Other Subscriber Secondary Identification*

Loop ID - 2330B - Other Payer Name

- **NM1 - Other Payer Name**
  Entity Identifier Code
  Entity Type Qualifier
  Name Last or Organization Name
  Identification Code Qualifier
  Identification Code
- N3 - Other Payer Address*
- **N4 - Other Payer City, State, ZIP Code**
- DTP - Claim Check or Remittance Date*
- REF - Other Payer Secondary Identifier*
- REF - Other Payer Prior Authorization Number*
- REF - Other Payer Referral Number*
- REF - Other Payer Claim Adjustment Indicator*
- REF - Other Payer Claim Control Number*

There may be certain circumstances where Other Insurance may not be applicable but should still be listed. We're constantly reviewing our procedures and code lists and conferring with MDHHS about discrepancies. However, we must still require providers to list Other Insurance in these circumstances until further notice.

Medicaid edit 21007

In January 2021, MDHHS implemented Medicaid edit 21007 which rejects claims that don't meet the criteria listed above.

In November 2021, we instituted our own edit 21007 to front-end reject these claims as well. If the edit identifies another payer based on a membership list provided by the State, and that payer isn't identified on the claim with all the information the state needs, it rejects the claim with the following message:

"Beneficiary Has Other Insurance so providers Must Submit Other Insurance Payer Information on the Encounter"

If your claim is rejected due to edit 21007, follow the steps in **How to ensure your claims get paid** above before resubmitting a corrected claim.

Medicaid edit 5169

Pay close attention to the provider types you enter into the Attending, Referring and Ordering fields for Medicaid claims. Medicaid edit 5169 rejects claims for "non-approved provider types." Below are the allowed provider types per Medicaid policy:

Dates of service before Jan. 1, 2022

For dates of service before Jan. 1, 2022, the provider types below are allowed* in the Attending, Referring and Ordering fields:

- Physicians (MD/DO)
- Certain mid-level practitioners (Nurse practitioners, certified nurse midwives, physician assistants)
- Podiatrists

- Optometrists
- Chiropractors
- Dentists

*For Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), the Attending field should be limited to Physician (MD/DO), Nurse Practitioner and Physician Assistant.

If you're experiencing claim rejections for dates of service before Jan. 1, 2022, check the following:

- All providers in the Attending, Referring and Ordering fields are allowable provider types as described above
- Type 2 (Facility/Group) NPIs aren't listed in the Attending, Referring or Ordering fields
- The taxonomy code assigned to the provider in the National Plan & Provider Enumeration System (NPPES) is up-to-date and corresponds to an acceptable provider type as described above. For example: If the provider still has the specialty "Student" in NPPES, the claim will reject. Additionally, the taxonomy Specialist (174400000X) is not appropriate as it is not clinical.
- The provider is registered in CHAMPS and has both an active business status and an active specialty

Dates of service on or after Jan. 1, 2022
For dates of service on or after Jan. 1, 2022, the allowable provider types vary by claim type:

- **Inpatient Attending**: Physicians (MD/DO), Dentist, Certified Midwives and Podiatrists only

- **Outpatient Attending**: Many different provider types are allowed. **See the full list here.**

- **Nursing Facility Attending**: Physicians (MD/DO) only

- **Hospice and Home Health Attending**: Physicians (MD/DO), Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants only

- **FQHC, RHC, THC Attending**: Refer to **MSA 21-47** for a list of allowable provider types

- **DME Referring/Ordering**: Physicians (MD/DO), Nurse Practitioners, Certified Nurse Midwives, Physician Assistants and Podiatrists only

If you're experiencing claim rejections for dates of service on or after Jan. 1, 2022, check the following:

- Type 2 (Facility/Group) NPIs aren't listed in the Attending, Referring or Ordering fields

- The taxonomy code assigned to the provider in the National Plan & Provider Enumeration System (NPPES) is up-to-date and corresponds to an acceptable

provider type as described above. For example: If the provider still has the specialty “Student” in NPPES, the claim will reject. Additionally, the taxonomy Specialist (174400000X) is not appropriate as it is not clinical.

- The provider is registered in CHAMPS and has both an active business status and an active specialty

- For FQHC / RHC / THC, Limited Liability Social Workers aren’t allowed in the Attending field. Check the provider’s registration in CHAMPS to see if it needs to be updated.

- Only Local Health Departments may list Physical Therapists, Occupational Therapists and behavioral health professionals in the Referring or Ordering fields on their claims.

Medicaid 180-day rule

As of Jan. 7, 2019, the 180-day rule, which allowed providers to resubmit claims subject to third party liability (TPL) investigation, is no longer in effect. When you submit a Medicaid claim that requires TPL review, the claim will be pended, reviewed and paid if no other liable parties are identified. Claims will continue to deny if our review determines there's another primary payer, including motor vehicle, worker's compensation or school-related injuries.

Medicaid short stays

Effective Jan. 1, 2018, the Michigan Department of Health and Human Services (MDHHS) established a Short Hospital Stay reimbursement rate of $1,608 for certain outpatient and inpatient hospital stays.

The qualification criteria, as outlined by MDHHS, are listed below. If a stay doesn’t qualify for the Short Hospital Stay rate, we’ll reimburse it at the normal Medicaid rate.

Outpatient hospital claims

An outpatient hospital claim will qualify if all the following criteria are met:

- The primary diagnosis code billed on the outpatient claim is listed in the **diagnosis table**
- The claim does not include a surgical revenue code (36x) billed on any line of the outpatient claim
- The claim does not include cardiac catheterization lab revenue code 481
- The claim includes observation revenue code 762
- The claim must include discharge status codes 01, 06, 09, 21, 30, 50 or 51

Inpatient hospital claims

An inpatient hospital claim will qualify if all the following criteria are met:

- The primary diagnosis code billed on the inpatient claim is listed in the **diagnosis table**

- The claim does not include a surgical revenue code (36x) billed on any line of the inpatient claim
- The claim has a date of discharge equal to or one day greater than the date of admission
- The claim does not include cardiac catheterization lab revenue code 481
- The claim must include discharge status codes 01, 06, 09, 21, 30, 50 or 51

Exclusions

Claims with the following conditions will not qualify:

- Claims where Medicaid is the secondary payer. MDHHS will follow the rules of the primary payer, and MDHHS will be responsible for payment up to co-insurance and/or deductible
- Claims for patients who leave the hospital Against Medical Advice
- Claims for deceased patients
- Claims that include primary diagnoses not listed in the diagnosis table, including claims for births and deliveries, for example: **Diagnosis table**

Diagnoses

To qualify, a claim must include one of the primary diagnosis codes listed here:
Inpatient and Outpatient Short Stay Reimbursement for ICD-10

Medicaid fee schedules vs Priority Health policy

Priority Health is a Medicaid Health Plan (MHP).

Per the Medicaid Provider Manual, MHPs must consistently comply with and apply all applicable published Medicaid coverage guidelines and limitation policies for claims processing. MHPs have the option to provide benefits for services over and above the defined criteria within the Medicaid Provider Manual and MDHHS. The Medicaid fee schedule is one of the factors utilized to determine if CPT and HCPCS codes are payable services.

- If the CPT or HCPCS code isn't on the Medicaid fee schedule, this service isn't a payable service unless detailed within the Priority Health provider manual.
- If the CPT or HCPCS code is listed within the Medicaid fee schedule, these services are payable if any medical criteria defined for these services is met.

A CPT or HCPCS code being listed in the Medicaid fee schedule doesn't automatically deem the service payable. MHPs can govern medical criteria for coverage of services through utilization management activities. This means that MHPs can define prior authorization requirements, utilization management and review criteria that determine if service is payable for CPT and HCPCS codes on the Medicaid fee schedule.

Priority Health defines these criteria in our medical policies and/or payment policy details throughout this Provider Manual.

Appealing claim denials by indicating the CPT or HCPCS is on the Medicaid fee schedule is insufficient to overturn appeals. As noted above, coverage criteria may exist that affects the claim processing as a payable service.

Submitting claims

Claim requirements

- ✓ **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.
- ✓ **Multiple services on the same day must bill on one claim.** Effective May 1, 2018, multiple services reported by the same provider for the same day of service will be denied or adjusted to deny if services are split between multiple claims.
- ✓ **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

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 and drugs

Services not covered

Billing by provider type, including:

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

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
- 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**

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
- Spine surgery
- Joint surgery
- Home health care
- Planned surgeries and procedures

eviCore authorization types

- High-tech imaging
- Lab and genetic services

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 14 days or less.

Outpatient, elective/planned inpatient admissions

Medical prior authorization form

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

Use this form for all post-acute facility requests. Note: We've updated this form. Effective May 22, 2022, we will only accept this new form. Old forms will be returned via fax as they don't have all the necessary information.

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 Provider Services** for help checking the status of your authorization request.

Urgent 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**.

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 24 hours for Commercial group, Individual and Medicaid/Healthy Michigan Plan members and within 72 hours for Medicare members.

- 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.

After-hours urgent/emergent authorizations

- Participating providers must use our Auth request tool for all authorization requests. We process urgent authorization requests within 24 hours, 7 days a week.
- 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 critical judgment.

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

Medicaid and Healthy Michigan Plan medical criteria

For these members, Priority Health Choice®, Inc., follows:

- InterQual® guidelines; see medical authorization criteria, above
- State and Federal laws and guidelines regarding coverage and benefits

Priority Health has medical policies that address benefits that are specific to Medicaid and Healthy Michigan Plan members. The medical policies 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**

Medicaid reviews & appeals

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

Informal reviews under Medicaid

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

Complex claim reviews

For 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, Medicaid plan rules

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.

Providers only have one appeal right with Priority Health. Any future claim corrections performed within the remaining 12 months won't result in additional appeal rights.

Level I appeal process

Deadline

- 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.

4. Complete the required fields and attach your supporting documentation
5. 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

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, Medicaid plan rules

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.

4. Complete the required fields and attach your supporting documentation.
5. 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, Medicaid

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

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 Service at 616.942.4765 or 800.942.4765
- 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**

Reporting Medicaid Fraud
You may also report suspected cases of fraud related to Priority Health Medicaid 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

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

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.