PRACTITIONER MANUAL

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Dear Provider and Office Staff:

MyMichigan Health Network (MHN) welcomes you as a provider of medical services for our members! MHN is a Physician Hospital Organization (PHO) joint venture between Physicians Associates of Michigan, PC (PAM) and MyMichigan Health. We are committed to making your relationship with MHN a positive one.

The Practitioner Manual is intended to provide you with helpful information. If you have questions or need assistance after reviewing the information, a service directory has been included to help you reach specific departments.

This manual contains important information for your review, including:

• **Practitioner Responsibilities**: Credentialing-Recredentialing, Site Visit Tool, Procedure for Termination

• **Medical Management**: Utilization Management, ConnectCare Pre-Certification Fax Form

• **Billing and Claims Information**

• **Member Services**: Enrollee Rights and Responsibilities, Complaint/Grievance Policy, Confidentiality Policy

We look forward to working together to deliver high-quality, cost effective, patient-centered care to the members we serve.

Sincerely,

Madhura Mansabdar

Ashleigh Palmer, MSA

President, MHN

Madhura Mansabdar, MD, MMM, DipABLM, CPE

Medical Director, MHN/ConnectCare

My **Michigan Health Network**

Mission Statement

It is MyMichigan Health Network's mission to provide a full range of efficient managed health care services through an integrated delivery system that is focused on the needs of customers in the service area.

This may be accomplished through directly partnering with employers, managed care organizations and further development of ConnectCare.

6810 Eastman Avenue
Midland, MI 48642
989-839-1629 phone
989-839-1626 fax

www.connectcare.com

IMPORTANT TELEPHONE NUMBERS

PRESIDENT	Ashleigh Palmer		989-839-3970
MEDICAL DIRECTOR	Madhura Mansabdar, MD		989-488-5956
FINANCE MANAGER	Julie Skutt		989-839-1613
DIRECTOR OF OPERATIONS	Sara O'Dell		989-839-1662
POPULATION HEALTH MANAGER	Suzie Knoff		989-839-1617
UTILIZATION MANAGEMENT			989-839-1629
CUSTOMER SERVICE & GENERAL INQUIRY		Toll-free:	888-646-2429
DISEASE REGISTRY HOT-LINE			989-839-1682

Staff members are available to discuss UM criteria related to coverage decisions with enrollees and practitioners. Questions and/or other issues may be addressed during normal business days, Monday through Friday, from 8:00 am to 12:00 pm and 1:00 pm to 5:00 pm Eastern Time, at the above number. Information may be received at any time via our confidential UM fax at (989) 839-1679.

For members who speak a language other than English and for the deaf, hard of hearing, or speech impaired enrollees call (989)839-1629 option 3, or toll free (888) 646-2429 option 3, or email: heather.guerrieri@ConnectCare.com or peggy.cameron@ConnectCare.com

Revised: 3/16, 4/18
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PRACTITIONER RIGHTS & RESPONSIBILITIES

MyMichigan Health Network (MHN) recognizes the vital role that practitioners of all specialties and services play in the success of managed care. Effective communication between practitioners and MHN is essential.

In order to ensure consistency of the information provided to enrollees, please contact Customer Service to report changes in any of the following:

- Name
- Office or Billing Address
- Telephone Number
- Office Hours
- Procedures for Call Coverage or On-call Arrangements
- Tax I.D. Number or Corporate Name
- Medicare Provider Number
- DEA Number
- Status of Hospital Privileges
- License to Practice
- Limits Placed on Practice
- Professional Liability Insurance Coverage
- Specialty Change or Change in Board Certification Status
- Physician joining or leaving practice
- Decision to terminate participation in any/all contracts (requires written notice)
- Any information that may affect current contracted relationship

As a network practitioner, you have the responsibility to direct patients to other network practitioners for specialty care and to network hospitals and laboratories for testing and treatments whenever possible.

Practitioners have the right to review information submitted in the credentialing process and the right to correct erroneous information. Further, practitioners have the right to request a status of their credentialing or recredentialing application. A practitioner is entitled to a formal hearing and appeals process. For additional information regarding rights related to credentialing, please see MHN Credentials Policies and Procedures.

A practitioner may review UM criteria utilized in decision-making with a UM staff member at the ConnectCare offices on usual business days from 8:00 am-12:00 pm and 1:00 pm-5:00 pm. Proprietary criteria are exclusively governed by the terms and conditions of a time-limited License Agreement and may be shared only under the terms of these agreements. To address questions and issues related to utilization please contact (989) 839-1629 option 3 or toll free at (888) 646-2429 or fax (989) 839-1679.

Rev. 1/11/06, 2/06, 7/08, 10/08. 12/09, 5/10, 6/12, 3/14, 3/16, 4/18, 6/21, 2/23, 4/24

Scope of Practitioners

MHN practitioner acceptance requires the approval of the MHN Credentials Committee. Once this group has reached a decision for acceptance or denial, the application is forwarded to the MHN Board of Managers for final approval.

The credentialing and recredentialing processes apply to all licensed practitioners who provide care for the organization's enrollees, including:

A. ***Participating Physician***: a duly licensed M.D. or D.O. who elects to become part of MHN's provider network, meets or exceeds MHN's credentialing and recredentialing criteria and is accepted by MHN as a Participating Practitioner.

B. ***Primary Care Practitioner (PCP):*** Participating Physician in General Practice, Internal Medicine, Family Practice, Obstetrics/Gynecology or Pediatrics, whose practice consists of more than fifty (50) percent primary care medical services and who has elected to be designated as a Primary Care Physician.

C. ***Specialist Physician:*** Participating Physician who is certified or is eligible to be certified by an approved specialty board as a specialist and has elected to be designated as a Specialist Physician in that specialty.

D. ***Participating Practitioner:*** a Participating Physician, or other health care provider including D.D.S., D.P.M., D.M.D., PhD., O.D.

E. ***Participating Provider:*** a hospital or other facility with which MHN contracts.

F. ***Participating Advanced Practice Provider:*** a duly licensed Primary Care Physician Assistant or Nurse Practitioner who elects to become part of MHN's provider network, meets or exceeds MHN's credentialing and recredentialing criteria and is accepted by MHN as a Participating Practitioner.

Approved 12/96
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MyMichigan Health Network
Credentialing Policy, Procedure and Criteria

PHILOSOPHY

MyMichigan Health Network (MHN) has the responsibility to select and evaluate practitioners via a fair, accurate and non-discriminatory method, recognizing that practitioners assume responsibility for managing the health care of MHN's enrollees. In order to achieve this, MHN has developed and implemented credentialing and recredentialing processes to select and evaluate those practitioners who practice within MHN. On the recommendation of the MHN Credentials Committee and approval of the MHN Board of Managers, these credentialing policies and procedures follow the National Committee for Quality Assurance (NCQA) Standards.

SCOPE

All physicians (M.D., D.O., D.P.M., D.D.S., D.M.D., Ph.D., O.D.) and other licensed healthcare providers (Nurse Practitioners-NP, Physicians Assistants-PA, Certified Nurse Midwives-CNM) seeking to participate in the MHN provider network shall be credentialed by and satisfactorily meet all of the credentialing criteria of MHN. Covering practitioners (i.e. locum tenens) who have an independent relationship with the organization must be credentialed if they will serve in this capacity for more than sixty (60) consecutive calendar days.

POLICY

It is MHN policy to exercise reasonable care in selecting, reviewing and periodically evaluating the physicians, other licensed healthcare providers and facilities included in its provider network. MHN will initially credential and recredential bi-annually each provider in its provider network in accordance with its credentialing and recredentialing procedure.

Credentialing is the initial process through which MHN confidentially determines whether or not to grant network participation to a provider. MHN will collect, review and verify specific information regarding each applicant, determine if the applicant meets the specific criteria set forth for such providers and approve or deny a provider's application for participation in the MHN provider network.

Recredentialing is the process thorough with MHN confidentially updates and verifies pertinent information, reviews the provider's performance, and examines the clinical competence of the provider. It is MHN's policy to recredential every provider at least every other year.

MHN will not consider a provider's sex, race, religion, creed, national origin, or any other criteria lacking professional or business justification in determining whether the provider may participate in MHN. MHN will treat information it receives as part of its credentialing and recredentialing activities confidentially. MHN will not disclose information to individuals who

are not members of the MHN Credentials Committee or MHN Board of Managers except as authorized in writing by the concerned individual or facility as permitted or required by the credentialing and recredentialing procedure or as required by state or federal statues or judicial order in order to maintain the confidentiality of the application and credentialing process. Practitioners are notified of the credentialing or recredentialing decision within thirty (30) calendar days of the committee decision.

PROCEDURE

This credentialing and recredentialing procedure shall apply to all physicians and other licensed healthcare providers in MHN.

A. Applicant for MHN provider network must:
    1. Submit a completed application and consent to disclosure of information form;
    2. Fulfill all acceptance criteria for participation in the MHN provider network;
    3. Complete or supply all required documentation to support the application for participation.

B. The MHN Credentials Committee will not assess the applicant until all documentation is complete. Only after the designated MHN Medical Director and/or MHN Credentials Committee has determined that the applicant satisfactorily fulfills all criteria will the applicant be accepted as a participation network provider.

C. MHN network providers must continuously maintain participation criteria. The MHN Credentials Committee will assess whether each provider continue to satisfactorily fulfill all criteria by conducting a recredentialing process at least every second year. Provider will be asked to furnish information regarding their malpractice insurance coverage and licensure coverage annually. The MHN Credentials Committee may reassess any participating provider on an ad hoc basis at any time to verify the provider status or to conduct a formal review of the practice patterns or quality of that provider.

CRITERIA

Physicians and Advanced Practice Providers must meet the following MHN criteria in order to be offered participating as a network provider.

1. Possess and maintain at all times a valid license to practice as an M.D., D.O., D.P.M., D.D.S., D.M.D., Ph.D., Psy.D., O.D., N.P., P.A., or C.N.M in the State of Michigan
2. Physicians (M.D., D.O., D.P.M., D.D.S., D.M.D.) must be board certified or board eligible in his or her current specialty, by a Board which is a member of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Podiatric/Foot and Ankle Surgery or the American Board

of Podiatric Medicine. Board eligibility means that the physician has obtained appropriate training in a program approved by the Residency Review Committee or the Council on Postdoctoral Training for the respective specialty and that a letter of recommendation from the residency Chairman has been provided to the respective Board confirming the physician's eligibility to sit for the Board exam. New applicants who are board eligible are required to obtain board certification within five years of residency or fellowship. Additionally, if there is an urgent or special need in the community, the board certification requirement may be waived by the MHN Board of Managers. Practitioners who were credentialed prior to January 1, 2011 are not required to obtain board certification. Exceptions to this requirement may be granted in certain circumstances and will include those physicians who are neither Board certified nor Board eligible but have met all the criteria for being on the medical staff at one of the MyMichigan Health Affiliated hospitals and are actively working towards Board eligibility.

Physicians whose primary board certification requires renewal must be appropriately recertified at least on time in their specialty according to the rules of the respective board.

Physician (M.D., D.O.) who are required to actively participate in Maintenance of Certification (MOC) or Osteopathic Continuous Certification (OCC), as required by their respective issuing Boards, must continuously and actively participate in the MOC and OCC programs throughout their tenure as an MHN network provider.

A. In the event a practitioner has allowed his/her MOC or OCC participation to lapse, a written notification will be sent to the practitioner, requiring he/she:

   1. Submit a written plan and timeline to come into compliance with MOC or OCC requirement within ten (10) business days of request; or

   2. Submit a written plan, time line and documentation from the issuing Board that he/she is scheduled to sit for the respective Board recertification examination within ten (10) business days of request.

Failure to fulfill one of the above requirements will result in the physician no longer meeting the Board certification requirement for continued PAM Membership and MHN Network participation.

Exceptions may include:

A. There is a need for the specialty to provide an acceptable network.
   Additional information obtained may include one or more of the following:
   1. Letters of reference from the Chief of Staff and/or the Chief of the

hospital department where the physician admits, and/or from the Medical Director of an IPA, PHO or PO to which the Physician belongs.

2. Interview with a physician member of the MHN Credentials Committee.

3. Letter(s) concerning any case reviews or actions taken from the peer review/quality audit committee of the hospital(s) to which the physician admits.

4. Information from the hospital's medical record department concerning the physician's thoroughness and timeliness in completing and signing medical records.

5. Review of five (5) inpatient and five (5) office patient charts.

6. Verification of type and hours of Continuing Medical Education Credits for the previous six (6) years.

B. The physician may be "grandfathered" if the Board in the respective specialty did not exist when the physician completed residency training.

Each case will be considered on an individual basis and the Committee may request additional information as listed above before the review is complete. The Committee may also look specifically at the type of medical training completed, including residency training.

3. NPs, PAs, and CNMs must be Board certified at the time of initial credentialing and maintain Board certification throughout their MHN membership tenure.

4. Possess and maintain privileges at one of the MyMichigan Health affiliated hospitals as appropriate to his/her specialty and commensurate with the services he/she will be required to perform as a network provider.

5. Possess and maintain a valid DEA License and Michigan Controlled Substance License as appropriate to his/her specialty. If the provider does not maintain both licenses in spite of it being appropriate for their specialty, they must provide a written explanation as to why.

6. Possess and maintain professional liability insurance in the amount not less than $200,000 per occurrence and $600,000 aggregate, or maintain a mechanism for funding reserves to be used solely for professional liability purposes. Evidence of such a reserve and the mechanism for funding shall be described to and approved by MHN.

7. Be accessible by telephone either personally or through back-up coverage by other

participating providers 24 hours per day.

8. Certify that he/she is free of any physical or mental conditions or impairments which could affect he/her ability to deliver adequate care, such as alcoholism, chemical dependency or depression.

9. Certify that he/she has not been convicted of a felony or criminal misdemeanor relating to his/her professional practice, other health care related matters, third party reimbursement, including Medicaid and/or Medicare fraud, or have been required to pay civil penalties for same.

10. Possess satisfactory malpractice history as may be deemed appropriate by the MHN Credentials Committee, considering area and specialty.

11. Certify an absence of actions against his/her license to practice.

12. Certify that no actions have been taken, or explain actions to deny, revoke or terminate his/her hospital staff or clinical privileges by any health care facility.

13. Demonstrate consistent practice of quality care.

14. Certify that the provider must attest that the information provided in the application is true and complete.

15. Notify MHN regarding any changes in the status of items such as licenses, insurance, hospital privileges, primary/billing address, tax ID numbers, etc., at any time between recredentialing cycles.

As part of the initial and recredentialing process intervals, MHN will perform the following:

1. Distribute or obtain candidate credentialing applications.

2. Collect and/or receive and review incoming applications.

3. Assemble copies of the following documents:

    a. Michigan License to practice

    b. Board Certificate or letter of residency competition an evidence of eligibility

    c. Michigan Controlled Substance License, as applicable

    d. DEA License, as applicable

    e. Face sheet of current professional liability insurance including effective date and coverage limitations

    f. Face sheets of professional liability information for the past five (5) years and specific information related to any malpractice claims and/or settlements on initial credentialing; two (2) years on recredentialing related to any malpractice claims and/or settlements

4. Receive primary source verification of the following:

    a. License to Practice and Ongoing verification of licensure upon expiration (MI Department of Commerce-LARA). The License to Practice must be in effect at the time of the credentialing decision.

    b. DEA Certificate (DEA Diversion website). The DEA Certificate must be in effect at the time of the credentialing decision.

    c. Michigan Controlled Substance License (MI Department of Commerce-LARA). The Michigan Controlled Substance License must be in effect at the time of the credentialing decision.

    d. Medical education; residency and post graduate education in writing/telephone directly with institution or American Medical Association (AMA) Profile, ABMS CertiFacts, AOA Profile, American Board of Foot and Ankle Surgery. **(Verification of Board Certification fully meets the requirement to verify education and training)**

e. For non-M.D.s, D.O.s and D.P.M.s, education will be verified directly with the issuing institution or through the National Student Clearinghouse, as applicable.

f. Status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility (in writing/telephone directly with institution).

g. Specialty Board certification (directly with the issuing Board, ABMS CertiFacts, AMA Profile, AOS Profile, ABFAS Profile, American Academy of Nurse Practitioners-AANP, American Nurses Credentialing Center-ANCC, Pediatric Nursing Certification Board – PNCB, National Commission on Certification of Physician Assistants-NCCPA, American College of Nurse Midwives-ACNM).

h. Work history – collection of the most recent five (5) year work history to include beginning and ending month/year for each position (information can be taken from application or C.V.). If any gap in these timeframes greater than ninety (90) days exists, a letter is forwarded to the provider requesting clarification of what took place during the non-specified time and a period of ten (10) days is given to the applicant to respond in writing with this information. Documentation of work history includes the signature or initials of staff person who verified this information and the date of the verification.

i. Professional liability insurance and liability claims history (confirmation with carrier) and documentation that active coverage will remain in force through the date that the candidate's application is approved by the MHN Credentialing Committee.

j. The practitioner is given the right to review the information submitted in support of their credentialing application, excluding peer review protected information, such as recommendations.

k. If information becomes available during the credentialing process which varies substantially from the information provided by the practitioner or which the provider has not disclosed on the application the provider is written a letter notifying him/her of the information obtained. The practitioner s given the right to correct the erroneous information and respond to MHN within ten (10) days.

l. The practitioner is given the right, upon verbal request or written request, to be informed of the status of their credentialing or recredentialing application at any time during those processes.

5. Query the National Practitioner Data Bank.

6. Query the CMS Office of Inspector General (OIG) Exclusion and Reinstatement website listing.

7. Query CMS Medicare Opt-Out website listing.

8. Query the System for Award Management ('SAM') website listing.

9. Query the current, published CMS Preclusion Listing.

10. Query the OFAC—SDN website listing.

11. Query of the NPPES website listing to confirm authenticity of provider's NPI number.

12. Query of the MDHHS Michigan Medicaid sanction report.

13. Ongoing review of the Office of Inspector General (OIG) exclusions and reinstatements report to determine any applicant who has been excluded from Medicare or Medicaid participation. This review is completed within thirty (30) days of the repots dissemination.

14. Ongoing review of the CMS Medicare Opt-Out listing to determine any applicant who has voluntarily opted out of Medicare participation. This review is completed quarterly.

15. Ongoing review of the Disciplinary Action Report from the Michigan Department of Commerce-LARA, to determine any current or past restrictions on the candidate's license to practice. This review is completed within fifteen (15) to thirty (30) days of the reports' dissemination. A folder is maintained and utilized for sanctions and limitation of licensure information.

16. Ongoing, monitoring and assessment of sanctions, complaints, quality concerns and adverse events is performed to ensure no adverse practice patterns develop. Findings are immediately reviewed and interventions applied in singular cases and in cases where patterns have been identified, as applicable, and as approved by the MHN Board, up to and including termination. In the event an adverse practice pattern or patterns are identified, a range of actions are considered to improve performance prior to termination.

    a. Findings are immediately reviewed by the MHN Medical Director and/or the MHN Credentials Committee. Interventions are applied in singular cases and in cases where patterns have been identified, which may include one or more of the following, as applicable to the situation:

i. Collegial peer to peer discussion with the MHN Medical Director;
ii. Development and execution of a performance improvement plan;

iii. A conditional, abbreviated recredentialing interval to monitor improvement;
iv. Other intervention

Interventions are communicated to the practitioner and associated documentation is made part of the practitioner's file. In the event performance improvement interventions do not result in improvement and the MHN Board may approve termination of the provider due to poor quality or egregious adverse actions. MHN will take action to notify the appropriate federal and state authorities of the termination as required by law.

*Ongoing review indicates that there is continuous and indefinite review of the information as identified.

17. Prepare and present the completed credentialing information to the MHN Credentials Committee. This presentation of information must take place and contain no information greater than 180 days old at the time of the credentialingdecision.

PRACTITIONER SITE REVIEW PROCEDURE

Practitioner Facility Site Review

Site visit reviews *may be required in the event of a quality concern, complaint or as mandated by credentialing authorities defined as NCQA, CMS, State Medicaid and the State of Michigan.*

Content

Site reviews focus on the following primary components:

1. **Physical setting**: When an MHN reviewer assesses the physical office setting, they look at several areas including the cleanliness of the facility, its accessibility to the physically or otherwise challenged individual, and the adequacy of waiting room and exam areas. Many of the items on the site review tool may be assessed simply by observation and inspection.

2. **Medical record keeping practices**: In order to assess an office's medical record keeping practices, MHN reviewers will request to examine actual or blinded medical records. Among other items, reviews evaluate the overall design of records, the adequacy and completeness of baseline histories and physicals, and the adequacy of treatment plans.

3. **Availability of appointments**: The MHN reviewer will assess scheduled wait times for physical exams, routine care, urgent and non-urgent care to ensure the provision of enrollee care. Officers are asked whether the practice is open to new patients, and in order to provide primary care access to ConnectCare enrollee into their practice.

Process

In an effort to make the site reviews consistent and objective, MHN reviewers use the standard MHN Practitioner Site Visit form.

Upon identification that a site visit is required,
MHN will:

Contact the office to notify the reason for the site visit and schedule a convenient time to conduct the site review.

1. Send a letter to the physician and office staff contact explaining the purpose and process of the site review and include a sample of the Practitioner Site Visit form.

2. At the conclusion of the visit, the reviewer will provide the office contact with a verbal summary of the findings. This is followed within 2 weeks with a written report reflecting the findings of the site visit and will include recommendations for improvement. A copy will be included in the practitioner's credentials file, available for review by the Credentials Committee.

Primary Components

1. The practitioner need not be present during the review; however, a member of the office staff must accompany the reviewer.

2. All reviews shall be documented on the standard form developed by MHN. Items of noncompliance shall be noted along with recommendations for change. A summary of the review findings will be provided to the practitioner within 2 weeks of the review.

3. Areas of noncompliance shall be rechecked at intervals deemed appropriate by the MHN Credentials Committee, and the date of next review scheduled with the practitioner or office staff member.

4. Continued noncompliance with any regulations and/or recommendations of the MHN Credentials Committee shall be noted and shared with the MHN Credentials Committee and Board of Managers and may result in disciplinary action.

5. In accordance with the appropriate licensing/regulatory agencies, reviewers shall evaluate the areas detailed below.

Medical Records Review

A. A unit clinical record shall be maintained for each enrollee. The record shall be organized and maintained in a manner that facilitates easy access for review and reporting of clinical information.

B. The clinical record shall contain an identification sheet which, at a minimum, includes

the enrollee's name, date of birth or age, gender, and name and telephone number of a contact person in case of emergencyThere should also be past medical history of the enrollee, family history, and social history.

C. The clinical record documentation shall be up to date and include:
   - a problem list
   - medication list
   - drug reactions
   - immunizations
   - the presence or absence of all allergies

D. The clinical record for each member visit shall contain documentation of:
   - reason for visit and chief complaint
   - objective findings
   - working diagnosis
   - treatment plan and follow-up including prescribed medications
   - patient education, as indicated

All entries in the clinical record must be dated and signed or initialed by the person making the entry.

E. The clinical record shall contain written reports of all laboratory services, x-ray services, and consultations provided. Copies of discharge summaries from all inpatient admissions and reports of services by referral providers shall also be maintained in the clinical record. These reports shall be dated and initialed by the provider as an indication that the report has been received and reviewed.

F. Chronic problems should be reflected as such in the patient record, noting patient progress, response to treatment or change in treatment or diagnosis, patient's compliance or non-compliance, and follow-up education.

Facility Tour

A. Office:
   - The exterior of the facility shall be adequately identifiable, with posted office hours
   - There shall be handicapped access to the facility, exam rooms, and restrooms
   - Complies with local fire code to include smoke detectors and sprinklers
   - Fire extinguishers are visible and easy to access, with staff trained in use
   - Office and waiting rooms are clean, neat and well maintained
   - Corridors, hallways, and exits shall be free of obstruction with no items stored on floors
   - A method exists for informing patients of office hours and after hours emergency numbers

B. Exam Room:
   - Exam room is clean, neat and well maintained

- Provides adequate privacy for patient
- Equipped with necessary supplies and access to sink
- Infection control is provided by ease of access for disposal of sharps and biohazards

C. Emergency Procedures:
- Evidence (interviews with staff, written procedures, etc.) that office staff is aware of emergency procedures appropriate to the type of office site
- During all patient care hours, there will be at least one staff member currently certified in CPR present at all times
- All staff know the process for contacting EMS

D. Infection Control:
- Needles and sharp instruments shall be disposed of in accordance with Universal Precautions. Needles shall not be recapped, bent, broken, removed from syringes, or otherwise manipulated. Needles and syringes shall be disposed of as one unit in a puncture resistant container. Such containers shall be sealed prior to being discarded and shall not be placed in an areas accessible to the general public while awaiting trash collection
- Soap dispensers and paper towels shall be available throughout the facility. Bar soap and cloth towels are not acceptable
- Staff should be trained in procedure for cleaning and disinfecting patient care areas
- Exam tables should be equipped with a disposable cover that is changed after each patient
- If cold sterilization is utilized, at least a 2% glutaraldehyde solution or a solution which is designed to destroy HIV and HepB viruses must be used. All trays, containers, or basins containing cold sterilant solution shall be labeled with the name of the solution and the last date the solution was changed. Solutions shall be changed at least once per month or per manufacturer's recommendation to assure their proper activity
- Disposable otoscope and thermometer covers are single use.

E. Internal Policies and Procedures:
- Written patient confidentiality policy
- Written procedure for treating the walk-in and work-in patients
- Written procedure for follow-up with patients who have missed appointments without calling to cancel, as well as for patients who may habitually cancel appointments.
- Written procedure require all medical calls to be documented and followed up by the end of the day
- Schedule for appointment wait times are monitored and maintained within acceptable limits
- Written procedure for handling and sterilizing reusable equipment
- Provision for 24 hours coverage 7 days a week is communicated to patients with appropriate instructions

- Written procedure for identification, handling and disposal of hazardous waste.
- Written procedure for office cleaning
- Written procedure for cleaning and disinfecting care areas
- Necessary licensure, registrations and certifications are current and visibly posted in appropriate areas of the facility:
  - X-ray certification by State of Michigan Regulatory Agencies
  - Dispensing license - if applicable
  - Medical Waste Management Registration
  - CLIA registration
- Laboratory services provided in offices shall be certified in accordance with state licensing regulations. The current licensing certificate shall be posted in the laboratory area
- Laboratory services exempt from such licensure shall be operated in compliance with any other applicable state regulations
- All equipment shall be maintained and calibrated according to the manufacturer recommendations as evidenced by written documentation
- Written emergency plan and posted evacuation plan exists with all staff having been trained in various emergency procedures i.e.: fire, tornadoes, etc.
- A policy for storing of drugs and drug accessories such as needles, syringes, and medication order pads. Policy should specify staff members who have access.
- Evidence of monitoring patient satisfaction

F. Drug Safety:
- All reagents and medications, including sample drugs, shall be stored in non-patient care areas. Reagents and medications shall be checked regularly to assure that all expired drugs are discarded. Sample drugs are marked with current dates or a log is maintained to identify expirations
- Oral, injectable, and external medications are stored separately
- Controlled substances (Class II) shall be double locked and a sign-out log shall be maintained. Access to controlled substances shall be limited to appropriate staff
- Medications and laboratory specimens shall be stored separately from food. Refrigerators are required to have a refrigerator thermometer to ascertain that the temperature is maintained between 36-46 degrees Fahrenheit. Medications should not be stored in the door of the refrigerator as the temperature in this area tends to vary
- Multiple dose vials are marked with the date first opened and date to discard based on manufacturer recommendations
- Injectable medications are not pre-drawn

G. Autoclave:
- Autoclaves shall be checked and the results documented at regular intervals using steam indicators to assure the proper functioning of the equipment
- A required minimum of weekly live spore check to be performed and results documented. However, a daily test is recommended
- Non-disposable instruments shall be sterilized using an autoclave. Such

instruments shall be wrapped and dated when autoclaved. Re-sterilization of unopened instruments shall be performed in accordance with infection control guidelines. Re-sterilization is recommended after six (6) months of non-use

- Disposable items shall not be autoclaved or reused

H. Safety/Sanitation:

- Safe and thorough cleaning procedures exist
- Hazardous/toxic waste shall be bagged and stored out of sight, away from patient treatment areas, while awaiting disposal
- Patient care items shall not be stored under sinks or directly on the floor
- Waste cans should contain liners and lids and be emptied frequently
- Cylindrical gas tanks shall be stored in a secure manner such as a portable cart, stationary stand or wall fastener
- Cleaning supplies are stored away from patient care areas
- Combustible materials shall not be stored near heat sources

I. X-Ray:

- On site X-ray equipment shall be certified in accordance with state licensing regulations. The current licensing certificate shall be posted near the equipment
- Ionizing radiation rules posted
- Door to radiology area clearly marked “X-ray” with Warning to Pregnant Females

MyMichigan Health Network/ConnectCare

Practitioner Site Visit

Practice Name: ______________________ **Date:** __________

Address: ______________________

Practitioners: ______________________

Office Manager: ______________________

Medical Records		
☐ **History Form/Patient Identification Sheet includes**		
Patient name	☐YES ☐NO ☐N/A	
Patient age or date of birth	☐YES ☐NO ☐N/A	
Gender	☐YES ☐NO ☐N/A	
Address, home and work phone numbers	☐YES ☐NO ☐N/A	
Marital Status	☐YES ☐NO ☐N/A	
Contact person in case of emergency	☐YES ☐NO ☐N/A	
Signature of patient or responsible adult	☐YES ☐NO ☐N/A	
Past medical history	☐YES ☐NO ☐N/A	
Immunization record up to date	☐YES ☐NO ☐N/A	
Family history	☐YES ☐NO ☐N/A	
Social history, including appropriate notation concerning use of cigarettes, alcohol and substances for ages 14 & older	☐YES ☐NO ☐N/A	
Date with Practitioners signature	☐YES ☐NO ☐N/A	12
☐ **Record for each visit includes**		
Date	☐YES ☐NO ☐N/A	
Chief Complaint or reason for visit	☐YES ☐NO ☐N/A	
Subjective & objective information on history and physical exam	☐YES ☐NO ☐N/A	
Review of diagnostic studies ordered	☐YES ☐NO ☐N/A	
Working diagnoses consistent with findings	☐YES ☐NO ☐N/A	
Treatment plan consistent with diagnoses	☐YES ☐NO ☐N/A	6
☐ **When appropriate**		
Unresolved problems from previous office visits addressed	☐YES ☐NO ☐N/A	
Treatments and medication specifying frequency and dosage	☐YES ☐NO ☐N/A	
Referrals and consultations	☐YES ☐NO ☐N/A	
Patient and family education	☐YES ☐NO ☐N/A	
Instructions for follow-up	☐YES ☐NO ☐N/A	5
☐ **Documentation of**		
Patient progress or response to treatment or change in treatment or diagnosis	☐YES ☐NO ☐N/A	
Patient's non-compliance-if applicable	☐YES ☐NO ☐N/A	2
☐ **Record supports**		
Intensity of patient's evaluation and/or treatment plan	☐YES ☐NO ☐N/A	
Reason for lab, x-ray, other studies, referrals and consults	☐YES ☐NO ☐N/A	
☐ **All entries are signed and dated; use of a signature control sheet recommended**	☐YES ☐NO ☐N/A	3
☐ **During site visit surveyors look to see that medical records**		
Are available and accessible during office hours	☐YES ☐NO ☐N/A	
Are in a secured/confidiental system	☐YES ☐NO ☐N/A	
Are adequately identified by patient name or number on each page of the record	☐YES ☐NO ☐N/A	
Are secured with adequate fasteners to prevent loss	☐YES ☐NO ☐N/A	
Are organized in chronological order, including dividers for major chart sections	☐YES ☐NO ☐N/A	
Contain documentation noting allergies or no known allergies and adverse reactions	☐YES ☐NO ☐N/A	
Contain results of consultations, lab, x-ray and other reports & are initialed by physician	☐YES ☐NO ☐N/A	
Contain a problem list, noting significant illnesses and medical conditions	☐YES ☐NO ☐N/A	
Records are complete and legible	☐YES ☐NO ☐N/A	
Use of consent form when indicated	☐YES ☐NO ☐N/A	
Use of medical release form/informed consent	☐YES ☐NO ☐N/A	11

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Practice Name: ______________________________ **Date:** ______________

Facility Tour

Office			
Name visible from street	☐YES ☐NO ☐N/A	Posted office hours	☐YES ☐NO ☐N/A
Adequate parking, designated handicapped parking	☐YES ☐NO ☐N/A	Handicap access to building (after 1965)	☐YES ☐NO ☐N/A
Restroom with handicap Access	☐YES ☐NO ☐N/A	Smoke detectors, sprinklers or compliance with local fire code	☐YES ☐NO ☐N/A
Fire extinguishers visible with clear access	☐YES ☐NO ☐N/A	Staff knowledgeable in use of fire extinguisher	☐YES ☐NO ☐N/A
Office areas & Exam/treatment rooms clean, neat and well maintained with adequate space and lighting.	☐YES ☐NO ☐N/A	All items stored off the floor	☐YES ☐NO ☐N/A
Corridors clear	☐YES ☐NO ☐N/A	Exits clearly marked	☐YES ☐NO ☐N/A
After hours recording for informing patients of office hours and emergency numbers	☐YES ☐NO ☐N/A	Licensure current and displayed - if applicable *C.L.I.A. Registration *Medical Waste Management Registration *(or medical waste plan)* *Dispensing License	☐YES ☐NO ☐N/A Expiration date:_______ Expiration date: _______ 14
Exam Room			
Exam table covering used and changed for each patient	☐YES ☐NO ☐N/A	Provides adequate privacy for the patient	☐YES ☐NO ☐N/A
Under sink storage clear of patient care items	☐YES ☐NO ☐N/A	Provides easy access for disposal of sharps and biohazards	☐YES ☐NO ☐N/A 4
Infection Control			
Proper disposal of needles, drugs and non-reusable supplies & equipment	☐YES ☐NO ☐N/A	Paper towels and soap in dispenser in each exam room and bathroom	☐YES ☐NO ☐N/A
Availability of personal protective equipment	☐YES ☐NO ☐N/A	Otoscope and thermometer covers are single use	☐YES ☐NO ☐N/A
For high level disinfection, use of a solution which is designed to destroy HIV and HepB viruses	☐YES ☐NO ☐N/A	Solution name and expiration date or date of last change on containers	☐YES ☐NO ☐N/A
Clean and dirty work areas identified	☐YES ☐NO ☐N/A		7

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MHN Reviewer______________________________

MyMichigan Health Network/ConnectCare

Practitioner Site Visit

Practice Name: ______________________________ **Date:** ______________

Safety/Sanitation			
Gas tanks properly secured by storage on carts or anchored to the wall	□YES □NO □N/A	Hazardous/toxic materials, including cleaning supplies, are stored away from treatment areas	□YES □NO □N/A
Combustible materials stored away from heat sources	□YES □NO □N/A	Bagged waste stored out of sight in opaque bags	□YES □NO □N/A
Waste cans with liners and lids are clean	□YES □NO □N/A	Dumpster or covered receptacle for waste	□YES □NO □N/A
Ionizing radiation rules posted	□YES □NO □N/A		
X-ray equipment certified by State of Michigan regulatory Agencies	□YES □NO □N/A	Door clearly marked "X-ray" with Warning to Pregnant Females	□YES □NO □N/A 9
Drug Safety			
Medications and reagents stored in non-patient areas or locked	□YES □NO □N/A	Separate storage space for oral/injectible/external medications	□YES □NO □N/A
Injectible medications are not pre-drawn	□YES □NO □N/A	Stock/sample medications and supplies are marked with current dates and log maintained.	□YES □NO □N/A
Controlled substances double locked	□YES □NO □N/A	Sign out log for controlled Substances with limited staff	□YES □NO □N/A
Refrigerated medications and lab specimens are stored separately from food. Medications are not stored in refrigerator door	□YES □NO □N/A	Refrigerator(s) has thermometer and is maintained at 36-46 degrees Fahrenheit or 2-7 degrees Centigrade as noted on daily log	□YES □NO □N/A
		If multiple dose vials are used, they are marked with date first opened	□YES □NO □N/A 9
Autoclave			
Documentation of regular steam checks (in each package) using appropriate indicators	□YES □NO □N/A	Non-disposable instruments are autoclaved	□YES □NO □N/A
Live spore checks with every batch if autoclave not used often. If frequently used, ex: 2 batches per day, check weekly.	□YES □NO □N/A	Autoclaved instruments wrapped and marked with date autoclaved	□YES □NO □N/A 4
Emergency Procedures			
Maintains a list of medications, supplies and equipment, and checks them at regular intervals	□YES □NO □N/A	Documentation that staff is trained in CPR	□YES □NO □N/A
Procedure for accessing EMS	□YES □NO □N/A		3

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MHN Reviewer ______________________________

Practice Name: ______________________________ **Date:** ______________

Internal Policies & Procedures			
Aware of ConnectCare's website and has necessary reference materials		Written patient confidentiality policy	☐YES ☐NO ☐N/A
Written procedure for walk-in and work in patients	☐YES ☐NO ☐N/A	Written follow-up on missed appointments	☐YES ☐NO ☐N/A
Written procedure requiring that all medical calls are followed-up by end of day and documented	☐YES ☐NO ☐N/A	Schedule for appointment wait times » Physicals - 6 weeks » Routine care - 2 weeks » Non-urgent care - 5 days » Urgent care - same day » Emergency care- immediate »Accepting new patients?	☐YES ☐NO ☐N/A
Written procedure for handling and sterilizing reusable equipment	☐YES ☐NO ☐N/A		
Provision for 24-hour, 7-days a week coverage » Well informed answering service or answering machine with appropriate instructions » Arrangements for ER and/or after-hour coverage	☐YES ☐NO ☐N/A	Written procedure for identification, handling and disposal of hazardous waste	☐YES ☐NO ☐N/A
		Written procedure for office cleaning	☐YES ☐NO ☐N/A
Maintains documentation of equipment maintenance and calibration	☐YES ☐NO ☐N/A	Written emergency procedure for fire, tornado, etc. and posted evacuation plan	☐YES ☐NO ☐N/A
Written procedure for cleaning and disinfecting patient care areas	☐YES ☐NO ☐N/A	Monitors patient satisfaction	☐YES ☐NO ☐N/A
Written policy for storing drugs, needles syringes and prescription pads, with secured access	☐YES ☐NO ☐N/A		14

Facility Total Possible: 64

NOTES:

____

____

Scoring Formula Number of Yes Answers divided by number of Yes + No Answers = percent achieved

- A score of 90% or more requires no follow up.
- A score of 85-89% requires the office to submit a written corrective action plan to MHN.
- A score below 85% requires the office to submit a written corrective action plan and to have a revisit done in order to determine compliance.

Facility & Medical Records are scored separately.

Revised 9/99; 3/01, 12/01, 8/02, 7/05, 10/08, 8/09
Reviewed: 09/03; 05/04, 2/07, 5/10, 9/10, 9/11, 1/12, 1/13, 8/14, 3/16

MHN Reviewer ______________________________

PROCEDURE FOR TERMINATION OF PRACTITIONER RELATIONSHIP

A. Voluntary Termination:

1. A practitioner wanting to voluntarily relinquish his/her participation with MHN may do so, without cause, by submitting at least 30 days advance written notification to the MHN Credentials Committee.

2. In the event that a practitioner decides to terminate his/her participation with MHN for cause, written notice of the reason for termination must be provided to MHN. MHN is allowed 30 days in which to address the allegation.

3. Voluntary relinquishment of clinical privileges or staff appointment while under an investigation or in exchange for not conducting an investigation is considered a termination of participation and is reported as such.

B. Involuntary Termination:

1. In the event that MHN decides to terminate a practitioner's participation for cause, written notice of the reason for termination must be provided to the practitioner by the Medical Director. The practitioner is allowed 30 days in which to address the allegation.

2. In the event that the practitioner refutes the reason for termination, the Medical Director may convene a special meeting of the Credentials Committee to review the information. The Credentials Committee may request a meeting with the practitioner. A report of such meetings shall be submitted to the MHN Board of Managers with the recommendation(s) of the Committee.

3. The MHN Board of Managers makes the final decision regarding the matter which is provided in writing via certified mail to the practitioner.

4. Following termination, the practitioner will cooperate with MHN to assure continuity of care for enrollees under their treatment.

C. Termination Notice:

Termination notice is made in writing and sent by certified mail by MHN to the practitioner's last known address. The practitioner is expected to make written termination notice to:

MyMichigan Health Network
6810 Eastman Avenue
Midland, MI 48642
ATTN: Medical Director

PROVIDER SUSPENSION/TERMINATON PROCEDURE

Except as otherwise specified herein, if the Committee recommends that a network provider be suspended or terminated, MHN will grant the provider the right to a hearing in order to resolve matters bearing on professional competence and conduct in accordance with the following procedure. MHN will conduct the hearing according to the procedural safeguards set forth below. A provider shall not be entitled to a hearing if, in fact, MHN suspends or terminates the provider due to non-quality, administrative issues such as, but not limited to, failure to meet and maintain established credentialing criteria, breach of contract or an at will termination.

The provider will exhaust all hearing procedures afforded by this policy before resorting to any other action against MHN on procedural or substantive grounds. If the provider takes legal action before exhausting all hearing procedures, the provider will be deemed to have waived all rights to a hearing and if the provider does not prevail in such action, the provider will bear the legal costs, including reasonable attorney fees, incurred by PHO in defending the legal action.

If the Committee recommends that a provider be suspended or terminated from the network, the Committee will notify the provider within five (5) days of its decision by certified mail. The notice will:

1. State the recommendation;

2. State the Committee's reasons for the recommendation, including the acts or omissions attributed to the provider;

3. State that the provider has a right to request a hearing on the recommendation;

4. State that the provider has thirty (30) days within which to make a written request for hearing; and

5. Summarize the hearing process and the provider's rights as they relate to the hearing, including who presides over the hearing, how the hearing will be conducted, the provider's right to representation, the provider's right to receive a written recommendation and opinion after the hearing, and the forfeiture of the provider's right to hearing if the provider fails, without good cause, to appear at the hearing.

If the provider requests a hearing, the Committee will give the provider written notice of the hearing date, which will be at least thirty (30) days after the date of the notice. The notice will state:

1. The place, time and date of hearing; and

2. The names of any witnesses expected to testify at the hearing on behalf of MHN.

The provider shall have fifteen (15) days following receipt of the notice to confirm, in writing (by certified mail, return receipt requested), acceptance of the established hearing and identify any attorney or other representative the provider will bring to the hearing. If the provider does not confirm acceptance of the established hearing within the timeframe and in the manner described above or fails to appear at a scheduled hearing, the provider shall be deemed to have waived any right to hearing and to have accepted the recommendation. Such recommendation shall then become final action of the Committee.

Approved 12/96
Last Revised: 2/02, 8/09, 12/10
Last Reviewed: 9/08, 5/10, 9/10, 8/11, 9/12, 12/13, 5/15, 9/16, 12/17, 12/18, 4/19, 4/20, 2/23, 4/24

MyMichigan Health Network – ConnectCare Utilization Management Description

A. Philosophy:

MyMichigan Health Network (MHN) is committed to providing quality health care and services to its enrollees. MHN recognizes the need for a Utilization Management Program to integrate and review services in a cooperative effort with other parties to ensure the most appropriate use of resources and to provide the best outcomes for our enrollees. It is our goal to ensure that enrollees receive equitable, impartial utilization decisions in a timely manner. Case management services are also provided to assist enrollees to obtain quality care and to understand their disease and treatment options.

Further, MHN is committed to providing quality health care and services to its enrollees by coordinating activities relating to quality of care and service. The quality improvement program includes but is not limited to planning, implementation, analyses and evaluation activities focused on continuously improving performance throughout the organization. This program monitors care delivered by participating providers to enrollees, as well as services offered by MHN, and strives to improve care and service where unacceptable variation from established standards is found.

B. Definition:

Utilization Management (UM) – The process of evaluating and determining coverage for and appropriateness of medical services, as well as providing any needed assistance to clinicians or enrollees in cooperation with other parties. A critical aspect of UM is attention to quality, which denotes adherence to standards and a commitment to improvement.

Case Management (CM) – A shared process between the enrollee and family, medical management team, and involved health care providers. This process includes assessing, planning, implementing, coordinating, monitoring and evaluating options and services in order to meet an enrollee's and his/her family's needs.

C. Structure and Accountability:

UM includes precertification or preauthorization of selected services, concurrent review, retrospective review, discharge planning and case management, with attention to providing quality outcomes for enrollees.

The UM staff includes:

Medical Director: The Medical Director, a board-certified physician, provides clinical supervision, guidance, and coordination of activities within the UM Program, which includes contributing to and overseeing its development and implementation. The Medical Director is responsible for final decisions made on the basis of medical or clinical necessity. The Medical Director acts as a liaison between MHN and its practitioners, providing information and

education regarding UM activities and processes. The Medical Director attends meetings of the MHN Care Management and Credentialing Committees and the MHN Board of Managers, presenting information that focuses on utilization and case management concerns. The Medical Director has day-to-day involvement in UM activities and is consistently available to staff, either on site or by telephone. The Medical Director has support provided as needed by the Associate Medical Director.

Associate Medical Director: The Associate Medical Director, a board-certified physician, functions in coordination with the Medical Director to provide clinical supervision, guidance, and coordination of activities within the UM Program. When needed, the Associate Medical Director acts as a liaison between MHN and its practitioners, providing information and education regarding medical management activities and processes. In the Medical Director's absence, the Associate Medical Director may attend meetings of the MHN Care Management and Credentialing Committees and the MHN Board of Managers, focusing on utilization and case management concerns.

Behavioral Health Consultant - The Behavioral Health Consultant, a psychiatrist, doctoral-level psychologist, or certified addiction medicine specialist, provides guidance within the UM Program regarding the evaluation and treatment of psychological and substance abuse disorders, related to utilization and case management concerns. The Behavioral Health Consultant collaborates with the Medical Director in the development and operation of the behavioral health aspects of the UM program. This practitioner assists in the review of behavioral health criteria, case review and treatment, and issues related to clinical management.

Case Manager/Utilization Review Nurse(s): A Registered Nurse, performs UM activities, focuses on individualized and coordinated care for enrollees, and serves as a vital connection linking agencies, disciplines, and providers within the delivery system to ensure continuity of care. The Case Manager works in collaboration with physicians, enrollees and families of care, as well as the Medical Management Team, including the Medical Director(s) to promote optimal enrollee outcomes in the most efficient, cost effective manner. This nurse acts as the Privacy Officer and also identifies opportunities for improvement in the UM program and performs quality improvement (QI) studies to enhance UM operations.

Also contributing to the UM program development:

MHN Board of Managers: The Board meets routinely and has ultimate responsibility for the quality of care and services enrollees receive. The Board receives regular reports from all MHN committees and is responsible for reviewing and approving the annual QI program evaluation and the annual QI plan. The Board routinely delegates quality activities to MHN committees and may delegate special quality activities to individuals on an ad hoc basis.

MHN Care Management Committee: This Committee is responsible for the development, operation, maintenance, and refinement of the QI program. The MHN Care Management Committee coordinates QI activities, physician education programs, approves the annual QI plan, and develops and reviews UM activities. In doing so, this Committee reviews utilization data,

reports, claim trends, provider performance, and projects performed by the Medical Director, remaining mindful of opportunities for QI.

Privacy Officer: The Privacy Officer oversees all ongoing activities related to the development, implementation, maintenance of and adherence to MHN's policies and procedures covering privacy and access to protected health information (PHI). Additionally, the Privacy Officer provides an annual report of the year's activities to the Medical Director for communication at the MHN Care Management Committee.

Complaint Officer: As outlined in the MHN complaint policy, the Complaint Officer monitors and works to resolve complaints received. Annually, the Complaint Officer provides a report of complaint data and trends to the Medical Director for communication at the MHN Care Management Committee.

D. Scope:

The UM Program coordinates the review and evaluation of multiple aspects of care and service provided throughout the organization. Components of the program include, but are not limited to the following:

- clinical care, access and quality indicators
- case management
- medical necessity determinations
- precertification and preauthorization of selected services
- concurrent and retrospective utilization review
- current practice guidelines
- assessment of and assistance with discharge planning needs
- enrollee satisfaction, rights and responsibilities
- focused studies and reports
- practitioner, provider and enrollee education
- wellness program activities
- monitoring of utilization
- complaint investigation, resolution and tracking
- adherence to HIPAA and privacy guidelines
- data collection, ongoing assessment and evaluation
- coordination of care
- resource management

E. Confidentiality:

In adherence with the MHN Confidentiality Policy, all information related to the Utilization Management Program activities are considered confidential and are treated as such. Only those with the need to know have access to information, records, and reports.

F. UM Determinations:

The enrollee's health plan is reviewed for benefit coverage and the requirement for authorizations of services. MHN uses InterQual, current peer review journals, evidence based clinical decision support resources, and/or internally developed criteria based on nationally recognized research in order to identify the medical appropriateness of the service under review. Secondary resources may also be used in making UM determinations, including consultation with the enrollee's primary care physician or a physician of the appropriate specialty. MHN uses objective medical evidence when making determinations of coverage which includes but is not limited to, the following:

- Office and hospital records
- A history of the presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

G. Appeals:

While MHN is not involved in the appeal process, appeals procedures are outlined in plan documents and materials provided to the enrollee by the plan sponsor. When a service is denied, a notice of enrollee appeal rights is provided with the denial letter.

H. Behavioral Health:

The Medical Director and Behavioral Health Consultant provide clinical supervision related to behavioral health care services. Behavioral health cases are reviewed with the Behavioral Health Consultant for quality of care concerns, failure to meet admission or concurrent review criteria, and level of care issues. In order to verify that appropriate care was provided for inpatient behavioral health admissions, the Behavioral Health Consultant retrospectively reviews all inpatient stays on a quarterly basis. Although ConnectCare does not require or provide a centralized triage and referral process for mental health or substance abuse services based on his/her recommendations, UM processes and criteria related to behavioral healthcare may be amended in order to improve the quality of care to ConnectCare enrollees. He/she contributes to

the development and implementation of the behavioral health aspects of the UM Program by providing a review of new or amended policies and procedures, internally developed behavioral health criteria, analysis of utilization data, and/or reports to identify areas for improvement, and physician education.

I. CM Criteria:

Indications: There are two (2) indications for initiating CM activity. The first reason to initiate CM activity is derived from various other sources, which may include referrals from physicians, enrollees, medical personnel and reports. These cases are documented in the medical management database with a CM indicator. The second reason is derived from reports that identify an enrollee with a potentially serious diagnosis. These cases are documented in the medical management database with a stop loss indicator.

Screening Once an enrollee is identified for possible case management, a request for further information and/or contact is made with the enrollee and/or treating physicians in order to further evaluate his/her current condition and care needs.

Assessment Once the necessary information is received, a determination is made, and a plan initiated for those enrollees appropriate and agreeable to CM services. Methods of assessment may include contact with the enrollee, physician, family, or other healthcare providers.

Monitoring Oversight includes evaluation of utilized services, linkage with available resources, education regarding diagnosis and health plan benefits, and recommendations for follow up with healthcare providers. Periodic reviews are individually determined through oversight of the enrollee's health status and needs.

J. Quality:

MHN recognizes the need for a Quality Improvement (QI) Program to define and coordinate activities relating to quality of care and services. UM staff are directly involved in the QI process, using identified quality indicators to discover opportunities for or barriers to improving enrollee health care and service. The QI Description and QI Plan further delineate the UM staff's role in QI including the collection of information and its use in QI activities.

K. UM Program Documentation:

1. UM Description
    - provides the structure and principles that govern the program
    - includes philosophy, definition, scope, structure, and accountability
    - is reviewed annually by the Medical Management Team
    - may be revised with Medical Management Team review and approval, as needed
    - may be revised with MHN Care Management Committee and/or Board of Managers review and approval as needed

2. Medical Necessity Criteria
    - facilitates prompt, efficient delivery, and monitoring of health care services
    - is developed with practitioner review and input
    - is reviewed annually by the Medical Management Team
    - may be revised with Medical Management Team review and approval, as needed
    - follows applicable state and federal regulations

3. Case Management
    - evaluates enrollee health conditions and care needs
    - is reviewed annually by the Medical Management Team
    - may be revised with Medical Management Team review and approval, as needed

4. Quality Improvement Program
    - coordinates activities relating to quality of care and services
    - is reviewed annually and may be revised by the Medical Management Team
    - is reviewed annually by the MHN Care Management Committee
    - is reviewed annually by the MHN Board of Managers

L. Action and Follow-up:

When areas of opportunity for improvement of the UM Program are identified, MHN takes action to correct any barriers to care and services. Documentation of the analysis of quality-related information, actions and interventions taken and follow-up evaluation is done to ascertain that the action taken is effective in resolving the identified concern.

M. Program Evaluation:

MidMichigan Health Network's UM program is reviewed by the Medical Management Team with program updates made as needed. Each quarter, additions or changes to the program are documented and a report is written outlining the year's activities for annual review by the Care Management Committee.

Annually, the MHN Care Management Committee evaluates the previous year's activities and Medical Management Team reports, providing revision and/or approval of the next year's activities and functions, as needed.

ConnectCare PRECERTIFICATION FORM

DATE ______________

EMPLOYEE NAME ______________________________

PATIENT NAME ______________________ **PATIENT DOB** ______________

COVERAGE INFORMATION

PLEASE CIRCLE MEMBER'S GROUP

POLICY NUMBER ______________________ MyMichigan Health

GROUP NUMBER ______________________ Northwood University

PHYSICIAN NAME: ______________________________

☐ INPATIENT ADMISSION ☐ OUTPATIENT PROCEDURE OR SURGERY

☐ DME (Attach prescription)

DATE OF ADMISSION/SURGERY/PROCEDURE ______________

Inpatient admissions and certain outpatient procedures may require preauthorization prior to approval

FACILITY NAME ______________________________

PLACE OF SERVICE: ☐ PROVIDER OFFICE ☐ HOSPITAL ☐ OTHER
If not INPATIENT

REASON FOR SERVICE: ICD-10 DIAGNOSIS CODE(S) ________ ________

PROCEDURE/CPT 4 CODE(S) ________ ________

DIAGNOSIS ______________________________

Person Making Request ______________________ **Telephone** ______________

Office or Facility ______________________ **FAX Number** ______________

Precertification Number ______________________ Duration ______________

Comments ______________________________

____

____

Representative ______________________ Date Received ______________

Precertification telephone number in Midland (989) 839-1629 option 3 or toll-free (888) 646-2429 or FAX (989) 839-1679

BILLING AND CLAIMS

Compensation and Claims Payment

Payment is based on the reimbursement schedule set forth in the contracts. An explanation of benefits (EOB) will accompany all payments.

Balance Billing

Please refer to the EOB provided to determine the amount billable to the patient. In addition to collecting the co-payments at the time of the office visit, the practitioner may bill for deductibles, coinsurance, and amounts for services not covered under the benefit plan (e.g. cosmetic surgery). Patients cannot be billed for the difference between the provider's normally billed charges and the rates agreed to for covered services.

Claims Information

The following information must be included on all claim forms:

- Description of services or supplies, detailing the CPT/HCPCS 5-digit procedure code and the charge for each supply or service.
- The diagnosis
- The date(s) of service
- The patient's name
- The insured's identification number
- The provider's name, address, phone number, and degree
- The federal tax identification number of the provider.
- All claims must be submitted within a 12 month period from the date of service.

Submitting Claims by Mail

Submission of claims should be done on a standard form for professional services, or for facility charges. The appropriate address for claim submission is noted on the member identification card.

Submitting Electronic Claims

Claims can be submitted electronically through transaction networks and clearing houses. This method may promote faster, more accurate claims processing and is generally preferred.

Claims Appeal Procedure

If you believe that a claim was improperly settled, appeal procedures for the particular claims payor must be followed. All requests for review of denied benefits should be submitted in writing and should include a copy of the initial denial letter and any other pertinent information. Refer to each plan for the address for submission of the appeal.

CLAIMS QUESTIONS

ConnectCare:

MyMichigan Health	Automated Benefit Solutions	1-833-239-1273
Northwood University	Key Benefit Administrators	1-877-453-0556

Cofinity	1-888-632-3862

MyMichigan Health Network 4000 Wellness Drive Midland, MI 48670	Effective Date: 6/11 Revised Date: Subject or Title: **Enrollee Rights and Responsibilities Policy**
Approved by:	Prepared and Reviewed by: Terri Shaf RN

Reviewed By	TT/KB	TT	KB	KB	KB	KB	NG
Year	2/12	1/13	3/14	2/15	2/16	3/17	1/18
Reviewed By	MM	SKO	SKO				
Year	6/21	2/23	4/24				

PURPOSE:

To promote effective health care, ConnectCare is committed to maintaining a mutually respectful relationship with enrollees. A statement of enrollees' rights recognizes the specific needs of enrollees, including the right to privacy and the right to be treated with dignity when receiving health care.

PROCEDURE:

ConnectCare is committed to treating enrollees in manner that respects their rights and recognizes their responsibilities. This information is made available on the ConnectCare Web site at www.connectcare.com with a hard copy available upon request.

An enrollee has a right to:

- Be treated with respect and without discrimination
- Dignity and privacy
- Confidentiality and privacy regarding medical records and health information
- Prompt access to quality healthcare services
- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Participate in decisions regarding his/her healthcare
- Refuse treatment and to be informed of the consequences of doing so
- Review test or exam results and to have them explained in an understandable language
- Obtain copies of medical records upon request and payment of a fee
- Express complaints and/or make appeals regarding medical care or ConnectCare
- Receive information about ConnectCare, its services, practitioners and providers, and enrollee rights and responsibilities
- Make recommendations regarding ConnectCare's enrollee rights and responsibilities policies

An enrollee has a responsibility to:

- Supply information needed by ConnectCare, practitioners and providers in order to provide care
- Be on time for appointments and to provide notice of appointment cancellations
- Pay applicable co-payments at time of service
- Follow prescribed treatment, advice, and instructions agreed upon with providers and/or practitioners, asking for clarification when needed
- Provide accurate and complete information regarding medical history and current problems
- Be familiar with his/her health care plan and to adhere to its requirements
- Notify the plan of changes in address, phone number, job status, family size or other factors affecting eligibility
- Be an informed consumer of healthcare and to assume responsibility for his/her health
- Understand his/her health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- Assume responsibility for his/her actions if the member refuses treatment and does not follow the provider's instructions

MyMichigan Health Network 4000 Wellness Drive Midland, MI 48670	Effective Date: 10/24/97 Revised Date: 1/26/99, 4/12/02, 11/02, 7/04; 1/05, 3/06, 1/07, 1/09, 4/09, 1/10, 6/10 Subject or Title: **COMPLAINT/GRIEVANCE POLICY**
Approved by:	Prepared and Reviewed by:

Reviewed By	JC	JC	JC	JC/TT	TT	JC	TT
Year	7/07	1/08	12/08	1/09	12/09	1/10	12/11
Reviewed By	TT	TT	KB	KB	KB	KB	NG
Year	12/12	9/13	8/14	12/15	2/16	2/17	1/18
Reviewed By	NG	NG	MM	SKO	SKO		
Year	1/19	2/20	6/21	2/23	4/24		

PURPOSE:

In the interest of fairness, the preservation of quality care, confidentiality, and the promotion of opportunities for improvement, MyMichigan Health Network (MHN) recognizes the need for an organized and consistent procedure to address complaints and grievances. Ongoing monitoring of complaints and grievances is one aspect considered in the re-credentialing process. Complaints and grievances are readily accepted, taken seriously, investigated carefully, and responded to in a timely and respectful manner with regard given to maintaining confidentiality. All potential quality of care issues are handled by the Medical Director.

DEFINITIONS:

Formal Complaint: A written complaint or grievance that expresses objection or dissatisfaction, other than one that involves a medical necessity determination, requiring follow up by the Medical Director and/or Complaint Officer (CO).

Informal Complaint: Occurs when a complaint or grievance expressing an objection or dissatisfaction, but the grievant does not want to file a formal complaint. Follow up is performed by the staff member receiving the complaint and/or the Medical Director. All complaints involving the Medical Director are logged by the CO.

Adverse Event: An injury that occurs while an enrollee is receiving health care services from a practitioner.

PROCEDURE:

A. Responsibility - Because of the nature of the relationship between MHN and the plan sponsors certain kinds of grievances, such as those dealing with plan design or benefit issues, are directed to the plan sponsor.

B. Complaint Officer - The MHN President appoints a Complaint Officer who is responsible for documenting and maintaining records of all complaints/grievances, providing necessary

follow up, and notifying the Medical Director who determines what investigation is warranted.

C. Complaints/Grievances - When an MHN employee receives a complaint, an attempt is made to resolve the problem through discussion with the complainant. The employee keeps careful notes about the discussion(s), and forwards this information to the CO and Medical Director. Once the CO receives a complaint, he/she sends written acknowledgement of receipt of the formal complaint within seven (7) days, unless the Medical Director has already contacted the complainant regarding the problem.

D. Adverse Events - MHN performs ongoing monitoring and considers all adverse events to be quality of care matters and refers them immediately to the Medical Director for investigation.

E. Quality of Care - If the employee or the CO suspects that a grievance involves a clinical quality of care issue, a copy of the grievance is immediately provided to the Medical Director for evaluation and investigation. If the Medical Director finds that a medical or clinical quality of care issue is involved, he/she assumes responsibility for the investigation according to credentialing procedures for actions.

F. Office Site Complaint Thresholds - When enrollee complaints are received regarding physical accessibility and appearance, or adequacy of exam or waiting room space, a copy of the grievance is immediately provided to the Medical Director for evaluation and determination whether follow up assessment is required based on the type, severity and frequency of the complaint.

G. Named Practitioner - If a grievance names a specific practitioner and the complainant is agreeable, the practitioner is notified by either the Medical Director or via certified mail. If notification is made in writing, the practitioner is asked to respond in writing within fifteen (15) days. The CO notifies the grievant that the practitioner has been advised of the complaint. At the conclusion of the investigation, a copy of the grievance and the written practitioner's response is forwarded to the Credentials Committee for inclusion in the named practitioner's file, and consideration in the recredentialing process.

H. Formal Grievances/Complaints - Complaints/grievances can be submitted to the attention of the Complaint Officer, MyMichigan Health Network, 6810 Eastman Avenue Midland, MI 48642. If the grievant believes that MHN's response is inadequate, unfair, or otherwise unsatisfactory, he/she may appeal the grievance to a higher level. The three levels of the appeals process are as follows:

- **Level One**: The CO delegates the investigation to the appropriate personnel for evaluation. A written response is sent within thirty (30) days, or notification is sent indicating that additional time is needed to process the complaint/grievance. MHN recognizes that some situations require a more rapid response and the CO or staff member handles these cases on an urgent basis, when necessary. Furthermore, the grievant may request expedited processing of the complaint/grievance. The CO's

response includes notification to the grievant regarding the right of appeal to level two within thirty (30) days.

- **Level Two**: The complaint/grievance is resubmitted in writing, along with any additional information, to the MHN President, MyMichigan Health Network, 6810 Eastman Avenue Midland, MI. The President will investigate and reply to the grievant in writing within thirty (30) days, or notify the grievant of the need for additional time. The written response will notify the grievant of the right of appeal to level three within thirty (30) days.
- **Level Three**: The appeal is submitted in writing to the MHN Board of Managers, MyMichigan Health Network, 6810 Eastman Avenue Midland, MI 48642. Upon request, the grievant may present the complaint in person or via a personal representative before the Board or an ad-hoc committee appointed by the Board. The Board will investigate the grievance and issue a reply within thirty (30) days, or notify the grievant of the need for additional time.

I. Reporting - The CO is responsible for identifying trends and developing reports and to provide them to the Medical Director on an annual basis, or more frequently as needed. The Medical Director presents these reports to the MHN Credentials Committee and/or the Board of Managers for their review and consideration.

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<tr><td colspan="4">MyMichigan Health Network
4000 Wellness Drive
Midland, MI 48670</td><td colspan="4">Effective Date: 2/17/98
Revised Date: 4/01, 6/02, 1102, 6/03, 3/05, 3/06, 9/10, 6/11
Subject or Title:
CONFIDENTIALITY POLICY</td></tr>
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<tr><td>Year</td><td>1/18</td><td>1/19</td><td>2/20</td><td>7/21</td><td>2/23</td><td>5/24</td><td></td></tr>
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PURPOSE:

At MyMichigan Health Network (MHN), protecting confidentiality is a matter of high priority. Confidential information may include protected health information, employee, volunteer, and student information, privileged discussions, financial data, information obtained in the credentialing and recredentialing processes as well as other proprietary materials, such as business/employment records, internal reports, memos, contracts and computer programs. Confidential information is valuable and sensitive, and is protected by law, professional ethics, regulatory or accreditation guidelines, and policy. The intent of this policy is to assure that confidential information remains confidential, and is used only as necessary to accomplish MHN's objectives, as well as to comply with the guidelines of the Health Insurance Portability Accountability Act (HIPAA).

Violation of this policy is grounds for disciplinary action up to and including termination of employment, criminal investigation, or professional sanctions in accordance with MHN's policies and personnel rules and regulations. Violations could also result in professional license disciplinary action and/or criminal prosecution.

DEFINITIONS:

Protected Health Information (PHI) – health information, such as medical records, claims, and other administrative data that identifies or can lead to identification of an individual.

Routine Consent – for future, known or routine needs, permission given for the use of health information allowing an organization to release information without prior written consent. This may include treatment, performing utilization review, or claims processing.

Authorization – permission given for non-routine uses of personal health information as stipulated in the authorization for a specified period of time.

Implicit Information – information that does not include specific names, but does include

information that may be used to identify individuals.

Explicit Information – information that is clearly identifiable with enrollee names.

PROCEDURE:

A. Employment:

By accepting employment or otherwise being granted access to information at MHN, the individual agrees to protect the confidentiality, security, and integrity of private information. Use and/or disclosure of information learned or acquired through association with MHN will be used only in the performance of job duties and only to the extent necessary and authorized. PHI must not be used for individual benefit. Activities by any individual or entity suspected of compromising confidentiality must be reported to the Privacy Officer and/or MidMichigan Health Corporate Compliance Officer. Reports made in good faith about suspicious activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.

All employees, students, volunteers, and obliged visitors are required to sign a confidentiality agreement in order to meet the objectives of this policy upon employment or association with MHN and upon termination of that employment or association. All obligations in this policy shall continue and apply regardless of work location or assignment, and after termination of employment or affiliation with MHN.

B. Routine Consent:

While MHN is not directly involved in enrollment, contracts with business associates explicitly state expectations about the confidentiality of enrollee information. When data is transmitted to another entity as permitted by routine consent, the entity is expected to protect the transmitted data according to MHN's expectations. Routine consent addresses future, known or routine needs and the use of PHI, which allows the organization to release information without prior written consent for:

- treatment
- management and coordination of care
- quality assessment and measurement
- accreditation
- billing
- utilization review
- determining eligibility

C. Authorization:

MHN obtains authorization for the use or disclosure of non-routine PHI for reasons other than treatment, payment or health care operations. Each authorization must state specifically what PHI is to be disclosed and the length of time that the authorization is in effect.

D. Access to Confidential Information:

Records containing confidential information are stored in locked, secure areas in the MHN offices. All personnel at MHN have access to information that would not be available to the general public. The following principles are applicable to all personnel, regardless of their classification. The staff member will:

- understand that access to PHI is a privilege and not a right afforded to him/her and agree to protect the security of this information and maintain all PHI in a manner consistent with the requirements outlined under the federal privacy regulations
- agree that during or after his/her employment not to disclose or use, except with the prior written consent of MHN, proprietary information, confidential business information or PHI
- use confidential information only as needed to perform his/her legitimate duties as an employee, volunteer, student, or visitor
- safeguard and not disclose any codes or other authorizations that allow access to confidential information
- not utilize anyone else's code or other authorization in order to access confidential information
- accept responsibility for all activities undertaken using assigned access codes or other authorizations, not seek personal benefit or permit others to benefit personally by any confidential information or use of equipment available through work assignments
- understand that the information accessed through all information systems is sensitive and confidential and should only be disclosed to those authorized to receive it
- not exhibit or divulge the contents of any record, manual, notebook, note, photograph, report, or any other recorded, written or printed matter relating to the operations or business of MHN, except to fulfill a work assignment
- prevent unauthorized use of any information in files maintained, stored or processed
- return all such materials and property of MHN upon request, but in any event no later than on termination of employment
- not knowingly include or cause to be included in any record or report, a false, inaccurate, or misleading entry
- not remove any record or report from the office where it is kept except in the performance of duties
- respect the confidentiality of any reports printed from information systems containing confidential information and handle, store, and dispose of these reports appropriately
- not divulge any information that identifies an enrollee
- not operate any non-licensed software on any computer provided
- respect the ownership of proprietary software and not make unauthorized copies of such software for personal use, regardless of whether or not the software is physically protected against copying

- respect the privacy and rules governing the use of any information accessible through the computer system or network and only utilize information necessary for performance of job duties

- respect the finite capability of the systems and limit use so as not to interfere unreasonably with the activities of others
- respect the procedures established to manage the use of the computer system
- understand that all access to the computer systems will be monitored
- report any violation of this policy to his/her supervisor and/or the Privacy Officer
- understand that failure to comply with this policy may result in disciplinary action, up to and including discharge
- understand that all obligations under this policy will continue after termination of employment

E. Protection of PHI:

In order to protect the privacy of PHI, MHN limits the use of identifiable data whenever possible, ensuring that only those authorized and with a need to know have access. In such circumstances where the organization is obligated to share information with other entities, the following precautions are maintained:

- individually-identifiable information is not shared with any employer without consent from the enrollee
- when contractually obligated to provide identifiable information to employers, the information is de-identified in order to preserve confidentiality and prevent misuse of the information
- information pertaining to complaints and any appeal information relating to the complaints are kept in a secure, locked area, available only to those who have a need to know and who have signed a confidentiality statement

F. Protection of Credentialing and Re-credentialing Information:

In order to protect the privacy of information acquired in the credentialing and re-credentialing process, MHN limits access only to those with a need to know. In such circumstances where the organization is obligated to share information, the following precautions are maintained:

- employees who have access to credentialing information are responsible for maintaining the security and confidentiality of that information, in accordance with the Protection of Credentialing Information policy
- during orientation employees who are authorized to use and/or disclose credentialing and recredentialing information learned or acquired through their association with MHN do so only for the performance of their jobs and only to the extent necessary and authorized and must not be used for individual benefit
- as part of the orientation process, employees are educated regarding the need for security and confidentiality of credentialing information, password protection, and authorization levels for access to credentialing information

- in the application process, MHN obtains authorization from the applicant or appointee to consult with third parties who may have information, privileged or otherwise, relating to professional credentials or any other matter pertinent to assessing
- qualifications of eligibility for membership as an MHN practitioner

- authorization includes the right to inspect or obtain any communications, reports, records, statements, documents, recommendations or disclosures from any third party that may be material to the credentialing process
- committee members agree to use confidential information only as needed to perform his/her legitimate duties
- when reviews are performed by outside entities, such as for the purpose of delegation oversight, a business associate agreement is required to be signed

G. Protection of Other Confidential Information:

Other confidential information includes employee, volunteer, and student information, privileged discussions, financial data, and proprietary materials and is afforded the same protection as PHI and credentialing or re-credentialing data.

H. Communications to Enrollees, Practitioners and Providers:

Upon request, enrollees are provided with information about MHN's confidentiality policy. MHN communicates its confidentiality policy and expectations in the practitioner manual. Any changes or modifications to this policy are communicated in the practitioner newsletters and in updates to the manual.

I. Privacy Officer:

In order to comply with state and federal laws and regulatory guidelines, the Privacy Officer oversees all ongoing activities related to the development, implementation, maintenance of and adherence to MHN's policies and procedures covering privacy, confidentiality and access to protected health information (PHI).

The Privacy Officer responsibilities include:

- reviewing, implementing policies and overseeing the application of HIPAA regulations and MHN confidentiality policies
- monitoring developments in the HIPAA regulations and ensuring MHN's ongoing compliance
- coordinating HIPAA compliance with other state and federal laws and regulatory guidelines mechanisms to limit access to data
- identifying unnecessary confidential data collection
- contributing to the appeals process for confidentiality issues
- providing an annual report of the year's activities to the Medical Director for communication at MHN Care Management Committee
- monitoring levels of user access to data and implementing mechanisms to limit access
- assisting in investigation of complaints related to improper PHI disclosure
- assisting in investigation of complaints related to improper disclosure of credentialing or re-credentialing information
- assisting in investigation of complaints related to improper use or disclosure of other confidential information