

HealthPlus of Michigan Commercial HMO members must choose a primary care physician (PCP). For this purpose, a primary care physician is defined as one of the following medical specialties:

- Family Practice (General Practitioner)
- Pediatrics
- Internal Medicine

It is the PCP's role to coordinate all health care, and when medically necessary, refer HealthPlus members to specialists in the HealthPlus network of health care providers.

It is the PCP's responsibility to:

- Accept members up to the contracted limit and render services to any member at the same level, scope, and quality of care provided to all other clients and not discriminate based on frequency or extent of covered services needed, age, sex, health status, race, religion, national origin, marital status, height, weight, or disability
- Be available and accessible for medically necessary emergencies, outpatient and inpatient services 24 hours-a-day, seven days a week, including an appropriate on call system
- Understand the reimbursement for his or her professional services rendered to HealthPlus members will be based on the HealthPlus fee-for-service, Medicaid or Medicare fee schedule
- Look to HealthPlus for compensation for services rendered to a member when such services are covered by HealthPlus' subscriber contract
- Agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against a member except to the extent that copays are specified in an HealthPlus subscriber contract, or as permitted under principles of coordination of benefits for covered benefits
- Preserve and enhance the member's dignity
- Prescribe or direct patient education for members, including personal health measures and social service assistance, when deemed appropriate
- Provide services in a manner that assures the continuity of care and commitment of each physician to full cooperation in a health record-keeping system through which all pertinent information relating to the health care of its members is accumulated and readily available to persons authorized to review these records
- Use his or her best efforts to bill within 60 days, but in all events, to submit to HealthPlus all claims for covered services within one year of the date of service or hospital inpatient discharge
- Participate in and fully cooperate with HealthPlus' utilization review, peer review, and quality assurance programs, including by way of example, not by way of limitation, pre-admission certification, emergency admission certification, and extension of hospital stays
- Not discharge a member, except in situations that meet criteria established by HealthPlus
- Comply with HealthPlus' system for referrals and consultations among physicians and affiliated hospitals to facilitate coordination of health services and ensure continuity of care for members, specifically by communicating pertinent medical history and

procedural results to providers to eliminate duplication of services and enhance quality of care

- Engage the services of non-plan physicians through HealthPlus approved referrals only when medically necessary and in conformity with the quality assurance and cost effectiveness programs of HealthPlus

HealthPlus members obtain the names of participating PCPs from the appropriate HealthPlus provider directory. The directories are updated on the website throughout the year. It is important that information regarding your practice is correct, including patient accepting status.

The following are accepting status definitions:

- Yes. Accepting new or existing patients
- Yes, Newborns Only. Accepting newborns or existing patients. Conversion
- Yes, Families Only. Accepting entire families or existing patients. Conversion
- Yes, Age Limitations Apply. Accepting new patients within age limits or existing patients. Conversion
- Conversions. Open to existing patients
- No. Not accepting new or conversion patients. This classification is only available through individual consideration, determined by HealthPlus (e.g., physician leaving practice, prolonged illness).

If a PCP is listed in the provider directory as accepting patients, a member may select the PCP as his or her physician. Each member of a family may choose a different PCP. The member contacts HealthPlus Customer Service to have his or her physician selection entered into the computer system. At this time, members are encouraged to contact the PCP's office to arrange an initial visit. Members may also select or change their PCP via the HealthPlus website at www.healthplus.org.

After being notified a member has selected you as his or her PCP, we ask that you schedule a visit with the patient as soon as possible. This will provide you with an opportunity to talk about managed care and the referral process and to emphasize prevention and wellness. It can also be a good time to begin a member "health plan." While this process is especially helpful for patients new to your practice, it also may be helpful for existing patients who are switching from traditional insurance to HealthPlus.

If a PCP decides that a member requires care from a specialist, the PCP will refer the member to a participating HealthPlus specialist, through the appropriate HealthPlus referral process.

It is the responsibility of the specialist to:

- Understand the reimbursement for his or her professional services rendered to HealthPlus members will be based on the HealthPlus fee-for-service, Medicaid or Medicare fee schedule
- Look to HealthPlus for compensation for services rendered to a member when such services are covered by HealthPlus' subscriber contract
- Agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against an enrollee except to the extent that copays are specified in an HealthPlus subscriber contract, or as permitted under the principles of coordination of benefits for covered benefits
- Use his or her best efforts to bill within 60 days, but in all events to submit to HealthPlus, all claims for covered services, within one year of the date of service or hospital inpatient discharge
- Participate in and fully cooperate with HealthPlus' utilization review, peer review, and quality assurance programs, including by way of example and not by way of limitation, pre-admission certification, emergency admission certification and extension of hospital stays
- Provide written reports to the referring primary care physician, to include his or her clinical findings and conclusions, in a timely manner, which will not be later than 30 days from date of service
- Utilize providers who are contracted with or through HealthPlus whenever medically appropriate
- Provide necessary covered services, as the result of a properly executed written referral authorization from a primary care physician, and to obtain and review any authorization from HealthPlus, for any subspecialty diagnostic procedure, which may exceed the scope of a participating provider's area of practice and for which he or she has been credentialed
- Preserve and enhance the member's dignity

Specialists are listed in the HealthPlus provider directory by specialty type. This allows the PCP easy identification of specialists who participate with HealthPlus.

General Questions/Inquiries

If you have questions regarding claims-related issues such as: status inquiry, denial resolution, rebilling, adjustments, and afterhours/urgent issues, call:

1-800-332-9161

Reimbursement

Services provided to HealthPlus of Michigan Commercial members by non-contracted HealthPlus providers may be subject to deductibles and copays.

Services provided to HealthPlus Partners members by non-contracted HealthPlus providers will be reimbursed at the prevailing Medicaid fee for service rate(s).

How to become a Contracted HealthPlus Provider

If you are interested in becoming a HealthPlus of Michigan contracted provider, please contact the Provider Network Management Department at (810) 230-2172.

Included in this section are tips for effective practice management. These tips are designed to assist physicians in providing quality care to HealthPlus members. HealthPlus encourages providers to advocate for the member and discuss medical treatment options, services, quality assurance and utilization management programs between providers and HealthPlus.

HealthPlus Clinical Practice Guidelines

HealthPlus works in collaboration with the Michigan Quality Improvement Consortium (MQIC), and with input from its practitioners, to develop clinical practice guidelines based on nationally recognized, evidence-based guidelines. The guidelines are developed for high-priority clinical areas identified based upon Plan demographics, prevalence of clinical conditions, cost of care, and service utilization. HealthPlus' goal is to improve patient care by developing, implementing and monitoring scientifically sound, evidence-based guidelines; however, none of the guidelines are intended to replace a physician's clinical judgment in treating an individual patient.

Each clinical practice guideline is reviewed and updated at least every two years, with new guidelines introduced periodically, to assist in the management of important aspects of clinical care. ***The guidelines are reviewed and approved by HealthPlus' Quality Improvement Committee and the Board of Directors.***

The Clinical Practice Guidelines are generally presented as a one-page "quick reference" summary. ***Clinical indicators monitored*** may also be included as attachments. The Clinical Practice Guidelines are posted on the HealthPlus website at www.healthplus.org in the *Providers* section. Paper copies of the guidelines are available upon request. Reminders about updated and new guidelines are distributed periodically in ProviderPlus newsletter.

HealthPlus Formulary

The HealthPlus Formulary was designed to aid physicians and pharmacists in providing cost-effective medication therapy, while maintaining a high quality prescription drug benefit. This can be achieved by selecting agents, including generically available medications, which are listed in the HealthPlus Formulary. The Formulary is described in detail in Chapter 13, and is also available on our website at www.healthplus.org.

Medical Record Forms

Several sample medical record forms have been created to assist practitioners in patient recordkeeping. These, and other materials to assist with practice management, are available on our website at www.healthplus.org in the *Providers* section. You may also contact the HealthPlus Quality Management Department to request copies of the forms.

Tips for Efficient Practice Management

- *Take a positive approach with patients.* Let patients know that the PCP can improve quality of care through the coordination of health care services
- *Utilize generic drugs whenever possible.* The average cost difference between a generic drug and a brand name drug is at least \$90
- *Perform physicals and encourage immunizations and maintenance of health.* Detect illness early

- *Be actively involved in the hospital care of patients.* Inpatient services and costs can be managed more effectively if the PCP is involved in all aspects of patient care
- *Take the time to coordinate care by communicating with other health care providers who treat your patients.* A PCP should be explicit in instructions regarding services needed and location of services, and provide pertinent medical history to specialist providers. Specialist physicians should send a written report to the PCP after rendering services to a patient
- *Increase telephone access to patients outside normal working hours.* This will allow a PCP to properly coordinate and direct health care for his or her patients through more frequent checks with the answering service. Clear instructions on the answering machine are vital; provide your service with instructions as well
- *PCPs should direct patients to urgent care centers in lieu of the emergency room when medically appropriate.* Be sure your answering machine/service has the appropriate information
- *Utilize Quest Diagnostics for all laboratory services.* See exceptions in Chapter 7
- *Utilize DME providers listed in the Provider Directory.* See Chapter 7 for details
- *Direct patients to participating facilities for diagnostic services (e.g., CT scans, routine x-rays)*
- *Schedule physician and/or nurse availability for telephone conversations with patients.* Some repeat visits can be avoided by arranging for referrals or coordinating other care by telephone service

Nondiscrimination

The hospital will agree to furnish covered services to any HealthPlus member at the same level, scope and quality of care provided to all other patients and will not discriminate because of frequency or extent of covered services needed, age, sex, race, religion, marital status, height, weight, disability, national origin, health status or benefit carrier assignment.

Licensing and Accreditation

The hospital will be duly licensed by the State of Michigan and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or the American Osteopathic Association (AOA) to render covered services to members. The hospital and each hospital affiliate will maintain such licensure and accreditation and will notify HealthPlus within five days of any loss of such licensure or accreditation.

The hospital will require any employee or agent who renders services to HealthPlus members to be appropriately supervised and have the appropriate license and/or certification to render such services. All personnel, facilities, equipment and support services must meet all appropriate licensure and certification requirements.

Patient Safety

HealthPlus encourages hospitals to participate in patient safety activities and reporting through local and national organizations such as Leapfrog, the Michigan Health and Safety Committee, National Quality Forum and Michigan Hospital Association.

Admissions

It is the responsibility of participating hospitals to accept HealthPlus members as patients. Elective and urgent admissions will be made only upon the member being appropriately referred by a participating HealthPlus physician. The hospital is required to notify HealthPlus within 24 hours after learning a member's identity following an emergent situation.

Member Information

At the time of admission, the hospital will obtain the following information from the member:

- Possession of a valid HealthPlus subscriber card
- Disclosure of duplicate coverage, including policy numbers where applicable
- Eligibility of coverage under any private or governmental program
- Execution of a Release of Information form

Census

Hospitals will provide HealthPlus a daily written census of inpatient members.

Authorization

In order to receive compensation for the rendering of covered hospital services, the hospital will secure a complete billing number from HealthPlus.

HealthPlus will issue a complete billing number if:

- The hospital notified HealthPlus within 24 hours in the case of an emergent admission
- The hospital notified HealthPlus of an elective or urgent admission pursuant to HealthPlus' Case Management Program
- The medical care given was deemed medically necessary according to HealthPlus' utilization criteria

Neither HealthPlus nor a member will be responsible to compensate the hospital for covered hospital services rendered without proper HealthPlus issuance of a billing number. For services rendered with a HealthPlus billing number, for which the member was eligible on the date of service and was subsequently retroactively disenrolled from HealthPlus, the hospital will pursue payment for services from the member or appropriate collateral sources.

Behavioral Health Services

Except in the case of an emergency, the hospital must obtain an authorization from HealthPlus prior to rendering inpatient or outpatient behavioral services (mental health or substance abuse) in accordance with HealthPlus' behavioral health policies and procedures.

Unauthorized Services

Except in the case of an emergency, in the event a member presents himself or herself for service(s) without the necessary prior authorization and approval, the hospital must contact HealthPlus for approval prior to treatment.

Submission of Invoices

The hospital must submit claims for covered services to HealthPlus, according to the contracted timeframe. Claims received after this period of time has elapsed will not be paid. The hospital may not bill or collect payment from a subscriber.

The hospital must separate invoices for outpatient services from other hospital services and will identify those invoices associated with outpatient service.

The hospital may look only to HealthPlus for compensation for services rendered to a member, when HealthPlus' Subscriber Contract covers such services. The hospital may not bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against a member or persons acting on behalf of a member (other than HealthPlus), except to the extent that copays are specified in an HealthPlus Subscriber Contract, or as permitted under principles of coordination of benefits.

HealthPlus encourages PCPs and specialists to participate in structured physician committees to assist in reviewing and developing standards for quality of care and organizational improvements. HealthPlus currently facilitates and strongly supports the following physician committees:

- **Medical Directors Council**
Meetings are held ***at least three times a year*** with the leaders of the physician groups to discuss quality ***initiatives and medical management*** at a plan-wide level
- **Pharmacy and Therapeutics Committee (P & T)**
Meetings are generally held on a bi-monthly basis (and no less than five times per year) to discuss the maintenance of the HealthPlus drug formulary, including the evaluation and selection of drug products. The committee is comprised of HealthPlus staff, affiliated physicians and pharmacists
- **Credentialing Committee**
Meetings are held no less than nine times per year to discuss the credentialing and recredentialing of contracted practitioners and organizational providers. When there is an adverse determination based on quality concerns, the appeal process provides for selection of a physician peer review committee to specifically deal with the issue
- **Quality Improvement Committee (QIC)**
Meetings are held no less than ***five*** times per year to discuss quality improvement and utilization management policies, programs, and issues. The QIC monitors the structure, process and outcome of the delivery of health care to HealthPlus enrollees
- **Medical Affairs Committee (MAC)**
This is a committee ***composed of HealthPlus Board members*** and has ***independent*** physician representation, ***to oversee the corporation's*** Quality Improvement and *Medical Management Programs*. Meetings are held no less than 10 times per year.