

Pro Care Health Plan, Inc. (Pro Care)		Claims Department	
		Policy & Procedure	
Subject: Payment to Providers		Line of Business: [X] Medicaid	
Effective Date: 2/1/06		Document Number: CM-11-001	
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I. SCOPE

The scope of this policy involves all Practitioners /Providers of the Pro Care Health Plan, Inc. (Pro Care) network; Pro Care’s Contract and Credentialing Committee and Provider Services.

II. POLICY

Pro Care maintains its Payment to Providers Policy and Procedures for processing all Practitioners/Providers claims for services provided to eligible Medicaid Members. Pro Care shall make timely payments to all Providers for covered services rendered to eligible Members when submitted as a clean claim and is in compliance with established Michigan Department of Community Health (“MDCH”) performance standards.

Pro Care shall meet HIPAA and MDCH guidelines and requirements for electronic capacity, including compliance with HIPAA Transactions and Code Sets Standards.

Pro Care’s Payment to Providers Policy and Procedures is also available on the Pro Care website and will be updated as changes are necessary.

III. DEFINITIONS:

A. Clean Claim: a claim that at a minimum identifies or describes all of the following:

1. The Pro Care’s Member number, and the member’s name, address, and date of birth;
2. The day, month, and year the service was provided;
3. The name, appropriate tax identification number, national Practitioners/Providers identification number (NPI), and Pro Care’s Practitioners/Providers identification number (PIN) of the Practitioners/Providers rendering the service, and the location of the service;
4. A description of the covered service rendered using the universal identifying procedure code, as designated by the

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Michigan Office of Insurance and Financial Services
Commissioner, including the ICD-9-CM diagnosis code;

5. Practitioners/Providers certification as required under MCL 400.111b(17) (that a claim for payment for services rendered to a medically indigent individual is true, accurate, prepared with the knowledge and consent of the Provider, and does not contain untrue, misleading, or deceptive information) and identifying information required by MCL 400.111b(21) (Practitioners/Providers must identify each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment);
6. Substantiation of medical necessity and appropriateness of service;
7. An authorization number, if applicable; and
8. Any additional documentation required by Pro Care, if applicable.

B. Emergency Medical Care/Services: Those services necessary to treat an emergency medical condition. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily function;
3. Serious dysfunction of any bodily organ or part.

C. HIPAA: The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

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D. Practitioner / Provider: a licensed professional , physician , nurse practitioner , hospital , group practice , nursing home , pharmacy , home health care agency , durable medical equipment agency , maternal infant health provider or any individual or group of individuals that provides a health care service .

IV. PROCEDURE

A. General Requirements

1. All Providers are responsible for knowing what services are covered Medicaid benefits. All professional services must be submitted on a CMS-1500 claim form. Facility claims must be submitted on a UB-04 claim form.
2. Pro Care will not pay for any services rendered to a Medicaid recipient prior to his/her effective date except services for a newborn that is retroactively enrolled back to the date of birth. Payments will not be made for Members after the date of disenrollment except for an inpatient hospitalization that is concurrent with the date of disenrollment.
3. Providers must verify member’s eligibility for covered services before providing the service. If eligibility is not verified when required before submission of the claim, the claim will not be considered a clean claim. Prior authorization policy and procedures are outlined in the Health Care Management / Utilization Management Program
4. Pro Care shall inform Providers of its prior authorization policy and procedures including elements needed to substantiate medical necessity of a claim.
5. Providers are required to verify that the patient is a Pro Care Member before submitting a claim for payment.
6. Providers who are not contracted with Pro Care must follow all Pro Care guidelines and procedures for the filing of clean claims.

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7. Claims submitted for Medicaid Members for which another known payment source is available are not considered to be clean claims until the Practitioners/Providers has exhausted all other sources of payment before billing Pro Care.

8. Pro Care or its Practitioners/Providers shall not require co-payments, patient-pay amounts, or other cost-sharing arrangements unless authorized by MDCH. Providers shall not bill Members for the difference between the Provider's charge and Pro Care's payment for covered services. Providers will not seek or accept additional or supplemental payment from a Member, his/her family, or representative, in addition to the amount paid by Pro Care even if the Member has signed an agreement to do so. These provisions also apply to out-of-network Providers.

9. Members shall not be held liable for any of the following provisions (consistent with 42 CFR 438.106 and 42 CFR 438.116):
 - a. Pro Care's debts, in case of insolvency;
 - b. Covered services provided to the Member for which the State did not pay Pro Care;
 - c. Covered services provided to the Member for which the State or Pro Care does not pay the Practitioners/Providers due to contractual, referral or other arrangement; or
 - d. Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if Pro Care provided the services directly.

10. Pro Care may use a pre and post-payment review methodology to assure claims have been paid appropriately.

B. Claims Processing

Approved by: Pro Care Health Plan, Inc.
See Master P&P List for signatures

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1. Each claim received by Pro Care will be stamped with the date received and are entered into Pro Care's Management Information System ("MIS") within an appropriate time frame to ensure payment within 45 days from the received date. When the claim is entered into Pro Care's MIS, a Claim Reference Number is assigned. This Claim Reference Number is used to track the claim.
2. The Practitioners/Providers must send a claim to Pro Care within 365 days of the date of service. The claim is then date stamped and logged into an inventory control report.
3. Claims over 365 days old must have had some activity to be considered for Pro Care reimbursement (rejected for additional information, benefit structure, etc.). When a claim is submitted that is over 365 days from the date of service, supporting documentation must accompany the claim that explains why the claim is being submitted beyond the time limit. The claim will be reviewed for reconsideration. If approved, claim adjustments will be submitted within 30 days after Pro Care's determination.
4. Pro Care grants exceptions to the claim submission filing requirement in the following circumstances:
 - a. The Practitioners/Providers received proven erroneous instructions from Pro Care staff;
 - b. Pro Care staff failed to enter authorization or referral;
 - c. Other documented administrative errors by Pro Care or its contractors;
 - d. Pro Care Practitioners/Providers were issued an incorrect prior authorization;
 - e. Eligibility was established retroactively;
 - f. Processing of primary insurance was delayed; and

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- g. Practitioners/Providers received incorrect billing information from the patient and billed the Medicaid program first.
5. All claims processed through Pro Care’s processing system undergo a full audit prior to payment. A Pre-Pay out Edit Listing Report is generated prior to each check-run and is reviewed against the claims for accuracy. All claims needing corrections are adjusted to reflect the appropriateness of the claim by the processor that made the error. The reports are initialed and filed for corrective actions and training.
 6. Pro Care generates and mails claim checks, along with explanations of benefits (remittance advice) to Providers biweekly or more frequently as required by contractual agreement.

C. Primary Care Practitioners/Providers Payments

1. Pro Care Primary Care Provider (PCP) capitation reimbursement model: dollar amount per member per month (PMPM).
 - a. For Providers paid under a capitation rate, all procedures performed by the PCP not listed within the capitation will be paid fee-for-service.
 - b. All PCPs under capitation must submit encounter data to Pro Care. In some cases a PCP may be reimbursed on a fee-for-service basis rather than a capitation reimbursement model.
 - c. The fee-for-service model may be most appropriate when Pro Care membership is insufficient or financial viability is threatened for either the Practitioners/Providers or the Plan if operated under a capitation reimbursement model.
 - d. Any PCP reimbursed on a fee-for-service basis must submit claims to receive payment for services rendered. All encounters or claims shall be submitted electronically

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unless the Practitioners/Providers do not have the capability to do so.

2. All new Pro Care Members are assigned a PCP by the 1st of every month.
 - a. When a Member is given retroactive eligibility and PCP assignment has been made, the PCP will be paid the PMPM amount on a retroactive basis.
 - b. Each capitated PCP is paid on a biweekly, or more frequent, basis for Members who have been assigned to him/her. Pro Care will issue a biweekly, or more frequent, capitation check to all PCPs and any fee-for-service checks once a week.

D. Payments to Specialty or Referring Physicians

1. Specialty Providers are paid fee-for-service or a fee negotiated by Pro Care for each individual claim submitted to Pro Care. The Michigan Health Benefits Claim form, or the HCFA-1500 is used by Pro Care for submission of procedures provided to eligible Members
2. All claim forms must be submitted electronically or mailed to the Pro Care address as instructed in the Provider Manual.

E. Payments for Outpatient Hospital Services

1. Outpatient Hospital Services are paid fee-for-service according to the ambulatory payment classification (APC) guidelines using the outpatient perspective payment system (OPPS) methodology for each individual claim submitted to Pro Care.
2. Pro Care also pays flat rates for some services provided within Pro Care's network.
3. The UB04 claim form is required for all professional charges.

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4. All claim forms must be submitted electronically or mailed to the Pro Care address as instructed in the Provider Manual.

F. Hospital Payments

1. Pro Care shall pay out-of-network hospitals for authorized covered services provided outside of Pro Care’s established network.
2. Hospital payments shall include payment for Diagnosis Related Groups (DRGs, as defined in the Medicaid Institutional Provider Chapter IV), outliers, as applicable, and capital costs at the per-discharge rate.

G. Payments to Providers for Mental Health Services

1. Mental Health Services are covered by a Specialty Provider contract with Pro Care’s mental health practitioners/providers .
2. Specialty Providers are paid fee-for-service or a fee negotiated by Pro Care for each individual claim submitted to Pro Care .The Michigan Health Benefits Claim Form , or the HCFA 1500 is required by Pro Care for submission of services and or treatments provided to eligible Members.
3. All claim forms must be submitted electronically or mailed to the Pro Care address as instructed in the Provider Manual .
4. Services provided by Community Mental Health are not reimbursed by Pro Care.

H. Payment to Providers for Emergency

1. Pro Care will cover emergency services, as well as medical screening examinations and ancillary services routinely available to the emergency department to determine whether or not an emergency medical condition exists consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA).

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2. Emergency services also include those services provided to a person suffering from an acute problem in behavior or mood which requires immediate intervention (mental health services).
3. A Member may be screened and stabilized without requiring prior authorization.
4. If care is obtained from a non-contracting Practitioner/Provider within the service area of the health plan, the same standards would apply if a prudent layperson with an average knowledge of health and medicine, would reasonably expect the absence of immediate medical attention to result in:
 - a. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
 - b. Serious impairment to bodily functions; or
 - c. Serious dysfunction of any bodily organ or part.
5. Out of network hospital claims will be paid at the established Medicaid rate in effect on the date of service for paying participating Medicaid Providers.
6. If a Member requires hospitalization or other health care services from the hospital emergency department for treatment of life threatening conditions, prior authorization of treatment from Pro Care is not required.
7. Treatment given after screening the patient for a non-life threatening condition requires prior authorization from Pro Care for payment to be made.
8. If, however, Pro Care fails to contact the emergency department within one hour of their initial call for authorization for treatment, services rendered in the emergency department will be paid.

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9. In all cases, emergency departments of hospitals will be reimbursed fee-for-service or a flat rate depending upon the contracted agreement.

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I. Payment Procedures

1. Pro Care shall pay all clean claims for in-plan and out-of-plan providers within 45 days of receipt. Pro Care shall pay all pharmaceutical clean claims within the industry standard time frame for paying the claim or within 45 days after the receipt of the claim by Pro Care, whichever is sooner.
2. When Pro Care has received the claim, it has 30 days from that date to identify in writing to the Practitioners/Providers any defects in the claim.
 - a. If the claim is defective due to failure to comply with any of the established Medicaid clean claim requirements, the claim does not qualify as a clean claim and the 45 day payment timeline for clean claims no longer applies.
 - b. Pro Care shall notify the Practitioners/Providers of the claim defect either electronically or on paper.
 - c. The Practitioners/Providers has 30 days from the date of receipt of the notice of defective claim to correct the defect and resubmit the corrected claim to Pro Care.
 - d. Pro Care has 30 days from the date of receipt of the corrected claim to pay it if the corrected claim meets the definition of a clean claim.
 - e. If the corrected claim that is returned to Pro Care is still defective for the same or another reason, Pro Care shall notify the Practitioners/Providers of the remaining defect within 30 days from the date Pro Care receives the corrected claim.
 - f. Pro Care will also notify the Insurance Commissioner of the defect on the required form.

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3. Upon receipt of any claim, if Pro Care determines that one or more covered services listed on a claim are payable, Pro Care will pay for those services and will not deny the entire claim because one or more services listed are in dispute or not covered.
4. The Practitioners/Providers must allow Pro Care at least 30 days to provide notice of any reason for not paying the claim. If a nonpayment notice has not been sent within 30 days, the Practitioners/Providers may assume payment will be made within 45 days from the date of receipt by Pro Care. If Practitioners/Providers resubmit a claim before the 45 days have elapsed, it will not be considered a clean claim.
5. If the claim or a service listed on a claim form becomes the subject of an adverse determination on payment, Pro Care maintains a Claims Payment Appeals process which the Practitioners/Providers may utilize (see Pro Care's Practitioner/Provider Complaints and Appeals Process).
6. Alternately, the Practitioner/Provider may:
 - a. Request an external review by the Insurance Commissioner within 30 days after the Practitioner/Provider receives notice of the adverse determination; or
 - b. Request arbitration of the dispute.
 - i. If the Practitioner/Provider requests arbitration, Pro Care shall participate with the Practitioner/Provider in a binding arbitration process pursuant to a model arbitration agreement developed by DCH.
 - ii. The party found to be at fault will be assessed the costs of the arbitrator.
 - iii. If both parties are at fault, the cost of the arbitrator will be apportioned.
 - iv. However, Practitioners/Provider may only choose either an external review by the Insurance Commissioner or arbitration, not both.

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V. MATERIALS

1. Claims and Encounter Data Process Flow Chart
2. Pre-Pay Out Audit Process Tool
3. DCH Model Arbitration Agreement
4. Pro Care Provider Manual
5. OFIR Forms (Defective Claim Notification ; Request for OFIR External Review)

VI. REPORTING/RECORDS

1. MDCH "Monthly Claims Report "
2. Pre -Pay Out Edit Listing Report