

# PRO CARE PROVIDER HANDBOOK

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## General Information

Overview and general information to assist the provider in doing business with Pro Care Health Plan, Inc. (Pro Care). Welcome to Pro Care's provider network of participating providers. We are pleased that you have chosen to partner with us and our outstanding panel of Physicians and medical professionals. This manual is provided to facilitate your understanding of our network services and how to access these services.

Included in this section are:

- ❖ Important telephone numbers and contact information
- ❖ How to use this manual
- ❖ What to do if you change your address, phone number, etc.
- ❖ General Plan Description
- ❖ Pro Care Website

## How to Contact Pro Care

Contact: Your Provider Service Representative

Phone Number: Provider Services Department at **313-925-1668**

Pro Care Address: **Pro Care Health Plan, Inc.**  
**3968 Mt. Elliott Ave.**  
**Detroit, MI 48207**

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## **About Your Provider Service Representative**

Pro Care has designated staff to assist providers with information and resources, including provider/staff orientation, assistance with claims issues and contracting activities. Please contact the Provider Services Department for the name of your provider representative at (313) 925-1668.

### **IMPORTANT TELEPHONE NUMBERS**

PRO CARE ADMINISTRATIVE OFFICE .....	(313) 267-0300
CLAIM INQUIRES .....	(313) 267-0300
CUSTOMER SERVICES .....	(313) 267-0300
CREDENTIALING .....	(313) 267-0318
HEALTH SERVICES MANAGEMENT .....	(313) 925-1672
FAX NUMBER .....	(313) 921-0841
HOSPITAL AUTHORIZATION .....	(313) 925-1672
HEALTH CARE SERVICES .....	(313) 925-1672
PRO CARE ELIGIBILITY INQUIRES .....	(313) 267-0300
PHARMACY AUTHORIZATIONS .....	(313) 267-0340
PROVIDER CONTRACTING & SERVICES .....	(313) 925-1668
PROVIDER SERVICE FAX .....	(313) 921-0841
INTERPRETIVE SERVICES .....	(313) 267-0300
HEARING IMPAIRED (CALL MICHIGAN RELAY).....	(800) 432-0762 OR 711

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## **About This Manual**

Pro Care's Provider Manual is designed for providers and their office staff to provide vital information helpful to facilitate the care and service to Pro Care members. The manual outlines and defines the particular items necessary to carry out the procedures required by Pro Care and its' regulatory agencies.

This Manual is a user-friendly instructional tool organized by section. Page numbering is unique to each section.

### **PROVIDER STAFF TRAINING/ORIENTATION**

Your provider office/administrative headquarters will be contacted by your Provider Service Representative to facilitate an orientation and/or training session that is scheduled at your convenience. During the orientation, the Provider Representative will review the manual and answer any questions you may have.

- ❖ The Provider Services Staff is available to serve and support your office staff and their needs. Please notify your Provider Representative if you have a need for additional training.

### **REVISIONS AND UPDATES TO THIS MANUAL**

It is important that your office staff maintain a copy of this manual. Your office will be notified of any changes or revisions to this manual. When updates occur, an update/revision will be mailed to your office and will be accompanied by a cover letter indicating the subject matter being addressed along with section location and page numbers to be replaced or added. Please note the date reference at the bottom of each page. Refer to this date when calling Pro Care with questions concerning this manual.

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## **General Plan Description**

Pro Care Health Plan, Inc. (Pro Care) is a physician-owned Health Maintenance Organization (HMO) in the State of Michigan. The Plan's Chief Executive Officer and President, Dr. Augustine Kole-James, is a well-known physician in the city of Detroit and has practiced in Wayne County for thirty years. Pro Care is licensed by the State of Michigan as a for-profit commercial HMO and as a Medicaid Health Plan. Pro Care Health Plan, Inc. became certified as a Clinic Plan in 1996, as a Qualified Health Plan in 1998 and a licensed HMO in 2000. Pro Care Health Plan, Inc. was accredited in January 2007 by the external, national accreditation body Utilization Review Accreditation Commission (URAC).

### ***Service Area: Wayne County***

#### **PROVIDER ADDRESS CHANGES AND ADDITIONS**

Pro Care must meet its contractual requirements with the State of Michigan to provide continuity of care for our members. Therefore, Pro Care requires providers to notify the Plan in writing as expeditiously as possible when you:

- ❖ Add new office locations or move
- ❖ Change phone/fax numbers
- ❖ Add Physicians to your practice (Physicians that will provide services to Pro Care Members)

***Please notify Pro Care in writing at the following address:***

**Pro Care Health Plan, Inc.  
3968 Mt. Elliott Ave.  
Detroit, MI 48207**








Or you may fax your notice to the Provider Services Department at **(313) 921-0841**

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**PRO CARE WEB SITE** – [www.procarehp.com](http://www.procarehp.com)

The site features the following:

-  Provider Directory
-  Provider Manual
-  Drug Formulary
-  Michigan Quality Improvement Consortium (MQIC)
-  How to submit Claims
-  Quick Reference Authorization Grid
-  Authorization Form

## **PROVIDER INFORMATION DATABASE**

Provider contact information and addresses from the Provider Directory are posted on the Provider Web Site. Members and Providers can locate providers by searching by county, specialty or by name. You may access the website for additional information about Pro Care, its provider network, access medical services and benefits.

## Customer Services

This section provides Member Related Information that will help your office provide services to Pro Care Health Plan, Inc. (Pro Care) members. Trained staff will answer questions and provide information important to members and providers.

Included in This Section are:

- Phone Numbers for the Customer Services Department
- Co-Pays
- Member eligibility information and member rosters
- Member ID cards
- Member PCP assignment/Change
- Where to direct members regarding complaints and appeals
- Member Rights and Responsibilities
- Language Interpretation
- Hearing Impaired

The Customer Services Department is a resource for members and providers. Members are to contact the Customer Services Department for answers to questions, to file a complaint/grievance and to notify Pro Care of a change of address. Please direct members to call the Customer Services Department at (877) 255-3055 or (313) 267-0315, Monday – Friday 8:30am – 5:00pm.

The Customer Services Department will assist Pro Care members with situations that may arise during their membership with Pro Care, including the following:

- Care & Service Delivery Issues
- Enrollment Related issues
- Plan Identification Cards
- Physician Selection or Changes

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## **A RESOURCE FOR PROVIDERS**

Providers are to contact the Customer Services Department for answers to questions or to file a complaint.

### **CO-PAYS**

No co-pays should be collected from Medicaid members. They have no co-pay for primary or specialty care services.

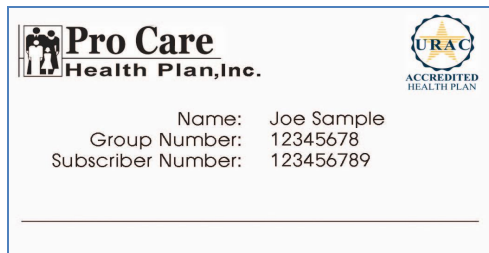
### **MEMBER ROSTER/ELIGIBILITY**

You will receive a Member Roster for the current month. You should receive your member roster on or before the first of each month. You may receive your roster electronically or by mail. If a member does not appear on your roster, it does not mean that the member is not eligible to receive services. If this situation occurs, call our Customer Services Department to verify eligibility and physician assignment.

If you do not receive your Member Roster by the 1st of the month, contact our Customer Services Department at 877-255-3055 or 313-267-0300.

### **MEMBER ID CARD**

Pro Care will issue an Identification Card to the Member. The member must present the Identification Card to Participating Providers each time the member obtains covered services. The Identification Card is the property of Pro Care and Pro Care may request the Member to return an Identification Card at any time. Providers should ask to see the members Pro Care ID card. Any questions about the members' benefits should be directed to Pro Care's Customer Services Department at 1-313-267-0300 (local) or 1-877-255-3055 (toll free).



## **IMPROPER USE OF A PRO CARE MEMBER IDENTIFICATION CARD**

It is against company policy, state and federal law for members to allow another person to use their member ID card. This is considered "FRAUD" and the member who allows fraudulent use of their member ID card can be disqualified from the Plan and may face legal action. Pro Care is bound by state and federal law to monitor and report any fraudulent use of member ID card. Please assist Pro Care by verifying member identity.

If you suspect fraud, please contact Pro Care's Fraud and Abuse Hotline at 313-267-0307.

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## **PCP ASSIGNMENT/CHANGE PROCESS**

At the time of enrollment in Pro Care, the Member chooses his/her PCP from Pro Care's Provider Directory. The Provider Directory lists all Participating Physicians who are primary care Physicians, specialists, ancillary providers and hospitals. If a Member is a minor or otherwise incapable of selecting a PCP, an authorized person may select a PCP on behalf of the Member. An authorized person may select a pediatrician who is a Participating Physician as the PCP for a Member who is a minor. Pro Care will allow a Specialist to be the Member's PCP if it is necessary for the Specialist to manage the Member's medical condition. This might be necessary for a medical condition such as diabetes, end-stage renal disease, HIV/AIDS or other chronic disease or disability. If the member does not choose a PCP at the time of enrollment, Pro Care will automatically assign a PCP by member zip code/location. Plan members will be notified of the auto-assignment and given the opportunity to request a PCP change if they are not satisfied with the auto-assignment.

The Member may change to a different PCP by making a verbal or written request to Pro Care's Customers Services Department. Plan members may request a PCP without cause. PCP change request made before the fifteenth (15th) of the month will become effective the first (1st) of the next month. PCP change request made after the fifteenth (15th) of month will be effective the (1st) of the following month for example

- ❖ Request made before March 15th, Effective date April 1st
- ❖ Request made after March 15th, Effective date, May 1st

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## **Provider Services Department**

This section also includes information regarding contracting and services providers.

Provider Services is responsible for the development and maintenance of the provider network including hospital, practitioner, specialist and ancillary providers. Additional responsibilities of the Provider Services Department are provider recruiting, contracting, contract maintenance and network expansion.

### **PROVIDER DISAFFILIATION**

Pro Care requires a 60 day written notification prior to your disaffiliation date. This will give the plan an opportunity to notify your assigned patients and allow the time to select another provider. This requirement also helps ensure continuity of care for the member.

### **INVOLUNTARY DISAFFILIATION**

The plan may elect under the provisions of the contract to terminate its relationship with a provider. If so, the provider will be afforded an opportunity to appeal any decision by the Plan as outlined in the provider agreement.

### **PROVIDER NOTIFICATION TO DISCONTINUE SERVICE**

Providers should notify Pro Care in writing of their intent to discontinue service to an assigned Plan member.

### **PROVIDER DISPUTES**

It is the policy of Pro Care to provide a process for Provider Dispute Resolution. This policy will be reviewed at least annually with input from participating providers. It is also the policy of Pro Care to provide a mechanism to make available the provider dispute resolution process to all plan providers (Refer to Provider Communication). Additionally, Pro Care will investigate all provider disputes on an expedited basis.

It is the responsibility of Pro Care's Grievance and Appeals Hearing Committee to meet with the aggrieved party (provider) and negotiate in a good faith effort to resolve the dispute. The Hearing Committee will consist of at least three participating network physicians appointed by the Peer Review Committee with at least one of the physicians possessing related specialty expertise as the affected Physician. Appointed Hearing Committee members: must not be in direct economic competition with the Physician involved; must not stand to gain direct financial benefit from the outcome of the matter; must not be current members of the Peer Review Committee; and must not have participated in any manner in the Peer Review's consideration

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of the matter.

If a party perceives the existence of a dispute, the provider shall give written notice to the Plan (Hearing Committee), describing the dispute and a proposed resolution. The parties shall then meet and negotiate in a good faith effort to resolve the dispute.

If the dispute cannot be resolved by negotiation, the parties may, but shall not be obligated to, submit the dispute to a mediator.

Provider Disputes should be submitted to:

**Pro Care Health Plan, Inc.**

**Attn: Provider Services Department**

**3956 Mt. Elliott St.**

**Detroit, MI 48207**

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## Provider Portal

Pro Care Health Plan is expanding its website by launching the Pro Care Provider Portal (P3) section. This will allow providers to status claims and view eligibility on line.

To start using the Pro Care Provider Portal (P3) you must:

1. Select an Administrator.
2. Contact Pro Care for you Administrator account information.
3. Log onto [www.procarehp.com](http://www.procarehp.com)
4. Create users

### **1. SELECT AND ADMINISTRATOR:**

This person should be the office manager or a staff member within the management team.

#### *AS THE ADMINISTRATOR, YOU WILL BE ABLE TO:*

1. Create new users
2. Update users
3. Delete users
4. Change passwords
5. Reset passwords

For security, reasons the administrator login does not have access to status claims or download reports. You must create a user ID for yourself in order to use all the functionality within Pro Care Provider Portal (P3).

### **2. LOGGING ON ADMINISTRATORS**

- Pro Care Health Plan's website is located at [www.procarehp.com](http://www.procarehp.com)
- Enter the Provider Section by clicking on the "providers" icon at the top of the screen.
- Click on the word "Pro Care Provider Portal" on the menu bar.
- P3ID = your provider's tax id  
User Name = Administrator  
Password = As assigned by Pro Care or the password you have chosen  
Click "Login"

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## **3. CREATING USERS**

- Click on the "Admin" icon
- Click on "User Maintenance"
- All user maintenance is done on this screen. All fields are required.

When setting up new users check the Active Account box and select what type of access by checking the Claims Status and/or Reports boxes.

An e-mail will be automatically sent to that new user giving them a temporary password so they can login to the Pro Care Provider Portal (P3). Upon logging in the new user will be prompted to change his/her password.

If all users do not have separate e-mail accounts, you can use one e-mail account for everyone.

When a user leaves your organization or no longer needs access to the Pro Care Provider Portal (P3), the administrator should deactivate the account by unchecking the Active Account box, then click "Update"

## **USEFUL TIPS**

- For best results, access Pro Care Provider Portal (P3) using Internet Explorer 6.0 with a resolution of 1024 x 768.
- All printing should be done in Landscape and not portrait.
- The system will automatically log off if there has been no activity for more than 20 minutes.

## **USER LOGIN**

- Pro Care Health Plan's website is located at [www.procarehp.com](http://www.procarehp.com)
- Enter the Provider Section by clicking on the "providers" icon at the top of the screen.
- Click on the word "Pro Care Provider Portal" on the menu bar.
- WebID = your provider's tax id
- User Name = your user name – assigned by your administrator
- Password = administrator will assign one for first login.

**Click "Login"**

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## **STATUSING CLAIMS**

Once logged in, click on the "Status Claims" icon.

From this point, you have the ability to utilize the following search criteria:

- Any provider pin number within the specified tax identification number
- Claim type, i.e., HCFA or UB92
- Patient Acct #
- Member ID
- Primary date range (only available for a 90 day search)

## **PROVIDER APPEALS**

A standard appeal can be initiated in writing to Pro Care or by telephone call during normal business hours to 313 267-0300 within 180 days of the issuance of the written non-certification determination. A determination will be made within fifteen (15) calendar days of the receipt of the request but no longer than thirty (30) calendar days from initiation of the entire appeals process. Pro Care will take into account all relevant documents, records and any other information submitted by the member, providers and /or facility rendering service without regard to whether this information was submitted for consideration in the initial phase of the case. The Appeal should be submitted to:

**Pro Care Health Plan, Inc.**

**Attn: Appeals Department**

**3956 Mt. Elliott St.**

**Detroit, MI 48207**

## **EXPEDITED REQUEST**

An expedited appeal can be initiated in writing to Pro Care or by telephone call to (313) 267-0300. The completion of the appeal will be as soon as possible, usually 24 hours but no later than 72 hours after the initiation of the appeals process\*.

Note: "Initiation of the appeals process" means that the times frame begins with Pro Care's receipt of the request. For verbal requests, it is the day the call came in; for written requests, it is the date the request arrived via mail. Pro Care will take responsibility for any delay in deliverance of the written appeal to the UM department and count the delay days as part of the allotted time frame.

Providers should request an expedited request when waiting would seriously jeopardize the health of the member. A verbal request by the provider indicating the need for an expedited review can be made by contacting the Customer Services Department at (313) 267-0300 or toll free at (877) 255-3055.

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## **EXTERNAL INDEPENDENT REVIEW (IRO)**

Providers can dispute a decision made by Pro Care on the member's behalf. After the internal process, providers have sixty (60) days to appeal to the Office of Insurance Services (OFIR). OFIR will respond to expedited appeals with seventy-two (72) hours.

## **INTERPRETATION SERVICES**

Members in need of interpretation services should contact the Customer Services Department for assistance at (313) 267-0300 or toll free at (877) 255-3055.

## **HEARING IMPAIRED**

Members in need of assistance should contact Michigan Relay at (800) 432-0762

## **Member Rights and Responsibilities**

### **A PRO CARE MEMBER HAS THE FOLLOWING RIGHTS:**

- ❖ To receive courteous and quality health care, regardless of nationality, race, creed, color, age, sex, economic status or state of health
- ❖ To ask your doctor about any medical procedures or treatments that he/she is going to be doing prior to the treatment
- ❖ To get timely responses from us for your questions, concerns, or complaints
- ❖ To select your own PCP
- ❖ To inspect your medical records
- ❖ To expect the confidentiality of your medical records
- ❖ To refuse to accept treatment
- ❖ To become involved in Pro Care by seeking election as an adult member of the Pro Care Board of Directors

### **A PRO CARE MEMBER HAS THE FOLLOWING RESPONSIBILITIES:**

- ❖ To treat other Members, your doctor, your doctor's office staff, and our staff with respect and dignity
- ❖ To advise your doctor of your medical, family and social history and the signs and symptoms of your medical complaint before and during the course of your care
- ❖ To cooperate fully with the people caring for you and to ask questions when you do not understand your condition or treatment
- ❖ To report the loss or theft of your Pro Care Member ID card immediately and to protect your Pro Care Member card from the fraudulent use by others
- ❖ To notify us of any change in name, address or telephone number, insurance coverage, family circumstances, or employment
- ❖ To notify your PCP or us within 24 hours of receiving emergency care
- ❖ To understand and follow our procedures

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## Health Care Management

### **AUTHORIZATION AND REFERRAL PROCEDURES:**

It is the policy of Pro Care Health Plan (Pro Care) to require a referral form for services rendered to Plan members outside of the PCP's office. Exceptions to this Policy are:

- ❖ Life-threatening emergency services provided in an Emergency Room
- ❖ Family planning services
- ❖ Sexually transmitted disease (STD) services
- ❖ Services provided by Federally Qualified Health Centers (FQHC's)
- ❖ Services provided by public health departments.

Pro Care has a vast network of specialists and ancillary providers. It is **expected that referrals for services are** made to in-network providers whenever possible. The Plan should be contacted for any questions. Questions can be directed to the Provider Services Department or the Utilization Department.

### **PRO CARE CONSULTATION REQUEST FORM**

Pro Care has its own referral request form but will accept the Universal Referral Form for the Medicaid Program.

### **SERVICES REQUIRING CONSULTATION REQUEST FORM**

The following in-network services require a Pro Care Request Form to be issued by the PCP:

- ❖ Allergy Testing
- ❖ Outpatient Radiology - other than at PCP's office
- ❖ Outpatient Diagnostics - other than at PCP's office
- ❖ Podiatry Referrals
- ❖ Chemotherapy
- ❖ Radiation Therapy
- ❖ Certified Nurse Midwife Services
- ❖ Certified Nurse Practitioner Services - other than at PCP's office
- ❖ Outpatient Specialty Physician Consults and Services (other than PCP)  
Including but not limited to:
  - Allergy and Immunology
  - Cardiology
  - Chiropractic Services (limited to 18 visits)
  - Colon/Rectal Surgery
  - Dermatology
  - Endocrinology
  - Gastroenterology

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- Geriatric Medicine
- General Surgery
- Gynecology
- Hematology
- Hand Surgery
- Infectious Disease
- Internal Medicine
- Outpatient Mental Health Visits (20 visit limit)
- Neonatology
- Nephrology
- Obstetrics
- Oncology
- Ophthalmology (excluding vision exams/glasses)
- Oral Surgery (medically necessary and preauthorized by Pro Care)
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatric Specialties
- Plastic and Reconstructive Surgery (medically necessary and preauthorized by Pro Care)
- Pulmonary Disease
- Reproductive Endocrinologist (infertility treatment is not a covered benefit)
- Retinal Specialist
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery
- Other Medical Specialties

## **COMPLETION OF THE REFERRAL FORM**

When the PCP determines the medical necessity of the above services for a Pro Care member, the PCP or his/her designee must complete the Pro Care Health Plan Referral Form. Pro Care has its own referral form, but will accept the Universal Referral Form. It is most important that the referral form be completed in its entirety **AND** is legible. The absence of information (services being authorized, length of time for treatment, name of provider) or a form that is unreadable can result in:

- ❖ Unauthorized or unplanned services being charged to the PCP
- ❖ Denials of claims causing inconvenience to the member as well as the provider.
- ❖ Forms being returned to the PCP for completion which may cause a delay in treatment

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A copy of the Referral form is to be given to the Member, a copy **must** be faxed to Pro Care for data entry, and the original is placed in the medical record. The Utilization fax number is (313) 921-0841.

**IT IS THE RESPONSIBILITY OF THE PRIMARY CARE PHYSICIAN TO ENSURE THE REFERRALS ARE SENT TO PRO CARE. IF A CLAIM IS RECEIVED AND THERE IS NO REFERRAL IN THE SYSTEM, THE CLAIM WILL BE REJECTED.**

Due to potential changes in member eligibility, the Referral Request Form should generally be issued within the same month that the services are rendered (exceptions would include prenatal care and dialysis).

**PCP's should also verify that a member is assigned to them prior to the issuance of a referral. If a referral is issued for a member not assigned to the PCP, it will be charged to their referral fund.**

## **RETROACTIVE CONSULTATION REQUEST FORMS**

The PCP may issue a retroactive referral to a specialist or other provider under **limited** circumstances. If a situation arises where the Member received medical treatment PRIOR to obtaining the PCP Consultation Request Form; **and** the PCP determines that the treatment rendered was reasonable and necessary; **and** the reason for not obtaining prior authorization was valid, a retroactive referral may be issued. **A PCP has the right to refuse to issue a retroactive referral.** When a retro referral is issued, the PCP, or his/her designee should complete the referral form as usual, **indicating the date the services were actually rendered.** If the referral is **not identified as a retroactive referral, it will be entered into the system as of the date received.** Retro referrals should not be issued past 60 days.

## **PRO CARE PRIOR AUTHORIZATION**

### ***Services Requiring Pre-Approval by Pro Care Health Plan<sup>1</sup>***

The following services require Pre-Approval from Pro Care Health Plan. Depending on the circumstance they may require a referral and prescription from the PCP. If there is a question regarding the need for an authorization please contact the Utilization Department at 313-267-0314. Services / equipment issued without an authorization number from Pro Care Health Plan will be denied upon billing.

- ❖ Elective Inpatient Admissions
- ❖ Bariatric Surgery
- ❖ Durable Medical Equipment

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- ❖ Medical Supplies
- ❖ Prosthetics and Orthotics
- ❖ Home Oxygen and Related Supplies
- ❖ Home Infusion Care
- ❖ Home Health Care - RN, PT, OT
- ❖ Hospice Care
- ❖ Hearing Aids
- ❖ Nursing Home Care (Non-Custodial)
- ❖ Transplant Services
- ❖ Any service not covered by Medicaid
- ❖ All out-of-network services (This includes out of state referrals)

## **HOW TO OBTAIN PLAN APPROVAL**

Pre-approval from the Plan for the above services must be obtained by the Member's PCP. (The only exception is for services following an inpatient admission. Those services and referrals will be authorized by Pro Care Utilization / Case Management nurses.) Referrals must be issued (along with all pertinent medical documentation) and sent to the Plan. When a request is approved, the Plan authorization will be issued to the provider of services and the PCP. All such providers requesting direct authorization from the Plan will be referred to the Member's PCP, or the Plan will contact the Member's PCP for information prior to issuing the authorization. **Elective procedures and admissions must be reported to the Plan 72 hours in advance.** Failure to do so may result in unnecessary delays or cancellations of procedures. Requests should be faxed to (313-921-0841)

## **HOSPITAL ADMISSIONS**

When the PCP has a member requiring an **elective** admission, the PCP must contact Pro Care's Utilization Department. The contact can be by telephone or fax. The PCP or his/her designee should provide the following information:

- ❖ Member's Name and Recipient ID Number
- ❖ Name of Provider Being Referred to
- ❖ Address/Telephone number of the Referred Provider
- ❖ Diagnosis and Diagnosis Code
- ❖ Specific services being requested, including procedure code and quantity if applicable.
- ❖ Admission/Appointment Date

The request will be reviewed by the Plan's UR staff and, based on the information provided; the Utilization Services staff will give one of the following responses:

1. Notify PCP that the service is authorized via fax.
2. Request additional information
3. Refer the request for Medical Director's review and approval.

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4. Issue a denial (if done by the Medical Director) with reason for denial.

If requested service is approved, the Utilization Management staff member will issue a Plan authorization number to the hospital on the day of service. **Pro Care does not issue authorization numbers prospectively. Elective admissions that are not pre-approved will be denied.**

*For the PCP's convenience, requests for Plan precertification may be faxed to the Plan.*

### **EMERGENCY TREATMENT AND EMERGENCY INPATIENT ADMISSIONS**

Emergency services, for screening and stabilization where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed, do not need prior approval from the plan.

Emergency admissions require an authorization number from Pro Care. This number is obtained by the hospital the next business day after the admission. Once Pro Care is notified and the admission is approved, based on all information relevant to the member's care and following the admission policy, the PCP is notified of the admission via fax. Pro Care uses nationally accepted criteria as a guideline for authorizing admissions as well as accepted local standards of treatment and medical knowledge. When questions regarding medical necessity for admissions arise, an expert panel of board certified physicians may be contacted. Pro Care does not give financial incentives for the denial of any type of service by the PCP or physician advisors. Financial incentives for decision makers do not encourage decisions that result in underutilization. Decisions are based solely on the appropriateness of care and service and existence of coverage.

### **AMBULATORY SURGERY (SAME DAY SURGERY)**

**Pre-approval from the Plan for services must be obtained by the Member's PCP.** Plan authorizations will be issued directly to the Provider of service. All such providers requesting direct authorization from the Plan will be referred to the Member's PCP, or the Plan will contact the Member's PCP for approval prior to issuing the authorization. **Elective procedures and admissions must be reported to the Plan 72 hours in advance.** Failure to do so may result in unnecessary delays or cancellations of procedures.

### **VISION SERVICES AUTHORIZATION:**

Pro Care members may access vision services directly. Vision services include eye examination (refraction), lenses and frames. Members seeking vision services should be directed by the PCP or the Plan contracted vision provider. A list of contracted Vision Providers is available to members and providers. The vision providers have been instructed to contact the Plan's

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Customer Services department directly for authorization. Referrals for medical eye care (ophthalmology) require the issuance of a Referral form from the PCP.

## **SERVICES THAT DO NOT REQUIRE A REFERRAL FORM OR PLAN PRECERTIFICATION:**

Per the terms of the Plan contract with the Michigan Department of Community Health, the following services do not require any type of prior authorization:

- Emergency Room Services – Screening and Stabilization, Facility and Professional Components
- Family Planning Services at any provider
- STD Services at any provider
- Well-Women exams with a contracted provider
- Well-Child exams with a contracted provider
- Emergency Transportation
- Services provided by Federally Qualified Health Centers
- Services provided by Public Health Departments

Members may access any of the above services directly, without pre approval from the PCP or Pro Care.

## **BEHAVIORAL HEALTH SERVICES**

By our contract with the State of Michigan, Pro Care members are allowed 20 out-patient mental health visits per calendar year. Behavioral Health visits are referral services and are charged against the PCP referral fund. Members can access these services in several ways:

1. Pro Care has contracts with local behavioral health providers that will allow members to call them directly and schedule an appointment. The provider will then contact the Utilization Department for an approval number. A referral is faxed to the provider that includes the PCP information, which facilitates contact between the provider and PCP. Members can be directed to Pro Care's Customer Service for information. The number is 1-877-255-3055
2. PCP's may issue referrals for these services.
3. Referrals are generated for the processing of payments only.

Inpatient behavioral health is not a benefit under the health plan. Members requiring inpatient psychiatric services must be referred by their county community mental health agency. Pro Care Health Plan can assist members or providers in contacting agencies if necessary.

## **SUBSTANCE ABUSE SERVICES ARE NOT A COVERED BENEFIT OF PRO CARE**

Members seeking those services should be referred to the Community Mental Health Department in their county of residence.

# **PRO CARE PROVIDER HANDBOOK**

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## **SKILLED NURSING**

Per contract with the State of Michigan, all Pro Care Health Plan Medicaid members have a limited skilled nursing benefit. This benefit covers inpatient admissions to physical rehabilitative facilities, not substance abuse rehabilitation facilities. Each request for admission is reviewed by the Medical Director or his / her designee for appropriateness of admission, length of stay, etc. Custodial care is not a covered benefit under Pro Care Health Plan. Members needing admission for long-term non-rehabilitative care must be disenrolled to straight Medicaid. The Utilization Department will assist with this process.

## **INCENTIVES**

Pro Care does not give financial incentives for the denial of any type of service by the PCP or physician advisors. Financial incentives for decision makers do not encourage decisions that result in underutilization. Decisions are based solely on the appropriateness of care and service and existence of coverage.

## **UTILIZATION REVIEW PROVIDER APPEAL PROCESS**

Pro Care Health Plan recognizes that participating providers may choose to exercise their right to appeal a utilization management decision. A physician reviewer or other applicable reviewer is available to discuss any health UM denial decision during normal business hours. This may include a physician, pharmacist, or chiropractor.

The appeals process is established to facilitate this right to appeal as follows:

1. If a provider disagrees with a Utilization Management decision, the provider has the right to appeal and must do so within 30 days of receipt of the decision. The provider must make the appeal in writing to the Pro Care Health Plan Medical Director.
2. If there is a specific reason that a provider is unable to supply the additional information within the time allotted (30 days), a 30-day extension will be granted upon written request. The request for extension **MUST** be postmarked no later than 30 days from the initial denial. The extension will be granted for an additional 30 days from the date of receipt.
3. An appeal **must** include new supporting evidence and / or documentation. Portions of the medical record may be submitted, however, the submission of the medical record without an explanation will not be considered for appeal nor will it constitute a request for an appeal.
4. Requests for an appeal of a Utilization Management decision received after 30 days or beyond the granted extension period will not be considered for an appeal.
5. Pro Care Health Plan will accept verbal appeals in emergent situations. These are defined as "health care issues requiring a response from the Medical Director or Associate Medical Director in less than 24 hours."

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6. Upon the receipt of the appeal, the Medical Director or Associate Medical Director will review additional information supplied by the provider and gather other information as needed. The Medical Director or Associate Medical Director may solicit input from the physicians of the Peer Review Committee (or other groups of physicians designated for this purpose) prior to making a decision. No physician may participate in the decision process that could create a conflict of interest.
7. The Medical Director or Associate Medical Director will give the provider an answer in writing within 30 days or less as medical necessity dictates.
8. If the provider disagrees with the decision of the Medical Director or Associate Medical Director, the provider has the right to appeal the decision in writing to the Peer Review Subcommittee. This appeal must be received within 30 days of the denial of the appeal.
9. The Peer Review Subcommittee will review all information, make a determination and inform the provider of its decision within 30 days after the regular scheduled meeting.
10. If the provider disagrees with the Peer Review Subcommittee's decision, the provider has the right to appeal in writing to the Quality Improvement Committee. The appeal must be received within 30 days of the written denial from the Peer Review Subcommittee.
11. The Quality Improvement Committee will review all information and inform the provider of its decision with 30 days of its regularly scheduled meeting. The decision of the Quality Improvement Committee is the final decision.
12. All appeals are tracked and reported to the Quality Improvement Committee. At each level of appeal, the provider is informed in writing of the next step in the appeal process.

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## CLAIMS

### CLAIM SUBMISSION REQUIREMENTS

*To ensure that clean claims are received for timely processing, the following criteria should be met.*

- ❖ Pro Care requires that standard CMS 1500 or UB 04 Claim Form.
- ❖ Specialty physician claims should include a referral form or prior authorization number (s) for payment.
- ❖ Industry standard HCPCS, CPT, Revenue, DRG, and ICD-9 codes should be used when submitting claims to Pro Care for payment consideration.
- ❖ Provider tax ID and NPI numbers must be on the claim forms.
- ❖ Member ID numbers must be accurate and indicated in box 1a of the CMS 1500 and in box 60 of the UB04 claim form.

Claims Mailing Address Requirements

Re-submission of claims for status or correction should have "Status" or "Corrected Claim" indicated on the claim

### **Submit all initial Medicaid claims to:**

**Pro Care Health Plan, Inc.  
Medicaid  
PO Box 3160  
Detroit, MI 48203**

### **ELECTRONIC CLAIM SUBMISSION**

Pro Care is currently accepting claims from Emdeon Clearinghouse. Please submit your claims for payment electronically. This will enhance our ability to process your claims in a timely manner.

When submitting claims electronically through the clearinghouse; please use Payer ID # 70259 for Medicaid claims.

Contact your system vendor or clearinghouse if you have any difficulty submitting electronic claims. For the Billing Provider: in addition to your Federal tax ID; when submitting electronic claims to Pro Care, you must send either your Pro Care assigned Provider ID Number and your Michigan Medicaid Provider ID Number.

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BILLING PROVIDER ID	FORMAT	HARD COPY CLAIM REFERENCE
Pro Care Provider ID	6-9 digits	CMS = Box 33 UB = Box 51
Michigan Medicaid Provider ID	2 digit provider ID type then the 7 digit provider ID number	CMS = Box 33 UB = Box 51
NPI Number	10 digits	CMS = Box 33a UB = Box 76

If you need assistance in identifying your Pro Care Provider ID, please do not hesitate to contact the Customer Services Division at 1-877-255-3055.

## **EXPLANATION OF BENEFITS**

Pro Care forwards providers remittance advice (RA) vouchers as a form of explanation of benefits for claims processed through its system. The RA indicates the document number of the claim processed, member's ID number and service (s) rendered.

Rejected line items are indicated with a zero payment and status code describing the position of the rejection.

Rejected claims with status code requiring a response from the provider should be handled accordingly. It is important to reference the document number from the RA when making an inquiry of a claim.

## **COORDINATION OF BENEFITS**

Pro Care is a Medicaid Health Plan and is always considered the payer of last resort. Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Providers should always ask the member if other insurance coverage exists at the time of service. If the member identifies other insurance coverage, providers must bill that other insurance first.

Providers must secure response (s) from other insurance (e.g., explanation of benefits, denials, etc.) prior to billing Pro Care. If payments are made by another insurance carrier, the amount paid, whether it is paid to the provider or the member, must be reflected on the claim. It is the provider's responsibility to obtain the payment/from the member if the other insurance pays the member directly.

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## **GRIEVANCE & APPEALS PROCESS FOR DENIED CLAIMS**

Pro Care understands that Providers may not always agree with claim payment decisions. Therefore, we provide a process to resolve these issues in a timely manner. All administrative issues must be resolved within 365 days from date of service with supporting documents.

Types of grievances/appeals that can be filed:

- Incorrect benefit
- Underpayment/overpayment
- Rejected due to coding errors
- Fee payment errors
- Remittance advise issues
- Claims not processed within 45 days of received date
- Referral/authorization concerns.

## **WHEN AND HOW TO FILE AN GRIEVANCE/APPEAL?**

- Appeals must be submitted within 60 days of receipt of the date of denial from the Plan. A Provider has the right to appeal a claims payment decision and must do so within 60 days.
- An Appeal must include a cover letter from the physician, supporting documentation (different than the one submitted with the original claim) to justify the need for service that were denied, and a copy of the denial.
- Resubmission of a claim without written supporting documentation requesting an appeal and without indicating the basic for such appeal is not considered an appeal. These will be returned as unprocessed appeals.
- Submission of a copy of the medical record without any reference to an appeal request is not acceptable. These will be returned as unprocessed appeals.

1. You may submit your request and the additional information via:

Fax: **313-921-0841**  
**Pro Care Health Plan**  
**Claims Department – Claims Appeal**

Telephone: **313-267-0313**

2. You may also submit your request and additional information in writing:

**Pro Care Health Plan, Inc.**  
**Claims Department – Claims Appeals**  
**3956 Mount Elliott**  
**Detroit, Michigan 48207**

## Quality Improvement

### **INCLUDED IN THIS SECTION:**

- ❖ Responsibility of Quality Improvement Department
- ❖ Quality Improvement Committee
- ❖ Plan Medical Director Responsibility
- ❖ Pediatric Care and Services
- ❖ Adult Care and Services
- ❖ Preparing for Site Audits
- ❖ Conducting Medical Record Audits

In the interest of assuring the quality of services provided by the Plan, the Provider agrees to participate in the Plan's Quality Improvement Program. Pro Care Quality Improvement Committee will be structured and function as described below:

### **QUALITY IMPROVEMENT COMMITTEE**

The Quality Improvement Committee's responsibility is to set the guidelines for the delivery of services by the Plan and to develop mechanisms for monitoring the quality of these services. The guidelines used by the committee will be governed by standard medical practice in the community as well as the guidelines specified in the respective specialty boards. At the committee's direction, Quality Improvement activities will include but are not limited to:

- ❖ Auditing of medical records
- ❖ Reviewing office procedures
- ❖ Reviewing complaints of Plan members when appropriate
- ❖ Conducting disease specific studies
- ❖ Satisfying HEDIS requirements
- ❖ Working collaboratively with Michigan Department of Community Health (MDCH) and meet the accreditation and regulatory requirements
- ❖ Maintain updated clinical Practice Guidelines through Michigan Quality Improvement Consortium (MQIC) and distribute to provider.

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**The provider shall conduct the Early Periodic Screening Detection Tester (EPSDT) screening by administering the following test and procedures** according to the American Academy of Pediatrics' periodicity schedule and the test/procedure recommendation of the Michigan Department of Community Health.

- ❖ A health history
- ❖ An immunization review and administration of immunizations, when appropriate
- ❖ Measurements for – height and weight, head circumference through age 2, blood pressure
- ❖ A vision test using a preschool vision training card, a stereoscopic instrument, or a test of the provider's choice
- ❖ A hearing test as appropriate for the child's age
- ❖ Audiometer screening.
- ❖ A developmental assessment test.
- ❖ A complete physical examination
- ❖ A dental inspection
- ❖ Collection of blood samples at appropriate ages for:
  - Lead
  - Sickle cell
  - Hematocrit or hemoglobin
- ❖ Urinalysis
- ❖ A nutritional assessment
- ❖ An interpretive conference with the parent or guardian
- ❖ Anticipatory guidance with the parent/guardian
- ❖ A tuberculin (TB) test.

## **CARE OF THE ADULT MEMBERS**

All adult members will received care and service according to Michigan Quality Improvement Guidelines (MQIC)

## **PLAN MEDICAL DIRECTOR**

The Plan Medical Director is responsible for the supervision and management of medical services provided to Plan members. In relation to these responsibilities, the Plan Medical Director or his/her designee will chair the Plan QI Committee.

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## PREPARING FOR THE SITE AUDIT

If patients enrolled in your practice are included in any of the Plan's quality studies you will be informed. Informational letters are sent to the practitioner listing the audits that will be performed. Also included in the letters are the methods by which the reviews will be conducted, i.e., by on-site visit by a Quality Analyst or by request via telephone, mail or fax the data.

The reviewer will contact the practitioner/office manager to arrange an appointment to review medical records. A list of medical records needed for review will be faxed to the office prior to the appointment date. **When possible, several of the audits are combined and performed simultaneously to avoid multiple visits to the practitioner's office.** Unfortunately, it is sometimes impossible for all the required audits to be completed in one visit.

## CONDUCTING THE AUDIT

If data is to be telephoned, mailed, or faxed to the Plan, instructions are given to the practitioner/office manager. Data that is collected via telephone, mail, or fax must include a copy of the requested information so that the data can be verified. If a site visit is required to perform the audit the office is expected to provide an area for the reviewers to work while they collect the required data. We would also prefer the records to have been pulled prior to the reviewer's arrival.



When the data collection is completed, all information is submitted to the QI Director. A quality check is performed for completeness and accuracy for the collection process. The data is then compiled, analyzed, and a compliance rate is determined. The results are reported to the appropriate Pro Care staff, the requesting regulatory agencies, and the practitioners.

## DISEASE MANAGEMENT PROGRAMS

The following Disease Management Programs are provided for members:

- ❖ Diabetes
- ❖ Childhood Wellness
- ❖ Asthma
- ❖ Mommy & Me (Prenatal and Postpartum Care)
- ❖ Smoking Cessation (American Cancer Society (ACS))
- ❖ Positive Healthy Behavior Program – Incentive Program
- ❖ Health Risk Assessment Program
- ❖ Emergency Room Assessment Program

## **CREDENTIALING**

A general overview of the Credentialing/Recredentialing Process

This section provides information regarding the provider credentialing process. The Provider Contracting, Credentialing and Quality Management Departments work cross-functionally to ensure that providers are properly credentialed and contracted.

Included in this section are:

- ❖ Credentialing Overview
  - Credentialing Application and Recredentialing Process
  - Facility Site Review Standards
  - Medical Record Review Standards

### **CREDENTIALING OVERVIEW**

Pro Care credentials and recredentials practitioners/providers who provide services to Plan members. The Plan is dedicated to contracting with high quality institutions, physicians and allied health care professionals to ensure members are receiving quality health care and services. Specifically, the Plan attempts to contract with practitioners/providers who share the philosophy of preventive health maintenance, are willing to participate in membership outreach programs, membership satisfaction enhancement programs, coordination of health care services, assist in the development and implementation of utilization management programs and a willingness to serve on various committees of the Plan.

### **CREDENTIALING PURPOSE**

The purpose of credentialing is to establish and implement the process by which the Plan authorizes to contract with practitioners/providers who are licensed to practice independently to provide services to its' members.

Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, and conformance with the Plan's utilization and quality management requirements. The Plan's decision to contract may also be influenced by such non-credentialing factors as the need for services in the geographic area and the practitioner's fee schedule.

Practitioners and providers applying for participation or reappointment shall not be unlawfully discriminated against because of race, religion, color, sex, age, height, weight, marital status or national origin.

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## **OBJECTIVES**

A solid credentialing/recredentialing program integrated with ongoing quality management/quality improvement helps the Plan to:

- ❖ Determine which practitioners/providers meet the Plan's credentialing standards to become participating members of the Plan.
- ❖ Maintain high standards of provider participation
- ❖ Monitor and trend the performance of the practitioners and providers.

## **SCOPE**

The scope of the Plan's Credentialing Program encompasses credentialing and recredentialing activities for:

### **A. Practitioners**

- ❖ Physicians (MD/DO)
- ❖ Podiatrists (DPM)
- ❖ Optometrists (OD)
- ❖ Chiropractors (DC)
- ❖ Nurse Practitioners
- ❖ Physician Assistants
- ❖ Counselors/Psychiatrist

### **B. Organizational Providers**

- ❖ Hospitals
- ❖ Behavioral Medicine Facilities
- ❖ Home Health Agencies
- ❖ Ambulatory Surgery Centers
- ❖ Skilled Nursing Facilities and Nursing Homes
- ❖ Urgent Care Centers
- ❖ Durable Medical Equipment Suppliers
- ❖ Maternal Infant Health Providers
- ❖ Physical Therapy
- ❖ Vision
- ❖ Laboratory
- ❖ Diagnostic Radiology
- ❖ MIHP

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## **CRITERIA FOR PARTICIPATION**

The Credentialing Department uses nationally developed criterion to determine the qualifications of practitioners applying to the Plan:

- ❖ Current & valid State of Michigan license to practice.
- ❖ Current & valid State of Michigan license to prescribe controlled substance, if applicable
- ❖ Current valid Federal DEA Controlled Substance Registration Certificate, if applicable
- ❖ Current malpractice coverage (minimum amount required by Pro Care is \$100,000/300,000).
- ❖ Graduation from medical or professional school and completion of residency training in practice specialty, as applicable
- ❖ Evidence of American Board certification/qualification. In absence of Board certification/qualification, must have completed residency/fellowship training in practice specialty. (Special note for DPM's: must have completed 2-year residency program)
- ❖ Clinical privileges in good standing at a participating hospital (if applicable). Exceptions include dermatologists, radiologists and chiropractors. Medical doctors with no clinical privileges must have an agreement with a participating physician with privileges at a participating hospital to cover inpatient admissions.
- ❖ Eligible to participate in the Medicaid program with no past or pending sanctions.
- ❖ Successful completion of facility site review (FSR).

## **CREDENTIALING INFORMATION RESOURCES**

The following organizations are queried about verification and histories of professional practitioners: Hospitals, medical schools, graduate training programs, state board of medical examiners, the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Medical Association (AMA), the National Practitioner Data Bank (NPDB), the Office of Inspector General and the Excluded Parties List System.

***The Provider Services Department*** supports the Credentialing Department by assisting with the facility and medical record reviews. To complete the credentialing/recredentialing process and become an affiliated practitioner of the Plan, the Credentialing Specialist or Provider Services Representative will make an appointment with the practitioner to ensure the facility and the medical record documentation meets the standards (see documents listed below) of Pro Care Health Plan and Regulatory and Accrediting agencies.

If a practitioner fails to meet these standards, the Credentialing Specialist will provide the practitioner's office with a letter detailing the areas that did not meet Pro Care's standards. The practitioner will have 30 days to make the necessary changes to correct the deficient

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areas. A follow-up site review will be conducted once the practitioner has made such changes.

1. A facility site review is conducted for all Primary Care Physicians OB/GYN's and Behavioral Health Providers.
2. A facility Site review is completed for each location that the practitioner sees patients.
3. A facility site review must be conducted prior to committee decision.
4. A medical record review is conducted annually once the doctor has seen Pro Care patients.
5. Contact the Credentialing Department with any questions regarding this process at (313) 267-0318.

### **APPLICATION AND RECREDENTIALING PROCESS**

All applicants must complete an application with the appropriate attachments that are validated by the Credentialing Department. Every three years these credentials must be updated and revalidated. The Credentialing Department uses nationally developed criterion to determine the qualification of practitioners re-applying to the Plan for participation as listed below:

1. State License
2. DEA Certificate
3. Liability Coverage
4. Board Certification/If status has changed since last credentialed
5. Malpractice History
6. No Sanctions

### **ADDITIONAL PLAN-SPECIFIC CRITERIA**

7. Hospital Privileges at Participating Hospital (if applicable)
8. No quality of care or quality of service complaints.

### **IF YOU ADD A PRACTITIONER TO YOUR STAFF, YOU MUST NOTIFY THE PLAN**

Pro Care must successfully credential the practitioner before he/she can service the members. Please contact the Provider Services Department for an application.

The completed practitioner applications are presented to the Contracts and Credentialing committee for the following actions/reasons:

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<b>Credentialing:</b>	A new practitioner or provider requesting membership and participating in the Plan.
<b>Recredentialing:</b>	Current active practitioners and providers who are part of the routine periodic recredentialing process for the purpose of reappointment
<b>Termination:</b>	Involuntary due to identified quality issues, when practitioner or provider does not meet Plan standards, when there is a change in Pro Care's need for specialty or provider type and for no cause.
<b>Voluntary:</b>	When a practitioner has decided to stop practicing or has relocated to another area or changed groups.

### **THE COMMITTEE CAN MAKE THE FOLLOWING DETERMINATIONS REGARDING A PRACTITIONER:**

<b>Accept:</b>	All Credentialing criteria and necessary information met Plan standards.
<b>Deny:</b>	All information is available but does not meet Plan standards.
<b>Pend:</b>	Additional information is necessary before reaching a decision.
<b>Terminate:</b>	The plan has received sanction, quality of care, quality of service, disciplinary or some adverse action regarding the practitioner that no longer allows he/she to participate as a provider without jeopardizing patient care and safety.

## FRAUD AND ABUSE

### I. **POLICY:**

Pro Care strives to comply with applicable federal and state fraud and abuse Laws by taking appropriate measures that are reasonably capable of detecting, preventing and/or reducing the occurrence of fraud and abuse by Pro Care Personnel and other agents, contracted and non-contracted health care providers (“Providers”), other Contractors, and Members.

### II. **DEFINITIONS:**

1. **Fraud** is defined as the intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable state and federal Laws. Examples of fraud include, but are not limited to:

- Billing for services not provided;
- Billing for services in a manner other than as actually provided;
- Billing for services which were not medically necessary or provided by an unqualified person;
- Services provided are accompanied by an illegal inducement to utilize or refrain from utilizing a service (kickback); and
- Underutilization and denial of necessary medical care;
- Member using expired ID card;
- Someone other than a Member using an ID card;
- Member’s giving false information to get medical or pharmacy services.

2. **Abuse** is defined as Personnel or Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program.

If you suspect Fraud and Abuse, please contact Pro Care’s Fraud and Abuse Hotline at (877) 255-3055 ext.136. You may also contact The Michigan Department of Community Health Program Investigation Section by calling (866) 428-0005 or you may send a letter to:

Program Investigation Section  
Capital Commons Building  
400 S. Pine St., 6<sup>th</sup> Floor  
Lansing, Mi 48909.