

STATE OF MICHIGAN  
DEPARTMENT OF MANAGEMENT AND BUDGET  
PURCHASING OPERATIONS  
P.O. BOX 30026, LANSING, MI 48909  
OR  
530 W. ALLEGAN, LANSING, MI 48933

January 29, 2008

**CHANGE NOTICE NO. 5**  
**TO**  
**CONTRACT NO. 071B5200162**  
**between**  
**THE STATE OF MICHIGAN**  
**and**

NAME & ADDRESS OF VENDOR  <b>Michigan Peer Review Organization</b> <b>22670 Haggerty Road, Suite 100</b> <b>Farmington Hills, MI 48335-2611</b>  <b>ccieszko@mpro.org</b>	TELEPHONE (248) 465-7377 <b>Colleen Cieszkowski</b>
	VENDOR NUMBER/MAIL CODE <b>(002)</b>
	BUYER/CA (517) 241-4225 <b>Kevin Dunn</b>
Contract Compliance Inspector: Renate Rademacher <b>Hospital Admission Review and Certification Program - DCH</b>	
CONTRACT PERIOD: From: <b>January 1, 2005</b> To: <b>December 31, 2008</b>	
TERMS <b>N/A</b>	SHIPMENT <b>N/A</b>
F.O.B. <b>N/A</b>	SHIPPED FROM <b>N/A</b>
MINIMUM DELIVERY REQUIREMENTS <b>N/A</b>	

**NATURE OF CHANGE(S):**

Effective immediately, the vendor contact for this Contract is hereby **CHANGED** to:

**Colleen Cieszkowski**  
**Interim CEO and Senior Vice President**  
**22670 Haggerty Road, Suite 100**  
**Farmington Hills, MI 48335**  
**Email: [ccieszko@mpro.org](mailto:ccieszko@mpro.org)**  
**Fax: (248) 465-7428**  
**Phone: (248) 465-7377**

All other terms, conditions, specifications, and pricing remain unchanged.

**AUTHORITY/REASON:**

Per vendor and DMB/Purchasing Operations.

**TOTAL REVISED ESTIMATED CONTRACT VALUE REMAINS: \$8,153,803.00**

STATE OF MICHIGAN  
 DEPARTMENT OF MANAGEMENT AND BUDGET  
 PURCHASING OPERATIONS  
 P.O. BOX 30026, LANSING, MI 48909  
 OR  
 530 W. ALLEGAN, LANSING, MI 48933

November 9, 2007

**CHANGE NOTICE NO. 4**  
**TO**  
**CONTRACT NO. 071B5200162**  
**between**  
**THE STATE OF MICHIGAN**  
**and**

NAME & ADDRESS OF VENDOR  <b>Michigan Peer Review Organization</b> <b>22670 Haggerty Road, Suite 100</b> <b>Farmington Hills, MI 48335-2611</b>	TELEPHONE (248) 465-7300 <b>Debra L. Moss, MD</b>
	VENDOR NUMBER/MAIL CODE <b>(002)</b>
	BUYER/CA (517) 241-4225 <b>Kevin Dunn</b>
Contract Compliance Inspector: Renate Rademacher <b>Hospital Admission Review and Certification Program - DCH</b>	
CONTRACT PERIOD: From: <b>January 1, 2005</b> To: <b>December 31, 2008</b>	
TERMS <p style="text-align: center;"><b>N/A</b></p>	SHIPMENT <p style="text-align: center;"><b>N/A</b></p>
F.O.B. <p style="text-align: center;"><b>N/A</b></p>	SHIPPED FROM <p style="text-align: center;"><b>N/A</b></p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;"><b>N/A</b></p>	

**NATURE OF CHANGE(S):**

Effective immediately, this Contract is hereby **INCREASED** by \$1,424,808.00, and **EXTENDED** through December 31, 2008. Furthermore, the attached Work Statement is hereby incorporated into this Contract and replaces all prior work statements. All other terms, conditions, specifications, and pricing remain unchanged.

**AUTHORITY/REASON:**

Per agency request, Ad Board approval (11/6/07) and DMB/Purchasing Operations.

**TOTAL REVISED ESTIMATED CONTRACT VALUE:                   \$8,153,803.00**

**SECTION II  
WORK STATEMENT**

**PART I PACER/LONG TERM CARE PACER**

**A. BACKGROUND STATEMENT**

The Michigan Department of Community Health is the single state agency responsible for health policy, the purchase of health care services, and accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population.

The purpose of this contract is to have a qualified Contractor conduct telephonic/electronic authorization of inpatient services to determine compliance with Medicaid Policy & Guidelines as outlined in the Provider Manuals and Bulletins; and to determine appropriateness of Medicaid coverage for all inpatient admissions utilizing current standards of practice, the Michigan State Plan, and Federal Regulations.

Additionally, a portion of this contract is to provide for the private administration of a state-wide admission review and certification system for Michigan Medicaid long term care programs that must utilize nursing facility level of care criteria. The Contractor will authorize appropriate exceptions to current Medicaid Nursing Facility Policy and Guidelines as outlined in Provider Manuals and Bulletins; determine appropriateness of Medicaid coverage for nursing facility level of care programs (Medicaid covered nursing facility admissions, MI Choice Home and Community Based Waiver Program for the Elderly and Disabled, and the Program for All Inclusive Care for the Elderly and Disabled); and provide analytical reports regarding long term care utilization.

The contract shall be for three years beginning January 1, 2005 through December 31, 2007 with the option of two yearly extensions.

**B. OBJECTIVES**

1. MDCH seeks a Contractor to perform a telephonic/electronic authorization in compliance with Medicaid Program Policy and Procedure. This inpatient authorization will be conducted on Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries includes ABW population through 2-28-2005. For long-term care, the review will be conducted on Medicaid Fee For Service, and possibly Medicare/Medicaid beneficiaries.

2. The Contractor will conduct the following reviews:

- a. Inpatient Prior Authorization –PACER (Prior Authorization Certification Evaluation Review)-telephonic/electronic for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries. MDCH anticipates approximately 10,800 calls annually.

8/28/2007

b. Long Term Care Immediate Reviews and Long Term Care Exception Reviews-telephonic/electronic reviews for exceptions to Michigan Medicaid Nursing Facility Level of Care Determination for Medicaid beneficiaries and MI Choice Waiver and Program Of All Inclusive Care For The Elderly (PACE) participants. MDCH anticipates approximately 2,000 requests annually.

3. The following are the mandatory elements for the program, the Contractor is not, however, constrained from supplementing this listing with additional steps, sub tasks or elements deemed necessary to permit the development of alternative approaches or the application of proprietary analytical techniques:

- a. Responsibility for the authorization must be implemented no later than the first day of this contract.
- b. This process shall be continued through the contract termination date.
- c. The telephone/computer system shall be available from 8AM-5PM Monday through Friday except for State approved/sanctioned holidays.
- d. Providers will be notified 30 days prior to an approved holiday.
- e. The Contractor must be HIPAA compliant.
- f. Telephonic/Computer Electronic system must be in place the first day of the contract.
- g. The Contractor must be available for the Appeals Process.
- h. The Contractor must have a system or process in place that allows the validation of the PACER authorizations:
  - i. Assigned PACER numbers.
  - ii. Documentation provided at the time of PACER request.
    - aa. Review Coordinator documentation.
    - bb. Physician Reviewer documentation.
- i. The Contractor must have a system or process in place that allows the validation of LTC Immediate Review and LTC Telephonic Exception Review.
  - i. Review Coordinator documentation and summary.

4. A copy of the information received from the provider at the time the PACER authorization was requested will be validated by the Contractor. The information received from the provider for PACER authorization both approvals and denials, including the Review Coordinator's and Physician's documentation, must be stored electronically or via hard copy.

8/28/2007

5. A copy of the information received from the provider at the time the LTC Immediate review was requested will be validated by the Contractor. The information received from the provider for the LTC Immediate review, including Review Coordinator's and Physician's documentation, must be stored electronically or via hard copy.
6. A copy of the Review Coordinator's summary for the LTC Telephonic Exception review must be stored electronically.

### **C. INPATIENT PRIOR AUTHORIZATION-PACER-TELEPHONIC/ELECTRONIC REVIEW PROCESS**

1. Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.
2. The Contractor shall provide the telephone/computer prior authorization system, (PACER), that shall include, at a minimum, all of the following:
  - a. clinically experienced Registered Nurses to receive the authorization request, elicit all relevant information and reach an initial decision based on admission criteria approved by MDCH;
  - b. use of appropriately qualified physicians to assist the Registered Nurses in their decision as appropriate, to query requesters in all questioned requests and render all denial determinations;
  - c. render and communicate by telephone/electronic computer system all authorization decisions on the same day requested;
  - d. generate and communicate to the requesting provider a unique identifying authorization number for each authorized case; and
  - e. data processing storage and retrieval of all requests, i.e., documentation and disposition, requesting providers, and other information taken in by the system as part of the request for prior authorization.
  - f. the Contractor will maintain a toll-free telephone number and electronic computer system for the providers to request an authorization number. The Contractor shall answer all incoming phone calls promptly with average time to answer of less than ninety (90) seconds.
3. The PACER system shall certify as appropriate for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries: all elective inpatient hospital admissions; all re-admissions within 15 days; all transfers between hospitals and between units within a single hospital having different Medicaid ID/National Provider Identifier/Taxonomy Code numbers or provider types; all admissions and continued stays for inpatient rehabilitative facilities.

8/28/2007

4. The basis of the decisions shall include the medical need and appropriateness of the following:

- a. the condition to be treated on an inpatient basis;
- b. to have treatment continued for rehabilitative facilities;
- c. to be treated at another hospital if already hospitalized;
- d. to be re-hospitalized.

Denials for inpatient admissions and any changes to the request shall be transmitted to the MDCH. The Contractor must send a negative action letter to the beneficiary developed by the State Administrative Tribunal to Medicaid and Medicaid/CSHCS dually enrolled beneficiaries utilizing the appropriate denial statement. The beneficiary will be notified of a denial of services for an elective admission. Transfers and readmissions within 15 days do not need a letter to the beneficiary as no services were suspended, terminated or reduced. An appeals form (DCH-092 Hearing Request) (See Part III, Attachment E) provided by the State must accompany the negative action letter to the beneficiary. The negative action letter and appeal form must be sent to the beneficiary the day of the negative action. Copies of all negative action letters shall be sent to the MDCH Contract Administrator on a monthly basis.

Providers are notified verbally at the time of the telephonic/computer request and given appeal rights verbally at the same time.

5. It is essential that the prior authorization number comply with the following composition in order to integrate with the MDCH computer system:

Nine-digit number:

The first four digits are the Julian date; and the last five digits are the beneficiaries ID number coded into the prior authorization master report numbers by formula. The requester for the authorization number supplies the beneficiaries ID number. The listing for the prior authorization master report numbers can be supplied by the MDCH.

The payment system reads the authorization numbers, compares information, pends the inappropriate claims for various reasons by edits.

6. The Contractor shall develop a process for PACER and it must include:

- a. The review is initiated by the attending physician or designated other, by telephone or electronically, requesting prior authorization for a patient's elective admission, a transfer, readmission within 15 days, or continued stay for inpatient rehabilitative facilities. The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all prior authorization requests including the negative action letter.

b. In a transfer/readmission within 15 days (to another hospital) should the transferring physician not obtain an authorization as required, the receiving physician or second hospital may request this before the beneficiary is discharged.

c. Any case request must include at the minimum; beneficiary ID number, sex, birth date, county of residence, procedure code, hospital name, transfer code (transfer, readmission, urgent/emergent/elective), discharge date of first admission, justification code (reason for admission), and patient's name (required for physician advisor referrals).

7. If the Severity of Illness/Intensity of Service (SI/IS) admission criteria approved by MDCH and/or Policy are met, the Contractor's nurse approves the admission and a nine-digit prior authorization number is issued to the physician. The number is valid for 30 days and must be entered on both the physician and hospital claims for the admission.
8. If the criteria screens are not met or if there are any questions requiring medical judgment, the case shall be referred to a Contractor's physician consultant by the Contractor's nurse. The Contractor's physician consultant may confer by telephone with the attending physician. Ninety eight percent, (98%), of referral cases must be resolved, either approved or denied for Medicaid coverage by the Contractor during the same day of the request. All cases must be resolved within one working day of the request. Cases approved by the physician will be considered complete. The Contractor will report all adverse determinations to the MDCH after the reconsideration process is completed.
9. The Contractor shall have a process to reconsider denials of all PACER reviews at the request of the provider. At a minimum, the process must include:
  - a. Reconsideration must be requested by the provider within three (3) working days of receipt of the denial.
  - b. The Contractor will provide a reconsideration of adverse determinations upon written request from the provider(s).
  - c. All reconsideration's will be conducted by a like specialty physician (when applicable) who will consider the entire medical record and all additional written information supplied by the provider who performed the services. The Contractor must complete reconsideration decisions for elective admissions (excluding rehab) and retrospective PACER requests within thirty (30) working days. The Contractor must complete reconsideration decisions for all transfers, rehab admissions and continued stay within one (1) working day of receipt of the request or the date of receipt of written documentation.
  - d. The Contractor shall have a two step review process to review all denials at the request of the hospital or physician. The original request if denied by the Contractor review coordinator (RN) goes to the Contractor physician for review. If denied, the provider is verbally told of the denial and given appeal (reconsideration) rights. The second request (reconsideration) is submitted

8/28/2007

via a Request for Retrospective PACER Review form, (this may include a complete medical record), with a detailed description of the case including case specific information. If denied, the provider is informed verbally that they may appeal to MDCH.

e. Whenever possible the Contractor shall match the reviewing physician specialty with that of the attending physician's. After the initial denial, by the first physician, the affected parties would have a right to reconsideration by a second physician.

10. Should the provider request an appeal of a denied PACER from the Contractor they may appeal to MDCH. The provider is to submit the medical record, for review to the MDCH Office of Medical Affairs. The Office of Medical Affairs will make the determination. Should the denied service be overturned, than a PACER number will be authorized by MDCH and assigned by the Contractor. Should the case be upheld by the Office of Medical Affairs, then a letter of denial will be sent by the Contractor. The MDCH Contract Manager will notify the Contractor of the PACER decision verbally and follow-up with a faxed memo. Provider appeals to the MDCH will be conducted so that whenever possible, multiple claim appeals from an individual provider will be heard together.
11. For the inpatient rehabilitative facility, inpatient stays beyond 30 days in the rehabilitation hospital require additional inpatient authorization. The provider must contact the Contractor between the 27<sup>th</sup> and 30<sup>th</sup> days if the stay is expected to exceed 30 days. If the extended stay is approved, a nine-digit certification is issued to the provider. If the stay is expected to exceed 60 days, the provider must call the Contractor between the 57<sup>th</sup> and 60<sup>th</sup> days of stay for additional inpatient authorization. If the additional extended stay is approved, the Contractor will issue another nine-digit authorization number to the provider. For any case not meeting admission criteria approved by MDCH, the Contractor's nurse shall refer the case to the Contractor's physician consultant. The remainder of the review and approval/disapproval process follows that of the PACER review. Any authorization denial of any extended stay review point terminates Medicaid coverage of the hospital stay.
12. The Contractor must have available or be able to develop software compatible with any electronic prior authorization system to be designed by MDCH.
13. Complete data for all requests shall be individually stored and retrievable by the Contractor for six years.
14. The Contractor must be able to provide MDCH access to the PACER Program by a means determined by MDCH within one month of startup.
15. All documents and/or information obtained by the Contractor from the Department in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the Department.
16. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing data prior to the start of this Contract.

8/28/2007

**D. Inpatient Hospital and Long Term Care Immediate Review NOTICE OF NON-COVERAGE EXCEPTION Process**

**1. Inpatient Hospital:**

The hospital inpatient program utilization review committee may issue a notice of non-coverage to the patient if it determines that the admission or continued stay in the hospital or nursing facility is not medically necessary.

If the patient or patient representative disagrees with the notice, the patient or representative may contact the Contractor to appeal the decision. If the Contractor has previously issued an adverse determination for the period of hospitalization covered by the notice, the Contractor informs the patient of concurrence with the hospital decision. If the Contractor has not previously issued an adverse determination for the period, a review of the medical record is conducted. The Contractor contacts the hospital program to obtain a copy of the medical record. A Contractor physician advisor reviews and issues a decision on the case within three days of the receipt of the final determination and the related documentation. The Contractor will provide the written decision along with the Appeal Process if the Contractor agrees with the hospital provider.

If issued, the notice is the responsibility of the hospital/nursing facilities utilization review committee and is not related to any decision that may have been rendered by the Contractor on the case. The decision must be based on the findings of the utilization review committee and not on the determination of the Contractor.

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal provides an administrative hearing to appellants requesting a hearing who do not agree with a decision made by MDCH or a MDCH contracted agency (i.e., any agency, organization, or health plan contracted by the MDCH) that either determines eligibility for a department program, or delivers a service provided under a department program to a beneficiary, patient or resident. The Administrative Tribunal issues timely, clear, concise and legally accurate hearing decisions and orders. The Administrative Tribunal Policy and Procedures Manual is located on the website [Michigan.gov/mdch](http://Michigan.gov/mdch), click on links to Inside Community Health, Policy and Legal Affairs, Administrative Tribunal. This website explains the process by which each different type of case is brought to completion.

**2. Long Term Care Immediate Review Process:**

- a. Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.
- b. The Contractor shall provide an Immediate Review when the program/provider has issued an adverse/adequate action notice to the beneficiary and the beneficiary/beneficiary representative has requested

an Immediate Review before noon of the first business day following receipt of the action notice.

- c. The Contractor's clinically experienced Registered Nurses shall provide Immediate Reviews upon request of the ineligible beneficiary/beneficiary representative as follows:
  - i. clinically experienced Registered Nurses shall receive the Immediate Review request by telephone or in writing from the beneficiary/beneficiary's representative and shall perform, at a minimum, all of the following:
    - o elicit all relevant medical documentation (medical records for up to the past 60 days, including physician and nursing progress notes, skilled therapy notes, plan of care, physician orders and logs identifying risk, services or therapy days, and the most current MDS (nursing facilities and PACE) or most current MDS-HC (MI Choice Waiver);
  - ii. complete all required fields in the Contractor's portion of the online Michigan Medicaid Nursing Facility Level of Care Determination
    - o Exception or Immediate Review
    - o Provider Call Date and Time
    - o NRC ID
    - o Information Summary
    - o Determination Date and Time
    - o RC ID
    - o Denial Upheld or Approved
    - o Approval Code (if Approved)
    - o Final Denial Letter Date (if Denied) (See Section II, Part III, Attachment C-D)
  - iii. reach a determination based on current Nursing Facility Level of Care Exception criteria within three business days of receiving medical documentation;
  - iv. notify the provider and the ineligible beneficiary of the Immediate Review determination on the date of the determination:
    - o A determination of 'ineligibility' shall be issued in writing to the beneficiary/beneficiary's legal representative by way of an Adequate (does not meet criteria, See Section II, Part III, Attachment C) or Advanced (no longer meets criteria, See Section II, Part III, Attachment D) Action Notice. The notices shall include appeal rights. The Adequate and Advanced Action Notices shall include language from MDCH Adequate and Advanced Action Notice sample letters in Section II, Part III, Attachments C and D. An appeals form (DCH-092 Hearing Request)(See Section III, Part

8/28/2007

- III, Attachment E) provided by the State shall accompany the Adequate and Advanced Action Notices.
- A determination of 'ineligibility' shall be issued to the Provider telephonically within three business days of receiving medical documentation.
  - A determination of 'eligibility' shall be issued telephonically to the beneficiary/beneficiary's legal representative and to the Provider.
- v. The Contractor shall maintain a toll-free telephone number for providers and beneficiaries to request an Immediate Review. The Contractor shall answer all incoming phone calls promptly with average time to answer of less than ninety(90) seconds.
- d. The Contractor shall not perform an Immediate Review under the following conditions:
- An Exception Review or Retrospective Review has been conducted based on the same beneficiary's Michigan Medicaid Nursing Facility Level of Care Determination and/or review period;
  - An ineligible Michigan Medicaid Nursing Facility Level of Care Determination does not exist in the online database for the same beneficiary under the same provider/program;
  - If the Provider has not issued an Adequate or Advanced Action Notice to the beneficiary/beneficiary's legal representative;
  - If the MI Choice Waiver program participant has received an Adequate Action Notice addressing **only** the **suspension** or **reduction** of MI Choice Program **services** and the suspension or reduction does not terminate the participant's eligibility in the MI Choice Waiver program;
  - If the Michigan Medicaid Nursing Facility Level of Care Determination was conducted for residents/participants who are not Medicaid eligible or Medicaid Pending beneficiaries.

#### **E. LONG TERM CARE EXCEPTION (TELEPHONIC) REVIEW PROCESS**

1. Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.
2. The Contractor's clinically experienced Registered Nurses shall provide telephonic Exception Reviews upon request of the provider/program who has determined the beneficiary to be ineligible as follows:

8/28/2007

- a. clinically experienced Registered Nurses shall receive Exception Reviews by telephone. The Contractor shall answer all incoming calls promptly with average time to answer of less than ninety (90) seconds;
  - b. the Exception Review may include all of the following medical information:
    - i. all relevant medical information, verbally (medical information for up to the last 60 days, which may include physician and nursing progress information, skilled therapy information, plan of care, physician orders and logs identifying risk, services or therapy days, and information from the most current MDS (nursing facilities and PACE) or most current MDS-HC (MI Choice Waiver);
  - c. complete all required fields in the Contractor's portion of the online Michigan Medicaid Nursing Facility Level of Care Determination:
    - i. Exception or Immediate Review
    - ii. Provider Call Date and Time
    - iii. NRC ID
    - iv. Information Summary
    - v. Determination Date and Time
    - vi. RC ID
    - vii. Denial Upheld or Approved
    - viii. Approval Code (if Approved)
  - d. reach a determination based on current Nursing Facility Level of Care Exception criteria within twenty-four hours of the provider/program's call date/time;
  - e. notify the provider of the Exception Review determination telephonically on the date of the determination:
    - i. a determination of 'ineligibility' shall be issued to the Provider telephonically.
    - ii. a determination of 'eligibility' shall be issued to the Provider telephonically.
  - f. the Contractor shall maintain a toll-free telephone number for providers to request a telephonic Exception Review. The Contractor shall answer all incoming phone calls promptly with average time to answer of less than ninety (90) seconds.
3. The Contractor shall not perform an Exception Review under the following conditions:

8/28/2007

- a. An Immediate Review or Retrospective Review has been conducted based on the same beneficiary's Michigan Medicaid Nursing Facility Level of Care Determination and/or review period;
- b. an ineligible Michigan Medicaid Nursing Facility Level of Care Determination does not exist in the online database for the same beneficiary under the same provider/program;
- c. if the MI Choice Waiver program is addressing **only** the **suspension** or **reduction** of MI Choice Program **services** and the suspension or reduction does not terminate the participant's eligibility in the MI Choice Waiver program;
- d. if the Michigan Medicaid Nursing Facility Level of Care Determination was conducted for residents/participants who are not Medicaid eligible or Medicaid Pending beneficiaries.

#### F. APPEALS PROCESS:

##### 1. PACER Appeals:

Only after the internal appeals have been exhausted may any appeal be made directly to the MDCH. When such an appeal is made, the Contractor will provide the written reports, and make direct testimony available to the MDCH as the MDCH deems necessary.

The MDCH allows the provider the right of appeal through the Medicaid Provider Reviews and Hearings Administrative Rules MAC (R400.3401-400.3425) under the authority conferred on the Director of MDCH by Sections 6 and 9 of Act No. 280 of the Public Acts of 1939. The Contractor shall provide sufficient staff including RNs/Physicians for participation and testimony in the MDCH appeals process. This involvement shall begin at the Bureau Conference level and continue as required through the Administrative Law Judge (ALJ) level or until the provider has accepted a final decision of the case.

The Contractor will make decisions that may result in an appeal to the State. The Contractor must notify the Medicaid beneficiary in writing of any adverse action, i.e., denial, reduction, or termination of services and their appeal rights, when such denial, reduction, or termination results from the Prior Authorization process. (See Section II, Part III, Attachments A-B.) The Department's Administrative Manual, Hearings and Appeals Section, contains the Department of Community Health's policies and procedures regarding administrative hearings. The Contractor must comply with this policy and all relevant federal regulations and state statutes. The Contractor shall prepare the hearing summary for all requests for hearings involving fee for service beneficiaries covered by this contract. The Contractor shall be solely responsible for presenting its position at the beneficiary's administrative hearing. The Contractor shall present the hearing summary and testify at all hearings involving the Department's fee-for-service beneficiaries covered by this contract.

8/28/2007

## 2. Long Term Care Appeals:

### a. Beneficiary Appeals

An ineligible beneficiary may appeal directly to the MDCH, and/or request an Immediate Review from the Contractor after an adverse action notice has been issued by the provider, and within the guidelines stated in the provider's Adverse Action Notice. When an MDCH appeal is made, the Contractor will provide the written reports and make direct testimony available to the MDCH as the MDCH deems necessary.

The provider may request an Exception Review on behalf of the ineligible beneficiary without issuance of an adverse action notice to the ineligible beneficiary. If an Exception Review was conducted by the Contractor, then an Immediate Review may not be conducted by the Contractor if the Immediate Review is for the same LOCD for the same period.

The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all prior authorization/Immediate and Exception Review requests including the negative action letter(Adverse and Adequate Action Notices). The Contractor must send a negative(Adverse) action letter(Notice) to all persons determined ineligible by the Contractor based on the Immediate or Exception review criteria who were seeking Medicaid coverage in one of the above listed FFS Long Term Care Programs utilizing the appropriate denial statement. (See Section II, Part III, Attachments C-D).

An appeals form (DCH-092 Hearing Request) (See Section II, Part III, Attachment E) and addressed stamped envelope provided by the State must accompany the negative(Adverse) action letter(Notice). The negative(Adverse) action letter(Notice) and appeal form must be sent to the Beneficiary the day of the negative action. Copies of all negative(Adverse) action letters (Notices) shall be stored by the Contractor and be available upon request.

## G. SANCTIONS

### PACER

Sanctions will be imposed based on the results of the monthly billing validation conducted by the MDCH Contract Manager and the PACER validation performance review conducted as part of the Inpatient Audit process. The penalty will be determined by the number of incorrect authorizations; authorizations by telephone/electronic computer system not completed in a timely manner; telephone response time with average time to answer greater than 90 seconds (See Section II, Part I, C, 2f).

The MDCH Contract Manager reserves the right to change the PACER validation process with thirty (30) day notice to the Contractor. The MDCH Contract Manager also reserves the right to change the PACER review process or cancel the Contract with thirty (30) day notice to the Contractor.

8/28/2007

Monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction shall be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the MDCH shall give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions.

1. Number of Incorrect Authorizations. With the beginning of this Contract, if the Contractor inappropriately authorizes inpatient admissions, transfers, readmissions within 15 days, and continued stay for rehabilitative facilities, then the MDCH will give written notice to the Contractor of the number of Incorrect Admissions by fax, (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor shall have ten (10) calendar days following the notice in which to submit a corrective action plan. If the corrective action plan has not been submitted within ten (10) calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than \$10,000. At the end of each subsequent ten (10) day period in which the corrective action plan has not been submitted, the Department may, without further notice, impose further sanctions of \$10,000.

In addition to the above, beginning April 1, 2005, additional sanctions will begin. If greater than ten (10) PACER authorizations per audit are determined to be inappropriately authorized during the PACER validation conducted by MPRO during the audit process, the Contractor will be sanctioned the amount of the hospitalizations approved in error.

2. Authorization Process not completed in a timely manner. (Section II, Part I, C, 2c). Upon review by the MDCH Contract Manager, if authorizations from the previous month are not completed in a timely manner, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

3. Telephone response time. If telephone response time is greater than 90 seconds for two consecutive months, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

4. Based on the monthly billing validation performed by the MDCH Contract Manager, (part of the PACER validation that MDCH reviews monthly via the complete listing of all PACER activity the previous month), if 10% of the PACER determinations for inpatient elective admissions, transfers, and readmissions within 15 days are incorrect, \$10,000 or the amount of the dollars for the hospitalization, whichever is less, will be taken back from the Contractor. MDCH selects a random sample of PACER validations of the previous month PACER activity. The selection by MDCH is random, i.e., if the number for validation was

8/28/2007

40 PACER cases then 10% would be 4. The number of cases to be selected on a monthly basis is determined by MDCH.

#### LONG TERM CARE

Sanctions will be imposed based on the results of the monthly billing validation conducted by the MDCH LTC Contract Manager. The penalty will be determined by the number of incorrect Immediate and Exception Review determinations; determinations not completed in a timely manner; telephone response time with average time to answer greater than 90 seconds (See Section II, Part I, E, 2f).

The MDCH Contract Manager reserves the right to change the LTC validation process with thirty (30) day notice to the Contractor. The MDCH Contract Manager also reserves the right to change the LTC review process or cancel the Contract with thirty(30) day notice to the Contractor.

Monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction shall be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the MDCH shall give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions.

1.Number of Incorrect Immediate and Exception Review determinations. With the beginning of this Contract, if the Contractor inappropriately determines LTC admission or enrollment, then the MDCH will give written notice to the Contractor of the number of incorrect admissions by fax, (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor shall have ten (10) calendar days following the notice in which to submit a corrective action plan. If the corrective action plan has not been submitted within ten (10) calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than \$10,000. At the end of each subsequent ten (10) day period in which the corrective action plan has not been submitted, the MDCH may, without further notice, impose further sanctions of \$10,000.

2. Immediate and Exception Review process not completed in a timely manner. (Section II, Part I, D, 3d; and E, 2d). Upon review by the MDCH Contract Manager, if authorizations from the previous month are not completed in a timely manner, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

3.Telephone response time. If telephone response time is greater than 90 seconds

8/28/2007

for two consecutive months, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

## **H. REPORTS**

### **PACER:**

Reports shall be provided electronically to the contract manager weekly, monthly, quarterly, and annually. They shall include: number of cases reviewed; number review coordinator approved, number referred, and number of cases denied; number of cases physician approved, and denied; number of reconsideration cases; number of reconsideration cases overturned and upheld; number of net denials and percent of denials; number of cases appealed, number of appealed cases overturned and upheld.

The Contractor shall report by percentage and whole numbers all telephone calls where the provider remains on hold greater than 90 seconds. The Contractor shall report, by percentage, the numbers of calls not completed in a timely manner.

The Contractor shall provide Inter-rater Reliability Reports to the Department of Community Health on a quarterly basis. The Inter-rater Reliability Report is a validation of employee internal monitoring performed by the Contractor. Inter-rater instructions as well as the process for the review are required. One actual example of a report identified for each part of the Program is requested (PACER, Inpatient Audits, Outpatient Audits).

### **Long Term Care:**

Reports shall be provided electronically or by mail to the LTC Contract Manager monthly, quarterly and annually. For Immediate and Exception Reviews, they shall include: number of Exception Reviews and Immediate Reviews performed, of those, the number approved and the approval code, the number denied, copies of the denial letter and the documentation used in the Immediate Reviews; the number of reviews appealed. For Retrospective Reviews, they shall include: the number of retrospective reviews performed; the number of retrospective reviews overturned and upheld; the number of net denials and percent of denials and copies of the denial letter; the number of retrospective reviews denials appealed, number of appealed cases overturned and upheld.

The Contractor shall report by percentage and whole numbers all telephone calls where the provider remains on hold greater than 90 seconds. The Contractor shall report, by percentage, the numbers of calls not completed in a timely manner.

## **I. QUALIFICATIONS OF CONTRACTOR'S STAFF FOR PACER/LONG TERM CARE PACER**

### **1. Staff Requirements**

- a. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing/licensure prior to the start of this Contract. Attestation of licensure will be required at the end of each year

8/28/2007

thereafter. In addition, proof of licensure will be sent to the State at time of hire for all new employees where licensure is required. The Registered Nurse Reviewers must report directly to an RN who must report directly to an RN. Necessary substitutions due to change of employment status and other unforeseen circumstances may be made with prior notification to the MDCH and for employees with the same licensure (i.e., RN replaces RN). If the replacement does not have the same licensure prior authorization is required by the MDCH.

b. The Contractor shall utilize Registered Nurse Reviewers who demonstrate knowledge of Inpatient Hospital admission criteria approved by MDCH and Nursing Facility Level of Care Exception Criteria. The Registered Nurses performing the PACER authorization cannot perform the audit/Statewide Utilization Review and Long Term Care Immediate and Exception review functions; MDCH expects the Contractor to designate separate staff for each. The Registered Nurses performing the LTC Immediate and Exception Reviews cannot perform the Retrospective review and PACER functions; MDCH expects the Contractor to designate separate staff for each.

c. The Contractor shall be staffed by Physician Reviewers with expertise in the areas listed above and to participate in the PACER/Long Term Care PACER authorization process.

## 2. Other Requirements

a. The Contractor shall maintain all reporting requirements established by the MDCH (See Section II, Part I, H, Reports).

b. The Contractor shall maintain a positive working relationship with Providers of medical care and Provider Organizations.

c. The Contractor shall maintain confidentiality of Provider/Beneficiary information and provide the MDCH with its confidentiality policy and procedure.

d. Should the Contractor be a vendor from a State other than Michigan, the Contractor's Project Manager and staff must have an office located in the Greater Lansing Area.

## J. CONTRACT MONITORING

### PACER

The MDCH PACER Contract Manager will review the following reports: number of cases reviewed; number review coordinator approved, number referred, and number denied; number physician approved, and denied; number reconsideration cases; number reconsideration overturned and upheld; net denials number and percent of denials; number of abandoned calls, number of PACER calls, number of informational calls. The Contract Manager shall also review that the date and time of the request, approval, or denial was within the timeframes mentioned in Section II, Part I, C & F, Review Process. The Contractor shall meet/teleconference with MDCH contract management at least weekly during the first month of the contract and at least monthly for the remainder of the contract to review the above reports.

8/28/2007

At least once per contract year MDCH will complete a yearly site visit of the Contractor to monitor work in progress. If the Contractor is in/out of the State of Michigan, the monitoring will occur at the Contractor site. All travel, lodging and meal expenses for up to two (2) State of Michigan employees shall be paid by the Contractor for this yearly review should the Contractor be in/out of the State of Michigan.

The MDCH Long Term Care Manager will review long term care reports as defined in Section II, Part I, H, Reports.

#### **LONG TERM CARE**

The MDCH LTC Contract Manager will review the following reports: number of Immediate and Exception Reviews performed; number approved and the approval code, number denied; number of Retrospective reviews performed; number overturned and upheld; net denials number and percent of denials; number of abandoned calls. The Contract Manager shall also review that the date and time of the request, approval, or denial was within the timeframes mentioned in Section II, Part I, C & F, Review Process. The Contractor shall meet/teleconference with MDCH contract management at least weekly during the first month of the contract and at least monthly for the remainder of the contract to review the above reports.

#### **K. PAYMENT SCHEDULE**

The payment schedule will be based on the number of PACER reviews ,LTC Immediate and Exception reviews, LTC Retrospective reviews and LTC Appeal Process with an RN and PACER Appeal Process with RN and Physician (telephonic/electronic) completed the previous month. The Contractor is required to be available at all appeal levels. The Contractor's nurse reviewer/physician reviewer, (if applicable), must be available to testify as to the results of the PACER or LTC review at any preliminary or bureau conference; administrative hearing or judicial proceeding.

#### **L. FRAUD AND ABUSE**

The Contractor shall report suspected fraud, and/or abuse by PACER and LTC Medicaid beneficiaries and/or providers to the MDCH Program Investigation Section. The report shall detail the provider, beneficiary and all information on the situation. The link to information regarding fraud and abuse and how to report it is located on the website [michigan.gov/mdch](http://michigan.gov/mdch), click on the links to inside Community Health, and Fraud and Abuse.

### **PART II AUDITS/STATEWIDE UTILIZATION REVIEW AND LONG TERM CARE RETROSPECTIVE ELIGIBILITY REVIEWS**

#### **A. BACKGROUND STATEMENT**

The Michigan Department of Community Health is the single state agency responsible for health policy, the purchase of health care services, and accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population.

8/28/2007

The purpose of this contract is to have a qualified Contractor conduct audits/utilization review of inpatient services, outpatient services, and emergency room services; and LTC Retrospective reviews for the Michigan Medicaid Nursing Facility Level of Care Determination; and PACER validation to determine compliance with Medicaid Policy & Guidelines as outlined in the Provider Manuals and Bulletins; and to determine appropriateness of Medicaid coverage for all of the above services utilizing current standards of practice, the Michigan State Plan, and Federal Regulations.

An audit is a post payment review of a statistically valid random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider. [42 CFR 447.201, 447.202, and Social Welfare Act 280 of the Public Acts of 1939, Section 111a.(7)(d), 111b.(6), (7), & (23)]. A review is considered a random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider. The Long Term Care Retrospective Reviews will be completed as per the requirements of Social Security Act §1919, [42 U.S.C. 1396r](a).

Utilization review is also required. The Michigan State Plan states that the State of Michigan meets the requirements of 42 CFR 456 for the control of the utilization of inpatient hospital services. The Michigan State Plan further states that the medical and utilization review requirements will be met through a contract with a Utilization and Quality Control Peer Review Organization as designated under 42 CFR 475.

LTC Retrospective Reviews are a post-payment review of a random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider.

The contract shall be for three years beginning January 1, 2005 through December 31, 2007 with the option of two yearly extensions.

## **B. OBJECTIVES**

Audits will be conducted on Medicaid Fee For Service (Title XIX), Medicare/Medicaid dually eligible (Title XVIII/IXX), Children's Special Health Care Services dual eligible (Title V/XIX), and ABW beneficiaries through 2-28-2005, utilizing statistically valid random samples. The average number of beneficiaries to be reviewed for each audit is 250.

LTC Retrospective Reviews will be conducted on Medicaid Fee For Service (Title XIX) and Medicare/Medicaid beneficiaries (Title XVIII/XIX), of Nursing Facilities and MI Choice Waiver utilizing statistically valid random samples. The average number of Medicaid beneficiaries to be reviewed for the combined provider types (Nursing Facilities, MI Choice Waiver) for each quarter is 500.

For Statewide Utilization Review, utilization review will be conducted on Medicaid Fee For Service (Title XIX) and Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries. Medical records will be

8/28/2007

selected by a statewide random sample by facility of Provider Type 30 Inpatient facilities. The Contractor will draw a random sample of 20 records per facility per year. Approximately 4 hospitals per week will be reviewed for a total of 16 hospitals per month. If an inpatient hospital has been selected to be audited that year, they will be exempt from the Review for that year.

Random sample PACER validations will be conducted as part of the audit process on all Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligibles (Title V/XIX) beneficiaries who had a request for PACER through the Contractor. The Registered Nurses performing this validation will not be the same Registered Nurses performing the PACER authorizations.

The Contractor will be paid per audit/Statewide Utilization Review/LTC review completed (See Section II, Part II, N for Timeframes of review).

**1. Audits will be conducted on the following:**

- **Inpatient Hospital Services:** Twelve audits with the possibility of 15 audits will be completed each year. The review will include all inpatient services paid to the provider including but is not limited to medical detoxification, elective admissions, transfers, readmissions within 15 days, inpatient rehabilitative facilities. See Section II, Part II, N for Timeframes of review.
- **Outpatient Hospital/Emergency Room Services:** Twelve audits with the possibility of 15 audits will be completed each year. The review will include all Outpatient Hospital and Emergency Room services paid to the provider. See Section II, Part II, N for Timeframes of review.

**2. PACER Validation:**

All cases included in the inpatient hospital audit sample that require a PACER authorization will be reviewed for PACER validation. The Contractor will validate all PACER authorization numbers assigned for these beneficiaries for the date(s) of service included in the audit sample. The Contractor has the responsibility to have a system/process in place that will validate PACER numbers assigned.

During review of the inpatient hospital medical records included in the audit sample, if it is determined the admission, transfer, readmission within 15 days or continued stay for inpatient rehabilitative facilities does not meet criteria for PACER authorization, the Contractor will request the information received from the provider at the time of the PACER request including both review coordinator and physician documentation. If it is determined the information in the hospital record matches the information provided at the time of the PACER request, the elective admission, transfer, readmission within 15 days or continued stay for inpatient rehabilitative facilities, will be allowed. The Contractor will report the case to the MDCH Contract Manager as the PACER authorization was approved in error. If the information given at the time of the request differs from the information found in the hospital record and the information given at the time of

the PACER authorization meets criteria, however, the hospital record does not, the hospital stay will be refunded to the MDCH.

In addition to the PACER validation performed as part of the audit process, PACER validation will be performed on medical records selected by a statewide random sample by facility of Provider Type 30 Inpatient facilities.

### **3. Utilization Review:**

Utilization review will be performed on all records requested for the Audits. This will include Inpatient/ Outpatient/Emergency Room/PACER services.

In addition to the utilization review performed as part of the Audit Process utilization review will be performed on medical records selected by a statewide random sample by facility of Provider Type 30 Inpatient facilities.

### **4. Long Term Care Retrospective Review:**

LTC Retrospective reviews will be performed based on current Michigan Medicaid Nursing Facility Level of Care Determination criteria or, for beneficiaries who qualified via the Nursing Facility Level of Care Exception criteria. Retrospective Reviews will be conducted for Medicaid beneficiaries of nursing facilities and MI Choice Waiver. Retrospective reviews are conducted strictly to determine appropriate utilization, however, serious quality issues will be referred by the Contractor to the Health Policy, Regulation, and Professions Administration.

## **C. AUDIT/UTILIZATION**

### **1) Audit Review Requirements:**

The Contractor must maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately. The Contractor must be in compliance with HIPAA. All documents and/or information obtained by the Contractor from the Department in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the Department.

The Contractor shall audit from a statistically valid random sample as generated by the MDCH. The audit sample will contain the following: the provider name, review period, services or codes to be reviewed, dates of service, beneficiary's name and identification number, date and claim reference number paid.

The audit sample will be given to the Contractor by MDCH. The Contractor will supply the audited provider (CEO and Health Information/Medical Records Manager) with a list of those beneficiaries to be reviewed thirty (30) calendar days prior to the audit begin date. The Contractor will go to each facility to copy/scan records utilizing their own equipment. The review of the copied records will occur at the Contractor's place of business. When the provider elects

8/28/2007

to copy/scan records, prior approval is needed from the MDCH Contract Manager. Once the records have been copied, reviewed, and a determination made, the Contractor shall write a Nurse Review Report (See Section II, Part III, Attachment I). Each claim line in the workbook will be reviewed and documented with an annotation provided by MDCH (See Section II, Part III, Attachment F) based on the documentation found in the medical record. If errors have been identified a mis-payment amount of the sample is calculated by MDCH. The mis-payment information is sent to the MDCH statistician for extrapolation of the mis-payment amount to the entire audit population. The Nurse Review Report will be reviewed by MDCH prior to insertion into the Exhibit Book.

a. For Inpatient review the Contractor will review medical records using the following criteria:

- i. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing admission criteria approved by MDCH per body system.
- ii. Continued stay criteria utilizing admission criteria approved by MDCH per body system for inpatient rehabilitation.
- iii. Discharge criteria admission criteria approved by MDCH criteria per body system.
- iv. Review for correct procedure.
- v. Review for diagnosis coding via DRG assignment validation.
- vi. Quality of care shall be monitored in each audit utilizing admission criteria approved by MDCH.
- vii. Services were performed in the appropriate setting.
- viii. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- ix. Services performed are in accordance with current professional standards of care.
- x. If the IPH stay is related to the CSHCS qualifying diagnosis and changes are made to the hospital stay (e.g. recoded or not allowed), the changes will be reported to the MDCH Contract Manager at the end of the audit review via the template provided by MDCH. See Attachment W

b. For Outpatient and Emergency Room Services review the Contractor will review medical records using the following criteria:

- i. Services were performed in the appropriate setting.
- ii. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- iii. Services performed are in accordance with current professional standards of care.
- iv. Services performed are medically necessary in appropriate scope, duration, and intensity.
- v. Verify procedure code/Ambulatory Payment Classification codes/revenue codes billed.
- vi. Verify adherence to EMTALA, (for Emergency Room Services only).
- vii. Quality of care provided to the beneficiary will be reviewed.

8/28/2007

viii. When the amount paid is lower than the fee screen, MPRO will need to check eligibility via list provided by MDCH to determine if the beneficiary is dual eligible Medicare/Medicaid. If the amount paid by Medicaid is for copay or deductible only, the (DOC) documented annotation will be used.

ix. If the OPH services are related to the CSHCS qualifying diagnosis and changes are made (e.g. recoded or not allowed), the changes will be reported to the MDCH Contract Manager at the end of the audit review via the template provided by MDCH. See Attachment W

## 2) Audit Review Process:

The Contractor shall have a system in place comprised of Nurse Reviewers with audit/utilization review and quality review experience in all types of review processes.

a. The Contractor is expected to complete Utilization Review of all audit cases selected by MDCH.

The Audit Review Process for Inpatient/Outpatient /Emergency Room includes the following:

Contractor receives "Workbook" from MDCH.

i. The outpatient/emergency room audit workbook will include an alphabetical and numeric beneficiary list; audit worksheets; line paid procedure code, procedure code on line, procedure code and revenue code on line for sample; sample and population summary statistics. The inpatient audit workbook will include all of the above plus a DRG code list.

b. MDCH will provide an accordion file containing file folders for Analysis (Nurse Review Report), and correspondence (copies of letters) and reports.

c. Prior to beginning the audit the Nurse Reviewer will complete the following:

i. Review and copy Medicaid policy and procedures pertinent to the audit sample.

ii. Review and copy procedure/APC/revenue codes/appropriate Grouper/ICD-9-CM included in the audit sample.

iii. Review and copy fee screens for procedure/APC/revenue codes included in the audit sample.

iv. Contact the provider within one week of assignment to schedule an appointment to copy records.

8/28/2007

v. Send a confirmation letter (See Section II, Part III, Attachment G- G1), to the provider (CEO and Health Information/Medical Records Manager) following the initial contact reiterating the information provided during the initial contact. A copy of the correspondence will be kept with the audit file.

The items listed above (2c, i-iii) will be what were in effect for the time period of the audit.

d. Contractor copies/scans medical records at the provider's place of business utilizing the Contractor's own equipment. When the provider elects to copy/scan records, prior approval is needed from the MDCH Contract Manager. An on-site visit consists of an introduction, including presentation of credentials, picture identification, the legal basis and the reason for the audit. (To determine compliance with Medicaid policy and guidelines; to verify services billed and paid to Medicaid were provided.)

e. Contractor reviews medical records at the Contractor's place of business. If after collating, documentation is found to be missing, a letter is sent to the provider (CEO and Health Information/Medical Records Manager), (See Section II, Part III, Attachment H). A copy of the correspondence will be kept with the audit file. The Contractor's Nurse Reviewer should initiate review of records on hand while waiting for missing documentation.

f. The initial review shall be conducted by the Nurse Reviewer utilizing the appropriate criteria at Section II, Part II, C. All claim lines in the sample are adjudicated based on the medical record review using annotations (See Section II, Part III, Attachment F).

g. After receipt and review of any missing documentation the Nurse Reviewer writes the Nurse Review Report (See Section II, Part III, Attachment I.) The Nurse Review Report will include:

- i. Reason for the Review.
- ii. Sample Statistics.
- iii. Summary of Field Activities.
- iv. Nurse Review Findings and Attachments.

The Contractor will submit the workbook and Nurse Review Report and copies of 2 c, i-iii, and 2e to MDCH.

h. Mis-payment amount of the audit sample is calculated by MDCH and sent to the MDCH Statistician.

i. Extrapolation of the mis-payment amount to the entire audit population shall be made by the MDCH Statistician.

j. MDCH will create and review the "Exhibit Book" and make five (5) copies.

k. MDCH will notify the provider in writing of audit results, appeal rights, and hearing dates.

8/28/2007

#### **D. PACER VALIDATION**

##### **1.) PACER Validation Requirements:**

For PACER validation, the Contractor will review records in the audit sample using the following criteria:

- a. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing admission criteria approved by MDCH per body system.
- b. Continued stay criteria utilizing admission criteria approved by MDCH per body system for inpatient rehabilitation.
- c. Discharge criteria utilizing admission criteria approved by MDCH per body system.
- d. Services were performed in the appropriate setting.
- e. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- f. Services performed are in accordance with current professional standards of care.
- g. PACER number obtained for readmissions within 15 days, transfers, elective admissions, and continued stays for rehabilitative facilities.

##### **2.) PACER Validation Process:**

The validation process of the PACER review includes the criteria listed at Section II, Part II, D 1 a-g:

During the record review, if the criteria are not met for the PACER authorization the documentation used by the Contractor for the PACER authorization will be reviewed. This will include:

- a. PACER Number.
- b. Documentation provided at the time of the PACER request.
  - i. Review Coordinator documentation.
  - ii. Physician Reviewer documentation.

#### **E. STATEWIDE UTILIZATION REVIEW**

##### **1.) Statewide Utilization Review Requirements:**

For the Utilization Review, the Contractor shall review records based on the following criteria:

- a. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing admission criteria approved by MDCH per body system.
- b. Continued stay criteria utilizing admission criteria approved by MDCH per body system for inpatient rehabilitation.

8/28/2007

- c. Discharge criteria utilizing admission criteria approved by MDCH per body system.
- d. Services were performed in the appropriate setting.
- e. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- f. Services performed are in accordance with current professional standards of care.
- g. PACER number obtained for readmissions within 15 days, transfers, elective admissions, and continued stays for rehabilitative facilities.

2.) Statewide Utilization Review Process:

The Contractor is expected to complete Utilization Review of Hospital Provider Type 30 Inpatient services provided to Medicaid beneficiaries.

a. Selection for the Statewide Utilization Review Process will include a random sample from a universe of paid claims data downloaded weekly from the MDCH Data Electronic Gateway (DEG) by the Contractor. The Contractor will draw a random sample of 20 records per facility per year. Approximately 4 hospitals per week will be reviewed for a total of 16 hospitals per month. The sample will be drawn on a monthly basis by the Contractor for the hospitals selected for review for that month. The hospitals will be sampled individually going back one (1) year from the date drawn utilizing a past year of data for the review. EXAMPLE: Start June 2006, go back one (1) year, sampling June 1, 2005 through May 31, 2006 data. If an inpatient hospital has been selected to be audited that year, they will be exempt from the Review for that year.

b. The medical record for the Medicaid Beneficiary will be requested by the Contractor from Hospital Provider Type 30 via fax/mail. A letter will be sent by MPRO so that the provider receives the letter by the first of the month, see Attachment L for an example. This letter will give the provider thirty (30) days to submit the record. If no record(s) are submitted, MDCH may decide to initiate an audit. MPRO will have 30 (thirty) days from the provider deadline to review the records. For example, the letter requesting records is sent so the provider receives the letter by June 1, records are required to arrive to the Contractor by June 30, the Contractor has until July 31 to review.

c. Reporting is expected for all facilities whether there is an issue or not. Reporting to MDCH is expected on a monthly basis utilizing the spreadsheets attached, see Attachments M and M1:

- i. Spreadsheet I:  
List Hospitals selected for month in Alphabetical Order by Name and ID number. See Attachment M
- ii. Spreadsheet II:  
List by Provider; Provider ID number/NPI Number/Taxonomy Code; Time period sample pulled from; date medical records requested; total number member requested; Listed alphabetically by: Beneficiary Name; Beneficiary ID number; Dates of Service; Date Medical Record Received; Findings; Total number of Findings and Comments. See Attachment M1

8/28/2007

This report/spreadsheet will then be utilized for future audit selection. A cumulative report must be submitted annually within 30 days of the end of the fiscal year. See Attachment M2.

The Contractor will send an educational letter to the provider if there are any findings/issues identified at the end of the monthly review.

d. A quarterly report will be reviewed by the MDCH Contract Manager. See Attachment M3.

e. The Contractor shall apply quality of care criteria/screens in all reviews- in every category undertaken and in every admission request or treated case reviewed.

i. Criteria may be the same as or similar to those required by CMS. The Contractor will inform the MDCH of any quality problem that has resulted in serious patient harm as soon as it is identified. All other quality of care findings and their severity level will be reported on a regular basis to the MDCH. The Contractor will recommend to MDCH the appropriate provider sanctions/interventions.

ii. Sanctions/interventions- may include provider participation, termination, education, or other appropriate action. The Contractor and the MDCH shall work together in determining the appropriateness of these sanctions/interventions and in applying them.

#### **F. LONG TERM CARE RETROSPECTIVE REVIEW**

##### **1.) Long Term Care Retrospective Review Requirements:**

The Contractor must maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately. The Contractor must be in compliance with HIPAA. All documents and/or information obtained by the Contractor from the Department in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the Department.

The Contractor shall perform the Retrospective reviews from a statistically valid random sample as generated by the MDCH. The review sample will contain the following:

- a. Provider's Medicaid ID/NPI Number/ Taxonomy Code, ,
- b. Beneficiary's name,
- c. Beneficiary's Medicaid ID,
- d. Beneficiary's date of birth,
- e. Date the online Michigan Medicaid Nursing Facility Level of Care was created,
- f. Door through which the beneficiary qualified.

8/28/2007

The Retrospective review sample will be given to the Contractor by MDCH. The Contractor will inform the nursing facility or MI Choice Waiver provider of a Retrospective review by way of Notification of Retrospective Review letter (See Section II, Part III, Attachment N-O). The letter shall include the Medicaid ID(s) of the beneficiary(s) who will receive a Retrospective review, the 'to' and 'from' dates that the Contractor will be reviewing, and a list of the medical records required from the provider by the Contractor in order to conduct the Retrospective review.

The provider has thirty (30) calendar days from the date of the Contractor's Notification of Retrospective Review letter to respond by way of receipt of all requested medical records to the Contractor. The Contractor has thirty (30) calendar days from the date the medical records are received from the provider to complete the Retrospective review. The Contractor will review the medical records at the Contractor's place of business.

Should the provider not respond to the Contractor's Notification of Retrospective review letter within thirty (30) calendar days from the date of the request, the Contractor shall issue a Retrospective Review Reminder letter (See Section II, Part III, Attachment P-Q). Should the provider submit incomplete medical records as requested in the Notification of Retrospective review letter, the Contractor shall issue an Incomplete Retrospective Review Medical Records letter (See Section II, Part III, Attachment R). The Nurse Reviewer shall initiate review of the medical records on hand while waiting for missing medical records.

Should the provider not respond to the request in the Retrospective Review Reminder letter or to the Incomplete Retrospective Review Medical Records letter within five (5) business days following the thirtieth (30) calendar day from the date the letter was sent, the Contractor shall issue a Pending Technical Denial letter (See Section II, Section III, Attachment S) to the provider.

The Contractor's Pending Technical Denial letter shall inform the provider that medical records as requested in the Retrospective Review Reminder letter or the Incomplete Retrospective Review Medical Records letter were not received from the provider within thirty (30) calendar days from the date of the request. The Pending Technical Denial letter shall inform the provider that they have fourteen (14) calendar days from the date of the Pending Technical Denial letter to comply with the Contractor's request.

Should the provider not respond to the Contractor's Pending Technical Denial letter within fourteen (14) calendar days from the date of the Pending Technical Denial letter, the Contractor shall issue to the provider within five (5) business days following the fourteenth (14) calendar day in which the request should have been responded to by the provider, a Final Determination letter. The Contractor shall also forward to MDCH a recommendation for Technical Denial with the monthly reports.

a. Nursing Facility Retrospective Review Process:

8/28/2007

The Contractor will request from the Nursing Facility provider copies of the beneficiary's medical records (case record) for the ninety (90) day period under retrospective review as follows:

- i. Copy of the Michigan Medicaid Nursing Facility Level of Care Determination
- ii. Copy of the Computer Generated Freedom of Choice Form
- iii. PASARR screen Level I
- iv. PASARR screen Level II, if indicated by PASARR screen Level I
- v. MDS documents
- vi. Nursing notes
- vii. Physician notes
- viii. Interdisciplinary Care Plan notes
- ix. Quarterly Care Planning notes
- x. Skilled therapy evaluations and progress notes
- xi. Discharge plans
- xii. Medicare Certification/Recertification form

The Contractor shall review the case records based on the following criteria:

- i. Medical necessity for admission based on the Michigan Medicaid Nursing Facility Level of Care Determination
- ii. Continued stay criteria based on the Michigan Medicaid Nursing Facility Level of Care Determination

Should the Contractor, upon Retrospective Review, discover missing required documents/procedures as stated in policy, the Contractor shall issue to the facility a Nursing Facility Retrospective Review Determination letter (See Section II, Part III, Attachment U). The Nursing Facility Retrospective Review Determination letter is informational only.

The Contractor shall report their findings to the LTC Contract Manager on a monthly basis. Findings shall include the number of approvals, technical denials, final denials, and copies of informational Retrospective Review Determinations. The Contractor shall also report on the number of outstanding Nursing Facility Retrospective reviews, the number of Retrospective Reviews conducted to date and their findings.

b. MI Choice Waiver Retrospective Review Process:

The Contractor will request from MI Choice Waiver program providers copies of the beneficiary's medical records for the ninety (90) day period under retrospective review, as follows:

- i. Copy of the Michigan Medicaid Nursing Facility Level of Care Determination
- ii. Copy of the Computer Generated Freedom of Choice Form
- iii. MDS-Home Care Assessment documents
- iv. Medical Notes

8/28/2007

- v. Physician Notes and Orders
- vi. MI Choice Waiver contact notes from friends, family of the enrollee, or from the enrollee
- vii. MI Choice Waiver participant's Plan of Care

The Contractor shall review the records based on the following criteria:

- i. Medical necessity for enrollment based on the Michigan Medicaid Nursing Facility Level of Care Determination
- ii. Continued program participation based on the Michigan Medicaid Nursing Facility Level of Care Determination

Should the Contractor, upon Retrospective Review, discover non-compliance to required documents/procedures as stated in policy, the Contractor shall issue to the agency a MI Choice Waiver Retrospective Review Determination letter (See Section II, Part III, Attachment V). The MI Choice Waiver Retrospective Review Determination letter is informational only.

The Contractor shall report their findings to the LTC Contract Manager on a monthly basis. Findings shall include approvals, technical denials, final denials, and copies of information Retrospective Review Determinations. The Contractor shall also report on the number of outstanding MI Choice Waiver Retrospective reviews, the number of Retrospective Reviews conducted to date and their findings.

## **G. APPEALS PROCESS**

### **1. Inpatient/Outpatient/Emergency Room Audits**

MDCH Program Investigation Section will notify the providers of the audit results, hearing dates, and appeal rights by mail.

The Contractor's nurse reviewer and a like specialty physician (when applicable) must be available to testify as to the results of the audit review at any preliminary or bureau conference; administrative hearing or judicial proceeding. MPRO physician representation at the appeals will be at the request of the Administrative Tribunal and the Office of Medical Affairs on an as needed basis for hospital audits.

### **2. Long Term Care Retrospective Review**

#### **a. Provider Appeals**

The Contractor shall send final denial recommendations to MDCH following the completion of the Contractor's Retrospective review. The Contractor shall send notice to the facility to recover funds paid for that stay. The Provider must be able to request reconsideration (appeal) of any adverse determination made by the Contractor for admission or extended stay within three (3) working days of receipt of the initial denial. MDCH allows the provider the right of appeal through the Medicaid Provider Reviews and Hearings Administrative Rules, MAC

8/28/2007

R400.3401-400.3425 under the authority conferred on the Director of MDCH by Sections 6 and 9 of Act. No. 280 of the Public Acts of 1939. The Contractor's nurse reviewer and a like specialty physician (when applicable) must be available to testify as to the results of the Retrospective review at any preliminary or bureau conference; administrative hearing or judicial proceeding. MPRO physician representation at the appeals will be at the request of the Administrative Tribunal.

b. Beneficiary Appeals

Beneficiaries as well as providers have the right to appeal a denial of service. As is the case for Medicare, beneficiary appeals made during the inpatient stay must be resolved by the Contractor within three working days. Appeals made to the Contractor following discharge must be resolved within thirty (30) working days.

Only after these appeals have been exhausted, may any appeal be made directly to the MDCH. When such an appeal is made, the Contractor will provide the written reports, and make direct testimony available to the MDCH as the MDCH deems necessary.

An appeals form (DCH-0092 Hearing Request)(See Section II, Part III, Attachment C) and an addressed stamped envelope provided by the State must accompany the negative action letter (See Section II, Part III, Attachment A). The negative action letter and appeal form must be sent to the Beneficiary the day of the negative action. Copies of all negative action letters shall be stored by the Audit Contractor and available upon request.

**H. QUALIFICATIONS OF CONTRACTOR'S STAFF FOR AUDITS/STATEWIDE UTILIZATION REVIEW AND LONG TERM CARE RETROSPECTIVE REVIEW, IMMEDIATE REVIEW AND EXCEPTION REVIEW**

1. Staff Requirements

a. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing/licensure prior to the start of this Contract. Attestation of licensure will be required at the end of each year thereafter. In addition, proof of licensure will be sent to the State at time of hire for all new employees where licensure is required. The Registered Nurse Reviewer must report directly to an RN who must report directly to an RN. Necessary substitutions due to change of employment status and other unforeseen circumstances maybe made with prior notification to the MDCH and for employees with the same licensure (i.e., RN replaces RN). If the replacement does not have the same licensure prior authorization is required by the MDCH.

b. The Contractor shall utilize Registered Nurse Reviewers who demonstrate knowledge of Inpatient /Outpatient Hospital/Emergency Room Services/PACER/Utilization Review. The Contractor shall utilize Registered Nurse Reviewers for Long Term Care Immediate, Exception and Retrospective Reviews who demonstrate knowledge of Long Term Care and Michigan's Medicaid criteria. The Registered Nurses performing the audit/Statewide

8/28/2007

Utilization Review/Long Term Care review functions cannot perform the PACER authorizations, MDCH expects the Contractor to designate separate staff for each.

c. The Contractor shall be staffed by Physician Reviewers with expertise in the above areas listed under H, 1, b, to act only as a resource for audits and Statewide Utilization Review and Retrospective Review appeal representation, when requested by the ALJ.

d. The coding review for inpatient hospital review shall be validated by a Registered Health Information Technologist, RHIT.

## 2. Other Requirements

a. The Contractor shall maintain all reporting requirements established by the MDCH. (See Section II, Part II, I, Reports.)

b. The Contractor shall maintain a positive working relationship with Providers of medical care and Provider Organizations.

c. The Contractor shall maintain confidentiality of Provider/Beneficiary information and provide the MDCH with its confidentiality policy and procedure.

d. Should the Contractor be a vendor from a State other than Michigan, the Contractor's Project Manager and staff must have an office located in the Greater Lansing Area.

## I. REPORTS

The reporting mechanisms are listed below under 1-3. MDCH reserves the right to adjust the number of audits conducted per provider type, (inpatient/outpatient hospital/emergency room services), and the number of Long Term Care Retrospective Reviews with thirty (30) day notice to the Contractor. The MDCH reserves the right to change/cancel the audit/review process or cancel the contract with thirty (30) day notice to the Contractor.

A "work plan" for the first quarter of the contract will be submitted electronically to MDCH by January 31, 2005 describing proposed audit/review activities. An "updated work plan" shall be provided electronically by the last day of the preceding quarter beginning with the April quarter describing proposed audit activities.

The Contractor shall report the following information to the MDCH at the designated time frames in a format agreed upon by the MDCH and the Contractor. The MDCH reserves the right to modify the reporting requirements. Proposals for alternative reporting requirements will be considered by the MDCH.

### AUDITS

1. A "monthly report" shall be provided electronically to MDCH by close of business on the 5<sup>th</sup> calendar day of each month. The report will list newly

8/28/2007

initiated audits/reviews and activities on audits/reviews initiated during previous months. Activities shall include:

- a. Name and date of audit(s)/reviews initiated.
  - b. Name and date of audit(s)/reviews completed.
  - c. Number retrospective reviews of PACER authorization not meeting criteria.
    - i. number of authorizations given in error
    - ii. number of provider errors
  - d. For Statewide Utilization Review, a summary of review findings to include provider name alphabetically and ID number, time period sample pulled from, date medical record requested, beneficiary name alphabetically and ID number, findings see Attachment M1.
2. A "quarterly report" shall be provided electronically to MDCH by the last calendar day of the month following the reporting quarter detailing year-to-date totals for all activities described at Section II, Part II, I, 1, a-d .
  3. An "annual report" shall be provided electronically by the Contractor to MDCH by the last calendar day of the month following the annual reporting period that is an accumulation of the quarterly reports.

#### Long Term Care

1. A "monthly report" shall be provided electronically or by mail to MDCH LTC Contract Manager by close of business on the 5<sup>th</sup> calendar day of each month. The report will list:
  - a. Number of Retrospective Reviews for the selection date
  - b. Number of Retrospective Reviews de-selected (void)
  - c. Number of Retrospective Reviews completed
  - d. Number of Retrospective Reviews approved/technical denial/denial recommendation to MDCH
  - e. Number of Retrospective Reviews pending
2. A "quarterly report" shall be provided electronically to MDCH by the last calendar day of the month following the reporting quarter detailing year-to-date totals for all activities described at Section II, Part II, I, a-d.

Reports and information shall be submitted to the MDCH Contract Manager at the address listed in the front of this contract. The Contract Manager shall evaluate the reports submitted as described in this section for their completeness and adequacy.

The Contractor shall provide Inter-rater Reliability reports to the Department of Community Health on a quarterly basis. The Inter-rater Reliability Rater is a

8/28/2007

validation of work by the Contractor. Inter-rater instructions as well as the process for the review are required. One actual example of a report de-identified for each part of the Program is requested (PACER, Inpatient Audits, Outpatient Audits).

## **J. CONTRACT MONITORING**

The MDCH Contract Manager through reports and financial statements shall monitor the audit progress as listed above. Reports shall be electronically transmitted to MDCH in compliance with HIPAA transactions.

The MDCH Long Term Care Manager shall review long term care reports as defined in Section II, Part II, I, Reports. Reports shall be transmitted electronically or by mail to MDCH in compliance with HIPAA transactions.

The Contractor shall meet/teleconference with MDCH contract management at least weekly during the first month of the contract and at least monthly for the remainder of the contract to review all Nurse Review Reports etc.

The Contractor shall permit the Department or its designee to visit and to make an evaluation of the project as determined by the contract manager. At least once per contract year MDCH will complete a site visit of the Contractor to monitor work in progress. If the Contractor is in/out of the State of Michigan, the monitoring will occur at the Audit Contractor site. All travel, lodging and meal expenses for up to two (2) State of Michigan employees shall be paid by the Contractor for this yearly review should the Contractor be in/out of the State of Michigan.

For this Contract, each phase of the audit/Statewide Utilization Review/LTC review process will be monitored by the MDCH Contract Manager. At a maximum, five percent of audit total (or a number determined by MDCH) will be submitted to MDCH for validation. At a maximum, five records per provider for the Statewide Utilization Review Process (or a number determined by MDCH) will be submitted to MDCH for validation.

The Contract Manager shall monitor that the Contractor complete work within the timeframes listed in Section II, Part II, I, Reports and Section II, Part II, N, Timeframes.

For this Contract, the MDCH LTC Contract Manager shall monitor that the Contractor complete work within the timeframes listed in Section II, Part II, I, Reports and Section II, Part II, N, Timeframes.

## **K. MILESTONES AND DELIVERABLES**

For the Contract the following mechanisms must be in place:

### **1. Readiness for Implementation**

- a. The Contractor must have an operational system in place no later than one month from the start up of the Contract including but not limited to sufficient staff.

8/28/2007

b. The Contractor shall demonstrate to MDCH's satisfaction no later than one month from the start up of the Contract, that the Contractor is fully capable of performing all duties under this Contract, including demonstration of the following:

i. That the Contractor demonstrates a sufficient number of RN's experienced in the areas of Inpatient, Outpatient, Emergency Room, PACER and Long Term Care, and Physician's experienced in the area of Long Term Care, to perform the audit/review duties as specified herein. The Registered Nurses performing the audit/Statewide Utilization Review/LTC review functions cannot perform the PACER authorizations. MDCH expects the Contractor to designate separate staff for each.

ii. That the Contractor has thoroughly trained its staff on the specifics of the audit/Statewide Utilization Review/LTC review processes and that the Contractor's staff has sufficient knowledge to make determinations of medical services needed.

iii. That the Contractor has the ability to accept, process and to transmit to MDCH those audits/ Statewide Utilization Review/LTC reviews that have been completed.

iv. That the Contractor has quality assurance procedures in place that assures it follows all State and Federal laws for confidentiality.

c. The Contractor's inability to demonstrate, to the Department's satisfaction and as provided herein, that the Contractor is fully capable of performing all duties under this Contract no later than February 1, 2005, shall be grounds for the immediate termination of this Contract by the Department in accordance with the terms specified herein.

## 2. Program Specification.

a. The Contractor shall complete the audit/review process within the Timeframes described in Section II, Part II, N and submit the required reports within the Timeframes described in Section II, Part II, I, Reports.

b. The Contractor shall retain all records until the audit/review is closed, (settlement is reached) or the records are requested by the Appeals Section.

## L. FRAUD AND ABUSE

The Contractor shall report suspected fraud, and/or abuse by Medicaid beneficiaries and/or providers to the MDCH Program Investigation Section. The report shall detail the

8/28/2007

provider, beneficiary and all information on the situation. The link to information regarding fraud and abuse and how to report it is located on the website [michigan.gov/mdch](http://michigan.gov/mdch), click on the links to inside Community Health, and Fraud and Abuse.

#### **M. SANCTIONS**

For the first year of the Contract, the Contractor is expected to correct any inability to meet Timeframes (See Section II, Part II, N). MDCH reserves the right to adjust the number of audits/ Statewide Utilization Review/LTC reviews conducted per provider type with thirty (30) day notice to the Contractor. MDCH also reserves the right to change the audit/review process or cancel the Contract with thirty (30) day notice to the Contractor.

In the second year, monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction shall be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the MDCH shall give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions. Sanctions will be imposed based on the following:

1. Failure to Report. If the Contractor fails to submit, by the due date, any report or other material required by this Contract to be submitted to the MDCH, the MDCH will give written notice to the Contractor of the late report or material by fax (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor shall have ten (10) calendar days following the notice in which to cure the failure by submitting the complete and accurate report or material. If the report or other material has not been submitted within ten (10) calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than \$10,000. At the end of each subsequent ten (10) day period in which the complete and accurate report has not been submitted, the Department may, without further notice, impose further sanction of \$10,000.

2. Audits/ Statewide Utilization Review/LTC Reviews. The number of audits/ Statewide Utilization Review/LTC reviews to be completed are outlined in Section II, Part II, B. Upon review by the MDCH Contract Manager, if the audit/ Statewide Utilization Review/LTC reviews from the previous month are not completed correctly or in a timely manner, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

#### **N. TIMEFRAMES**

The following timeframes listed in Table I-III are for the first, second, third, and fourth years of the contract. For the purposes of the table listed below, an audit/reviews is considered completed once the workbook and reports are

8/28/2007

submitted to the MDCH. The Contractor is still responsible for participating in the Appeal Process until a settlement is reached.

**TABLE I**

Type of Hospital Audits	Fiscal Year	Number of Audits to be completed by Quarter			
		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
<b>Inpatient Audits</b>	FY2005	0	3	3	1
	FY2006	3	3	3	3
	FY2007	3	3	3	3
	FY2008	3	3	3	3
	FY2009	3	0	0	0
<b>Three Year Total plus extension</b>		<b>46</b>			
<b>Outpatient/Emergency Room Audits</b>	FY2005	0	3	3	1
	FY2006	3	3	3	3
	FY2007	3	3	3	3
	FY2008	3	3	3	3
	FY2009	3	0	0	0
<b>Three Year Total plus extension</b>		<b>46</b>			

\*Audits will average 250 beneficiaries per audit

**TABLE II**

Type of Long Term Care Review	Fiscal Year	Number of Reviews to be completed by Quarter			
		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
<b>Retrospective Review</b>	FY2005	0	250	250	250
	FY2006	250	250	250	250
	FY2007	250	250	250	250
	FY2008	500	500	500	500
	FY2009	500			
<b>Three Year Total plus extension</b>		<b>4500</b>			
<b>Immediate Reviews (NONC)</b>	FY2008/1 <sup>st</sup> qtr FY2009	30 Annual Projection			
<b>Exception Reviews (telephonic)</b>	FY2008/1 <sup>st</sup> qtr FY2009	180 Annual Projection			

8/28/2007

**TABLE III**

Statewide Utilization Review	Fiscal Year	Number of Utilization Reviews completed by Quarter			
		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
<b>Inpatient</b>	FY2005	0	0	0	0
	FY2006	0	0	0	960
	FY2007	960	960	960	960
	FY2008	960	960	960	960
	FY2009	960			
<b>Total</b>		9600			

**O. PAYMENT SCHEDULE**

The payment schedule will be based on the number of audits/Statewide Utilization Reviews/LTC reviews completed. The per audit and LTC review payment will include both the medical record review and the appeal process through settlement. Although the Contractor will receive payment upon completion of the audit or Retrospective Review, the Contractor is still required to participate in the Appeal process even though payment has been received. The Statewide Utilization Review payment includes medical record review only as there is no appeal process.

The Contractor will be paid monthly based on the number of hospital audits completed the previous month of the contract.

The Contractor will be paid monthly based on the number of Statewide Utilization Reviews completed the previous month of the contract.

The Contractor will be paid monthly based on the number of Long Term Care Immediate (NONC), Exception (Telephonic) and Retrospective Reviews completed the previous month of the contract.

8/28/2007

## **PART III DEFINITIONS/ATTACHMENTS**

### **A. Definitions**

The following terms, as used in the Request for Proposals and the Attachments, Appendices, Exhibits, Schedules and Amendments hereto, shall be construed and interpreted as follows, unless the context otherwise expressly requires a different construction and interpretation.

**Admission criteria approved by MDCH:** the most current edition of copyrighted criterion used to assess the clinical appropriateness of acute care admission; continued stay and discharge; and quality of care ensuring the proper care setting for the appropriate length of time.

**Ambulatory Payment Classifications (APCs):** According to Medicare/CMS, and as developed and implemented in 2000 by CMS - All services paid under OPSS are classified into groups called Ambulatory Payment Classifications known as APCs. Services represented by/in each APC are similar clinically and by the services/terms of the resources they require. A payment assignment or rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Under OPSS/APC methodology - providers bill individual claim line, date of service - and a single claim is considered an 'encounter' which may be >1 DOS. Medicare considers the 'encounter' from start to finish of the OP visit - whereas under old FFS, we considered 'one' claim as a single DOS. OPSS allows for predictability of payment. The APCs are reviewed as needed to determine their level of specificity - if they need to be reassigned to a higher/lower APC for payment. Information is updated on a quarterly basis and published in the Federal Regs.

**Annotations:** information written in the audit workbook that is used by MDCH and the Contractor's Nurse Reviewer when reviewing medical records for audits. See Attachment F.

**Beneficiary:** all Medicaid eligible individuals in the Fee For Service Program, (FFS), (Title XIX), Children's Special Health Care Services Program, (CSHCS dual eligibles) (Title V/XIX), Medicare/Medicaid, Title XVIII/XIX).

**CEO:** Chief Executive Officer

**Coding Validation:** means comparing principal and all secondary diagnosis and procedure codes billed to the Department with documentation in the beneficiaries medical record to determine the appropriateness and accuracy of the billed codes.

**Diagnosis Related Groups (DRG):** the Department's reimbursement methodology for inpatient services which is a single payment per discharge which is calculated according to the billed diagnosis and procedure codes and other relative factors including, but not limited to, the patient's age.

**Emergency Room Criteria:** currently accepted standards of care for Emergency Department service consistent with coverage in Hospital Provider Manual Chapter III.

**Exception Criteria:** specific criteria developed by MDCH to determine whether or not the participant is at risk of imminent institutionalization.

8/28/2007

**Health Insurance Portability and Accountability Act (HIPAA):** a Federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives the U.S. Department of Health and Human Services (DHHS) the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative codes sets should be used within those standards; to require the use of national identification systems for health care patients, provider, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

**Inpatient Criteria:** currently accepted standards of care for Inpatient Hospital service consistent with coverage in Hospital Provider Manual.

**Long Term Care:** for this RFP only, Long Term Care includes those programs that are required to adhere to the Michigan Medicaid Definition for nursing facility level of care; specifically Nursing Facilities, MI Choice Waiver Program for Elderly and Disabled, and the Program for All Inclusive Care for the Elderly.

**MDS:** Minimum Data Set-assessment information required for all nursing facility and MI Choice Program in Michigan.

**MDS-HC:** Minimum Data Set-Home Care assessment information required for all MI Choice Waiver programs in Michigan.

**MI Choice Program:** MI Choice is Michigan's 1915c(SSA) Home and Community Based Waiver for Elderly and Disabled. Services are provided to participants within the community to maintain the most integrated setting possible.

**Michigan Department of Community Health (MDCH):** the State of Michigan Department requesting the services.

**Michigan Medicaid Nursing Facility Level of Care Determination:** Medicaid criteria established by the Michigan Department of Community Health, utilized by Medicaid providers, to determine a beneficiary's medical/functional eligibility for nursing facility admission or MI Choice Waiver and PACE program enrollment.

**NPI Number:** National Provider Identifier is part of the HIPAA mandate requiring a standard unique identifier for health care providers.

**Nurse Reviewer:** a registered professional nurse with a current Michigan license and with appropriate education and clinical background, trained in the performance of utilization review, and quality assurance.

**Nurse Review Report:** a written report of the audited record by the nurse reviewer, see Attachment I.

**Nursing Facility Level of Care Exception Process Criteria:** Criteria established by the Michigan Department of Community Health, utilized by the Contractor, in determining Medicaid

8/28/2007

eligibility based on frailty for beneficiaries who do not meet the Michigan Medicaid Nursing Facility Level of Care Determination criteria.

**Nursing Facility Level of Care:** Each state that participates in the Medicaid program is required to provide nursing facility care as a mandatory state plan service. Each state must determine function/medical eligibility criteria to determine the appropriateness for that setting. Federal regulations state that Medicaid covered nursing facility care must include the following:

- (A)skilled nursing care and related services for residents who require medical or nursing care,
- (B)rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
- (C)on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

**Outpatient Services Criteria:** currently accepted standards of care for Outpatient Department service consistent with coverage in Hospital Provider Manual.

**PACE:** The Program of All Inclusive Care for the Elderly, a capitated community program for persons with long term care needs. Funds are blended from both Medicare and Medicaid sources.

**PACER:** Prior Authorization Certification Evaluation Review. The Prior Authorization Certification Evaluation Review number consists of nine-digits. The first four digits are the Julian date; and the last five digits are the beneficiaries ID number coded into the prior authorization master report numbers by formula. The requestor for the authorization number supplies the beneficiaries ID number. The listing for the prior authorization master report numbers can be supplied by the MDCH.

**PASARR:** The Pre-Admission Screening/Annual Resident Review is required to be completed for all potential nursing facility residents. This review ensures that persons with mental health conditions are placed in the most appropriate setting.

**Peer Review Organization or PRO:** an organization that is URAC (Utilization Review Accreditation Commission) approved and experienced in utilization review and quality assurance which meets the guidelines set forth in 42 USC 1320(c) (1) and 42 CFR 475.

**Physician Reviewer:** a physician licensed to practice medicine in Michigan engaged in the active practice of medicine; board certified or board eligible in his/her specialty; with admitting privileges in one or more Michigan hospitals; and familiar with Medicare principles, experienced in Nursing Facility Care and Utilization Review.

**Proposal:** the response to this RFP submitted to the Department by a Vendor.

**Provider:** Medicaid enrolled Provider for Inpatient Hospital, Outpatient Hospital/Emergency Room Hospital services, and Long Term Care Facilities.

**RHIT:** Registered Health Information Technologist with appropriate education and coding background trained in the performance of coding/DRG validations, International Classification of Diseases Ninth revision clinical modifications, (ICD-9-CM), Ambulatory Patient Groups (APG), Health Care Financing Administration Common Procedural Coding System (HCPC), and Current Procedural Terminology (CPT) methodologies.

8/28/2007

**SI/IS:** Severity of Illness/Intensity of Service.

**Taxonomy Code:** Provider Taxonomy code set is an external non-medical data code set designed for use in classifying health care providers according to type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute (ANSI) Accredited Standards Committee(ASC) health care transaction.

**Utilization Review Accreditation Commission (URAC):** a non-profit charitable organization founded in 1990 to establish standards for the health care industry.

**Workbook:** a comprehensive collection of data provided to the Contractor by MDCH for use by contract review staff. The data includes: the beneficiary name and date of birth; stratum number; beneficiary sample number; provider identification number; total payments made; date of service; services/codes billed; and date of payment. This book is to be utilized by contract review staff to document review findings from the medical record.

8/28/2007

**ATTACHMENT A**

**HOSPITAL ADEQUATE ACTION NOTICE**

Denial of Service

Date

Beneficiary Name

Beneficiary Address

RE: Beneficiary Name

Beneficiary Medicaid ID #

Dear (Beneficiary Name):

(Contractor Name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for services for Medicaid or Medicaid/CSHCS dually enrolled coverage under this contract. Following a review of the services for which you have applied, it has been determined that the following service(s) shall not be authorized. The reason for this action is the physician reviewer determined that the admission and procedure are not medically necessary. The documentation did not support symptomatology that would warrant an acute care admission/procedure. Therefore, authorization for the admission has been denied. The legal basis for this decision is 42CFR440.230(d).

**Service(s)**

**Effective Date**

---

---

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30763  
LANSING, MI 48909-7695

If you have any questions about this denial, you may call the Contractor Manager for the (Contractor Name) Contract at (phone number).

If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:

Hearing Request Form

Return Envelope

8/28/2007

**ATTACHMENT B**

**HOSPITAL ADVANCE ACTION NOTICE  
Suspension, Reduction or Termination**

Date  
Name  
Address  
City, State, Zip

RE: Beneficiary's Name  
Beneficiary's Medicaid ID Number

Dear \_\_\_\_\_:

(Contractor name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for services for Medicaid, or Medicaid/CSHCS dually enrolled coverage under this contract. Following a review of the services that you are currently receiving, it has been determined that the following service(s) shall not be authorized. The reason for this action is \_\_\_\_\_  
\_\_\_\_\_. The legal basis for this decision is 42CFR440.230(d).

<b>Service(s)</b>	<b>Effective Date</b>
_____	_____
_____	_____

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30763  
LANSING, MI 48909-7695

You will continue to receive the affected services in most circumstances until the hearing decision is rendered if your request for a department hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a department hearing you may be required to repay the benefits. This will occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

If you have any questions about this denial, you may call the Contractor Manager for the (Contractor Name) Contract at (phone number).

If you want to know more about how a departmental hearing works, call (877) 833-0870.  
Enclosures: Hearing Request Form/Return Envelope

8/28/2007

**ATTACHMENT C**

**LONG TERM CARE  
Adequate Action Notice**

**Date:**  
**Name:**  
**Address:**  
**City, State, Zip Code**

**Dear \_\_\_\_\_:**

Following a review of your long term care needs, it has been determined that you do not qualify for nursing facility level services based on the Michigan Medicaid Nursing Facility Level of Care Determination. You did not qualify under any of the following eligibility categories: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies. The legal basis for this decision is 42 CFR 440.230 (d).

If you do not agree with this action, you may request all or any of the following:

**Medicaid Fair Hearing:** to request a Medicaid Fair Hearing, complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to:

**Administrative Tribunal  
Michigan Department of Community Health  
P.O.Box 30763  
Lansing, Michigan 48909**

The Medicaid Fair Hearing Request **must be**

- **Received within 90 calendar days of the date of this notice**
- **In writing, and**
- **Signed by you or a person authorized to sign for you**

Sincerely,  
(provider representative)

8/28/2007

**ATTACHMENT D**

**LONG TERM CARE  
Advance Action Notice**

**Date:**  
**Name:**  
**Address:**  
**City, State, Zip Code**

**Dear \_\_\_\_\_ :**

Following a review of your long term care needs, it has been determined that you no longer qualify for nursing facility level services based on the Michigan Medicaid Nursing Facility Level of Care Determination. You did not qualify under any of the following eligibility categories: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies. Nursing facility level services will be terminated 90 days from the date of this notice. The final date of nursing facility level services will be \_\_\_\_\_. The legal basis for this decision is 42 CFR 440.230 (d).

If you do not agree with this action, you may request all or any of the following:

**Medicaid Fair Hearing:** to request a Medicaid Fair Hearing, complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to:

**Administrative Tribunal  
Michigan Department of Community Health  
P.O.Box 30763  
Lansing, Michigan 48909**

The Medicaid Fair Hearing Request **must be**"

- Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action as stated above.

Sincerely,  
(provider representative)

8/28/2007

**ATTACHMENT E**

**REQUEST for HEARING**

**INSTRUCTIONS**

You may use this form to request a hearing. You may also submit your hearing request in writing on any paper.

A hearing is an impartial review of a decision made by the Michigan Department of Community Health or one of its contract agencies that client believes is wrong.

**GENERAL INSTRUCTIONS:**

- Read ALL instructions FIRST, then remove this instruction sheet before completing the form.
- Complete Section 1.
- Complete Section 2 only if you want someone to represent you at the hearing.
- Do NOT complete Section 4.
- Please use a PEN and PRINT FIRMLY.
- If you have any questions, please call toll free: 1 (877) 833 - 0870.
- Remove the BOTTOM (Yellow) copy and save with the instruction sheet for your records.
- After you complete this form, mail it in the enclosed self addressed, postage paid envelope or mail to:

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES  
FOR THE DEPARTMENT OF COMMUNITY HEALTH  
PO BOX 30763  
LANSING MI 48909

- You may choose to have another person represent you at a hearing.
  - This person can be anyone you choose but he/she must be at least 18 years of age.
  - You MUST give this person written permission to represent you.
  - You may give written permission by checking YES in SECTION 2 and having the person who is representing you complete SECTION 3. You MUST still complete and sign SECTION 1.
  - Your guardian or conservator may represent you. A copy of the Court Order naming the guardian/conservator must be included with this request.

8/28/2007

- The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.
- If you need help with reading, writing, or hearing, you are invited to make your needs known to the Department of Community Health.

If you do not understand this, call the Department of Community Health at (877) 833-0870.

Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria.

إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لولاية ميتشيغن.

**1 (877) 833 - 0870**

**Completion:** Is Voluntary

DCH-0092 (SOAHR) INSTRUCTION SHEET (Rev. 3-06) **See the Request Form Underneath**

8/28/2007

**REQUEST FOR HEARING  
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES  
FOR THE DEPARTMENT OF COMMUNITY HEALTH  
PO BOX 30763  
LANSING, MI 48909  
1 (877) 833-0870**

**SECTION 1 – To be completed by PERSON REQUESTING A HEARING:**

Your Name			Your Telephone Number (     )	Your Social Security Number	
Your Address (No. & Street, Apt. No.)			Your Signature		Date Signed
City	State	ZIP Code			
What Agency took the action or made the decision that you are appealing.				Case Number	
<b>I WANT TO REQUEST A HEARING:</b> The following are my reasons for requesting a hearing. <b>Use Additional Sheets if Needed.</b> <hr/> <hr/> <hr/> <hr/> <hr/>					
Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing? <input type="checkbox"/> NO <input type="checkbox"/> YES (Please Explain in Here):					

**SECTION 2 – Have you chosen someone to represent you at the hearing?**

Has someone agreed to represent you at a hearing? <input type="checkbox"/> NO <input type="checkbox"/> YES (If YES, have the individual complete section 3)
--

**SECTION 3 – Authorized Hearing Representative Information:**

Name of Representative			Representative Telephone Number (     )		
Address (No. & Street, Apt. No.)			Representative Signature		Date Signed
City	State	ZIP Code			

**SECTION 4 – To be completed by the AGENCY distributing this form to the client**

Name of Agency			AGENCY Contact Person Name		
AGENCY Address (No. & Street, Apt. No.)			AGENCY Telephone Number (     )		
City	State	ZIP Code	State Program or Service being provided to this appellant		

DCH-0092 (SOAHR) (Rev 3/06)  
DISTRIBUTION: WHITE (2<sup>nd</sup> page) Administrative Tribunal, YELLOW - Person Requesting Hearing

8/28/2007

**Attachment F**

**Annotations**

**DOC** (documented), meaning the service conformed to Program regulations, policies and procedures.

**NF** (not found), meaning the provider did not provide any record substantiating that the service was performed.

**NS-1** (not supported), meaning the service was improperly billed.

**NS-2**, meaning the service is not a covered benefit of the Program.

**NS-3**, meaning the service was not medically necessary.

**NS-4**, meaning the record(s) was insufficient to support the service paid by the Program.

**NS-7**, meaning the record(s) was illegible.

**RC**, meaning that the record did not support the service paid but supported another service. The procedure code for the appropriate service will be annotated beneath the printed procedure code.

**RC/UP** (recoded underpayment), meaning that the record did not support the service paid but supported another service. The procedure code for the appropriate service will be annotated beneath the printed procedure code. If this results in an underpayment to the provider the annotation will be reflected by RC/UP (recoded underpayment).

8/28/2007

**Attachment G**

September 25, 2004 [Outpatient Letter] Revised 7/18/06

Jane Doe  
Utilization Review Specialist  
Sample Road  
Anywhere, MI xxxxx

Dear Ms.Doe:

The Michigan Peer Review Organization (MPRO) as a contracted agent of the Michigan Department of Community Health, is currently performing an audit of your Provider Type 40 (Outpatient Hospital) facility. As I explained during my telephone conversation, this post payment medical record review is being conducted to determine compliance with Medicaid policy and guidelines.

This letter is to confirm our appointment scheduled for \_\_\_\_\_ and \_\_\_\_\_ at \_\_\_\_\_ a.m. in your facility. These visits are to copy records for approximately two hundred fifty (250) Medicaid beneficiaries for whom you provided services for the review period of 1/1/200\_ thru 12/31/200\_. All Outpatient Services for the beneficiaries included in the sample, for the review period are needed. Examples of some of the Outpatient Hospital services that may be included are: laboratory, radiology, Emergency Room visits, physical therapy etc. Some of the services may include items that are series billed such as physical therapy visits. An itemized bill is needed for the following Revenue Center Codes 250, 251, 252, 257, 258, 259, 260, 262, 270, 271, 272, and 370. The dates of service that require the itemized bill are highlighted on the case listing.

In addition to myself there will be another nurse reviewer. We will require a room with an electrical outlet and will be bringing equipment to your facility. You will be furnished with a beneficiary list thirty (30) calendar days prior to our arrival. It is estimated we will need \_\_\_\_\_ days at your facility to copy the records.

If you have any questions regarding this correspondence or if there is difficulty locating a record and you need assistance identifying the Outpatient Hospital service provided please call. I can be reached at (---) --- - ----.

Thank-you again for your cooperation and continued participation in the Medicaid Program.

Sincerely,

\_\_\_\_\_, RN,  
Michigan Peer Review Organization  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

Cc: CEO

8/28/2007

**Attachment G1**  
**September 25, 2004 [Inpatient Letter] Revised 7/18/06**

Jane Doe  
Utilization Review Specialist  
Sample Road  
Anywhere, MI xxxxx

Dear Ms.Doe:

The Michigan Peer Review Organization (MPRO) as a contracted agent of the Michigan Department of Community Health, is currently performing a audit of your Provider Type 30 (Inpatient Hospital) facility. As I explained during my telephone conversation, this post payment medical record review is being conducted to determine compliance with Medicaid policy and guidelines.

This letter is to confirm our appointment scheduled for \_\_\_\_\_ and \_\_\_\_\_ at \_\_\_\_\_ a.m. in your facility. These visits are to copy records for approximately two hundred fifty (250) Medicaid beneficiaries for whom you provided services for the review period of 1/1/200\_ thru 12/31/200\_. The beneficiaries may have more than one (1) Inpatient Hospital admission during the audit review period. All admissions for the beneficiaries included in the sample for the audit timeframe are needed.

In addition to myself there will be another nurse reviewer. We will require a room with an electrical outlet and will be bringing equipment to your facility. You will be furnished with a beneficiary list thirty (30) calendar days prior to our arrival. It is estimated we will need \_\_\_\_\_ days at your facility to copy the records.

If you have any questions regarding this correspondence or if there is difficulty locating a record and you need assistance identifying the Inpatient Hospital admission please call. I can be reached at (---) --- - ----.

Thank-you again for your cooperation and continued participation in the Medicaid Program.

Sincerely,

\_\_\_\_\_, RN,  
Michigan Peer Review Organization  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

Cc: CEO

8/28/2007

**ATTACHMENT H**

September 25, 2004(Revised 7-18-06)

Jane Doe  
Utilization Review Specialist  
Sample Road  
Anywhere, MI xxxxx

Dear Ms. Doe:

Attached you will find a list of the records that are missing from the audit sample. As per our telephone conversation this afternoon, please send me all records you are able to locate within ten (10) business days of the date of this letter. Any record not found for this audit will be considered Not Found (NF) and monies will be recouped accordingly.

If you have any questions regarding this correspondence please call. I can be reached at (---) -----  
-.

Thank-you again for your cooperation and continued participation in the Medicaid Program.

Sincerely,

\_\_\_\_\_, RN, \_\_\_\_\_  
Contractor Name  
Contractor Address

CC:CEO

8/28/2007

Attachment H cont'

BENEFICIARY NAME	MEDICAID ID NUMBER	DATE OF BIRTH	DATES OF SERVICE	SERVICE PROVIDED
Xxxx xxxxx	#####	D/M/YY	1/15/98-1/16/98	Newborn care
Xxxx xxxxx	#####	D/M/YY	3/20/98-5/8/98	Newborn care
Xxxx xxxxx	#####	D/M/YY	6/30/98-9/15/98	Newborn care, circumcision
Xxxx xxxxx	#####	D/M/YY	7/12/98-7/27/98	Newborn care, circumcision

8/28/2007

**ATTACHMENT I**

**Nurse Review Report**

**For**

**Case Number:**

**ID Number:**

**Review Period:**            **thru**

**Sample Size: Stratum**  
**Stratum**

**Missing Records:**

**Review By:** \_\_\_\_\_  
**(Signature)**

**Date:**

**(Organization Name)**  
**(Organization Address)**

8/28/2007

**Provider Name**  
Nurse Review Report

**Reason For Review:**

This review was conducted to determine compliance with Medicaid Policy and guidelines.

**Sample Statistics:**

Review Period:  
Run Date:  
I.D. Number:  
Total Payments:  
Sample Payments:  
Total Beneficiaries:  
Sample Beneficiaries:  
Total Claims:  
Sample Claims:

**Summary of Field Activities:**

The on-site visits were conducted on \_\_\_\_\_ at \_\_\_\_\_.  
\_\_\_\_\_ was our contact person. All available medical records were copied. \_\_\_\_\_  
assisted in the copying of records.

**Nurse Review Findings:**

(This section summarizes the results of the audit review. Policy and Procedure, as well as Procedure and Revenue Codes should be referenced where applicable. Examples stating the stratum and beneficiary number should be listed with each finding. In addition to the above, every finding should include an attachment which contains a copy of the policy, procedure and revenue code supporting the finding.)

8/28/2007

**ATTACHMENT J**

**ADEQUATE ACTION NOTICE**

Denial of Service

Date

Beneficiary Name  
Beneficiary Address

RE: Beneficiary Name  
Beneficiary Medicaid ID #

Dear (Beneficiary Name):

(Contractor Name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for services for Medicaid Long Term Care Services. Following a review of the services for which you have applied, it has been determined that the following service(s) shall not be authorized. It has been determined that you do not meet the functional/medical eligibility requirements for this program. Therefore, authorization for the admission has been denied. The legal basis for this decision is the 42CFR 440.230(d).

**Service(s)**

**Effective Date**

<b>Service(s)</b>	<b>Effective Date</b>
_____	_____
_____	_____

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30763  
LANSING, MI 48909-7695

If you have any questions about this denial, you may call the Contractor Manager for the (Contractor Name) Contract at (phone number).

If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:  
Hearing Request Form  
Return Envelope

8/28/2007

**ATTACHMENT K**

**ADVANCE ACTION NOTICE  
Suspension, Reduction or Termination**

Date  
Name  
Address  
City, State, Zip

RE: Beneficiary's Name  
Beneficiary's Medicaid ID Number

Dear \_\_\_\_\_:

(Contractor name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for Medicaid Long Term Care Services. Following a review of the services that you are currently receiving, it has been determined that the following service(s) shall not be authorized. The reason for this action is \_\_\_\_\_. The legal basis for this decision is 42CFR 440.230(d).

<b>Service(s)</b>	<b>Effective Date</b>
_____	_____
_____	_____

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30763  
LANSING, MI 48909-7695

You will continue to receive the affected services in most circumstances until the hearing decision is rendered if your request for a department hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a department hearing you may be required to repay the benefits. This will occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

If you have questions about this denial, you may call the Contract Manager for the Contract at (517)-----. If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:  
Hearing Request Form, Return Envelope

8/28/2007











ATTACHMENT N

**NURSING FACILITY RETROSPECTIVE REVIEW NOTIFICATION**

**DATE:**

**NAME:**

**ADDRESS:**

**CITY, STATE, ZIP**

**Dear Administrator/Director of Nursing:**

In accordance with MSA 05-09, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The Michigan Peer Review Organization (MPRO) is the contractor for MDCH's Retrospective Reviews.

Attached are the case listing and label(s) for the nursing facility resident's(s') medical records that must be submitted by the provider, and received by MPRO, within thirty (30) calendar days from the date of this letter.

The enclosed case listings include selections based on completion of the LOC Determination for a specific review period. The beginning and end dates of the review period may or may not correspond directly with the admission and/or discharge dates for this beneficiary. The submitted record must include all required documentation for any care provided during this period that will be billed to Medicaid, including, but not limited to, the following:

1. Copy of the LOC Determination
2. Copy of the Freedom of Choice Form
3. PASARR evaluation-level 1, and level 2 when indicated (Form-DCH-3877 and 3878)
4. All Minimum Data Set documents for the period under review
5. Face sheet
6. Original History and Physical
7. Physician Orders for the period under review
8. All nursing notes, rehabilitation notes, physician progress notes, or interdisciplinary team notes for the period under review
9. Skilled therapy evaluations and progress notes for the period under review
10. Discharge plans
11. Medicare Recertification/Certification form

8/28/2007

Again, copies of the above mentioned resident's (s') medical records for this review must be submitted to, and received by, MPRO within thirty (30) calendar days from the date of this letter, therefore, the due date for the above medical records is \_\_\_\_\_.

Failure to provide MPRO with the requested medical records will result in a technical denial, which imposes a monetary penalty. Please attach the enclosed label to the medical record file and mail it to:

LTC Medicaid Medical Review  
MPRO  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

If you have any questions, please contact Yvonne Kendall at (248) 465-7414.

Sincerely,

Director, Medical Review Services  
Enclosures: Label(s) and Case Listing

8/28/2007

ATTACHMENT O

**MI CHOICE WAIVER RETROSPECTIVE REVIEW NOTIFICATION**

**DATE:**

**NAME:**

**ADDRESS:**

**CITY, STATE, ZIP**

**Dear Administrator/Director of Nursing:**

In accordance with MSA 05-09, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The Michigan Peer Review Organization (MPRO) is the contractor for MDCH's Retrospective Reviews.

Attached are the case listing and label(s) for the MI Choice Waiver participant's(s') medical records that must be submitted by the provider, and received by MPRO, within thirty (30) calendar days from the date of this letter.

The enclosed case listings include selections based on completion of the LOC Determination for a specific review period. The beginning and end dates of the review period may or may not correspond directly with the admission and/or discharge dates for this beneficiary. The submitted record must include all required documentation for any care provided to the participant(s) during this period that will be billed to Medicaid, including, but not limited to, the following:

1. Copy of the LOC Determination
2. Copy of the Freedom of Choice Form
3. Minimum Data Set –Home Care Assessment documents for the period under review
4. All available medical records for the period under review
5. All physician notes and orders for the period under review
6. All MI Choice Program contact notes from the family, friends or the participant for the period under review
7. MI Choice Program's Plan of Care for the participant during the period of review

Again, copies of the above medical records for the participant's (s') review must be submitted to, and received by, MPRO within thirty (30) calendar days from the date of this letter, therefore, the due date for the above medical records is **(Date)**.

Failure to provide MPRO with the requested medical record will result in a technical denial, which imposes a monetary penalty. Please attach the enclosed label to the medical record file and mail it to:

8/28/2007

LTC Medicaid Medical Review  
MPRO  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

If you have any questions, please contact (name) at (phone number).

Sincerely,

Director, Medical Review Services  
Enclosures: Label(s) and Case Listing

8/28/2007

ATTACHMENT P

**NURSING FACILITY RETROSPECTIVE REVIEW REMINDER**

**DATE:**

**NAME:**

**ADDRESS:**

**CITY, STATE, ZIP**

RE: (Beneficiary's Name)

**Dear Administrator/Director of Nursing:**

In accordance with MSA 05-09, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The Michigan Peer Review Organization (MPRO) is the contractor for MDCH's Retrospective Reviews.

On (DATE) the following medical records were requested from your facility for the review period from (DATE) to (DATE). The records were required to have been submitted and received by MPRO, within thirty (30) calendar days from the date of this letter. At this time, we have not received copies of the following requested record(s).

Beneficiary ID

Selection Date

As mentioned in the initial request, the submitted record must include all required documentation for any care provided to the resident(s) during the period that will/was billed to Medicaid, including, but not limited to, the following:

1. Copy of the LOC Determination
2. Copy of the Freedom of Choice Form
3. PASARR evaluation- level 1, and level 2 when indicated (Form DCH 3877 and 3878)
4. All Minimum Data Set documents for the period under review
5. Face Sheet
6. Original History and Physical
7. Physician Orders for the period under review
8. All nursing notes, rehabilitation notes, physician progress notes, or interdisciplinary team notes for the period under review.
9. Skilled therapy evaluations and progress notes for the period under review
10. Discharge Plans
11. Medicare Recertification/Certification form

8/28/2007

The medical records must be received by, MPRO no later than (date). Should the requested record(s) not be received by (date), a notice of inaction by your facility will be forwarded to the Michigan Department of Community Health.

If you have any questions, please contact (name) at (phone number).

LTC Medicaid Medical Review  
MPRO  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

Sincerely,

Director, Medical Review Services  
Enclosures: Label(s) and Case Listing

8/28/2007

ATTACHMENT Q

**MI CHOICE WAIVER RETROSPECTIVE REVIEW REMINDER**

**DATE:**

**NAME:**

**ADDRESS:**

**CITY, STATE, ZIP**

**Dear Administrator/Director of Nursing:**

In accordance with MSA 05-09, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The Michigan Peer Review Organization (MPRO) is the contractor for MDCH's Retrospective Reviews.

On (DATE) the following medical records were requested from your agency for the review period from (DATE) to (DATE). The records are required to have been submitted and received by MPRO, within thirty (30) calendar days from the date of this letter. At this time, we have not received copies of the following requested record(s).

Beneficiary ID

Selection Date

As mentioned in the initial request, the submitted record must include all required documentation for any care provided to the resident(s) during the period that will/was billed to Medicaid, including, but not limited to, the following:

1. Copy of the LOC Determination
2. Copy of the Freedom of Choice Form
3. Minimum Data Set –Home Care Assessment documents for the period under review
4. All available medical records for the period under review
5. All physician notes and orders for the period under review
6. All MI Choice Program contact notes from the family, friends or the participant for the period under review
7. MI Choice Program's Plan of Care for the participant during the period of review

The medical records must be received by, MPRO no later than (date). Should the requested record(s) not be received by (date), a notice of inaction by your agency will be forwarded to the Michigan Department of Community Health.

8/28/2007

If you have any questions, please contact (name) at (phone number).

LTC Medicaid Medical Review  
MPRO  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

Sincerely,

Director, Medical Review Services

8/28/2007

ATTACHMENT R

**INCOMPLETE RETROSPECTIVE REVIEW MEDICAL RECORD**

**DATE:**

**NAME:**

**ADDRESS:**

**CITY, STATE, ZIP**

RE: (Beneficiary's Name)

**Dear Administrator/Director of Nursing/MI Choice Program Director:**

In accordance with MSA 05-09, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The Michigan Peer Review Organization (MPRO) is the contractor for MDCH's Retrospective Reviews.

On (DATE) the following case record was requested for the review period from (DATE) to (DATE). Although the case record was received, the record did not include the following requested document(s):

Beneficiary Medicaid ID

1. (List Item)
2. (List Item)

This initially requested documentation must be received by MPRO no later than (date). Should the requested documentation not be received by (date), a notice of inaction will be forwarded to the Michigan Department of Community Health.

If you have any questions, please contact (name) at (phone number).

LTC Medicaid Medical Review  
MPRO  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

Sincerely,  
Director, Medical Review Services

8/28/2007

ATTACHMENT S  
PENDING TECHNICAL DENIAL

**DATE:**  
**NAME:**  
**ADDRESS:**  
**CITY, STATE, ZIP**

RE: Notice of Pending Technical Denial

In accordance with MSA 05-09, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The Michigan Peer Review Organization (MPRO) is the contractor for MDCH's Retrospective Reviews.

On (date) and (date), MPRO requested medical records to conduct Retrospective Reviews on behalf of MDCH, in compliance with state policy. No response was received from either request.

The medical records as requested in the previous notices must be received by MPRO within fourteen (14) calendar days from the date of this letter. Should the requested records not be received within fourteen (14) calendar days, a notice of Technical Denial will be forwarded to MDCH for further action by the Department.

If you have any questions, please contact (name) at (phone number).

Sincerely,

Melody Petrul, RN  
Director, Medical Review Services

8/28/2007

ATTACHMENT T

FINAL DENIAL

**DATE:**

**NAME:**

**ADDRESS:**

**CITY, STATE, ZIP**

RE: Notice of Final Denial

In accordance with MSA 05-09, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The Michigan Peer Review Organization (MPRO) is the contractor for MDCH's Retrospective Reviews.

On (date) MPRO sent a Pending Technical Denial letter to your (facility/agency) based upon non-compliance to the request of medical records to conduct Retrospective Reviews on behalf of MDCH, in compliance with state policy. Medical records as requested in the Pending Technical Denial letter were not forwarded to MPRO as requested in the notice of Technical Denial.

Notice of Retrospective Review Final Denial will be forwarded to MDCH as notice of inaction by you (facility/agency) to the requests made by MPRO.

Sincerely,

Melody Petrul, RN  
Director, Medical Review Services

8/28/2007

ATTACHMENT U

NURSING FACILITY RETROSPECTIVE REVIEW DETERMINATION

**DATE:**

**NAME:**

**ADDRESS:**

**CITY, STATE, ZIP**

RE: (beneficiary's name)

Dear Administrator/Director of Nursing,

In accordance with MSA 05-09, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The Michigan Peer Review Organization (MPRO) is the contractor for MDCH's Retrospective Reviews.

The MPRO nurse reviewer has conducted a Retrospective Review by evaluating the case record documentation submitted by your facility for the above beneficiary for the review period beginning (date) through (date). Based upon the Retrospective Review conducted by MPRO, it has been determined that:

This is an informational letter to assist your facility in understanding and implementing MDCH policy MSA 05-09, in particular, regarding Informed Choice, Preadmission Screening and Quarterly and Annual Resident Review requirements. Data from these reviews have been forwarded to MDCH for further evaluation and trending as needed. Continued non-adherence to policy may result in further action by MDCH.

Questions may be forwarded to (name) at:

LTC Medicaid Medical Review  
MPRO  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

Sincerely,

Melody Petrul, RN  
Director, Medical Review Services

8/28/2007



STATE OF MICHIGAN  
 DEPARTMENT OF MANAGEMENT AND BUDGET  
 PURCHASING OPERATIONS  
 P.O. BOX 30026, LANSING, MI 48909  
 OR  
 530 W. ALLEGAN, LANSING, MI 48933

March 2, 2007

**CHANGE NOTICE NO. 3**  
**TO**  
**CONTRACT NO. 071B5200162**  
**between**  
**THE STATE OF MICHIGAN**  
**and**

NAME & ADDRESS OF VENDOR  <b>Michigan Peer Review Organization</b> <b>22670 Haggerty Road, Suite 100</b> <b>Farmington Hills, MI 48335-2611</b>		TELEPHONE (248) 465-7300 <b>Debra L. Moss, MD</b>
		VENDOR NUMBER/MAIL CODE <b>(002)</b>
		BUYER/CA (517) 241-4225 <b>Kevin Dunn</b>
Contract Compliance Inspector: Renate Rademacher <b>Hospital Admission Review and Certification Program - DCH</b>		
CONTRACT PERIOD: From: <b>January 1, 2005</b> To: <b>December 31, 2007</b> with two 1-year renewal options		
TERMS <b>N/A</b>	SHIPMENT <b>N/A</b>	
F.O.B. <b>N/A</b>	SHIPPED FROM <b>N/A</b>	
MINIMUM DELIVERY REQUIREMENTS <b>N/A</b>		

**NATURE OF CHANGE(S):**

Effective immediately, this Contract is hereby **INCREASED** by \$213,199.99. All other terms, conditions, specifications, and pricing remain unchanged.

**AUTHORITY/REASON:**

Per agency request, Ad Board approval (2/6/07) and DMB/Purchasing Operations.

**TOTAL REVISED ESTIMATED CONTRACT VALUE: \$6,728,994.99**

STATE OF MICHIGAN  
 DEPARTMENT OF MANAGEMENT AND BUDGET  
 PURCHASING OPERATIONS  
 P.O. BOX 30026, LANSING, MI 48909  
 OR  
 530 W. ALLEGAN, LANSING, MI 48933

October 4, 2006

**CHANGE NOTICE NO. 2**  
**TO**  
**CONTRACT NO. 071B5200162**  
**between**  
**THE STATE OF MICHIGAN**  
**and**

NAME & ADDRESS OF VENDOR  <b>Michigan Peer Review Organization</b> <b>22670 Haggerty Road, Suite 100</b> <b>Farmington Hills, MI 48335-2611</b>		TELEPHONE (248) 465-7300 <b>Debra L. Moss, MD</b>
		VENDOR NUMBER/MAIL CODE <b>(002)</b>
		BUYER/CA (517) 241-4225 <b>Kevin Dunn</b>
Contract Compliance Inspector: Renate Rademacher <b>Hospital Admission Review and Certification Program - DCH</b>		
CONTRACT PERIOD: From: <b>January 1, 2005</b>		To: <b>December 31, 2007</b> with two 1-year renewal options
TERMS <b>N/A</b>	SHIPMENT <b>N/A</b>	
F.O.B. <b>N/A</b>	SHIPPED FROM <b>N/A</b>	
MINIMUM DELIVERY REQUIREMENTS <b>N/A</b>		

**NATURE OF CHANGE(S):**

Effective immediately, the attached work statement is hereby incorporated into this Contract and replaces all prior work statements. All other terms, conditions, specifications and pricing remain unchanged.

Please note: The buyer has been changed to Kevin Dunn.

**AUTHORITY/REASON:**

Per agency request and DMB/Purchasing Operations approval.

**TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$6,515,795.00**

**SECTION II  
WORK STATEMENT**

**PART I PACER/LONG TERM CARE PACER**

**A. BACKGROUND STATEMENT**

The Michigan Department of Community Health is the single state agency responsible for health policy, the purchase of health care services, and accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population.

The purpose of this contract is to have a qualified Contractor conduct telephonic/electronic authorization of inpatient services to determine compliance with Medicaid Policy & Guidelines as outlined in the Provider Manuals and Bulletins; and to determine appropriateness of Medicaid coverage for all inpatient admissions utilizing current standards of practice, the Michigan State Plan, and Federal Regulations.

Additionally, a portion of this contract is to provide for the private administration of a state-wide admission review and certification system for Michigan Medicaid long term care programs that must utilize nursing facility level of care criteria. The Contractor will authorize appropriate exceptions to current Medicaid Nursing Facility Policy and Guidelines as outlined in Provider Manuals and Bulletins; determine appropriateness of Medicaid coverage for nursing facility level of care programs (Medicaid covered nursing facility admissions, MI Choice Home and Community Based Waiver Program for the Elderly and Disabled, and the Program for All Inclusive Care for the Elderly and Disabled); and provide analytical reports regarding long term care utilization.

The contract shall be for three years beginning January 1, 2005 through December 31, 2007 with the option of two yearly extensions.

**B. OBJECTIVES**

1. MDCH seeks a Contractor to perform a telephonic/electronic authorization in compliance with Medicaid Program Policy and Procedure. This inpatient authorization will be conducted on Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries includes ABW population through 2-28-2005. For long-term care, the review will be conducted on Medicaid Fee For Service, and possibly Medicare/Medicaid beneficiaries.

2. The Contractor will conduct the following reviews:

- a. Inpatient Prior Authorization –PACER (Prior Authorization Certification Evaluation Review)-telephonic/electronic for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries. MDCH anticipates approximately 10,800 calls annually.

b. Long Term Care-telephonic/electronic reviews will be performed for requests for exceptions to the Michigan nursing facility level of care definition. Explicit exception criteria will be used for this review. For some cases, professional clinical judgment may be used to determine persons who are at risk for institutionalization. MDCH anticipates approximately 2,000 requests annually.

3. The following are the mandatory elements for the program, the Contractor is not, however, constrained from supplementing this listing with additional steps, sub tasks or elements deemed necessary to permit the development of alternative approaches or the application of proprietary analytical techniques:

- a. Responsibility for the authorization must be implemented no later than the first day of this contract.
- b. This process shall be continued through the contract termination date.
- c. The telephone/computer system shall be available from 8AM-5PM Monday through Friday except for State approved/sanctioned holidays.
- d. Providers will be notified 30 days prior to an approved holiday.
- e. The Contractor must be HIPAA compliant.
- f. Telephonic/Computer Electronic system must be in place the first day of the contract.
- g. The Contractor must be available for the Appeals Process.
- h. The Contractor must have a system or process in place that allows the validation of the PACER authorizations:
  - i. Assigned PACER numbers.
  - ii. Documentation provided at the time of PACER request.
    - aa. Review Coordinator documentation.
    - bb. Physician Reviewer documentation.

4. A copy of the information received from the provider at the time the PACER authorization was requested will be validated by the Contractor. The information received from the provider for PACER authorization both approvals and denials, including the Review Coordinator's and Physician's documentation, must be stored electronically or via hard copy.

**C. INPATIENT PRIOR AUTHORIZATION-PACER-TELEPHONIC/ELECTRONIC REVIEW PROCESS**

1. Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.
2. The Contractor shall provide the telephone/computer prior authorization system, (PACER), that shall include, at a minimum, all of the following:
  - a. clinically experienced Registered Nurses to receive the authorization request, elicit all relevant information and reach an initial decision based on InterQual® criteria;
  - b. use of appropriately qualified physicians to assist the Registered Nurses in their decision as appropriate, to query requesters in all questioned requests and render all denial determinations;
  - c. render and communicate by telephone/electronic computer system all authorization decisions on the same day requested;
  - d. generate and communicate to the requesting provider a unique identifying authorization number for each authorized case; and
  - e. data processing storage and retrieval of all requests, i.e., documentation and disposition, requesting providers, and other information taken in by the system as part of the request for prior authorization.
  - f. the Contractor will maintain a toll-free telephone number and electronic computer system for the providers to request an authorization number. The Contractor shall answer all incoming phone calls promptly with average time to answer of less than ninety (90) seconds.
3. The PACER system shall certify as appropriate for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries: all elective inpatient hospital admissions; all re-admissions within 15 days; all transfers between hospitals and between units within a single hospital having different Medicaid ID numbers or provider types; all admissions and continued stays for inpatient rehabilitative facilities.
4. The basis of the decisions shall include the medical need and appropriateness of the following:
  - a. the condition to be treated on an inpatient basis;
  - b. to have treatment continued for rehabilitative facilities;
  - c. to be treated at another hospital if already hospitalized;
  - d. to be re-hospitalized.

Denials for inpatient admissions and any changes to the request shall be transmitted to the MDCH. The Contractor must send a negative action letter to the beneficiary developed by the State Administrative Tribunal to Medicaid and Medicaid/CSHCS dually enrolled beneficiaries utilizing the appropriate denial statement. The beneficiary will be notified of a denial of services for an elective admission. Transfers and readmissions within 15 days do not need a letter to the beneficiary as no services were suspended, terminated or reduced. An appeals form (DCH-092 Hearing Request) (See Part III, Attachment C) provided by the State must accompany the negative action letter to the beneficiary. The negative action letter and appeal form must be sent to the beneficiary the day of the negative action. Copies of all negative action letters shall be sent to the MDCH Contract Administrator on a monthly basis.

Providers are notified verbally at the time of the telephonic/computer request and given appeal rights verbally at the same time.

5. It is essential that the prior authorization number comply with the following composition in order to integrate with the MDCH computer system:

Nine-digit number:

The first four digits are the Julian date; and the last five digits are the beneficiaries ID number coded into the prior authorization master report numbers by formula. The requester for the authorization number supplies the beneficiaries ID number. The listing for the prior authorization master report numbers can be supplied by the MDCH.

The payment system reads the authorization numbers, compares information, pends the inappropriate claims for various reasons by edits.

6. The Contractor shall develop a process for PACER and it must include:

a. The review is initiated by the attending physician or designated other, by telephone or electronically, requesting prior authorization for a patient's elective admission, a transfer, readmission within 15 days, or continued stay for inpatient rehabilitative facilities. The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all prior authorization requests including the negative action letter.

b. In a transfer/readmission within 15 days (to another hospital) should the transferring physician not obtain an authorization as required, the receiving physician or second hospital may request this before the beneficiary is discharged.

c. Any case request must include at the minimum; beneficiary ID number, sex, birth date, county of residence, procedure code, hospital name, transfer code (transfer, readmission, urgent/emergent/elective), discharge date of first admission, justification code (reason for

admission), and patient's name (required for physician advisor referrals).

7. If the Severity of Illness/Intensity of Service (SI/IS) InterQual® criteria and/or Policy are met, the Contractor's nurse approves the admission and a nine-digit prior authorization number is issued to the physician. The number is valid for 30 days and must be entered on both the physician and hospital claims for the admission.
8. If the criteria screens are not met or if there are any questions requiring medical judgment, the case shall be referred to a Contractor's physician consultant by the Contractor's nurse. The Contractor's physician consultant may confer by telephone with the attending physician. Ninety eight percent, (98%), of referral cases must be resolved, either approved or denied for Medicaid coverage by the Contractor during the same day of the request. All cases must be resolved within one working day of the request. Cases approved by the physician will be considered complete. The Contractor will report all adverse determinations to the MDCH after the reconsideration process is completed.
9. The Contractor shall have a process to reconsider denials of all PACER reviews at the request of the provider. At a minimum, the process must include:
  - a. Reconsideration must be requested by the provider within three (3) working days of receipt of the denial.
  - b. The Contractor will provide a reconsideration of adverse determinations upon written request from the provider(s).
  - c. All reconsideration's will be conducted by a like specialty physician (when applicable) who will consider the entire medical record and all additional written information supplied by the provider who performed the services. The Contractor must complete reconsideration decisions for elective admissions (excluding rehab) and retrospective PACER requests within thirty (30) working days. The Contractor must complete reconsideration decisions for all transfers, rehab admissions and continued stay within one (1) working day of receipt of the request or the date of receipt of written documentation.
  - d. The Contractor shall have a two step review process to review all denials at the request of the hospital or physician. The original request if denied by the Contractor review coordinator (RN) goes to the Contractor physician for review. If denied, the provider is verbally told of the denial and given appeal (reconsideration) rights. The second request (reconsideration) is submitted via a Request for Retrospective PACER Review form, (this may include a complete medical record), with a detailed description of the case including case specific information. If denied, the provider is informed verbally that they may appeal to MDCH.
  - e. Whenever possible the Contractor shall match the reviewing physician specialty with that of the attending physician's. After the initial denial, by the first physician, the affected parties would have a right to reconsideration by a second physician.

10. Should the provider request an appeal of a denied PACER from the Contractor they may appeal to MDCH. The provider is to submit the medical record, for review to the MDCH Office of Medical Affairs. The Office of Medical Affairs will make the determination. Should the denied service be overturned, than a PACER number will be authorized by MDCH and assigned by the Contractor. Should the case be upheld by the Office of Medical Affairs, then a letter of denial will be sent by the Contractor. The MDCH Contract Manager will notify the Contractor of the PACER decision verbally and follow-up with a faxed memo. Provider appeals to the MDCH will be conducted so that whenever possible, multiple claim appeals from an individual provider will be heard together.
11. For the inpatient rehabilitative facility, inpatient stays beyond 30 days in the rehabilitation hospital require additional inpatient authorization. The provider must contact the Contractor between the 27<sup>th</sup> and 30<sup>th</sup> days if the stay is expected to exceed 30 days. If the extended stay is approved, a nine-digit certification is issued to the provider. If the stay is expected to exceed 60 days, the provider must call the Contractor between the 57<sup>th</sup> and 60<sup>th</sup> days of stay for additional inpatient authorization. If the additional extended stay is approved, the Contractor will issue another nine-digit authorization number to the provider. For any case not meeting InterQual® criteria, the Contractor's nurse shall refer the case to the Contractor's physician consultant. The remainder of the review and approval/disapproval process follows that of the PACER review. Any authorization denial of any extended stay review point terminates Medicaid coverage of the hospital stay.
12. The Contractor must have available or be able to develop software compatible with any electronic prior authorization system to be designed by MDCH.
13. Complete data for all requests shall be individually stored and retrievable by the Contractor for six years.
14. The Contractor must be able to provide MDCH access to the PACER Program by a means determined by MDCH within one month of startup.
15. All documents and/or information obtained by the Contractor from the Department in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the Department.
16. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing data prior to the start of this Contract.

**D. NOTICE OF NON-COVERAGE EXCEPTION**

The hospital inpatient/LTC program utilization review committee may issue a notice of non-coverage to the patient if it determines that the admission or continued stay in the hospital or nursing facility is not medically necessary.

If the patient or patient representative disagrees with the notice, the patient or representative may contact the Contractor to appeal the decision. If the Contractor has previously issued an adverse determination for the period of

hospitalization covered by the notice, the Contractor informs the patient of concurrence with the hospital decision. If the Contractor has not previously issued an adverse determination for the period, a review of the medical record is conducted. The Contractor contacts the hospital/LTC program to obtain a copy of the medical record. A Contractor physician advisor reviews and issues a decision on the case within three days of the receipt of the final determination and the related documentation. The Contractor will provide the written decision along with the Appeal Process if the Contractor agrees with the hospital/LTC provider.

If issued, the notice is the responsibility of the hospital/nursing facilities utilization review committee and is not related to any decision that may have been rendered by the Contractor on the case. The decision must be based on the findings of the utilization review committee and not on the determination of the Contractor.

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal provides an administrative hearing to appellants requesting a hearing who do not agree with a decision made by MDCH or a MDCH contracted agency (i.e., any agency, organization, or health plan contracted by the MDCH) that either determines eligibility for a department program, or delivers a service provided under a department program to a beneficiary, patient or resident. The Administrative Tribunal issues timely, clear, concise and legally accurate hearing decisions and orders. The Administrative Tribunal Policy and Procedures Manual is located on the website [Michigan.gov/mdch](http://Michigan.gov/mdch), click on links to Inside Community Health, Policy and Legal Affairs, Administrative Tribunal. This website explains the process by which each different type of case is brought to completion.

#### **E. LONG TERM CARE EXCEPTION REQUIREMENTS**

##### Telephonic Exception Review:

The Contractor shall respond to requests for exceptions to the nursing facility level of care criteria for three long term care programs: Medicaid Covered Nursing Facility care, MI Choice Home and Community Based Waiver Program for Elderly and Disabled, and the Program for All Inclusive Care for the Elderly.

Telephonic requests will be reviewed in real time, using MDCH developed exception criteria. Nurses and physician advisors may override this criteria when the individual has an established risk of institutionalization.

1. Nurse reviewers will utilize a specific exception criteria to determine appropriate exceptions to the nursing facility level of care criteria.
2. Approvals will be documented within the web based tool, citing the exception criteria used.
3. Beneficiaries and Providers will be provided appropriate denial notification as identified under Section II, Part I, G, Appeals Process. Example denial notices are included in Section II, Part III, Attachments H and I.
4. Reconsideration reviews will be performed when filed within the guidelines established.
5. The Contractor will represent the Department in any Administrative Appeals.

## **F. LONG TERM CARE EXCEPTION PROCESS**

### Telephonic Review

1. Provider initiates request for exception.
2. Review Coordinator finds current review within the web based electronic system.
3. Review Coordinator reviews additional telephonic information and makes a decision or refers to physician adviser.
4. Review Coordinator completes initial process level information in web based tool.
5. Review Coordinator processes denials as necessary.
6. The Contractor will provide a monthly list of approval and denial recommendations to MDCH.

## **G. APPEALS PROCESS:**

### 1. PACER Appeals:

Only after the internal appeals have been exhausted may any appeal be made directly to the MDCH. When such an appeal is made, the Contractor will provide the written reports, and make direct testimony available to the MDCH as the MDCH deems necessary.

The MDCH allows the provider the right of appeal through the Medicaid Provider Reviews and Hearings Administrative Rules MAC (R400.3401-400.3425) under the authority conferred on the Director of MDCH by Sections 6 and 9 of Act No. 280 of the Public Acts of 1939. The Contractor shall provide sufficient staff including RNs/Physicians for participation and testimony in the MDCH appeals process. This involvement shall begin at the Bureau Conference level and continue as required through the Administrative Law Judge (ALJ) level or until the provider has accepted a final decision of the case.

The Contractor will make decisions that may result in an appeal to the State. The Contractor must notify the Medicaid beneficiary in writing of any adverse action, i.e., denial, reduction, or termination of services and their appeal rights, when such denial, reduction, or termination results from the Prior Authorization process. (See Section II, Part III, Attachments A-B.) The Department's Administrative Manual, Hearings and Appeals Section, contains the Department of Community Health's policies and procedures regarding administrative hearings. The Contractor must comply with this policy and all relevant federal regulations and state statutes. The Contractor shall prepare the hearing summary for all requests for hearings involving fee for service beneficiaries covered by this contract. The Contractor shall be solely responsible for presenting its position at the beneficiary's administrative hearing. The Contractor shall present the hearing summary and testify at all hearings involving the Department's fee-for-service beneficiaries covered by this contract.

### 2. Long Term Care Appeals:

#### a. Provider Appeals

The Contractor shall have available at least two physicians for review of cases referred by the nurse review coordinator. The Contractor must utilize a physician with experience

in nursing facility care. After the initial denial, if a physician reviewer were consulted, the affected parties would have a right to reconsideration by a second physician.

The Contractor shall send final denial recommendations to MDCH following the completion of the Contractor's review process. MDCH allows the provider the right of appeal through the Medicaid Provider Reviews and Hearings Administrative Rules, MAC R400.3401-400.3425 under the authority conferred on the Director of MDCH by Sections 6 and 9 of Act. No. 280 of the Public Acts of 1939. The Contractor shall provide nurses for participation and testimony in the MDCH appeals process beginning at the preliminary hearing level.

The Provider must be able to request reconsideration (appeal) of any adverse determination made by the Contractor for admission within three (3) working days of the receipt of the initial denial. The Contractor must be able to receive and respond electronically to a request for reconsideration. The Contractor will notify the provider of the reconsideration decision within one working day of receipt of the reconsideration request.

#### b. Beneficiary Appeals

Beneficiaries as well as providers have the right to appeal a denial of service. As is the case for Medicare, beneficiary appeals made during the inpatient stay must be resolved by the Contractor within three working days. Appeals made to the Contractor following discharge must be resolved within thirty (30) working days.

Only after these appeals have been exhausted may any appeal be made directly to the MDCH. When such an appeal is made, the Contractor will provide the written reports, and make direct testimony available to the MDCH as the MDCH deems necessary.

The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all prior authorization requests including the negative action letter. The Contractor must send a negative action letter to all persons seeking Medicaid coverage in one of the above listed FFS Long Term Care Programs utilizing the appropriate denial statement. (See Section II, Part III, Attachments H-I).

An appeals form (DCH-092 Hearing Request) (See Section II, Part III, Attachment C) and addressed stamped envelope provided by the State must accompany the negative action letter. The negative action letter and appeal form must be sent to the Beneficiary the day of the negative action. Copies of all negative action letters shall be stored by the contractor and be available upon request.

### **H. SANCTIONS**

Sanctions will be imposed based on the results of the monthly billing validation conducted by the MDCH Contract Manager and the PACER validation performance review conducted as part of the Inpatient Audit process. The penalty will be determined by the number of incorrect authorizations; authorizations by telephone/electronic computer system not completed in a timely manner; telephone response time with average time to answer greater than 90 seconds (See Section II, Part I, C, 2f).

The MDCH Contract Manager reserves the right to change the PACER validation process with thirty (30) day notice to the Contractor. The MDCH Contract Manager also reserves the right to change the PACER review process or cancel the Contract with thirty (30) day notice to the Contractor.

Monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction shall be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the MDCH shall give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions.

1. Number of Incorrect Authorizations. With the beginning of this Contract, if the Contractor inappropriately authorizes inpatient admissions, transfers, readmissions within 15 days, and continued stay for rehabilitative facilities, then the MDCH will give written notice to the Contractor of the number of Incorrect Admissions by fax, (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor shall have ten (10) calendar days following the notice in which to submit a corrective action plan. If the corrective action plan has not been submitted within ten (10) calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than \$10,000. At the end of each subsequent ten (10) day period in which the corrective action plan has not been submitted, the Department may, without further notice, impose further sanctions of \$10,000.

In addition to the above, beginning April 1, 2005, additional sanctions will begin. If greater than ten (10) PACER authorizations per audit are determined to be inappropriately authorized during the PACER validation, the Contractor will be sanctioned the amount of the hospitalizations approved in error.

2. Authorization Process not completed in a timely manner. (Section II, Part I, C, 2c). Upon review by the MDCH Contract Manager, if authorizations from the previous month are not completed in a timely manner, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

3. Telephone response time. If telephone response time is greater than 90 seconds for two consecutive months, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

4. Based on the monthly billing validation performed by the MDCH Contract Manager, (part of the PACER validation that MDCH reviews monthly via the complete listing of all PACER activity the previous month), if 10% of the PACER determinations for inpatient elective admissions, transfers, and readmissions within 15 days are incorrect, \$10,000 or the amount of the dollars for the

hospitalization, whichever is less, will be taken back from the Contractor. MDCH selects a random sample of PACER validations of the previous month PACER activity. The selection by MDCH is random, i.e., if the number for validation was 40 PACER cases then 10% would be 4. The number of cases to be selected on a monthly basis is determined by MDCH.

## **I. REPORTS**

### **PACER:**

Reports shall be provided electronically to the contract manager weekly, monthly, quarterly, and annually. They shall include: number of cases reviewed; number review coordinator approved, number referred, and number of cases denied; number of cases physician approved, and denied; number of reconsideration cases; number of reconsideration cases overturned and upheld; number of net denials and percent of denials; number of cases appealed, number of appealed cases overturned and upheld.

The Contractor shall report by percentage and whole numbers all telephone calls where the provider remains on hold greater than 90 seconds. The Contractor shall report, by percentage, the numbers of calls not completed in a timely manner.

### **Long Term Care:**

For Long Term Care, a monthly report shall be provided electronically to MDCH. The number of exception reviews performed, approvals, denials, appeals, and exception approval trends by code must be submitted.

## **J. QUALIFICATIONS OF CONTRACTOR'S STAFF FOR PACER/LONG TERM CARE PACER**

### **1. Staff Requirements**

a. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing/licensure prior to the start of this Contract. Attestation of licensure will be required at the end of each year thereafter. In addition, proof of licensure will be sent to the State at time of hire for all new employees where licensure is required. The Registered Nurse Reviewers must report directly to an RN who must report directly to an RN. Necessary substitutions due to change of employment status and other unforeseen circumstances maybe made with prior notification to the MDCH and for employees with the same licensure (i.e., RN replaces RN). If the replacement does not have the same licensure prior authorization is required by the MDCH.

b. The Contractor shall utilize Registered Nurse Reviewers who demonstrate knowledge of Inpatient Hospital InterQual® criteria and Long Term Care Medicaid Exception Criteria. The Registered Nurses performing the PACER authorization cannot perform the audit/Statewide Utilization Review and Long Term Care review functions, MDCH expects the Contractor to designate separate staff for each.

c. The Contractor shall be staffed by Physician Reviewers with expertise in the areas listed above and to participate in the PACER/Long Term Care PACER authorization process.

## 2. Other Requirements

a. The Contractor shall maintain all reporting requirements established by the MDCH (See Section II, Part I, I, Reports).

b. The Contractor shall maintain a positive working relationship with Providers of medical care and Provider Organizations.

c. The Contractor shall maintain confidentiality of Provider/Beneficiary information and provide the MDCH with its confidentiality policy and procedure.

d. Should the Contractor be a vendor from a State other than Michigan, the Contractor's Project Manager and staff must have an office located in the Greater Lansing Area.

## **K. CONTRACT MONITORING**

The MDCH Contract Manager will review the following reports: number of cases reviewed; number review coordinator approved, number referred, and number denied; number physician approved, and denied; number reconsideration cases; number reconsideration overturned and upheld; net denials number and percent of denials; number of abandoned calls, number of PACER calls, number of informational calls. The Contract Manager shall also review that the date and time of the request, approval, or denial was within the timeframes mentioned in Section II, Part I, C & F, Review Process. The Contractor shall meet/teleconference with MDCH contract management at least weekly during the first month of the contract and at least monthly for the remainder of the contract to review the above reports.

At least once per contract year MDCH will complete a yearly site visit of the Contractor to monitor work in progress. If the Contractor is in/out of the State of Michigan, the monitoring will occur at the Contractor site. All travel, lodging and meal expenses for up to two (2) State of Michigan employees shall be paid by the Contractor for this yearly review should the Contractor be in/out of the State of Michigan.

The MDCH Long Term Care Manager will review long term care reports as defined in Section II, Part I, I, Reports.

## **L. PAYMENT SCHEDULE**

The payment schedule will be based on the number of PACER/LTC telephonic/electronic authorizations completed the previous month. The Contractor is required to be available at all appeal levels. The Contractor's nurse reviewer/physician reviewer, (if applicable), must be available to testify as to the results of the PACER review at any preliminary or bureau conference; administrative hearing or judicial proceeding.

**M. FRAUD AND ABUSE**

The Contractor shall report suspected fraud, and/or abuse by Medicaid beneficiaries and/or providers to the MDCH Contract Manager. The report shall detail the provider, beneficiary and all information on the situation. The link to information regarding fraud and abuse and how to report it is located on the website [michigan.gov/mdch](http://michigan.gov/mdch), click on the links to inside Community Health, and Fraud and Abuse.

**PART II AUDITS/STATEWIDE UTILIZATION REVIEW/LONG TERM CARE  
RETROSPECTIVE ELIGIBILITY REVIEWS**

**A. BACKGROUND STATEMENT**

The Michigan Department of Community Health is the single state agency responsible for health policy, the purchase of health care services, and accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population.

The purpose of this contract is to have a qualified Contractor conduct audits/utilization review of inpatient services, outpatient services, and emergency room services along with long term care retrospective eligibility reviews and PACER validation to determine compliance with Medicaid Policy & Guidelines as outlined in the Provider Manuals and Bulletins; and to determine appropriateness of Medicaid coverage for all of the above services utilizing current standards of practice, the Michigan State Plan, and Federal Regulations.

An audit is a post payment review of a statistically valid random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider. [42 CFR 447.201, 447.202, and Social Welfare Act 280 of the Public Acts of 1939, Section 111a.(7)(d), 111b.(6), (7), & (23)]. A review is considered a random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider. The Long Term Care Retrospective Exception Review will be completed as per the requirements of Social Security Act §1919, [42 U.S.C. 1396r](a). Utilization review is also required. The Michigan State Plan states that the State of Michigan meets the requirements of 42 CFR 456 for the control of the utilization of inpatient hospital services. The Michigan State Plan further states that the medical and utilization review requirements will be met through a contract with a Utilization and Quality Control Peer Review Organization as designated under 42 CFR 475.

Additionally, a portion of this contract is to provide for the private administration of a state-wide retrospective review and certification system for Michigan Medicaid long term care programs that must utilize nursing facility level of care criteria. The Contractor will determine appropriateness of Medicaid coverage for nursing facility level of care programs (Medicaid covered nursing facility admissions, MI Choice Home and Community Based Waiver Program for the Elderly and Disabled, and the Program for All Inclusive Care for the Elderly); and provide analytical reports regarding long term care utilization.

The contract shall be for three years beginning January 1, 2005 through December 31, 2007 with the option of two yearly extensions.

## **B. OBJECTIVES**

Audits will be conducted on Medicaid Fee For Service (Title XIX), Medicare/Medicaid dually eligible (Title XVIII/IXX), Children's Special Health Care Services dual eligibles (Title V/XIX), and ABW beneficiaries through 2-28-2005, utilizing statistically valid random samples. The average number of beneficiaries to be reviewed for each audit is 250.

For long term care, reviews will be conducted on Medicaid Fee For Service and Medicare/Medicaid beneficiaries. Random sample reviews will be conducted on Long Term Care, (LTC), beneficiaries to determine eligibility to specific LTC programs; these reviews will be retrospective. For the review of Long Term Care, a targeted random sample of monthly new admissions to nursing facilities and the PACE program will be reviewed for Medicaid functional/medical eligibility. The number of retrospective reviews will total 1000.

For Statewide Utilization Review, utilization review will be conducted on Medicaid Fee For Service (Title XIX) and Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries. Medical records will be selected by a statewide random sample by facility of Provider Type 30 Inpatient facilities. The Contractor will draw a random sample of 20 records per facility per year. Approximately 4 hospitals per week will be reviewed for a total of 16 hospitals per month. If an inpatient hospital has been selected to be audited that year, they will be exempt from the Review for that year.

Random sample PACER validations will be conducted as part of the audit process on all Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligibles (Title V/XIX) beneficiaries who had a request for PACER through the Contractor. The Registered Nurses performing this validation will not be the same Registered Nurses performing the PACER authorizations.

The Contractor will be paid per audit/Statewide Utilization Review/LTC review completed (See Section II, Part II, N for Timeframes of review).

### **1. Audits will be conducted on the following:**

- **Inpatient Hospital Services:** Twelve audits with the possibility of 15 audits will be completed each year. The review will include all inpatient services paid to the provider including but is not limited to medical detoxification, elective admissions, transfers, readmissions within 15 days, inpatient rehabilitative facilities. See Section II, Part II, *N* for Timeframes of review.
- **Outpatient Hospital/Emergency Room Services:** Twelve audits with the possibility of 15 audits will be completed each year. The review will include all Outpatient Hospital and Emergency Room services paid to the provider. See Section II, Part II, *N* for Timeframes of review.

## **2. PACER Validation:**

All cases included in the inpatient hospital audit sample that require a PACER authorization will be reviewed for PACER validation. The Contractor will validate all PACER authorization numbers assigned for these beneficiaries for the date(s) of service included in the audit sample. The Contractor has the responsibility to have a system/process in place that will validate PACER numbers assigned.

During review of the inpatient hospital medical records included in the audit sample, if it is determined the admission, transfer, readmission within 15 days or continued stay for inpatient rehabilitative facilities does not meet criteria for PACER authorization, the Contractor will request the information received from the provider at the time of the PACER request including both review coordinator and physician documentation. If it is determined the information in the hospital record matches the information provided at the time of the PACER request, the elective admission, transfer, readmission within 15 days or continued stay for inpatient rehabilitative facilities, will be allowed. The Contractor will report the case to the MDCH Contract Manager as the PACER authorization was approved in error. If the information given at the time of the request differs from the information found in the hospital record and the information given at the time of the PACER authorization meets criteria, however, the hospital record does not, the hospital stay will be refunded to the MDCH.

In addition to the PACER validation performed as part of the audit process, PACER validation will be performed on medical records selected by a statewide random sample by facility of Provider Type 30 Inpatient facilities.

## **3. Utilization Review:**

Utilization review will be performed on all records requested for the Audits. This will include Inpatient/ Outpatient/Emergency Room/PACER services.

In addition to the utilization review performed as part of the Audit Process utilization review will be performed on medical records selected by a statewide random sample by facility of Provider Type 30 Inpatient facilities.

## **4. Long Term Care Review:**

Retrospective reviews will be performed based on explicit nursing facility level of care criteria.

Exceptions to these criteria can be approved by Registered Nurse Reviewers or Physician reviewers as appropriate. This review is strictly to determine appropriate utilization only; however, serious quality issues will be referred to the Health Policy, Regulation, and Professions Administration.

### C. AUDIT/UTILIZATION

#### 1) Audit Review Requirements:

The Contractor must maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately. The Contractor must be in compliance with HIPAA. All documents and/or information obtained by the Contractor from the Department in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the Department.

The Contractor shall audit from a statistically valid random sample as generated by the MDCH. The audit sample will contain the following: the provider name, review period, services or codes to be reviewed, dates of service, beneficiary's name and identification number, date and claim reference number paid.

The audit sample will be given to the Contractor by MDCH. The Contractor will supply the audited provider with a list of those beneficiaries to be reviewed thirty (30) calendar days prior to the audit begin date. The Contractor will go to each facility to copy/scan records utilizing their own equipment. The review of the copied records will occur at the Contractor's place of business. Once the records have been copied, reviewed, and a determination made, the Contractor shall write a Nurse Review Report (See Section II, Part III, Attachment G). Each claim line in the workbook will be reviewed and documented with an annotation provided by MDCH (See Section II, Part III, Attachment D) based on the documentation found in the medical record. If errors have been identified a mis-payment amount of the sample is calculated by MDCH. The mis-payment information is sent to the MDCH statistician for extrapolation of the mis-payment amount to the entire audit population. The Nurse Review Report will be reviewed by MDCH prior to insertion into the Exhibit Book.

a. For Inpatient review the Contractor will review medical records using the following criteria:

- i. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing InterQual® criteria per body system.
- ii. Continued stay criteria utilizing InterQual® criteria per body system for inpatient rehabilitation.
- iii. Discharge criteria InterQual® criteria per body system.
- iv. Review for correct procedure.
- v. Review for diagnosis coding via DRG assignment validation.
- vi. Quality of care shall be monitored in each audit utilizing InterQual® criteria.
- vii. Services were performed in the appropriate setting.
- viii. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- ix. Services performed are in accordance with current professional standards of care.

b. For Outpatient and Emergency Room Services review the Contractor will review medical records using the following criteria:

- i. Services were performed in the appropriate setting.
- ii. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- iii. Services performed are in accordance with current professional standards of care.
- iv. Services performed are medically necessary in appropriate scope, duration, and intensity.
- v. Verify procedure code billed.
- vi. Verify adherence to EMTALA, (for Emergency Room Services only).
- vii. Quality of care provided to the beneficiary will be reviewed.

2) Audit Review Process:

The Contractor shall have a system in place comprised of Nurse Reviewers with audit/utilization review and quality review experience in all types of review processes.

a. The Contractor is expected to complete Utilization Review of all audit cases selected by MDCH.

The Audit Review Process for Inpatient/Outpatient /Emergency Room includes the following:

Contractor receives "Workbook" from MDCH.

i. The outpatient/emergency room audit workbook will include an alphabetical and numeric beneficiary list; audit worksheets; line paid procedure code, procedure code on line, procedure code and revenue code on line for sample; sample and population summary statistics. The inpatient audit workbook will include all of the above plus a DRG code list.

b. MDCH will provide an accordion file containing file folders for Analysis (Nurse Review Report), and correspondence (copies of letters).

c. Prior to beginning the audit the Nurse Reviewer will complete the following:

- i. Review and copy Medicaid policy and procedures pertinent to the audit sample.
- ii. Review and copy procedure/revenue codes/appropriate Grouper/ICD-9-CM included in the audit sample.
- iii. Review and copy fee screens for procedure/revenue codes included in the audit sample.
- iv. Contact the provider within one week of assignment to schedule an appointment to copy records.

v. Send a confirmation letter (See Section II, Part III, Attachment E), to the provider following the initial contact reiterating the information provided during the initial contact. A copy of the correspondence will be kept with the audit file.

The items listed above (2c, i-iii) will be what were in effect for the time period of the audit.

d. Contractor copies/scans medical records at the provider's place of business utilizing the Contractor's own equipment. An on-site visit consists of an introduction, including presentation of credentials, picture identification, the legal basis and the reason for the audit. (To determine compliance with Medicaid policy and guidelines; to verify services billed and paid to Medicaid were provided.)

e. Contractor reviews medical records at the Contractor's place of business. If after collating, documentation is found to be missing, a letter is sent to the provider, (See Section II, Part III, Attachment F). A copy of the correspondence will be kept with the audit file. The Contractor's Nurse Reviewer should initiate review of records on hand while waiting for missing documentation.

f. The initial review shall be conducted by the Nurse Reviewer utilizing the appropriate criteria at Section II, Part II, C. All claim lines in the sample are adjudicated based on the medical record review using annotations (See Section II, Part III, Attachment D).

g. After receipt and review of any missing documentation the Nurse Reviewer writes the Nurse Review Report (See Section II, Part III, Attachment G.) The Nurse Review Report will include:

- i. Reason for the Review.
- ii. Sample Statistics.
- iii. Summary of Field Activities.
- iv. Nurse Review Findings and Attachments.

The Contractor will submit the workbook and Nurse Review Report and copies of 2 c, i-iii, and 2e to MDCH.

h. Mis-payment amount of the audit sample is calculated by MDCH and sent to the MDCH Statistician.

i. Extrapolation of the mis-payment amount to the entire audit population shall be made by the MDCH Statistician.

j. MDCH will create and review the "Exhibit Book" and make five (5) copies.

k. MDCH will notify the provider in writing of audit results, appeal rights, and hearing dates.

#### **D. PACER VALIDATION**

##### 1.) PACER Validation Requirements:

For PACER validation, the Contractor will review records in the audit sample using the following criteria:

- a. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing InterQual® criteria per body system.
- b. Continued stay criteria utilizing InterQual® criteria per body system for inpatient rehabilitation.
- c. Discharge criteria utilizing InterQual® criteria per body system.
- d. Services were performed in the appropriate setting.
- e. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- f. Services performed are in accordance with current professional standards of care.
- g. PACER number obtained for readmissions within 15 days, transfers, elective admissions, and continued stays for rehabilitative facilities.

##### 2.) PACER Validation Process:

The validation process of the PACER review includes the criteria listed at Section II, Part II, D 1 a-g:

During the record review, if the criteria are not met for the PACER authorization the documentation used by the Contractor for the PACER authorization will be reviewed. This will include:

- a. PACER Number.
- b. Documentation provided at the time of the PACER request.
  - i. Review Coordinator documentation.
  - ii. Physician Reviewer documentation.

#### **E. STATEWIDE UTILIZATION REVIEW**

##### 1.) Statewide Utilization Review Requirements:

For the Utilization Review, the Contractor shall review records based on the following criteria:

- a. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing InterQual® criteria per body system.
- b. Continued stay criteria utilizing InterQual® criteria per body system for inpatient rehabilitation.
- c. Discharge criteria utilizing InterQual® criteria per body system.
- d. Services were performed in the appropriate setting.
- e. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.

- f. Services performed are in accordance with current professional standards of care.
- g. PACER number obtained for readmissions within 15 days, transfers, elective admissions, and continued stays for rehabilitative facilities.

2.) Statewide Utilization Review Process:

The Contractor is expected to complete Utilization Review of Hospital Provider Type 30 Inpatient services provided to Medicaid beneficiaries.

a. Selection for the Statewide Utilization Review Process will include a random sample from a universe of paid claims data downloaded weekly from the MDCH Data Electronic Gateway (DEG) by the Contractor. The Contractor will draw a random sample of 20 records per facility per year. Approximately 4 hospitals per week will be reviewed for a total of 16 hospitals per month. The sample will be drawn on a monthly basis by the Contractor for the hospitals selected for review for that month. The hospitals will be sampled individually going back one (1) year from the date drawn utilizing a past year of data for the review. **EXAMPLE:** Start June 2006, go back one (1) year, sampling June 1, 2005 through May 31, 2006 data. If an inpatient hospital has been selected to be audited that year, they will be exempt from the Review for that year.

b. The medical record for the Medicaid Beneficiary will be requested by the Contractor from Hospital Provider Type 30 via fax/mail. A letter will be sent by MPRO so that the provider receives the letter by the first of the month, see Attachment J for an example. This letter will give the provider thirty (30) days to submit the record. If no record(s) are submitted, MDCH may decide to initiate an audit. MPRO will have 30 (thirty) days from the provider deadline to review the records. For example, the letter requesting records is sent so the provider receives the letter by June 1, records are required to arrive to the Contractor by June 30, the Contractor has until July 31 to review.

c. Reporting is expected for all facilities whether there is an issue or not. Reporting to MDCH is expected on a monthly basis utilizing the spreadsheets attached, see Attachments K and K1:

- i. Spreadsheet I:  
List Hospitals selected for month in Alphabetical Order by Name and ID number.
- ii. Spreadsheet II:  
List by Provider; Provider ID number; Time period sample pulled from; date medical records requested; total number member requested; Listed alphabetically by: Beneficiary Name; Beneficiary ID number; Dates of Service; Date Medical Record Received; Findings; Total number of Findings and Comments.

This report/spreadsheet will then be utilized for future audit selection. A cumulative report must be submitted annually within 30 days of the end of the fiscal year. See Attachment K2.

The Contractor will send an educational letter to the provider if there are any findings/issues identified at the end of the monthly review.

d. A quarterly report will be reviewed by the MDCH Contract Manager. See Attachment K3.

e. The Contractor shall apply quality of care criteria/screens in all reviews- in every category undertaken and in every admission request or treated case reviewed.

i. Criteria may be the same as or similar to those required by CMS. The Contractor will inform the MDCH of any quality problem that has resulted in serious patient harm as soon as it is identified. All other quality of care findings and their severity level will be reported on a regular basis to the MDCH. The Contractor will recommend to MDCH the appropriate provider sanctions/interventions.

ii. Sanctions/interventions- may include provider participation, termination, education, or other appropriate action. The Contractor and the MDCH shall work together in determining the appropriateness of these sanctions/interventions and in applying them.

#### **F. LONG TERM CARE RETROSPECTIVE REVIEW**

##### 1.) Long Term Care Retrospective Review Requirements:

a. MDCH will provide a monthly electronic list for cases for review. For CY2005, cases will consist of new admissions to nursing facilities and PACE Program only. Following year reviews may consist of ongoing case reviews also.

b. This list will include consumer identifiers, date of admission, and period under review.

c. The Contractor will request the medical record for the individual nursing facility resident or PACE participant.

The medical record must contain the following documents for nursing facility reviews:

- Eligibility and Informed Choice Preprint
- PASARR evaluation-level 1, and level 2 if indicated
- All MDS documents for the period under review
- All nursing notes for the period under review
- All physician notes and orders for the period under review
- An interdisciplinary care plan for the period under review
- All quarterly care planning notes for the period under review
- Skilled therapy evaluations and progress notes for the period under review
- Discharge plans

The medical record must contain the following documents for PACE reviews:

- Eligibility and Informed Choice Preprint
- All intake assessment documents
- All nursing/community care coordination records for the period under review
- All physician notes and orders for the period under review
- An interdisciplinary care plan for the period under review
- All quarterly care planning notes for the period under review
- Skilled therapy evaluations and progress notes for the period under review

d. The Contractor will review the case based on nursing facility level of care criteria and exception criteria developed by MDCH. Cases may be approved based on professional judgment when it is clear that the consumer has a documented risk for institutionalization. All approvals based on professional judgment will be subject to MDCH evaluation.

e. The Contractor will communicate a list of approval and denial recommendations to MDCH on a monthly basis.

2.) Long Term Care Retrospective Review Process:

For Long Term Care Program review, the Contractor shall review records based on the following criteria:

- a. Appropriateness for the nursing facility level of care definition.
- b. Exceptions based on explicit MDCH developed exception criteria.
- c. Clinical professional judgment. All cases approved outside of a and b above will be subject to individual review by MDCH.

**G. APPEALS PROCESS**

1. Inpatient/Outpatient/Emergency Room Audits

MDCH Program Investigation Section will notify the providers of the audit results, hearing dates, and appeal rights by mail.

The Contractor's nurse reviewer must be available to testify as to the results of the audit review at any preliminary or bureau conference; administrative hearing or judicial proceeding.

2. Long Term Care Retrospective Review

a. Provider Appeals

The Contractor shall have available at least two physicians for review of cases referred by the nurse review coordinator. The Contractor must utilize a physician with experience in nursing facility care. After the initial denial, if a physician reviewer were consulted, the affected parties would have a right to reconsideration by a second physician.

The Contractor shall send final denial recommendations to MDCH following the completion of the Contractor's review process. The Contractor shall send notice to the facility to recover funds paid for that stay. MDCH allows the provider the right of appeal through the Medicaid Provider Reviews and Hearings Administrative Rules, MAC R400.3401-400.3425 under the authority conferred on the Director of MDCH by Sections 6 and 9 of Act. No. 280 of the Public Acts of 1939. The Contractor shall provide nurses for participation and testimony in the MDCH appeals process beginning at the preliminary hearing level.

The Provider must be able to request reconsideration (appeal) of any adverse determination made by the Contractor for admission or extended stay within three (3) working days of receipt of the initial denial. This involvement shall begin at the Bureau Conference level and continue as required through the Administrative Law Judge (ALJ) level, including Circuit Court, or until a final case decision has been reached.

b. Beneficiary Appeals

Beneficiaries as well as providers have the right to appeal a denial of service. As is the case for Medicare, beneficiary appeals made during the inpatient stay must be resolved by the Contractor within three working days. Appeals made to the Contractor following discharge must be resolved within thirty (30) working days.

Only after these appeals have been exhausted, may any appeal be made directly to the MDCH. When such an appeal is made, the Contractor will provide the written reports, and make direct testimony available to the MDCH as the MDCH deems necessary.

The Contractor must send a negative action letter to all persons seeking Medicaid coverage in one of the above listed FFS Long Term Care Programs utilizing the appropriate denial statement.

An appeals form (DCH-0092 Hearing Request)(See Section II, Part III, Attachment C) and an addressed stamped envelope provided by the State must accompany the negative action letter (See Section II, Part III, Attachment A). The negative action letter and appeal form must be sent to the Beneficiary the day of the negative action. Copies of all negative action letters shall be stored by the Audit Contractor and available upon request.

**H. QUALIFICATIONS OF CONTRACTOR'S STAFF FOR AUDITS/STATEWIDE UTILIZATION REVIEW/LONG TERM CARE RETROSPECTIVE ELIGIBILITY REVIEW**

1. Staff Requirements

a. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing/licensure prior to the start of this Contract. Attestation of licensure will be required at the end of each year thereafter. In addition, proof of licensure will be sent to the State at time of hire for all new employees where licensure is required. The Registered Nurse Reviewer must report directly to an RN who must report directly to an RN.

Necessary substitutions due to change of employment status and other unforeseen circumstances maybe made with prior notification to the MDCH and for employees with the same licensure (i.e., RN replaces RN). If the replacement does not have the same licensure prior authorization is required by the MDCH.

b. The Contractor shall utilize Registered Nurse Reviewers who demonstrate knowledge of Inpatient /Outpatient Hospital/Emergency Room Services/PACER/Utilization Review/Long Term Care. The Registered Nurses performing the audit/Statewide Utilization Review/LTC review functions cannot perform the PACER authorizations, MDCH expects the Contractor to designate separate staff for each.

c. The Contractor shall be staffed by Physician Reviewers with expertise in the above areas listed under H, 1, b, to act only as a resource for audits and Statewide Utilization Review and to participate in the long term care review process.

d. The coding review for inpatient hospital review shall be validated by a Registered Health Information Technologist, RHIT.

## 2. Other Requirements

a. The Contractor shall maintain all reporting requirements established by the MDCH. (See Section II, Part II, I, Reports.)

b. The Contractor shall maintain a positive working relationship with Providers of medical care and Provider Organizations.

c. The Contractor shall maintain confidentiality of Provider/Beneficiary information and provide the MDCH with its confidentiality policy and procedure.

d. Should the Contractor be a vendor from a State other than Michigan, the Contractor's Project Manager and staff must have an office located in the Greater Lansing Area.

## **I. REPORTS**

The reporting mechanisms are listed below under 1-3. MDCH reserves the right to adjust the number of audits conducted per provider type, (inpatient/outpatient hospital/emergency room services), with thirty (30) day notice to the Contractor. The MDCH reserves the right to change/cancel the audit/review process or cancel the contract with thirty (30) day notice to the Contractor.

A "work plan" for the first quarter of the contract will be submitted electronically to MDCH by January 31, 2005 describing proposed audit/review activities. An "updated work plan" shall be provided electronically by the last day of the preceding quarter beginning with the April quarter describing proposed audit activities.

The Contractor shall report the following information to the MDCH at the designated time frames in a format agreed upon by the MDCH and the Contractor.

The MDCH reserves the right to modify the reporting requirements. Proposals for alternative reporting requirements will be considered by the MDCH.

1. A "monthly report" shall be provided electronically to MDCH by close of business on the 5<sup>th</sup> calendar day of each month. The report will list newly initiated audits/reviews and activities on audits/reviews initiated during previous months. Activities shall include:
  - a. Name and date of audit(s)/reviews initiated.
  - b. Name and date of audit(s)/reviews completed.
  - c. Number retrospective reviews of PACER authorization not meeting criteria.
    - i. number of authorizations given in error
    - ii. number of provider errors
  - d. For Long Term Care Retrospective Reviews, a summary of review findings to include number reviewed, approved, denied at level 1 and 2, appeals, utilization trends and quality findings.
  - e. For Statewide Utilization Review, a summary of review findings to include provider name alphabetically and ID number, time period sample pulled from, date medical record requested, beneficiary name alphabetically and ID number, findings see Attachment J.
2. A "quarterly report" shall be provided electronically to MDCH by the last calendar day of the month following the reporting quarter detailing year-to-date totals for all activities described at Section II, Part II, I, 1, a-c and e.
3. An "annual report" shall be provided electronically by the Contractor to MDCH by the last calendar day of the month following the annual reporting period that is an accumulation of the quarterly reports.

Reports and information shall be submitted to the MDCH Contract Manager at the address listed in the front of this contract. The Contract Manager shall evaluate the reports submitted as described in this section for their completeness and adequacy.

#### **J. CONTRACT MONITORING**

The MDCH Contract Manager through reports and financial statements shall monitor the audit progress as listed above. Reports shall be electronically transmitted to MDCH in compliance with HIPAA transactions.

The MDCH Long Term Care Manager shall review long term care reports as defined in Section II, Part II, I, Reports.

The Contractor shall meet/teleconference with MDCH contract management at least weekly during the first month of the contract and at least monthly for the remainder of the contract to review all Nurse Review Reports etc.

The Contractor shall permit the Department or its designee to visit and to make an evaluation of the project as determined by the contract manager. At least once per contract year MDCH will complete a site visit of the Contractor to monitor work in progress. If the Contractor is in/out of the State of Michigan, the monitoring will occur at the Audit Contractor site. All travel, lodging and meal expenses for up to two (2) State of Michigan employees shall be paid by the Contractor for this yearly review should the Contractor be in/out of the State of Michigan.

For this Contract, each phase of the audit/Statewide Utilization Review/LTC review process will be monitored by the MDCH Contract Manager. At a maximum, five records per audit (or a number determined by MDCH) will be submitted to MDCH for validation. At a maximum, five records per provider for the Statewide Utilization Review Process (or a number determined by MDCH) will be submitted to MDCH for validation.

The Contract Manager shall monitor that the Contractor complete work within the timeframes listed in Section II, Part II, I, Reports and Section II, Part II, N, Timeframes.

#### **K. MILESTONES AND DELIVERABLES**

For the Contract the following mechanisms must be in place:

##### 1. Readiness for Implementation

a. The Contractor must have an operational system in place no later than one month from the start up of the Contract including but not limited to sufficient staff.

b. The Contractor shall demonstrate to MDCH's satisfaction no later than one month from the start up of the Contract, that the Contractor is fully capable of performing all duties under this Contract, including demonstration of the following:

i. That the Contractor demonstrates a sufficient number of RN's experienced in the areas of Inpatient, Outpatient, Emergency Room, PACER and Long Term Care, and Physician's experienced in the area of Long Term Care, to perform the audit/review duties as specified herein. The Registered Nurses performing the audit/Statewide Utilization Review/LTC review functions cannot perform the PACER authorizations. MDCH expects the Contractor to designate separate staff for each.

ii. That the Contractor has thoroughly trained its staff on the specifics of the audit/Statewide Utilization Review/LTC review

processes and that the Contractor's staff has sufficient knowledge to make determinations of medical services needed.

iii. That the Contractor has the ability to accept, process and to transmit to MDCH those audits/ Statewide Utilization Review/LTC reviews that have been completed.

iv. That the Contractor has quality assurance procedures in place that assures it follows all State and Federal laws for confidentiality.

c. The Contractor's inability to demonstrate, to the Department's satisfaction and as provided herein, that the Contractor is fully capable of performing all duties under this Contract no later than February 1, 2005, shall be grounds for the immediate termination of this Contract by the Department in accordance with the terms specified herein.

## 2. Program Specification.

a. The Contractor shall complete the audit/review process within the Timeframes described in Section II, Part II, N and submit the required reports within the Timeframes described in Section II, Part II, I, Reports.

b. The Contractor shall retain all records until the audit/review is closed, (settlement is reached) or the records are requested by the Appeals Section.

## **L. FRAUD AND ABUSE**

The Contractor shall report suspected fraud, and/or abuse by Medicaid beneficiaries and/or providers to the MDCH Contract Manager. The report shall detail the provider, beneficiary and all information on the situation. The link to information regarding fraud and abuse and how to report it is located on the website [michigan.gov/mdch](http://michigan.gov/mdch), click on the links to inside Community Health, and Fraud and Abuse.

## **M. SANCTIONS**

For the first year of the Contract, the Contractor is expected to correct any inability to meet Timeframes (See Section II, Part II, N). MDCH reserves the right to adjust the number of audits/ Statewide Utilization Review/LTC reviews conducted per provider type with thirty (30) day notice to the Contractor. MDCH also reserves the right to change the audit/review process or cancel the Contract with thirty (30) day notice to the Contractor.

In the second year, monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction shall be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in

determining the sanction amount. Upon determination of substantial noncompliance, the MDCH shall give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions. Sanctions will be imposed based on the following:

1. Failure to Report. If the Contractor fails to submit, by the due date, any report or other material required by this Contract to be submitted to the MDCH, the MDCH will give written notice to the Contractor of the late report or material by fax (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor shall have ten (10) calendar days following the notice in which to cure the failure by submitting the complete and accurate report or material. If the report or other material has not been submitted within ten (10) calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than \$10,000. At the end of each subsequent ten (10) day period in which the complete and accurate report has not been submitted, the Department may, without further notice, impose further sanction of \$10,000.

2. Audits/ Statewide Utilization Review/LTC Reviews. The number of audits/ Statewide Utilization Review/LTC reviews to be completed are outlined in Section II, Part II, B. Upon review by the MDCH Contract Manager, if the audit/ Statewide Utilization Review/LTC reviews from the previous month are not completed correctly or in a timely manner, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

#### **N. TIMEFRAMES**

The following timeframes listed in Table I are for the first, second, and third year of the contract. For the purposes of the table listed below, an audit/reviews is considered completed once the workbook and reports are submitted to the MDCH. The Contractor is still responsible for participating in the Appeal Process until a settlement is reached.

**TABLE I**

Type of Audits	Fiscal Year	Number of Audits to be completed by Quarter			
		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
<b>Inpatient Audits</b>	<i>FY2005</i>	0	3	3	1
	<i>FY2006</i>	3	3	3	3
	<i>FY2007</i>	3	3	3	3
	<i>FY2008</i>	3	0	0	0
<b>Outpatient/Emergency Room Audits</b>	<i>FY2005</i>	0	3	3	1
	<i>FY2006</i>	3	3	3	3
	<i>FY2007</i>	3	3	3	3
	<i>FY2008</i>	3	0	0	0
<b>Three Year Total</b>		68			

\*Audits will average 250 beneficiaries per audit

**TABLE II**

Type of Service	Fiscal Year	Number of Reviews to be completed by Quarter			
		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
<b>Long Term Care</b>	<i>FY2005</i>	0	250	250	250
	<i>FY2006</i>	250	250	250	250
	<i>FY2007</i>	250	250	250	250
	<i>FY2008</i>	250	0	0	0
<b>Three Year Total</b>		3000			

\*Long term care review will consist of 250 beneficiaries per review

**TABLE III**

Statewide Utilization Review	Fiscal Year	Number of Utilization Reviews completed by Quarter			
		1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
<b>Inpatient</b>	<i>FY2005</i>	0	0	0	0
	<i>FY2006</i>	0	0	0	960
	<i>FY2007</i>	960	960	960	960
	<i>FY2008</i>	960	0	0	0
<b>Total</b>		5760			

**O. PAYMENT SCHEDULE**

The payment schedule will be based on the number of audits/Statewide Utilization Reviews/LTC reviews completed. The per audit and LTC review payment will include both the medical record review and the appeal process through settlement. Although the Contractor will receive payment upon completion of the audit, the Contractor is still required to participate in the Appeal process even though payment has been received. The Statewide Utilization Review payment includes medical record review only as there is no appeal process.

The Contractor will be paid monthly based on the number of hospital audits completed the previous month of the contract.

The Contractor will be paid monthly based on the number of Statewide Utilization Reviews completed the previous month of the contract.

The Contractor will be paid monthly based on the number of Long Term Care retrospective reviews completed the previous month of the contract.

## **PART III DEFINITIONS/ATTACHMENTS**

### **A. Definitions**

The following terms, as used in the Request for Proposals and the Attachments, Appendices, Exhibits, Schedules and Amendments hereto, shall be construed and interpreted as follows, unless the context otherwise expressly requires a different construction and interpretation.

**Annotations:** information written in the audit workbook that is used by MDCH and the Contractor's Nurse Reviewer when reviewing medical records for audits. See Attachment D.

**Beneficiary:** all Medicaid eligible individuals in the Fee For Service Program, (FFS), (Title XIX), Children's Special Health Care Services Program, (CSHCS dual eligibles) (Title V/XIX), Medicare/Medicaid, Title XVIII/XIX).

**Coding Validation:** means comparing principal and all secondary diagnosis and procedure codes billed to the Department with documentation in the beneficiaries medical record to determine the appropriateness and accuracy of the billed codes.

**Diagnosis Related Groups (DRG):** the Department's reimbursement methodology for inpatient services which is a single payment per discharge which is calculated according to the billed diagnosis and procedure codes and other relative factors including, but not limited to, the patient's age.

**Emergency Room Criteria:** currently accepted standards of care for Emergency Department service consistent with coverage in Hospital Provider Manual Chapter III.

**Exception Criteria:** specific criteria developed by MDCH to determine whether or not the participant is at risk of imminent institutionalization.

**Health Insurance Portability and Accountability Act (HIPAA):** a Federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives the U.S. Department of Health and Human Services (DHHS) the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative codes sets should be used within those standards; to require the use of national identification systems for health care patients, provider, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

**Inpatient Criteria:** currently accepted standards of care for Inpatient Hospital service consistent with coverage in Hospital Provider Manual Chapter III.

**InterQual®:** the most current edition of copyrighted criterion used to assess the clinical appropriateness of acute care admission; continued stay and discharge; and quality of care ensuring the proper care setting for the appropriate length of time.

**Long Term Care:** for this RFP only, Long Term Care includes those programs that are required to adhere to the Michigan Definition for nursing facility level of care; specifically Nursing

Facilities, MI Choice Waiver Program for Elderly and Disabled, and the Program for All Inclusive Care for the Elderly.

**MDS:** Minimum Data Set-assessment information required for all nursing facility and MI Choice Program in Michigan.

**MI Choice Program:** MI Choice is Michigan's 1915c(SSA) Home and Community Based Waiver for Elderly and Disabled. Services are provided to participants within the community to maintain the most integrated setting possible.

**Michigan Department of Community Health (MDCH):** the State of Michigan Department requesting the services.

**Nurse Reviewer:** a registered professional nurse with a current Michigan license and with appropriate education and clinical background, trained in the performance of utilization review, and quality assurance.

**Nurse Review Report:** a written report of the audited record by the nurse reviewer, see Attachment G.

**Nursing Facility Level of Care:** Each state that participates in the Medicaid program is required to provide nursing facility care as a mandatory state plan service. Each state must determine function/medical eligibility criteria to determine the appropriateness for that setting. Federal regulations state that Medicaid covered nursing facility care must include the following:

- (A)skilled nursing care and related services for residents who require medical or nursing care,
- (B)rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
- (C)on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

**Outpatient Services Criteria:** currently accepted standards of care for Outpatient Department service consistent with coverage in Hospital Provider Manual Chapter III.

**PACE:** The Program of All Inclusive Care for the Elderly, a capitated community program for persons with long term care needs. Funds are blended from both Medicare and Medicaid sources.

**PACER:** Prior Authorization Certification Evaluation Review. The Prior Authorization Certification Evaluation Review number consists of nine-digits. The first four digits are the Julian date; and the last five digits are the beneficiaries ID number coded into the prior authorization master report numbers by formula. The requestor for the authorization number supplies the beneficiaries ID number. The listing for the prior authorization master report numbers can be supplied by the MDCH.

**PASARR:** The Pre-Admission Screening/Annual Resident Review is required to be completed for all potential nursing facility residents. This review ensures that persons with mental health conditions are placed in the most appropriate setting.

**Peer Review Organization or PRO:** an organization that is URAC (Utilization Review Accreditation Commission) approved and experienced in utilization review and quality assurance which meets the guidelines set forth in 42 USC 1320(c) (1) and 42 CFR 475.

**Physician Reviewer:** a physician licensed to practice medicine in Michigan engaged in the active practice of medicine; board certified or board eligible in his/her specialty; with admitting privileges in one or more Michigan hospitals; and familiar with Medicare principles, experienced in Nursing Facility Care and Utilization Review.

**Proposal:** the response to this RFP submitted to the Department by a Vendor.

**Provider:** Medicaid enrolled Provider for Inpatient Hospital, Outpatient Hospital/Emergency Room Hospital services, and Long Term Care Facilities.

**RHIT:** Registered Health Information Technologist with appropriate education and coding background trained in the performance of coding/DRG validations, International Classification of Diseases Ninth revision clinical modifications, (ICD-9-CM), Ambulatory Patient Groups (APG), Health Care Financing Administration Common Procedural Coding System (HCPC), and Current Procedural Terminology (CPT) methodologies.

**SI/IS:** Severity of Illness/Intensity of Service.

**Utilization Review Accreditation Commission (URAC):** a non-profit charitable organization founded in 1990 to establish standards for the health care industry.

**Workbook:** a comprehensive collection of data provided to the Contractor by MDCH for use by contract review staff. The data includes: the beneficiary name and date of birth; stratum number; beneficiary sample number; provider identification number; total payments made; date of service; services/codes billed; and date of payment. This book is to be utilized by contract review staff to document review findings from the medical record.

**ATTACHMENT A**

**ADEQUATE ACTION NOTICE**  
Denial of Service

Date

Beneficiary Name  
Beneficiary Address

RE: Beneficiary Name  
Beneficiary Medicaid ID #

Dear (Beneficiary Name):

(Contractor Name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for services for Medicaid or Medicaid/CSHCS dually enrolled coverage under this contract. Following a review of the services for which you have applied, it has been determined that the following service(s) shall not be authorized. The reason for this action is the physician reviewer determined that the admission and procedure are not medically necessary. The documentation did not support symptomatology that would warrant an acute care admission/procedure. Therefore, authorization for the admission has been denied. The legal basis for this decision is 42CFR440.230(d).

Service(s)

Effective Date

---

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30195  
LANSING, MI 48909-7695

If you have any questions about this denial, you may call the Contractor Manager for the (Contractor Name) Contract at (phone number).

If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:  
Hearing Request Form  
Return Envelope

**ATTACHMENT B**

**ADVANCE ACTION NOTICE  
Suspension, Reduction or Termination**

Date

Name

Address

City, State, Zip

RE: Beneficiary's Name

Beneficiary's Medicaid ID Number

Dear \_\_\_\_\_:

(Contractor name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for services for Medicaid, or Medicaid/CSHCS dually enrolled coverage under this contract. Following a review of the services that you are currently receiving, it has been determined that the following service(s) shall not be authorized. The reason for this action is \_\_\_\_\_ . The legal basis for this decision is 42CFR440.230(d).

**Service(s)**

**Effective Date**

\_\_\_\_\_  
\_\_\_\_\_

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30195  
LANSING, MI 48909-7695

You will continue to receive the affected services in most circumstances until the hearing decision is rendered if your request for a department hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a department hearing you may be required to repay the benefits. This will occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

If you have any questions about this denial, you may call the Contractor Manager for the (Contractor Name) Contract at (phone number).

If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:

Hearing Request Form

Return Envelope

**ATTACHMENT C**

**REQUEST for an ADMINISTRATIVE HEARING  
INSTRUCTIONS**

**Michigan Department of Community Health**

Use this form to request an administrative hearing. An administrative hearing is an impartial review of a decision made by the Michigan Department of Community Health (or one of its contracted agencies) that the appellant (beneficiary, resident, patient, consumer, or responsible party) believes is inappropriate.

**AUTHORIZED HEARING REPRESENTATIVE:**

You may choose to have another person represent you at a hearing.

- This person can be anyone you choose.
- This person may request a hearing for you.
- This person may also represent you at the hearing.
- You **MUST** give this person written permission to represent you. You may provide a letter or a copy of a court order naming this person as your guardian or conservator.
- You **DO NOT** need any written permission if this person is your spouse or attorney.

**GENERAL INSTRUCTIONS:**

- Read ALL Instructions FIRST, then remove this instruction sheet before completing the form.
- Complete Sections 1 and 2 ONLY. Do NOT complete Section 3.
- Please use a PEN and PRINT FIRMLY.
- Remove the BOTTOM (Pink) copy and save with the Instruction Sheet for your records.
- If you have any questions, please call toll free 1 (877) 833 - 0870.
- After you complete this form, mail it in the enclosed postage paid envelope to:

**ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
PO BOX 30195  
LANSING MI 48909**

**IMPORTANT:**

- After the Administrative Tribunal receives your request for a hearing, your hearing will be scheduled and a notice will be mailed to you and/or your representative within 30 days.

<b>Authority:</b> MCL 330.114; MCL 333.5451; MCL 400.9; Executive Order No. 1996-1; Executive Order No. 1996-4; 42 CFR 431.200; 7CFR 246.18; MAC R 325.910, <i>et seq.</i> ; MAC R 330.4011; MAC R 330.5011; MAC R 330.8005, <i>et seq.</i> ; MAC R 400.3401, <i>et seq.</i> ; and relevant Interagency Agreements.
<b>Completion:</b> Is Voluntary, but if NOT completed, a hearing will not take place.
<ul style="list-style-type: none"><li>• The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.</li><li>• If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Department of Community Health.</li></ul>
If you do not understand this, call the Department of Community Health. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لولاية ميشيغن.
1 (877) 833 - 0870

DCH-0092 INSTRUCTION SHEET (Rev. 8-99)

See the Request Form Underneath



City	State	ZIP Code	State Program or Service being provided to this appellant
------	-------	----------	---

DCH-0092 (8-99) DISTRIBUTION: WHITE - Administrative Tribunal, YELLOW - Person Requesting

## **Attachment D**

### **Annotations**

**DOC** (documented), meaning the service conformed to Program regulations, policies and procedures.

**NF** (not found), meaning the provider did not provide any record substantiating that the service was performed.

**NS-1** (not supported), meaning the service was improperly billed.

**NS-2**, meaning the service is not a covered benefit of the Program.

**NS-3**, meaning the service was not medically necessary.

**NS-4**, meaning the record(s) was insufficient to support the service paid by the Program.

**NS-7**, meaning the record(s) was illegible.

**RC**, meaning that the record did not support the service paid but supported another service. The procedure code for the appropriate service will be annotated beneath the printed procedure code.

**RC/UP** (recoded underpayment), meaning that the record did not support the service paid but supported another service. The procedure code for the appropriate service will be annotated beneath the printed procedure code. If this results in an underpayment to the provider the annotation will be reflected by RC/UP (recoded underpayment).

**Attachment E**

September 25, 2004 *[Outpatient Letter] Revised 7/18/06*

Jane Doe  
Utilization Review Specialist  
Sample Road  
Anywhere, MI xxxxx

Dear Ms.Doe:

The Michigan Peer Review Organization (MPRO) as a contracted agent of the Michigan Department of Community Health, is currently performing a audit of your Provider Type 40 (Outpatient Hospital) facility. As I explained during my telephone conversation, this post payment medical record review is being conducted to determine compliance with Medicaid policy and guidelines.

This letter is to confirm our appointment scheduled for \_\_\_\_\_ and \_\_\_\_\_ at \_\_\_\_\_ a.m. in your facility. These visits are to copy records for approximately two hundred fifty (250) Medicaid beneficiaries for whom you provided services for the review period of 1/1/200\_ thru 12/31/200\_. All Outpatient Services for the beneficiaries included in the sample, for the review period are needed. Examples of some of the Outpatient Hospital services that may be included are: laboratory, radiology, Emergency Room visits, physical therapy etc. Some of the services may include items that are series billed such as physical therapy visits. An itemized bill is needed for the following Revenue Center Codes 250, 251, 252, 257, 258, 259, 260, 262, 270, 271, 272, and 370. The dates of service that require the itemized bill are highlighted on the case listing.

In addition to myself there will be another nurse reviewer. We will require a room with an electrical outlet and will be bringing equipment to your facility. You will be furnished with a beneficiary list thirty (30) calendar days prior to our arrival. It is estimated we will need \_\_\_\_\_ days at your facility to copy the records.

If you have any questions regarding this correspondence or if there is difficulty locating a record and you need assistance identifying the Outpatient Hospital service provided please call. I can be reached at (---) --- - ----.

Thank-you again for your cooperation and continued participation in the Medicaid Program.

Sincerely,

\_\_\_\_\_  
RN.

Michigan Peer Review Organization  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

Cc: CEO

**Attachment E1**

September 25, 2004 *[Inpatient Letter]Revised 7/18/06*

Jane Doe  
Utilization Review Specialist  
Sample Road  
Anywhere, MI xxxxx

Dear Ms.Doe:

The Michigan Peer Review Organization (MPRO) as a contracted agent of the Michigan Department of Community Health, is currently performing a audit of your Provider Type 30 (Inpatient Hospital) facility. As I explained during my telephone conversation, this post payment medical record review is being conducted to determine compliance with Medicaid policy and guidelines.

This letter is to confirm our appointment scheduled for \_\_\_\_\_ and \_\_\_\_\_ at \_\_\_\_\_ a.m. in your facility. These visits are to copy records for approximately two hundred fifty (250) Medicaid beneficiaries for whom you provided services for the review period of 1/1/200\_ thru 12/31/200\_ . The beneficiaries may have more than one (1) Inpatient Hospital admission during the audit review period. All admissions for the beneficiaries included in the sample for the audit timeframe are needed.

In addition to myself there will be another nurse reviewer. We will require a room with an electrical outlet and will be bringing equipment to your facility. You will be furnished with a beneficiary list thirty (30) calendar days prior to our arrival. It is estimated we will need \_\_\_\_\_ days at your facility to copy the records.

If you have any questions regarding this correspondence or if there is difficulty locating a record and you need assistance identifying the Inpatient Hospital admission please call. I can be reached at (---) --- - ----.

Thank-you again for your cooperation and continued participation in the Medicaid Program.

Sincerely,

\_\_\_\_\_  
RN,  
Michigan Peer Review Organization  
22670 Haggerty Road, Suite 100  
Farmington Hills, MI 48335-2611

Cc: CEO



**ATTACHMENT G**

**Nurse Review Report**

**For**

**Case Number:**

**ID Number:**

**Review Period:**            **thru**

**Sample Size: Stratum**  
**Stratum**

**Missing Records:**

**Review By:** \_\_\_\_\_  
**(Signature)**

**Date:**

**(Organization Name)**  
**(Organization Address)**

**Provider Name**  
Nurse Review Report

**Reason For Review:**

This review was conducted to determine compliance with Medicaid Policy and guidelines.

**Sample Statistics:**

Review Period:  
Run Date:  
I.D. Number:  
Total Payments:  
Sample Payments:  
Total Beneficiaries:  
Sample Beneficiaries:  
Total Claims:  
Sample Claims:

**Summary of Field Activities:**

The on-site visits were conducted on \_\_\_\_\_ at \_\_\_\_\_.  
\_\_\_\_\_ was our contact person. All available medical records were copied. \_\_\_\_\_  
assisted in the copying of records.

**Nurse Review Findings:**

(This section summarizes the results of the audit review. Policy and Procedure, as well as Procedure and Revenue Codes should be referenced where applicable. Examples stating the stratum and beneficiary number should be listed with each finding. In addition to the above, every finding should include an attachment which contains a copy of the policy, procedure and revenue code supporting the finding.)

**ATTACHMENT H**

**ADEQUATE ACTION NOTICE**

Denial of Service

Date

Beneficiary Name  
Beneficiary Address

RE: Beneficiary Name  
Beneficiary Medicaid ID #

Dear (Beneficiary Name):

(Contractor Name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for services for Medicaid Long Term Care Services. Following a review of the services for which you have applied, it has been determined that the following service(s) shall not be authorized. It has been determined that you do not meet the functional/medical eligibility requirements for this program. Therefore, authorization for the admission has been denied. The legal basis for this decision is the 42CFR 440.230(d).

**Service(s)**

**Effective Date**

_____	_____
_____	_____

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30195  
LANSING, MI 48909-7695

If you have any questions about this denial, you may call the Contractor Manager for the (Contractor Name) Contract at (phone number).

If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:  
Hearing Request Form  
Return Envelope

**ATTACHMENT I**

**ADVANCE ACTION NOTICE  
Suspension, Reduction or Termination**

Date

Name

Address

City, State, Zip

RE: Beneficiary's Name  
Beneficiary's Medicaid ID Number

Dear \_\_\_\_\_:

(Contractor name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for Medicaid Long Term Care Services. Following a review of the services that you are currently receiving, it has been determined that the following service(s) shall not be authorized. The reason for this action is \_\_\_\_\_. The legal basis for this decision is 42CFR 440.230(d).

**Service(s)**

**Effective Date**

\_\_\_\_\_  
\_\_\_\_\_

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30195  
LANSING, MI 48909-7695

You will continue to receive the affected services in most circumstances until the hearing decision is rendered if your request for a department hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a department hearing you may be required to repay the benefits. This will occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

If you have questions about this denial, you may call the Contract Manager for the Contract at (517)-----.

If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:

Hearing Request Form

Return Envelope









