

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

CHANGE NOTICE NO. 5
 to
CONTRACT NO. 071B0200072
 between
THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335	Melody Petrul, RN	mpetrul@mpro.org
	TELEPHONE	CONTRACTOR #, MAIL CODE
	(248) 465-7366	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Laura Dotson	517-241-4686	dotsonl1@michigan.gov
BUYER	DTMB	Lance Kingsbury	517-241-7366	kingsbury@michigan.gov

CONTRACT SUMMARY:			
Hospital Admissions Review and Certification – Michigan Department of Community Health			
INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2010	December 31, 2012	2, 1 yr. options	December 31, 2013
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
1% Net 15	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
<input type="checkbox"/> P-card <input type="checkbox"/> Direct Voucher (DV) <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

DESCRIPTION OF CHANGE NOTICE:				
EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1 year	December 31, 2014
VALUE/COST OF CHANGE NOTICE:		ESTIMATED REVISED AGGREGATE CONTRACT VALUE:		
\$1,218,610.00		\$11,226,700.00		
Effective immediately, the second option year will be utilized to extend this Contract out to December 31, 2014 and funds added in the amount of \$1,218,610.00. Per the attached, Attachment A has been modified and Contract language changes as listed. All other terms, conditions, specifications and pricing remain unchanged.				

Attachment A, Pricing

Pricing is modified to read as follows:

HOSPITAL ADMISSIONS REVIEW & CERTIFICATION FOR DEPARTMENT OF COMMUNITY HEALTH

Program		Projected Volume/Month (estimated)	Total Annual Per Program (estimated)	Unit Price	One Year Pricing
PACER	FFS Reviews	900/month	10,800	\$56.75 ✓	\$ 612,900.00
	FFS Appeals	RN=6.25 hours	75 hours	\$27.00/per half hour	\$ 4,050.00
		MD=6.25 hours	75 hours	\$77.00/per half hour	\$ 11,550.00
LTC	Immediate Reviews	8.33/month	100	\$124.50 ✓	\$ 12,450.00
	Exception Reviews	13.33/month	160	\$65.00	\$ 10,400.00
	Immediate & Exc Appeals	RN=8.33/month	100 hours	\$27.00/per half hour	\$ 5,400.00
		MD=8.33/month	100 hours	\$77.00/per half hour	\$ 15,400.00
	Retrospective Reviews	150/month	1,800	\$35.00	\$ 63,000.00
	Retrospective Appeals	RN=41.66 hours/month	500 hours	\$27.00/per half hour	\$ 27,000.00
		MD=20.83hours/month	250 hours	\$77.00/per half hour	\$ 38,500.00
DME/MS	Reviews	600	7200	\$56.75	\$ 408,600.00
	Appeals	RN=6.25	45	\$54.00	\$ 2,430.00
		MD = 6.25	45	\$154.00	\$ 6,930.00
	Grand Total				\$1,218,610.00

Change Notice Number 5
 Contract Number 071B0200072

CONTRACT #071B0200072 DELETIONS EFFECTIVE 10/01/2013 (Original contract 12/07/2010 / utilized revised doc dated 01/01/2013)AUDIT/SWUR PORTION SEPARATED FROM CONTRACT

PAGE	SECTION	Deletion Item
2	Attachment A, Pricing	Columns and Rows for Audits and SWUR - Revised Attachment A, Pricing w/DCH-1508
3	Change Notice No. 2	Remove information for Donna O'Shesky; no longer associated with this contract. Add Michelle Mapes; PACER and DME/MS Contract Manager; MDCH; 400S. Pine Street; Lansing, MI 48909; Phone: 517-335-5572; Fax: 517-241-7813; Email mapesm@michigan.gov
5	1.012 Background	Delete B
5	1.102 Background	Second paragraph (after alpha list): 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). MDCH has a Statistician that determines the statistically valid random sample audits.
5	1.102 Background	Delete Verbiage: MDCH has a Statistician that determines the statistically valid random sample audits.
11	1.022 Work and Deliverable	Number 19 and following verbiage: 19. Grouper 26 is currently being used; however, the Grouper that was in effect all the time the services were provided must be utilized for Inpatient audits and Statewide Utilization Review. There are no modifiers/codes for retrospective exemptions to prior authorization. C. ii. 27 pertains to Inpatient/Outpatient audit process.
11	2.023 Project Manager	Delete: Renate Rademacher, Outpatient Hospital Contract Manager Michigan Department of Community Health 400 S. Pine St., Lansing MI 48909 RademacherR@michigan.gov Phone: 517-335-5070 Fax: 517-241-9087
12	Attachment A, Pricing	See revised Attachment A sent with form DCH-1508 and this revision document.
22	Definitions by MDCH	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.
23	Definitions by MDCH	Nurse Review Report: a written report of the audited record by the nurse reviewer, see Attachment J.
23	Definitions by MDCH	Outpatient Services Criteria: currently accepted standards of care for Outpatient Department service consistent with coverage in Hospital Provider Manual.
24	Definitions by MDCH	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.
25	1.012 Background	2nd paragraph verbiage: The purpose of this contract is to have a qualified Contractor conduct telephonic/electronic authorization of inpatient services; audits utilization review of inpatient services; outpatient services, and emergency-room services; including PACER validation and specified DME/MS items (add this) 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.

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25	1.012 Background	4th paragraph verbiage: 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). MDCH has a Statistician that determines the statistically valid random sample audits.
25	1.012 Background	5th paragraph verbiage: 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 and outpatient 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.
27	1.021 In Scope	Delete: 8. All Michigan Inpatient and Outpatient Hospitals are included in the Statewide Utilization Review. In 2008, there were 188 Michigan Inpatient/Outpatient Hospitals.
29	1.021 In Scope	Make these changes to existing verbiage found in table: For the contract beginning January 1, 2014, the PACER validations will take place through the inpatient audit program and Statewide Utilization Review (SWUR) program for inpatient services. We will validate each case selected for audit/SWUR that has a PACER assigned.
29	1.021 In Scope	Delete last heading/paragraph: HOSPITAL AUDITS/STATEWIDE UTILIZATION REVIEW AND LONG TERM CARE RETROSPECTIVE ELIGIBILITY REVIEWS Hospital audits will be conducted on Medicaid Fee For Service (Title XIX), Medicare/Medicaid dually eligible (Title XVIII/XX), Children's Special Health Care Services dual eligible (Title V/XIX), utilizing statistically valid random samples. The average number of beneficiaries to be reviewed for each audit is two hundred fifty (250).
30	1.021 In Scope	Delete verbiage (2nd paragraph): 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 CHAMPS Specialty Code B205 that crosswalks to Legacy Provider Type 30 Inpatient Hospital and/or CHAMPS Specialty Codes B206 or B210 that crosswalks to Legacy Provider Type 40 Outpatient Hospital facilities. The Contractor will draw a random sample of twenty (20) records per facility per year. For Inpatient Hospital services, if the Contractor has flagged a PACER case(s), the case(s) may be substituted for one or more of the twenty (20) random cases selected for that facility. Approximately four (4) hospitals per week will be reviewed for a total of sixteen (16) hospitals per month. If an inpatient/outpatient hospital has been selected to be audited that year, they will be exempt from the Review for that year.

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30	1.021 In Scope	<p>will be paid per audit/Statewide Utilization Review/LTC retrospective review completed.</p> <p>1. Audits will be conducted on the following:</p> <p>a. Inpatient Hospital Services: Twelve (12) audits with the possibility of fifteen (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 fifteen (15) days, inpatient rehabilitative facilities.</p> <p>b. Outpatient Hospital/Emergency Room Services: Twelve (12) audits with the possibility of fifteen (15) audits will be completed each year. The review will include all Outpatient Hospital and Emergency Room services paid to the provider.</p> <p>c. For Hospital Audits, the Contractor will conduct up to 15 Inpatient Hospital and up to 15 Outpatient Hospital Audits selected by the Michigan Department of Community Health. For Statewide Utilization Review the Contractor selects approximately four (4) hospitals per week to be reviewed for a total of sixteen (16) hospitals per month for inpatient and outpatient hospital providers. For hospital audits up to 15 inpatient and 15 outpatient audits are conducted annually. The statistically valid random sample for audits is determined by the Michigan Department of Community Health statistician from the universe of paid claims for the provider to be audited for a designated time period.</p> <p>Up to 15 Inpatient Hospital audits and 15 Outpatient Hospital audits will be audited on an annual basis. Michigan Department of Community Health selects the hospitals to be audited.</p> <p>2. PACER Validation:--</p> <p>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/tracking 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 authorization/tracking numbers assigned utilizing MDCH CHAMPS.</p> <p>During review of the inpatient hospital medical records included in the audit sample, if it is</p>
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31	1.021 In Scope	<p>From top of page: 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.</p> <p>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 CHAMPS Specialty Code B205 that crosswalks to Legacy Provider Type 30 Inpatient Hospital facilities.</p> <p>3. Utilization Review:</p> <p>Utilization review will be performed on all records requested for the Audits. This will include Inpatient/ Outpatient/Emergency Room/PACER services.</p> <p>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 CHAMPS Specialty Codes B205 that crosswalks to Legacy Provider Type 30 Inpatient Hospital and/or CHAMPS Specialty Codes B206 or B210 that crosswalks to Legacy Provider Type 40 Outpatient Hospital facilities.</p> <p>41. Long Term Care Retrospective Review:</p> <p>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.</p>
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31	1.021 In Scope	<p>Contractor Response (See box) - Delete strike through verbiage: MPRO has been successfully performing hospital audits, LTC retrospective reviews, and SWURs during the last five years in our contract with the State and we are prepared to continue performing these tasks upon contract award. The following provides a summary of each review type.</p> <p>AUDITS</p> <p>MPRO will conduct hospital audits on Medicaid Fee for Service (Title XIX), Medicare/Medicaid dually eligible (Title XVII/IXX), Children's Special Health Care Services dual eligible (Title V/XIX) utilizing the statistically valid random sample produced by MDCH. The average number of beneficiaries for review per audit is 250.</p> <p>MDCH will select 12 inpatient and 12 outpatient providers (with the possibility of 15 per audit type) to be audited each year. We will review all inpatient services paid to the provider including, but not limited to, medical detoxification, elective admissions, transfers, readmissions within 15 days, and inpatient rehabilitative facilities. Our RHITs will perform the coding validation of all inpatient audits. RNs will review each case for the appropriateness of the admission, continued stay, stability at discharge, and quality of care provided.</p> <p>MPRO will review all outpatient hospital/ER services. The average number of beneficiaries for review per audit is 250. An RN performing the audit will validate each claim line on the audit. The RN will focus on whether services ordered were performed and coded accurately. In addition, the RN will review for appropriateness of setting and quality of care provided.</p> <p>PACER VALIDATION</p> <p>MPRO will continue to perform PACER validation for all inpatient audits and inpatient SWUR where prior authorization was obtained. The RN who made the PACER determination will not be the RN performing the audits. Validation includes evaluating the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Does the admission fall into a category that required prior authorization (i.e., elective admissions, 15-day readmissions, transfers, rehabilitation admissions, and 30-day and 60-day rehabilitation continued stays)? <input type="checkbox"/> If the admission falls into one of these categories, was a PACER number issued?
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		<p>Delete strikethrough verbiage: <input type="checkbox"/> If a PACER number was not issued, was there a reason (self-pay, other insurance at time of admission, etc.)?</p> <p>PACER PROCESS</p> <p><input type="checkbox"/> A PACER number was obtained. The RN opens the PACER review and evaluates RN and physician reviews performed on the case. The RN confirms that the information provided telephonically is documented in the medical record. If the information provided is not substantiated in the medical record, the RN will recommend the provider refund the hospital stay to MDCH. If the information in the medical record supports the information provided during the prior telephonic authorization review, the RN approves the admission and notes "payer validated."</p> <p><input type="checkbox"/> If a PACER number should have been obtained, but was not, the RN notes this as "the record was insufficient to support the services paid by the program" in the audit. For the SWUR inpatient program, the RN sends an educational letter to the provider advising him/her that prior authorization was indicated and codes it in our SWUR system that a PACER was not obtained. If we identify that we issued a PACER in error, we will immediately notify MDCH.</p> <p>UTILIZATION REVIEW</p> <p>MPRO performs utilization review on all audit and SWUR inpatient/outpatient cases, ER, and PACER services. Utilization review consists of the RN determining that services requested were performed in the appropriate setting. The RN evaluates an inpatient stay utilizing InterQual® criteria. An outpatient stay is assessed for the potential need for a higher level of care. On an ER visit, the RN ensures the patient received the correct services and the severity level assigned was accurate. The RN will consider MDCH 051 edits because these are typically non-ER visits and consider the ER severity level coding assignments. In addition, the medical stability of the patient will be assessed (EMTALA) at the time of discharge or transfer from the ER.</p> <p>LONG TERM CARE RETROSPECTIVE REVIEW</p> <p>MPRO will conduct LTC retrospective reviews 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 sampling selected by MDCH. The review volume anticipated is 450 beneficiaries per quarter. Our RNs will use the Level of Care Determination criteria for beneficiaries who qualified by means of the exception criteria to determine appropriate utilization.</p>
32	1.021 In Scope	
32	1.021 In Scope	Delete table contents at bottom of this page (#1).
33	1.021 In Scope	Delete #2, #3, #4. Keep Long Term Care Retrospective Review (2nd #3 - erroneously numbered) and Delete the second #4 (erroneously numbered PACER Validation. Renumber.
		Delete strikethrough verbiage: 18- Grouper 26 is currently being used, however, the Grouper that was in effect all the time the services were provided must be utilized for Inpatient audits and Statewide Utilization Review. There are no modifiers/codes for retrospective exemptions to prior authorization. C. ii. 27 pertains to Inpatient/Outpatient audit process.
36	1.022 Work and Deliverable	
58-61	1.022 Work and Deliverable	Delete entire section titled - Hospital audit/utilization.

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		<p>Contractor Response to tasks section - delete strike through verbiage: HOSPITAL AUDIT/UTILIZATION REVIEW SUMMARY</p> <p>MPRO's hospital audit and utilization review process will fulfill MDCH's regulatory requirements for the control of utilization of inpatient hospital services, as well as its mandate to ensure that only appropriate and necessary services are provided to the Medicaid population in the most economical manner.</p> <p>The primary objectives of the inpatient and outpatient/ER audits are to determine medical necessity, appropriate setting, and correct billing of the services by each provider. The PACER validation reviews determine the accuracy of the authorization process used by the PACER Review Coordinators, as well as evaluate the accuracy of the provider's medical record documentation compared to the clinical information provided by telephone. RNs who are not part of the PACER program conduct the PACER validation reviews. Utilization review is performed for all inpatient, outpatient/ER, and PACER validation audits.</p> <p>The long term care reviews are designed to ensure that the beneficiaries admitted to a nursing facility or the PACE program, including any admissions based upon MDCH's exception criteria or professional judgment, meet the level of care criteria designed by MDCH.</p> <p>MPRO has designed a solution to provide a sound, criteria-based, independent audit/review outcome that meets MDCH's objectives. The reviews consider appropriate utilization and quality of care issues, as required by MDCH.</p> <p>HOSPITAL AUDIT/UTILIZATION REVIEW REQUIREMENTS</p> <p>To establish and maintain credibility with providers, the audit and review processes must use clearly defined criteria in a consistent manner. The CONTRACT outlines criteria that are required for each of the audit and review processes. These criteria vary based upon the type of services reviewed and the setting where care is provided. The following table outlines the criteria used for each.</p>
62	1.022 Work and Deliverable	
62	1.022 Work and Deliverable	Delete: Table 3. Summary of Criteria for Each Type of Audit
63-75	1.022 Work and Deliverable	Delete verbiage on these pages.
		<p>Unter "Appeals process for Hospital Audits and Long Term Care Retrospective Review". 4- Inpatient/Outpatient/Emergency Room Audits:</p> <p>The MDCH Medicaid Integrity Program will notify the providers of the audit results, hearing dates, and appeal rights by mail.</p> <p>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. Contractor physician representation at the appeals will be at the request of the State Office of Administrative Hearings and Rules and the Office of Medical Affairs on an as needed basis for hospital audits.</p>
80	1.022 Work and Deliverable	Renumber - 2. Long Term Care Retrospective Review.

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81	1.022 Work and Deliverable	Under "Timeframes" - Delete strikethrough verbiage in first paragraph language found below, Delete Table I and Table III; Renumber Table II to Table i. First paragraph verbiage: The following timeframes listed in Table I-III are for the first, second, and third years 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.
83	1.022 Work and Deliverable	Under "Contractor Response to Task" - As a current contractor of the State of Michigan and CMS, we are currently in compliance with all required contract timeframes. Our proven processes and our commitment to quality improvement assures that we meet or exceed review timeline expectations. Further, we will meet the review timeframes set forth by URAC in our accreditation as a Health Utilization Management (HUM) organization (see Appendix B for a copy of our accreditation). Under our current Medicaid FFS Review contract, we complete 99.5% of all inpatient retrospective reviews within 30 days receipt of the medical record. We will complete all inpatient and outpatient/ER audits, SWUR inpatient and outpatient, and LTC retrospective reviews in a timely manner, according to schedule in the table below.
83	1.022 Work and Deliverable	Delete all items in "Table 11: Audit and Review Schedule" except items under Long Term Care Retrospective Review columns. This includes deletion of the boxed paragraph at the end of page 83 (audit related).
84	1.030 Roles and Responsibilities	1.031 Contractor Staff, Roles, and Responsibilities QUALIFICATIONS OF CONTRACTOR'S STAFF FOR PACER AND LONG TERM CARE IMMEDIATE AND EXCEPTION REVIEW AND HOSPITAL AUDITS/STATEWIDE UTILIZATION REVIEW AND LONG TERM CARE RETROSPECTIVE REVIEW
84	1.031 Contractor Staff, Roles, and Responsibilities	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 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 audit/Statewide Utilization Review/Long Term Care Immediate and Exception review functions cannot perform the Retrospective Review and PACER authorizations, MDCH expects the Contractor to designate separate staff for each.
84	1.031 Contractor Staff, Roles, and Responsibilities	c. The Contractor shall be staffed by Physician Reviewers with expertise in the areas listed above and to participate in the PACER authorization process, and to act as a resource for audits and Statewide Utilization Review and Long Term Care Retrospective Review appeal representation, when requested by the ALJ.
84	1.031 Contractor Staff, Roles, and Responsibilities	d. The coding review for inpatient hospital review shall be validated by a Registered Health Information Technologist, RHIT.
85	1.031 Contractor Staff, Roles, and Responsibilities	MPRO's Michigan Medicaid Audit Review Team is comprised of a multidisciplinary staff of individuals with experience in Michigan Medicaid policies, utilization review, billing and coding, medical record review, use of InterQual® and long term criteria, and project management.

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88	1.031 Contractor Staff, Roles, and Responsibilities	Nurse Review Staff section: Our nurse review team has more than 70 combined years of experience in Michigan Medicaid and utilization review and quality assurance. Our nurse reviewers are licensed in the State of Michigan as Registered Nurses (RNs) and are knowledgeable of all inpatient/outpatient/hospital/ER services/PACER/utilization review/long term care. Additional qualifications for our nurse reviewers include: minimum of five years experience in an acute care or outpatient clinical setting, personal computer competency, quality improvement, utilization review experience, and excellent verbal/written communication skills.
88	1.031 Contractor Staff, Roles, and Responsibilities	Professional Review Staff section: Our professional review network is an integral component of our utilization review program. It is comprised of over 150 licensed, board-certified, and credentialed physicians. We have experienced physician reviewers representing the entire spectrum of medical specialties and sub-specialties. Our physician reviewers are knowledgeable of all inpatient/outpatient/hospital/ER services/PACER/utilization review/long term care. For this review program, our physician reviewers will serve as a resource for audits. Through quarterly educational sessions, newsletters, and hands-on orientation, we will keep physician reviewers abreast of current trends and changes in Medicare and Medicaid principles that affect health care. In addition, our physician reviewers have current clinical knowledge and clinical experience, have no history of disciplinary action or sanctions related to quality of care, fraud, or other criminal activity and have no conflicts-of-interest with any case under review. These physicians maintain active medical practices while participating in our medical review processes and/or committee activities. Biographies of the key staff and additional professional and technical staff that comprise our Audit-Review Team follow. For detailed resumes of key staff, see Appendix C.
89	1.031 Contractor Staff, Roles, and Responsibilities	Audit/Statewide Utilization Process Manager – Jan Howe, RN - Role – Develops and maintains review processes, acts as liaison to project managers, performs MPRO's responsibilities relative to auditing review program appeals, confirms the accuracy of SWUR program data, performs reviews, and conducts employee orientations.
90	1.031 Contractor Staff, Roles, and Responsibilities	Delete entire page contents.
91	1.031 Contractor Staff, Roles, and Responsibilities	Delete contents up to "PACER Review Coordinator - Susan Birch, RN" section.
92	1.031 Contractor Staff, Roles, and Responsibilities	Support Technician - Lori Peterson - Role – Scans inpatient/ER/outpatient records, ensuring medical record integrity and confidentiality of the records, and prepares audit and SWUR program records for review.
92	1.031 Contractor Staff, Roles, and Responsibilities	Support Technician - Joanne Kovacs - Role – Scans inpatient/ER/outpatient records, ensuring medical record integrity and confidentiality of the records, and prepares audit and SWUR program records for review.
93	1.031 Contractor Staff, Roles, and Responsibilities	Privacy, Data Security, and Confidentiality section: MPRO's Audit Review Team has significant experience in the proper handling of confidential information, and we have documented policies and procedures to ensure the confidentiality and security of all data we maintain.

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93	1.031 Contractor Staff, Roles, and Responsibilities	<p>Milestones and Deliverables section: b. The Contractor shall demonstrate to the MDCH's satisfaction no later than one (1) 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:</p> <p>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. The MDCH expects the Contractor to designate separate staff for each review.</p> <p>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.</p> <p>iii. That the Contractor has the ability to accept, process and transmit to the MDCH those audits Statewide Utilization Review/LTC reviews that have been completed.</p> <p>iv. That the Contractor has quality assurance procedures in place that assures it follows all State and Federal laws for confidentiality.</p>
94	1.031 Contractor Staff, Roles, and Responsibilities	<p>2. Program Specification - a. The Contractor shall complete the audit review process within the Timeframes described under Article 1.022 and submit the required reports within the Timeframes described under Article 1.042. 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.</p>
94	1.031 Contractor Staff, Roles, and Responsibilities	<p>Implementation Readiness - As the current FFS contractor, MPRO is in a unique position to meet MDCH's contract milestones and deliverables with little or no start-up time. We have a Michigan-based facility, management infrastructure, experienced staff, phone system, MDCH-specific computer system, and audit review processes in place for immediate start up after contract negotiations are completed. The following outlines milestones and deliverables and our compliance plan.</p>
94	1.031 Contractor Staff, Roles, and Responsibilities	<p>Table 13: Milestones/Deliverables – Readiness for Implementation - Delete any reference to outpatient, ER, SWUR or audit.</p>
95	1.031 Contractor Staff, Roles, and Responsibilities	<p>Program Specifications - Table 14: Milestones/Deliverables – Program Specifications. Delete any reference to outpatient, ER, SWUR or audit. Delete third row entirely.</p>
96	1.041 Project Plan Management	<p>Contract Monitoring - The Contractor shall permit the MDCH or its designee to visit and to make an evaluation of the project as determined by the Contract Manager: At least once (1) per contract year the 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 three (3) 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.</p>
97	1.041 Project Plan Management	<p>Delete #3 and renumber #4 to be #3.</p>
98	1.041 Project Plan Management	<p>In table 15 delete information in the two columns for Programs "Hospital Audits" and "Statewide Utilization Review"</p>

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 SEPARATED FROM CONTRACT

98	1.041 Project Plan Management	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 review 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 an average time to answer greater than ninety (90) seconds.
99	1.041 Project Plan Management	Sanctions - Pacer: Under #1 (second paragraph): In addition to the above, beginning April 1, 2010, additional sanctions will begin. If greater than ten (10) PACER authorizations per audit review are determined to be inappropriately authorized during the PACER validation conducted by Contractor during the audit review process, the Contractor will be sanctioned the amount of the hospitalizations approved in error.
100	1.041 Project Plan Management	2nd Paragraph after Table 16 - Sanctions PACER: We acknowledge that MDCH may elect to adjust the number of audits/reviews conducted per provider type within 30 days notice to MPRO. MDCH may also change the audit/review process or cancel the contract with 30 days notice to MPRO.
102	1.041 Project Plan Management	Hospital Audits/Statewide Utilization Review/LTC Retrospective Reviews: For the first year of the Contract, the Contractor is expected to correct any inability to meet Timeframes. The MDCH reserves the right to adjust the number of Hospital Audits/Statewide Utilization Review/LTC Retrospective Reviews conducted per provider type with a thirty (30) day notice to the Contractor. The MDCH also reserves the right to change the audit/review process or cancel the Contract with a thirty (30) day notice to the Contractor.
103	1.041 Project Plan Management	2. Audits/Statewide Utilization Review/LTC Retrospective Reviews. The number of Hospital Audits/Statewide Utilization Review/LTC Retrospective Reviews to be completed are outlined under Article 1.021. Upon review by the MDCH Contract Manager, if the Hospital Audit/ Statewide Utilization Review/LTC Retrospective Reviews from the previous month are not completed correctly or in a timely manner, the MDCH will withhold twenty five percent (25%) of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.
103	1.041 Project Plan Management	Table 18 - Sanctions - Hospital Audits/SWUR/LTC Retrospective Reviews - Under Contract Violation column; 2nd row delete "Audits/SWUR" verbiage.
103	1.041 Project Plan Management	In box below Table 18: 1st paragraph - MPRO acknowledges that MDCH may elect to adjust the number of audits/reviews conducted per provider type within 30 days notice to MPRO. MDCH may also change the audit/review process or cancel the contract with 30 days notice to MPRO.
104	1.042 Reports	The MDCH reserves the right to adjust the number of audits conducted per provider type, (inpatient/outpatient hospital/emergency room services), the number of Statewide Utilization Review records and the number of Long Term Care Retrospective Reviews with a thirty (30) day notice to the Contractor. The MDCH reserves the right to change/cancel the audit/review process or cancel the contract with a thirty (30) day notice to the Contractor.
104	1.042 Reports	The Contractor shall provide Inter-rater Reliability reports to the MDCH on a quarterly basis. The inter-rater Reliability Rater is a 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).

CONTRACT #071B0200072 DELETIONS EFFECTIVE 10/01/2013 (Original contract 12/07/2010 / utilized revised doc dated 01/01/2013)AUDIT/SWUR PORTION
 SEPARATED FROM CONTRACT

104	1.042 Reports	The Contractor shall provide Inter-rater Reliability Reports to the MDCH 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 de-identified for each part of the Program is requested (PACER, Inpatient Audits, Outpatient Audits).
105	1.042 Reports	Delete section under "Hospital Audits/Statewide Utilization Review Reports".
106	1.042 Reports	MPRO will submit electronic reports to MDCH's Contract Manager that document the progress and results of the audits and retrospective reviews conducted for inpatient, outpatient, ER and long term care admissions, and SWUR. Based upon our activities with the current Medicaid FFS review contract, we are equipped to provide the required reports and can easily adapt our process to accommodate new reports. At the onset of the contract, we will coordinate with MDCH to develop a reporting format that best meets the needs of both parties, and we will be flexible to respond to any changes requested by MDCH throughout the term of the contract.
109	1.042 Reports	Delete section under "Hospital Audits/Statewide Utilization Review Reports". Keep items under "Long Term Care Retrospective Review Reports".
110	1.061 Proposal Pricing	PAYMENT SCHEDULE- HOSPITAL AUDITS/STATEWIDE UTILIZATION REVIEWS/ LONG TERM CARE RETROSPECTIVE REVIEWS AND LONG TERM CARE RETROSPECTIVE APPEAL PROCESS
110	1.061 Proposal Pricing	The payment schedule will be based on the number of audits/Statewide Utilization Reviews/LTC Retrospective Reviews completed. The per audit payment will include both the medical record review and the appeal process through settlement. The LTC Retrospective Review payment will include the medical/case record review. The Appeal Process for Long Term Care Retrospective Review will be paid separately. Although the Contractor will receive payment upon completion of the audit or LTC 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.
111	1.061 Proposal Pricing	For Inpatient Statewide Utilization Review payment will occur if the medical record is received and reviewed.
111	1.061 Proposal Pricing	For Outpatient Statewide Utilization Review payment will occur if seventy five percent (75%) of the services paid for date of service selected are received and reviewed.
111	1.061 Proposal Pricing	The Contractor will be paid monthly based on the number of hospital audits completed the previous month of the contract.
111	1.061 Proposal Pricing	The Contractor will be paid monthly based on the number of Statewide Utilization Reviews completed the previous month of the contract.

Change Notice Number 5
 Contract Number 071B0200072

CONTRACT #071B0200072 DELETIONS EFFECTIVE 10/01/2013 (Original contract 12/07/2010 / utilized revised doc dated 01/01/2013)AUDIT/SWUR PORTION

CONTRACT #071B0200072 DELETIONS EFFECTIVE 10/01/2013 (Original contract 12/07/2010 / utilized revised doc dated 01/01/2013)AUDIT/SWUR PORTION
 SEPARATED FROM CONTRACT

144	Referenced Attachments-Attachment A, Pricing	Revised Attachment A deleting Audits and SWUR information submitted with this email/spreadsheet.
163	Referenced Attachments-Attachment G - Annotations	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
164	Referenced Attachments-Attachment H - Outpatient Ltr	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
165	Referenced Attachments-Attachment H1 - Inpatient Ltr	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
166-167	Referenced Attachments-Attachment I	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
168-169	Referenced Attachments-Attachment J	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
172	Referenced Attachments-Attachment M (Inpatient)	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
173	Referenced Attachments-Attachment M1 (Outpatient)	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
174	Referenced Attachments-Attachment N	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
175	Referenced Attachments-Attachment N1	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
176	Referenced Attachments-Attachment N2	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
177	Referenced Attachments-Attachment N3	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
178	Referenced Attachments-Attachment N4 (Outpatient)	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
179-180	Referenced Attachments-Attachment N5 (Outpt Ed Ltr)	Delete this page (deals with audits/SWURS and that is no longer part of this contract).
189	Referenced Attachments-Attachment U	Delete this page (deals with audits/SWURS and that is no longer part of this contract).

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

CHANGE NOTICE NO. 4
 to
CONTRACT NO. 071B0200072
 between
THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335	Melody Petrul, RN	mpetrul@mpro.org
	TELEPHONE	CONTRACTOR #, MAIL CODE
	(248) 465-7366	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Laura Dotson	517-241-4686	Dotsonl1@michigan.gov
BUYER	DTMB	Lance Kingsbury	517-241-7366	kingsburyl@michigan.gov

CONTRACT SUMMARY:			
DESCRIPTION: Hospital Admissions Review and Certification – Michigan Department of Community Health			
INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2010	December 31, 2012	2, one year	December 31, 2013
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
1% Net 15	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
<input type="checkbox"/> P-card <input type="checkbox"/> Direct Voucher (DV) <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

DESCRIPTION OF CHANGE NOTICE:				
EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>		December 31, 2013
VALUE/COST OF CHANGE NOTICE:			ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:	
\$0.00			\$10,008,090.00	

Effective immediately, the following HIPAA Business Associate Agreement Addendum is hereby incorporated into this Contract.

All other terms, conditions, pricing and specifications remain the same.

Per vendor and agency agreement, DTMB Procurement approval.

HIPAA BUSINESS ASSOCIATE AGREEMENT ADDENDUM

This Business Associate Agreement Addendum ("Addendum") is made a part of the contract ("Contract") between the Michigan Department of Community Health ("Covered Entity"), and **Michigan Peer Review Organization** ("Business Associate").

The Business Associate performs certain services for the Covered Entity under the Contract that requires the exchange of information including protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub.L. No. 111-5). The Michigan Department of Community Health is a hybrid covered entity under HIPAA and the parties to the Contract are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and have the underlying Contract comply with HIPAA.

RECITALS

- A. Under the terms of the Contract, the Covered Entity wishes to disclose certain information to the Business Associate, some of which may constitute Protected Health Information ("PHI"). In consideration of the receipt of PHI, the Business Associate agrees to protect the privacy and security of the information as set forth in this Addendum.
- B. The Covered Entity and the Business Associate intend to protect the privacy and provide for the security of PHI disclosed to the Business Associate under the Contract in compliance with HIPAA and the HIPAA Rules.
- C. The HIPAA Rules require the Covered Entity to enter into a contract containing specific requirements with the Business Associate before the Covered Entity may disclose PHI to the Business Associate.

1. Definitions.

a. The following terms used in this Agreement have the same meaning as those terms in the HIPAA Rules: Breach; Data Aggregation; Designated Record Set; Disclosure; Health Care Obligations; Individual; Minimum Necessary; Notice of Privacy Practices; Protected Health Information; Required by Law; Secretary; Security Incident; Security Measures, Subcontractor; Unsecured Protected Health Information, and Use.

b. "Business Associate" has the same meaning as the term "business associate" at 45 CFR 160.103 and regarding this Addendum means [Insert Name of Business Associate]

c. "Covered Entity" has the same meaning as the term "covered entity" at 45 CFR 160.103 and regarding this Addendum means the Michigan Department of Community Health.

d. "HIPAA Rules" means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

e. "Agreement" means both the Contract and this Addendum.

f. "Contract" means the underlying written agreement or purchase order between the parties for the goods or services to which this Addendum is added.

2. Obligations of Business Associate.

The Business Associate agrees to

a. use and disclose PHI only as permitted or required by this Addendum or as required by law.

b. implement and use appropriate safeguards, and comply with Subpart C of 45 CFR 164 regarding electronic protected health information, to prevent use or disclosure of PHI other than as provided in this Addendum. Business Associate must maintain, and provide a copy to the Covered Entity within 10 days of a request from the Covered Entity, a comprehensive written information privacy and security program that includes security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI relative to the size and complexity of the Business Associate's operations and the nature and the scope of its activities.

c. report to the Covered Entity within 24 hours of any use or disclosure of PHI not provided for by this Addendum of which it becomes aware, including breaches of Unsecured Protected Health Information as required by 45 CFR 164.410, and any Security Incident of which it becomes aware. If the Business Associate is responsible for any unauthorized use or disclosure of PHI, it must promptly act as required by applicable federal and State laws and regulations. Covered Entity and the Business Associate will cooperate in investigating whether a breach has occurred, to decide how to provide breach notifications to individuals, the federal Health and Human Services' Office for Civil Rights, and potentially the media.

d. ensure, according to 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate regarding such information. Each subcontractor must sign an agreement with the Business Associate containing substantially the same provisions as this Addendum and further identifying the Covered Entity as a third party beneficiary of the agreement with the subcontractor. Business Associate must implement and maintain sanctions against subcontractors that violate such restrictions and conditions and must mitigate the effects of any such violation.

e. make available PHI in a Designated Record Set to the Covered Entity within 10 days of a request from the Covered Entity to satisfy the Covered Entity's obligations under 45 CFR 164.524.

f. within ten days of a request from the Covered Entity, amend PHI in a Designated Record Set under 45 CFR § 164.526. If any individual requests an amendment of PHI directly from the Business Associate or its agents or subcontractors, the Business Associate must notify the Covered Entity in writing within ten days of the request, and then, in that case, only the Covered Entity may either grant or deny the request.

g. maintain, and within ten days of a request from the Covered Entity make available the information required to enable the Covered Entity to fulfill its obligations under 45 CFR § 164.528. Business Associate is not required to provide an accounting to the Covered Entity of disclosures : (i) to carry out treatment, payment or health care operations, as set forth in 45 CFR § 164.506; (ii) to individuals of PHI about them as set forth in 45 CFR § 164.502; (iii) under an authorization as provided in 45 CFR § 164.508; (iv) to persons involved in the individual's care or other notification purposes as set forth in 45 CFR § 164.510; (v) for national security or intelligence purposes as set forth in 45 CFR § 164.512(k)(2); or (vi) to correctional institutions or law enforcement officials as set forth in 45 CFR § 164.512(k)(5); (vii) as part of a limited data set according to 45 CFR 164.514(e); or (viii) that occurred before the compliance date for the Covered Entity. Business Associate agrees to implement a process that allows for an accounting to be collected and maintained by the Business Associate and its agents or subcontractors for at least six years before the request, but not before the compliance date of the Privacy Rule. At a minimum, such information must include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. If the request for an accounting is delivered directly to the Business Associate or its agents or subcontractors, the Business Associate must forward it within ten days of the receipt of the request to the Covered Entity in writing.

h. to the extent the Business Associate is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity when performing those obligations.

i. make its internal practices, books, and records relating to the Business Associate's use and disclosure of PHI available to the Secretary for purposes of determining compliance with the HIPAA Rules. Business Associate must concurrently provide to the Covered Entity a copy of any PHI that the Business Associate provides to the Secretary.

j. retain all PHI throughout the term of the Agreement and for a period of six years from the date of creation or the date when it last was in effect, whichever is later, or as required by law. This obligation survives the termination of the Agreement.

k. implement policies and procedures for the final disposition of electronic PHI and the hardware and equipment on which it is stored, including but not limited to, the removal of PHI before re-use.

l. within ten days after a written request by the Covered Entity, the Business Associate and its agents or subcontractors must allow the Covered Entity to conduct a reasonable

inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI under this Addendum for the purpose of determining whether the Business Associate has complied with this Addendum; provided, however, that: (i) the Business Associate and the Covered Entity must mutually agree in advance upon the scope, timing and location of such an inspection; (ii) the Covered Entity must protect the confidentiality of all confidential and proprietary information of the Business Associate to which the Covered Entity has access during the course of such inspection; and (iii) the Covered Entity or the Business Associate must execute a nondisclosure agreement, if requested by the other party. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, the Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve the Business Associate of its responsibility to comply with this Addendum. The Covered Entity's (i) failure to detect or (ii) detection, but failure to notify the Business Associate or require the Business Associate's remediation of any unsatisfactory practices, does not constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this Addendum.

3. Permitted Uses and Disclosures by the Business Associate.

a. Business Associate may use or disclose PHI:

(i) for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate; provided, however, either (A) the disclosures are required by law, or (B) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;

(ii) as required by law;

(iii) for Data Aggregation services relating to the health care operations of the Covered Entity;

(iv) to de-identify, consistent with 45 CFR 164.514(a) – (c), PHI it receives from the Covered Entity. If the Business Associates de-identifies the PHI it receives from the Covered Entity, the Business Associate may use the de-identified information for any purpose not prohibited by the HIPAA Rules; and

(v) for any other purpose listed here: carrying out the Business Associate's duties under the Contract.

b. Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.

c. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity except for the specific uses and disclosures described above in 3(a)(i) and (iii).

4. Covered Entity's Obligations

Covered entity agrees to

a. use its Security Measures to reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of PHI transmitted to the Business Associate under the Agreement until the PHI is received by the Business Associate.

b. provide the Business Associate with a copy of its Notice of Privacy Practices and must notify the Business Associate of any limitations in the Notice of Privacy Practices of the Covered Entity under 45 CFR 164.520 to the extent that such limitation may affect the Business Associate's use or disclosure of PHI.

c. notify the Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose the individual's PHI to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

d. notify the Business Associate of any restriction on the use or disclosure of PHI that the Covered Entity has agreed to or is required to abide by under 45 CFR 164.522 to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

5. Term. This Addendum must continue in effect as to each Contract to which it applies until such Contract is terminated or is replaced with a new contract between the parties containing provisions meeting the requirements of the HIPAA Rules, whichever first occurs.

6. Termination.

a. Material Breach. In addition to any other provisions in the Contract regarding breach, a breach by the Business Associate of any provision of this Addendum, as determined by the Covered Entity, constitutes a material breach of the Addendum and is grounds for termination of the Contract by the Covered Entity under the provisions of the Contract covering termination for cause. If the Contract contains no express provisions regarding termination for cause, the following apply to termination for breach of this Addendum, subject to 6.b.:

(i) Default. If the Business Associate refuses or fails to timely perform any of the provisions of this Addendum, the Covered Entity may notify the Business Associate in writing of the non-performance, and if not corrected within thirty days, the Covered Entity may immediately terminate the Contract. Business Associate must continue performance of the Contract to the extent it is not terminated.

(ii) Associate's Duties. Notwithstanding termination of the Contract, and subject to any directions from the Covered Entity, the Business Associate must timely, reasonably and necessarily act to protect and preserve property in the possession of the Business Associate in which the Covered Entity has an interest.

(iii) Compensation. Payment for completed performance delivered and accepted by the Covered Entity must be at the Contract price.

(iv) Erroneous Termination for Default. If the Covered Entity terminates the Contract under Section 6(a) and after such termination it is determined, for any reason, that the Business Associate was not in default, or that the Business Associate's action/inaction was excusable, such termination will be treated as a termination for convenience, and the rights and obligations of the parties will be the same as if the Contract had been terminated for convenience.

b. Reasonable Steps to Cure Breach. If the Covered Entity knows of a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of the Business Associate's obligations under the provisions of this Addendum or another arrangement and does not terminate this Contract under Section 6(a), then the Covered Entity must notify the Business Associate of the pattern of activity or practice. The Business Associate must then take reasonable steps to cure such breach or end such violation, as applicable. If the Business Associate's efforts to cure such breach or end such violation are unsuccessful, the Covered Entity must either (i) terminate this Agreement, if feasible or (ii) if termination of this Agreement is not feasible, the Covered Entity must report the Business Associate's breach or violation to the Secretary of the Department of Health and Human Services.

c. Effect of Termination. After termination of this Agreement for any reason, the Business Associate, with respect to PHI it received from the Covered Entity, or created, maintained, or received by the Business Associate on behalf of the Covered Entity, must:

- (i) retain only that PHI which is necessary for the Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
- (ii) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that the Business Associate still maintains in any form;
- (iii) continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as the Business Associate retains the PHI;
- (iv) not use or disclose the PHI retained by the Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 3(a)(1) which applied before termination; and
- (v) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the PHI retained by the Business Associate when it is no longer needed by the Business Associate for its proper management and administration or to carry out its legal responsibilities.

7. No Waiver of Immunity. The parties do not intend to waive any of the immunities, rights, benefits, protection, or other provisions of the Michigan Governmental Immunity Act, MCL 691.1401, *et seq.*, the Federal Tort Claims Act, 28 U.S.C. 2671 *et seq.*, or the common law.

8. Data Ownership. The Business Associate has no ownership rights in the PHI. The covered entity retains all ownership rights of the PHI.

9. Disclaimer. The Covered Entity makes no warranty or representation that compliance by the Business Associate with this Addendum, HIPAA or the HIPAA Rules will be adequate or satisfactory for the Business Associate's own purposes. Business Associate is solely responsible for all decisions made by the Business Associate regarding the safeguarding of PHI.

10. Certification. If the Covered Entity determines an examination is necessary to comply with the Covered Entity's legal obligations under HIPAA relating to certification of its security practices, the Covered Entity or its authorized agents or contractors, may, at the Covered Entity's expense, examine the Business Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to the Covered Entity the extent to which the

Business Associate's security safeguards comply with HIPAA, the HIPAA Rules or this Addendum.

11. Amendment.

a. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA and the HIPAA Rules. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA and the HIPAA Rules. Either party may terminate the Agreement upon thirty days written notice if (i) the Business Associate does not promptly enter into negotiations to amend this Agreement when requested by the Covered Entity under this Section or (ii) the Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Rules.

12. Assistance in Litigation or Administrative Proceedings. Business Associate must make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to Covered Entity, at no cost to Covered Entity, to testify as witnesses, or otherwise, if someone commences litigation or administrative proceedings against the Covered Entity, its directors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA or the HIPAA Rules relating to the Business Associate's or its subcontractors use or disclosure of PHI under this Agreement, except where the Business Associate or its subcontractor, employee or agent is a named adverse party.

13. No Third Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer any rights, remedies, obligations or liabilities upon any person other than the Covered Entity, the Business Associate and their respective successors or assigns.

14. Effect on Contract. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Contract must remain in force and effect. The parties expressly acknowledge and agree that sufficient mutual consideration exists to make this Addendum legally binding in accordance with its terms. Business Associate and the Covered Entity expressly waive any claim or defense that this Addendum is not part of the Contract.

15. Interpretation and Order of Precedence. This Addendum is incorporated into and becomes part of the Contract. Together, this Addendum and each separate Contract constitute the "Agreement" of the parties with respect to their Business Associate relationship under HIPAA and the HIPAA Rules. The provisions of this Addendum must prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the Contract must be interpreted as broadly as necessary to implement and comply with HIPAA and the HIPAA Rules. The parties agree that any ambiguity

in this Addendum must be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Rules. This Addendum supersedes and replaces any previous separately executed HIPAA addendum between the parties. If this Addendum conflicts with the mandatory provisions of the HIPAA Rules, then the HIPAA Rules control. Where the provisions of this Addendum differ from those mandated by the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Addendum control.

16. Effective Date. This Addendum is effective upon receipt of the last approval necessary and the affixing of the last signature required.

17. Survival of Certain Contract Terms. Notwithstanding anything in this Addendum to the contrary, the Business Associate's obligations under Section 6(d) and record retention laws ("Effect of Termination") and Section 13 ("No Third Party Beneficiaries") survive termination of this Addendum and are enforceable by the Covered Entity if the Business Associate fails to perform or comply with this Addendum.

18. Representatives and Notice.

a. Representatives. For the purpose of this Addendum, the individuals identified in the Contract must be the representatives of the respective parties. If no representatives are identified in the Contract, the individuals listed below are designated as the parties' respective representatives for purposes of this Addendum. Either party may from time to time designate in writing new or substitute representatives.

b. Notices. All required notices must be in writing and must be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

Covered Entity:

Name: Kim Stephen, Director

Title: Bureau of Budget and Purchasing

Department and Division: Michigan Department of Community Health

Address: 320 South Walnut Street

Lansing, Michigan 48913

Business Associate Representative:

Name: Robert J. Yellan

Title: CEO/President

Department and Division: MPRO

Address: 22670 Haggerty Road, Suite 100

Farmington Hills, Michigan 48335-2611

Any notice given to a party under this Addendum must be deemed effective, if addressed to such party, upon: (i) delivery, if hand delivered; or (ii) the third (3rd) Business Day after being sent by certified or registered mail.

Business Associate

MPRO

By: _____

Date: September 17, 2013

Print Name: Robert J. Yellan

Title: President/CEO

Covered Entity

[INSERT NAME]

By: _____

Date: _____

Print Name: Kim Stephen, Director
Bureau of Budget and Purchasing

Title: _____

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

December 20, 2012

CHANGE NOTICE NO. 3
 to
CONTRACT NO. 071B0200072
 between
THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335	Melody Petrul, RN	mpetrul@mpro.org
	TELEPHONE	CONTRACTOR #, MAIL CODE
	(248) 465-7366	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DCH	Laura Dotson	517-241-4686	Dotsonl1@michigan.gov
BUYER	DTMB	Lance Kingsbury	517-241-7366	kingsburyl@michigan.gov

CONTRACT SUMMARY:			
DESCRIPTION: Hospital Admissions Review and Certification – Michigan Department of Community Health			
INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2010	December 31, 2012	2, one year	December 31, 2012
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
1% Net 15	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
<input type="checkbox"/> P-card <input type="checkbox"/> Direct Voucher (DV) <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

DESCRIPTION OF CHANGE NOTICE:				
EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1 year	Dec. 31, 2013
VALUE/COST OF CHANGE NOTICE:		ESTIMATED REVISED AGGREGATE CONTRACT VALUE:		
\$1,656,570.00		\$10,008,090.00		

Effective December 19, 2012, contract exercises option year, new contract end date is December 31, 2013. Contract is increased by \$1,656,570.00. \$5,640.00 of the \$1,656,570.00 is to correct the funds needed for Change Notice No.2. Attached is the corrected Attachment A to reflect formatting changes. All other terms, conditions, pricing and specifications remain the same. Per vendor and agency agreement, DTMB Procurement approval and the approval of the State Administrative Board on December 18, 2012.

Attachment A, Pricing

Pricing is modified to read as follows:

HOSPITAL ADMISSIONS REVIEW & CERTIFICATION FOR DEPARTMENT OF COMMUNITY HEALTH

Program		Projected Volume/Month (estimated)	Total Annual Per Program (estimated)	Unit Price	One Year Pricing	Three Year Pricing
PACER	FFS Reviews	900/month	10,800	\$56.75	\$ 612,900.00	\$1,838,700.00
	FFS Appeals	RN=6.25 hours	75 hours	\$27.00/per half hour	\$ 4,050.00	\$ 12,150.00
		MD=6.25 hours	75 hours	\$77.00/per half hour	\$ 11,550.00	\$ 34,650.00
Audits	Inpatient	1 audit	15	\$43,250	\$ 648,750.00	\$1,946,250.00
	Outpatient	1 audit	15	\$28,000	\$ 420,000.00	\$1,260,000.00
SWUR	Inpatient	320 reviews/month	3,840	\$80.00	\$ 307,200.00	\$ 921,600.00
	Outpatient	320 reviews/month	3,840	\$80.00	\$ 307,200.00	\$ 921,600.00
LTC	Immediate Reviews	8.33/month	100	\$124.50	\$ 12,450.00	\$ 37,350.00
	Exception Reviews	13.33/month	160	\$65.00	\$ 10,400.00	\$ 31,200.00
	Immediate & Exc Appeals	RN=8.33/month	100 hours	\$27.00/per half hour	\$ 5,400.00	\$ 16,200.00
		MD=8.33/month	100 hours	\$77.00/per half hour	\$ 15,400.00	\$ 46,200.00
	Retrospective Reviews	150/month	1,800	\$35.00	\$ 63,000.00	\$ 189,000.00
	Retrospective Appeals	RN=41.66 hours/month	500 hours	\$27.00/per half hour	\$ 27,000.00	\$ 81,000.00
		MD=20.83hours/month	250 hours	\$77.00/per half hour	\$ 38,500.00	\$ 115,500.00
DME/MS	Reviews	600	7200	\$56.75	\$ 408,600.00	
	Appeals	RN=6.25	45	\$54.00	\$2,430.00	
		MD = 6.25	45	\$154.00	\$6,930.00	
					\$ 417,960.00	\$905,580.00*
	Grand Total				\$2,901,760.00	\$8,356,980.00

*This change effective for 26 months out of 36 months.

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT & REAL ESTATE SERVICES ADMINISTRATION
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

January 14, 2011

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B0200072
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR		TELEPHONE (248) 465-7366
Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335 mpetrul@mpro.org		Melody Petrul, RN
		BUYER/CA (517) 241-3768 Lance Kingsbury
Contract Compliance Inspector: Laura Dotson (517) 241-4686		
Hospital Admissions Review and Certification – Michigan Department of Community Health		
CONTRACT PERIOD:		From: January 1, 2010 To: December 31, 2012
TERMS	1% Net 15	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective immediately, the following Project Manager is hereby added to this Contract:

Donna O'Shesky
Inpatient Audits and SWUR Contract Manager
Michigan Department of Community Health
400 S. Pine Street
Lansing, MI 48909
Phone: 517-335-5204
Fax: 517-241-9087
Email: OSheskyD@michigan.gov

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

AUTHORITY/REASON:

Per DTMB/Procurement & Real Estate Services Administration and Agency request.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$8,351,520.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PROCUREMENT & REAL ESTATE SERVICES ADMINISTRATION
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

December 8, 2010

CHANGE NOTICE NO. 1
TO
CONTRACT NO. 071B0200072
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (248) 465-7366 Melody Petrul, RN
Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335 mpetrul@mpro.org	
	BUYER/CA (517) 241-3768 Lance Kingsbury
Contract Compliance Inspector: Laura Dotson (517) 241-4686 Hospital Admissions Review and Certification – Michigan Department of Community Health	
CONTRACT PERIOD: From: January 1, 2010 To: December 31, 2012	
TERMS 1% Net 15	SHIPMENT N/A
F.O.B. N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A	

NATURE OF CHANGE (S):

Effective immediately, this contract is **INCREASED** by \$900,120.00 and the following changes are now incorporated (following this page).

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

AUTHORITY/REASON:

Per DTMB/Purchasing Operations, Agency request and approval of the State Administration Board on 12/7/2010.

TOTAL REVISED ESTIMATED CONTRACT VALUE: \$8,351,520.00

Contract Change Notice 1
Contract 071B0200072 – Michigan Peer Review Organization
Hospital Admissions Review and Certification

Section 1.012 is modified to read as follows:

1.012 Background

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

The purpose of this Contract is:

- A. To have a qualified Contractor conduct telephonic/electronic authorization of inpatient services (PACER), selected durable medical equipment and medical supplies (DME/MS) and Ventilator Dependent Care Unit (VDCU) admissions and continued stays for the MDCH FFS Medicaid and CSHCS beneficiaries.
- B. To have a qualified Contractor conduct audits/utilization review of inpatient services, outpatient services, and emergency room services.
- C. 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.
- D. To provide for the private administration of a State-wide Long Term Care Admission Review and Certification system for Michigan's Medicaid Long Term Care Programs (Medicaid covered nursing facilities and MI Choice Waiver) that must utilize nursing facility level of care criteria. The Contractor will also conduct Long Term Care Nursing Facility Level of Care Exception Process reviews as exceptions to current Medicaid nursing facility eligibility as outlined in Medicaid Policy and the Medicaid Provider Manual. The Contractor will provide analytical reports regarding long term care utilization.

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). MDCH has a Statistician that determines the statistically valid random sample audits.

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 and outpatient 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.

Section 1902 (a)(30)(A) of the Social Security Act (the Act) requires that State Medicaid Agencies provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure "efficiency, economy and quality of care." Under section 1902 (d), a State can contract with a QIO or QIO-like entity to perform medical and utilization review functions required by law. The contracts must be consistent with the QIO legislation. Section 1903 (a)(3)(C) of the Act specifies that 75 percent Federal Financial Participation is available for State expenditures for the performance of medical and utilization reviews or external quality reviews by a QIO, or by entity, which meets the requirements of section 1152 of the Act (i.e., "QIO-like entity").

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.

Section 1.021 is modified to read as follows:

Telephonic/Electronic Prior Authorization for MDCH Approved DME/MS and VDCU Admissions

1. The Contractor must perform a telephonic/electronic authorization in compliance with MDCH/Medicaid/CSHCS policies and procedures for selected DME/MS and VDCU for beneficiaries covered under the Medicaid Fee For Service [Title XIX] and Children's Special Health Care Services Program [Title V and Title V/XIX].
2. The Contractor must set up a process to receive and respond to requests for prior authorization for MDCH selected DMS/MS by telephone, fax or electronically through the MDCH CHAMPS system. These reviews include the MDCH selected DME/MS codes and VDCU admissions and continued stays.

The MDCH selected DME/MS include:

- a. Negative Wound Therapy
 - b. Enteral – Oral and Tube Feeding over 3000 calories and TPN
 - c. Infusion therapy
 - d. Home Uterine Activity Monitors
3. The Contractor must receive telephonic, electronic or faxed requests from the clinical practitioners and/or the Ventilator Dependent Unit and then provide the medical supplier with the prior authorization number, if approved. If denied, MPRO must send the beneficiary a notice of due process rights or departmental review.
 4. The Contractor must receive telephonic, electronic or faxed requests from the Ventilator Dependent Unit [VDCU] representative and provide the VDCU representative with the prior authorization number, if approved. If denied, MPRO must send the beneficiary a notice of due process rights or departmental review.
 5. 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. The telephone/computer system must be available from 8:00 a.m. – 5 p.m. Monday through Friday except for State approved/sanctioned holidays.
 - b. Notice on phone message of closures [state approved holidays or for training].
 - c. The Contractor must be HIPAA compliant.
 - d. Telephonic/Computer Electronic system must be in place on the Contract start date.
 - e. The Contractor must assign staff to represent MDCU in the Appeals Process.
 - f. The Contractor must establish and make available for practitioner use a fax or electronic submission information sheet that can be completed and submitted either electronically or faxed to and from the practitioner.
 - g. The Contractor must utilize MDCH Office of Medical Affairs physician for approval of denial or for consultation as to clinical appropriateness of care if required by MDCH. The Contractor must have available the appropriate subspecialists for reviews for CHSCS children as required in MDCH published policy.
 - h. The Contractor must utilize the MDCH CHAMPS Program.

Page 17 is modified to read as follows:

2. PACER Validation:

Random sample PACER authorization will be conducted as part of the process on all Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (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.

All cases provided by the MDCH contract manager that require a PACER authorization will be reviewed for PACER validation. The Contractor will validate all PACER authorization/tracking 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 authorization/tracking numbers assigned utilizing MDCH CHAMPS.

During review of the inpatient hospital medical records included in the 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.

Page 20 is modified to read as follows:

DME/MS, and VDCU Admissions Validations

A random sample of DME/MS authorizations and VDCU admission/continued stay authorization will be conducted as part of the review process on all Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual (Title V/XIX) beneficiaries who had a request DME/MS service or admission or continued stay in a VDCH 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 review completed. The Contractor will validate all PACER authorization/tracking 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 authorization/tracking numbers assigned utilizing MDCH CHAMPS.

- a. During the review of medical records included in the audit sample, if it is determined that the approval did not meet MDCH standards of coverage, because documentation did not verify information provided by the clinical practitioners or the VDCU staff, the provider will be notified and a referral to the Medical Services Administration for review and determination of monetary recovery.
- b. If MPRO inappropriately authorizes a service that does not meet MDCH standards of coverage, approved criteria for exceptions, or is determined to be a medically appropriate exception, MPRO will be responsible for reimbursement to the State of coverage of an inappropriate service.

Section 1.022 is modified to read as follows:

1.022 Work and Deliverable

The Contractor must provide Deliverables/Services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

INPATIENT PRIOR AUTHORIZATION-PACER/MDCH SELECTED DME/MEDICAL SUPPLY TELEPHONIC

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 must provide for a PACER/selected DMB/medical supply telephonic prior authorization system and provide access and utilize the MDCH computer prior authorization system that must 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 and appropriate pediatric subspecialists or assigned MDCH OMA physician 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 PACER/PA authorization/tracking number for each authorized case
 - 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 PACER/PA telephone number. The Contractor must answer all incoming phone calls promptly with average time to answer of less than 90 seconds
 - g. the Contractor must input all authorization decisions into the MDCH CHAMPS system.
3. The PACER system must 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.
4. The basis of the decisions must 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 must be transmitted to the MDCH. The Contractor must send an adverse action notice developed by the State Office of Administrative Hearings and Rules for MDCH 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 notice to the beneficiary as no services were suspended, terminated or reduced. An appeals form (DCH-092 Hearing Request) provided by the State must accompany the adverse action notice to the beneficiary. The adverse action notice and appeal form must be sent to the beneficiary the day of the adverse action. Copies of all adverse action notices must be sent to the MDCH Contract Manager 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. Authorizations for the MDCH selected DME/Medical Supply authorizations for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries must be based on the MDCH published standards of coverage and/or exceptions based on medical necessity within established standards of practice.

Denials for MDCH selected DME/Medical supply authorizations and any changes to the request must be transmitted to the MDCH. The Contractor must send an adverse action notice developed by the State Office of Administrative Hearings and Rules for MDCH to Medicaid and Medicaid/CSHCS dually enrolled beneficiaries utilizing the appropriate denial statement. The beneficiary will be notified of a denial of within 10 days of the decision date. An appeals form (DCH-092 Hearing Request) provided by the State must accompany the adverse action notice to the beneficiary. The adverse action notice and appeal form must be sent to the beneficiary the day of the adverse action. Copies of all adverse action notices must be sent to the MDCH Contract Manager on a monthly basis.

A notice of department review must be sent to CSHCS only beneficiaries within 10 days of the decision date.

6. It is essential that the Contractor has the capability to access and utilize the MDCH electronic computer authorization/tracking for all PACER and MDCH selected DME/Medical supply requests.

The payment system reads the PACER and selected DME/Medical supply authorization/tracking numbers, compares information, and suspend or deny payment of inappropriate claims for various reasons by edits.

7. The Contractor must develop a process for PACER and selected DME/medical supply 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, admission or continued stay for VDCU or MDCH selected DMB/medical supplies. The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all prior authorization requests including the adverse action notice.
 - 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).
8. 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 PACER authorization/tracking number is issued to the physician. The number is valid for 30 days and must be entered for hospital claims for the admission.
9. If the criteria screens are not met or if there are any questions requiring medical judgment, the case must be referred to a Contractor's physician consultant or MDCH OMA designated physician by the Contractor's nurse. The Contractor's physician consultant may confer by telephone with the attending physician. Ninety eight percent 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.

10. The Contractor must have a process to reconsider denials of all PACER and VDCU admissions and continued stays and MDCH selected DME/Medical supply reviews at the request of the provider, practitioner or VDCU. At a minimum, the process must include:
 - a. Reconsideration must be requested by the provider within three 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 reconsiderations 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 30 working days. The Contractor must complete reconsideration decisions for all transfers, rehab admissions and continued stay within one working day of receipt of the request or the date of receipt of written documentation.
 - d. The Contractor must 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 or MDCH OMA designated 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.

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

11. Should the provider request an appeal of a denied PACER/VDCU admission and continued stay, and MDCH selected DME/Medical supplies 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, then 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.
12. 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 27th and 30th days if the stay is expected to exceed 30 days. If the extended stay is approved, a PACER authorization/tracking number is issued to the provider. If the stay is expected to exceed 60 days, the provider must call the Contractor between the 57th and 60th days of stay for additional inpatient authorization. If the additional extended stay is approved, the Contractor will issue another PACER authorization/tracking number to the provider. For any case not meeting admission criteria approved by the MDCH, the Contractor's nurse must 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.
13. The Contractor must have the capability to access and utilize the MDCH electronic prior authorization system.
14. Complete data for all requests must be individually stored and retrievable by the Contractor for seven years.
15. The Contractor must be able to provide the MDCH access to the Contractor's PACER Program, VDCU Program, and MDCH selected DME/medical supply program by a means determined by the MDCH within one month of startup.
16. All documents and/or information obtained by the Contractor from the MDCH in connection with this Contract must be kept confidential and must not be provided to any third party unless disclosure is approved in writing by the MDCH.

17. The Contractor must specify the number of staff dedicated to the duties explained in this Contract and provide credentialing data prior to the start of this Contract.
18. The PACER/VDCU/DME/Medical supply/Authorization Tracking number will be generated by MDCH/Community Health Automated Medicaid Processing System.
19. Grouper 26 is currently being used; however, the Grouper that was in effect all the time the services were provided must be utilized for Inpatient audits and Statewide Utilization Review. There are no modifiers/codes for retrospective exemptions to prior authorization. C. ii. 27 pertains to Inpatient/Outpatient audit process.

Section 2.023 is modified to read as follows:

2.023 Project Manager

The following individuals will oversee the project:

Michelle Mapes, PACER/LTC Immediate Review, MDCH Selected DME/Medical Supply
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Attachment A, Pricing

Pricing is modified to read as follows:

HOSPITAL ADMISSIONS REVIEW & CERTIFICATION FOR DEPARTMENT OF COMMUNITY HEALTH

Program		Projected Volume/Month (estimated)	Total Annual Per Program (estimated)	Unit Price	One Year Pricing	Three Year Pricing	
PACER	FFS Reviews	900/month	10,800	\$56.75	\$ 612,900.00	\$1,838,700.00	
	FFS Appeals	RN=6.25 hours	75 hours	\$27.00/per half hour	\$ 4,050.00	\$ 12,150.00	
		MD=6.25 hours	75 hours	\$77.00/per half hour	\$ 11,550.00	\$ 34,650.00	
Audits	Inpatient	1 audit	15	\$43,250	\$ 648,750.00	\$1,946,250.00	
	Outpatient	1 audit	15	\$28,000	\$ 420,000.00	\$1,260,000.00	
SWUR	Inpatient	320 reviews/month	3,840	\$80.00	\$ 307,200.00	\$ 921,600.00	
	Outpatient	320 reviews/month	3,840	\$80.00	\$ 307,200.00	\$ 921,600.00	
LTC	Immediate Reviews	8.33/month	100	\$124.50	\$ 12,450.00	\$ 37,350.00	
	Exception Reviews	13.33/month	160	\$65.00	\$ 10,400.00	\$ 31,200.00	
	Immediate & Exc Appeals	RN=8.33/month	100 hours		\$27.00/per half hour	\$ 5,400.00	\$ 16,200.00
		MD=8.33/month	100 hours		\$77.00/per half hour	\$ 15,400.00	\$ 46,200.00
	Retrospective Reviews	150/month	1,800	\$35.00	\$ 63,000.00	\$ 189,000.00	
	Retrospective Appeals	RN=41.66 hours/ month	500 hours		\$27.00/per half hour	\$ 27,000.00	\$ 81,000.00
		MD=20.83hours/ month	250 hours		\$77.00/per half hour	\$ 38,500.00	\$ 115,500.00
DME/MS		600	7200	\$56.75	\$ 408,600.00		
	Reviews	RN=6.25	45	\$54.00	\$2,430.00		
	Appeals	MD = 6.25	45	\$154.00	\$6,930.00		
					\$ 417,960.00	\$905,580.00*	
	Grand Total				\$2,901,760.00	\$8,356,980.00	

*This change effective for 26 months out of 36 months.