Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **June 23, 2006**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 1
TO
CONTRACT NO. 071B5200162
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 465-7300 **Debra L. Moss, MD**
Michigan Peer Review Organization **22670 Haggerty Road, Suite 100** **Farmington Hills, MI 48335-2611**	VENDOR NUMBER/MAIL CODE **(002)**
	BUYER/CA (517) 241-1647 **Irene Pena**

Contract Compliance Inspector: Renate Rademacher
Hospital Admission Review and Certification Program - DCH

CONTRACT PERIOD: From: **January 1, 2005** To: **December 31, 2007**
with two 1-year renewal options

TERMS	SHIPMENT
N/A	**N/A**
F.O.B.	SHIPPED FROM
N/A	**N/A**

MINIMUM DELIVERY REQUIREMENTS
N/A

NATURE OF CHANGE(S):

Please note: Effective immediately, this Contract is hereby INCREASED by $1,166,600.00 to incorporate the attached additional work statement into the Contract. All other terms, conditions, specifications and pricing remain the same.

AUTHORITY/REASON:

Per vendor request and DMB/Purchasing Operations approval.

INCREASE: $1,166,600.00

TOTAL REVISED ESTIMATED CONTRACT VALUE: $6,515,795.00

SECTION II
WORK STATEMENT

PART I PACER/LONG TERM CARE PACER

A. BACKGROUND STATEMENT

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

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

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

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

B. OBJECTIVES

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

2.The Contractor will conduct the following reviews:

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

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

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

a. Responsibility for the authorization must be implemented no later than the first day of this contract.

b. This process shall be continued through the contract termination date.

c. The telephone/computer system shall be available from 8AM-5PM Monday through Friday except for State approved/sanctioned holidays.

d. Providers will be notified 30 days prior to an approved holiday.

e. The Contractor must be HIPAA compliant.

f. Telephonic/Computer Electronic system must be in place the first day of the contract.

g. The Contractor must be available for the Appeals Process.

h. The Contractor must have a system or process in place that allows the validation of the PACER authorizations:

i.Assigned PACER numbers.

ii.Documentation provided at the time of PACER request.

aa.Review Coordinator documentation.

bb.Physician Reviewer documentation.

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

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

1.Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.

2.The Contractor shall provide the telephone/computer prior authorization system, (PACER), that shall include, at a minimum, all of the following:

a. clinically experienced Registered Nurses to receive the authorization request, elicit all relevant information and reach an initial decision based on InterQual® criteria;

b.use of appropriately qualified physicians to assist the Registered Nurses in their decision as appropriate, to query requesters in all questioned requests and render all denial determinations;

c.render and communicate by telephone/electronic computer system all authorization decisions on the same day requested;

d.generate and communicate to the requesting provider a unique identifying authorization number for each authorized case; and

e.data processing storage and retrieval of all requests, i.e., documentation and disposition, requesting providers, and other information taken in by the system as part of the request for prior authorization.

f.the Contractor will maintain a toll-free telephone number and electronic computer system for the providers to request an authorization number. The Contractor shall answer all incoming phone calls promptly with average time to answer of less than ninety (90) seconds.

3.The PACER system shall certify as appropriate for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries: all elective inpatient hospital admissions; all re-admissions within 15 days; all transfers between hospitals and between units within a single hospital having different Medicaid ID numbers or provider types; all admissions and continued stays for inpatient rehabilitative facilities.

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

a.the condition to be treated on an inpatient basis;

b.to have treatment continued for rehabilitative facilities;

c.to be treated at another hospital if already hospitalized;

d.to be re-hospitalized.

Denials for inpatient admissions and any changes to the request shall be transmitted to the MDCH. The Contractor must send a negative action letter developed by the State Administrative Tribunal to Medicaid and Medicaid/CSHCS dually enrolled beneficiaries utilizing the appropriate denial statement. An appeals form (DCH-092 Hearing Request) (See Part III, Attachment C) provided by the State must accompany the negative action letter. The negative action letter and appeal form must be sent to the beneficiary the day of the negative action. Copies of all negative action letters shall be sent to the MDCH Contract Administrator on a monthly basis.

Untimely prior authorization requests by the provider requires submission of the entire medical record to the Contractor for retrospective prepayment review.

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

Nine-digit number:

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

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

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

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

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

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

7. If the Severity of Illness/Intensity of Service (SI/IS) InterQual® criteria and/or Policy are met, the Contractor's nurse approves the admission and a nine-digit prior authorization number is issued to the physician. The number is valid for 30 days and must be entered on both the physician and hospital claims for the admission.

8. If the criteria screens are not met or if there are any questions requiring medical judgment, the case shall be referred to a Contractor's physician consultant by the Contractor's nurse. The Contractor's physician consultant may confer by telephone with the attending physician. Ninety eight percent, (98%), of referral cases must be resolved, either approved or denied for Medicaid coverage by the Contractor during the same day of the request. All cases must be resolved within one working day of the request. Cases approved by the physician will be considered complete. The Contractor will report all adverse determinations to the MDCH after the reconsideration process is completed.

9. The Contractor shall have a process to reconsider denials of all PACER reviews at the request of the provider. At a minimum, the process must include:

    a. Reconsideration must be requested by the provider within *three (3) working days* of receipt of the denial.

    b.The Contractor will provide a reconsideration of adverse determinations upon written request from the provider(s).

    c.All reconsideration's will be conducted by a like specialty physician (when applicable) who will consider the entire medical record and all additional written information supplied by the provider who performed the services. The Contractor must complete reconsideration decisions for *elective admissions (excluding rehab) and retrospective* PACER requests within thirty (30) working days. *The Contractor must complete reconsideration decisions for all transfers, rehab admissions and continued stay within one (1) working day of receipt of the request or the date of receipt of written documentation.*

    d.The Contractor shall have a two step review process to review all denials at the request of the hospital or physician.

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

10. Should the provider request an appeal of a denied PACER from the Contractor they may appeal to MDCH. The provider is to submit the medical record, for review to the MDCH Office of Medical Affairs. The Office of Medical Affairs will make the determination. Should the denied service be overturned, than a PACER number will be authorized by MDCH and assigned by the Contractor. Should the case be upheld by the Office of Medical Affairs, then a letter of denial will be sent by the Contractor. Provider appeals to the MDCH will be conducted so that whenever possible, multiple claim appeals from an individual provider will be heard together.

11. For the inpatient rehabilitative facility, inpatient stays beyond 30 days in the rehabilitation hospital require additional inpatient authorization. The provider must contact the Contractor between the 27th and 30th days if the stay is expected to exceed 30 days. If the extended stay is approved, a nine-digit certification is issued to the provider. If the stay is expected to exceed 60 days, the provider must call the Contractor between the 57th and 60th days of stay for additional inpatient authorization. If the additional extended stay is approved, the Contractor will issue another nine-digit authorization number to the provider. For any case not meeting InterQual® criteria, the Contractor's nurse shall refer the case to the Contractor's physician consultant. The remainder of the review and approval/disapproval process follows that of the PACER review. Any authorization denial of any extended stay review point terminates Medicaid coverage of the hospital stay.

12. The Contractor must have available or be able to develop software compatible with any electronic prior authorization system to be designed by MDCH.

13. Complete data for all requests shall be individually stored and retrievable by the Contractor for six years.

14. The Contractor must be able to provide MDCH access to the PACER Program by a means determined by MDCH within one month of startup.

15. All documents and/or information obtained by the Contractor from the Department in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the Department.

16. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing data prior to the start of this Contract.

D.NOTICE OF NON-COVERAGE EXCEPTION

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

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

If issued, the notice is the responsibility of the hospital/nursing facilities utilization

review committee and is not related to any decision that may have been rendered by the Contractor on the case. The decision must be based on the findings of the utilization review committee and not on the determination of the Contractor.

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

E. LONG TERM CARE EXCEPTION REQUIREMENTS

Telephonic Exception Review:

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

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

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

F. LONG TERM CARE EXCEPTION PROCESS

Telephonic Review

1. Provider initiates request for exception.
2. Review Coordinator finds current review within the web based electronic system.
3. Review Coordinator reviews additional telephonic information and makes a decision or refers to physician adviser.
4. Review Coordinator completes initial process level information in web based tool.
5. Review Coordinator processes denials as necessary.

6. The Contractor will provide a monthly list of approval and denial recommendations to MDCH.

G.APPEALS PROCESS:

1. PACER Appeals:

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

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

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

2. Long Term Care Appeals:

a.Provider Appeals

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

The Contractor shall send final denial recommendations to MDCH following the completion of the Contractor's review process. MDCH allows the provider the right of appeal through the Medicaid Provider Reviews and Hearings Administrative Rules, MAC R400.3401-400.3425 under the authority conferred on the Director of MDCH by

Sections 6 and 9 of Act. No. 280 of the Public Acts of 1939. The Contractor shall provide nurses for participation and testimony in the MDCH appeals process beginning at the preliminary hearing level.

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

b. Beneficiary Appeals

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

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

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

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

H. SANCTIONS

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

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

Monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish

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

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

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

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

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

4. Based on the monthly billing validation performed by the MDCH Contract Manager, if 10% of the PACER determinations for inpatient elective admissions, transfers, and readmissions within 15 days are incorrect, $10,000 or the amount of the dollars for the hospitalization, whichever is less, will be taken back from the Contractor.

I. REPORTS

PACER:

Reports shall be provided electronically to the contract manager weekly, monthly, quarterly, and annually. They shall include: number of cases reviewed; number review coordinator approved, number referred, and number of cases denied; number of cases

physician approved, and denied; number of reconsideration cases; number of reconsideration cases overturned and upheld; number of net denials and percent of denials; number of cases appealed, number of appealed cases overturned and upheld.

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

Long Term Care:

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

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

1. Staff Requirements

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

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

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

2. Other Requirements

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

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

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

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

K. CONTRACT MONITORING

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

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

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

L. PAYMENT SCHEDULE

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

M. FRAUD AND ABUSE

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

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

A. BACKGROUND STATEMENT

The Michigan Department of Community Health is the single state agency responsible for health policy, the purchase of health care services, and

accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population.

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

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

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

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

B. <u>OBJECTIVES</u>

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

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

and the PACE program will be reviewed for Medicaid functional/medical eligibility. The number of retrospective reviews will total 1000.

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

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

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

1. Audits will be conducted on the following:

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

- **Outpatient Hospital/Emergency Room Services**: Twelve audits with the possibility of 15 audits will be completed each year. The review will include all Outpatient Hospital and Emergency Room services paid to the provider. See Section II, Part II, *N* for Timeframes of review.

2.PACER Validation:

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

During review of the inpatient hospital medical records included in the audit sample, if it is determined the admission, transfer, readmission within 15 days or continued stay for inpatient rehabilitative facilities does not meet criteria for PACER authorization, the Contractor will request the information received from the provider at the time of the PACER request including both review coordinator and physician documentation. If it is determined the information in the hospital

record matches the information provided at the time of the PACER request, the elective admission, transfer, readmission within 15 days or continued stay for inpatient rehabilitative facilities, will be allowed. The Contractor will report the case to the MDCH Contract Manager as the PACER authorization was approved in error. If the information given at the time of the request differs from the information found in the hospital record and the information given at the time of the PACER authorization meets criteria, however, the hospital record does not, the hospital stay will be refunded to the MDCH.

3. Utilization Review:

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

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

4. Long Term Care Review:

Retrospective reviews will be performed based on explicit nursing facility level of care criteria.
Exceptions to these criteria can be approved by Registered Nurse Reviewers or Physician reviewers as appropriate. This review is strictly to determine appropriate utilization only; however, serious quality issues will be referred to the Health Policy, Regulation, and Professions Administration.

C. AUDIT/UTILIZATION

1) Audit Review Requirements:

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

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

The audit sample will be given to the Contractor by MDCH. The Contractor will supply the audited provider with a list of those beneficiaries to be reviewed thirty (30) calendar days prior to the audit begin date. The Contractor will go to each facility to copy/scan records utilizing their own equipment. The review of the copied records will occur at the Contractor's place of business. Once the records have been copied, reviewed, and a determination made, the Contractor shall write a Nurse Review Report (See Section II, Part III, Attachment G). Each claim line

in the workbook will be reviewed and documented with an annotation provided by MDCH (See Section II, Part III, Attachment D) based on the documentation found in the medical record. If errors have been identified a mis-payment amount of the sample is calculated by MDCH. The mis-payment information is sent to the MDCH statistician for extrapolation of the mis-payment amount to the entire audit population. The Nurse Review Report will be reviewed by MDCH prior to insertion into the Exhibit Book.

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

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

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

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

2) Audit Review Process:

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

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

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

Contractor receives "Workbook" from MDCH.

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

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

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

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

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

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

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

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

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

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

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

f. The initial review shall be conducted by the Nurse Reviewer utilizing the appropriate criteria at Section II, Part II, C. All claim lines in the sample are

adjudicated based on the medical record review using annotations (See Section II, Part III, Attachment D).

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

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

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

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

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

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

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

D. PACER VALIDATION

1.) PACER Validation Requirements:

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

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

2.) PACER Validation Process:

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

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

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

E.STATEWIDE UTILIZATION REVIEW

1.) Statewide Utilization Review Requirements:

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

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

2.) Statewide Utilization Review Process:

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

a. Selection for the Statewide Utilization Review Process will include a random sample from a universe of paid claims data downloaded monthly from the MDCH Data Electronic Gateway (DEG) by the Contractor. The Contractor will draw a random sample of 20 records per facility per year. Approximately 4 hospitals per week will be reviewed for a total of 16 hospitals per month. The sample will be drawn on a monthly basis by the Contractor for the hospitals selected for review for that month. The hospitals will be sampled individually going back 3 months from the date drawn utilizing a past year of data for the review. EXAMPLE: Start June 2006, go back 3 months to March 2006, sampling March 2005 to March 2006 data.

b. The medical record for the Medicaid Beneficiary will be requested by the

Contractor from Hospital Provider Type 30 via fax/mail. A letter will be sent by MPRO so that provider receives the letter by the first of the month, see Attachment J for an example. This letter will give the provider thirty (30) days to submit the record. If no record is submitted, MDCH may decide to initiate an audit.

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

i. Spreadsheet I:
List Hospitals selected for month in Alphabetical Order by Name and ID#.

ii. Spreadsheet II:
List by Provider; Provider ID#; Time period sample pulled from; date medical records requested; total # medical records requested; Listed alphabetically by: Beneficiary Name; Beneficiary ID#; Dates of Service; Record Received; Finding; Total # of Findings and Comments.

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

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

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

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

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

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

F. LONG TERM CARE RETROSPECTIVE REVIEW

1.)Long Term Care Retrospective Review Requirements:

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

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

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

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

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

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

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

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

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

2.)Long Term Care Retrospective Review Process:

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

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

G. APPEALS PROCESS

1. Inpatient/Outpatient/Emergency Room Audits

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

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

2. Long Term Care Retrospective Review

a. Provider Appeals

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

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

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

b. Beneficiary Appeals

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

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

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

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

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

1. Staff Requirements

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

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

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

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

2. Other Requirements

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

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

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

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

I. REPORTS

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

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

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

1. A "monthly report" shall be provided electronically to MDCH by close of business on the 5th calendar day of each month. The report will list newly initiated audits/reviews and activities on audits/reviews initiated during previous months. Activities shall include:

    a. Name and date of audit(s)/reviews initiated.

    b. Name and date of audit(s)/reviews completed.

    c. Number retrospective reviews of PACER authorization not meeting criteria.

        i. number of authorizations given in error
        ii. number of provider errors

    d. For Long Term Care Retrospective Reviews, a summary of review findings to include number reviewed, approved, denied at level 1 and 2, appeals, utilization trends and quality findings.

e. *For Statewide Utilization Review, a summary of review findings to include provider name alphabetically and ID number, time period sample pulled from, date medical record requested, beneficiary name alphabetically and ID number, findings see Attachment J.*

2. A "quarterly report" shall be provided electronically to MDCH by the last calendar day of the month following the reporting quarter detailing year-to-date totals for all activities described at Section II, Part II, I, 1, a-c *and e* .

3. A "annual report" shall be provided electronically by the Contractor to MDCH by the last calendar day of the month following the annual reporting period that is an accumulation of the quarterly reports.

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

J. CONTRACT MONITORING

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

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

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

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

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

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

Timeframes.

K. MILESTONES AND DELIVERABLES

For the Contract the following mechanisms must be in place:

1.Readiness for Implementation

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

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

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

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

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

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

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

2. Program Specification.

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

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

L. FRAUD AND ABUSE

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

M. SANCTIONS

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

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

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

2. Audits/ Statewide Utilization Review/LTC Reviews. The number of audits/ Statewide Utilization Review/LTC reviews to be completed are outlined in Section II, Part II, B. Upon review by the MDCH Contract Manager, if the audit/ Statewide Utilization Review/LTC reviews from the previous month are not

completed *correctly or* in a timely manner, the MDCH will withhold 25% of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

N. TIMEFRAMES

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

TABLE I

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

*Audits will average 250 beneficiaries per audit

TABLE II

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

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

TABLE III

StatewideUtilization Review	Fiscal Year	Number of Utilization Reviews completed by Quarter			
		1st	2nd	3rd	4th
Inpatient	*FY2005*	0	0	0	0
	FY2006	0	0	0	960
	FY2007	960	960	960	960
	FY2008	960	0	0	0
Total		5760			

O. PAYMENT SCHEDULE

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

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

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

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

PART III DEFINITIONS/ATTACHMENTS

A. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A)skilled nursing care and related services for residents who require medical or nursing care,

(B)rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(C)on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT A

ADEQUATE ACTION NOTICE
Denial of Service

Date

Beneficiary Name
Beneficiary Address

RE: Beneficiary Name
Beneficiary Medicaid ID #

Dear (Beneficiary Name):

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

Service(s)	**Effective Date**

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

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

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

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

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

Enclosures:
Hearing Request Form
Return Envelope

ATTACHMENT B

ADVANCE ACTION NOTICE
Suspension, Reduction or Termination

Date

Name
Address
City, State, Zip

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

Dear_____:

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

Service(s)	**Effective Date**
_____	_____
_____	_____

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

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

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

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

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

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.

- You or the person you asked to represent you does not attend the hearing.

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

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

ATTACHMENT C

REQUEST for an ADMINISTRATIVE HEARING
INSTRUCTIONS

Michigan Department of Community Health

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

AUTHORIZED HEARING REPRESENTATIVE:
You may choose to have another person represent you at a hearing.

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

GENERAL INSTRUCTIONS:

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

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

IMPORTANT:

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

Authority:	MCL 330.114; MCL 333.5451; MCL 400.9; Executive Order No. 1996-1; Executive Order No. 1996-4; 42 CFR 431.200; MAC R 325.910, *et.seq.*; MAC R 330.4011; MAC R 330.5011; MAC R 330.8005, *et.seq.*; MAC R 400.3401, *et.seq.*; and rel Interagency Agreements.
Completion:	Is Voluntary, but if NOT completed, a hearing will **not** take place.

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

If you do not understand this, call the Department of Community Health. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لو لاية مينتشيجن.	**1 (877) 833 - 0870**

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

See the Request F

REQUEST FOR AN ADMINISTRATIVE HEARING
Michigan Department of Community Health

IMPORTANT:

- Read the instruction sheet first.
- See the instruction sheet for **non-discrimination** and **PA 431** information.

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEAL
PO BOX 30195
LANSING MI 48909 **1 (877) 833-0870**

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

Your Name			Your Telephone Number ( )	Your Social Security Nu
Your Address (No. & Street, Apt. No., etc.)			Your Signature	D
City	State	ZIP Code		
What **Agency** took the action or made the decision that you are appealing.				Case Number

I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. ***Use Additional Sheets if Needed.***

Do you have Physical or other Conditions requiring Special Arrangements for you to Attend or Participate in a Hearing?

☐ **NO**

☐ **YES** (Please Explain in **Here**):

SECTION 2 – Authorized Hearing Representative Information:
Read the information near the top of the Instruction Sheet FIRST

Has Someone Agreed to Represent you at a Hearing?

☐ **NO** ☐ **YES** (If Yes, complete the information below)

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

SECTION 3 – To be completed by the AGENCY distributing this form to the appellant:

Name of Agency	AGENCY Contact Person Name

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

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

Attachment D

Annotations

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

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

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

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

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

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

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

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

Attachment E

September 25, 2004 ***[Outpatient Letter]Revised 5/25/05***

Jane Doe
Utilization Review Specialist
Sample Road
Anywhere, MI xxxxx

Dear Ms.Doe:

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

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

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

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

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

Sincerely,

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

Attachment E1
September 25, 2004 ***[Inpatient Letter]Revised 5/25/05***

Jane Doe
Utilization Review Specialist
Sample Road
Anywhere, MI xxxxx

Dear Ms.Doe:

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

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

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

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

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

Sincerely,

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

ATTACHMENT F

September 25, 2004

Jane Doe
Utilization Review Specialist
Sample Road
Anywhere, MI xxxxx

Dear Ms.Doe:

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

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

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

Sincerely,

_____RN,_____
Contractor Name
Contractor Address

Exhibit B

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

ATTACHMENT G

Nurse Review Report

For

Case Number:

ID Number:

Review Period: thru

Sample Size: Stratum
Stratum

Missing Records:

Review By:_____
(Signature)

Date:

(Organization Name)
(Organization Address)

Provider Name
Nurse Review Report

Reason For Review:

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

Sample Statistics:

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

Summary of Field Activities:

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

Nurse Review Findings:

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

ATTACHMENT H

ADEQUATE ACTION NOTICE
Denial of Service

Date

Beneficiary Name
Beneficiary Address

RE: Beneficiary Name
Beneficiary Medicaid ID #

Dear (Beneficiary Name):

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

Service(s)	**Effective Date**

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

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

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

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

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

Enclosures:
Hearing Request Form
Return Envelope

ATTACHMENT I

ADVANCE ACTION NOTICE
Suspension, Reduction or Termination

Date

Name
Address
City, State, Zip

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

Dear_____:

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

Service(s)	**Effective Date**
_____	_____
_____	_____

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

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

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

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

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

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

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

Attachment J

Name (DATE)
Address

Dear Provider:

The Michigan Peer Review Organization (MPRO), the contractor for the State of Michigan Hospital Admissions Review & Certification Program has selected the Inpatient stay for the listed beneficiaries for Statewide Utilization Review.

Beneficiary Name	Beneficiary ID#	Dates of Service

You have thirty (30) days to submit these records from the date noted at the top of this letter. Failure to submit the record in a timely fashion may result in an audit of your facility. This will be your only notice of this request.

You may send the medical record via mail or fax to:

MPRO
22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335
Attn: _____

Fax # 248-465-7428

If you have questions about this request, you may call the MDCH Contract Manager for the MPRO Contract at (517) 335-5204.

Attachment K1
Provider :
Provider ID #
Time Period sample pulled from:
Date medical records requested:
Total # medical records requested:

Beneficiary Name (Listed Alphabetically)	**Beneficiary ID#**	**Dates of Service**	**Date medical record received**	**Findings** (*insert # (s) from key*)
Total # of findings:				
Comments				

Key for Findings

1. No findings
2. Medical necessity for admission, SI/IS utilizing InterQual® criteria per body system not met
3. Continued stay utilizing InterQual® criteria per body system for inpt rehab not met
4. Discharge criteria InterQual® criteria per body system not met
5. Incorrect Procedure
6. Diagnosis coding via DRG assignment validation incorrect
7. Quality of Care utilizing InterQual® criteria not met
8. Services not performed in appropriate setting
9. Services not in compliance with Medicaid Policy, Federal/State statutes
10. Services not performed in accordance with current professional standards of care
11. PACER # not obtained for readmission w/in 15 days, transfers, elective admissions and continued stays for rehab facilities

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

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

May 23, 2005

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

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 465-7300 **Debra L. Moss, MD**
Michigan Peer Review Organization **22670 Haggerty Road, Suite 100** **Farmington Hills, MI 48335-2611**	VENDOR NUMBER/MAIL CODE **(002)**
	BUYER/CA (517) 241-1647 **Irene Pena**

Contract Compliance Inspector: Renate Rademacher
Hospital Admission Review and Certification Program - DCH

CONTRACT PERIOD:	From: **January 1, 2005**	To: **December 31, 2007** **with two 1-year renewal options**

TERMS	SHIPMENT
N/A	**N/A**
F.O.B.	SHIPPED FROM
N/A	**N/A**

MINIMUM DELIVERY REQUIREMENTS
N/A

The terms and conditions of this Contract are those of ITB #071I4001348, this Contract Agreement and the vendor's quote dated 08/17/2004. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Contract Value: $5,349,195.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

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

CONTRACT NO. 071B5200162
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE (248) 465-7300 **Debra L. Moss, MD**
Michigan Peer Review Organization **22670 Haggerty Road, Suite 100** **Farmington Hills, MI 48335-2611**	VENDOR NUMBER/MAIL CODE **(002)**
	BUYER/CA (517) 241-1647 **Irene Pena**

Contract Compliance Inspector: Renate Rademacher
Hospital Admission Review and Certification Program – DCH

CONTRACT PERIOD:	From: **December 1, 2004**	To: **November 30, 2007** **with two 1-year renewal options**

TERMS	SHIPMENT
N/A	**N/A**
F.O.B.	SHIPPED FROM
N/A	**N/A**

MINIMUM DELIVERY REQUIREMENTS
N/A

MISCELLANEOUS INFORMATION:

The terms and conditions of this Contract are those of ITB #071I4001348, this Contract Agreement and the vendor's quote dated 08/17/2004. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Contract Value: $5,349,195.00

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the ITB No.071I4001348. A Purchase Order Form will be issued only as the requirements of the Department of Community Health are submitted to Acquisition Services. Orders for delivery may be issued directly by the Department of Community Health through the issuance of a Purchase Order Form.

All terms and conditions of the invitation to bid are made a part hereof.

FOR THE VENDOR:	**FOR THE STATE:**
Michigan Peer Review Organization	
Firm Name	Signature
	Sean L. Carlson
Authorized Agent Signature	Name
	Director, Acquisition Services
Authorized Agent (Print or Type)	Title
Date	Date

SECTION I
CONTRACTUAL SERVICES TERMS AND CONDITIONS

I-A PURPOSE

The purpose of this Contract is to have a qualified Contractor conduct telephonic/electronic authorization of inpatient services along with long term care retrospective eligibility to determine compliance with Medicaid Policy & Guidelines as outlined in the Provider Manuals and Bulletins; and to determine appropriateness of Medicaid coverage of the above services utilizing current standards of practice, the Michigan State Plan, and Federal Regulations.

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

This contract will be the following type

-X- Fixed price Contract

I-B TERM OF CONTRACT

The State of Michigan is not liable for any cost incurred by any bidder prior to signing of this Contract by all parties. The activities in this Contract cover the period January 1, 2005 to December 31, 2007. The State fiscal year is October lst through September 30th. The Contractor should realize that payments in any given fiscal year are contingent upon enactment of legislative appropriations.

I-C ISSUING OFFICE

This Contract is issued by the State of Michigan, Department of Management and Budget (DMB), Acquisition Services, hereafter known as Acquisition Services, for the State of Michigan, Michigan Department of Community Health. Where actions are a combination of those of Acquisition Services and Michigan Department of Community Health, the authority will be known as the State.

Acquisition Services is the sole point of contact in the State with regard to all procurement and contractual matters relating to the services described herein. Acquisition Services is the only office authorized to change, modify, amend, alter, clarify, etc., the prices, specifications, terms, and conditions of this Contract. Acquisition Services will remain the SOLE POINT OF CONTACT throughout the procurement process, until such time as the Director of Acquisition Services shall direct otherwise in writing. See Paragraph II-C below. All communications concerning this procurement must be addressed to:

Irene Pena, CPPB
Buyer, Strategic Procurement
DMB, Acquisition Services
2nd Floor, Mason Building
P.O. Box 30026
Lansing, MI 48909
Penai1@michigan.gov
(517) 241-1647

I-D CONTRACT ADMINISTRATOR

Upon receipt at Acquisition Services of the properly executed Contract Agreement, it is anticipated that the Director of Acquisition Services will direct that the person named below or any other person so designated be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of this Contract implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of such Contract. That authority is retained by Acquisition Services. The Contract Administrator for this project is:

David McLaury. Director
Bureau of Medicaid Financial Management
P.O. Box 30479
400 South Pine 7th Floor
Lansing, MI 48909-7979
mclauryd@michigan.gov
(517) 241-7135

I-E COST LIABILITY

The State of Michigan assumes no responsibility or liability for costs incurred by the Contractor prior to the signing of this Contract. Total liability of the State is limited to the terms and conditions of this Contract.

I-F CONTRACTOR RESPONSIBILITIES

The Contractor will be required to assume responsibility for all contractual activities offered in this proposal whether or not that Contractor performs them. Further, the State will consider the Prime Contractor to be the sole point of contact with regard to contractual matters, including but not limited to payment of any and all costs resulting from the Contract. If any part of the work is to be subcontracted, the contractor must notify the state and identify the subcontractor(s), including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities. The State reserves the right to approve subcontractors for this project and to require the Contractor to replace subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract.

I-G NEWS RELEASES

News releases pertaining to this document or the services, study, data, or project to which it relates will not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the program are to be released without prior approval of the State and then only to persons designated.

I-H DISCLOSURE

All information in a bidder's proposal and this Contract is subject to the provisions of the Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, *et seq*.

I-I ACCOUNTING RECORDS

The Contractor will be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted principles of accounting and other procedures specified by the State of Michigan. Financial and accounting records shall be made available, upon request, to the State of Michigan, its designees, or the Michigan Auditor General at any time during the Contract period and any extension thereof, and for three (3) years from the expiration date and final payment on the Contract or extension thereof.

I-J INDEMNIFICATION

A. General Indemnification

To the fullest extent permitted by law, the Contractor shall indemnify, defend and hold harmless the State, its departments, divisions, agencies, sections, commissions, officers, employees and agents, from and against all losses, liabilities, penalties, fines, damages and claims (including taxes), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties), arising from or in connection with any of the following:

1. any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from (1) the product provided or (2) performance of the work, duties, responsibilities, actions or omissions of the Contractor or any of its subcontractors under this Contract.

2. any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from a breach by the Contractor of any representation or warranty made by the Contractor in the Contract;

3. any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or related to occurrences that the Contractor is required to insure against as provided for in this Contract;

4. any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from the death or bodily injury of any person, or the damage, loss or destruction of any real or tangible personal property, in connection with the performance of services by the Contractor, by any of its subcontractors, by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable; provided, however, that this indemnification obligation shall not apply to the extent, if any, that such death, bodily injury or property damage is caused solely by the negligence or reckless or intentional wrongful conduct of the State;

5. any claim, demand, action, citation or legal proceeding against the State, its employees and agents which results from an act or omission of the Contractor or any of its subcontractors in its or their capacity as an employer of a person.

6. any and all actions, suits, claims or proceedings incident to any of the foregoing or to the enforcement of this Section 7.

7.4 Third Part Claims

a. If any third party shall notify any party to this Agreement (the “Indemnified Party”) with respect to any matter (a “Third Party Claim”) which may give rise to a claim for indemnification against any other party to this Agreement (the “indemnifying Party”) under this Section 7, then the Indemnified Party shall promptly notify the Indemnifying Party thereof in writing; provided, however, that no delay on the part of the Indemnified Party in notifying the Indemnifying Party shall relieve the Indemnifying Party from any obligation hereunder unless (and then solely to the extent) the Indemnifying Party thereby is prejudiced.

b. Any Indemnifying Party will have the right to assume the defense of the Third Party Claim with counsel of its choice at any time within fifteen (15) days after the Indemnified Party has given notice of the Third Party Claim; provided, however, that the Indemnifying Party must conduct the defense of the Third Party Claim actively and diligently thereafter in order to preserve its rights in this regard; and provided further that the Indemnified Party may retain separate co-counsel at its sole cost and expense and participate in the defense of the Third Party Claim.

c. As long as the Indemnifying Party has assumed and is conducting the defense of the Third Party Claim in accordance with Section 7.4(b.) above, (i) the Indemnifying Party will not consent to the entry of any judgment or enter into any settlement with respect to the Third Party Claim without the prior written consent of the Indemnified Party, and (ii) the Indemnified Party will not consent to the entry of any judgment or enter into any settlement with respect to the Third Party Claim without the prior written consent of the Indemnifying Party (not to be unreasonably withheld).

d. In the event that the Indemnifying Party does not assume or conduct the defense of the Third Party Claim in accordance with Section 7.4(b.) above, however, (i) the Indemnified Party may defend against, and consent to the entry of any judgment of or enter into any settlement with respect to, the Third Party Claim in any manner it reasonably may deem appropriate (and the Indemnified Party need not consult with, or obtain any consent from, the Indemnifying Party in connection therewith), and (ii) the Indemnifying Party will remain responsible for any Losses the Indemnified party may suffer resulting from, arising out of, relating to, in the nature of , or caused by the Third Party Claim to the fullest extent provided in this Section 7.

B. Patent/Copyright Infringement Indemnification

To the fullest extent permitted by law, the Contractor shall indemnify, defend and hold harmless the State, its employees and agents from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that such action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its subcontractors, or the operation of such equipment, software, commodity or service, or the use or reproduction of any documentation provided with such equipment, software,

commodity or service infringes any United States or foreign patent, copyright, trade secret or other proprietary right of any person or entity, which right is enforceable under the laws of the United States. In addition, should the equipment, software, commodity, or service, or the operation thereof, become or in the Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor shall at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if such option is not reasonably available to the Contractor, (ii) replace or modify the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if such option is not reasonably available to Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

C. Indemnification Obligation Not Limited

In any and all claims against the State of Michigan, or any of its agents or employees, by any employee of the Contractor or any of its subcontractors, the indemnification obligation under the Contract shall not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its subcontractors under worker's disability compensation acts, disability benefits acts, or other employee benefits acts. This indemnification clause is intended to be comprehensive. Any overlap in subclauses, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other subclause.

D. Continuation of Indemnification Obligation

The duty to indemnify will continue in full force and affect not withstanding the expiration or early termination of the Contract with respect to any claims based on facts or conditions, which occurred prior to termination.

I-K LIMITATION OF LIABILITY

Except as set forth herein, neither the Contractor nor the State shall be liable to the other party for indirect or consequential damages, even if such party has been advised of the possibility of such damages. Such limitation as to indirect or consequential damages shall not be applicable for claims arising out of gross negligence, willful misconduct, or Contractor’s indemnification responsibilities to the State as set forth in Section I-J with respect to third party claims, action and proceeding brought against the State.

I-L NON INFRINGEMENT/COMPLIANCE WITH LAWS

The Contractor warrants that in performing the services called for by this Contract it will not violate any applicable law, rule, or regulation, any contracts with third parties, or any intellectual rights of any third party, including but not limited to, any United States patent, trademark, copyright, or trade secret.

I-M WARRANTIES AND REPRESENTATIONS

The Contract will contain customary representations and warranties by the Contractor, including, without limitation, the following:

The Contractor will perform all services in accordance with high professional standards in the industry;

The Contractor will use adequate numbers of qualified individuals with suitable training, education, experience and skill to perform the services;

The Contractor will use its best efforts to use efficiently any resources or services necessary to provide the services that are separately chargeable to the State;

The Contractor will use its best efforts to perform the services in the most cost effective manner consistent with the required level of quality and performance;

The Contractor will perform the services in a manner that does not infringe the proprietary rights of any third party;

The Contractor will perform the services in a manner that complies with all applicable laws and regulations;

The Contractor has duly authorized the execution, delivery and performance of the Contract;

The Contractor has not provided any gifts, payments or other inducements to any officer, employee or agent of the State;

I-N TIME IS OF THE ESSENCE

The Contractor agrees that time is of the essence in the performance of the Contractor's obligations under this Contract.

I-O STAFFING OBLIGATIONS

The State reserves the right to approve the Contractor's assignment of Key Personnel to this project and to recommend reassignment of personnel deemed unsatisfactory by the State.

The Contractor shall not remove or reassign, without the State's prior written approval any of the Key Personnel until such time as the Key Personnel have completed all of their planned and assigned responsibilities in connection with performance of the Contractor's obligations under this Contract. The Contractor agrees that the continuity of Key Personnel is critical and agrees to the continuity of Key Personnel. Removal of Key Personnel without the written consent of the State may be considered by the State to be a material breach of this Contract. The prohibition against removal or reassignment shall not apply where Key Personnel must be replaced for reasons beyond the reasonable control of the Contractor including but not limited to illness, disability, resignation or termination of the Key Personnel's employment.

I-P WORK PRODUCT AND OWNERSHIP

Work Products shall be considered works made by the Contractor for hire by the State and shall belong exclusively to the State and its designees, unless specifically provided otherwise by mutual agreement of the Contractor and the State. If by operation of law any of the Work Product, including all related intellectual property rights, is not owned in its entirety by the State automatically upon creation thereof, the Contractor agrees to assign, and hereby assigns to the State and its designees the ownership of such Work Product, including all related intellectual property rights. The Contractor agrees to provide, at no additional charge, any assistance and to execute any action reasonably required for the State to perfect its intellectual property rights with respect to the aforementioned Work Product.

Notwithstanding any provision of this Contract to the contrary, any preexisting work or materials including, but not limited to, any routines, libraries, tools, methodologies, processes or technologies (collectively, the "Development Tools") created, adapted or used by the Contractor in its business generally, including any and all associated intellectual property rights, shall be and remain the sole property of the Contractor, and the State shall have no interest in or claim to such preexisting work, materials or Development Tools,

except as necessary to exercise its rights in the Work Product. Such rights belonging to the State shall include, but not be limited to, the right to use, execute, reproduce, display, perform and distribute copies of and prepare derivative works based upon the Work Product, and the right to authorize others to do any of the foregoing, irrespective of the existence therein of preexisting work, materials and Development Tools, except as specifically limited herein.

The Contractor and its subcontractors shall be free to use and employ their general skills, knowledge and expertise, and to use, disclose, and employ any generalized ideas, concepts, knowledge, methods, techniques or skills gained or learned during the course of performing the services under this Contract, so long as the Contractor or its subcontractors acquire and apply such information without disclosure of any confidential or proprietary information of the State, and without any unauthorized use or disclosure of any Work Product resulting from this Contract.

I-Q CONFIDENTIALITY OF DATA AND INFORMATION

1. All financial, statistical, personnel, technical and other data and information relating to the State's operation which are designated confidential by the State and made available to the Contractor in order to carry out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. The identification of all such confidential data and information as well as the State's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by the State in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor' s data and information are deemed by the State to be adequate for the protection of the State's confidential information, such methods and procedures may be used, with the written consent of the State, to carry out the intent of this section.

The Contractor shall not be required under the provisions of this section to keep confidential, (1) information generally available to the public, (2) information released by the State generally, or to the Contractor without restriction, (3) information independently developed or acquired by the Contractor or its personnel without reliance in any way on otherwise protected information of the State.

Notwithstanding the foregoing restrictions, the Contractor and its personnel may use and disclose any information which it is otherwise required by law to disclose, but in each case only after the State has been so notified, and has had the opportunity, if possible, to obtain reasonable protection for such information in connection with such disclosure.

I-R REMEDIES FOR BREACH OF CONFIDENTIALITY

The Contractor acknowledges that a breach of its confidentiality obligations as set forth in section I-Q of this Contract shall be considered a material breach of the Contract. Furthermore the Contractor acknowledges that in the event of such a breach the State shall be irreparably harmed. Accordingly, if a court should find that the Contractor has breached or attempted to breach any such obligations, the Contractor will not oppose the entry of an appropriate order restraining it from any further breaches or attempted or threatened breaches. This remedy shall be in addition to and not in limitation of any other remedy or damages provided by law.

I-S CONTRACTOR'S LIABILITY INSURANCE

The Contractor is required to provide proof of the minimum levels of insurance coverage as indicated below. The purpose of this coverage shall be to protect the State from claims which may arise out of or result from the Contractor's performance of services under the terms of this Contract, whether such services are performed by the Contractor, or by any subcontractor, or by anyone directly or indirectly employed by any of them, or by anyone for whose acts they may be liable.

The Contractor waives all rights against the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents for recovery of damages to the extent these damages are covered by the insurance policies the Contractor is required to maintain pursuant to this Contract. The Contractor also agrees to provide evidence that all applicable insurance policies contain a waiver of subrogation by the insurance company.

All insurance coverage provided relative to this Contract/Purchase Order is PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurances) carried by the State.

The Insurance shall be written for not less than any minimum coverage herein specified or required by law, whichever is greater. All deductible amounts for any of the required policies are subject to approval by the State.

The State reserves the right to reject insurance written by an insurer the State deems unacceptable.

BEFORE THE CONTRACT IS SIGNED BY BOTH PARTIES OR BEFORE THE PURCHASE ORDER IS ISSUED BY THE STATE, THE CONTRACTOR MUST FURNISH TO THE DIRECTOR OF Acquisition Services, CERTIFICATE(S) OF INSURANCE VERIFYING INSURANCE COVERAGE. THE CERTIFICATE MUST BE ON THE STANDARD "ACCORD" FORM. THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING. All such Certificate(s) are to be prepared and submitted by the Insurance Provider and not by the Contractor. All such Certificate(s) shall contain a provision indicating that coverage afforded under the policies WILL NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED without THIRTY (30) days prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Acquisition Services, Department of Management and Budget. Such NOTICE must include the CONTRACT NUMBER affected and be mailed to: Director, Acquisition Services, Department of Management and Budget, P.O. Box 30026, Lansing, Michigan 48909.

The Contractor is required to provide the type and amount of insurance checked () below:

[X] 1. Commercial General Liability with the following minimum coverage:

]$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit
$500,000 Fire Damage Limit (any one fire)

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability policy.

[X] 2. If a motor vehicle is used to provide services or products under this Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability policy.

[X] 3. Worker's disability compensation, disability benefit or other similar employee benefit act with minimum statutory limits. NOTE: (1) If coverage is provided by a State fund or if Contractor has qualified as a self-insurer, separate certification must be furnished that coverage is in the state fund or that Contractor has approval to be a self-insurer; (2) Any citing of a policy of insurance must include a listing of the States where that policy's coverage is applicable; and (3) Any policy of insurance must contain a provision or endorsement providing that the insurers' rights of subrogation are waived. This provision shall not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

[ ] 4. For contracts providing temporary staff personnel to the State, the Contractor shall provide an Alternate Employer Endorsement with minimum coverage of $1,000,000.

[X] 5. Employers liability insurance with the following minimum limits:

$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

[X] 6. Professional Liability Insurance (Errors and Omissions coverage) with the following minimum coverage

[X] $1,000,000 each occurrence and $3,000,000 annual aggregate

$3,000,000 each occurrence and $5,000,000 annual aggregate
$5,000,000 each occurrence and $10,000,000 annual aggregate

[X] 7. Medical Professional Liability, minimum coverage

$100,000 each occurrence and $300,000 annual aggregate
$200,000 each occurrence and $600,000 annual aggregate
[X] $1,000,000 each occurrence and $5,000,000 annual aggregate

I-T NOTICE AND RIGHT TO CURE

In the event of a curable breach by the Contractor, the State shall provide the Contractor written notice of the breach and a time period to cure said breach described in the notice. This section requiring notice and an opportunity to cure shall not be applicable in the event of successive or repeated breaches of the same nature or if the State determines in its sole discretion that the breach poses a serious and imminent threat to the health or safety of any person or the imminent loss, damage or destruction of any real or tangible personal property.

I-U CANCELLATION

The State may cancel this Contract without further liability or penalty to the State, its departments, divisions, agencies, offices, commissions, officers, agents and employees for any of the following reasons:

1.Material Breach by the Contractor. In the event that the Contractor breaches any of its material duties or obligations under the Contract, which are either not capable of or subject to being cured, or are not cured within the time period specified in the written notice of breach provided by the State, or pose a serious and imminent threat to the health and safety of any person, or the imminent loss, damage or destruction of any real or tangible personal property, the State may, having provided written notice of cancellation to the Contractor, cancel this Contract in whole or in part, for cause, as of the date specified in the notice of cancellation.

In the event that this Contract is cancelled for cause, in addition to any legal remedies otherwise available to the State by law or equity, the Contractor shall be responsible for all costs incurred by the State in canceling the Contract, including but not limited to, State administrative costs, attorneys fees and court costs, and any additional costs the State may incur to procure the services required by this Contract from other sources. All excess reprocurement costs and damages shall not be considered by the parties to be consequential, indirect or incidental, and shall not be excluded by any other terms otherwise included in the Contract.

In the event the State chooses to partially cancel this Contract for cause charges payable under this Contract will be equitably adjusted to reflect those services that are cancelled.

In the event this Contract is cancelled for cause pursuant to this section, and it is therefore determined, for any reason, that the Contractor was not in breach of contract pursuant to the provisions of this section, that cancellation for cause shall be deemed to have been a cancellation for convenience, effective as of the same date, and the rights and obligations of the parties shall be limited to that otherwise provided in the Contract for a cancellation for convenience.

2.Cancellation For Convenience By the State. The State may cancel this Contract for it convenience, in whole or part, if the State determines that such a cancellation is in the State's best interest. Reasons for such cancellation shall be left to the sole discretion of the State and may include, but not limited to (a) the State no longer needs the services or products specified in the Contract, (b) relocation of office, program changes, changes in laws, rules, or regulations make implementation of the Contract services no longer practical or feasible, and (c) unacceptable prices for additional services requested by the State. The State may cancel the Contract for its convenience, in whole or in part, by giving the Contractor written notice 30 days prior to the date of cancellation. If the State chooses to cancel this Contract in part, the charges payable under this Contract shall be equitably adjusted to reflect those services that are cancelled.

3.Non-Appropriation. In the event that funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available. The Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation or availability of funds for this project. If funds are not appropriated or otherwise made available, the State shall have the right to cancel this Contract at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of cancellation to the Contractor. The State shall give the Contractor written notice of such non-appropriation or unavailability within 30 days after it receives notice of such non-appropriation or unavailability.

4.Criminal Conviction. In the event the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which in the sole discretion of the State, reflects upon the Contractor's business integrity.

5.Approvals Rescinded. The State may terminate this Contract without further liability or penalty in the event any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services pursuant to Constitution 1963, Article 11, section 5, and Civil Service Rule 7. Termination may be in whole or in part and may be immediate as of the date of the written notice to Contractor or may be effective as of the date stated in such written notice.

I-V RIGHTS AND OBLIGATIONS UPON CANCELLATION

1. If the Contract is canceled by the State for any reason, the Contractor shall, (a) stop all work as specified in the notice of cancellation, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Work Product or other property derived or resulting from the Contract that may be in the Contractor's possession, (c) return all materials and property provided directly or indirectly to the Contractor by any entity, agent or employee of the State, (d) transfer title and deliver to the State, unless otherwise directed by the Contract Administrator or his or her designee, all Work Product resulting from the Contract, and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or cancellation settlement costs, to the maximum practical extent, including, but not limited to, canceling or limiting as otherwise applicable, those subcontracts, and outstanding orders for material and supplies resulting from the canceled Contract.

2. In the event the State cancels this Contract prior to its expiration for its own convenience, the State shall pay the Contractor for all charges due for services provided prior to the date of cancellation and if applicable as a separate item of payment pursuant to the Contract, for partially completed Work Product, on a percentage of completion basis. In the event of a cancellation for cause, or any other reason under the Contract, the State will pay, if applicable, as a separate item of payment pursuant to the Contract, for all partially completed Work Products, to the extent that the State requires the Contractor to submit to the State any such deliverables, and for all charges due under the Contract for any cancelled services provided by the Contractor prior to the cancellation date.

All completed or partially completed Work Product prepared by the Contractor pursuant to this Contract shall, at the option of the State, become the State's property, and the Contractor shall be entitled to receive just and fair compensation for such Work Product. Regardless of the basis for the cancellation, the State shall not be obligated to pay, or otherwise compensate, the Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.

3. If any such cancellation by the State is for cause, the State shall have the right to set-off against any amounts due the Contractor, the amount of any damages for which the Contractor is liable to the State under this Contract or pursuant to law and equity.

4. Upon a good faith cancellation, the State shall have the right to assume, at its option, any and all subcontracts and agreements for services and materials provided under this Contract, and may further pursue completion of the Work Product under this Contract by replacement contract or otherwise as the State may in its sole judgment deem expedient.

I-W EXCUSABLE FAILURE

1. Neither party shall be liable for any default or delay in the performance of its obligations under the Contract if and to the extent such default or delay is caused, directly or indirectly, by: fire, flood, earthquake, elements of nature or acts of God; riots, civil disorders, rebellions or revolutions in any country; the failure of the other party to perform its material responsibilities under the Contract (either itself or through another contractor); injunctions (provided the injunction was not issued as a result of any fault or negligence of the party seeking to have its default or delay excused); or any other cause beyond the reasonable control of such party; provided the non-performing party and its subcontractors are without fault in causing such default or delay, and such default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented by the non-performing party through the use of alternate sources, workaround plans or other means, including disaster recovery plans. In such event, the non-performing party will be excused from any further performance or observance of the obligation(s) so affected for as long as such circumstances prevail and such party continues to use its best efforts to recommence performance or observance whenever and to whatever extent possible without delay provided such party promptly notifies the other party in writing of the inception of the excusable failure occurrence, and also of its abatement or cessation.

2. If any of the above enumerated circumstances substantially prevent, hinder, or delay performance of the services necessary for the performance of the State's functions for more than 14 consecutive days, and the State determines that performance is not likely to be resumed within a period of time that is satisfactory to the State in its reasonable discretion, then at the State's option: (a) the State may procure the affected services from an alternate source, and the State shall not be liable for payments for the unperformed services under the Contract for so long as the delay in performance shall continue; (b) the State may cancel any portions of the Contract so affected and the charges payable thereunder shall be equitably adjusted to reflect those services canceled; or (c) the Contract will be canceled without liability of the State to the Contractor as of the date specified by the State in a written notice of cancellation to the Contractor.

The Contractor will not have the right to any additional payments from the State as a result of any excusable failure occurrence or to payments for services not rendered as a result of the excusable failure condition. Defaults or delays in performance by the Contractor which are caused by acts or omissions of its subcontractors will not relieve the Contractor of its obligations under the Contract except to the extent that a subcontractor is itself subject to any excusable failure condition described above and the Contractor cannot reasonably circumvent the effect of the subcontractor's default or delay in performance through the use of alternate sources, workaround plans or other means.

I-X ASSIGNMENT

The Contractor shall not have the right to assign this Contract or to assign or delegate any of its duties or obligations under this Contract to any other party (whether by operation of law or otherwise), without the prior written consent of the State. Any purported assignment in violation of this section shall be null and void. Further, the Contractor may not assign the right to receive money due under the Contract without the prior written consent of the Director of Acquisition Services.

I-Y DELEGATION

The Contractor shall not delegate any duties or obligations under this Contract to a subcontractor other than a subcontractor named in the bid unless the Director of Acquisition Services has given written consent to the delegation.

I-Z NON-DISCRIMINATION CLAUSE

In the performance of this Contract or purchase order resulting herefrom, the Contractor agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. The Contractor further agrees that every subcontract entered into for the performance of this Contract or purchase order resulting herefrom will contain a provision requiring non-discrimination in employment, as herein specified, binding upon each subcontractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 Public Act 453, as amended, MCL 37.2101, *et seq*, and the Persons with Disabilities Civil Rights Act, 1976 Public Act 220, as amended, MCL 37.1101, *et seq*, and any breach thereof may be regarded as a material breach of the Contract or purchase order.

I-AA WORKPLACE SAFETY AND DISCRIMINATORY HARASSMENT

In performing services for the State pursuant to this Contract, the Contractor shall comply with Department of Civil Service Rules 2-20 regarding Workplace Safety and 1-8.3 regarding Discriminatory Harassment. In addition, the Contractor shall comply with Civil Service Regulations governing workplace safety and discriminatory harassment and any applicable state agency rules on these matters that the agency provides to the Contractor.

Department of Civil Service Rules and Regulations can be found on the Department of Civil Service website at MACROBUTTON HtmlResAnchor www.michigan.gov/mdcs.

I-BB MODIFICATION OF SERVICE

The Director of Acquisition Services reserves the right to modify this service during the course of this Contract. Such modification may include adding or deleting tasks that this service shall encompass and/or any other modifications deemed necessary.

This Contract may not be revised, modified, amended, extended, or augmented, except by a writing executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

The State reserves the right to request from time to time, any changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract. The Contractor shall provide a change order process and all requisite forms. The State reserves the right to negotiate the process during contract negotiation. At a minimum, the State would like the Contractor to provide a detailed outline of all work to be done, including tasks necessary to accomplish the deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed cost justification.

1. Within five (5) business days of receipt of a request by the State for any such change, or such other period of time as to which the parties may agree mutually in writing, the Contractor shall submit to the State a proposal describing any changes in products, services, timing of delivery, assignment of personnel, and the like, and any associated price adjustment.

The price adjustment shall be based on a good faith determination and calculation by the Contractor of the additional cost to the Contractor in implementing the change request less any savings realized by the Contractor as a result of implementing the change request. The Contractor's proposal shall describe in reasonable detail the basis for the Contractor's proposed price adjustment, including the estimated number of hours by task by labor category required to implement the change request.

2. If the State accepts the Contractor's proposal, it will issue a change notice and the Contractor will implement the change request described therein. The Contractor will not implement any change request until a change notice has been issued validly. The Contractor shall not be entitled to any compensation for implementing any change request or change notice except as provided explicitly in an approved change notice.

3.If the State does not accept the Contractor's proposal, the State may:

a. withdraw its change request; or

b. modify its change request, in which case the procedures set forth above will apply to the modified change request.

If the State requests or directs the Contractor to perform any activities that are outside the scope of the Contractor's responsibilities under the Contract ("New Work"), the Contractor must notify the State promptly, and before commencing performance of the requested activities, that it believes the requested activities are New Work. If the Contractor fails to so notify the State prior to commencing performance of the requested activities, any such activities performed before notice is given by the Contractor shall be conclusively considered to be In-scope Services, not New Work. If the State requests or directs the Contractor to perform any services or functions that are consistent with and similar to the services being provided by the Contractor under the Contract, but which the Contractor reasonably and in good faith believes are not included within the scope of the Contractor's responsibilities and charges as set forth in the Contract, then prior to performing such services or function, the Contractor shall promptly notify the State in writing that it considers the services or function to be an "Additional Service" for which the Contractor should receive additional compensation.

If the Contractor does not so notify the State, the Contractor shall have no right to claim thereafter that it is entitled to additional compensation for performing such services or functions. If the Contractor does so notify the State, then such a service or function shall be governed by the change request procedure set forth in the preceding paragraph.

IN THE EVENT PRICES ARE NOT ACCEPTABLE TO THE STATE, THE CONTRACT SHALL BE SUBJECT TO COMPETITIVE BIDDING BASED UPON THE NEW SPECIFICATIONS.

I-CC NOTICES

Any notice given to a party under this Contract must be written and shall be deemed effective, if addressed to such party as addressed below upon (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this section; (iii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

For the Contractor: **Debra L. Moss, MD, MBA**
President and CEO
Michigan Peer Review Organization
22670 Haggerty Rd., Ste 100
Farmington Hills, MI 48335-2611

For the State: **Irene Pena, CPPB, Buyer Specialist**
Acquisition Services
530 W. Allegan St.
Lansing, MI 48933

Either party may change its address where notices are to be sent giving written notice in accordance with this section**.**

I-DD ENTIRE AGREEMENT

The contents of this document and the vendor's proposal will become contractual obligations. Failure of the Contractor to accept these obligations may result in cancellation of the award.

This Contract shall represent the entire agreement between the parties and supersedes all proposals or other prior agreements, oral or written, and all other communications between the parties relating to this subject.

I-EE NO WAIVER OF DEFAULT

The failure of a party to insist upon strict adherence to any term of this Contract shall not be considered a waiver or deprive the party of the right thereafter to insist upon strict adherence to that term, or any other term, of the Contract.

I-FF SEVERABILITY

Each provision of the Contract shall be deemed to be severable from all other provisions of the Contract and, if one or more of the provisions of the Contract shall be declared invalid, the remaining provisions of the Contract shall remain in full force and effect.

I-GG HEADINGS

Captions and headings used in the Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this Contract.

I-HH RELATIONSHIP OF THE PARTIES

The relationship between the State and the Contractor is that of client and independent Contractor. No agent, employee, or servant of the Contractor or any of its subcontractors shall be or shall be deemed to be an employee, agent, or servant of the State for any reason. The Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and subcontractors during the performance of this Contract.

I-II UNFAIR LABOR PRACTICES

Pursuant to 1980 Public Act 278, as amended, MCL 423.231, et seq, the State shall not award a Contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled pursuant to section 2 of the Act. This information is compiled by the United States National Labor Relations Board.

A Contractor of the State, in relation to the Contract, shall not enter into a Contract with a subcontractor, manufacturer, or supplier whose name appears in this register. Pursuant to section 4 of 1980 Public Act 278, MCL 423.324, the State may void any Contract if, subsequent to award of the Contract, the name of the Contractor as an employer, or the name of the subcontractor, manufacturer or supplier of the Contractor appears in the register.

I-JJ SURVIVOR

Any provisions of the Contract that impose continuing obligations on the parties including, but not limited to the Contractor's indemnity and other obligations shall survive the expiration or cancellation of this Contract for any reason.

I-KK GOVERNING LAW

This Contract shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan. Any dispute arising herein shall be resolved in the State of Michigan.

I-LL YEAR 2000 SOFTWARE COMPLIANCE

The Contractor warrants that services provided under this Contract including but not limited to the production of all Work Products, shall be provided in an accurate and timely manner without interruption, failure or error due the inaccuracy of Contractor's business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom.

I-MM CONTRACT DISTRIBUTION

Acquisition Services shall retain the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by Acquisition Services.

I-NN STATEWIDE CONTRACTS

If the contract is for the use of more than one agency and if the goods or services provided under the contract do not meet the form, function and utility required by an agency, that agency may, subject to state purchasing policies, procure the goods or services from another source.

I-OO ADHERANCE TO PM METHODOLOGY STANDARD

The State has adopted a standard, documented Project Management Methodology (PMM) for use on all Information Technology (IT) based projects. This policy is referenced in the document titled "Project Management Methodology" – DMB Administrative Guide Procedure 1380.02 issued June 2000. Vendors may obtain a copy of this procedure by contacting the DMB Office of Information Technology Solutions. The State of Michigan Project Management Methodology can be obtained from the DMB Office of Project Management's website at http://www.state.mi.us/cio/opm.

The contractor shall use the State's PMM to manage State of Michigan Information Technology (IT) based projects. The requesting agency will provide the applicable documentation and internal agency processes for the methodology. If the vendor requires training on the methodology, those costs shall be the responsibility of the vendor, unless otherwise stated.

I-PP ELECTRONIC FUNDS TRANSFER

Electronic transfer of funds is available to State contractors. Vendors are encouraged to register with the State of Michigan Office of Financial Management so the State can make payments related to this Contract electronically at www.cpexpress.state.mi.us.

I-QQ TRANSITION ASSISTANCE

If this Contract is not renewed at the end of this term, or is canceled prior to its expiration, for any reason, the Contractor must provide for up to 30 days after the expiration or cancellation of this Contract, all reasonable transition assistance requested by the State, to allow for the expired or canceled portion of the Services to continue without interruption or adverse effect, and to facilitate the orderly transfer of such services to the State or its designees. Such transition assistance will be deemed by the parties to be governed by the terms and conditions of this Contract, (notwithstanding this expiration or cancellation) except for those Contract terms or conditions that do not reasonably apply to such transition assistance. The State shall pay the Contractor for any resources utilized in performing such transition assistance at the most current rates provided by the Contract for Contract performance. If the State cancels this Contract for cause, then the State will be entitled to off set the cost of paying the Contractor for the additional resources the Contractor utilized in providing transition assistance with any damages the State may have otherwise accrued as a result of said cancellation.

I-RR DISCLOSURE OF LITIGATION

1. The Contractor shall notify the State, if it, or any of its subcontractors, or their officers, directors, or key personnel under this Contract, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation or deception. Contractor shall promptly notify the State of any criminal litigation, investigations or proceeding which may have arisen or may arise involving the Contractor or any of the Contractor's subcontractor, or any of the foregoing entities' then current officers or directors during the term of this Contract and three years thereafter.

2. The Contractor shall notify the State in its bid proposal, and promptly thereafter as otherwise applicable, of any civil litigation, arbitration, proceeding, or judgments that may have arisen against it or its subcontractors during the five years proceeding its bid proposal, or which may occur during the term of this Contract or three years thereafter, which involve (1) products or services similar to those provided to the State under this Contract and which either involve a claim in excess of $250,000 or which otherwise may affect the viability or financial stability of the Contractor , or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor hereunder violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Contractor or subcontractor, in any an amount less than $250,000 shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Contractor or subcontractor.

3. All notices under subsection 1 and 2 herein shall be provided in writing to the State within fifteen business days after the Contractor learns about any such criminal or civil investigations and within fifteen days after the commencement of any proceeding, litigation, or arbitration, as otherwise applicable. Details of settlements which are prevented from disclosure by the terms of the settlement shall be annotated as such. Semi-annually, during the term of the Contract, and thereafter for three years, Contractor shall certify that it is in compliance with this Section. Contractor may rely on similar good faith certifications of its subcontractors, which certifications shall be available for inspection at the option of the State.

4. Assurances - In the event that such investigation, litigation, arbitration or other proceedings disclosed to the State pursuant to this Section, or of which the State otherwise becomes aware, during the term of this Contract, causes the State to be reasonably concerned about:

a) the ability of the Contractor or its subcontractor to continue to perform this Contract in accordance with its terms and conditions, or

b) whether the Contractor or its subcontractor in performing services is engaged in conduct which is similar in nature to conduct alleged in such investigation, litigation, arbitration or other proceedings, which conduct would constitute a breach of this Contract or violation of Michigan or Federal law, regulation or public policy, then

The Contractor shall be required to provide the State all reasonable assurances requested by the State to demonstrate that: (a) the Contractor or its subcontractors hereunder will be able to continue to perform this Contract in accordance with its terms and conditions, (b) the Contractor or its subcontractors will not engage in conduct in performing services under this Contract which is similar in nature to the conduct alleged in any such litigation, arbitration or other proceedings.

5.The Contractor's failure to fully and timely comply with the terms of this section, including providing reasonable assurances satisfactory to the State, may constitute a material breach of this Contract.

I-SS STOP WORK

1. The State may, at any time, by written stop work order to the Contractor, require that the Contractor stop all, or any part, of the work called for by this Contract for a period of up to 90 days after the stop work order is delivered to the Contractor, and for any further period to which the parties may agree. The stop work order shall be specifically identified as such and shall indicate that it is issued under this section. Upon receipt of the stop work order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the stop work order during the period of work stoppage. Within the period of the stop work order, the State shall either:

a) Cancel the stop work order; or
b) Cancel the work covered by the stop work order as provided in the cancellation section of this Contract.

2. If a stop work order issued under this section is canceled or the period of the stop work order or any extension thereof expires, the Contractor shall resume work. The State shall make an equitable adjustment in the delivery schedule, the contract price, or both, and the Contract shall be modified, in writing, accordingly, if:

a) The stop work order results in an increase in the time required for, or in the Contractor's costs properly allocable to the performance of any part of this Contract; and
b)The Contractor asserts its right to an equitable adjustment within 30 days after the end of the period of work stoppage; provided, that if the State decides the facts justify the action, the State may receive and act upon a proposal submitted at any time before final payment under this Contract.

3. If the stop work order is not canceled and the work covered by the stop work order is canceled for reasons other than material breach, the State shall allow reasonable costs resulting from the stop work order in arriving at the cancellation settlement.

4. If a stop work order is not canceled and the work covered by the stop work order is canceled for material breach, the State shall not allow, by equitable adjustment or otherwise, reasonable costs resulting from the stop work order.

5. An appropriate equitable adjustment may be made in any related contract of the Contractor that provides for adjustment and is affected by any stop work order under this section. The State shall not be liable to the Contractor for loss of profits because of a stop work order issued under this section.

I-TT LIQUIDATED DAMAGES

A. The State and the Contractor hereby agree to the specific standards set forth in this Contract. It is agreed between the Contractor and the State that the actual damages to the State as a result of Contractor's failure to provide promised services would be difficult or impossible to determine with accuracy. The State and the Contractor therefore agree that liquidated damages as set out herein shall be a reasonable approximation of the damages that shall be suffered by the State as a result thereof. Accordingly, in the event of such damages, at the written direction of the State, the Contractor shall pay the State the indicated amount as liquidated damages, and not as a penalty. Amounts due the State as liquidated damages, if not paid by the Contractor within fifteen (15) days of notification of assessment, may be deducted by the State from any money payable to the Contractor pursuant to this Contract. The State will notify the Contractor in writing of any claim for liquidated damages pursuant to this paragraph on or before the date the State deducts such sums from money payable to the Contractor. No delay by the State in assessing or collecting liquidated damages shall be construed as a waiver of such rights.

B. The Contractor shall not be liable for liquidated damages when, in the opinion of the State, incidents or delays result directly from causes beyond the control and without the fault or negligence of the Contractor. Such causes may include, but are not restricted to, acts of God, fires, floods, epidemics, and labor unrest; but in every case the delays must be beyond the control and without the fault or negligence of the Contractor.

SECTION II
WORK STATEMENT

PART I PACER/LONG TERM CARE PACER

A. BACKGROUND STATEMENT

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

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

Additionally, beginning FY 2005 a portion of this contract is to provide for the private administration of a state-wide admission review and certification system for Michigan Medicaid long term care programs that must utilize nursing facility level of care criteria. The Contractor will authorize appropriate exceptions to current Medicaid Nursing Facility Policy and Guidelines as outlined in Provider Manuals and Bulletins; determine appropriateness of Medicaid coverage for nursing facility level of care programs (Medicaid covered nursing facility admissions, MI Choice Home and Community Based Waiver Program for the Elderly and Disabled, and the Program for All Inclusive Care for the Elderly and Disabled); and provide analytical reports regarding long term care utilization.

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

B. OBJECTIVES

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

2.The Contractor will conduct the following reviews:

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

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

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

a. Responsibility for the authorization must be implemented no later than the first day of this contract.

b. This process shall be continued through the contract termination date.

c. The telephone/computer system shall be available from 8AM-5PM Monday through Friday except for State approved/sanctioned holidays.

d. Providers will be notified 30 days prior to an approved holiday.

e. The Contractor must be HIPAA compliant.

f. Telephonic/Computer Electronic system must be in place the first day of the contract.

g. The Contractor must be available for the Appeals Process.

h. The Contractor must have a system or process in place that allows the validation of the PACER authorizations:

1.Assigned PACER numbers.

2.Documentation provided at the time of PACER request.

aa.Review Coordinator documentation.

bb.Physician Reviewer documentation.

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

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

1.Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.

2.The Contractor shall provide the telephone/computer prior authorization system, (PACER), that shall include, at a minimum, all of the following:

a. clinically experienced Registered Nurses to receive the authorization request, elicit all relevant information and reach an initial decision based on InterQual® criteria;

b.use of appropriately qualified physicians to assist the Registered Nurses in their decision as appropriate, to query requesters in all questioned requests and render all denial determinations;

c.render and communicate by telephone/electronic computer system all authorization decisions on the same day requested;

d.generate and communicate to the requesting provider a unique identifying authorization number for each authorized case; and

e.data processing storage and retrieval of all requests, i.e., documentation and disposition, requesting providers, and other information taken in by the system as part of the request for prior authorization.

f.the Contractor will maintain a toll-free telephone number and electronic computer system for the providers to request an authorization number. The Contractor shall answer all incoming phone calls promptly with average time to answer of less than ninety (90) seconds.

3.The PACER system shall certify as appropriate for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries: all elective inpatient hospital admissions; all re-admissions within 15 days; all transfers between hospitals and between units within a single hospital having different Medicaid ID numbers or provider types; all admissions and continued stays for inpatient rehabilitative facilities.

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

a.the condition to be treated on an inpatient basis;

b.to have treatment continued for rehabilitative facilities;

c.to be treated at another hospital if already hospitalized;

d.to be re-hospitalized.

Denials for inpatient admissions and any changes to the request shall be transmitted to the MDCH. The Contractor must send a negative action letter developed by the State Administrative Tribunal to Medicaid and Medicaid/CSHCS dually enrolled beneficiaries utilizing the appropriate denial statement. An appeals form (DCH-092 Hearing Request) (See Part III, Attachment C) provided by the State must accompany the negative action letter. The negative action letter and appeal form must be sent to the beneficiary the day of the negative action. Copies of all negative action letters shall be sent to the MDCH Contract Administrator on a monthly basis.

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

Nine-digit number:

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

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

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

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

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

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

7. If the Severity of Illness/Intensity of Service (SI/IS) InterQual® criteria and/or Policy are met, the Contractor's nurse approves the admission and a nine-digit prior authorization number is issued to the physician. The number is valid for 30 days and must be entered on both the physician and hospital claims for the admission.

8. If the criteria screens are not met or if there are any questions requiring medical judgment, the case shall be referred to a Contractor's physician consultant by the Contractor's nurse. The Contractor's physician consultant may confer by telephone with the attending physician. Ninety eight percent, (98%), of referral cases must be resolved, either approved or denied for Medicaid coverage by the Contractor during the same day of the request. All cases must be resolved within one working day of the request. Cases approved by the physician will be considered complete. The Contractor will report all adverse determinations to the MDCH after the reconsideration process is completed.

9. The Contractor shall have a process to reconsider denials of all PACER reviews at the request of the provider. At a minimum, the process must include:

   a. Reconsideration must be requested by the provider within one (1) working day of receipt of the denial.

   b.The Contractor will provide a reconsideration of adverse determinations upon written request from the provider(s).

   c.All reconsideration's will be conducted by a like specialty physician (when applicable) who will consider the entire medical record and all additional written information supplied by the provider who performed the services. The Contractor must complete reconsideration decisions within thirty (30) working days.

   d.The Contractor shall have a two step review process to review all denials at the request of the hospital or physician.

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

10. Should the provider request an appeal of a denied PACER from the Contractor they may appeal to MDCH. The provider is to submit the medical record, for review to the MDCH Office of Medical Affairs. The Office of Medical Affairs will make the determination. Should the denied service be overturned, than a PACER number will be authorized by MDCH and assigned by the Contractor. Should the case be upheld by the Office of Medical Affairs, and then a letter of denial will be sent by the Contractor. Provider appeals to the MDCH will be conducted so that whenever possible, multiple claim appeals from an individual provider will be heard together.

11. For the inpatient rehabilitative facility, inpatient stays beyond 30 days in the rehabilitation hospital require additional inpatient authorization. The provider must contact the Contractor between the 27th and 30th days if the stay is expected to exceed 30 days. If the extended stay is approved, a nine-digit certification is issued to the provider. If the stay is expected to exceed 60 days, the provider must call the Contractor between the 57th and 60th days of stay for additional inpatient authorization. If the additional extended stay is approved, the Contractor will issue another nine-digit authorization number to the provider. For any case not meeting InterQual® criteria, the Contractor's nurse shall refer the case to the Contractor's physician consultant. The remainder of the review and approval/disapproval process follows that of the PACER review. Any authorization denial of any extended stay review point terminates Medicaid coverage of the hospital stay.

12. The Contractor must have available or be able to develop software compatible with any electronic prior authorization system to be designed by MDCH.

13. Complete data for all requests shall be individually stored and retrievable by the Contractor for six years.

14. The Contractor must be able to provide MDCH access to the PACER Program by a means determined by MDCH within one month of startup.

15. All documents and/or information obtained by the Contractor from the Department in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the Department.

16. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing data prior to the start of this Contract.

D. NOTICE OF NON-COVERAGE EXCEPTION

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

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

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

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

E. LONG TERM CARE EXCEPTION REQUIREMENTS

Telephonic Exception Review:

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

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

1. Nurse reviewers will utilize a specific exception criteria to determine appropriate exceptions to the nursing facility level of care criteria.

2. Approvals will be documented within the web based tool, citing the exception criteria used.
3. Beneficiaries and Providers will be provided appropriate denial notification as identified under Section II, Part I, G, Appeals Process. Example denial notices are included in Section II, Part III, Attachments H and I.

4. Reconsideration reviews will be performed when filed within the guidelines established.
5. The Contractor will represent the Department in any Administrative Appeals.

F. LONG TERM CARE EXCEPTION PROCESS

Telephonic Review

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

G. APPEALS PROCESS:

1. PACER Appeals:

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

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

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

2. Long Term Care Appeals:

a. Provider Appeals

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

b. Beneficiary Appeals

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

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

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

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

H. SANCTIONS

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

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

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

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

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

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

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

I. REPORTS

PACER:

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

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

Long Term Care:

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

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

1. Staff Requirements

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

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

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

2. Other Requirements

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

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

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

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

K. CONTRACT MONITORING

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

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

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

L. PAYMENT SCHEDULE

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

M. FRAUD AND ABUSE

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

PART II AUDITS/LONG TERM CARE RETROSPECTIVE ELIGIBILITY REVIEWS

A. BACKGROUND STATEMENT

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

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

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

Additionally, beginning FY 2005 a portion of this contract is to provide for the private administration of a state-wide retrospective review and certification system for Michigan Medicaid long term care programs that must utilize nursing facility level of care criteria. The Contractor will determine appropriateness of Medicaid coverage for nursing facility level of care programs (Medicaid covered nursing facility admissions, MI Choice Home and Community Based Waiver Program for the Elderly and Disabled, and the Program for All Inclusive Care for the Elderly); and provide analytical reports regarding long term care utilization.

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

B. OBJECTIVES

Audits will be conducted on Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligibles (Title V/XIX) beneficiaries utilizing statistically valid random samples. The average number of beneficiaries to be reviewed for each audit is 250.

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

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

The Contractor will be paid per audit/review completed (See Section II, Part II, P for Timeframes of review).

1. Audits will be conducted on the following:

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

- **Outpatient Hospital/Emergency Room Services**: Ten audits will be completed each year. The review will include all Outpatient Hospital and Emergency Room services paid to the provider. See Section II, Part II, P for Timeframes of review.

2.PACER Validation:

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

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

If the information given at the time of the request differs from the information found in the hospital record and the information given at the time of the PACER authorization meets criteria, however, the hospital record does not, the hospital stay will be refunded to the MDCH.

3. Utilization Review:

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

4. Long Term Care Review:

Retrospective reviews will be performed based on explicit nursing facility level of care criteria.
Exceptions to these criteria can be approved by Registered Nurse Reviewers or Physician reviewers as appropriate. This review is strictly to determine appropriate utilization only; however, serious quality issues will be referred to the Health Policy, Regulation, and Professions Administration.

C. AUDIT/UTILIZATION REVIEW REQUIREMENTS

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

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

The audit sample will be given to the Contractor by MDCH. The Contractor will supply the audited provider with a list of those beneficiaries to be reviewed ten (10) days prior to the audit begin date. The Contractor will go to each facility to copy/scan records utilizing their own equipment. The review of the copied records will occur at the Contractor's place of business. Once the records have been copied, reviewed, and a determination made, the Contractor shall write a Nurse Review Report (See Section II, Part III, Attachment G). Each claim line in the workbook will be reviewed and documented with an annotation provided by MDCH (See Section II, Part III, Attachment D) based on the documentation found in the medical record. If errors have been identified a mis-payment amount of the sample is calculated by MDCH. The mis-payment information is sent to the MDCH statistician for extrapolation of the mis-payment amount to the entire audit population. The Nurse Review Report will be reviewed by MDCH prior to insertion into the Exhibit Book.

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

a. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing InterQual® criteria per body system.
b. Continued stay criteria utilizing InterQual® criteria per body system for inpatient rehabilitation.
c. Discharge criteria InterQual® criteria per body system.
d. Review for correct procedure.
e. Review for diagnosis coding via DRG assignment validation.
f. Quality of care shall be monitored in each audit utilizing InterQual® criteria.
g. Services were performed in the appropriate setting.
h. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
i.Services performed are in accordance with current professional standards of care.

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

a.Services were performed in the appropriate setting.
b.Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
c.Services performed are in accordance with current professional standards of care.
d.Services performed are medically necessary in appropriate scope, duration, and intensity.
e.Verify procedure code billed.
f.Verify adherence to EMTALA, (for Emergency Room Services only).
g.Quality of care provided to the beneficiary will be reviewed.

D. PACER VALIDATION REQUIREMENTS

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

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

E. LONG TERM CARE RETROSPECTIVE REVIEW REQUIREMENTS

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

1. Appropriateness for the nursing facility level of care definition.
2. Exceptions based on explicit MDCH developed exception criteria.
3. Clinical professional judgment. All cases approved outside of # 1 and 2 above will be subject to individual review by MDCH.

F. AUDIT/UTILIZATION REVIEW PROCESS

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

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

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

1. Contractor receives “Workbook” from MDCH.

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

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

2. Prior to beginning the audit the Nurse Reviewer will complete the following:
a.Review and copy Medicaid policy and procedures pertinent to the audit sample.

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

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

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

e.Send a confirmation letter (See Section II, Part III, Attachment E), to the provider following the initial contact reiterating the information provided during the initial contact. A copy of the correspondence will be kept with the audit file.
The items listed above (2 a-c) will be what were in effect for the time period of the audit.

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

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

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

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

a.Reason for the Review.
b.Sample Statistics.
c.Summary of Field Activities.
d.Nurse Review Findings and Attachments.

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

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

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

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

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

G.PACER VALIDATION PROCESS

The validation process of the PACER review includes the criteria listed at Section II, Part II, D 1-7:

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

1.PACER Number.
2.Documentation provided at the time of the PACER request.
  a. Review Coordinator documentation.
  b. Physician Reviewer documentation.

H.LONG TERM CARE RETROSPECTIVE REVIEW PROCESS

The Long Term Care Retrospective Review Process includes the following

1. MDCH will provide a monthly electronic list for cases for review. For FY2005, cases will consist of new admissions to nursing facilities and PACE Program only. Following year reviews may consist of ongoing case reviews also.

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

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

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

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

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

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

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

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

I.APPEALS PROCESS

1.Inpatient/Outpatient/Emergency Room Audits

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

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

2. Long Term Care Retrospective Review

a.Provider Appeals

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

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

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

b. Beneficiary Appeals

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

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

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

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

J. QUALIFICATIONS OF CONTRACTOR'S STAFF FOR AUDITS/LONG TERM CARE RETROSPECTIVE ELIGIBILITY REVIEW

1. Staff Requirements

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

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

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

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

2. Other Requirements

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

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

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

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

K. REPORTS

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

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

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

1. A "monthly report" shall be provided electronically to MDCH by close of business on the 5th calendar day of each month. The report will list newly initiated audits/reviews and activities on audits/reviews initiated during previous months. Activities shall include:

    a. Name and date of audit(s)/reviews initiated.

    b. Name and date of audit(s)/reviews completed.

    c. Number retrospective reviews of PACER authorization not meeting criteria.

        i. number of authorizations given in error
        ii. number of provider errors

    d. For Long Term Care Retrospective Reviews, a summary of review findings to include number reviewed, approved, denied at level 1 and 2, appeals, utilization trends and quality findings.

2. A "quarterly report" shall be provided electronically to MDCH by the last calendar day of the month following the reporting quarter detailing year-to-date totals for all activities described at Section II, Part II, K, 1, a-c .

3. A "annual report" shall be provided electronically by the Contractor to MDCH by the last calendar day of the month following the annual reporting period that is an accumulation of the quarterly reports.

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

L. CONTRACT MONITORING

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

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

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

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

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

M. MILESTONES AND DELIVERABLES

For the Contract the following mechanisms must be in place:

1.Readiness for Implementation

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

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

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

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

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

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

c. The Contractor's inability to demonstrate, to the Department's satisfaction and as provided herein, that the Contractor is fully capable of performing all duties under this Contract no later than November 1, 2004, shall be grounds for the immediate termination of this Contract by the Department in accordance with the terms specified herein.

2. Program Specification.

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

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

N. FRAUD AND ABUSE

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

O. SANCTIONS

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

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

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

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

P. TIMEFRAMES

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

TABLE I

Type of Audits	Contract Year	Number of Audits to be completed by Quarter			
		1st	2nd	3rd	4th
Inpatient Audits	2004/2005	3	3	3	1
	2005/2006	3	3	3	1
	2006-2007	3	3	3	1
Outpatient/Emergency Room Audits	2004/2005	3	3	3	1
	2005/2006	3	3	3	1
	2006-2007	3	3	3	1
Three Year Total		60			

*Audits will average 250 beneficiaries per audit

TABLE II

Type of Service	Contract Year	Number of Reviews to be completed by Quarter 1st	2nd	3rd	4th
Long Term Care	2004/2005	250	250	250	250
	2005/2006	250	250	250	250
	2006-2007	250	250	250	250
Three Year Total		3000			

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

Q. PAYMENT SCHEDULE

The payment schedule will be based on the number of audits/reviews completed. The per audit/review payment will include both the medical record review and the appeal process through settlement. Although the Contractor will receive payment upon completion of the audit, the Contractor is still required to participate in the Appeal process even though payment has been received.

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

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

See attached pricing sheet for dollar breakdowns.

PART III DEFINITIONS/ATTACHMENTS

A. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT A

ADEQUATE ACTION NOTICE
Denial of Service

Date

Beneficiary Name
Beneficiary Address

RE: Beneficiary Name
Beneficiary Medicaid ID #

Dear (Beneficiary Name):

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

Service(s)	**Effective Date**

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

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

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

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

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

Enclosures:
Hearing Request Form
Return Envelope

ATTACHMENT B

ADVANCE ACTION NOTICE
Suspension, Reduction or Termination

Date

Name
Address
City, State, Zip

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

Dear_____:

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

Service(s)	**Effective Date**
_____	_____
_____	_____

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

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

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

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

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

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

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

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

ATTACHMENT C

REQUEST for an ADMINISTRATIVE HEARING
INSTRUCTIONS

Michigan Department of Community Health

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

AUTHORIZED HEARING REPRESENTATIVE:
You may choose to have another person represent you at a hearing.

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

GENERAL INSTRUCTIONS:

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

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

IMPORTANT:

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

Authority:	MCL 330.114; MCL 333.5451; MCL 400.9; Executive Order No. 1996-1; Executive Order No. 1996-4; 42 CFR 431.200; 7CFR 246.18; MAC R 325.910, *et.seq*.; MAC R 330.4011; MAC R 330.5011; MAC R 330.8005, *et.seq*.; MAC R 400.3401, *et.seq*.; and relevant Interagency Agreements.
Completion:	Is Voluntary, but if NOT completed, a hearing will **not** take place.

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

If you do not understand this, call the Department of Community Health. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لو لاية ميتشيجن.	**1 (877) 833 - 0870**

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

See the Request Form Underneath

REQUEST FOR AN ADMINISTRATIVE HEARING
Michigan Department of Community Health

IMPORTANT:

- Read the instruction sheet first.
- See the instruction sheet for **non-discrimination** and **PA 431** information.

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30195
LANSING MI 48909 **1 (877) 833-0870**

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

Your Name			Your Telephone Number ( )	Your Social Security Number
Your Address (No. & Street, Apt. No., etc.)			Your Signature	Date Signed
City	State	ZIP Code		
What **Agency** took the action or made the decision that you are appealing.				Case Number

I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. ***Use Additional Sheets if Needed.***

Do you have Physical or other Conditions requiring Special Arrangements for you to Attend or Participate in a Hearing?
☐ **NO**
☐ **YES** (Please Explain in **Here**):

SECTION 2 – Authorized Hearing Representative Information:

Read the information near the top of the Instruction Sheet FIRST

<table>
<tr><td colspan="5">Has Someone Agreed to Represent you at a Hearing?
☐ NO ☐ YES (If Yes, complete the information below)</td></tr>
<tr><td colspan="3">Name of Representative</td><td colspan="2">Representative Telephone Number
( )</td></tr>
<tr><td colspan="3">Address (No. & Street, Apt. No., etc.)</td><td>Representative Signature</td><td>Date Signed</td></tr>
<tr><td>City</td><td>State</td><td>ZIP Code</td><td colspan="2"></td></tr>
</table>

SECTION 3 – To be completed by the AGENCY distributing this form to the appellant:

<table>
<tr><td colspan="3">Name of Agency</td><td>AGENCY Contact Person Name</td></tr>
<tr><td colspan="3">AGENCY Address (No. & Street, Apt. No., etc.)</td><td>AGENCY Telephone Number
( )</td></tr>
<tr><td>City</td><td>State</td><td>ZIP Code</td><td>State Program or Service being provided to this appellant</td></tr>
</table>

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

Attachment D

Annotations

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

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

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

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

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

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

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

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

Attachment E

September 25, 2004

Jane Doe
Utilization Review Specialist
Sample Road
Anywhere, MI xxxxx

Dear Ms.Doe:

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

This letter is to confirm our appointment scheduled for _____and _____at _____a.m. in your facility. These visits are to copy approximately two hundred fifty (250) Medicaid beneficiary records for whom you provided services for the review period of 1/1/2--- thru 12/31/2---.

In addition to myself there will be another nurse reviewer. We will require a room with an electrical outlet and will be bringing equipment to your facility. You will be furnished with a beneficiary list ten (10) days prior to our arrival. It is estimated we will need _____ days at your facility to copy the records.

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

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

Sincerely,

_____RN, _____
Contractor Name
Contractor Address

ATTACHMENT F

September 25, 2004

Jane Doe
Utilization Review Specialist
Sample Road
Anywhere, MI xxxxx

Dear Ms.Doe:

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

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

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

Sincerely,

_____RN, _____
Contractor Name
Contractor Address

Exhibit B

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

ATTACHMENT G

Nurse Review Report

For

Case Number:

ID Number:

Review Period: thru

Sample Size: Stratum
Stratum

Missing Records:

Review By:_____
(Signature)

Date:

(Organization Name)
(Organization Address)

Provider Name
Nurse Review Report

Reason For Review:

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

Sample Statistics:

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

Summary of Field Activities:

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

Nurse Review Findings:

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

ATTACHMENT H

ADEQUATE ACTION NOTICE
Denial of Service

Date

Beneficiary Name
Beneficiary Address

RE: Beneficiary Name
Beneficiary Medicaid ID #

Dear (Beneficiary Name):

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

Service(s)	**Effective Date**

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

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

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

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

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

Enclosures:
Hearing Request Form
Return Envelope

ATTACHMENT I

ADVANCE ACTION NOTICE
Suspension, Reduction or Termination

Date

Name
Address
City, State, Zip

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

Dear_____:

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

Service(s)	**Effective Date**
_____	_____
_____	_____

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

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

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

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

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

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

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

EXCERPTS FROM VENDOR RESPONSE

EXECUTIVE SUMMARY

INTRODUCTION

The staff of MPRO offers a combination of experience, responsiveness to change and contract performance history that serves as evidence of our enduring commitment to supporting the Michigan Department of Community Health (MDCH) and its objectives of quality, efficient health care for Medicaid beneficiaries. We welcome the opportunity for continued service.

Our staff is the substance behind our technical solutions in support of the Michigan Statewide Hospital Admission Certification and Review Program. Our strengths have evolved from more than 16 years of continuous support of this contract. Our solutions include:

1. Performance and improvement of our current prior authorization certification evaluation review (PACER) functions;
2. Implementation of a long term care exception review process; and
3. Successful implementation and operation of inpatient and outpatient/ER audits and long term care retrospective eligibility reviews.

In support of these solutions, our main strength is our experienced and dedicated Michigan-based staff, which has more than 150 years of collective experience in successful performance of this contract.

We back our clinical operations staff with strong, service-oriented corporate support including state-of-the-art telephone and computer systems, a comprehensive internal quality control program, a dedicated training and staff development program, and well-equipped facilities located within one hour of Lansing, Michigan. We also use logical up-to-date work processes that are typically supported by detailed, contract compliant flow charts. There are several examples of these flow charts within our proposal. Finally, we have developed practical and comprehensive Technical Work Plans outlined in Microsoft Project.

Our Michigan-based staff offers more than 150 collective years of experience in successful support of this contract.

Our entire package of staff and supporting resources allows us to guarantee ongoing support that will continue to meet or exceed the expectations of the MDCH. In addition, MPRO and its staff are respected as a QIO by providers and provider organizations. In our proposal, we offer several examples as performance statistics that exceed standards or as potential innovations subject to MDCH approval. Some of these examples are included in the summary of sections that follow this introduction.

This Executive Summary highlights major topics covered in the body of our proposal. It is organized in sequence with the Request for Proposal. Topics such as “IV-E Quick Payment Terms” and “IV-F Bidder’s Authorized Expeditor” are not covered here but are included within the proposal.

IV-A BUSINESS ORGANIZATION

MPRO is a nonprofit Michigan-based corporation with more than 100 employees. We are a recognized leader in health care quality improvement and utilization review with extensive experience in Medicaid programs, managed care operations, research methodologies and data analysis.

We have committed ourselves to promoting high quality health care, assisting health care consumers, and creating innovative solutions to health care challenges. Experience and innovation are the driving forces behind our mission:

MPRO Mission: To improve the quality of health care in the communities we serve through measurement, analysis, information, technology, education and change.

We have also served the State of Michigan as the Fee-For-Service Review contractor for more than 16 years, achieving continuous contract renewal/extension. We have been and are committed to remaining responsive to the questions, suggestions, and feedback from MDCH staff and management. We are Utilization Review Accreditation Commission (URAC) accredited and are the Centers for Medicare & Medicaid Services (CMS) designated Quality Improvement Organization (QIO) for the state of Michigan. In addition, we have served continuously as the Michigan QIO for more than 20 years, achieving non-competitive contract renewal through seven distinct Scopes of Work. We are proud of our achievements and are determined to continue to support Michigan Medicaid and Medicare beneficiaries.

IV-B STATEMENT OF THE PROBLEM

Michigan, like many states, is experiencing budgetary problems, with a projected budget shortfall of $1.3 billion for fiscal year 2005. The proposed state budget for fiscal year 2005 is $39.7 billion with $6.5 billion dedicated to the Medicaid program. Funding for the Medicaid program accounts for almost a third or $447 million of the projected budget gap. It is critical that each Medicaid dollar spent is spent wisely for services that are both medically necessary and performed in the appropriate setting.

The $6.5 billion allocated to the Medicaid program fund the provision of health care services to more than 1.3 million people. Although many beneficiaries are enrolled in a managed care arrangement, 400,000 remain in the Medicaid Fee-For-Service program. These beneficiaries will be directly affected by the Statewide Hospital Admission Review and Certification Program.

Michigan has had a Statewide Hospital Admission Review and Certification Program in place since 1988. MPRO is the current contractor and has been successfully providing PACER; inpatient and Emergency Room (ER)/outpatient retrospective utilization review; notice of non-coverage review; and validation of the prior authorization certification reviews. The PACER review program has been effective in controlling unnecessary admissions, transfers, readmissions, and continued stays in the rehabilitation setting. The inpatient and ER/outpatient retrospective review program has been very successful, especially in retrieving dollars from diagnostic related group (DRG) coding errors. The PACER validation review program has served as a necessary ‘check and balance’ to ensure that the information given by providers during the authorization process is accurate and reliable.

We are confident that we are able to provide all of the needed services under this procurement. Many services are already being provided under the current Statewide Hospital Admission Certification and Review Program contract. The additions in this procurement draw upon our established strengths; that is:

4. Well informed, experienced nurse and physician staff;
5. A sophisticated computer and phone system;
6. The ability to generate timely, accurate reports;
7. HIPAA compliance; and
8. The desire to continue to serve the State of Michigan and Michigan citizens by a Michigan based corporation.

IV-C MANAGEMENT SUMMARY

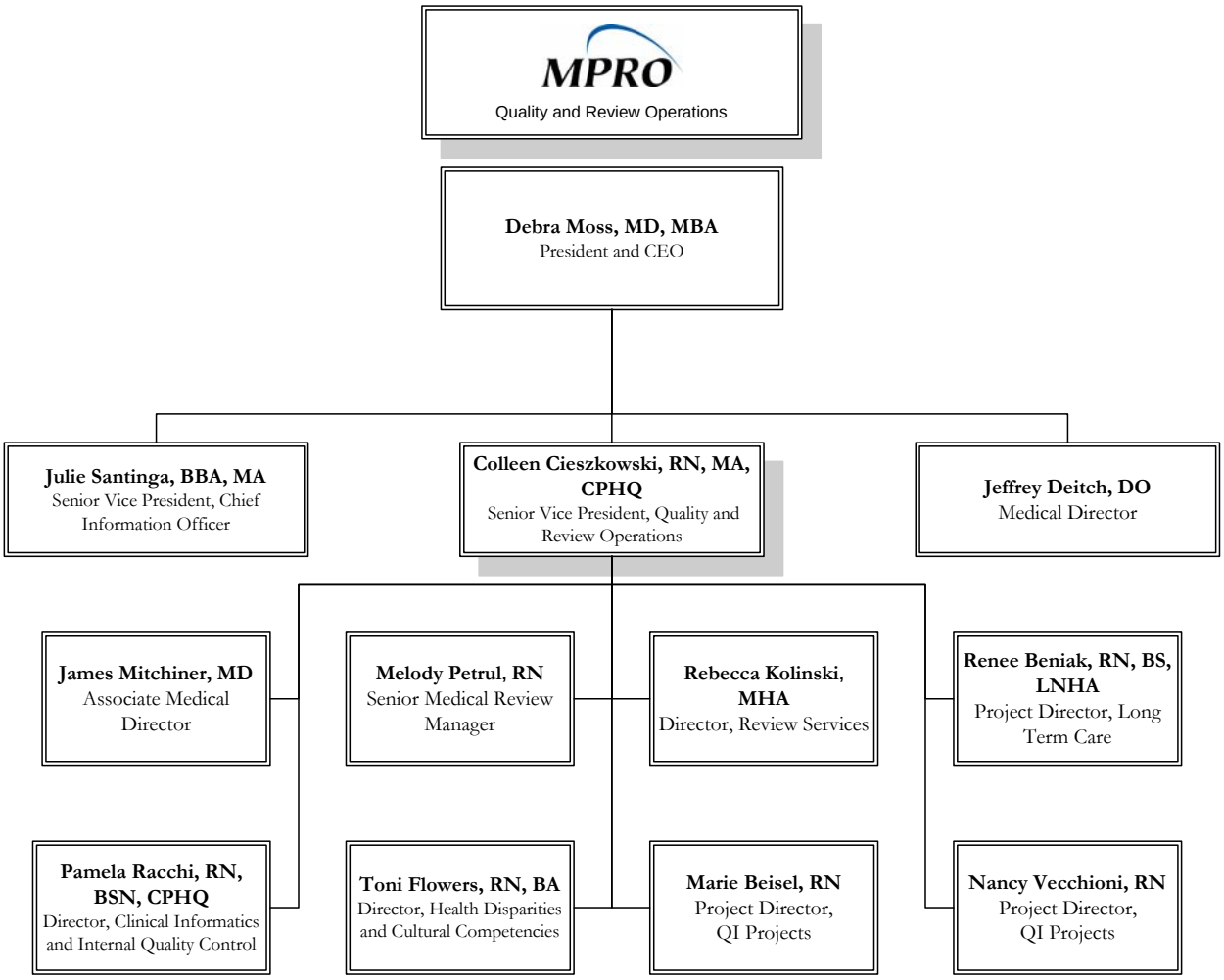
Our solution to the components of the Statewide Hospital Admission Certification and Review Program is detailed in two primary sections.

- Part I of our response addresses the PACER program for inpatient, rehabilitation, transfer, readmission, notice of non-coverage, continued stay and long term care eligibility exception review.
- Part II of our response focuses on retrospective audits for the inpatient, ER/outpatient settings and long term care retrospective eligibility reviews.

A detailed description of the review objectives, our processes for each review category, the appeals processes and reporting requirements are included in these sections. Flow charts accompany each of the narrative descriptions of our review processes to enable readers to easily follow the processes as they move from initial intake to final determination. We have also included descriptions of required qualifications of staff for each of the review components. Our existing staff meets or exceeds these qualifications for all review categories.

Organization charts showing our corporate support staff, Medicaid operations staff, PACER and Audit Review teams are also included. All review nurses and call-center staff will report to Melody Petrul, RN, Senior Medical Review Manager, who will report to Colleen Cieszkowski, RN, MA, CPHQ, Senior Vice President of Medical and Quality Review. Our Quality and Review Operations staff organizational chart reflects personnel whose qualifications and reporting relationships provide a solid foundation for continued successful contract performance:

Figure 1 - MPRO Quality and Review Services Organization



PART I PACER/LONG TERM CARE PACER

Our many years of experience give us substantial knowledge of state Medicaid regulations and clinical practices. We will apply the benefits of our experience, as well as our national credentials and Michigan citizenship to continue our successful track record for the inpatient review program and to develop and operate a successful new long term care exception review program.

Beginning in October 2004, we will operate the newly-added long term care authorization program using the same core review process that has been developed, refined and accepted by MDCH over the past 16 years. Our technological approach and review criteria will be modified as required to meet the long term care exception criteria developed by MDCH. Our experience in long term care through our QIO contract with CMS provides a strong background and knowledge base in long term care clinical data and review requirements.

PART II AUDITS/LONG TERM CARE RETROSPECTIVE ELIGIBILITY REVIEWS

Our experience gives us substantial knowledge of state Medicaid regulations and clinical practices. We will apply the benefits of our vast experience to continue our successful track record for the outpatient/ER audits, incorporate the inpatient audits and develop a long term care review program.

We have designed a comprehensive and streamlined audit process that will meet or exceed the requirements outlined in the RFP. Our process includes features that are already in place under our current FFS review contract for outpatient/ER audits, as well as some added features related to the inpatient audits. Our trained and highly skilled audit team has experience in inpatient, outpatient, emergency room and long term care services. In addition, MPRO's credentialed physician review network of board-certified physicians representing a wide variety of specialties is available throughout the audit process.

Long term care retrospective reviews represent a new review program for MPRO under the Medicaid FFS contract, but one that is compatible with our existing clinical expertise and skill sets. We will review a sample of long term care admissions based upon the criteria outlined in the RFP and in our proposal. The primary focus will be to validate the level of care determination based upon the clinical information provided in the medical record.

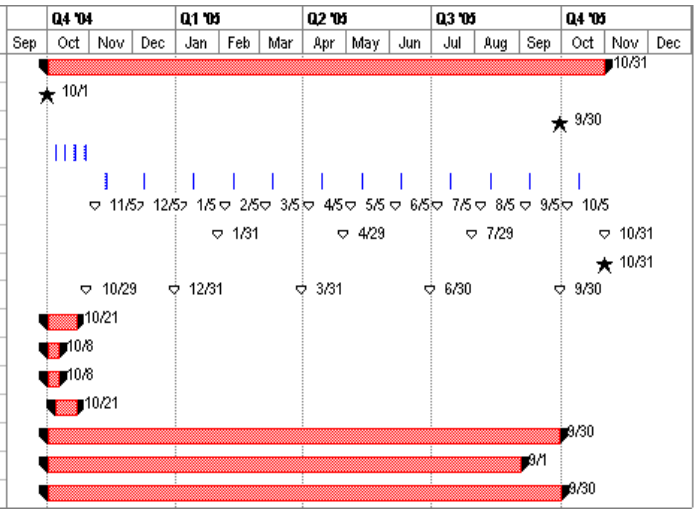
We are experienced in the timely and accurate disposition of provider and beneficiary appeals through our current scope of work for the Medicaid FFS review program, as well as our ongoing Medicare contract. We have enhanced our existing reconsideration and appeals process to incorporate the new program requirements dictated in the RFP. Our staff is well-versed in the Medicaid requirements and is experienced in providing documentation to support each determination that is made. In addition, we frequently participate in administrative hearings for MDCH as well as other customers and are highly-skilled at providing expert testimony.

TECHNICAL WORK PLANS

In this section, we have developed a detailed MS Project Schedule outlining the time related aspects of the work. We have also included information on the resources responsible for completing the work, and the hourly work effort associated with the different tasks.

Our work plan covers the first contract year and organizes tasks using a work-breakdown-structure (WBS) with tasks and sub-tasks. MS Project provides a large number of report and print options to display the information incorporated into the work plan. We have included several of these as exhibits at the end of this section. In addition, we have also submitted an electronic copy of the MS Project file where other views may be examined or printed.
A roll-up of the main tasks is displayed below.

ID	WBS	Task Name
1	1	**Contract Administration**
2	1.1	Contract period begins
3	1.2	End of contract year 1
4	1.3	**Weekly meeting/teleconference**
9	1.4	**Monthly meeting/teleconference**
22	1.5	**Submit electronic monthly status report**
35	1.6	**Submit Quarterly Report (electronically)**
40	1.7	**Submit Annual Report**
41	1.8	**Submit revised quarterly workplan**
47	2	**Start-up Activities**
48	2.1	**Staffing**
53	2.2	**Tools and Procedures**
57	2.3	**Report review**
63	3	**Part I - PACER Authorizations and Appeals**
84	4	**Part II - Audits**
287	5	**Part II - LTC Retrospective Review**



PRIOR EXPERIENCE

We have conducted the Michigan Statewide Hospital Admission Certification and Review Program for MDCH since 1988. Our experience includes prospective, concurrent, and retrospective ambulatory care and inpatient hospital care reviews for Michigan's Medicaid Fee-For-Service program. Throughout this contract, we have worked collaboratively with MDCH to refine and refocus the state's utilization review program. Many of these changes have been in response to legislation and departmental policies and objectives. These changes have also given us the opportunity to work directly with hospitals and practitioners across the state to educate them on revised utilization review procedures.

As part of the FY2003 Annual Report for the Michigan Statewide Hospital Admission Certification and Review Program, we conducted an extensive analysis of cost savings by review program, including descriptions of each program, the review process, program results, trending reports and recommendations for improvement or enhancement of potential savings. The analysis showed that the utilization review services we have provided resulted in an estimated annual gross cost savings of over $5 million dollars.

In addition to our QIO and Michigan medical utilization review contracts, we are under contract to provide independent review services to multiple state agencies, including Minnesota, Indiana, Michigan, Wisconsin, and Vermont. We were also recently awarded a contract with HealthNet Federal Services, a TRICARE contractor, to perform physician review services for 2.7 million military and retiree beneficiaries in the TRICARE North Region. This Region covers 23 states. Our experience translates to a number of benefits for MDCH, Michigan Medicaid beneficiaries and their health care providers:

Table 1 - MPRO Experience Summary

Our Experience	Benefit to MDCH
Over 150 years of cumulative staff experience in support of this contract	Smooth day-to-day performance with minimal contract disruption
Over 36 combined years of MPRO corporate experience serving Michigan's Medicare and Medicaid programs	A contractor with extensive knowledge of Michigan health care issues
Over 16 years of experience in Michigan Medicaid utilization management	A partner that has evolved with changes in Medicaid management techniques
Medical Director is board-certified in Family Practice and Geriatrics…has over 16 years experience in Michigan long term care; Associate Medical Director specialty is ER	A well managed, cohesive group of physician reviewers with high degree of Inter-Rater Reliability
Ability to successfully adapt program to meet MDCH needs	A motivated contractor with a history of successful change management
Over 20 years of QIO experience in Michigan	A partner with both a statewide and regional reputation for excellence
Extensive knowledge of Michigan Medicaid programs and processes	The detailed experience it takes to manage a successful program
Strong relationships with Michigan providers, including long term care	Low-risk implementation and operations management; program has credibility with providers
Customized information technology system	No implementation risk…PACER system is in place and operating effectively
Demonstrated track record in cost-savings	Demonstrated program effectiveness
Michigan-based company	Corporate and staff resources help stimulate Michigan economy

IV-A BUSINESS ORGANIZATION

The Michigan Peer Review Organization (MPRO) will serve as the prime contractor. MPRO operates as a domestic corporation and became incorporated as a nonprofit corporation in the state of Michigan in 1984. MPRO has been granted exempt status under Section 501(3)(c) of the Internal Revenue Code. Included in Appendix A are copies of our business license and Articles of Incorporation. Our corporate office is located at the following address:

MPRO
22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335-2611
Telephone: (248) 465-7300
Fax: (248) 465-7428

MPRO does not require the support of any subcontractors to perform the duties of this contract.

ABOUT MPRO

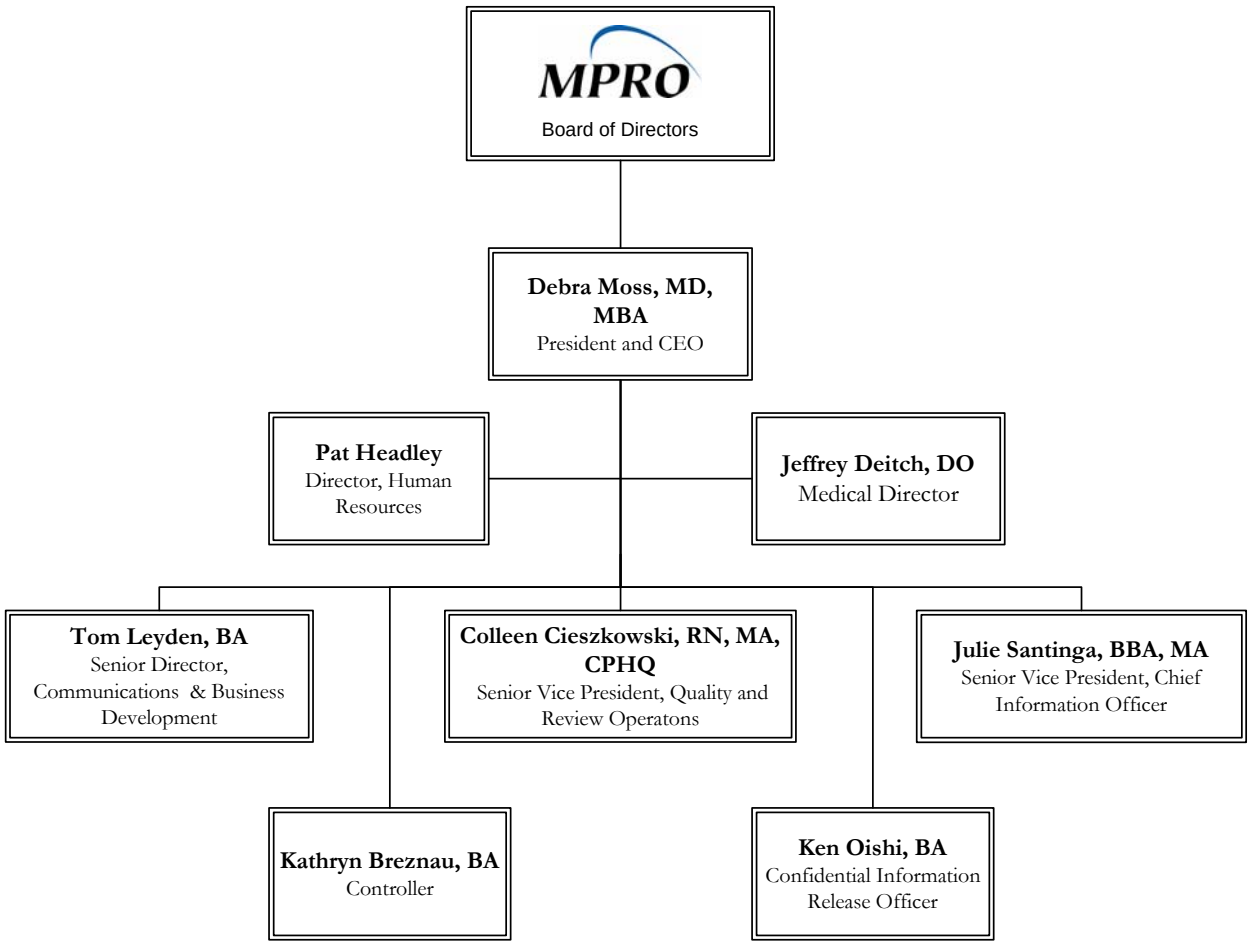
MPRO (www.mpro.org) is a recognized leader in health care quality improvement and utilization review with extensive experience in Medicaid programs, utilization review, health care billing practices and data analysis. For more than 20 years, we have committed ourselves to promoting high quality health care, assisting health care consumers, and creating innovative solutions to health care challenges. Experience and innovation are the driving forces behind our mission: *To improve the quality of health care in the communities we serve through measurement, analysis, information, education and change*.

We are designated by the Centers for Medicare & Medicaid Services (CMS) as the Quality Improvement Organization (QIO) for the Medicare program in the state of Michigan. Our exceptional performance has resulted in six non-competitive renewals of the CMS contract since the initial award in 1984. Included in Appendix B is a copy of our award letter from CMS. Our business has expanded beyond the Medicare program to include quality and utilization review services in multiple states, including Michigan, Minnesota, Wisconsin, New Mexico, Indiana and Vermont. We are also the medical review contractor for TRICARE to perform medical reviews in 23 states.

We have a multidisciplinary staff of more than 100 professionals representing registered nurses, long term care nurse administrators, medical reviewers, economists, physicians, health care administrators, statisticians, coders, epidemiologists, information systems experts and marketing specialists. As a team, we work together to successfully fulfill the duties and responsibilities of our many contracts. We also maintain a network of approximately 250 board-certified, credentialed and experienced physician reviewers. This network of expert clinical-reviewers represents the entire spectrum of medical specialties and sub-specialties to provide a full range of clinical review services.

Figure 2 presents a current high-level organization structure for MPRO. Our organization structure provides strong support for our Michigan Medicaid business activities through traditional line and staff functions such as marketing and communications, human resources, information technology, and finance.

Figure 2 - MPRO Corporate Organization Structure



We have a strong Michigan-based corporate support structure.

Accreditations/Certifications

In 2002, we earned full accreditation from the Utilization Review Accreditation Commission (URAC) as a Health Utilization Management (HUM) and Independent Review Organization (IRO). URAC was founded in 1990 to establish national standards for the health care industry. Accreditation from URAC is one of the highest levels of accreditation that a medical review organization can attain. We are one of only two non-profit QIOs with both Health Utilization Management and Independent Review Organization accreditations.

In receiving this accreditation, we also demonstrated compliance with URAC's Core Standards. These standards address several critical areas of basic structure and process, including: organizational structure, personnel management, quality improvement, oversight of delegated responsibilities and consumer protection. Copies of documentation are provided in Appendix C as evidence of the above accreditations.

IV-B STATEMENT OF THE PROBLEM

Overview and Environmental Assessment

MDCH is seeking a qualified contractor with experience and expertise to assume the following tasks in compliance with Medicaid Policy and Guidelines:

9. Conduct telephonic/electronic authorization of inpatient services (PACER);
10. Review and authorize appropriate exceptions to nursing facility level of care;
11. Conduct audits/utilization review of inpatient services, outpatient services, and emergency room services including validation of PACER authorizations; and
12. Conduct long term care retrospective eligibility reviews.

Michigan, like many states, is experiencing budgetary problems, with a projected budget shortfall of $1.3 billion for fiscal year 2005. The proposed state budget for fiscal year 2005 is $39.7 billion with $6.5 billion of these monies dedicated to the Medicaid program. It is critical that each Medicaid dollar spent is spent wisely and only for services that are medically necessary. Nursing facility level of care services and inpatient hospital services account for the majority of funds expended in the Medicaid program. Assuring that the services provided are medically necessary, meet the pertinent criteria for provision, and are provided only to recipients who are eligible to receive the services, is fiscally responsible and uses scarce state resources appropriately.

The $6.5 billion allocated to the Medicaid program allows the provision of health care services to more than 1.3 million people. Although many beneficiaries are enrolled in a managed care arrangement, 400,000 remain in the Medicaid Fee-For-Service program. These beneficiaries will be directly affected by the Medicaid Fee-For-Service Review program. The program will ensure that the Medicaid dollars spent in the Fee-For-Service program are for appropriate, medically necessary services.

HISTORY OF THE MEDICAID FEE-FOR-SERVICE REVIEW PROGRAM

Michigan has had a Statewide Hospital Admission Review and Certification Program in place since 1988. MPRO is the current contractor and since 1988 has been successfully providing PACER review; inpatient and ER/outpatient retrospective utilization review, notice of non-coverage review and validation of PACER reviews.

The PACER review program has been effective in controlling unnecessary admissions, transfers, readmissions, and continued stays both in the acute and the rehabilitation setting. The inpatient and ER/outpatient retrospective review program has been very successful, especially in retrieving dollars from DRG coding errors. The ER/outpatient program has been less successful due to policy and technical issues and the high volume of provider appeals that have encumbered the program from achieving its maximum potential for savings.

We are hopeful that the full potential can be achieved with the changes to the process for the new contract period. The PACER validation review program has served as an important 'check and balance' to ensure that providers are giving accurate and reliable clinical information when they request authorization.

NEW LONG TERM CARE REVIEW PROGRAMS

In fiscal year (FY) 2005, MDCH intends to contract for the private administration of a statewide admission review and certification system for Michigan Medicaid long term care programs. This contract will assign responsibility to a vendor for the administration of the nursing facility level of care exception process. It also will incorporate a retrospective review of the appropriateness of admissions to nursing facilities based upon the nursing facility level of care criteria. Even though we have not provided this specific service, we have the program knowledge and experienced staff to add these responsibilities to the current process.

A key concern for MDCH is that the contractor will be prepared to begin work on the new components of the Request For Proposal (RFP) upon initiation of the contract. We are prepared to do so and can make adjustments to meet the modifications in the existing contract requirements and to add the long term care program components.

CONTRACT MONITORING

In order to more effectively manage performance, MDCH has instilled new contract monitoring provisions that include sanctions and monetary penalties. Sanctions will be determined by validations conducted by the MDCH Contract Manager. The inclusion of performance measures and sanctions is consistent with the recent industry trend towards performance-based contracting. We applaud this approach by MDCH and are prepared to meet or exceed all contract requirements. Our record in performing under the current Medicaid Fee-For-Service Review contract attests to our ability to continue exemplary performance moving forward into FY 2005 and assuming responsibility for long term care program certification and retrospective reviews.

SUMMARY

The challenging financial environment emphasizes the importance of effective and efficient review processes that will preserve fiscal integrity for the State of Michigan. The Medicaid Fee-For-Service Review programs represent an important component of the State of Michigan's cost management strategy for the Medicaid program. The review programs help ensure that Medicaid funds are spent properly for inpatient, outpatient and emergency room and long term care program services, in conformance with Medicaid Policy and Guidelines. The review processes also help to ensure that services are medically necessary and provided in the appropriate setting.

We are confident that we are able to provide all of the needed services under this procurement. Many services are already being provided under the current Medicaid Fee-For-Service Review contract that MPRO has held since 1998. The additions in this procurement draw upon our established strengths, including:

13. Experienced nurse and physician staff that are knowledgeable both in Michigan Medicaid policy and in the practice of medicine specific to Michigan;
14. Staff and organization with credibility and reputation of objectivity among Michigan providers and managed care providers;
15. A sophisticated computer and phone system;
16. The ability to generate timely, accurate reports;
17. HIPAA compliance; and
18. The desire to continue to serve the State of Michigan and Michigan citizens.

IV-C MANAGEMENT SUMMARY

1. NARRATIVE

EFFORT DESCRIPTION & SERVICES

Our implementation solution to the components of the Statewide Hospital Admission Certification and Review Program is detailed in the sections that follow. Part I of our response addresses the PACER program for inpatient, rehabilitation, transfer, readmission, notice of non-coverage, continued stay and long term care eligibility exception review. Part II of our response focuses on retrospective audits for the inpatient, ER/outpatient setting and long term care eligibility review. A detailed description of the PACER process, review objectives, our processes for each review category, the appeals processes, and reporting requirements are included in each section.

Flow charts accompany each of the narrative descriptions of our review processes to enable readers to easily follow the processes as they move from initial intake to final determination. We have also included descriptions of required qualifications of staff for each of the review components. Our existing staff meets or exceeds these qualifications for all review categories. Organization charts of the PACER and Audit Review Teams are also included.

SUBCONTRACTORS

We will not use any subcontractors in the performance of the tasks specified in the RFP.

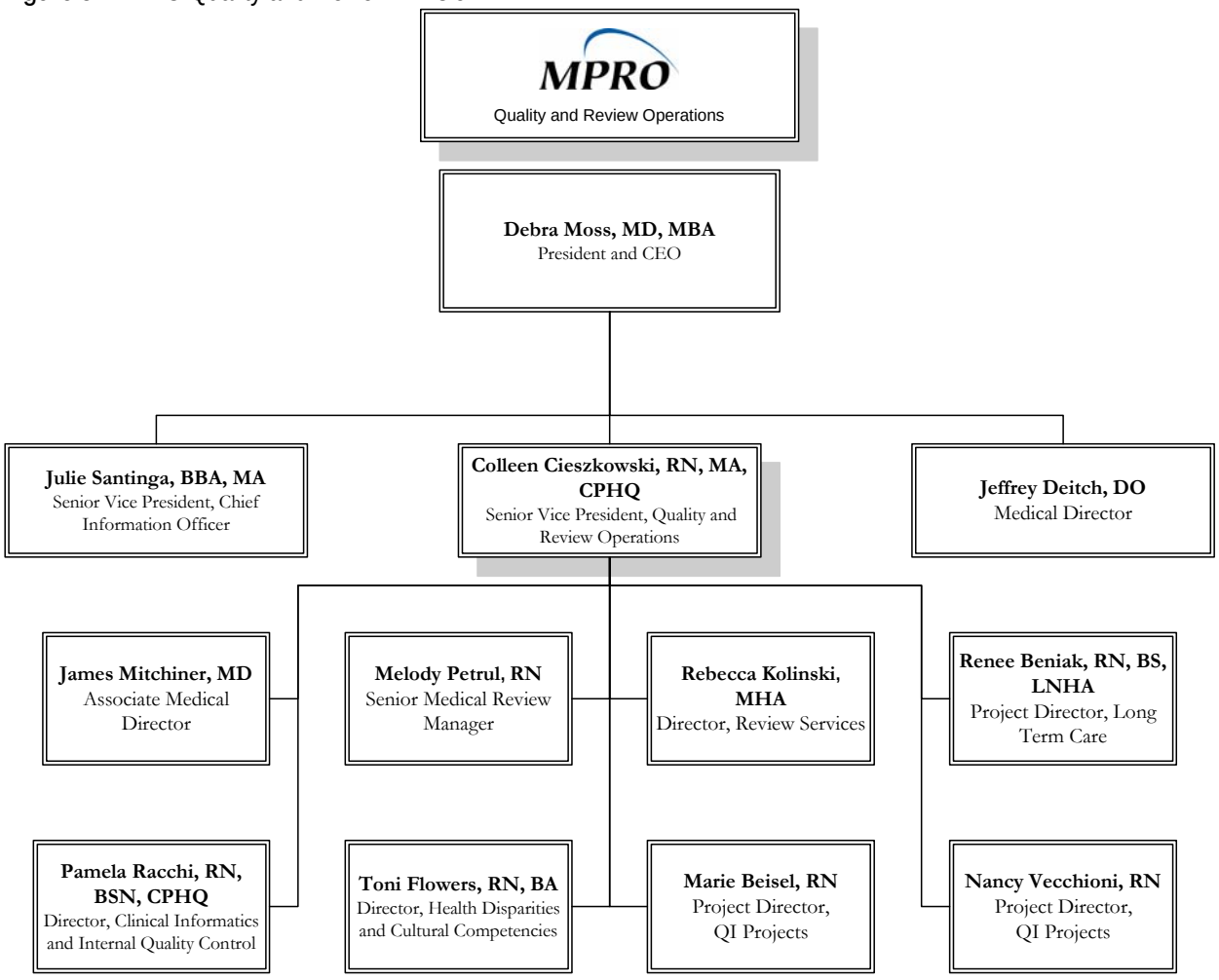
MPRO RESOURCES

Our contract support capabilities are described in the following sections. They include details about our staffing, phone system, computer systems, computer room and general facilities, security policies and procedures, confidentiality, Internal Quality Control Program, and training and staff development activities. Many of these functions create the infrastructure that supports the Medicaid Fee-For-Service Review programs. These descriptions are referenced within our response to the RFP Statement of Work, Part I – PACER/Long Term Care PACER and Part II – Audits/Long Term Care Retrospective Eligibility Reviews.

Michigan Medicaid Support Staff

Our response includes a corporate organization chart as well as contract-specific organization charts. Our corporate organization chart highlights the Michigan-based corporate resources available to support our Medicaid operations staff and is shown in Section IV-A, Business Organization. Our overall Michigan Medicaid Quality and Review Operations Division is shown in the following chart:

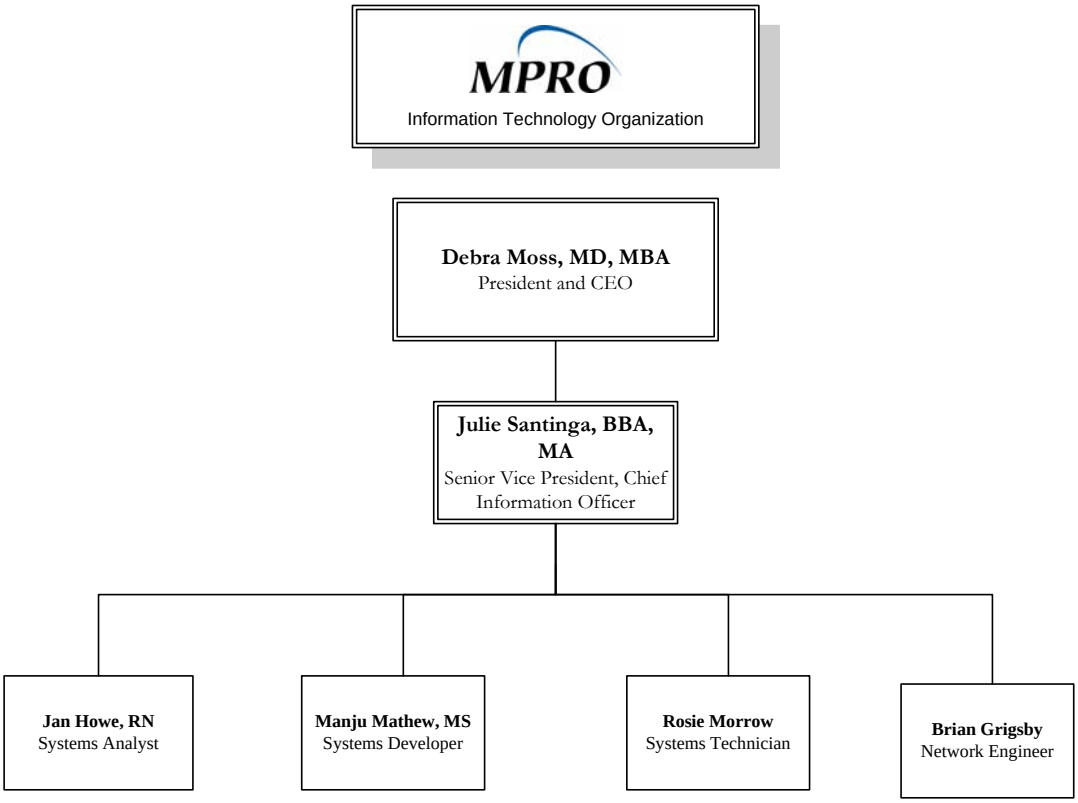
Figure 3 –MPRO Quality and Review Division



Our Michigan Medicaid organization is designed to help meet or exceed contract performance standards.

Organization charts for the Audit and PACER review teams are also included with the descriptions of each specific review component specified in the RFP and addressed in this proposal, Part I. J. and Part II. J. We are also including an organization chart for our Information Technology (IT) team. Our information technology department plays a critical role in assisting our Michigan Medicaid staff with fulfillment of contract obligations.

Figure 4 – MPRO Information Technology Organization Structure



Our IT department plays a critical role in helping us meet or exceed Michigan contract obligations.

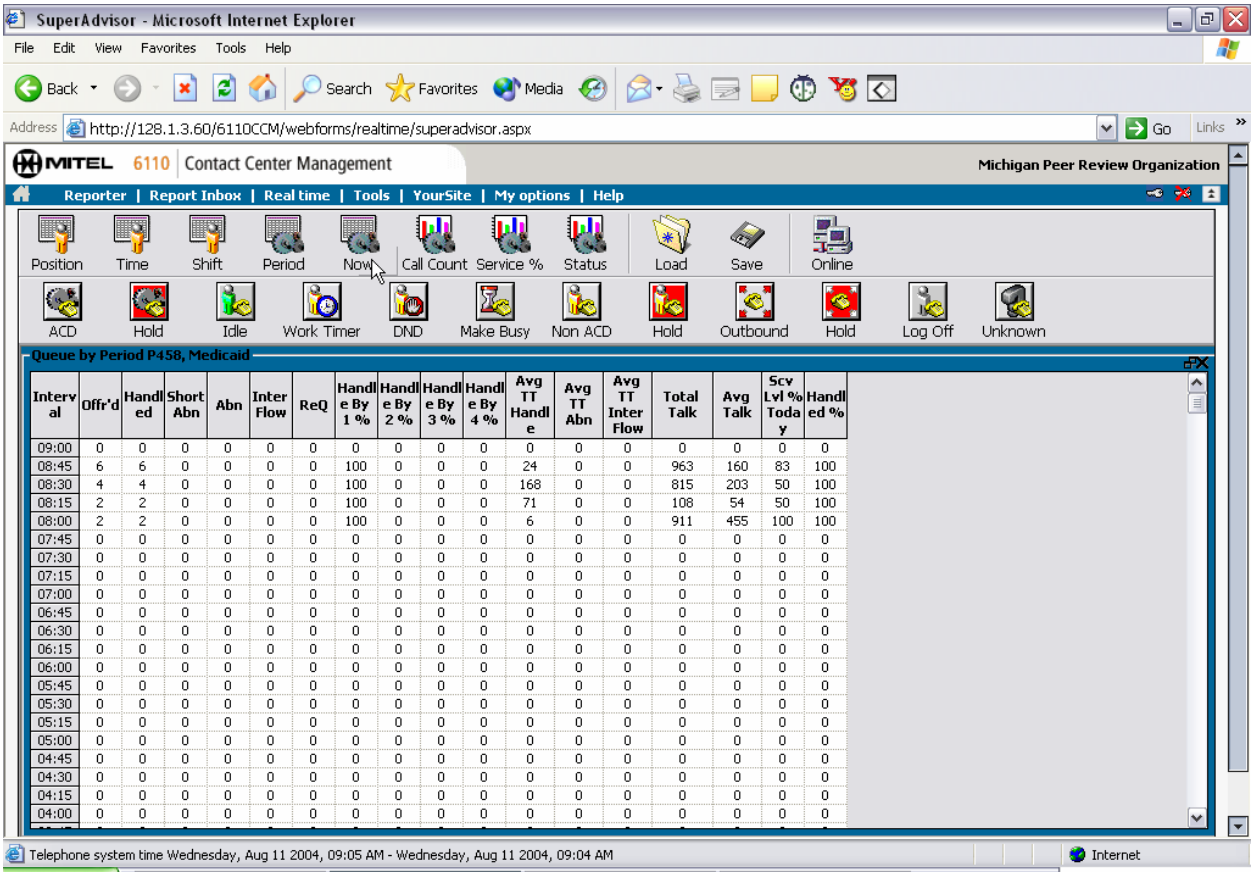
The technical staff assigned to this contract and included in Figure 4 plays an integral role in the implementation, support and maintenance of the technology systems that support this contract. Specifically, the telephone system, computer system, our physical facilities and security processes provide the foundation for our Medicaid review operations and are summarized below.

PACER Phone System

In support of our Michigan Medicaid Fee-for-Service (FFS) contract, we use a Mitel 6110 telephone system with automated call distribution which can be customized, as necessary, to meet our contract-specific needs for routing and tracking PACER calls. Before purchasing this phone system in 2004, we made great efforts to ensure it would absolutely meet or exceed the MDCH contract requirements.

Telephone statistics including, but not limited to, hold time, talk time, abandoned calls, length of calls, specific agents and time intervals can be monitored at any time and are regularly reviewed by the management team. A sample screen shot from the system used to monitor calls follows.

The system uses a first-in first-out process for calls and routes calls in the queue to the next available primary call center agent. A back-up call center agent is available for overflow if all of our primary call center agents are busy serving other customers. If the caller is ever on hold, they always have the option to immediately leave a message for a return call.



Interval	Offr'd	Handled	Short Abn	Abn	Inter Flow	ReQ	Handle By 1 %	Handle By 2 %	Handle By 3 %	Handle By 4 %	Avg TT Handle	Avg TT Abn	Avg TT Inter Flow	Total Talk	Avg Talk	Scv Lvl % Today	Handled %
09:00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
08:45	6	6	0	0	0	0	100	0	0	0	24	0	0	963	160	83	100
08:30	4	4	0	0	0	0	100	0	0	0	168	0	0	815	203	50	100
08:15	2	2	0	0	0	0	100	0	0	0	71	0	0	108	54	50	100
08:00	2	2	0	0	0	0	100	0	0	0	6	0	0	911	455	100	100
07:45	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
07:30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
07:15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
07:00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
06:45	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
06:30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
06:15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
06:00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
05:45	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
05:30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
05:15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
05:00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
04:45	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
04:30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
04:15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
04:00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

We use a Mitel Contact Center Management system to monitor the performance and efficiency of our call center agents to ensure they are working effectively.

Pacer telephone statistics are maintained in a central database so we can generate hard copy reports to track whether we are meeting MDCH contract requirements and internal quality management processes. Descriptions of the required contract reports and additional ad-hoc reports are presented in Part I, Section I and Part II, Section K. Examples of many of our reports are included in Appendix D.

The telephone circuits used to support our toll-free PACER number were installed to ensure that the service will always be available for Medicaid providers and beneficiaries. Out toll-free number normally uses a T1 circuit to connect incoming and outgoing calls. Should this T1 experience a malfunction that would cause our toll-free service to become unavailable, we have access to a separate T1 circuit and will temporarily redirect calls to it.

If both T1 circuits are malfunctioning simultaneously, we will redirect our toll-free line to analog phone lines reserved for this purpose. Ultimately, we have access to sufficient T1 circuits and analog phone lines so that our PACER number will always be available to serve the requirements of this contract.

The automatic call distribution system, voice mail system, reporting system and supporting hardware are connected to a sufficient uninterruptible power supply system (battery backup) in the event of a power outage. Load balancing and redundancy are built into the overall system hardware in the event we experience hardware failure. All systems are hosted in locked rooms that are only accessible to authorized staff. These systems are a part of our nightly back-up and off-site fire protected storage routine so that data can be recovered in the event of disaster or unintentional data deletion.

Our call center operates during the hours of 8 a.m. through 5 p.m., Monday through Friday, excluding state-approved holidays.

PACER Computer System

Our server operates on Dell hardware under Windows 2000® Server SP4 with the most current security patches. We use Oracle8i Enterprise Edition 8.1.7.3.0 to support the database. The database is populated by data entered during PACER requests. The PACER application is written in PowerBuilder Professional® for Windows version 8.0®. Our client workstations operate on Dell hardware under Windows XP and connect to the database server for data entry and to generate ad-hoc monthly, quarterly and annual reports. Reports are generated using Crystal Reports version 8.5®.

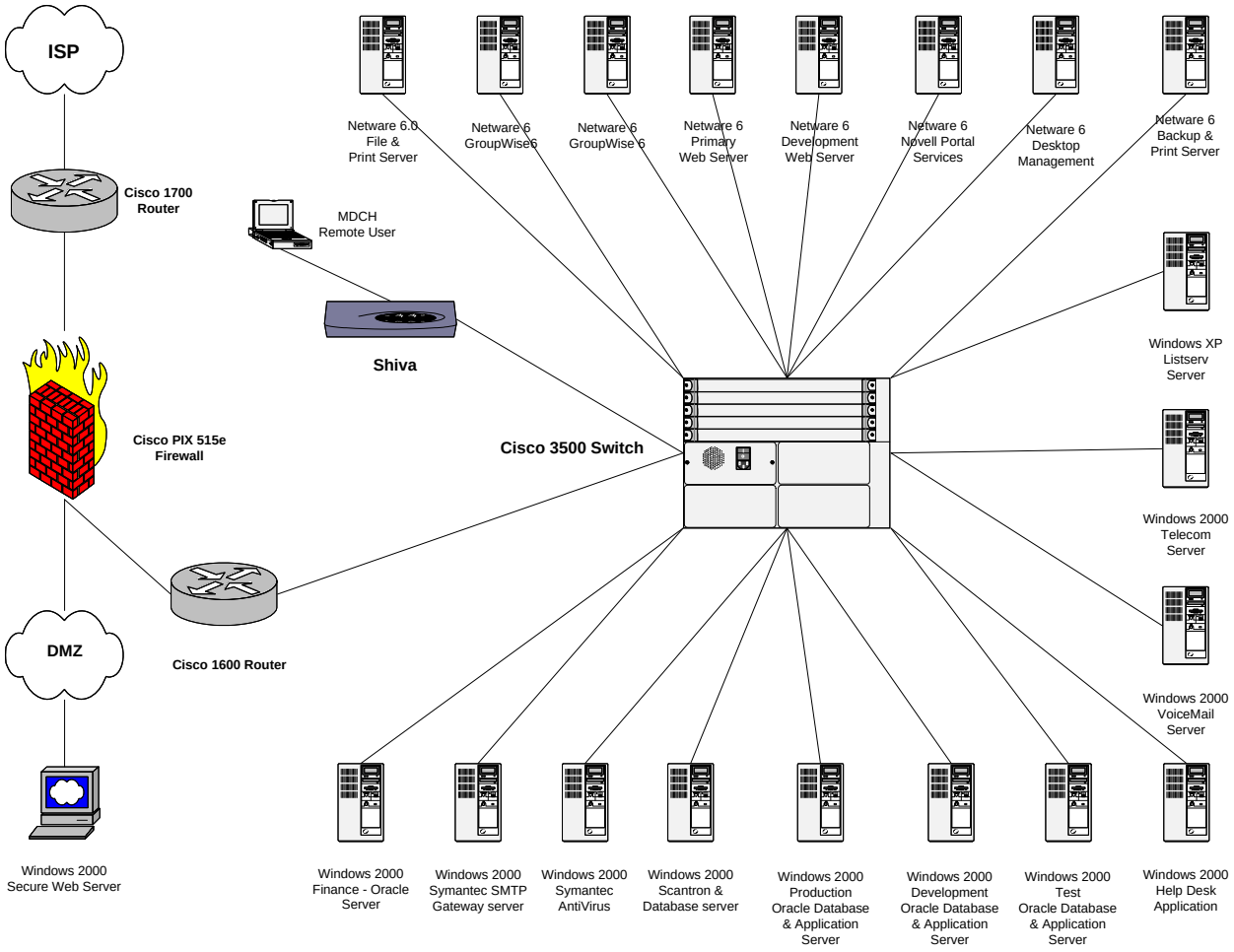
The PACER application was built to meet the specific needs of the MDCH PACER and review contract. It will require slight modifications to meet changes as identified in contract #071I4001348.

Computer system modifications made under the 2004-2007 contract will adhere to the process as spelled out in the state's Project Management Methodology (PMM) standards. For more detailed information regarding reports, please refer to Part I, Section I and Part II, Section K of this proposal. Sample reports are also included in Appendix D.

MDCH currently connects to our computer system via a dial-up connection from a laptop supplied by MPRO. Once connected, the MDCH user authenticates to our LAN using a secure ID and password. The user then executes a program on the laptop that accesses the database using their user ID and password assigned for database access. MPRO is willing to work with MDCH to provide an alternate means of access, if necessary.

A diagram of our network is shown here:

Figure 5 – MPRO Network Diagram



Our computer network provides a comprehensive system in support of the Michigan Medicaid contract operations.

Computer Room and Corporate Facilities

Servers are located in a locked state-of-the-art computer room in our facility at 22670 Haggerty Road, Farmington Hills, Michigan. The room is only accessible by the IT staff whose classification requires access. Servers are password-protected and screen locks are applied after 10 minutes of console inactivity. Systems can only be unlocked by IT staff whose classification requires access. All communication closets hosting network switches and cables related to our network infrastructure are locked and only accessible by IT staff that support network operations. Our network is protected against external unauthorized access by rules set in our Cisco 515E firewall.

Our corporate computer room includes a six-inch cement tile raised floor that provides opportunity for server growth, organized cable management and resistance to static electricity. For maximum electrical reliability, we have a separate power panel that only serves the load in the computer room.

All electrical outlets in the computer room are connected to a central Liebert® unit for uninterruptible power supply (battery backup) to our servers and related electronics. If a power outage occurs, servers and related electronics continue functioning for up to 90 minutes. If power is not restored within 90 minutes, systems are automatically shut down before battery power is completely consumed and remain down until power is restored.

To protect our systems from fire damage, the computer room has built-in smoke detectors and temperature sensors. If either smoke or heat is detected, a Healey fire protection system automatically dumps FM-200 gas. When the gas is dumped, an alarm is automatically triggered to Security Corporation who, staffed 24 hours a day/7 days a week, contacts the local fire department and at least one MPRO representative.

Our servers and associated electronic components run best in a cool environment. We have a separate air conditioning unit specifically for the computer room. This unit maintains a constant room temperature of 68 degrees Fahrenheit.

Server hardware is built with redundancy to protect against hardware failure or system downtime due to hardware failure. In addition, our servers are covered by Dell support contracts with a guaranteed four-hour turn-around time for onsite support including parts and labor.

All servers are backed up nightly, Monday through Friday, using two HP autoloader tape drives and Computer Associates® Brightstor version 11 Enterprise edition. Monday through Thursday we back up data that changed since the last backup. Every Friday and the last day of every month we run full system backups. Weekly and monthly tapes are stored offsite in a fireproof vault. If data loss occurs, data can be restored from these tapes. In the event of a major disaster where total server loss occurs, we hold a contract with Merit Network, Inc., to temporarily configure and host systems at their site in Ann Arbor until MPRO is relocated.

All servers are supported internally by our Information Technology team. Internal and external customers can request support by calling or sending an e-mail to our Helpdesk. Helpdesk hours are Monday through Friday, 8 a.m. to 5 p.m. Requests to the Helpdesk are tracked using Blue Ocean Track It!® software. Track It!® allows us to assign requests to appropriate technicians, track status and review previous resolution on repeat requests.

Servers and desktop computers are protected from viruses by running the latest version of Symantec Norton AntiVirus® software. We also use Symantec to protect the E-mail server from viruses by filtering incoming and outgoing E-mail. Symantec software scans for viruses. If a virus is found, it attempts to clean the virus and maintain the document or E-mail. If it is unable to do so, the document or E-mail is quarantined. Quarantined items can then be submitted to Symantec for research and analysis. The corporate Symantec server checks for updated virus definitions every hour to updates our systems occur as often as updates are released.

Security Policies and Procedures

Our facility has limited access that is secured by a key card access system. During normal business hours (8 a.m. to 5 p.m., Monday through Friday), a receptionist is stationed at the main entrance to our facility. Access to the building is only granted to employees and visitors who have appointments.

Outside of normal business hours, employees can gain access to the building by presenting their issued key card to either of the key card readers on the main or side entrance. Between the hours of 11 p.m. and 5:30 a.m., Sunday through Saturday, an alarm is triggered if any person attempts unauthorized access to our building. When this happens, Security Corporation automatically contacts police for dispatch and contacts at least one MPRO representative.

To provide easy client access, each employee has an individual direct-line telephone number. Our telephone system also offers an automated employee directory that is available 24 hours a day and provides direct access to staff or their voice mail.

Security of our information and the systems that process it is the fundamental responsibility of the Chief Information Officer of Information Technology. However, the entire organization plays an active role in maintaining the standards set forth by the security policies. Data security is paramount to our success because we are entrusted with confidential information from over a dozen clients covering hundreds of thousands of beneficiaries and thousands of their providers. The regulations that govern security of health care information including HIPAA, the Computer Security Act of 1987, and 42 CFR 480, among others, guide the policies of our security plan. The clinical information systems we support fully comply with MDCH's security policies.

All applications and systems require protection for confidentiality, integrity and availability. The level of protection required is determined by an evaluation of the sensitivity and critical nature of the information processed, the relationship of the application or system to the organization's mission, and the contractual obligations of the application or system components.

Our password policy is as follows:

19. Users are not to share their password or user name with anyone;
20. Passwords expire and must be changed every 40 days. The Novell® login system automatically prompts users to change their password. As the expiration date approaches, only five grace logins are allowed;
21. Users that have used the five grace logins and still have not changed the password will be locked out of the system and must contact MPRO's Helpdesk to get their password reset;
22. Passwords should be at least eight characters in length. They can be a combination of alpha, numeric and special characters;
23. Patterns are discouraged, as they are easier to figure out. An example of a pattern is using the month and year, i.e. nove1994. In this example, the user is only changing one

or two characters every month. More importantly, once someone has guessed the month and year pattern; the password is much easier to guess or break;

24. A password should not be found in the dictionary, should be easy to remember but hard to guess;

25. Other obvious passwords such as social security number, login ID, and the names of family members are not recommended;

26. After 10 minutes of inactivity, workstations are set to lock and request login by the last user logged into that workstation.

All of our employee positions have been reviewed for sensitivity level and access to systems. During the hiring process, all individuals are screened for appropriate backgrounds and skill sets for their assigned positions. Background checks are presented in detail in Section IV-D "Security" of our proposal. New hires are also required to read, adhere to, and sign a policy on password protection, security and the confidentiality of data and information responsibilities of the employee. Along with this policy, the employee is also required to sign a confidentiality statement. These policies and statements carry penalties as outlined in our Employee Policy and Procedure Handbook.

User access to data systems is restricted to a need-to-know basis for each user, based on the function they are required to perform. Access is issued only at the request of a director or manager who completes a request form for each new employee or if a current employee changes roles. Access is granted after the user has attended the appropriate training and updated their request form with appropriate authorization. Acceptance and use of a user name and password into any system or application is considered acceptance of the policies governing its use.

When a user no longer requires access to a system, our IT Department is immediately notified by the user's supervisor of a change in employee status. IT then adjusts privileges for the account. Accounts are removed immediately upon termination of an employee. As a double-check for accuracy, our Human Resources Department also notifies the IT Department of all employee status changes.

Critical security functions are divided among different individuals to better ensure a check-and-balance system by the separation of duties. All functions are under the oversight of the Chief Information Officer of IT. The IT Network Engineer and System Technician perform daily supervision of all security measures.

The sensitivity and critical nature of the information stored within, processed by, or transmitted by an application and/or system, provides a basis for the requisite security concerns of the application or system and is one of the major factors in risk management at MPRO. A description of the types of information handled by the application and/or system and an analysis of the critical nature of the information is completed and published for all stakeholders, as required. This description and analysis assists in customizing security controls, facilitating security audits, and implementing security countermeasures.

Confidentiality

The protection of health care data and administrative information is vital to the interests and success of MPRO and our various state and federal contracts. Such confidential information includes, but is not limited to, the following examples:

27. Medical information;
28. Patient-specific information; and
29. Provider-specific information.

Our confidentiality and data security policy is based on Title 42 Code of Federal Regulation Part 480 (42 CFR 480) and the HIPAA of 1996, Title 45 CFR Parts 160 and 164). We are a HIPAA-designated Business Associate of MDCH and have a signed Business Associate Agreement on file. Our confidentiality policy covers four major areas:

30. Employee confidentiality;
31. Safeguarding medical records and review findings;
32. Database access; and
33. Information release.

We have a designated Confidentiality/Information Release/Compliance Officer. He is very experienced in compliance and keeps up-to-date with any change in compliance regulations. Our Confidentiality Officer is responsible for ensuring that we are in compliance with 42 CFR 480 and 45 CFR 160 and 164. Our Confidentiality Officer is responsible for processing all confidentiality questions and requests (including subpoenas) for Medicare and Medicaid data and is responsible for proper interpretation of the regulations, answering questions, and fulfilling data requests. Requests for the release of Medicaid data are coordinated with our Senior Medical Review Manager and released only after approval.

Employee Confidentiality

Our employee confidentiality policy is outlined in our Employee Personnel Policies Manual. Each employee receives a copy of this manual at the start of their employment. All employees sign confidentiality statements upon hire. The confidentiality statement covers the types of confidential information employees may encounter, the employee's responsibilities for maintaining the confidentiality of this information, and the penalties associated with unauthorized disclosure of this information. This policy includes all full-time and part-time staff, physician reviewers, consultants, and contingent employees.

A signed confidentiality statement must be in the employee's personnel file prior to the employee receiving an initial paycheck. An employee who resigns or is terminated, signs a document during their exit interview that affirms the confidentiality policy and their obligation not to disclose confidential information.

Our Confidentiality Officer conducts staff education on confidentiality requirements on an annual basis. The training covers:

34. CMS and QIO confidentiality requirements (42 CFR 480 and Part 10 of the QIO Manual);
35. Michigan state confidentiality guidelines and standards;
36. Security measures, including electronic data security;
37. HIPAA regulations as they apply/do not apply to our Medicare and Medicaid contract performance and to other MPRO non-governmental contracts; and
38. Handling and directing of confidentiality questions and data requests by staff.

We continually emphasize the need for confidentiality with our staff because of the sensitivity of the information they hold.

Safeguarding Medical Records, Review Findings and Database Access

All medical records stored at MPRO are housed in a limited access medical records library. The medical records library entrances are secured by combination locks. The combinations are limited to staff who are assigned to this area.

Information Release

As stated above, requests for release of Medicaid data are coordinated with our Senior Medical Review Manager by the Confidentiality Compliance Officer. No Medicaid data is released by MPRO without the consent of the MDCH Contract Manager. Medicare data is released in accordance with the information release provisions outlined in 42 CFR 480; all release decisions are made by the Confidentiality Officer or in consultation with our Medicare Project Officer.

Internal Quality Control Program

To achieve quality and excellence in the services provided through this contract, we will integrate the contract monitoring and reporting activities into our existing Internal Quality Control (IQC) processes. Our complete IQC plan for the Statewide Hospital Admission Certification and Review Program is included in Appendix E.

Through IQC monitoring, we foster Continuous Quality Improvement (CQI) principles as the foundation to promote our project and support corporate teams to achieve the highest level of contract and operational performance. The key to this quality initiative is rigorous adherence to a systems perspective for all major activities and programs within the contract.

Our coordinated, cross-corporate approach to IQC begins with individual teams assuming accountability for the day-to-day implementation and maintenance of their IQC program. Early in the process, our teams develop strategies consistent with their work plan, critical work functions and activities. In addition, performance indicators developed by the team are reviewed with our Senior Statistical Analyst to ensure that they are measurable and that valid data sources for measurement are available. Our analysts create tracking graphs to allow the team to monitor its progress.

As performance indicators are measured and plotted over time, the team reviews the findings and makes a determination when intervention is required. Details regarding indicator performance are documented on an IQC worksheet that captures indicator goals, strategies, measurements,

evaluations, and action plans based on performance. The effectiveness of process improvement efforts is detailed on this worksheet.

Our IQC worksheets provide comprehensive sources for maintaining performance indicator history, action plans initiated to improve performance, and outcomes of these improvement strategies.

Availability of timely performance data and communication of findings is critical to the success of our quality improvement initiatives. Since the project team's inherent work responsibilities allow for key insight regarding performance levels, discussion of IQC activities is incorporated into regularly scheduled team meetings. Team members have ready access to indicator tracking graphs and related IQC documents through a shared network directory.

The progress, obstacles and opportunities identified through IQC monitoring are also shared between teams and across projects as appropriate. Separate peer groups of project managers, coordinators, directors and analysts meet regularly to discuss challenges and share knowledge gained from process improvement efforts. An established reporting structure for quality monitoring activities includes communication of information to appropriate committees, executive leadership, and our Board of Directors.

Training and Staff Development

We have an established training and staff development program designed to improve the performance of our employees by providing education directed at maintaining and enhancing effective performance. Our philosophy is that employees can perform skills at a higher level when they have received an organized orientation and regular educational opportunities to enhance their work skills. This department is charged with a number of company goals:

39. Provide educational activities and services that support our mission and vision;
40. Promote open communication and encourage active participation in education activities;
41. Collaborate with our Human Resources Department to implement and evaluate the orientation process;
42. Establish protocols for sharing information among colleagues (i.e. lunch and learn presentations, education programs, reporting on conference/seminar attendance, etc.);
43. Maintain educational standards consistent with those of Michigan Nurses Association (MNA) nursing continuing education;
44. Provide nursing continuing education (CE) contact hours when feasible;
45. Evaluate the impact of staff development activities;
46. Establish and evaluate CQI goals through quarterly monitoring;
47. Establish and maintain accurate record keeping and reports;
48. Cultivate presentation skills in employees;

49. Ensure baseline knowledge for new employees on quality improvement principles and processes; and

50. Support the education of collaborators, stakeholders and partners.

PART I PACER/LONG TERM CARE PACER

A. BACKGROUND STATEMENT

MDCH is seeking a qualified and experienced contractor to conduct telephonic/electronic authorizations for inpatient services. The authorization process will verify compliance with Medicaid Policy and Guidelines as outlined in the Provider Manuals and Bulletins and determine the appropriateness of the services provided to Medicaid beneficiaries based upon current standards of practice and applicable state and federal regulations. In addition, MDCH is seeking to implement a new certification and exception program for long term care, based upon the nursing facility level of care exception criteria. The selected contractor will perform exception reviews for the long term care program.

Under our current Medicaid Fee-For-Service (FFS) Review contract with the state of Michigan, we provide professional review services for inpatient care with the goal of ensuring that only appropriate, medically necessary services are provided to the Medicaid population. In addition with more than 16 years of experience in Medicaid Fee-For-Service utilization review, we are URAC accredited for Health Utilization Management and we are the CMS designated QIO for the state of Michigan.

MPRO is a Michigan-based company employing more than 100 staff members. Our experience gives us intimate knowledge of state Medicaid regulations and clinical practices. We will apply the benefits of our vast experience, as well as our national credentials and Michigan citizenship to continue our successful track record for the inpatient review program and to develop and operate a successful, new long term care exception review program. All nurses and physician reviewers involved in the PACER authorization process are experienced in utilization review and trained specifically in the PACER process.

Beginning in October 2004, we will operate the newly added long term care authorization program using the same core review process that has been developed, refined and accepted by MDCH for more than 16 years. Our technological approach and review criteria will be modified as required to meet the long term care exception criteria developed by MDCH. Our experience in long term care through our QIO contract with CMS provides a strong background and knowledge base in long term care clinical data and review requirements.

B. OBJECTIVES

We will meet or exceed 100% of the objectives set forth by MDCH to provide PACER reviews in a timely and accurate manner. We will perform telephonic and electronic authorizations in compliance with Medicaid policies and procedures for inpatient services for the Medicaid fee-for-service (Title XIX) population. In addition, inpatient authorizations will be conducted for the Children's Special Health Care Services (CSHCS) beneficiaries.

We will also perform telephonic and electronic reviews for all exception requests for exceptions to the Michigan nursing facility level of care definition, using explicit exception criteria provided by MDCH. These reviews will be provided for the Medicaid FFS population and the

Medicare/Medicaid dual eligibles, if requested by MDCH. We will develop and implement this new component of our contract within the time frames required by MDCH. In addition to mandatory program elements, we have added several supplemental program features that we believe enhance the results of this program. These supplemental features are summarized at the end of this section.

Mandatory Program Elements

The RFP outlines several mandatory program elements for the Medicaid FFS Review contract. The following table summarizes these program elements and our compliance plan.

Table 2 - PACER/LTC PACER Program Objectives and MPRO Compliance Plan

MDCH Requirement	MPRO Compliance Plan
Responsibility for the authorization process must be implemented by the first day of the contract.	MPRO is already in compliance with this requirement for the PACER authorization process. We currently have an operational PACER system that will be available on the first day of this contract. We will begin training and preparation for the long term care exception process immediately upon contract award. Our existing staff resources will meet the initial demand for LTC reviews until additional staff are hired and trained.
The authorization process will be continued through the contract termination date.	We recognize the importance of continuity and effective transition between vendors. We will operate the authorization process through the contract termination date and assist MDCH with any transitional activities.
The telephonic/computer system shall be available between the hours of 8:00 AM and 5:00 PM, Monday through Friday, except for State-approved holidays.	We will maintain constant accessibility of the telephone and computer system from 8:00 AM to 5:00 PM EST, Monday through Friday, except state approved/ sanctioned holidays. The performance of our computer and phone systems has been reliable with no downtime for the computer system in the past year, and no downtime for the new phone system since its installation four months ago. We are able to maintain this access due to back-up planning for both our computer and phone systems. Details of our system redundancy and disaster recovery plans are included in proposal section IV-C, Management Summary.
Providers will be notified thirty (30) days prior to an approved holiday.	Each year we obtain the list of State-approved holidays from MDCH and we will send a letter of notification to all of the hospitals operating in the State of Michigan that are affected by the PACER program. This notification will be sent in the month of December for all holidays scheduled for the following year, which exceeds the 30-day notification period required by MDCH. In addition to this annual mailing, our nurses provide verbal reminders during the review process two to five days prior to a scheduled holiday. We will also place reminders on our "on hold" messages for the 1-800 line.

MDCH Requirement	MPRO Compliance Plan
The contractor will be HIPAA compliant.	We are fully compliant with HIPAA regulations. Details of our HIPAA compliance related to transactions and security is included in proposal section IV-C, Management Summary.
The telephonic/computer system must be in place the first day of the contract.	Our telephone and computer systems are currently in place and will be fully operational on the first day of the contract, including any new requirements to accommodate the long term care reviews. Details on our new telephone system are included in proposal section IV-C, Management Summary. We have a mechanism in place for providers to initiate the PACER authorization process telephonically or electronically, by accessing the MDCH web-site.
The contractor must be available for the appeal process.	Our nurse reviewers and physician reviewers are located within the State of Michigan and are available to participate in the appeals process for our current Medicaid FFS Review contract. This availability will continue for the PACER and LTC exception appeals, starting October 1, 2004.
The Contractor must have a system or process in place that allows validation of the PACER authorizations, including: 1. Assigned PACER numbers 2. Documentation provided at the time of PACER request, including: ▪ Review Coordinator documentation ▪ Physician Reviewer documentation	MPRO currently has a PACER validation program in place for our Medicaid FFS review contract. For the new contract beginning on October 1, 2004 the PACER validations will take place through the inpatient audit program. We will validate each case selected for audit that has a PACER assigned. This process is described in Part II, Section G. We maintain all documentation provided at the time of the PACER including documentation made by the review coordinator and physician reviewer. The authorization information is stored using the assigned PACER number and can be easily accessed by the auditor during the PACER validation process.
A copy of the information received from the provider at the time of PACER authorization must be validated by the contractor. Information obtained during the review process must be stored electronically or via hard copy.	All approval documentation is stored for six years electronically, denials are stored both electronically and via hard copy for the same six-year period. This documentation is stored in our computer system and is available online for easy retrieval. Hard copy denials, reconsiderations and appeals are stored in our secured medical records room for one year and sent to a secure off-site storage facility for the remaining five years.

Supplemental Program Elements

In addition to the mandatory program elements, we have added several supplemental program components that enhance value to MDCH. Examples of program enhancements where we have made a significant impact include: confidential voice mail, informational calls, call screening, and criteria documentation.

Confidential Voice Mail

Through the use of our new telephone system, we have added a voice mail box feature for confidential messaging. This feature gives providers the option to leave a confidential voice mail message instead of waiting in a call queue. The review nurse retrieves the information on the voice mail box and promptly returns the call to the provider the same day.

We know that providers have time constraints and we have made enhancements to our process aimed at reducing the time commitment required to initiate and obtain a PACER authorization.

Informational Calls

We respond to approximately 700 in-bound provider phone calls per month that are purely informational. Upon receipt of these calls, our Registered Nurses provide education and instructions to the providers at no cost to MDCH.

Call Screening

We inquire and quickly determine the exact nature of the provider's request as a first priority when answering calls. This process was implemented to reduce unnecessary waiting by providers when their requested case does not require prior authorization.

Criteria Documentation

To support the timely and accurate validation and audit of authorizations, a field in our PACER software system was added by our Information Technology Resource Group.
The nurse-reviewer now documents the Intensity of Service and Severity of Illness codes assigned to each case in the added field as a process enhancement. This improved patient profile supports a more effective and efficient audit and PACER validation process.

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

During 2004, our registered nurses completed 10,385 PACER reviews and our physicians completed 2,721 PACER reviews for inpatient services. Approximately 94% of PACER authorization requests are approved. The PACER review process is conducted in accordance with the guidelines and time frames established by MDCH. Our process ensures the utmost confidentiality of beneficiary and provider information, assuring that no information is disclosed to outside parties without appropriate consent. This section describes our PACER review process and criteria that are used for PACER authorizations.

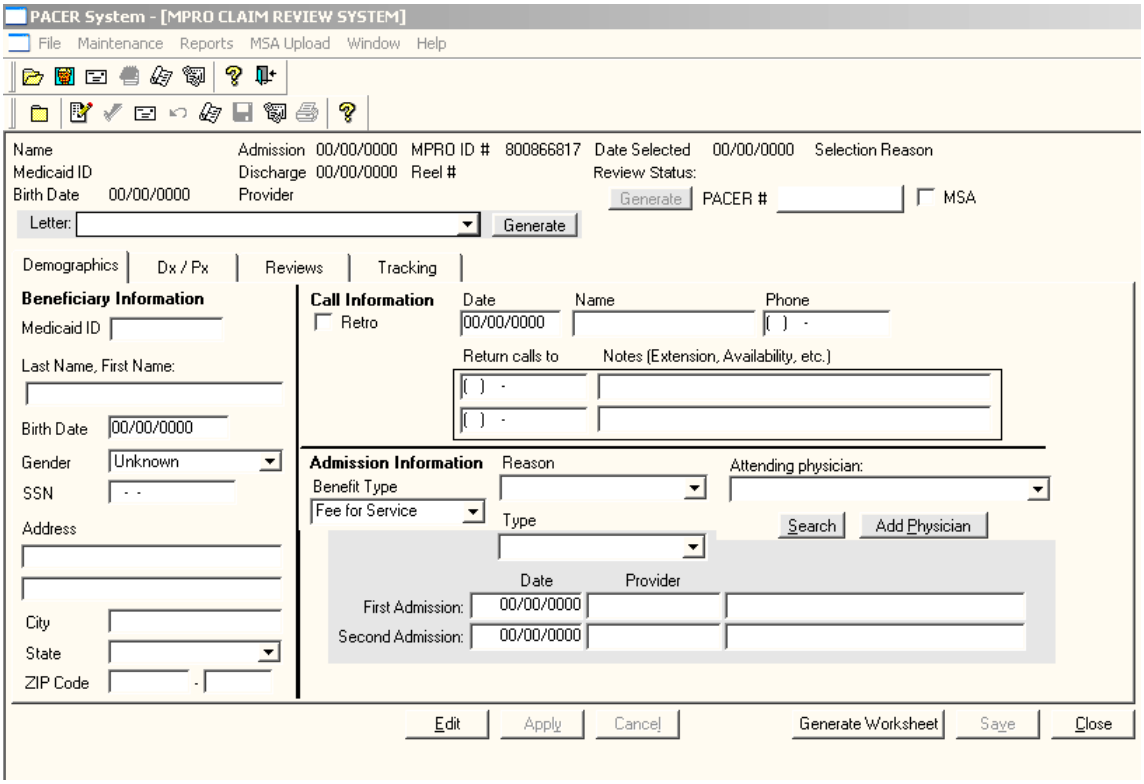
Our PACER process is compliant, timely and has been operating effectively for more than 16 years.

PACER Review Process

The review process begins when the attending provider or designated member of the provider's staff initiates a request for a PACER authorization via telephone or electronically through the MDCH website. Each PACER review is conducted by a review nurse who is licensed in the State of Michigan. Theses nurses are referred to as RN/PACER Review Coordinators (also known as review nurses). The RN/PACER Review Coordinators are experienced and cross-trained on all inpatient PACER review types. These qualifications ensure that they efficiently gather the necessary non-clinical and clinical information, refer to physician reviewers when appropriate, and accurately communicate authorization decisions to providers. At all times during the review process, patient confidentiality is maintained.

DOCUMENTATION OF NON-CLINICAL INFORMATION

The RN/PACER Review Coordinator collects and enters the beneficiary information, call information and admission information. This is entered on the 'Demographic' tab in our PACER computer system. The following screen print from our PACER system outlines the documentation format used by our review nurses.



The beneficiary information entered includes:

- Beneficiary ID number;
- Beneficiary name;
- Beneficiary birth date; and
- Beneficiary gender.

After entry of this information, the review nurse depresses the 'Enter' key and the current date is automatically populated. The call information and the admission data are then documented.

The call information entered includes:

- Caller's name; and
- Attending physician's phone number or other contact information.

The admission information entered includes:

- Reason for review (i.e. admission, readmission, transfer or continued rehabilitation stays at 30 days and 60 days);
- Attending physician's name;
- Benefit type (FFS or ABW);
- Admission type (elective, urgent/emergent, rehabilitation);
- First admission date;
- Provider Name/Medicaid ID number; and
- Second admission date for readmissions, or transfer date for transfers.

Other required demographic information is included in the free text portion of the review screen, including: county of residence, transfer code, discharge date of first admission and justification code. The review nurse then saves all recorded non-clinical information and starts the clinical documentation process.

TYPES OF REVIEW

The type of clinical documentation required varies based upon the type of PACER review that is being conducted. MPRO performs PACER authorizations for the following types of cases:

- All elective inpatient admissions;
- Transfers from acute facilities to rehabilitation facilities;
- Transfers from rehab/psych facilities to acute facilities;
- Transfers from one acute facility to another acute facility;
- Readmissions to the same hospital within 15 days;
- Readmissions to a different hospital within 15 days;
- Admission review for rehabilitation facilities;
- Continued stay reviews for rehabilitation admissions at 30 days; and
- Continued stay review for rehabilitation admissions at 60 days.

In order to establish and maintain credibility with providers, the PACER authorization process must use clearly defined criteria in a consistent manner. Although process requirements for each type of a review are similar, there are some important differences that the nurses and physician reviewers must be aware of. For this reason, we have created detailed flow charts for elective admissions, transfers, readmissions and continued stay reviews for rehabilitation facilities.

Flow charts for each of the four review types are included on the following pages.

Figure 6 - PACER Elective Admission Review Process

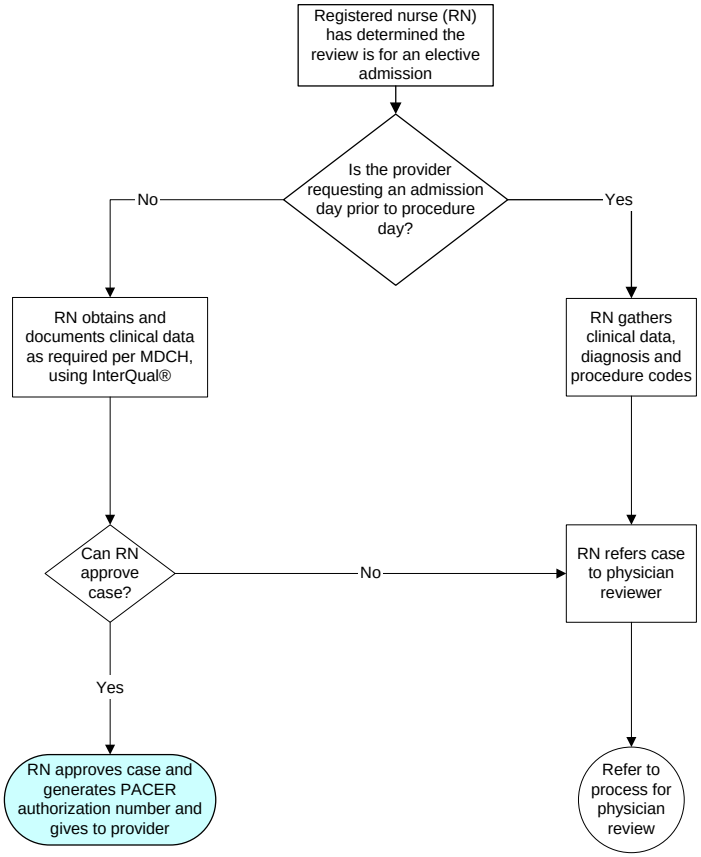


Figure 7 - PACER Readmission Review Process

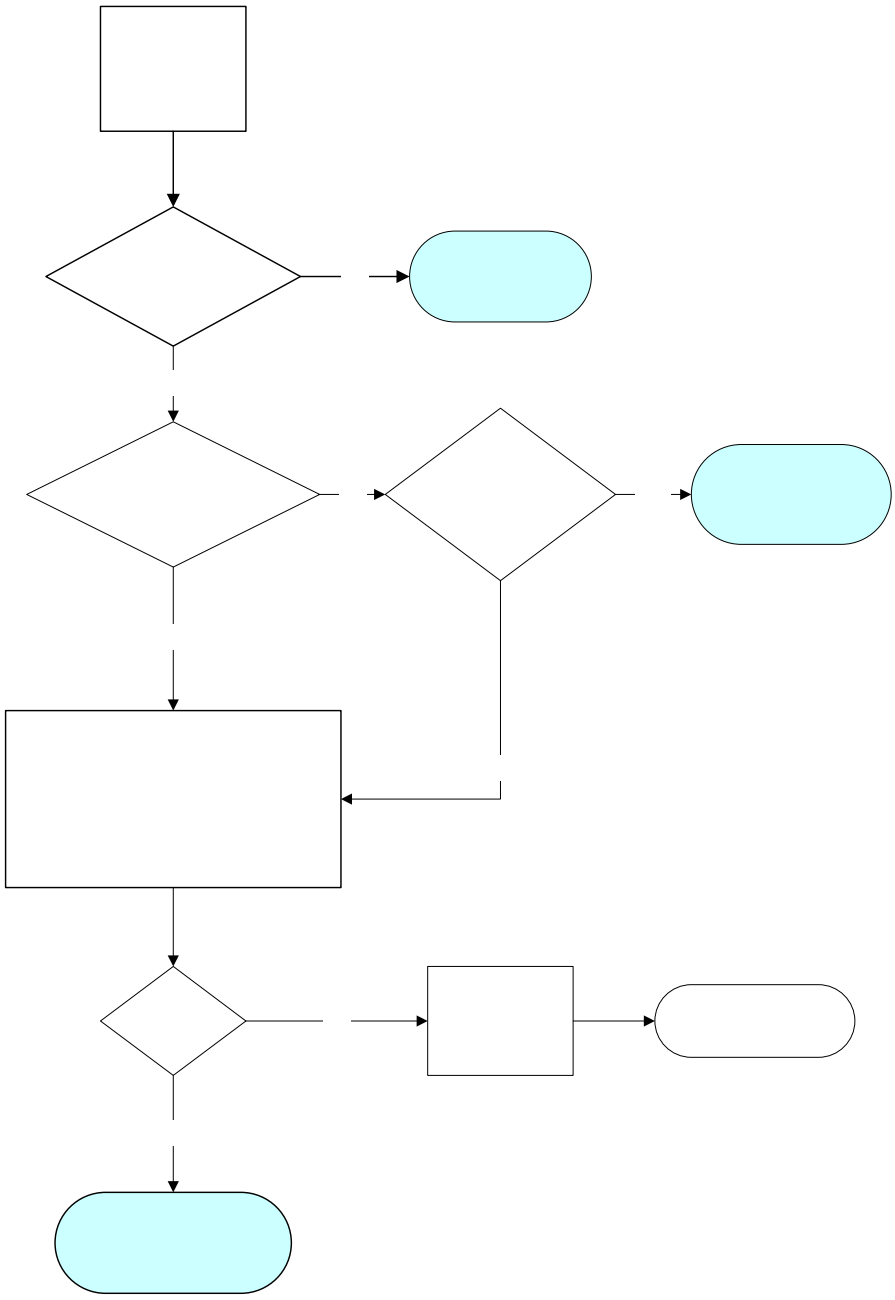


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Figure 8 - PACER Transfer Review Process

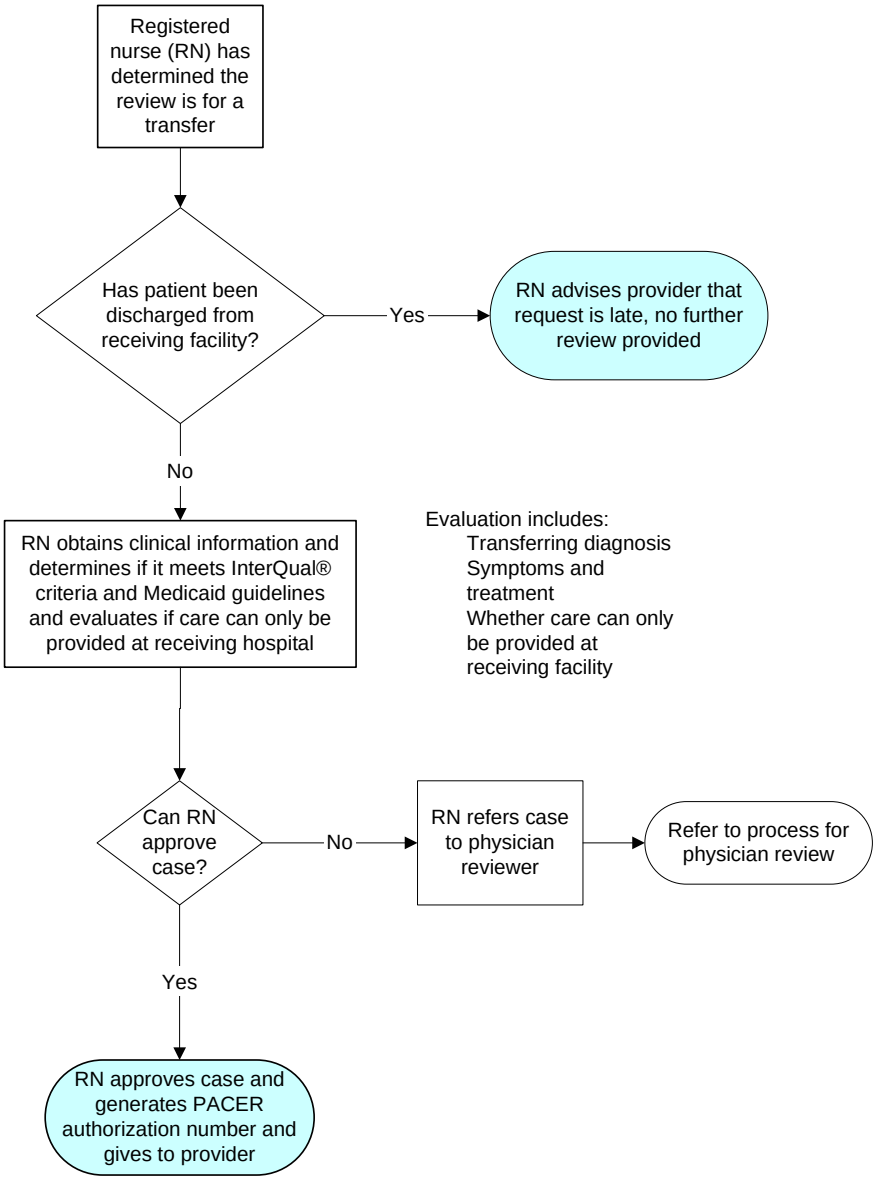
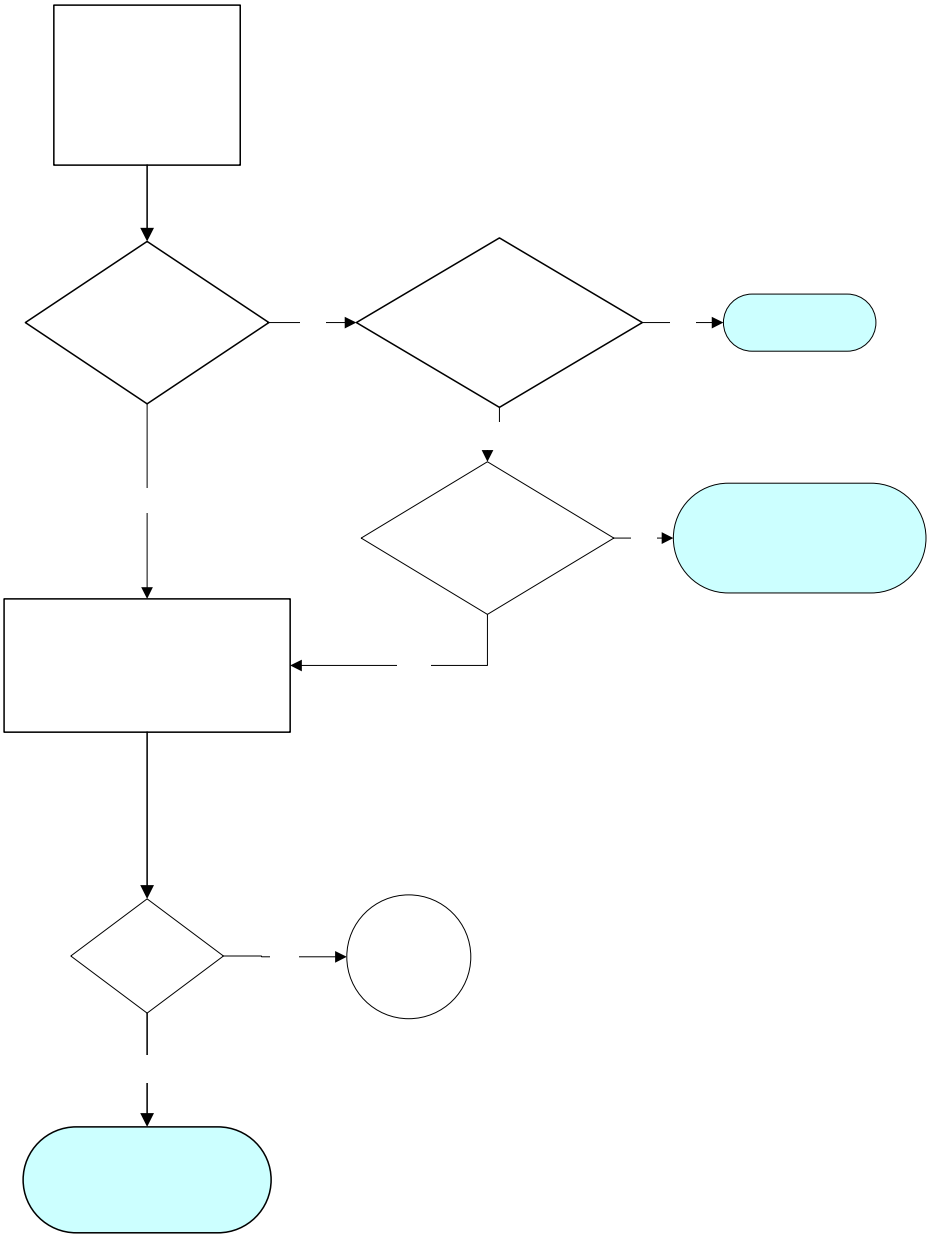
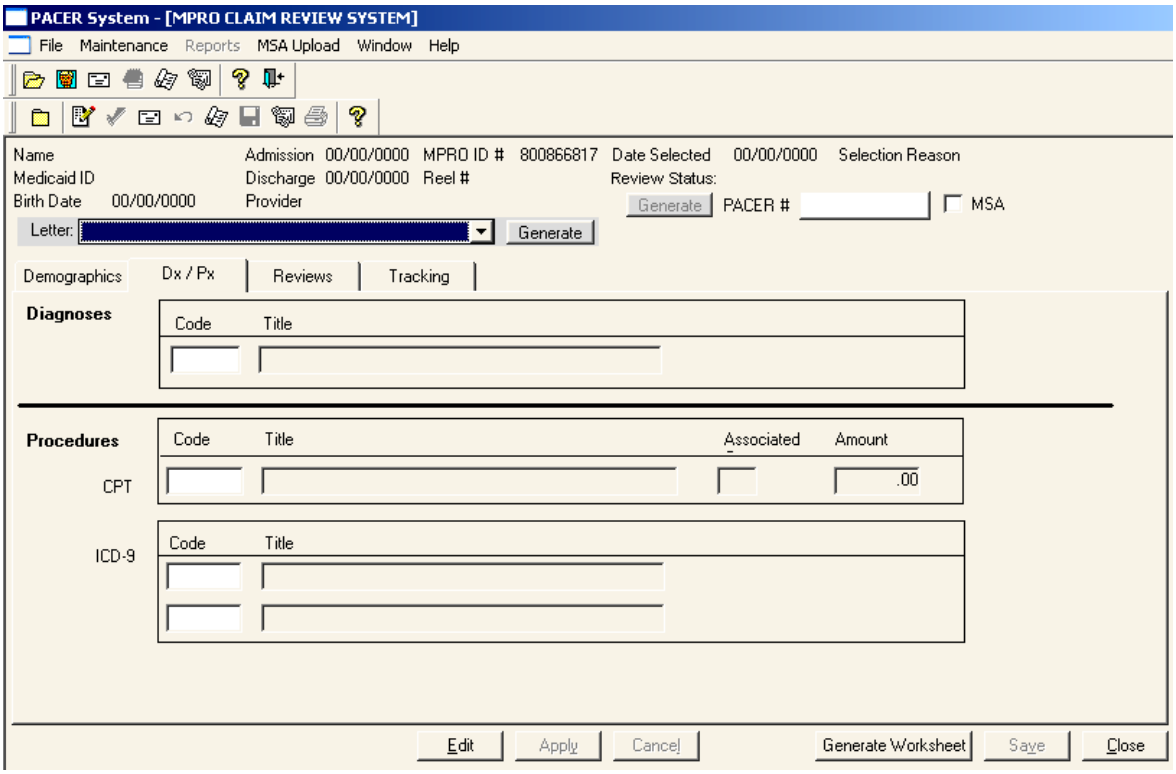


Figure 9- PACER Rehabilitation Continued Stay Review Process

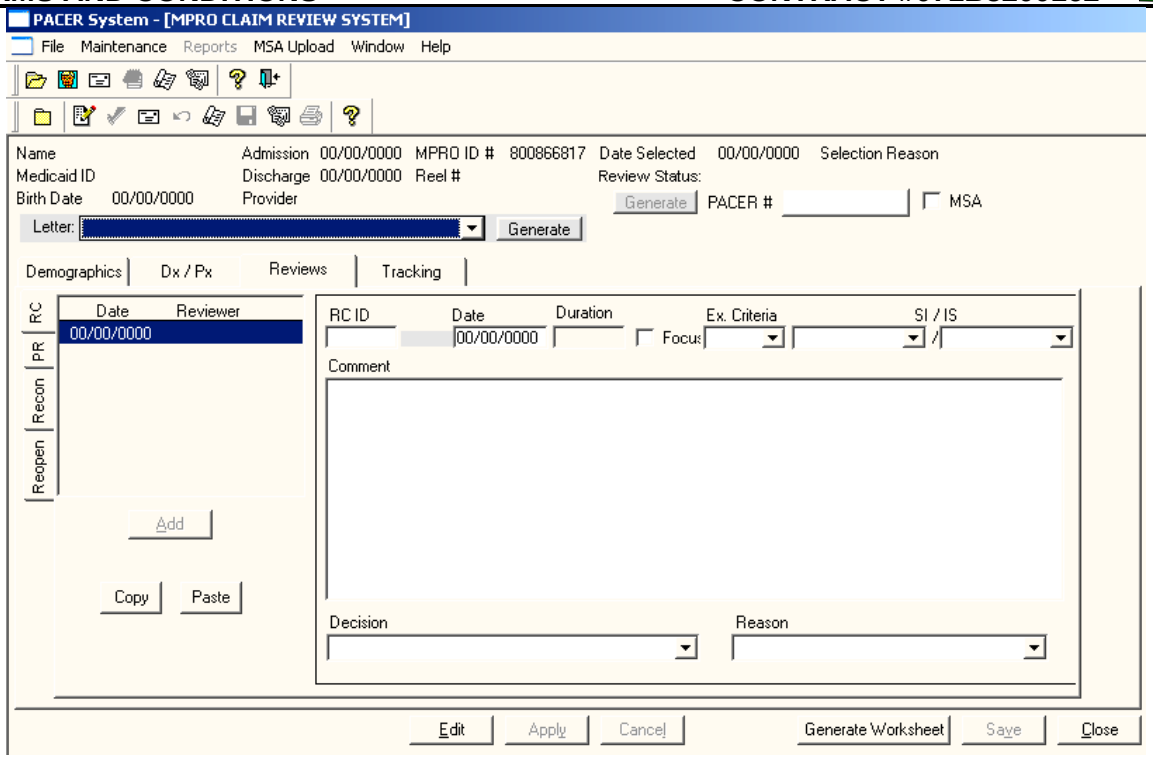


DOCUMENTATION OF CLINICAL INFORMATION

The RN/PACER Review Coordinator collects and enters the coding and clinical information regarding the case, depending upon which type of review is being conducted. This information is entered in the 'Coding' and 'Review Coordinator' tabs in our PACER system. The following screen print from the PACER System outlines the documentation format used by our review nurses for the coding screen.



The review nurse obtains the diagnosis and procedure code information from the provider caller and enters those data elements into the PACER system. The review nurse then advances to the 'Review' screen at the review coordinator level. The following screen print from the PACER system outlines the documentation format used by our review nurses for the 'Review Coordinator' screen.



Tabbing to the 'Comment' field, the review nurse enters all patient-specific clinical information in the free text area. Required clinical documentation includes, but is not limited to: relevant medical history, symptoms and reason for request. Based on this documentation, the review nurse evaluates the information against the appropriate InterQual® criteria set and determines the Severity of Illness and Intensity of Service (SI/IS) indicators. These indicators are entered into the SI/IS fields in the PACER system, according to InterQual® code structure as follows:

IS/SI ID	DESCRIPTION	IS/SI ID	DESCRIPTION
C-CV	Cardiac Critical	ID	Infectious Disease
C-MED	Medical Critical	NBN	Newborn (> 34 wks) Level 1
C-SRG	Surg/Trauma Intensive Care	NIC	Neonatal ICU Level 3
CNS-MS	CNS/Musculoskeletal	OB-ANT	OB-Antepartum
CV/PV	Cardiovascular/Peripheral Vascular	OB/GYN	Obstetrics/Gynecology/Genitourinary
END	Endocrine/Metabolic	PIC	Pediatric ICU
ENT	Eye, Ear, Nose, Throat	REHAB	REHAB
GI	Gastrointestinal/Biliary/Pancreatic	RSP	Respiratory/Chest
HEM/ON	Hematology/Oncology	SCN	Special Care Level 2
IC-CV	Cardiac/Telemetry Intermediate	SKIN	Skin/Connective Tissue
IC-M/S	Medical - Surgical Intermediate	SRG/TR	Surgery/Trauma
IC-PED	Pediatric Intermediate Care	TRNSPL	Transplant

PHYSICIAN REFERRAL AND REVIEW

If the review nurse cannot authorize the request because of an identified inconsistency with the InterQual® criteria, the request is referred to one of our physician reviewers.

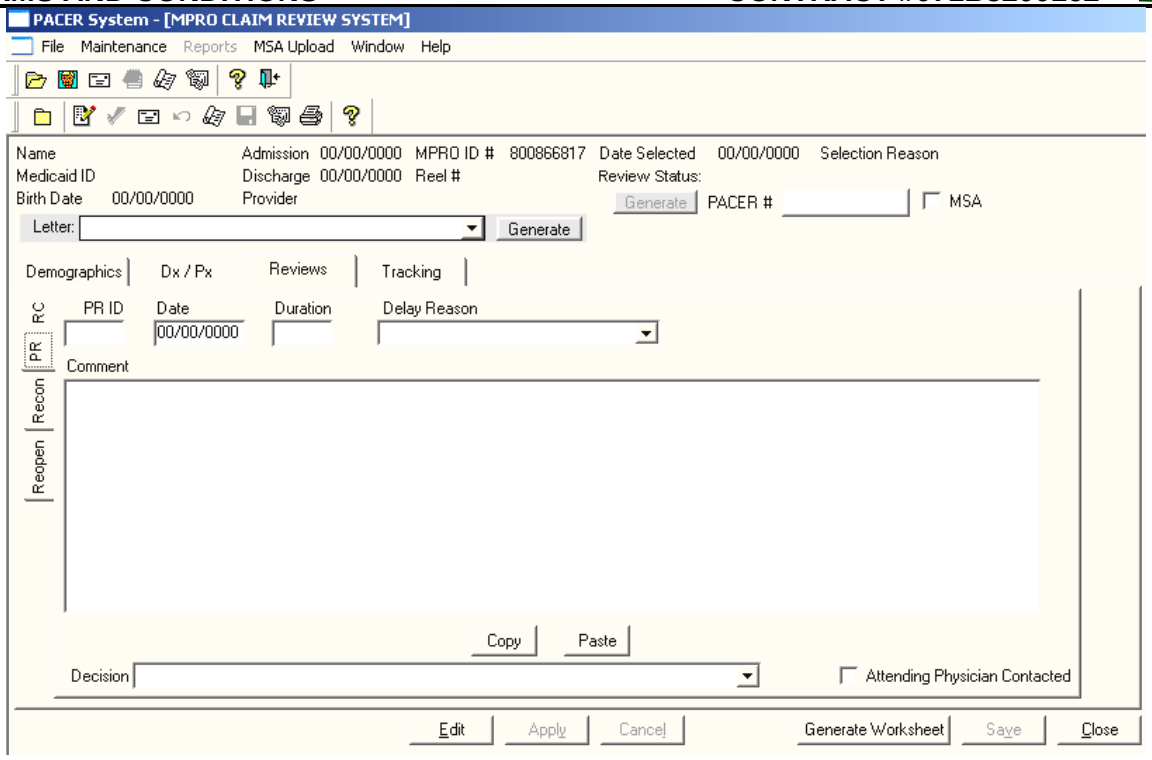
During FY 2004, 2,721 physician reviews were completed for PACER and 2,370 physician reviews were completed for the inpatient retrospective reviews. Our physician reviewers are board-certified in Michigan and are knowledgeable and experienced with the inpatient PACER process.

The review nurse notifies the provider that a physician review is needed and that we will finalize our decision within one business day. The review nurse prints a worksheet with all pertinent case information and delivers the worksheet to the physician reviewer's confidential mail area. Via telephone, the physician reviewer initiates contact with the attending physician to discuss the specifics of the case. If the attending physician is not available for this discussion, the physician reviewer makes two follow-up calls within the same day to provide additional opportunities for the attending physician to provide patient-specific clinical information that is relevant to the authorization.

The physician reviewer uses clinical knowledge and judgment, knowledge of state and federal regulations, and any additional clinical information obtained from discussions with the attending physician, to determine if the proposed care is within the definition of current standards of care and is appropriate for Medicaid coverage. If the physician reviewer was unable to reach the attending physician during the required review completion time frame, the physician reviewer will make a determination based on the information available.

At the completion of the physician review process, the review nurse will update the computer system by accessing the 'Physician Review' tab. Required fields on this screen include the physician reviewer's ID number and date, which is auto-populated by the system. The review nurse enters the physician's written comments documenting any discussions with the attending physician.

The following screen print from the PACER system outlines the documentation format used by our review nurses for the physician review screen.



RENDER AND COMMUNICATE DECISION

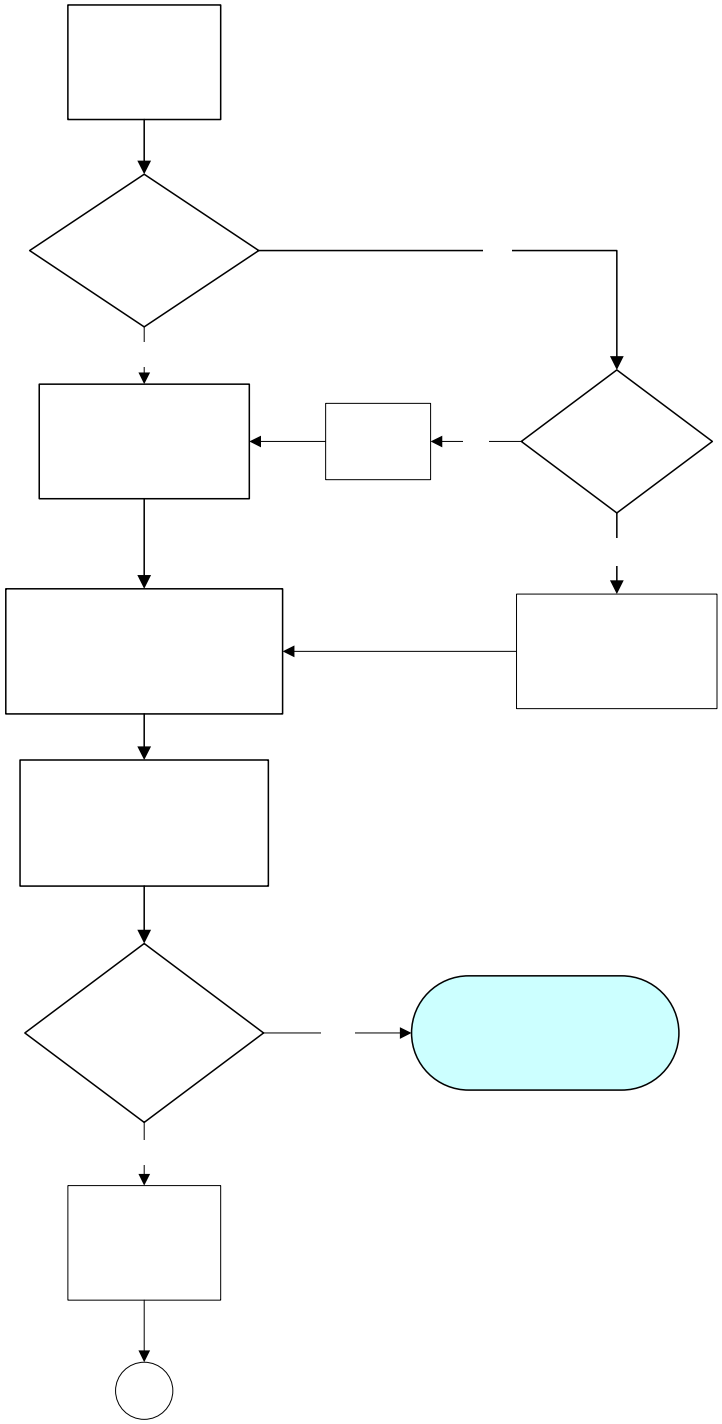
Once the review nurse and/or physician reviewer have completed their clinical evaluation and rendered an approval or denial decision, that determination is entered into the computer system. All decisions are made within one day of the request. The review nurse communicates the decision to the requesting provider, along with the unique identifying authorization number.

When the PACER review is approved, an authorization number is generated by the PACER system, consistent with the MDCH payment system requirements. In the event of computer downtime, the review nurse can also manually assign the number. The authorization number is communicated to the provider via phone during the same day as the request.

When the PACER review is denied by the physician reviewer, the review nurse enters the denial into the PACER system and notifies the provider via telephone of the decision and the opportunity to request a reconsideration. The review nurse documents the conversation with the provider by recording the provider name, date and time of notification. In addition, a negative action letter using the appropriate denial statement and a copy of the MDCH appeal form are sent to the beneficiary. All denials are sent to MDCH, along with a copy of each negative action letter. All letters and forms are approved by MDCH and compliant with the content and time frames required by the State.

Flow charts of the PACER telephonic and electronic authorization process are included in the following pages.

Figure 10 - PACER Authorization Process



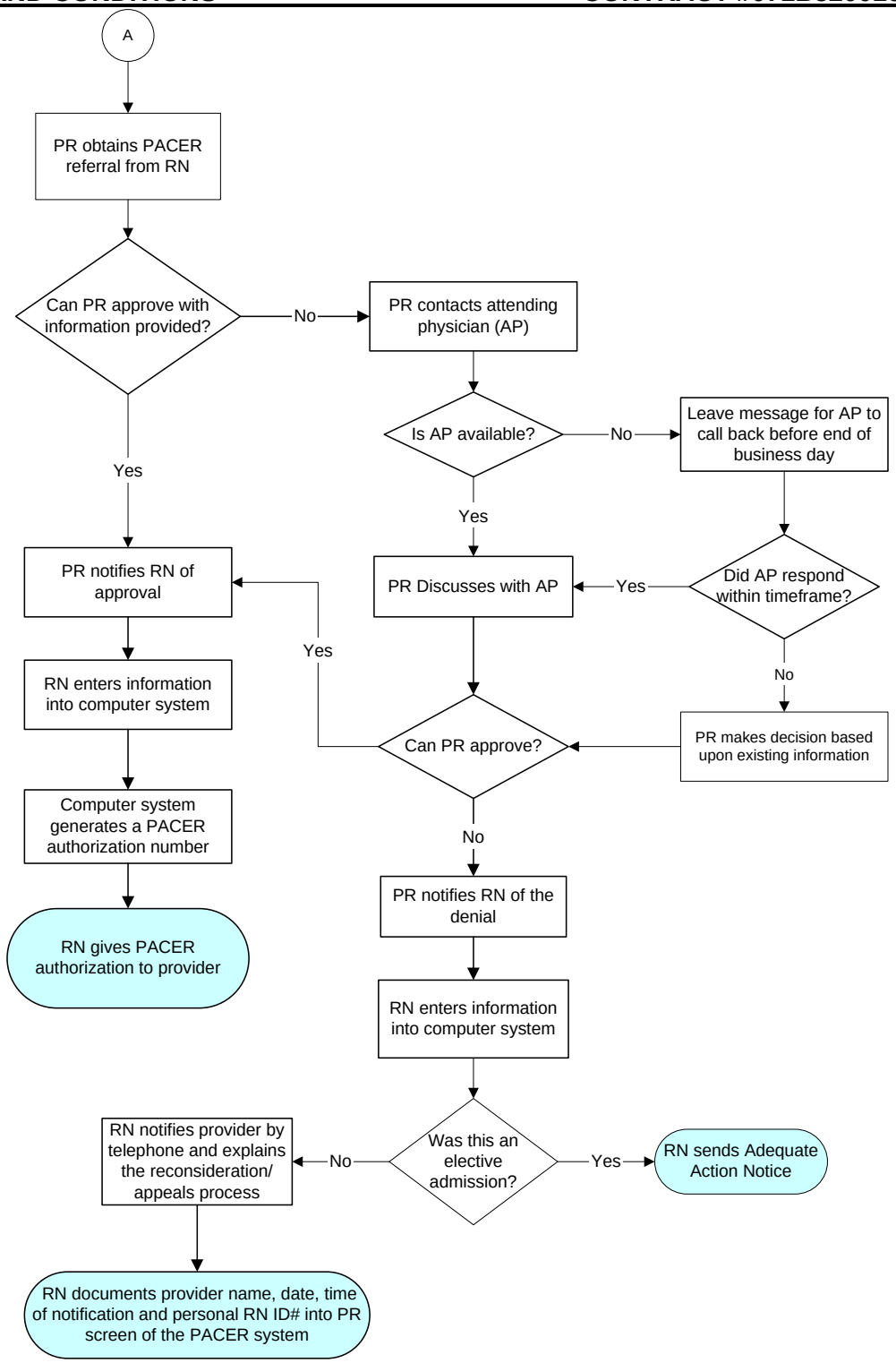
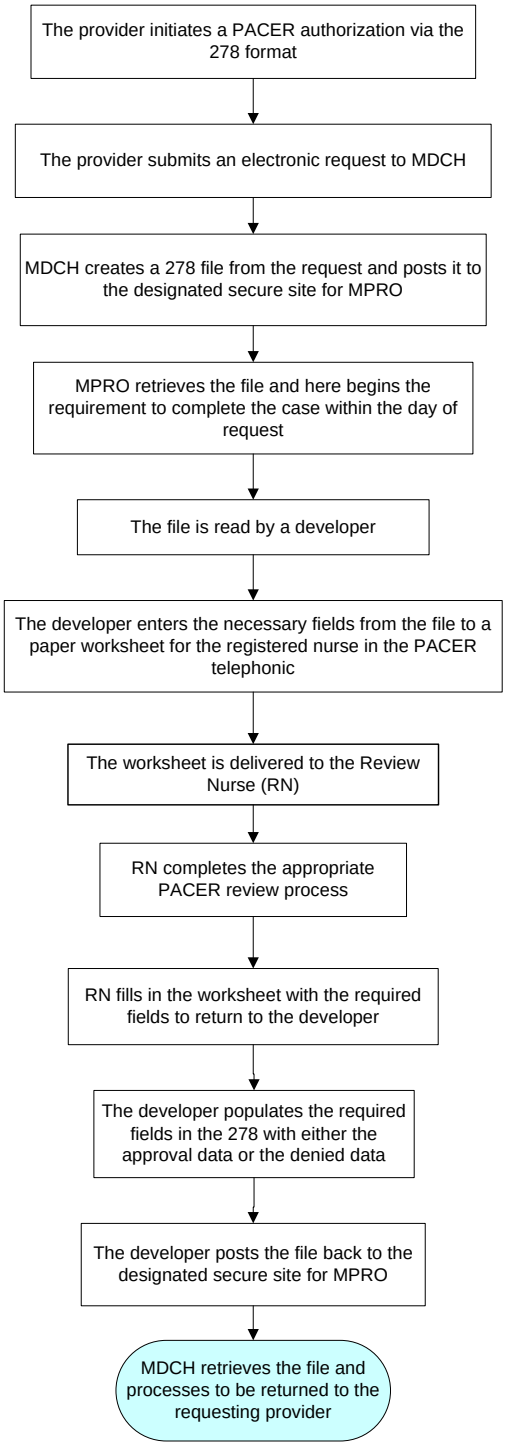

A
PR obtains PACER referral from RN
Can PR approve with information provided?
No
PR contacts attending physician (AP)
Is AP available?
No
Leave message for AP to call back before end of business day
Yes
Yes
PR notifies RN of approval
PR Discusses with AP
Yes
Did AP respond within timeframe?
Yes
No
RN enters information into computer system
Can PR approve?
PR makes decision based upon existing information
Computer system generates a PACER authorization number
No
RN gives PACER authorization to provider
PR notifies RN of the denial
RN enters information into computer system
RN notifies provider by telephone and explains the reconsideration/ appeals process
No
Was this an elective admission?
Yes
RN sends Adequate Action Notice
RN documents provider name, date, time of notification and personal RN ID# into PR screen of the PACER system

Figure 11 - Electronic PACER Process



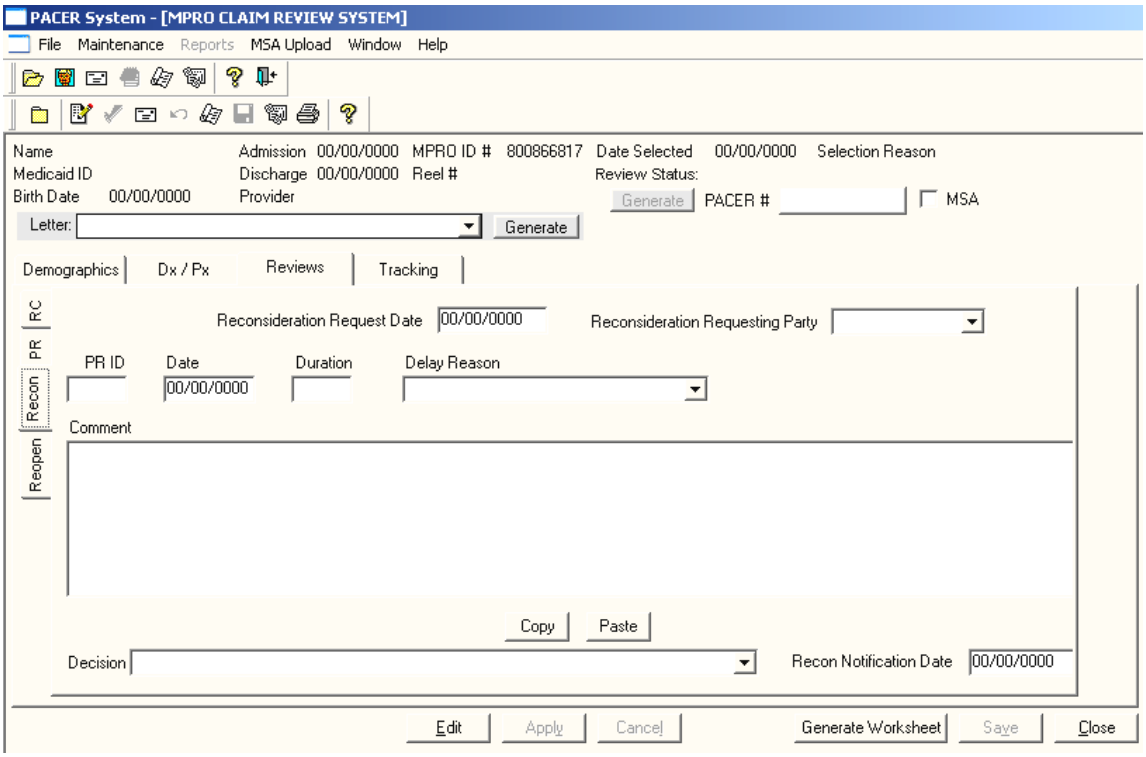
Note: Reviews are processes as outlined in the telephonic PACER authorization process.

Reconsideration Process

Our review nurse communicates the availability of a reconsideration to the provider at the time of a PACER denial. The provider has one day to submit a reconsideration request. This request can be submitted telephonically, or the provider can download a reconsideration form off of MPRO's website and fax it to MPRO. If the provider submits a request for reconsideration within one working day, the nurse reviewer will assign the case to a "like" (i.e., same specialty) specialty physician from our extensive, state-wide physician panel. The assigned physician will have no prior involvement with the case. The review nurse will include any additional documentation or medical record content with the case to be reviewed. The physician reviewer assigned to the reconsideration will consider all available information when determining the final disposition of the PACER authorization.

Reconsiderations are sent to a like specialty physician from our extensive, statewide physician panel.

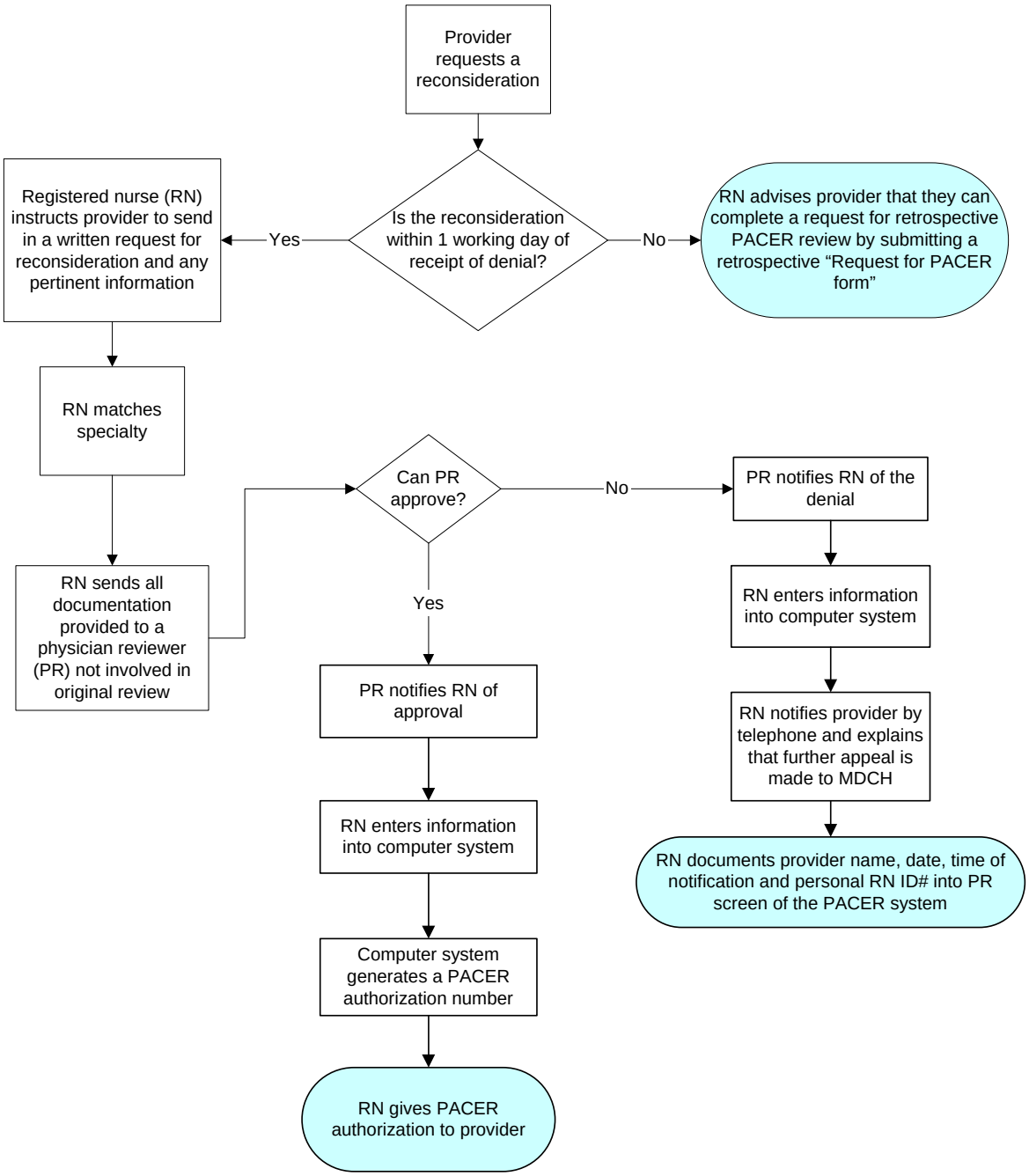
At the completion of the physician review process, the nurse will update the computer system by accessing the 'Recon' tab. Required fields on this screen include the reviewer's ID number and the review date, which is auto-populated by the system. The nurse-reviewer will enter the physician's written comments documenting any discussions with the attending physician. The following screen print from the PACER system outlines the documentation format used by our review nurses for the physician review screen.



MDCH requires that all reconsiderations are processed within 30 days. In FY 2004, we completed 166 PACER reconsiderations. The average time to process a reconsideration was 1.54 days, which significantly exceeds MDCH's performance standard. MPRO strives to complete all reconsideration requests in less than three days.

A summary of the reconsideration process is provided in the following flow chart.

Figure 12 - PACER Reconsideration Process



Other Required PACER Elements

This section summarizes other requirements for the PACER authorization process that are included in the RFP. This section will outline MPRO's compliance with each requirement.

CONFIDENTIALITY

A key component of the review process is protecting the confidentiality of the health information that is shared during the review process. Our review staff is guided by MPRO's Confidentiality Policy, which delineates the circumstances, requirements and limitations regarding access and disclosure of protected health information, assuring the security and confidentiality of all information under MPRO's control. Specific assurances regarding confidentiality include, but are not limited to the following:

- Nurse reviewers obtain clinical information during telephone calls from providers, but do not provide any information to providers;
- All case files will be maintained in locked storage areas inside secure office space and released in accordance with applicable regulations;
- All medical information will be transported and disposed of properly, in accordance with contractual obligations and applicable regulations;
- Only authorized MPRO employees and subcontractors who require the information to complete the proposed scope of work will have access to medical records and information;
- Only authorized support personnel will file or purge medical records;
- Employees are prohibited from discussing protected health information in public places;
- All systems are password protected and secured with multiple levels of access restrictions; and
- Our offices are located in a secure, locked facility that is accessible only by card key.

Additional information about MPRO's confidentiality policies and procedures is included in Section IV-C, Management Summary.

DATA PROCESSING STORAGE AND RETRIEVAL

All approval documentation is stored for six years electronically; denials are stored both electronically and via hard copy for the same six-year period. This documentation is stored in our computer system and is available online for easy retrieval. Hard copy denials, reconsiderations and appeals are stored in a locked file cabinet for one year and sent to a secure, locked, offsite storage facility for the remaining five years.

TELEPHONE AND COMPUTER SYSTEM

MPRO maintains a dedicated 1-800 phone line, and our sophisticated telephone system is familiar to the provider community in Michigan. We will maintain an average speed of answer of 90 seconds or less. Providers can request a PACER authorization number via this telephone system or electronically via MDCH's web-based application. More details on our supporting phone and computer systems are included in Section IV-C Management Summary.

ELECTRONIC NOTIFICATION TO MDCH

Decisions are transmitted electronically on a daily basis to MDCH for payment to be made to the provider. Data transmissions are HIPAA compliant to assure confidentiality. The nine-digit prior authorization number is compliant with MDCH's computer system.

PRIOR AUTHORIZATION NUMBER

The PACER system automatically generates the authorization number. The first four digits are the Julian date; and the last five digits are the beneficiary's ID coded into the prior authorization master report numbers by formula. The ID number is entered into the system at the time of PACER initiation as supplied by the provider. The listing for the prior authorization master report numbers are obtained from MDCH.

PRIOR AUTHORIZATION SYSTEM

Our software is compatible with MDCH's system and we have been transmitting data in a compatible format throughout the term of our current Fee-For-Service Review contract. We will make available or develop software to remain compatible should MDCH design a different electronic authorization system.

MDCH ACCESS TO OUR PACER SYSTEM

MDCH currently has access to our PACER system via a laptop dial-up connection. This capability is discussed in Section IV-C Management Summary.

DEDICATED STAFF

We currently employ a dedicated staff for the Medicaid FFS review contract. All review nurses are registered nurses and are credentialed by MPRO and licensed in the state of Michigan. We anticipate an expansion of the current staff by one full-time registered nurse to address the long term care exception reviews. More information on the staff experience and credentials is included in Part I, Section J of this proposal and in Appendices G and H.

D. NOTICE OF NON-COVERAGE EXCEPTION

Whenever a hospital or long-term care facility issues a notice of non-coverage letter for an admission or continued stay, the beneficiary or their representative may contact us to appeal the decision. We have been processing and responding to beneficiary appeals of hospital-issued notices of non-coverage as a part of our Medicare contract for more than 20 years. In addition, we currently perform this service for our Medicaid Fee-For-Service Review contract. Timeliness and consistency are critical elements of this review process. This section will describe our long-standing process for hospital-issued notices of non-coverage.

Appeals related to hospital-issued notices of non-coverage will be delivered to the Senior Medical Review Manager for assignment. Appeals related to inpatient hospital admissions/continued stays will be assigned to an RN/PACER Review Coordinator. Appeals related to a long-term care admission or continued stay will be assigned to the RN/Long Term Care Exception Coordinator for processing.

The assigned review nurse will search our PACER system and/or the web-based tool to determine if there has been any previous determination by us related to the case. If MPRO has made a prior adverse determination regarding the hospital or long term care admission, then no further review will be conducted. The review nurse will notify the beneficiary/representative that we are in agreement with the hospital or long term care facility's determination.

If the review nurse discovers that there has been no previous determination by MPRO related to the case, he or she will contact the hospital or long term care facility to request a copy of the medical record. Once the record is obtained, the review nurse will coordinate with a physician reviewer who will review the records and make a decision on the case within three days of receipt of the medical records. Once a decision has been made, the review nurse will contact the provider and the beneficiary by telephone to inform them of the outcome.

It is the responsibility of the hospital or long-term care facility's utilization review committee to decide whether to issue the notice of non-coverage based upon its internal process.

If we uphold the decision of the hospital or long-term care facility, the beneficiary may appeal the decision by requesting an administrative hearing. The Administrative Tribunal has the responsibility for coordinating administrative hearings related to decisions made by MDCH or its contracted agencies, such as MPRO. The final outcome of the administrative hearing will be binding on all parties. Our Review nurse reviewer will assist with preparation and participate in any administrative hearings related to the case, as requested by MDCH.

E. LONG TERM CARE EXCEPTION REQUIREMENTS

Effective October 1, 2004, MDCH is implementing a new policy and process related to level of care determinations for long term care facilities. The long term care exception review process is one component of this new approach to long-term care determinations. This service represents an addition to our current Fee-For-Service Review contract with the state of Michigan; however, we are well-equipped to implement it within the RFP's short time frame. Through our work as a QIO for the Medicare program, we have developed significant staff expertise in nursing facility care and we have board-certified physicians on our team with expertise in long-term care. This section will describe the requirements for conducting long-term care exception reviews.

We have reviewed the Notice of Proposed Policy, 0420-NF, that has a proposed effective date of October 1, 2004. This policy defines the process for obtaining a level of care determination through a web-based tool that has been developed by MDCH. Under this policy, all Medicaid beneficiaries that reside in a nursing facility on October 1, 2004, must undergo the evaluation process by the date of their annual recertification. The policy also allows for a level of care exception to be requested when a beneficiary demonstrates a significant level of long-term care needs, but does not meet the Michigan Medicaid Nursing Facility Level of Care criteria.

Under this contract, we will act as MDCH's designee to review the requests for exceptions to the nursing facility level of care determinations for the following populations:

- Medicaid Covered Nursing Facility Care;
- Michigan Choice Home and Community Based Waiver Program for Elderly and Disabled; and
- Program for All-Inclusive Care for the Elderly.

Long Term Care Exception Criteria

We will perform these reviews through a review of relevant clinical information based upon the exception criteria determined by MDCH. The following is a summary of the current proposed exception criteria from the MDCH proposed policy:

Frailty

The beneficiary has a significant level of frailty as demonstrated by at least one of the following categories:

- Applicant demonstrates late loss Activities of Daily Living (ADLs) (i.e. bed mobility, toileting, transferring, and eating); Applicant performs ADLs independently, but requires an unreasonable amount of time;
- Applicant's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity;
- Applicant has experienced at least two falls in the home in the past month;
- Applicant continues to have difficulties managing medications despite the receipt of medication set-up services;
- Applicant exhibits evidence of poor nutrition, such as continued weight loss, despite the receipt of meal preparation services; and
- Applicant meets criteria for Door 3 when emergency room visits for clearly unstable conditions are considered.

Behaviors

The beneficiary has at least a one month history of any of the following behaviors, and has exhibited two or more of these behaviors in the past seven days:

- Wandering,
- Verbal or physical abuse,
- Socially inappropriate behavior; or
- Resists care.

Treatments

The beneficiary has demonstrated a need for complex treatments or nursing care.

In addition to the exception criteria designed by MDCH, our long term care reviewers also have the ability to approve a case based upon professional judgment. The review nurse will consult with a physician reviewer before making a final determination based upon professional judgment. Approvals will be based upon the beneficiary's established risk of institutionalization.

MPRO Compliance with LTC Exception Requirements

The following table outlines MDCH's requirements for the long-term care exception reviews and our compliance plan.

Table 3 - Long Term Care Exception Process Requirements and MPRO Compliance Plan

MDCH Long-Term Care Exception Requirements	MPRO Compliance Plan
Telephonic requests will be reviewed in real time.	Our existing phone system has the capacity to serve the additional incoming long-term care exception calls. It is available immediately upon contract start-up.
Nurse-reviewers will use specific MDCH-developed exception criteria to determine appropriate exceptions to the nursing facility level of care criteria.	MPRO has reviewed the proposed exception criteria in the Notice of Proposed Policy 0420-NF issued by MDCH. Our understanding of the proposed criteria has been described in detail within this section of the proposal. Upon contract award, we will immediately train and prepare our staff to perform these reviews.
Approvals will be documented within the Web-based tool, citing the exception criteria used.	We will work with MDCH to gain appropriate access to the Web-based tool for performing reviews and documentation of findings. Each Long Term Care Review Coordinator will have access to the Web-based tool at their desktop for data entry.
Beneficiaries and providers will be given appropriate denial notification as outlined in Part I, Section G – Appeals.	We are currently in compliance for all notices to beneficiaries and providers under our current Fee-For-Service Review contract. We will train the Long Term Care Exception Coordinator in the process for sending denial notifications and will use the sample letters provided by MDCH in the RFP.
Contractor will represent MDCH in any administrative appeals.	We currently represent MDCH in appeals related to the PACER program and retrospective reviews. The nurse and physicians participating in the long term care exception process will be available to provide documentation and to participate in any required appeal hearings.

MPRO has developed a detailed process to support the requirements of the long term care exception review process. The process is described in detail in Part I, Section F.

F. Long Term Care Exception Process

MDCH has outlined the general process for conducting long term care exception reviews in the RFP. Our experience in PACER reviews will translate easily into the long term care exception review process. There are several key differences between the PACER authorization process and the long term care exception process.

First, the PACER reviews represent a first-line review process, whereas the long term care exceptions take place after the beneficiary has already been denied through MDCH's Web-based process. Second, the PACER reviews are conducted using MPRO's proprietary software program, while the long term care exception reviews are conducted in MDCH's Web-based tool. Finally, the two review processes use different criteria. This section will describe the components of the long term care exception review process.

Telephonic Request

The first step in the long term care exception review process is a phone contact from the provider to initiate the review. Providers will call the same 1-800 number that they call for PACER authorizations. The hours of operation for the phone lines will be the same as the PACER review program: 8:00 a.m. to 5:00 p.m.

Nurse Review

Our designated RN/Long Term Care Exception Coordinator will look up the case in the web-based tool and review the information provided in the initial review. She will then obtain additional information from the provider related to the long term care exception criteria in the areas of frailty, behaviors and treatment. If the provider offers information that meets the exception criteria, then the RN/Long Term Care Exception Coordinator will authorize the nursing home level of care and enter the information into the Web-based tool. The RN/Long Term Care Exception Coordinator will also enter the exception criteria upon which the approval was based.

Denial Notices

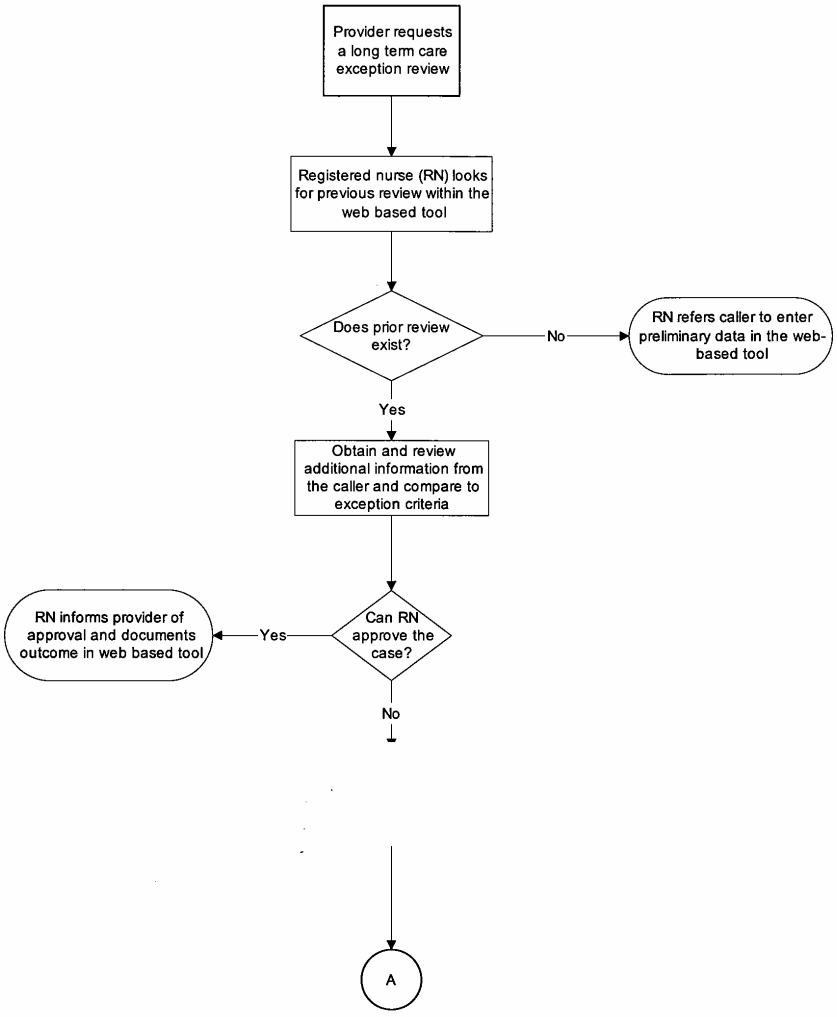
In cases where our review staff is recommending that a beneficiary does not meet the level of care exception criteria for admission to a nursing facility or the PACE program, we will send the appropriate negative action letter to the beneficiary, along with a description of their appeal rights. We will also advise the provider via telephone of the reconsideration process and the time frames for submission.

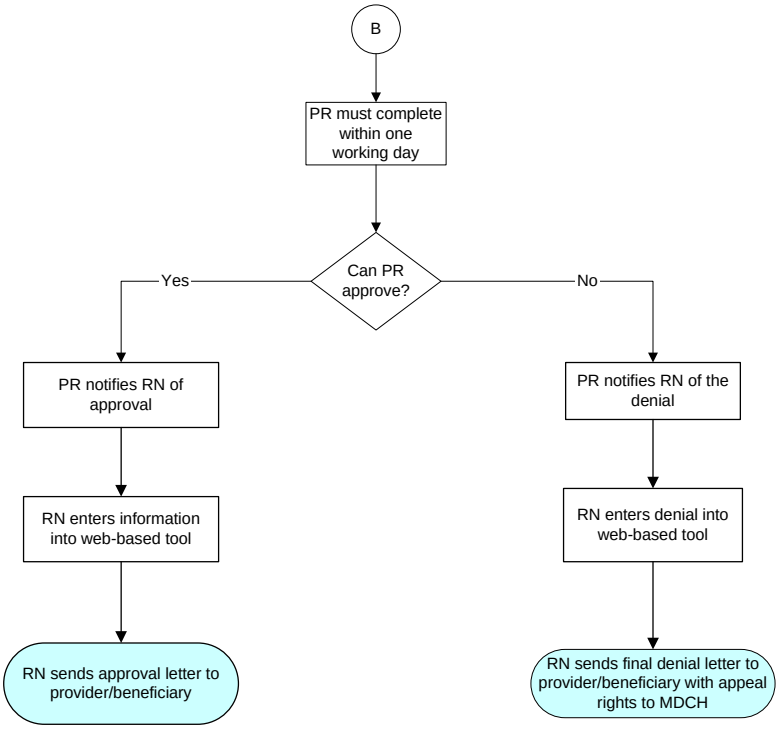
Report Findings

On a monthly basis, the Senior Medical Review Manager will send an electronic list of all approvals and denial recommendations to the MDCH Contract Manager. This list includes any cases that have been fully processed and for which the time frame to request a reconsideration has passed. Cases that have been recommended for denial, but are still in the reconsideration process will be included in the following month's report.

A flow chart of the long term care exception review process is included on the following pages.

Figure 13 - Long Term Care Exception Review Process




B
PR must complete within one working day
Can PR approve?
Yes
No
PR notifies RN of approval
RN enters information into web-based tool
RN sends approval letter to provider/beneficiary
PR notifies RN of the denial
RN enters denial into web-based tool
RN sends final denial letter to provider/beneficiary with appeal rights to MDCH

G. Appeals Process

We are experienced in the timely and accurate disposition of provider and beneficiary appeals through our current scope for the Medicaid Fee-For-Service Review contract, as well as our ongoing Medicare contract. We have enhanced our reconsideration and appeals process to incorporate the new program requirements dictated in the RFP. Our staff members are well-versed in the Medicaid requirements and are experienced in providing documentation to support each determination that is made. MPRO has adequate staff to manage the PACER appeals, including the addition of long term care appeals. MPRO is aware of the time constraints and is determined to meet or exceed them. We frequently participate in administrative hearings for MDCH as well as other customers and are highly skilled at providing expert testimony. This section will outline our process to comply with the appeals requirements.

PACER Appeals

When our staff members make a determination that denies, reduces or terminates services, and all internal appeal/reconsideration opportunities have been exhausted, we inform the beneficiary, in writing, of their appeal rights. We include copies of applicable forms for filing an appeal with the Administrative Tribunal at MDCH. The provider may also request an appeal to MDCH. The provider appeal process begins at the bureau conference level and continues through the Administrative Law Judge level, if the provider is dissatisfied with the decision.

We also provide the nurse and physician-reviewer involved in the case as expert testimony at all hearings. These staff members carefully review their findings, gather documentation and go over testimony in preparation for the hearing. Our staff routinely provide historical context to the MDCH staff attorney and the state appeals officer assigned to the case to prepare him/her for participation in the hearing.

Long Term Care Appeals

The long term care appeals process is available to both providers and beneficiaries. There are several components to the process, beginning with a reconsideration by us, prior to a formal appeal filed with the State. This section will outline our approach for the internal reconsideration process and responding to appeals that are filed with MDCH for both providers and beneficiaries. The following table defines the general process for long term care appeals and highlights differences among provider and beneficiary appeals.

Table 4 - Long Term Care Appeal Process Features

Process Features	Provider Appeals	Beneficiary Appeals
Reconsideration process	Review by a second physician not involved in the initial determination	Review by a second physician not involved in the initial determination
Time frame to request reconsideration	Within three working days of receipt of the initial denial	Not specified in the RFP
Time frame for us to process reconsideration	We will notify the provider of the reconsideration decision within one working day of receipt of the reconsideration request	Within three working days if the beneficiary is in the facility. Within 30 working days if the beneficiary has been discharged from the facility
Appeal to the state	Through the Medicaid Provider Reviews and Hearings Administrative Rules	Appeals are made directly to MDCH using the appeal form (DCH-092, Hearing Request) provided by us the day of the negative action
Time frame to appeal to the State	Within three working days of receipt of the final denial from MPRO	Within 90 days of the adequate action notice

The key to an effective reconsideration and appeals process is communication regarding the status of the case and the remedies that are available. Our approach includes written and/or verbal communication at the time the initial determination is made. We will explain the conditions under which the nursing facility or PACE program level of care was denied and the opportunity for a reconsideration through MPRO's internal process.

Upon completion of our internal reconsideration process, the provider or beneficiary will be notified of their right to file and appeal at the state, and will be provided with the appropriate forms and process for doing so.

PROVIDER APPEALS PROCESS

Whenever we recommend that an inpatient or long-term care facility stay be denied and payment recovered by MDCH, the provider will have an opportunity to request reconsideration. We have a team of physicians with expertise in long-term care available to review reconsideration requests. Because our policy is to always have a physician review the initial denial, the reconsideration will be processed by a second physician who was not involved in the initial determination.

All reconsiderations will be submitted to the RN/LTC Exception Coordinator who processed the initial determination. The case will be reviewed by the second physician independently against the level of care criteria. The physician will not have access to the notes or documentation of the first physician until after he has made a preliminary assessment of the case. The second physician will document his decision and will send the case back to the RN/LTC Exception Coordinator for processing.

If the case is approved, then the RN/LTC Exception Coordinator will notify the provider and the beneficiary of the decision and will submit the case to MDCH as approved. If the case is denied, then the RN/LTC Exception Coordinator will send the appropriate notice to the provider and beneficiary. The reconsideration process will be completed within one working day.

If the provider is not satisfied with our final determination, then they may request an appeal to MDCH. If such an appeal occurs, we will provide Registered Nurses and physician-reviewers involved in the initial determination to assist MDCH with preparation for the hearing and provide expert testimony.

BENEFICIARY APPEALS PROCESS

The beneficiary appeals process will operate in a similar manner as the provider appeals process described above. If the beneficiary is in the facility when the reconsideration is requested, then we will process the case within three working days. If the beneficiary has already been discharged from the facility when the reconsideration is filed, then we will process the case in up to 30 working days. If the case is upheld upon review, then the beneficiary will receive a negative action letter from us that includes the appeal form, an addressed envelope and instructions for appealing the case to the state. The negative action letter will be sent on the same date that the determination was made.

We will maintain copies of all letters and communications with providers and beneficiaries related to reconsiderations and appeals. All documentation will be available for review at the request of MDCH.

H. SANCTIONS

We will abide by the requirements set forth by MDCH regarding timeliness and accuracy of authorizations and telephone response time. If we are found to be out of compliance with any aspect of the contract, immediate steps will be taken to correct the situation.

These steps may include development of a corrective action plan, staff training or changes to the program operations. All of our efforts will be documented and reported to MDCH during our monthly project status meetings.

The MDCH Contract Manager will evaluate us for the number of incorrect authorizations, authorizations by telephone/electronic computer system not completed in a timely manner, and telephone response time with average time to answer of greater than 90 seconds. MDCH will notify us if we are out of compliance with any of the performance standards that are subject to sanctions and will allow for a corrective action plan within ten days. The following table summarizes the sanctions and notification process.

Table 5 - PACER Contract Sanctions and Notification Process

Contract Violation	Notification	Opportunity To Cure	Potential Sanction Imposed
1. Failure to authorize services correctly for: inpatient admissions, transfers, readmissions within 15 days, and continued stay for rehabilitative facilities Beginning April 1, 2005, greater than 10 PACER authorizations per audit are determined to be inappropriately authorized	MDCH provides notification via fax with hard copy to follow via overnight mail	MPRO shall have 10 calendar days to cure the failure by submitting a corrective action plan (CAP)	From October 1, 2004 – March 31, 2005: MDCH may charge MPRO $10,000 after the first 10 calendar days and for each subsequent 10-day period that the CAP has not been submitted Beginning in April, 2005: The amount MDCH paid for each of the hospitalizations approved in error
2. Failure to complete the PACER authorization process in a timely manner	Not specified in the RFP	Not specified in the RFP	MDCH will withhold 25% of the monthly future payments until MPRO achieves the schedule and demonstrates adherence to the contract
3. Failure to meet the required telephone response time of 90 seconds or less	Not specified in the RFP	Not specified in the RFP	MDCH will withhold 25% of the monthly future payments until MPRO achieves the schedule and demonstrates adherence to the contract

Our internal quality control process will be used to ensure that our review processes are in compliance with MDCH requirements and to proactively address any potential areas of non-compliance. Our commitment to quality monitoring and improvement recognizes the need to measure and report areas of non-compliance so that appropriate action may be taken to rectify the situation. All review staff are encouraged to notify the Senior Medical Review Manager or the Senior Vice President of Quality and Review Operations as soon as they become aware of any situation that might jeopardize our ability to meet a time frame or contract requirement. Additional detail about our IQC program is included in Section IV-C Management Summary and our complete plan is included in Appendix E.

MPRO will maintain all reporting requirements established by MDCH, as outlined in Part I, Section I. We currently produce detailed monthly reports outlining the work in PACER, ABW, and inpatient retrospective reviews. Adjustment reports, as well as quarterly and annual reports, are sent to MDCH. We will continue to produce any reports that are required under this contract in a timely and accurate manner.

We acknowledge that MDCH may elect to adjust the PACER validation process with 30 days notice to us. MDCH may also change the PACER review process or cancel the contract with 30 days prior notification.

I. REPORTS

We will provide reports to MDCH to document the progress and results of the PACER inpatient and long-term care exception reviews. Based on our activities with the current PACER review, we are already equipped to provide many of the desired reports and can easily adapt our process to accommodate new reports. We will coordinate with MDCH at the onset of the contract to develop a reporting format that best meets the needs of both parties and will be flexible to respond to any changes desired by MDCH throughout the term of the contract.

The reports provided to MDCH will track the progress in meeting contract requirements. Existing reports and ad-hoc reports will be developed and produced using the effective system and process that has provided accurate and timely report generation for more than 16 years. We use rigorous internal controls in the development, production and verification of reports prior to submission to MDCH.

Report Development

Our reports are developed using Visual Basic 6.0® and Crystal Reports 8.5® software by qualified, internal IT staff with years of experience in both report development, and Michigan Medicaid. This tool ensures that report development and modifications to existing reports are completed in a timely manner. To protect system integrity, programmers develop reports in a separate, development environment and separate IT staff members are responsible for testing in yet another, test environment.

Report accuracy is monitored by a rigorous quality control process which includes user testing. Staff members responsible for testing develop multiple case scenarios that simulate many of the possible situations that occur in a live environment. After staff members enter these scenarios into the test environment application, the report is generated and staff can validate the accuracy of the report through review of the expected and actual appearance of data.

Report Production

Our management staff or IT personnel initiate report production by accessing the reporting module. Report generation is triggered when our staff member selects the type of report and date parameters desired from a menu within the reporting module. Reports are then validated by the analyst in the IT Department, by verifying each row and column and by comparing data consistency to previously generated reports.

Our staff members generate reports on a weekly and monthly basis, dependent on MDCH's requirements. The reports are distributed to MDCH electronically and in HIPAA compliance through a secure E-mail or via fax, upon request. The following is a description of the reports to be provided for the inpatient and long term care PACER programs.

Monthly Reports

We will produce monthly reports that provide the information requested by MDCH for PACER authorizations, phone statistics and long term care exception reviews. We currently produce several reports that will fulfill the requirements of MDCH. The existing 'Pacer Review Summary' report contains all of the state-required data elements with the exception of appeals data for the inpatient PACER activities. Data columns for number of cases appealed, number of appealed cases overturned and number of appealed cases upheld will be added to this report to be compliant with MDCH's requirements. This report modification can be accomplished prior to the beginning date of the contract, provided that MDCH puts a system in place to notify MPRO of all appeals. We will also produce a similar report with information for the long term exception process.

We will also provide reports regarding our telephone responsiveness. The purpose of this report is to monitor our responsiveness to telephone intake and to ensure compliance with contract requirements regarding speed of answer. The existing report titled 'Performance Indicators' consists of four separate sections, phone statistics, review timeliness, reconsideration timeliness and appeal results.

The mandatory components of each report include the following:

1. Inpatient PACER Review Summary Report:
    a) Number of cases reviewed,
    b) Number of cases approved by the Review Coordinator,
    c) Number of cases referred,
    d) Number of cases denied,
    e) Number of cases approved by physician-reviewer,
    f) Number of cases denied by physician-reviewer,
    g) Number of reconsiderations,
    h) Number of reconsiderations upheld,
    i) Number of reconsiderations overturned,
    j) Number of net denials,
    k) Percentage denied,
    l) Number of cases appealed,
    m) Number of appeals overturned and
    n) Number of appeals cases upheld.

2. Long Term Care Review Summary Report:
    a) Number of exception reviews performed,
    b) Approvals,
    c) Denials,
    d) Appeals,
    e) Exception approval trends by code,
    f) List of cases with approval recommendation and
    g) List of cases with denial recommendation.

3. Performance Indicators: PACER Phone Statistics:
    a) Total number of calls,
    b) Total number of telephonic reviews,
    c) Number of informational calls,
    d) Number of calls answered within 90 seconds,
    e) Percentage of calls answered within 90 seconds,
    f) Average time to answer,
    g) Number of calls abandoned and
    h) Percentage of abandoned calls.

4. Performance Indicators: Inpatient Review Timeliness:
    a) Total number of reviews,
    b) Total coder reviews,
    c) Total physician reviews,
    d) Number completed on time and
    e) Percentage completed on time.

5. Performance Indicators: Inpatient Reconsideration Timeliness:
    a) Total number of reconsideration cases,
    b) Number completed less than 15 days,
    c) Number completed less than 30 days and
    d) Percentage completed on time.

6. Performance Indicators: Inpatient Reconsideration Timeliness:
    a) Total number of appealed cases,
    b) Number of cases upheld and
    c) Number of cases modified.

See Appendix D for copies of sample reports.

We will work with MDCH to review and interpret these reports to ensure the highest level of performance and provide insight into new program development. In addition, we will create ad-hoc reports as requested by MDCH.

Quarterly Reports

The quarterly reports will contain all of the information from the monthly report, with the totals rolled up to incorporate the entire quarter's worth of activity.

Annual Report

The Annual Report will contain all of the information from the monthly and quarterly reports, with the totals rolled up to incorporate the entire year's worth of activity.

Reporting Schedule

We will submit all reports to the MDCH Contract Manager electronically and in hard copy according to the following reporting time line. This time line covers the first year of the contract.

Table 6 – Report Schedule

Report Name	Time Period	Due Date
Monthly Reports	October 2004	November 5, 2004
	November 2004	December 5, 2004
	December 2004	January 5, 2005
Quarterly Report	October 1, 2004 through December 31, 2004	January 31, 2005
Monthly Reports	January 2005	February 5, 2005
	February 2005	March 5, 2005
	March 2005	April 5, 2005
Quarterly Report	January 1, 2005 through March 31, 2005	April 30, 2005
Monthly Reports	April 2005	May 5, 2005
	May 2005	June 5, 2005
	June 2005	July 5, 2005
Quarterly Report	April 1, 2005 through June 30, 2005	July 31, 2005
Monthly Reports	July 2005	August 5, 2005
	August 2005	September 5, 2005
	September 2005	October 5, 2005
Quarterly Report	July 1, 2005 through September 30, 2005	October 31, 2005
Annual Report	October 1, 2004 through September 30, 2005	October 31, 2005

We are willing to work with MDCH to adopt changes to the reporting formats or due dates at any time throughout the term of the contract. One suggestion from MPRO is to combine the final quarterly report and the annual report into one document, since they are due on the same date for each contract year.

J. Qualifications of Contractor's Staff for PACER/Long Term Care PACER

We have assembled an impressive and highly competent team of ten individuals to perform the tasks required for this contract. We have the distinct advantage of capitalizing on the collective strengths of our current review staff, including their combined experience and knowledge of Medicare and Medicaid programs and long term care, to quickly execute start-up operations for the contract. Our staffing model maximizes the strengths within our current review team and is further strengthened by the addition of highly-qualified registered nurses and physician-reviewers with long-term care experience.

Staff Requirements

Our Michigan Medicaid PACER Review Team is comprised of a multidisciplinary staff of individuals with experience in Michigan Medicaid policies, utilization review, medical record review, use of InterQual® and long term care exception criteria, and all inpatient PACER review types. This model has been designed so that the registered nurses that perform the PACER authorizations will not perform the audit/review functions of the contract.

Our PACER review program will be managed by a Senior Medical Review Manager, Melody Petrul, RN, who will serve as the primary point-of-contact for MDCH related project activities. Ms. Petrul has nearly 30 years of experience as an registered nurse in both the clinical setting and utilization and quality review management. Ms. Petrul has extensive experience in contract management, state and federal regulations related to medical review activities. Ms. Petrul will report to Colleen Cieszkowski, RN, MA, CPHQ, Senior Vice President of Quality and Review Operations.

Jeffrey Deitch, DO, has more than 17 years of quality improvement experience and has served as MPRO's Medical Director since 1998. As Medical Director, he provides overall medical leadership for many of MPRO's health care quality improvement activities and collaborates in the medical peer review process for MPRO's contractual programs. Dr. Deitch has significant expertise in medical review, the elderly and is knowledgeable of nursing home policies and procedures.

Organization Chart

Figure 14 shows the proposed organization structure for the Michigan Medicaid PACER Review Team. Lines of authority, responsibility, communication, and accountability are indicated. Following the organization chart is a table summarizing the key project staff, their relevant skills and expertise.

Figure 14 - PACER Review Organization Chart

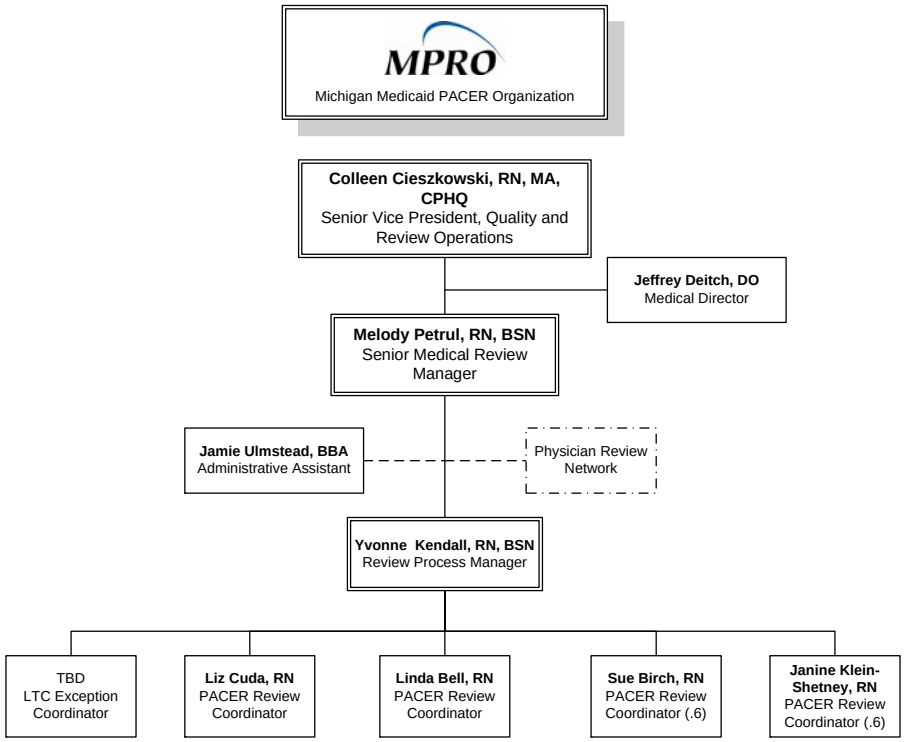


Table 7 - Staff Experience

Name/Project Role	Michigan Medicaid	Medicare and Medicaid Population Characteristics, Policies, Data Systems	Knowledge of Inpatient Hospital ® Criteria	Knowledge of Long-Term Care Medicaid Exception Criteria	Clinical Study Methodology	Research Design and Methodology, including Statistical Analysis	Quality Assurance Methodology (Assessment and Improvement Technologies)	Knowledge of Inpatient/Outpatient Hospital/ER/PACER/Utilization Review	Knowledge of Long-Term Care	Quality Assurance//Improvement Principles	Data Analysis/Reporting
Key Staff											
Colleen Cieszkowski, RN, MA, CPHQ Senior Vice President of Quality and Review Operations	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Julie Santinga, MA Chief Information Officer/Senior Vice President of Information Technology	✓										✓
Jeffrey Deitch, DO Medical Director	✓	✓	✓	✓	✓		✓	✓	✓	✓	
Melody Petrul, RN Senior Medical Review Manager	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Yvonne Kendall, RN, BSN Review Process Manager	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Additional Professional and Technical Staff											
Rebecca Kolinski, MHA Director of Review Services	✓	✓				✓	✓	✓		✓	✓
Albert Bayer, MD PACER Physician Reviewer	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Steven Katzman, DO PACER Physician Reviewer	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Manju Mathew, MS Systems Developer	✓	✓				✓					✓
Jan Howe, RN Systems Analyst	✓	✓			✓	✓	✓			✓	✓
Liz Cuda, RN, MS PACER Review Coordinator	✓	✓	✓	✓	✓		✓	✓		✓	
Linda Bell, RN PACER Review Coordinator	✓	✓	✓	✓	✓		✓	✓		✓	
Sue Birch, RN PACER Review Coordinator	✓	✓	✓	✓	✓		✓	✓		✓	
Janine Klein-Shetney, RN PACER Review Coordinator	✓	✓	✓	✓	✓		✓	✓		✓	

Continuity of Staff

The success of the Michigan Fee-For-Service Review contract depends upon consistent and reliable project staffing. We assure MDCH that the key project staff outlined in this proposal will be dedicated and available to fulfill their assigned duties throughout the duration of this contract. However, there are instances where changes in project staff may be necessary due to illness, disability or termination of employment. In the event that a change in project staffing is necessary, MDCH will be notified immediately. MDCH will also have the opportunity to review and approve any new additions to the core project team. We will facilitate an effective transition and thorough transfer of knowledge from the outgoing project team member to his or her replacement and assure MDCH that all replacement staff will have the same licensures as the outgoing staff member (i.e. RN replaces an RN).

Nurse Review Staff

Our nurse review team has more than 70 combined years of experience in Michigan Medicaid and utilization review and quality assurance. Our review nurses are licensed in the state of Michigan, and are knowledgeable of all inpatient PACER types and Inpatient Hospital InterQual® criteria and long term care exception criteria. Additional qualifications for our review nurses include:

- Minimum of five years experience in an acute care or outpatient clinical setting;
- Computer competency;
- Quality improvement/utilization review experience; and
- Excellent verbal/written communication skills.

Refer to IV-C Management Summary for more information on staff education and training. Included in Appendix F is a position description for the RN/Long Term Care Exception Coordinator position. Proof of licensure for all new employees (where licensure is required) will be sent to MDCH at the time of hire.

Professional Review Staff

An integral component of our utilization review program is our professional review network. Our professional review network is comprised of more than 200 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 local standards of care for peer-to-peer review activities and Medicare and Medicaid principles, and are experienced in nursing care and utilization review procedures. Physician reviewers are kept abreast of current trends and changes in Medicare and Medicaid principles through quarterly education sessions, newsletters, and hands-on orientation.

They also have current 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. More than 25 of our physician reviewers are also board-certified from the American Board of Quality Assurance and Utilization Review Physicians.

Key Staff Biographies

Brief biographies for key members of the Michigan Medicaid PACER Review Team are presented below. Also included are biographies for additional professional and technical staff. Detailed resumes with reference contact names and copies of relevant licensure for key staff and additional staff are included in Appendix G and Appendix H, respectively.

Colleen Cieszkowski, RN, MA, CPHQ – Senior Vice President of Quality and Review Operations

Role: Provide oversight of medical review operations, including resource utilization, budget and compliance with contract requirements. Provide clinical oversight and consultation to the review team. Facilitate positive customer relationship.

Colleen Cieszkowski has more than 23 years of clinical health care experience. Her professional background as a Registered Nurse includes more than 14 years of quality management experience crossing the entire continuum of care, encompassing the hospital acute care setting, emergency department setting, outpatient setting/physician office and the alternative care settings of home health and long-term care. She is currently the Senior Vice President of Quality and Review Operations for MPRO and is responsible for assessing the development needs of the management staff and providing opportunities for development through mentoring, coaching, counseling and referral to formal educational programs. She also develops and reports operational plans, monitors daily activities, monitors contract budgets and resource utilization. Prior to joining MPRO, Ms. Cieszkowski worked as Administrator - Continuum of Care Integration for Mercy Hospital. In this role, she was responsible for leading a management team to assure quality patient care and reliable fiscal performance. Her responsibilities included administrative oversight for key clinical operations including emergency services, quality improvement, clinical education, utilization review, case management, nursing services, social work services and risk management.

Ms. Cieszkowski received a Bachelor of Science in Health Service Administration and a Master of Arts in Economics and Finance from the University of Detroit/Mercy. She is a Certified Professional in Health Care Quality (CPHQ) as designated by the National Association for Healthcare Quality. She currently holds the position of President-Elect for the Michigan Association for Healthcare Quality and will assume the role of President in the fall of 2004.

Julie Santinga, MA - Chief Information Officer/Senior Vice President of Information Technology

Role: Provide leadership over the development, improvement and maintenance of technology to support the contract, including the phone and computer systems.
Ms. Santinga has 20 years of experience in the Information Technology field. She currently provides leadership to MPRO's Information Technology Department to ensure successful performance of contractual obligations. She is responsible for providing leadership and guidance to the staff to ensure daily operations are fulfilled and strategies are in place for future growth. Her experience with project management, customer relationship management, application development and system delivery and support add great value to her efforts in new business development and strategic planning.

Prior to joining MPRO, she worked with The MEDSTAT Group as a Network Systems Manager responsible for the staff and systems supporting corporate and client application servers. She also worked as a FoxPro programmer at the University of Michigan on a collaborative development project with IBM that sent electronic patient data to referring physicians.

Ms. Santinga graduated with honors from Eastern Michigan University and holds a Bachelor of Business Administration majoring in Management Information Systems and a Master of Arts majoring in Communications.

Jeffrey Deitch, DO – Medical Director

Role: Provide medical oversight for the contract and serves as a liaison to the physician reviewer staff. Provides physician review services for long term care reviews.

Jeffrey Deitch, DO has served as MPRO's Medical Director since 1998 and has been with MPRO since 1987. Dr. Deitch has 20 years of experience in conducting and overseeing medical review for quality of care issues and has over 15 years experience specifically in the areas of Medicare and Medicaid utilization management and quality improvement. As Medical Director, he provides medical leadership for MPRO's health care quality improvement activities and collaborates in the medical peer review process for MPRO's contractual programs. He represents MPRO at hearings and presentations and on coalitions at state and national levels including AMDA. He is a facilitator for CMS and MPRO at sanctions and EMTALA hearings. Dr. Deitch represents MPRO as a speaker and physician liaison at society, provider, and medical staff meetings.

Dr. Deitch is board-certified in Family Practice and Geriatrics and maintains an active practice. He is affiliated with three major hospitals and a number of long term care facilities in southeast Michigan. Dr. Deitch has significant expertise in medical review and the elderly. As the Medical Director for several Michigan skilled nursing facilities, he has extensive knowledge of nursing home policies and procedures. He has served as a physician-reviewer for several organizations and on credentialing committees for a number of years.
Dr. Deitch received a Bachelor of Science degree from the University of Michigan and a Doctor of Osteopathy degree from Michigan State University's College of Osteopathic Medicine.

His internship and residency were completed at Botsford General Hospital. Dr. Deitch is certified by the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP).

Melody Petrul, RN – Senior Medical Review Manager

Role: Responsible for managing, monitoring and reporting on contract progress and assuring that all deliverables are provided on time and within the project budget. Responsible for mentoring, educating and training nurse review staff and providers. Maintains ongoing customer relationships. Ensures contractual requirements are met.

Melody Petrul, RN is currently Senior Medical Review Manager at MPRO where she is responsible for the daily operations of MPRO's current Medicaid Fee-For-Service contract with the State of Michigan. She is responsible for ensuring MPRO's compliance with federal and state regulations related to medical review activities. She also provides education and training to the nurse review, coders, and medical records staff. Ms. Petrul is an expert resource on daily review activities and monitoring activities.

Additionally, Ms. Petrul works with MPRO's review staff to improve communication among beneficiaries and providers. MPRO's format for its written correspondence is now considered one of the best in the QIO community. Ms. Petrul also has significant experience in sanction activities and EMTALA cases and was responsible for preparing cases and presenting them to the committee. Recently, Ms. Petrul has worked with her staff in integrating the Medicare Advantage fast-track appeals process and long-term acute care hospital process into existing review activities. This project required the development and implementation of training sessions for staff at skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and long-term acute care hospitals. Ms. Petrul earned a degree in Nursing from Schoolcraft College in Livonia, Michigan.

Yvonne Kendall, RN, BSN - Review Process Manager

Role: Responsible for daily operations of the PACER/LTC Review program. Provides staff education and mentoring. Coordinates the activities of physician reviewers assigned to the PACER/LTC PACER program. Performs PACER/LTC exception monitoring and assures contract compliance.

Yvonne Kendall has nearly 30 years of experience as a Registered Nurse in a variety of clinical settings including pediatrics, PICU, ICU, medical-surgical, outpatient and long term care. In addition, Ms. Kendall also has nearly 10 years of experience in utilization review and quality assurance, specifically, in the areas of external quality review and conducting HEDIS audits. She has a keen sense of detail and is knowledgeable of clinical guidelines and criteria.

Ms. Kendall currently serves as the Review Process Manager for MPRO's current Fee-For-Service Review contract with the State of Michigan. In this role, she is responsible for performing inpatient reviews to determine appropriateness of admissions, determining appropriate referrals to physician reviewers and identifying quality issues.

She is also responsible for producing inpatient denial letters post physician review and manages the inpatient appeals process. Ms. Kendall provides expertise in the conduct of ER/OP reviews, monitors medical charts monthly, and produces reports to ensure contract deliverables are met. Ms. Kendall also serves as a liaison between MPRO's physician reviewers and medical records staff. She is a key participant in new ER audit process and performs PACER reviews.

Prior to joining MPRO, she worked for a local long term care facility as a staff nurse. Ms. Kendall holds a Bachelor of Science in Nursing from Madonna College.

Additional Professional and Technical Staff Biographies

Rebecca Kolinski, MHA – Director of Review Services

Role: Provide technical support for performance measurement, reporting and administrative process improvement. Assist with management of customer relationships.

Rebecca Kolinski has focused her career on improving quality and operational performance within the health care industry for over ten years. She is a respected leader with proven experience managing complex projects and producing deliverables in a timely and cost-effective manner. She is currently employed as Director of Review Services at MPRO. Her responsibilities include management of external quality review projects, administrative process improvement support for medical review contracts, interpretation and review of reports and enhancing client relationships. Previously, she served as a Clinical Project Manager for the implementation of Medicare's public reporting initiatives for nursing homes, home health agencies and hospitals.

Prior to working at MPRO, Ms. Kolinski was employed as the Senior Director of Quality Improvement for Great Lakes Health Plan (GLHP), a Medicaid HMO in Southfield, Michigan. In that position, she was responsible for developing, executing and evaluating the company's quality improvement plan. Ms. Kolinski also led the company's accreditation initiative and was instrumental in attaining a full three-year JCAHO accreditation. Through her management of the provider appeals process, Ms. Kolinski has gained significant knowledge and understanding of Medicaid managed care operations and information systems.

Ms. Kolinski earned a Bachelors degree in Political Science from Wayne State University and a Masters degree in Healthcare Administration from the University of Minnesota.

Albert N. Bayer, MD – PACER Physician Reviewer

Role: Serve as a physician reviewer for the PACER and LTC Exception review programs. Serve as a resource to other physician reviewers. Provide consultation for any cases requiring psychiatric background.

Dr. Bayer is a licensed, board-certified psychiatrist with added qualifications in Geriatric Psychiatry and more than 14 years of experience. He is also board certified by the American Board of Forensic Medicine and the National Board of Medical Examiners. Dr. Bayer completed both his medical internship and psychiatric residency at Sinai Hospital, Detroit, Michigan, and he served as Chief Resident in Psychiatry there from 1989 to 1990.
In addition to maintaining a private practice for more than 10 years, Dr. Bayer serves as the medical director for the West Bloomfield Day Hospital, a clinical instructor at the Wayne State University, School of Medicine, and a consultant for the Danto Nursing Home's Alzheimer's Unit. He is also the chairperson for the Geriatric Psychiatry Task Force with Sinai Hospital's Department of Psychiatry and is a member of the Quality Assurance and Utilization Review Committee there. Dr. Bayer recently began serving as a clinical coordinator for MPRO's Medicare Payment Error Protection Program, and he continues as a physician reviewer for MPRO's psychiatric review program. He has further experience as a psychiatric consultant to several hospitals and as a medical director in a counseling center.

Dr. Bayer holds a Bachelor of General Studies from the University of Michigan and a medical degree from Wayne State University, School of Medicine. He is active in several professional organizations, participates in a number of research activities, and is a frequent presenter/lecturer.

Steven Katzman, DO, FACOI - PACER Physician Reviewer
Role: Serve as a physician reviewer for PACER and retrospective LTC reviews. Participate in appeals involving PACER exception and retrospective LTC cases in conjunction with MDCH.

Dr. Katzman is currently a Clinical Advisor for MPRO's Doctor's Office Quality Project for the Centers for Medicare & Medicaid Services and a physician reviewer for our current Medicaid Fee-for-Service contract with MDCH. Previously, he was Clinical Coordinator for MPRO's Health Care Quality Improvement Program (HCQIP) *Improving Preventive Care in the Ambulatory Care Setting* projects in the 6SOW.

Dr. Katzman is a staff physician in internal medicine at Botsford General Hospital in Farmington Hills, Michigan. He is also active in several quality assurance and advisory committees at Botsford General Hospital. In addition to his hospital work, Dr. Katzman has an active internal medicine practice located in Livonia, Michigan. Dr. Katzman additionally serves as the president elect of the Oakland County Osteopathic Medical Association and is a board member of Blue Care Network, a subsidiary of Blue Cross Blue Shield of Michigan. Dr. Katzman is board–certified in Internal Medicine and received his Doctorate in Osteopathic Medicine from the University of Osteopathic Medicine and Health Sciences, Des Moines, Iowa. He is an active member in several professional organizations including the American Osteopathic Association, Michigan Osteopathic Association, and American College of General Practitioners.

Manju Mathew, MS – Systems Developer

Role: Create design specifications and programming logic to support the operations and reporting functions of the PACER system. Create mandated reports and assist with designing and producing ad-hoc reports as needed.

Manju Mathew is currently a Systems Developer in MPRO's Information Technology Resource Group (ITRG). Ms. Mathew is responsible for all aspects of application development, modifying and maintaining existing programs, and assists in the development of user training materials. Using her expertise in the latest programming languages and techniques, Ms. Mathew develops custom IT applications and supports third-party applications to meet the requirements of MPRO's contracts.

Prior to joining MPRO, Ms. Mathew was a consultant for Technical Software Consulting, Inc. and focused on developing customized programs, databases and report generation using programs like PowerBuilder 5.0, Oracle 7.0, and SQL. Previously, Ms. Mathew worked as a Programmer/Analyst for a variety of firms in India. She received a Bachelor of Science in physics from Mahatma Gandhi University and a Masters of Science in Computer Applications from Bharathiar University, both located in India.

Jan Howe, RN – Systems Analyst

Role: Runs and verifies reports, including ad-hoc report requests. Coordinates report modifications, implementation and system testing.

Jan Howe has over 16 years of experience with Michigan Medicaid data and information systems. Ms. Howe currently serves as a liaison between all the departments at MPRO and the Information Technology Resource Group (ITRG). As a part of the systems development service team, Ms. Howe gathers the required information for the project, assists in the planning and facilitates the testing applications. She also writes the manuals or instructions for MPRO's systems and implements training.

Ms. Howe's MPRO experience includes ten years in project data collection, the use of MedQuest to develop tools for data collection, reliability and validity testing, abstracting data and the review process for data collection. She serves as a resource for the Statistical Analysis Resource Group (SARG) during the analysis phase of projects, monitors and cleans data for review and for adjustments sent to the fiscal intermediary and creates monthly reimbursement reports for various programs. Ms. Howe earned a degree in nursing from Schoolcraft College.

Elizabeth Cuda, RN, MS - PACER Review Coordinator

Role: Reviews PACER authorization requests and coordinates physician reviews, if necessary, in order to make determinations based on InterQual criteria and Medicaid policies Documents decisions in the PACER system. Participates in the appeal process as required by MDCH.

Elizabeth Cuda has nearly 40 years of experience as a Registered Nurse and has extensive experience as a Review Coordinator in Medicaid and Medicare utilization review, quality assurance and audits in the both the inpatient and outpatient setting. Ms. Cuda is currently a Review Coordinator at MPRO and performs telephonic and retrospective reviews, physician referral processing, physician reconsideration processing, and notice of non-coverage reconsiderations for MPRO's current Medicaid Fee-for-Service contract with the State of Michigan. She has actively participated in the redesign of many of our computer forms and internal documentation for the Medicaid Fee-For-Service Review contract.

Prior to MPRO, Ms. Cuda worked in a variety of settings and gained clinical experience in medical/surgical, ER, and occupational health. She also gained experience in performing cost outlier and day outlier reviews. In addition, she also served as a Nurse Coordinator for MIS computer systems in a large regional teaching hospital.

Ms. Cuda earned a Bachelor's degree in nursing from the University of Southern Maine. She also earned a Master's degree in Education with a major in rehabilitation counseling from the University of Maine.

Linda Bell, RN - PACER Review Coordinator

Role: Reviews PACER authorization requests and coordinates physician reviews, if necessary, in order to make determinations based on InterQual criteria and Medicaid policies Documents decisions in the PACER system. Participates in the appeal process as required by MDCH.

Linda Bell has over 24 years of experience as a Registered Nurse. She currently is a Review Coordinator for MPRO's Fee-For-Service Review contract with the State of Michigan. In this role, she performs telephonic and retrospective reviews, physician referral processing, physician reconsideration processing, and notice of non-coverage reconsiderations.

Prior to MPRO, she was worked at Blue Cross Blue Shield of Michigan (BCBSM) for 20 years as a pre-certification and pre-certification telephonic reviewer, and as an inpatient and ER/PT/OT, SNF chart reviewer. She also gained significant experience at BCBSM as an Adjustment Analyst where she analyzed data collected on certain DRGs and their incidence of admission and readmissions to area hospitals. Her efforts in this area assisted client hospitals in their efforts to monitor their clinical pathway programs, etc.

Ms. Bell has worked in a variety of clinical settings including OB/GYN oncology, ophthalmology, medical/surgical, and home health care. Ms. Bell earned an Associates degree in nursing from Wayne County Community College.

Sue Birch, RN - PACER Review Coordinator

Role: Reviews PACER authorization requests and coordinates physician reviews, if necessary, in order to make determinations based on InterQual criteria and Medicaid policies Documents decisions in the PACER system. Participates in the appeal process as required by MDCH.

Sue Birch has 24 years of experience as a registered nurse in both the clinical setting and in utilization and quality management. Currently, she is a Nurse Review Supervisor at MPRO where she is responsible for performing medical chart review and overseeing the quality, integrity, and validity of the medical record/telephonic review process. Ms. Birch also supervises the nurse review coordinator staff and coordinates review schedules.

Prior to joining MPRO, she was the Continuous Quality Improvement Manager at Prime Care Services where she was responsible for overseeing the medical review documentation process to insure proper charting requirements and coordinated utilization review for all clinical resources. Ms. Birch earned an Associate degree in Nursing from Oakland Community College. She is also certified by the American Nurses Credentialing Center in general nursing practice.

Janine Klein-Shetney, RN - PACER Review Coordinator

Role: Reviews PACER authorization requests and coordinates physician reviews, if necessary, in order to make determinations based on InterQual criteria and Medicaid policies Documents decisions in the PACER system. Participates in the appeal process as required by MDCH.

Janine Klein-Shetney has over 25 years of experience as a Registered Nurse. She is currently a Review Coordinator for MPRO Fee-For-Service contract with the State of Michigan. In this role, she performs telephonic and retrospective reviews, physician referral processing, physician reconsideration processing, and notice of non-coverage reconsiderations for MPRO's current Medicaid Fee-for-Service contract with the State of Michigan. She actively works with providers to help identify areas of improvement on appropriate and necessary utilization of services and prepares written documentation to inform customers of decisions, and analyzes and reports on quarterly review outcomes.

Ms. Klein-Shetney earned a Bachelor's degree in Nursing from Mercy College of Detroit and has earned advanced certification in Continuous Quality Improvement (CQI).

Other Staffing Requirements

Reports

Our project team has significant experience in producing accurate and timely reports that meet or exceed MDCH requirements. Please refer to section IV-C Management Summary, Part I - Reports for more on our entire reporting process.

Collaboration with Providers

We have been operating within the state of Michigan for over 20 years, and have developed relationships with physicians, hospitals, nursing homes and home health agencies throughout the state. MPRO is respected as an unbiased and impartial clinical review organization. Our positive working relationship with the provider community is one of our strongest assets. By selecting us as the contractor for the Michigan Statewide Hospital Certification and Review Program, MDCH will maintain the trusted confidence of tried and true provider relations. Please refer to Prior Experience for more information on our provider collaborations.

Privacy, Data Security and Confidentiality

The Michigan Fee-For-Service Review Team has significant experience in the proper handling of confidential information and has documented policies and procedures to ensure the confidentiality and security of all data that are maintained by us. Refer to Section IV-C Management Summary – Narrative for more information on confidentiality and security.

K. CONTRACT MONITORING

As a current contractor of MDCH, we are committed to ensuring exceptional performance and full compliance with all contract terms and requirements. There are two aspects of contract monitoring that will be discussed in this section. First, we will focus on our role in supporting MDCH's contract monitoring process. Second, we will outline MPRO's internal mechanisms to monitor contract compliance through our internal quality control process.

MDCH Contract Monitoring

We will provide all necessary documentation and access so that the MDCH Contract Manager is able to effectively monitor our contract performance. This includes, but is not limited to the following activities:

- Offering the Senior Medical Review Manager as the primary point-of-contact in order to facilitate requests from MDCH;
- Arranging for access to the PACER program review system for the MDCH Contract Manager in a method to be determined by MDCH;
- Providing the required reports to the MDCH Contract Manager in a timely manner;
- Participation in weekly meetings or teleconferences with the MDCH Contract Manager during the first month of the contract and at least monthly for the remainder of the contract;
- Allowing access to MDCH or its designee to complete a site visit at our offices at least once per year to monitor work in progress under the contract. We will reimburse all travel, lodging and meal expenses for up to two State of Michigan representatives for this annual review;
- Measuring and providing documentation of timeliness and other performance standards as described in Part I, Sections H and I; and
- Providing timely notification to the MDCH Contract Manager related to any sanctions, as described in Part I, Section I.

MPRO Contract Monitoring

In order to ensure compliance with the contract requirements we have initiated our own contract monitoring system through our unique IQC process. In order to set up the IQC, we have defined all of the contract performance standards including anticipated volume, timeliness and accuracy standards. A summary of the key performance indicators have been developed for monitoring of contract activities. These key performance indicators are outlined in Table 8.

Table 8 – Key Performance Indicators for PACER/Long Term Care PACER

Review Type	Category	Performance Indicator
Telephonic PACER/ LTC PACER	Call Response	All incoming phone calls have average time to answer of less than 90 seconds.
Telephonic PACER/ LTC PACER	Call Response	100% of PACER authorization decisions are rendered and communicated on the same day of the request.
Telephonic PACER/ LTC PACER	Operations	The telephone/computer electronic system will be operational 100% of the time period from 8 a.m. to 5 p.m., Monday through Friday, except for state approved sanctioned holidays.
Telephonic PACER/ LTC PACER	Pattern Analysis	Monthly trending reports of telephonic profiling for incoming calls includes comparison of: ▪ total number of calls ▪ number of PACER calls ▪ number of abandoned calls ▪ number of informational calls
PACER Reviews	Review Time	98% of PACER physician referral cases are completed (resolved as either approved or denied) on the same day of the request.
PACER Reviews	Review Time	All copies of negative action letters (100%) are sent to MDCH monthly.
PACER Reviews	Review Time	100% of PACER physician referral cases are completed (resolved as either approved or denied) within one working day of the request.
PACER Reviews	Review Time	100% of PACER reconsiderations are completed within 30 working days of the request.
Long Term Care Exception	Review Time	100% of reconsideration decisions on provider appeals for long term care exception requests are completed, and the provider is notified within one working day of receipt of the request.
Long Term Care Exception	Review Time	100% of beneficiary appeals made during the inpatient stay for long term care exception requests are completed within three working days.
Long Term Care Exception	Review Time	100% of beneficiary appeals made after discharge for long term care exception requests are resolved within 30 working days.
Long Term Care Exception	Review Time	All negative action letters and appeal forms are sent to beneficiaries on the day of the negative action.
Notice of Non-Coverage (PACER and Long Term Care Exception)	Review Time	100% of notice of non-coverage decisions for PACER and for long term care exception requests are completed within three working days (unless otherwise specified by MDCH) of receipt of related documentation from the hospital.

Our Senior Medical Review Manager will diligently monitor performance indicators against the established standards. We will strive to meet and exceed the established thresholds for these indicators. Trends that signal areas for improvement will be reviewed, and process changes implemented when appropriate. Internal monitoring of the indicators will be maintained in graph format that allows for trending of performance over time, when appropriate. Other data display methodologies will be applied when necessary. MPRO will make these findings available to MDCH upon request.

Discussion of IQC activities will be incorporated into regularly scheduled team meetings. The progress, obstacles and opportunities identified through IQC monitoring will also be shared between and across projects as appropriate. The established reporting structure for quality improvement activities is included in Appendix E.

L. Payment Schedule

We hereby acknowledge and agree to the terms of payment as outlined in the RFP and will work with MDCH to develop a payment and billing schedule. MDCH will reimburse based upon the number of PACER/Long Term Care telephonic or electronic authorizations completed in the previous month. This payment schedule is subject to change based upon any sanctions imposed by MDCH, as described in Part I, Section H.

We agree that we will be available at all levels of the appeals process. Our nurses and physician-reviewers will provide expert testimony as to the results of the PACER review at any preliminary or bureau conference, administrative or judicial proceedings as directed by MDCH.

M. Fraud and Abuse

Our review staff members are trained on the importance of identifying and reporting suspected fraud and abuse. In providing these services, we will use the following definitions of fraud and abuse that were provided on the Web site, michigan.gov/mdch:

> **Fraud** – Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
>
> **Abuse** – Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

The Senior Medical Review Manager is the contact for all staff who suspects fraud or abuse. She will coordinate the preparation of the necessary documentation, including provider and beneficiary identifying information and a full description of the situation, along with any reports or other documentation that is available. The case will be reported to the MDCH Contract Manager within 48 hours of identification of the situation.

PART II AUDITS/LONG TERM CARE RETROSPECTIVE ELIGIBILITY REVIEWS

A. BACKGROUND STATEMENT

MDCH is seeking a vendor to conduct audits and retrospective reviews to determine compliance with Medicaid Policy and Guidelines as outlined in the Provider Manuals and Bulletins, Michigan Medicaid Nursing Facility Level of Care Determinations, as well as current standards of practice. The audits and reviews will be conducted in accordance with the applicable provisions of the Code of Federal Regulations and other state and federal requirements, and will include utilization review in accordance with 42 CFR 456. The following areas will be subject to audit and/or review:

- Inpatient Services;
- Outpatient Services;
- Emergency Room Services;
- Long Term Care Admissions; and
- PACER Authorizations provided by MPRO.

Through the audit and review processes, MDCH intends to validate the appropriateness of the services provided and ensure that the payment for those services was accurate. These processes also represent an important quality improvement opportunity to assess the effectiveness of the PACER authorization and LTC exception reviews provided by the vendor selected for this program. The audits and reviews will examine the extent to which required criteria were used and appropriate documentation provided during the PACER authorization and LTC exception review processes.

Under our current Medicaid FFS Review contract in the State of Michigan, MPRO provides retrospective review and audit services for inpatient care with the goal of ensuring that only appropriate, medically necessary services are provided to the Medicaid population. In addition to more than 16 years of experience in Medicaid FFS utilization review, we are URAC accredited for Health Utilization Management, and under provisions of 42 CFR 475, we are the CMS designated QIO for the state of Michigan. MPRO is a Michigan-based company employing over 100 staff members.

Our experience gives us intimate knowledge of state Medicaid regulations and clinical practices. We will apply the benefits of our vast experience to continue our successful track record for the outpatient/ER audits, incorporate the inpatient audits and develop a long term care review program. In providing these services, we will use the following definitions of audit and review as provided in the RFP:

Audit - A post-payment review of a statistically valid sample of beneficiary records maintained by a provider to ensure that services were medically necessary and billed correctly by that provider.

Review – A random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider.

The primary distinction between an audit and a review is that the audits are targeted to one provider and are based upon a statistically valid sample. The reviews can incorporate more than one provider within the random sample. Audit findings are to be extrapolated to the provider's entire population for purposes of payment reversals, while review findings apply only to the individual case that is reviewed.

This section of the proposal will describe the requirements, criteria and processes we will use to conduct audits and retrospective reviews to meet the needs outlined by MDCH.

B. OBJECTIVES

Our audit and 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. MDCH has outlined its expectations related to the audit and review services in the RFP document. The following table outlines the objectives for the audit/review processes:

Table 9 - MDCH Objectives for the Audit/Review Program

Topic	Population	Sampling Method	Sample Size	Audit or Review
1. Inpatient Hospital Services (Including medical detoxification, elective admissions, transfers, re-admits within 15 days and rehabilitative facilities	Medicaid FFS (Title XIX) and Children's Special Health Care Services (CSHCS) dual eligibles	Statistically valid random sample	10 providers per year and approximately 250 beneficiaries per provider	Audit
2. Outpatient and Emergency Room Services	Medicaid FFS (Title XIX) and Children's Special Health Care Services (CSHCS) dual eligibles	Statistically valid random sample	10 providers per year and approximately 250 beneficiaries per provider	Audit
3. Long Term Care	Medicaid FFS and Medicare/Medicaid beneficiaries admitted to a nursing facility or the PACE program	Targeted random sample of monthly new admissions	1,000 cases per year	Review
4. PACER Validation	Medicaid FFS (Title XIX) and Children's Special Health Care Services (CSHCS) dual eligibles who had a	Statistically valid random sample	All cases in the inpatient audit described in #1 above that had a PACER request/authorization	Review

Topic	Population	Sampling Method	Sample Size	Audit or Review
	request for a PACER authorization			

The primary objectives of the inpatient and outpatient/emergency room audits are to determine medical necessity, appropriate setting and correct billing of the services by each provider. The PACER validation reviews are intended to determine the accuracy of the authorization process used by the PACER review coordinators, as well as evaluate the accuracy of the provider's documentation in the medical record compared against the clinical information that was provided over the telephone. The PACER validation reviews will be conducted by review nurses that are not involved in the PACER program. Utilization review will be performed for all inpatient, outpatient/ER and PACER validation audits.

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.

MPRO has designed a solution that will provide a sound, criteria-based, independent audit/review outcome that meets all of MDCH's objectives. All of the reviews will consider appropriate utilization and quality of care issues, as required by MDCH. The detailed criteria and processes to be used for the audits and reviews are outlined in Part II, Sections C through H of this proposal.

C. AUDIT/UTILIZATION REVIEW REQUIREMENTS

In order to establish and maintain credibility with providers, the audit and review processes must use clearly-defined criteria in a consistent manner. The RFP outlines the criteria that are required for each of the audit and review processes. These criteria vary based upon the type of services being reviewed and the setting where care is provided. The following table outlines the criteria that will be used for each:

Table 10 – Summary of Criteria for Each Type of Audit/Review

Description of Review Criteria	Inpatient Audit	Outpatient/ ER Audit	PACER Validation Review	LTC Review
Medical necessity for admission, Severity of Illness/Intensity of Services (SI/IS) utilizing InterQual® criteria per body system	✓		✓	
Continued stay criteria utilizing InterQual® criteria per body system for inpatient rehabilitation	✓		✓	
Discharge criteria InterQual® per body system	✓		✓	
Review for correct procedure	✓			
Review for diagnosis coding via DRG assignment validation	✓			
Assess for quality of care utilizing InterQual® criteria for inpatient reviews, or other appropriate criteria	✓	✓		
Services were performed in the appropriate setting	✓	✓	✓	
Services performed are in compliance with Medicaid Program Policy and Federal/State statutes	✓	✓	✓	
Services performed are in accordance with current professional standards of care	✓	✓	✓	
Services performed are medically necessary in appropriate scope, duration and intensity		✓		
Verify procedure code billed		✓		
Verify Adherence to EMTALA, for emergency room services		✓		
PACER number obtained for readmissions within 15 days, transfers, elective admissions and continued stays for rehabilitative facilities			✓	
Appropriateness for the nursing facility level of care definition				✓
Exceptions based upon explicit MDCH-developed exception criteria				✓
Clinical professional judgment (subject to review by MDCH)				✓

Through our current contract with the State of Michigan, our review staff is familiar with the InterQual® criteria, Medicaid program policy and other criteria described above. The detailed qualifications and knowledge of our review staff are outlined in Section J.

In addition to using sound and valid criteria, another key aspect of the audit and review process is maintaining confidentiality of information. Our review team follows MPRO's HIPAA-compliant confidentiality and disclosure policy, which is described in more detail in Section IV-C Management Summary. All of the audit documentation, claims information, medical records and findings will be maintained in the strictest confidence and will not be disclosed to third parties without the prior written consent of MDCH.

MDCH has outlined its requirements and expectations for the audit process. Key requirements and MPRO's compliance plan are listed in the table below. A detailed description of the audit process is included in Section F. Additional requirements and processes related to the long term care reviews are described in Sections E and H.

Table 11 – Key Audit Requirements and MPRO Compliance Plan

Audit Requirement	MPRO Compliance Plan
Maintain confidentiality of providers and beneficiaries and ensure no disclosure takes place.	We have a comprehensive HIPAA-compliant policy and procedure related to confidentiality. See Section IC-C Management Summary for a complete description.
Conduct audits from a statistically valid random sample as generated by MDCH.	Our review team will use the MDCH-determined sample to conduct the audits. We currently have a process in place to receive these files from MDCH for the outpatient/ER audits and will use the same process for the inpatient audits.
Contractor will supply the provider with a list of those beneficiaries to be audited ten days prior to the audit	We currently comply with this requirement for the outpatient/ER audits. The list of beneficiaries is sent to the provider via mail ten working days prior to the audit.
Contractor will go to each facility to copy/scan the records utilizing their own equipment.	We currently use a portable scanner to obtain images of the medical records on site at the provider location.
The review will occur at the Contractor's place of business.	We currently have a fully-staffed office located in Farmington Hills, Michigan. Reviews for our current contract with MDCH take place at this location. We have capacity that is readily available to continue reviews and manage any projected increases in volume at this site.
Once the records have been reviewed and a determination made, the Contractor shall write a nurse review report.	The coordinator assigned to each audit will be responsible for writing the nurse review report using the format specified in Attachment G of the RFP. MPRO currently has review nurses on staff that are already trained in preparing these reports.

In addition to the requirements in the table above, we will use the criteria established by MDCH to conduct the reviews. The criteria for each audit and review are outlined in Tables 10 -11.

D. PACER VALIDATION REQUIREMENTS

MPRO will use the MDCH defined criteria outlined in Table 14 to review and validate PACER authorizations. The criteria for the PACER validation reviews are similar to the criteria for the inpatient audits. The only addition is the identification of the PACER number for the admission. PACER validation sample size will vary for each audit, based upon the number of beneficiary admissions in the inpatient sample that required a PACER authorization.

With over 70 years of cumulative experience, our nurse reviewers are very experienced with the PACER validation criteria and conduct PACER validations under MPRO's current contract with MDCH.

This is accomplished by reviewing the hospital medical record and comparing clinical information contained in the medical record to the documentation provided during the initial telephone contact to obtain the PACER authorization. The MPRO computer system is currently

in place and has the capability to validate the PACER authorization numbers. A detailed description of the PACER Validation process is included in Section G.

Aside from fulfilling the contract requirements, the PACER validation process provides valuable information to MPRO in our quest to improve the efficiency and effectiveness of our review processes. We will incorporate the PACER validation results into our internal quality control program, as described in Section IV-C Management Summary and detailed in Appendix E.

E. Long Term Care Retrospective Review Requirements

The long term care retrospective reviews represent a new review program for MPRO under the Medicaid FFS contract, but one that is compatible with our existing clinical expertise and skill sets. Our nurses will review a sample of long term care admissions based upon the criteria outlined in Table 10. The primary focus will be to validate the level of care determination based upon the clinical information provided in the medical record. All denials will be reviewed by a physician, as well as any requests for exception based upon professional judgment.

Currently, MPRO performs analysis of MDS data as part of our quality improvement efforts with nursing home providers for the Medicare program. This knowledge and expertise related to nursing home facility data will seamlessly translate to the Medicaid review process. Our management team and nurse reviewers are already familiar with the criteria and requirements outlined in the Notice of Proposed Policy, Project Number 0420-NF regarding the Michigan Medicaid Long Term Care Admission Requirements and are prepared to implement these criteria upon contract award.

Similar to the PACER validation process, the long term care retrospective reviews will provide information regarding the effectiveness of MPRO's long term care exception process, by identifying any cases where an exception was granted and the documentation in the medical record did not demonstrate a clear need for the exception. This process is discussed in more detail in the internal quality control program outlined in Appendix E. If any significant quality of care issues are identified during the review process, they will be referred to MDCH.

F. Audit/Utilization Review Process

MPRO has designed a comprehensive and streamlined audit process that fulfills the requirements outlined in the RFP. Our process includes features that are already in place under our current FFS review contract for outpatient/ER audits, as well as some added features related to the inpatient audits. Our trained and highly skilled audit team has experience in inpatient, outpatient, emergency room and long term care services, as described in Section J. In addition, board-certified physicians representing a wide variety of specialties are available throughout the audit process in a consultative role. This section will provide a description of the review process for outpatient/ER and inpatient audits, including flow charts of the process steps.

Audit Process

The audit process begins with the transmission of the audit sample from MDCH to MPRO through the audit workbook. There will be one workbook for each provider that is audited under

the outpatient/ER audit program and the inpatient audit program. MDCH also will provide an accordion file with folders for analysis to support the nurse review reports and correspondence. The audit workbooks will contain the following documentation:

- Alphabetical and numeric beneficiary lists;
- Audit worksheets;
- Line paid procedure codes;
- Procedure code on line;
- Procedure code and revenue code on line for sample;
- DRG code lists (for inpatient audits only); and
- Sample and population summary statistics.

The audit workbooks and related documentation will be sent to the Senior Medical Review Manager, who will serve as the primary contact for MDCH. She will assign the audit to an audit coordinator, who is also a registered nurse. For the inpatient audits, a coder who is a Registered Health Information Technologist (RHIT) also will be assigned to the audit. The RN/Audit Coordinator will be responsible for coordinating all audit activities within MPRO and with the provider.

Pre-Audit Preparation

The RN/Audit Coordinator will begin by gathering all relevant documentation that is needed to perform the audit. This includes Medicaid Policy and Procedures, definitions of procedure and revenue codes, appropriate DRG grouper and ICD-9 codes, as well as the applicable Medicaid fee screens that were in effect during the time period of the audit. Within the first week of the assignment, the RN/Audit Coordinator will also contact the provider to schedule a date to obtain the records and send out a confirmation letter. At least ten working days prior to the audit, the RN/Audit Coordinator will mail the list of beneficiaries and dates of service to the provider so that the medical records can be pulled for scanning on the date of the scheduled visit.

On-Site Visit to Obtain Records

On the scheduled audit date, the RN/Audit Coordinator will visit the provider site with a portable scanner to obtain the records for the audit. If necessary, one or two Medical Records Technicians may accompany the RN/Audit Coordinator in order to make the process more efficient. Upon arrival at the provider site, the RN/Audit Coordinator and other team members will present their identification and introduce themselves to the provider representative. The RN/Audit Coordinator will present a brief description of the audit process and the legal basis for the audit, clearly indicating that MPRO is conducting the audit under contract with and on behalf of MDCH. The RN/Audit Coordinator will respond to any questions the provider might have and then proceed with scanning the medical records. Once the records have been scanned, they will be brought back to the MPRO offices where they are saved to a CD.

Review Process

Once the records have been obtained, the review process will begin. Each record will be reviewed against the claim line detail information provided in the workbook and the documentation gathered in the pre-audit process. The MDCH annotations provided in the audit workbook will be used to document the findings. The review criteria used will depend upon the

type of audit being conducted. This section will outline the specific review criteria to be used, as well as the process to evaluate the medical record against the defined criteria.

For outpatient/ER audits, the following information will be reviewed by the RN/Audit Coordinator:

Table 12 - Outpatient Audit Criteria and Review Process

Outpatient Review Criteria	Reviewer Type	Review Process
Quality of care utilizing appropriate criteria	RN	Assess the medical record for gross and flagrant quality issues and refer to the physician reviewer if any issues are found.
Services were performed in the appropriate setting	RN	Determine whether the services performed were appropriate for the outpatient/ER setting based upon Medicaid Guidelines.
Services performed are in compliance with Medicaid Program Policy and Federal/State statutes	RN	Compare the services and documentation to the requirements of the Medicaid program.
Services performed are in accordance with current professional standards of care	RN	Based upon current knowledge of practice standards and professional judgment. If in doubt, refer to physician reviewer.
Services performed are medically necessary in appropriate scope, duration and intensity	RN	Review the services documented in the medical record against Medicaid guidelines and clinical professional judgment.
Verify procedure code billed	RN	Compare the procedure billed against the procedure that was documented in the medial record. Use the Current Procedural Terminology (CPT) for the given year.
Verify Adherence to EMTALA, for emergency room services	RN	Determine whether a medical screening exam was performed by a physician in the emergency room.

For the inpatient audits, the review will be divided among the RN/Audit Coordinator and the RHIT/Coder as follows:

Table 13 - Inpatient Audit Criteria and Review Process

Inpatient Review Criteria	Reviewer Type	Review Process
Medical necessity for admission, Severity of Illness/Intensity of Services (SI/IS) using InterQual® criteria per body system	RN	Compare clinical information in the medical record to the relevant SI/IS criteria. Use professional judgment to determine if the criteria are met. If the criteria are not met, refer the case to a physician reviewer.

Inpatient Review Criteria	Reviewer Type	Review Process
Continued stay criteria using InterQual® criteria per body system for inpatient rehabilitation	RN	Compare clinical information in the medical record to the relevant continued stay criteria. If the criteria are not met, refer the case to a physician reviewer.
Discharge criteria InterQual® per body system	RN	Review medical record to validate condition at discharge to determine if the patient was medically stable for discharge.
Review for correct procedure	RHIT	Compare the procedure billed against the procedure that was documented in the medical record. Use the following documents for verification: ICD-9-CM Volume 3, Medical Grouper and AHA Coding Clinics.
Review for diagnosis coding via DRG assignment validation	RHIT	Compare the diagnosis billed against the clinical information that was documented in the medial record. Use the following documents for verification: ICD-9-CM Volumes 1 and 2, Medical Grouper and AHA Coding Clinics.
Quality of care using InterQual® criteria	RN	Assess the record for any gross and flagrant quality of care issues using Medicaid quality categories. Refer any issues to the physician reviewer.
Services were performed in the appropriate setting	RN	Determine whether the services performed were appropriate for the inpatient setting based upon Medicaid Guidelines and InterQual® criteria.
Services performed are in compliance with Medicaid Program Policy and Federal/State statutes	RHIT	Compare the services and documentation to the requirements of the Michigan Department of Community Health Hospital Manual.
Services performed are in accordance with current professional standards of care	RN	Based upon current knowledge of practice standards and professional judgment. If in doubt, refer to physician reviewer.

Physician Reviewers are available throughout the audit process to answer questions or provide input for the RN/Audit Coordinator to make a final determination. All cases where the RN/Audit Coordinator is recommending a denial must be reviewed by a physician who will provide the final rationale and documentation to support the decision.

Obtaining Missing Documents

There are two occasions where the RN/Audit Coordinator reviewers will have to work with the provider in order to obtain missing documentation. First, when the RN/Audit Coordinator visits the provider site to scan the records, there may be instances where the record is not available. In that case, the RN/Audit Coordinator will send the provider a follow up letter to request that the missing records be located and shipped to MPRO offices within ten working days. If the

provider does not respond to the request, then the records will be recorded as missing in the audit workbook and will be considered out of compliance with the criteria.

The second situation where records may need to be requested is in cases where there is incomplete documentation. This event is most likely to take place after the RN/Audit Coordinator or RHIT has initiated review of a record and found that certain necessary components were not provided to be scanned. In this case, the RN/Audit Coordinator will contact the provider and request that they mail the missing components of the record within ten working days.

MPRO has been using the required letters outlined in Attachment E and F of the RFP since the inception of the outpatient/ER audits in 2003. All of the letters are currently set up in our computer system. The letter will be modified as necessary, upon approval by MDCH, to accommodate the inpatient and outpatient audits.

Final Audit Findings and Report Preparation

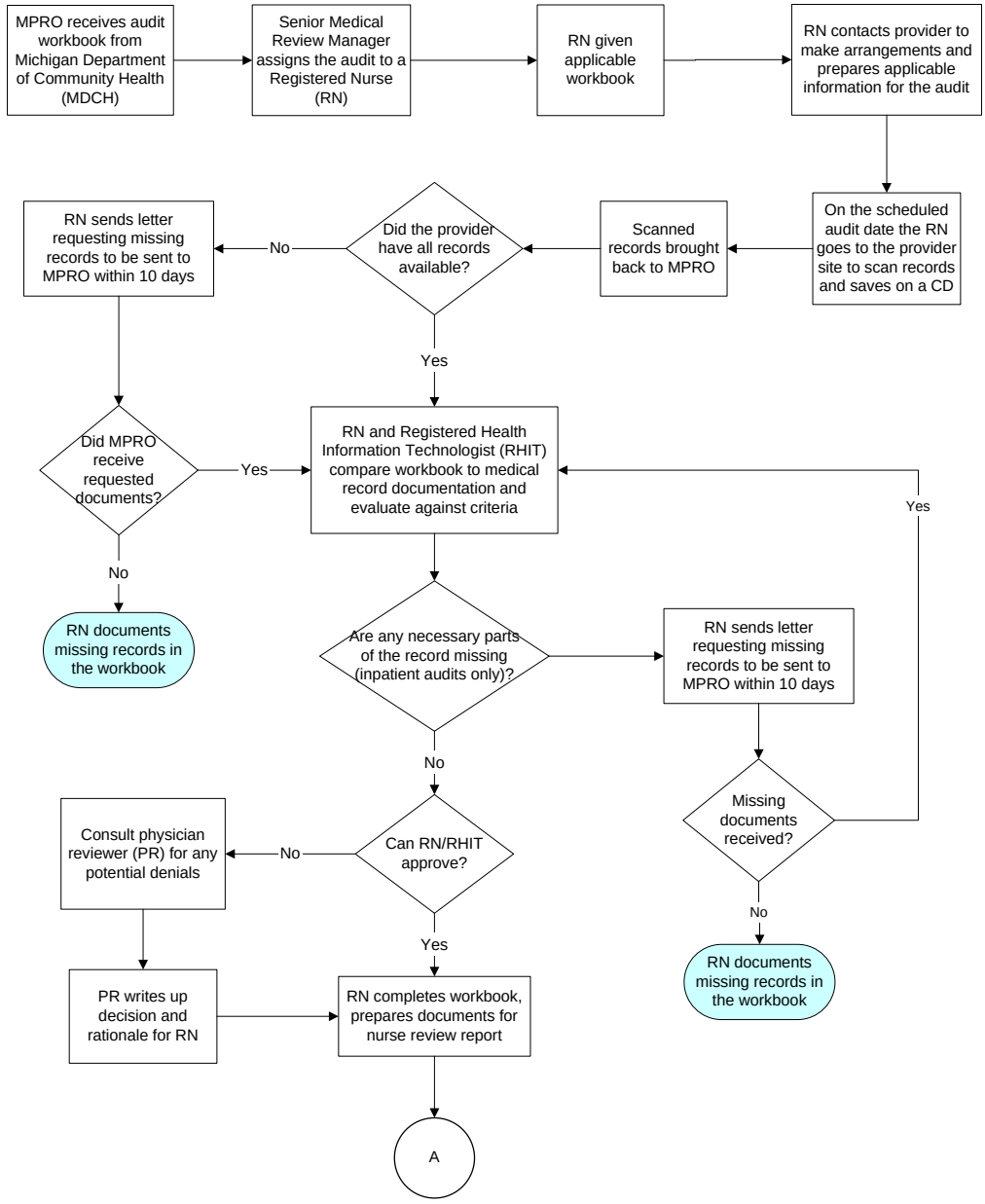
After the review has been completed, the RN/Audit Coordinator begins to collate all of the documentation needed to produce the nurse review report. If an RHIT participated in the audit, then the RN/Audit Coordinator will gather all of the RHIT's findings for inclusion in the report. If a physician reviewer's opinion was obtained, then the RN/Audit Coordinator will also include documentation of the physician's decision. The documentation includes the results of each record review, along with any correspondence related to missing records. The RN/Audit Coordinator will prepare the report and include the following information:

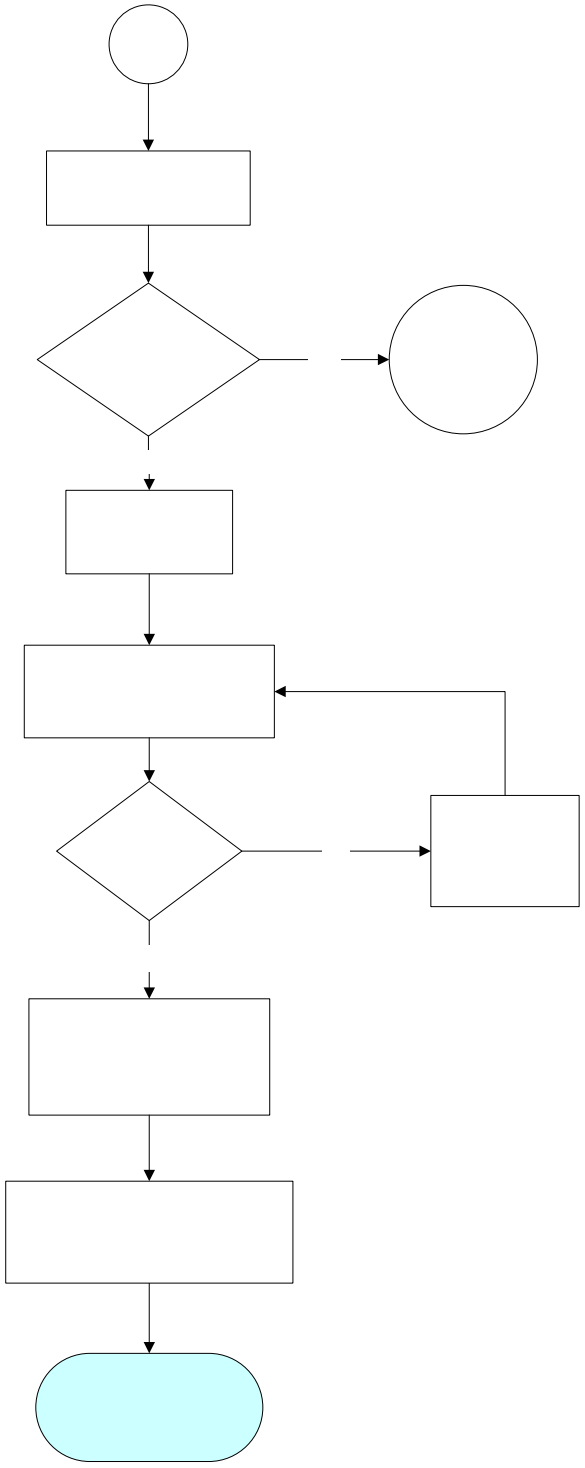
- Reason for the review;
- Sample statistics;
- Summary of field activities; and
- Nurse review findings and attachments.

Once the report has been drafted, it will be reviewed by the Senior Medical Review Manager. The manager will make the final determination regarding completeness and accuracy of the audit. After all documentation has been approved, the workbook, the nurse review report and copies of relevant documentation will be sent to the MDCH contract manager. We will complete three audits in each of the first three quarters and one audit in the fourth quarter of each year.

A flow chart of the process for the audits is included on the following pages.

Figure 15 - Inpatient and ER/Outpatient Audit Process





G. PACER VALIDATION PROCESS

MPRO has developed a process for PACER validation that is integrated within the inpatient audit process. The initial step in the process is to determine which cases within the inpatient audit are potentially eligible for a PACER validation. The RN/Audit Coordinator will review the documentation in each case to determine if a PACER authorization was included on the claim. In addition, she will search MPRO's PACER system to determine whether a PACER authorization was granted by MPRO for that admission. All cases that have a PACER authorization recorded in the MDCH workbook or have a PACER authorization in MPRO's system are eligible for a PACER validation review.

Once the cases requiring PACER validation are identified, the RN/Audit Coordinator conducts a review based upon the following criteria:

Table 14 - PACER Validation Review Criteria and Review Process

PACER Validation Review Criteria	Reviewer Type	Review Process
Medical necessity for admission, Severity of Illness/Intensity of Services (SI/IS) using InterQual® criteria per body system	RN	Compare clinical information in the medical record to the relevant SI/IS criteria. Use professional judgment to determine if the criteria are met. If the criteria are not met, refer the case to a physician reviewer.
Continued stay criteria using InterQual® criteria per body system for inpatient rehabilitation	RN	Compare clinical information in the medical record to the relevant continued stay criteria. For 30 and 60 day reviews, determine if the patient was progressing toward goals and whether discharge planning was ongoing. If the criteria are not met, refer the case to a physician reviewer.
Discharge criteria InterQual® per body system	RN	Review medical record to validate condition at discharge and determine if the patient was medically stable for discharge.
Services were performed in the appropriate setting	RN	Determine whether the procedures performed were appropriate for the inpatient setting based upon Medicaid Guidelines and InterQual® criteria.
Services performed are in compliance with Medicaid Program Policy and Federal/State statutes	RN	Compare the services and documentation to the requirements of the MDCH Hospital Manual.
Services performed are in accordance with current professional standards of care	RN	Based upon current knowledge of practice standards and professional judgment. If in doubt, refer to physician reviewer.

PACER Validation Review Criteria	Reviewer Type	Review Process
PACER number obtained for readmissions within 15 days, transfers, elective admissions and continued stays for rehabilitative facilities	RN	For 15-day readmissions verify same condition and determine whether the case was continuation of care. Review transfers against Medicaid guidelines for appropriateness. For elective procedures, verify that the procedure is on the InterQual® inpatient list and whether the procedure was performed on the same day as the admission. For rehabilitation continued stay reviews, determine if the patient received clinical benefit from the rehab stay or whether the patient was awaiting placement.

If the inpatient admission meets InterQual® and other required criteria, then the RN/Audit Coordinator verifies that the PACER authorization number matches with the PACER authorization number in MPRO's system and the review is completed. However, if the inpatient admission does not meet the InterQual® criteria, then additional review is required.

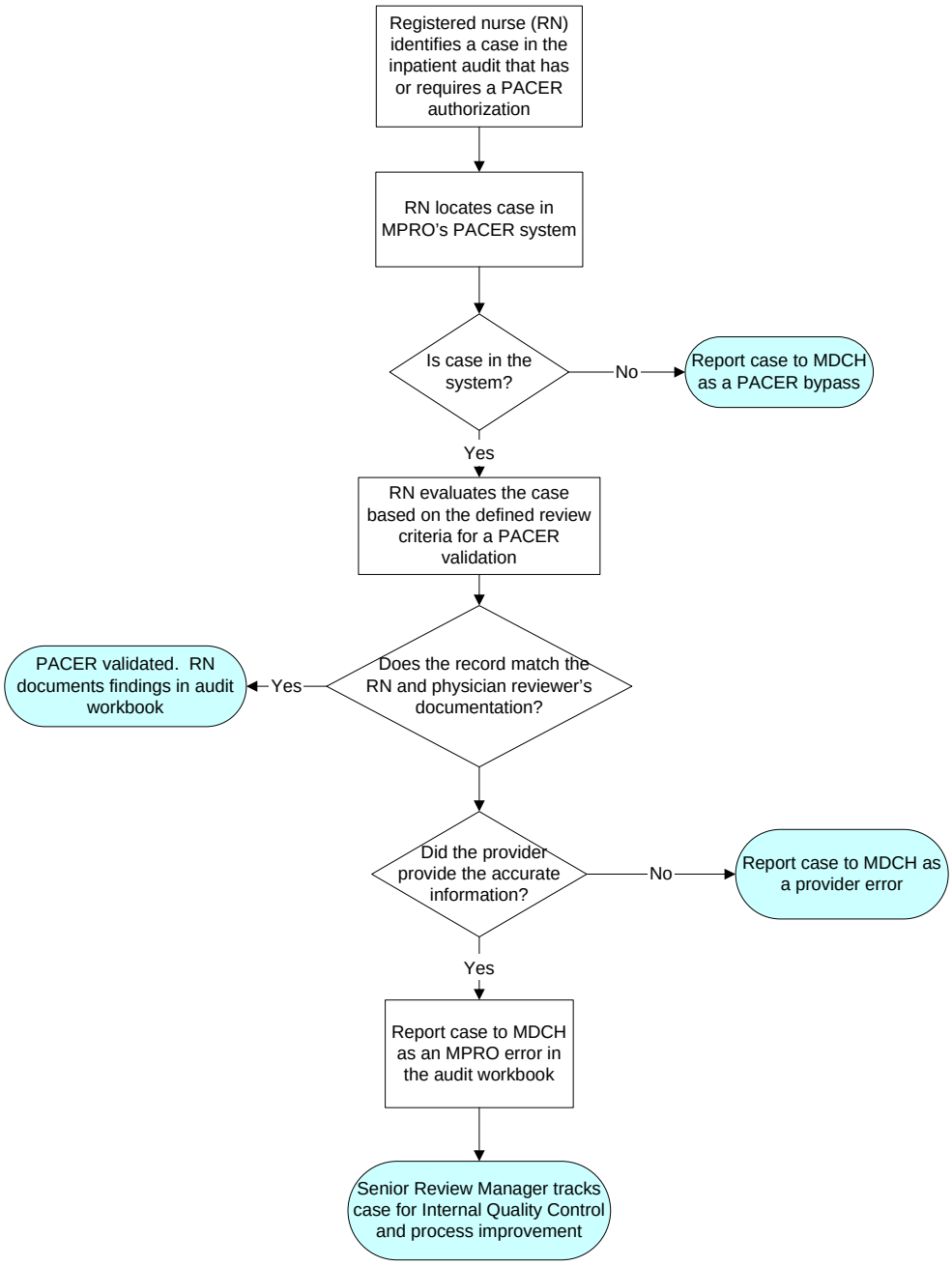
For cases where the admission is not found to be medically necessary, the RN/Audit Coordinator will obtain the documentation of the PACER Review Coordinator and the Physician Reviewer who initially approved the case. The RN/Audit Coordinator will review the documentation collected and compare it to what is present in the medical record. There are two possible types of errors as outlined below.

Scenario	Outcome
▪ Documentation in the medical record **matches** the information provided during the initial telephonic review, but criteria are not met.	MPRO Error
▪ Information in the medical record **does not match** the information provided during the initial telephonic review. Criteria were met on initial telephonic review, but documentation does not substantiate the admission.	Provider Error

The RN/Audit Coordinator will determine whether the case represents a provider error or an MPRO error, and will document the findings in the audit workbook. If the case is deemed to be an MPRO error, the information also will be provided to the Senior Medical Review Manager for internal quality control tracking.

A flow chart of the process for PACER validation is included on the following page.

Figure 16 - PACER Validation Process



H. Long Term Care Retrospective Review Process

MPRO has designed a process to accommodate the addition of retrospective reviews for new admissions to nursing facilities and the PACE program into our existing review process. Our existing inpatient retrospective review database can easily be accommodated to include the information related to the long term care retrospective reviews. Fields already exist to track the receipt of records, follow up activities and reviewer information. Other fields will be adjusted to capture the clinical and outcomes information that is specific to long term care reviews.

Review Process

The process for long term care retrospective reviews is different than the process used for inpatient and outpatient/ER audits in several ways. First, there is no site visit to the provider's facility in order to obtain records. Second, the review is based upon level of care criteria only and does not include a line-by-line billing audit. Finally, there is no workbook or review tool provided by MDCH. MPRO is responsible for developing and implementing its own tool for these reviews. This section will describe the process that we have developed for long term care retrospective reviews.

Identification of Sample

The first step in the process is for MDCH to send its monthly list of cases to MPRO, including the beneficiary identifiers (i.e. beneficiary name, identification number), date of admission and the period under review. The case list will be transmitted to the Senior Medical Review Manager. She will save a copy of the list in the file storage system and will assign the reviews to the LTC Review Coordinator, who is a registered nurse. The LTC Review Coordinator will use the web-based tool to locate the documentation related to level of care.

Obtain Medical Records

The LTC Review Coordinator will assign a Medical Records Technician to contact the appropriate providers to obtain a copy of the record for the period under review. For nursing facility records, we will request the following documentation:

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

For PACE program records, we will request the following documentation:

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

The nursing facility or PACE provider will have ten working days from the date of the letter to send the requested records to MPRO. If the records are not received by the tenth business day, the Medical Records Technician will contact the nursing facility or PACE provider via telephone to request the records. The provider will be granted an additional five working days to submit the requested record. Any records that have not been submitted after the fifth working day will be considered as not meeting the level of care criteria and will be documented as such.

Conduct Review

The LTC Review Coordinator will evaluate each case based upon nursing facility level of care criteria and exception criteria developed by MDCH. The documentation in the medical record will be evaluated for compliance with all required criteria. In addition, the LTC Review Coordinator will examine the information provided via the web-based tool to determine whether the case was approved based upon the nursing facility level of care definition, the MDCH exception criteria for frailty, behaviors or complex treatments or MPRO's documented professional judgment.

Each case will be documented as meeting level of care criteria or not meeting level of care criteria. Cases that are deemed not to meet the level of care criteria will be forwarded to a physician reviewer for a final determination. In addition, all cases that the LTC Review Coordinator recommends for approval based upon professional judgment will also be reviewed by a physician. For each case that meets level of care criteria, the LTC Review Coordinator will assign one of the following explanations:

- Meets MDCH nursing facility level of care criteria;
- Meets MDCH exception criteria; or
- Approved based on MPRO's professional judgment and documented risk for institutionalization.

The results will be documented on a paper worksheet that is attached to the medical record. The RN/Audit Coordinator will then enter the case information into the retrospective review database for reporting purposes.

Communication of Adverse Actions

In cases where our review staff are recommending that a beneficiary does not meet the level of care criteria for admission to a nursing facility or the PACE program, we will send the

appropriate notice of negative action letter to the beneficiary, along with a description of their appeal rights. Providers who are being denied payment for a nursing facility stay will be provided with a written notice to recover payment. MPRO will process any reconsideration requests prior to making its final determination regarding a case. The reconsideration process is further described in Part II, Section I.

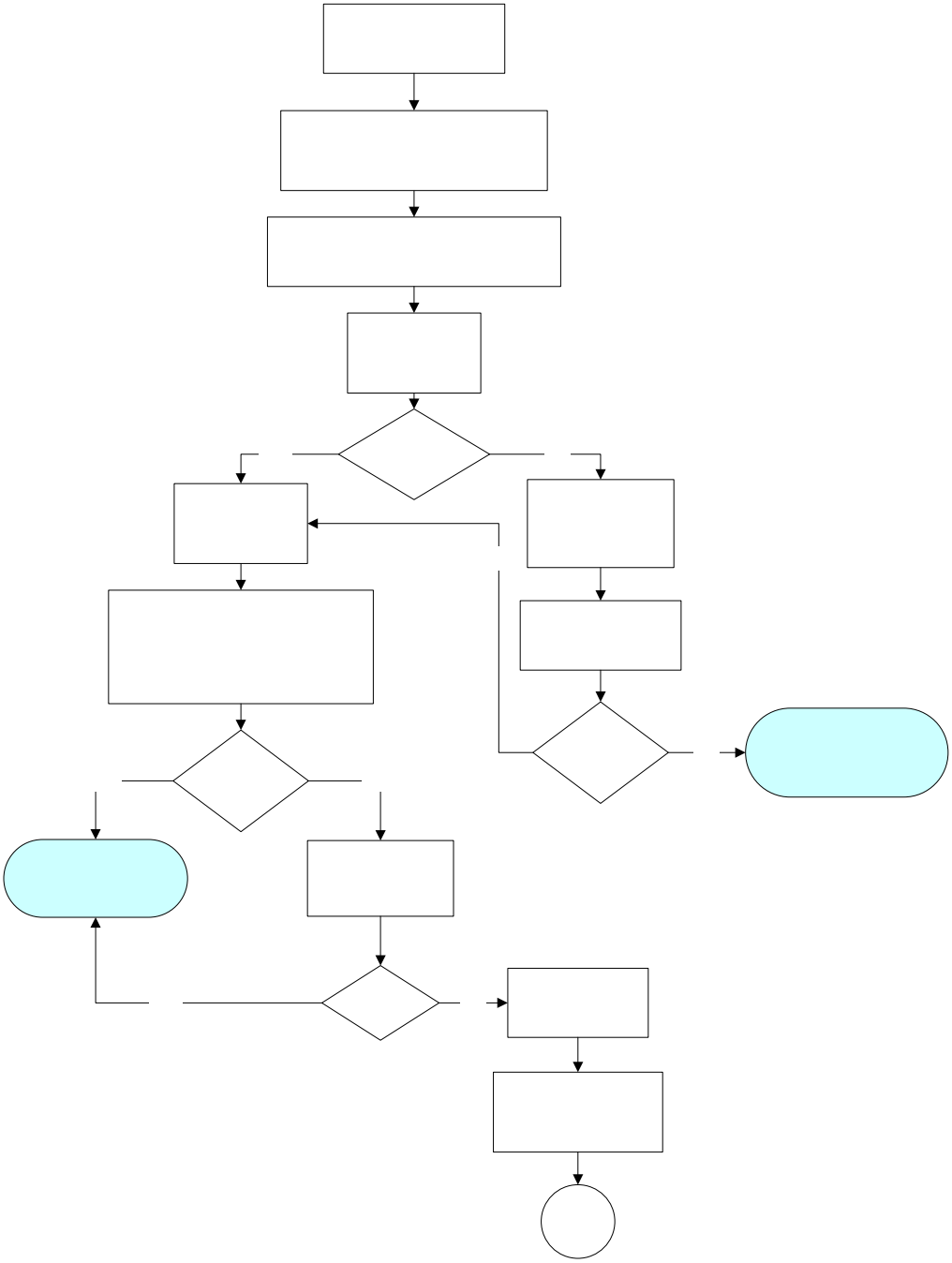
Report Findings

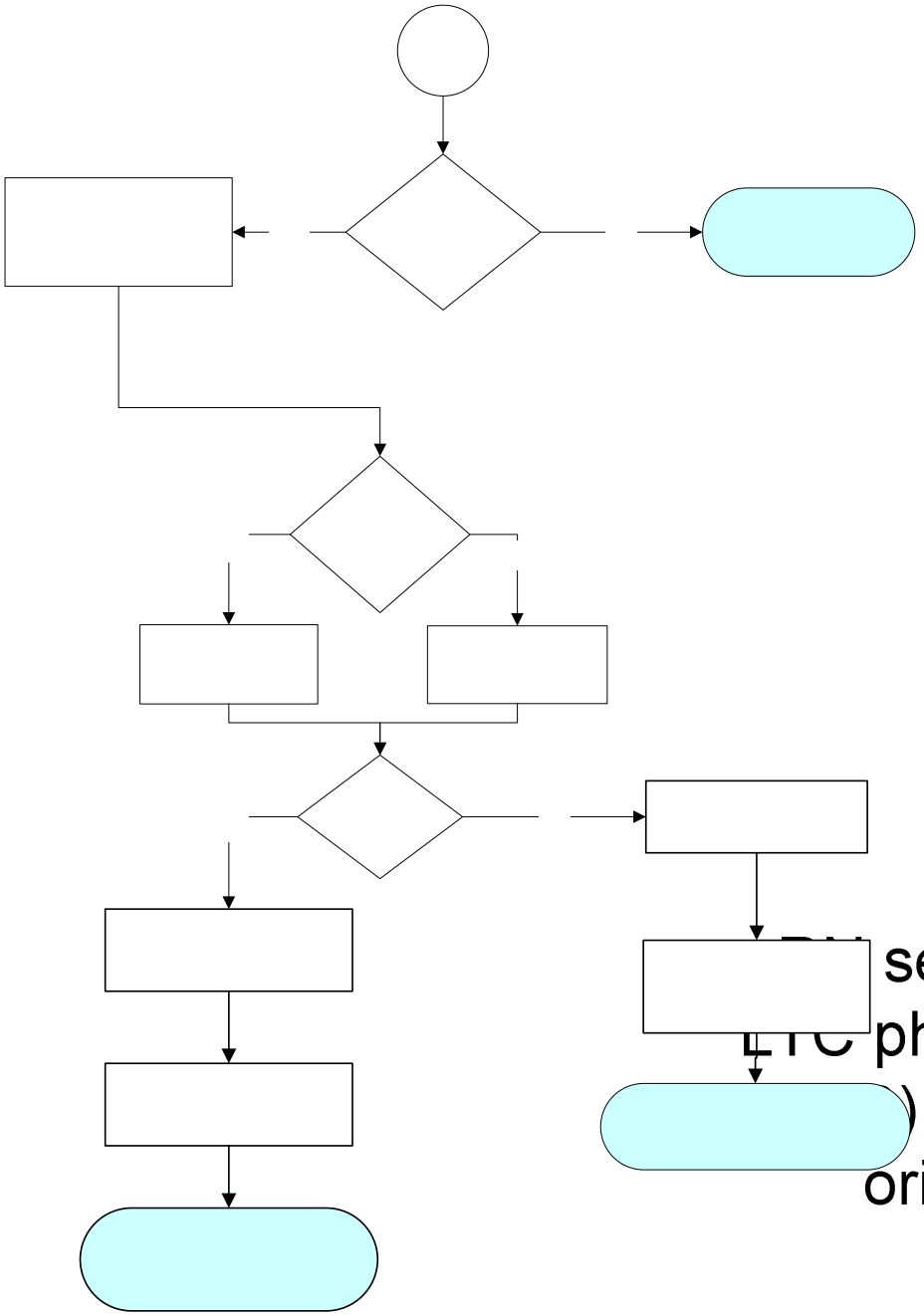
On a monthly basis, we will send an electronic list of all approvals and denial recommendations to the MDCH Contract Manager. This list includes any cases that have been fully processed and for which the time frame to request a reconsideration has passed. Cases that have been recommended for denial, but are still in the reconsideration process will be included in the following month's report.

Any cases that were approved by MPRO based on the level of care exception criteria and were found not to meet criteria during the retrospective review process will be investigated by the Senior Medical Review Manager in order to determine if process improvement opportunities exist or if staff training is needed.

The following pages include a flow chart of the long term care retrospective review process.

Figure 17 - Long Term Care Retrospective Review Process





sends to anoth
physician revie
not involved
original review

I. Appeals Process

MPRO is experienced in the timely and accurate disposition of provider and beneficiary appeals through our current scope for the Medicaid FFS review program, as well as our ongoing Medicare contract. MPRO has enhanced its existing reconsideration and appeals process to incorporate the new program requirements dictated in the RFP. Our staff is well-versed in the Medicaid requirements and is experienced in providing documentation to support each determination that is made. We frequently participate in administrative hearings for MDCH as well as other customers and are highly-skilled at providing expert testimony. This section will outline our process to comply with the appeals requirements.

Inpatient/Outpatient/Emergency Room Audits

Providers are still adjusting to the new approach for facility-specific outpatient/ER audits under our current contract with MDCH, and we anticipate that the addition of an inpatient audit may foster concern within the provider community. The sound and reliable audit processes used by MPRO will help to alleviate some of the provider concerns. However, MPRO anticipates that because each audit may result in a payment recovery that is spread across the entire audit population, most providers will initiate some form of appeal.

MDCH will be notifying the providers regarding the outcome of the audits, and will be the first to receive any appeals of the audit findings. Our role will be to support MDCH by providing expert nurses, coders and physician reviewers to testify at any preliminary or bureau conference, administrative hearing or judicial proceeding. The strength of our audit process is the assignment of a designated RN/Audit Coordinator for each facility's audit. This will enhance consistency and provide one point-of-contact related to the appeal. In addition, we use board-certified physicians who are actively practicing in Michigan but not at that specific hospital, to evaluate all denials and participate as needed in any appeal hearings.

The RFP specifies that MPRO shall return the audit workbook and related documentation to MDCH upon completion of the audit. In the event of an appeal, we will need access to this information in order to prepare our testimony. MPRO requests that MDCH allow us to retain a copy of the audit workbook for up to one year following the audit. If that is not amenable to MDCH, then we would like to develop an alternate process to ensure that the review staff has access to the necessary documentation to prepare for the appeal hearings.

In preparation for testimony, the RN/Audit Coordinator will review the audit results for each case in dispute and familiarize herself with the key findings and rationale. She will work with the physician reviewer and RHIT/coder (for inpatient audits only) to carefully review the findings, gathers documentation and prepares testimony for the hearing. In addition to testimony in the case, the RN/Audit Coordinator will be available to the MDCH representatives to prepare documents or answer questions that may arise prior to the hearing.

In our current contract with MDCH, MPRO staff routinely provide historical context to the MDCH staff attorney and the state appeals officer assigned to the case to prepare him/her for

participation in the hearing. We have been successfully performing the appeal process in support of this contract for the inpatient retrospective reviews for over 16 years.

Long Term Care Retrospective Reviews

The long term care appeals process is available to both providers and beneficiaries. Providers and beneficiaries must follow the internal reconsideration process at MPRO prior to filing a formal appeal with the State. This section will outline our approach for the internal reconsideration process and responding to appeals that are filed with MDCH for both providers and beneficiaries. The following table defines the general process for long term care appeals and highlights differences among provider and beneficiary appeals.

Table 15 - Long Term Care Appeals Process Features

Process Features	Provider Appeals	Beneficiary Appeals
Reconsideration Process	Review by a second physician not involved in the initial determination	Review by a second physician not involved in the initial determination
Time frame to request reconsideration	Within three working days of receipt of the initial denial	Not specified in the RFP; Will clarify with MDCH prior to implementation
Time frame for MPRO to process reconsideration	Not specified in the RFP. MPRO will respond within three working days if the beneficiary is in the facility and within thirty working days if the beneficiary has been discharged from the facility	Within three working days if the beneficiary is in the facility and within thirty working days if the beneficiary has been discharged from the facility
Appeal to the State	Through the Medicaid Provider Reviews and Hearings Administrative Rules	Appeals are made directly to MDCH using the appeal form (DCH-0092, Hearing Request) provided by MPRO
Time frame to appeal to the State	Within 3 working days of receipt of the final denial from MPRO	Not specified in the RFP; Will clarify with MDCH prior to implementation

The key to an effective reconsideration and appeals process is communication with the provider and beneficiary regarding the status of the case and the remedies that are available. Our approach includes written communication to the provider and beneficiary at the time the initial determination is made. The letter will describe the conditions under which the nursing facility or PACE program level of care was denied and the opportunity for a reconsideration through MPRO's internal process. Upon completion of our internal reconsideration process, the provider or beneficiary will be notified of their right to file and appeal at the State, and will be provided with the appropriate forms and process for doing so.

Provider Appeals Process

Whenever we recommend that a nursing facility stay be denied and payment recovered by MDCH, the provider will have an opportunity to request a reconsideration. We have a team of physicians with expertise in long term care available to review reconsideration requests.

Because MPRO's policy is to always have a physician review the initial denial, the reconsideration will be processed by a second physician who was not involved in the initial determination.

All reconsiderations will be submitted to the Senior Medical Review Manager, who will assign the request to the LTC Review Coordinator and an expert physician reviewer for processing. The case will be reviewed by the second physician independently against the level of care criteria. The physician will not have access to the notes or documentation of the first physician until after he or she has made a preliminary assessment of the case. The second physician will document his or her decision and will send the case back to the LTC Review Coordinator for processing.

If the case is approved, then the LTC Review Coordinator will send a letter to notify the provider and the beneficiary of the decision and will submit the case to MDCH as approved. If the case is denied, then the LTC Review Coordinator will send the appropriate notice to the provider. The reconsideration process will be completed within three working days.

If the provider is not satisfied with MPRO's final determination, then they may request an appeal to MDCH. If such an appeal occurs, we will provide registered nurses and physician reviewers to be involved the initial determination to assist MDCH with preparation for the hearing and provide expert testimony.

Beneficiary Appeals Process

The beneficiary appeals process will operate in a similar manner as the provider appeals process described above. If the beneficiary is in the facility when the reconsideration is requested, then we will process the case within three working days. If the beneficiary has already been discharged from the facility when the reconsideration is filed, then MPRO will process the case in up to 30 working days. If the case is upheld upon review, then the beneficiary will receive a negative action letter from MPRO that includes the appeal form, an addressed envelope and instructions for appealing the case to the State. The negative action letter will be sent on the same date that the determination was made.

In the event that a beneficiary and provider are requesting a reconsideration simultaneously, the Senior Medical Review Manager will make every effort to coordinate review of both cases by the same physician and ensure that a timely and consistent response is provided to both parties. If the provider has requested a reconsideration on a case and the beneficiary has not submitted a request, then the beneficiary will only be notified of the outcome of the provider's request in the event that the case status has changed (i.e. the case was approved on reconsideration.) Otherwise, no additional communication will be sent to the beneficiary since the status of the case remains the same.

We will maintain copies of all letters and communication with providers and beneficiaries related to reconsiderations and appeals. All documentation will be available for review at the request of MDCH.

J. Qualifications of Contractor's Staff for Audits/Long Term Care Retrospective Eligibility Review

Staff Requirements

MPRO has assembled an impressive and highly competent team of ten individuals to perform the tasks required for this contract. We have the distinct advantage of capitalizing on the collective strengths of our current review staff and executive leadership, their combined experience, and knowledge of Medicare and Medicaid programs and long term care to quickly execute start-up operations for the Michigan FFS Review contract.

Our staffing model maximizes the strengths within our current review team and is further strengthened by the addition of highly qualified registered nurses and physician reviewers with long term care experience.

Our 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. This model has been designed so that registered nurses that perform the audits will not perform the PACER review functions of the contract.

Our Audit Review Program will be managed by a Senior Medical Review Manager, Melody Petrul, RN who will serve as the primary point-of-contact for MDCH related to all project activities. Ms. Petrul has nearly 30 years of experience as a registered nurse in both the clinical setting and utilization and quality review management. Ms. Petrul is a registered nurse and has extensive experience in contract management, state and federal regulations related to medical review activities. Ms. Petrul will report to Colleen Cieszkowski, RN, MA, CPHQ, Senior Vice President of Quality and Review Operations.

Jeffrey Deitch, DO, has over 17 years of quality improvement experience and has served as MPRO's Medical Director since 1998. As Medical Director, he provides overall medical leadership for many of MPRO's health care quality improvement activities and collaborates in the medical peer review process for MPRO's contractual programs. Dr. Deitch is board-certified in both Family Practice and Geriatrics and maintains an active practice. He is affiliated with three major hospitals and a number of long term care facilities in southeast Michigan. Dr. Deitch has significant expertise in medical review and the elderly and is knowledgeable of nursing home policies and procedures.

Organization Chart

The following figure shows the proposed organization structure for the PACER/Long term Care PACER program. Lines of authority, responsibility, communication, and accountability are indicated. Following the organizational chart is a table summarizing the key project staff, their relevant skills and expertise, location, and dedicated hours to the project.

Figure 18 – Audit Organization Chart

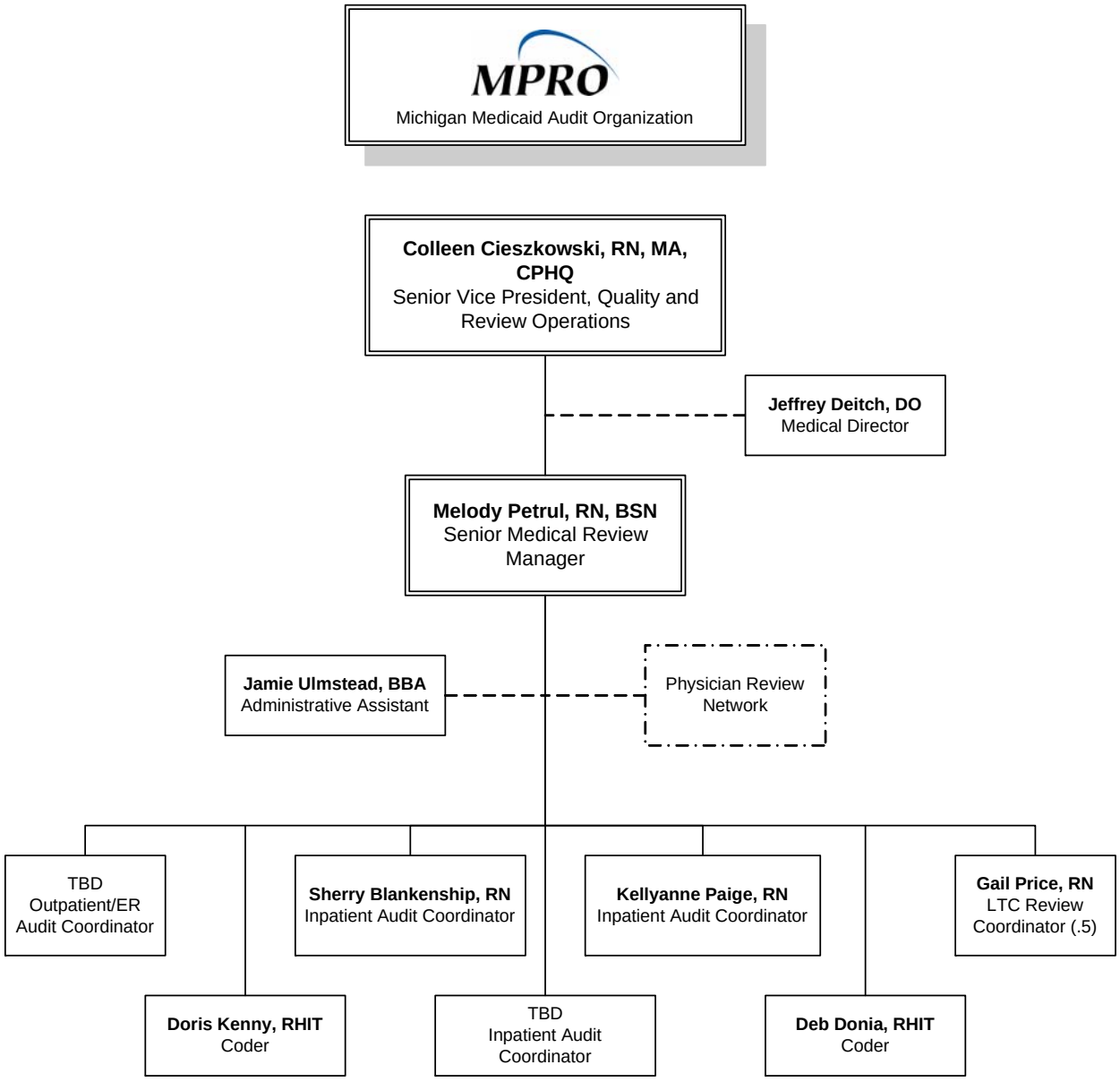

MPRO
Michigan Medicaid Audit Organization
Colleen Cieszkowski, RN, MA, CPHQ
Senior Vice President, Quality and Review Operations
Jeffrey Deitch, DO
Medical Director
Melody Petrul, RN, BSN
Senior Medical Review Manager
Jamie Ulmstead, BBA
Administrative Assistant
Physician Review Network
TBD
Outpatient/ER
Audit Coordinator
Sherry Blankenship, RN
Inpatient Audit Coordinator
Kellyanne Paige, RN
Inpatient Audit Coordinator
Gail Price, RN
LTC Review
Coordinator (.5)
Doris Kenny, RHIT
Coder
TBD
Inpatient Audit
Coordinator
Deb Donia, RHIT
Coder

Table 16 – Staff Experience

Name/Project Role	Michigan Medicaid	Medicare and Medicaid Population Characteristics, Policies, Data Systems	Knowledge of Inpatient Hospital ® Criteria	Knowledge of Long term Care Medicaid Exception Criteria	Clinical Study Methodology	Research Design and Methodology, Including Statistical Analysis	Quality Assurance Methodology (Assessment and Improvement Technologies)	Knowledge of Inpatient/Outpatient Hospital/ER/PACER/Utilization Review/	Knowledge of Long Term Care	Quality Assurance//Improvement Principles	Data Analysis/Reporting	Knowledge of Inpatient/Outpatient Hospital/ER/PACER/Utilization Review/ Long term care
Key Staff												
Colleen Cieszkowski, RN, MA, CPHQ Senior VP of Quality and Review Operations	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Julie Santinga, MA Chief Information Officer/Senior VP of Information Technology	✓										✓	
Jeffrey Deitch, DO Medical Director	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓
James Mitchiner, MD, MPH, FACEP Associate Medical Director	✓	✓	✓		✓		✓	✓	✓	✓		✓
Melody Petrul, RN Sr. Medical Review Manager	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓
Yvonne Kendall, RN, BSN Review Process Manager	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓
Additional Professional and Technical Staff												
Rebecca Kolinski, MHA Director of Review Services	✓	✓				✓	✓	✓		✓	✓	
Albert Bayer, MD Audit Physician Reviewer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steven Katzman, MD Audit Physician Reviewer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Manju Mathews, MS Systems Developer	✓	✓				✓					✓	
Jan Howe, RN Systems Analyst	✓	✓			✓	✓	✓			✓	✓	
Gail Price, RN LTC Review Coordinator	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓
Kellyanne Paige, RN Inpatient Audit Coordinator	✓	✓	✓		✓		✓	✓	✓	✓		✓
Sherry Blankenship, RN Inpatient Audit Coordinator	✓	✓	✓		✓		✓	✓	✓	✓		✓
Doris Kenny, RHIT Coder	✓	✓	✓		✓		✓	✓	✓	✓		✓
Debra Donia, RHIT Coder	✓	✓	✓		✓		✓	✓	✓	✓		✓

Continuity of Staff

The success of the Michigan FFS Review contract depends upon consistent and reliable project staffing. We assure MDCH that the key project staff outlined in this proposal will be dedicated and available to fulfill their assigned duties throughout the duration of this contract. However, there are instances where changes in project staff may be necessary due to illness, disability or termination of employment. In the event that a change in project staffing is necessary, MDCH will be notified immediately. MDCH will also have the opportunity to review and approve any new additions to the core project team. We will support an effective transition and thorough transfer of knowledge from the outgoing project team member to his or her replacement and assure the MDCH that all replacement staff will have the same licensures as the outgoing staff member (i.e. RN replaces an RN).

Nurse Review Staff

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 and are knowledgeable of all Inpatient/Outpatient Hospital/Emergency Room 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.

The nurse review team will be supported by coders who are Registered Health Information Technologists (RHIT.) All of the coding for inpatient hospital reviews will be validated by an RHIT/Coder.

We will provide MDCH with proof of licensure for all relevant staff members annually and each year thereafter. Please refer to section IV-C Management Summary for more information on our staff education and training program. A job description for the Outpatient/ER Audit Coordinator and Inpatient Audit Coordinator positions are included in Appendix F. Proof of licensure for all new employees (where licensure is required) will be sent to MDCH at the time of hire.

Professional Review Staff

Our professional review network is an integral component of our utilization review program. Our professional review network is comprised of over 200 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/Emergency Room Services/PACER/Utilization Review/Long term care. For this review program, our physician reviewers will serve as a resource for audits and will participate in the long term care review process.

Physician reviewers will be kept abreast of current trends and changes in Medicare and Medicaid principles that impact long term care facilities, and long term care trends through quarterly educational sessions, newsletters, and hands-on orientation. They also 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.

Please refer to section IV – C Management Summary, Part I - Qualifications of Contractors Staff for brief biographies of the key staff and additional professional and technical staff that comprise the Audit Review Team. In addition to the key staff presented in Part I, listed below are additional key staff and additional professional and technical staff dedicated exclusively to the Audit Review Team. Detailed resumes with reference contact names and copies of relevant licensure for key staff and additional professional and technical staff are included in Appendix G and Appendix H, respectively.

Key Staff Biographies

James C. Mitchiner, MD, MPH, FACEP – Associate Medical Director

Role: Provide physician review services related to the inpatient and outpatient/ER audits. Participate in hearings and appeals at MDCH as needed.

Dr. Mitchiner has over 20 years of clinical experience in the field of emergency medicine. He is currently a staff physician in two Ann Arbor, Michigan – area Emergency Departments at St. Joseph Mercy Hospital in Ann Arbor and Chelsea Community Hospital in Chelsea, Michigan and is a clinical faculty member of the University of Michigan – St. Joseph Mercy Hospital Emergency Medicine Residency Program. As part of his duties as Associate Medical Director at MPRO, Dr. Mitchiner develops and maintains collaborative relationships with pertinent organizations and clinical consultants, conducts Web-based conferences, and performs mandatory EMTALA reviews. Dr. Mitchiner is an active member in many professional medical associations and societies, including the American College of Emergency Physicians, the Michigan College of Emergency Physicians (Past President), and the Michigan State Medical Society. He is certified by the American Board of Emergency Medicine and is published in both the peer-reviewed and non-peer reviewed literature. He is a frequent lecturer on EMTALA and various health care quality improvement topics.

He has a Doctorate of Medicine from the University of Illinois College of Medicine and earned a Master's degree in Health Management and Policy from the University of Michigan. Dr. Mitchiner is also an Assistant Clinical Professor of Emergency Medicine at the University of Michigan Medical School.

Additional Professional and Technical Staff Biographies

Sherry Blankenship, RN – Inpatient Audit Coordinator

Role: Serve as lead auditor responsible for conducting quarterly hospital audits. Coordinates audit and prepares final report. Participates in the appeals process, as requested by MDCH.

Sherry Blankenship has 20 years of experience working in a variety of positions for MPRO. Ms. Blankenship is extremely knowledgeable of the review and coding process and has exceptional organizational skills. She currently is a Review Coordinator for MPRO's FFS contract with the State of Michigan and is responsible for performing PACER authorization telephonic reviews. She also performs coding review on retrospective cases and determines which cases require coder or physician review.

She has significant experience in performing inpatient retrospective review for both our Medicare and Medicaid contracts. In collaboration with hospital liaisons, she schedules on-site visits at hospitals, responds to questions, and performs on-site review. Ms. Blankenship earned a Bachelor's degree in nursing from Beaver County Community College, Monaca, Pennsylvania.

Kellyanne Paige, RN, BSN, MS – Inpatient Audit Coordinator

Role: Serve as lead auditor responsible for conducting quarterly hospital audits. Coordinates audit and prepares final report. Participates in the appeals process, as requested by MDCH.

Kellyanne Paige has over 20 years of experience as a registered nurse in a variety of clinical settings including long term care. At MPRO, she is a Review Coordinator and is responsible for applying appropriate criteria to necessity determinations, and serves as a liaison to physician reviewers, and performs ER and outpatient reviews for MPRO's current contract with MDCH. Prior to MPRO, she was Director of Clinical Services at SCCI-Detroit LTAC where she was responsible for the integration and coordination of clinical services, and ensured facility complied and upgraded all regulatory standards. She was also a leader of care management (SW/DCP/UR) and has experience in denial and appeals by working with the Blue Cross Blue Shield audits. In addition to her clinical experience, Ms. Paige has significant utilization review and quality management experience gained through previous positions of Leader of Care Management Services, Clinical Pathway Coordinator, QI Coordinator Homecare, Assistant Clinical Manager, and Administrative Nursing Supervisor. Ms. Paige earned a Bachelor's degree in Nursing from the Mercy College of Detroit and a Master of Science degree in Organizational Leadership and Administration from Concordia University.

Gail Price, RN – Long Term Care Review Coordinator

Role: Serve as lead auditor responsible for conducting long term care retrospective reviews and coordinating efforts with physician reviewers. Documents information in MDCH's web-based tool and prepares reports. Participates in the appeals process, as requested by MDCH.

Gail Price currently works for MPRO as a Review Coordinator. Her responsibilities include chart review, hospital readmissions, PACER inquiries, and hospital transfers. Before joining MPRO, Ms. Price was a Case Manager, where she monitored Medicare compliance. She worked as a critical care staff nurse at Methodist Hospital in Indianapolis, Indiana; and a surgical nurse at Rockford Memorial Hospital in Rockford, Illinois. She also has experience as a field auditor, where she reviewed medical records with hospitals invoices for billing accuracy.

Ms. Price received her degree of nursing from St. Francis School of Nursing, in Peoria, Illinois; and graduated summa cum laude with a Bachelor of Science in Nursing from Eastern Michigan University, in Ypsilanti, Michigan.

Doris Kenney, RHIT - Coder

Role: Provide coding assistance and support to the nurse reviewer for the inpatient audits. Performs review of procedure codes and DRG validations. Assists with preparing reports. Participates in the appeals process, as requested by MDCH.

Doris Kenney is a Coding Compliance Analyst for MPRO. Currently, her responsibilities include reviewing medical records to verify that the diagnostic and procedural coding practices within the review system are consistent with established coding rules and conventions. She identifies trends in her review findings and also trains review coordinators and physician reviewers on medical case review, guidelines and validation. Ms. Kenney represents MPRO at statewide DRG appeals and hearing processes. Ms. Kenney holds an Associate's degree in Science from Henry Ford Community College.

Debra Donia, RHIT – Coder

Role: Provide coding assistance and support to the nurse reviewer for the inpatient audits. Performs review of procedure codes and DRG validations. Assists with preparing reports. Participates in the appeals process, as requested by MDCH.

Debra Donia is a Coding Compliance Analyst at MPRO. Currently, her responsibilities include reviewing medical records to verify that the diagnostic and procedural coding practices within the review system are consistent with established coding rules and conventions. She identifies trends in her review findings and also trains review coordinators and physician reviewers on medical case review, guidelines and validation. She also represents MPRO at statewide DRG appeals and hearing process. Prior to joining MPRO, she was a coder at Henry Ford Hospital where she coded and abstracted inpatient records using current ICD-9 codes and guidelines, Coding Clinics, and Codemaster 32 Plus. Ms. Donia earned an Associate's degree in Applied Science from Schoolcraft College, Livonia, Michigan.

Other Staffing Requirements

Reports

Our project team has significant experience in producing accurate and timely reports that meet or exceed MDCH requirements. Please refer to section IV-C Management Summary, Part II-Reports for more on our entire reporting process.

Collaboration with Providers

We have been operating within the State of Michigan for over 20 years and have developed relationships with physicians, hospitals, nursing homes and home health agencies throughout the state. MPRO is respected as an unbiased and impartial clinical review organization. Our positive working relationship with the provider community is one of our strongest assets. By selecting us as the contractor for the Michigan Statewide Hospital Admission Certification and Review Program, MDCH will maintain the trusted confidence of tried and true provider relations. Refer to Prior Experience for more information on our provider collaborations.

Privacy, Data Security and Confidentiality

The Michigan Audit Review Team has significant experience in the proper handling of confidential information and has documented policies and procedures to ensure the confidentiality and security of all data that are maintained by MPRO. Refer to Section IV-C Management Summary for more detail on confidentiality and security.

K. Reports

We will provide reports to MDCH electronically to document the progress and results of the audits and retrospective reviews conducted for inpatient, outpatient, emergency room and long term care admissions. Based upon our activities with the current Medicaid FFS review contract, we are already equipped to provide many of the desired reports and can easily adapt our process to accommodate new reports. We will coordinate with MDCH at the onset of the contract to develop a reporting format that best meets the needs of both parties and will be flexible to respond to any changes desired by MDCH throughout the term of the contract.

Audit and Review Work Plan

In order to track anticipated audit activities, we will develop a quarterly audit work plan that will be submitted to MDCH. The work plan for the first quarter of the contract will be presented to MDCH on October 31, 2004. All subsequent work plans will be provided to MDCH according to the following schedule. If the due date falls on a non-working day, then we will submit the report on the last working day of the quarter.

Table 17 – Audit Work Plan Schedule

Audit/Review Quarter	Due Date
October 1, 2004 – December 31, 2004	October 31, 2004*
January 1, 2005 – March 31, 2005	December 31, 2005
April 1, 2005 – June 30, 2005	March 31, 2005
July 1, 2005 – September 30, 2005	June 30, 2005
October 1, 2005 – December 31, 2005	September 30, 2005

* Preliminary work plan due date for the first year of the contract.

Each report will contain a summary of proposed audit activities including the number of on-site audits for inpatient and outpatient/ER and the number of long term care reviews. This work plan is different from the quarterly work plans that we currently provide for MDCH, since it will be MDCH and not MPRO that is determining the sample sizes and the provider sites to be audited. In order to accurately complete the report, we will need for MDCH to notify us of the providers that they are scheduling for audit during the upcoming quarter prior to the due date of the report.

Our current work plan template includes the following for each audit to be completed:

- Receive audit packet;
- Review audit packet;
- Contact provider;
- Send case listings to provider;
- Retrieve medical records from provider;
- Create documentation for review;
- Perform review;
- Prepare reports; and
- Administrative tasks.

A sample work plan is included in Appendix D. The template is written in Microsoft Project and is easily applied to any audit for any time frame. This work plan will be adjusted to accommodate the changes in the audit strategy for this contract. The work plan will include a high level summary of all of the audit tasks to be completed, in addition to a work plan for each audit. A sample cover page reflecting these changes is also included in Appendix D.

Reports

The reports provided to MDCH will track MPRO's progress in meeting contract requirements. We use rigorous internal controls in the production and verification of reports prior to submission to MDCH, as described in Part I, Section I that outlines the process for PACER reports. The following is a description of the reports to be provided for the audits and long term care retrospective reviews:

Monthly Reports

This report will include a narrative description of the audits initiated, the audits in process and the audits completed during the past month. This report will allow MDCH to determine how many audits are in each stage of completion. The report will include the following components:

1. Summary of inpatient and outpatient/ER audits including the following:
   a) Audits initiated during the past month, including the provider name, date initiated, assigned staff and stage of completion;
   b) Audits in process from previous month, including the provider name, date initiated, assigned staff and stage of completion; and
   c) Audit completed in the past month, including the provider name, date initiated, date completed, assigned staff and status of report.

2. Summary of PACER validation review findings, including the following:
   a) Number of PACER validations conducted;
   b) Number of PACER authorizations not meeting criteria;
   c) Number of provider errors and percent of total errors assigned to providers; and
   d) Number of MPRO errors and percent of total errors assigned to MPRO.

3. Summary of review findings for long term care audits, including the following:
   a) Number of long term care cases reviewed;
   b) Number of cases approved;
   c) Number of cases denied at level 1 and level 2;
   d) Number of appeals and the outcomes of each appeal;
   e) Utilization trends; and
   f) Quality findings.

Quarterly Reports

The quarterly reports will contain all of the information from the monthly report, with the totals rolled up to incorporate the entire quarter's worth of activity.

Annual Report

The annual report will contain all of the information from the monthly and quarterly reports, with the totals rolled up to incorporate the entire year's worth of activity.

Reporting Schedule

We will submit all reports to the MDCH Contract Manager electronically and in hard copy according to the following reporting time line. This time line only covers the first year of the contract.

Table 18 – Audit/Review Reporting Schedule

Report Name	Time Period	Due Date
Monthly Status Report	October 2004	November 5, 2004
	November 2004	December 5, 2004
	December 2004	January 5, 2005
Quarterly Status Report	October 1, 2004 through December 31, 2004	January 31, 2005
Monthly Status Report	January 2005	February 5, 2005
	February 2005	March 5, 2005
	March 2005	April 5, 2005
Quarterly Status Report	January 1, 2005 through March 31, 2005	April 30, 2005
Monthly Status Report	April 2005	May 5, 2005
	May 2005	June 5, 2005
	June 2005	July 5, 2005
Quarterly Status Report	April 1, 2005 through June 30, 2005	July 31, 2005

Monthly Status Report	July 2005	August 5, 2005
	August 2005	September 5, 2005
	September 2005	October 5, 2005
Quarterly Status Report	July 1, 2005 through September 30, 2005	October 31, 2005
Annual Report	October 1, 2004 through September 30, 2005	October 31, 2005

We are willing to work with MDCH to adopt changes to the reporting formats or due dates at any time throughout the term of the contract. One suggestion from MPRO is to combine the final quarterly report and the annual report into one document, since they are due on the same date for each contract year.

L. CONTRACT MONITORING

As a current contractor of MDCH, we are committed to ensuring exceptional performance and full compliance with all contract terms and requirements. There are two aspects of contract monitoring that will be discussed in this section. First, we will focus on MPRO's role in supporting MDCH's contract monitoring process. Second, we will outline MPRO's internal mechanisms to monitor contract compliance through our internal quality control process.

MDCH Contract Monitoring

We will provide all necessary documentation and access so that so that the MDCH Contract Manager is able to effectively monitor MPRO's contract performance. This includes, but is not limited to the following activities:

- Offering the Senior Medical Review Manager as the primary point-of-contact in order to facilitate requests from MDCH;
- All reports are submitted electronically and in compliance with HIPAA transaction standards;
- Providing documents, reports and financial statements to the MDCH Contract Manager within the required time frames. Reports will be transmitted electronically to MDCH in compliance with HIPAA;
- Arranging for access to the PACER program review system for the MDCH Contract Manager in a method to be determined by MDCH;
- Participation in weekly meetings or teleconferences with the MDCH Contract Manager during the first month of the contract and at least monthly for the remainder of the contract;
- Allowing access to MDCH or its designee to complete a site visit at the MPRO offices at least once per year to monitor work in progress under the contract. We will reimburse all travel, lodging and meal expenses for up to two State of Michigan representatives for this annual review;
- Submitting up to five records per audit to MDCH for validation of MPRO's determination;
- Measuring and providing documentation of timeliness and other performance standards as described in Part II, Sections L and O; and

- Providing timely notification to the MDCH Contract Manager related to any sanctions, as described in Part II, Section O.

MPRO Contract Monitoring

In order to ensure compliance with the contract requirements we have initiated our own contract monitoring system through our unique internal quality control (IQC) process. In order to set up the IQC, we have defined all of the contract performance standards including anticipated volume, timeliness and accuracy standards. The following table summarizes the key performance indicators monitoring of contract activities.

Table 19– Key Performance Indicators for Audit/Retrospective Reviews

Review Type	Category	Performance Indicator
Audit: PACER Validation	Review Accuracy	Review information from PACER validation process will meet criteria for PACER authorization (e.g. appropriate application of IQ criteria and SI/IS, no errors identified) for all cases reviewed for PACER validation.
Audit	Review Time	100% completion of 10 audits per contract year for IP review. 3 audits completed per each 1st, 2nd, and 3rd quarter, and a 4th audit completed during the 4th quarter.
Audit	Review Time	100% completion of 10 audits per contract year for ER/OP review. 3 audits completed per each 1st, 2nd, and 3rd quarter, and a 4th audit completed during the 4th quarter.
Audit	Review Time	100% completion of 1 audit (250 cases) per each quarter of the contract year for LTC exception requests.
Audit	Review Time	100% of reconsideration decisions on provider appeals for adverse determinations for long term care exception requests (admission or continued stay) are completed within: ▪ Three working days of the appeal request for concurrent cases ▪ 30 working days from receipt of the record for retrospective cases
Audit	Review Time	100 % of beneficiary appeals requested during the inpatient stay for LTC exception requests must be completed within 3 working days of the appeal
Audit	Review Time	100 % of beneficiary appeals requested after discharge for LTC exception requests must be resolved within 30 working days of the appeal.
Telephonic and Audit	Operations	All work plans and reports are provided electronically to the MDCH contract manager according to the contract deliverable schedule for each document type no less than 100% of the time.

In addition to the key performance indicators listed in Table 19, we are committed to monitoring other critical internal processes that have an impact on the quality of the Audit/Long Term Care

Retrospective Review program. To promote the consistency of review decisions, we will implement inter-rater reliability (IRR) monitoring on a random sampling of cases. The IRR assessment tools will test whether or not the review processes are consistently followed and the review outcomes are determined in a reliable and consistent manner. Appendix E contains detailed information regarding MPRO's IRR process. The following table reflects our inter-rater reliability standards.

Table 20 – Inter-Rater Reliability Standards

Review Type	Category	Performance Indicator
Audit	Review Accuracy	100 % of cases selected for IRR review from the IP/ER/OP audit, receive a score of 90% or higher for the process validation and 100% on all outcome decisions.
Audit	Review Accuracy	100 % of cases selected for IRR review from the audit of LTC exception requests, receive a score of 90% or higher for the process validation and 100% on all outcome decisions.

MPRO has also identified additional administrative and operational indicators that we will monitor. These indicators will provide information about essential work processes and support services necessary to fulfill contractual obligations. A listing of these indicators can be found in the IQC plan included in Appendix E.

Indicators will be regularly analyzed for performance, and trended over time when appropriate. The Senior Medical Review Manager will have primary responsibility for administration of monitoring activities. We will monitor and adjust work processes as necessary in order to ensure rigorous adherence to the deliverables of this contract. Trends that signal areas for improvement will be reviewed, and process changes implemented when appropriate. Internal monitoring of the indicators will be maintained in graph format that allows for trending of performance over time, when appropriate. Other data display methodologies will be applied when necessary (e.g., tabular format). MPRO will make these findings available to MDCH.

M. MILESTONES AND DELIVERABLES

As the current contractor for the FFS review programs, we are in a unique position to be able to meet all of the MDCH contract milestones and deliverables with little or no start-up time. We have the Michigan-based facility, management infrastructure, experienced staff, capable phone system, MDCH-specific computer system and audit/review processes in place for immediate start-up after the contract negotiations are completed. The following matrix outlines MDCH's milestones and deliverables and our compliance plan.

Table 21 - Milestones/Deliverables - Readiness for Implementation

MDCH Milestone or Deliverable	Due Date	MPRO Compliance Plan

MDCH Milestone or Deliverable	Due Date	MPRO Compliance Plan
a) Operational system in place, including but not limited to sufficient staff.	November 1, 2004 or one month from start-up of the contract	MPRO is currently in compliance with this requirement with the exception of the process for long term care exception reviews, which will be in place prior to November 1, 2004.
b.i.) Sufficient number of RN's with experience in the areas of inpatient, outpatient, emergency room, PACER and long term care.	November 1, 2004 or one month from start-up of the contract	MPRO currently has a team of experienced review nurses in the areas of inpatient, outpatient, emergency room, PACER and long term care. Nurses with long term care experience will be reassigned from other duties at MPRO to meet the requirements of this contract, or additional staff will be hired and trained by the deadline of November 1, 2004.
b.i) Physicians experienced in the area of long term care to perform the audit/review duties in the contract	November 1, 2004 or one month from start-up of the contract	MPRO has physicians experienced in long term care reviews, including Dr. Jeffrey Deitch, our Medical Director. These physicians are available and accessible to the LTC Exception and LTC Review Coordinators to complete LTC reviews.
b.i) Separate staff designated for the PACER authorization and audit/review functions.	November 1, 2004 or one month from start-up of the contract	In order to meet the terms of this contract, we have divided the nurses between PACER and audit/review functions. As demonstrated in the organizational charts in Part I, Section J and Part II, Section J, there is no duplication of staff between the PACER and audit/review functions.
b.ii) Contractor has fully trained its staff on the specifics of the audit/review processes.	November 1, 2004 or one month from start-up of the contract	Our review staff is currently trained in the audit and review functions for PACER authorizations and inpatient, outpatient, emergency room and PACER validation reviews. We are in the process of reviewing the MDCH policy for long term care reviews and will train staff regarding this new process within two weeks of the contract start date.
b.ii) Contractor's staff has sufficient knowledge to make determinations of medical services needed.	November 1, 2004 or one month from start-up of the contract	Our review staff currently has the knowledge of Michigan-specific policies and review criteria in order to make determinations regarding medical services needed. The training provided for the long term care portion of the reviews will ensure our compliance with this requirement prior to November 1, 2004.
b.iii) Contractor has the ability in place to accept, process and transmit to MDCH those audits that have been completed.	November 1, 2004 or one month from start-up of the contract	Our current computer system is able to accept sample files, process audits and transmit results electronically to MDCH for inpatient audits, outpatient/emergency room audits and PACER validations processed. We will develop capacity to track long term care exception requests within our PACER system or the web-based tool provided by MDCH by November 1, 2004. We will design an electronic spreadsheet to track all long term care retrospective reviews by November 1, 2004.

MDCH Milestone or Deliverable	Due Date	MPRO Compliance Plan
b.iv) Contractor has quality assurance procedures in place to assure it follows all State and Federal laws for Confidentiality.	November 1, 2004 or one month from start-up of the contract	As a longstanding contractor of CMS and the State of Michigan, we have always had a solid infrastructure to preserve confidentiality of information in compliance with all applicable State and Federal laws. Our confidentiality and security procedures are in compliance with HIPAA and other applicable regulations. More information on our confidentiality policies is included in Section IV – C Management Summary.

Table 22 - Milestones/Deliverables – Program Specifications

MDCH Milestone or Deliverable	Due Date	MPRO Compliance Plan
a) Contractor will complete the audit/review process within the timeframes described in the RFP.	October 1, 2004	We are currently in compliance with all of the time frames for our current contract with MDCH. In Section P, we have outlined a plan to continue to meet these timeframes.
a) Contractor will submit the required reports within the timeframes specified in the RFP.	October 1, 2004	We are currently submitting reports to MDCH within the time frames required by our current FFS review contract. These time frames are similar to those requested in the RFP. We are prepared to meet all of the reporting time frames and have created a schedule of all report deadlines for the year, which is included in Part II, Section K.
b) Contractor shall retain all records until the audit/review is closed (settlement is reached) or the records are requested by the Appeals section.	October 1, 2004	We currently maintain all contract records at the MPRO office in Farmington Hills, Michigan. Archived records are maintained at an off-site storage facility. We have a medical records room where all of the documents are stored, either in paper copies or on CD. We store all case documents until the final determination is made and any appeals have been processed.

As outlined in the tables above, we are currently in compliance with all of the requirements, with the exception of the long term care exception reviews and retrospective reviews. With additional training and orientation, our team of experienced and knowledgeable reviewers will be prepared to initiate these services prior to the deadline of November 1, 2004.

N. Fraud and Abuse

Our review staff members are trained on the importance of identifying and reporting suspected fraud and abuse. In providing these services, we will use the following definitions of fraud and abuse that were provided on the Web-site, michigan.gov/mdch:

> **Fraud** – Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

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

The Senior Medical Review Manager is the contact for all staff who suspects fraud or abuse. She will coordinate the preparation of the necessary documentation, including provider and beneficiary identifying information and a full description of the situation, along with any reports or other documentation that is available. Our Manager will download and complete the fraud and abuse form from the MDCH website and submit it to the MDCH Contract Manager within 48 hours of identification of the situation.

O. SANCTIONS

MPRO will abide by the requirements set forth by MDCH regarding timeframes. During the first year of our contract, if we are found to be out of compliance with any aspect of contract, immediate steps will be taken to correct the situation. These steps may include development of a corrective action plan, staff re-training or changes to the program operations. All of our efforts will be documented and reported to MDCH during our monthly project status meetings.

In the second contract year, monetary sanctions may be imposed by MDCH. We hereby acknowledge the following terms and conditions under which sanctions may be imposed, beginning in the second year of the contract. The potential sanctions represent the maximum amount that may be enforced by MDCH. The actual amount of any sanctions will be determined at the sole discretion of MDCH after taking into account all factors related to the situation, including but not limited to MPRO's efforts in notifying MDCH regarding any contract violations or failures.

Table 23 – Audit and Review Sanctions and Notification Process

Contract Violation	Notification	Opportunity To Cure	Potential Sanction Imposed
1. Failure to submit any report or other material required under the contract by the specific due date.	MDCH provides notification via fax with hard copy to follow via overnight mail	MPRO shall have ten calendar days to cure the failure by submitting the required report or materials	$10,000 after the first ten calendar days and for each subsequent ten day period that the failure has not been cured
2. Failure to complete the required audits/reviews from the previous month in a timely manner	Not specified in the RFP	Not specified in the RFP	MDCH shall withhold 25% of the monthly future payments until the Contractor demonstrates adherence to the contract

Our internal quality control process will be used to ensure that our review processes are in compliance with MDCH requirements and to proactively address any potential areas of non-compliance. Our commitment to quality monitoring and improvement recognizes the need to measure and report areas of non-compliance so that appropriate action may be take to rectify the situation. All review staff are encouraged to notify the Senior Medical Review Manager or the

Senior Vice President of Quality and Review Operations as soon as they become aware of any situation that might jeopardize our ability to meet a time frame or contract requirement.

We acknowledge that MDCH may elect to adjust the number of audits/review conducted per provider type within 30 days notice to MPRO. MDCH may also change the audit/review process or cancel the contract with thirty (30) days notification to MPRO.

P. TIMEFRAMES

As a current contractor of the State of Michigan and the Centers for Medicare & Medicaid Services, we are currently in compliance with all required contract time frames. Further, we will meet the review time frames set forth by URAC in our accreditation as a Health Utilization Management organization. Under our current Medicaid FFS Review contract, 99.5% of all inpatient retrospective reviews are completed within 30 days of receipt of the medical record.

We will complete all inpatient and outpatient/ER audits and LTC retrospective reviews in a timely manner, according to the following schedule:

Table 24 – Retrospective Audit and Review Schedule

Type of Audit/Review	Contract Year	Number of Audits/Reviews Completed by Quarter				
		Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total
Inpatient Audits	2004 – 2005	3	3	3	1	10
	2005 – 2006	3	3	3	1	10
	2006 – 2007	3	3	3	1	10
	Contract Total	9	9	9	3	30
Outpatient/ER Audits	2004 – 2005	3	3	3	1	10
	2005 – 2006	3	3	3	1	10
	2006 – 2007	3	3	3	1	10
	Contract Total	9	9	9	3	30
Long Term Care Retrospective Reviews	2004 – 2005	250	250	250	250	1000
	2005 – 2006	250	250	250	250	1000
	2006 – 2007	250	250	250	250	1000
	Contract Total	750	750	750	750	3000

Each provider audit for inpatient and outpatient/ER will consist of approximately 250 beneficiaries, as defined by MDCH. The audits will include all inpatient admissions or outpatient/ER services provided to each beneficiary during the time frame covered by the audit.

Q. PAYMENT SCHEDULE

We hereby acknowledge and agree to the terms of payment as outlined in the RFP and will work with MDCH to develop a payment and billing schedule. The following are the terms of payment, notwithstanding any sanctions as defined in Part II, Section O:

- MDCH will reimburse based upon the number of audits/reviews completed. The payment will include the costs of the medical record review, report preparation and participation in any appeals or hearings as requested by MDCH;
- MDCH will reimburse monthly for hospital audits (both inpatient and outpatient/ER audits) based upon the number of audits completed in the previous month; and
- MDCH will reimburse for the long term care reviews based upon the number of reviews completed during the previous month.

MPRO agrees that we will provide expert testimony and assistance for any audits or reviews that are appealed, even if the appeal takes place after full payment has been rendered.

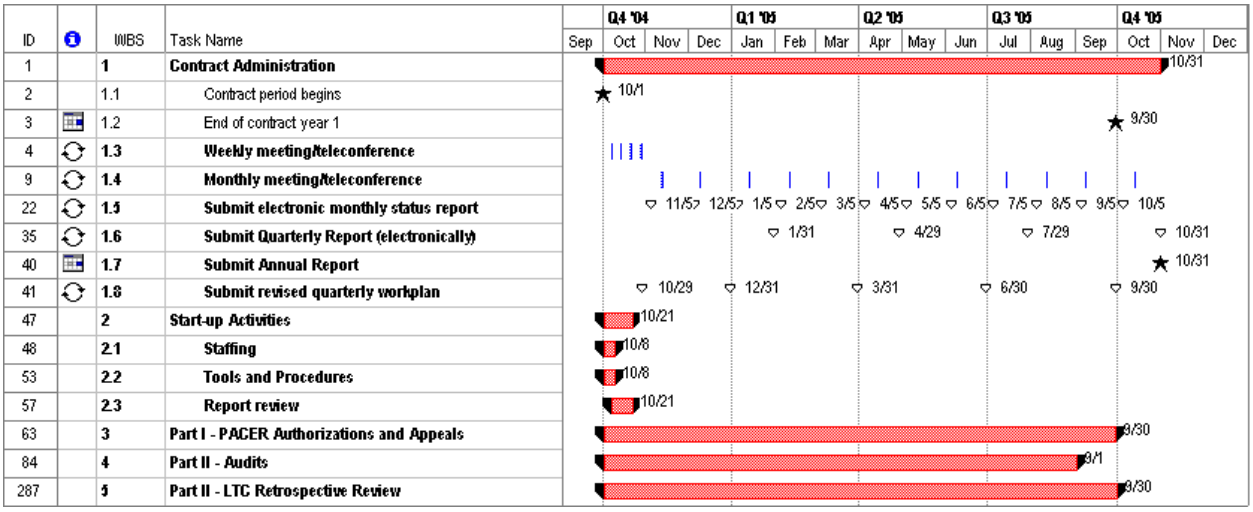
2. TECHNICAL WORK PLANS

In the previous section of this proposal we have described our approach to accomplishing all of the work of this contract including detailed flowcharts of all processes. In this section we have developed a comprehensive MS Project Schedule outlining the time-related aspects of the work. We have included information on the resources responsible for completing the work, and the hourly work effort associated with the different tasks. We acknowledge that our MS Project Schedule does not reflect the timeframes for inpatient audits as required in the bidder's questions and answers posted August 20th, 2004. Upon award of the contract, the timeframe for conducting these audits will be revised so that they take place monthly instead of quarterly.

The work plan covers the first contract year. The tasks are organized using a work-breakdown-structure (WBS) with tasks and sub-tasks. Dependencies between tasks (predecessors and successors) are incorporated when there is a logical connection between consecutive task elements.

MS Project provides a large number of report and print options to display the information incorporated into the work plan. We have included several of these as exhibits at the end of this section. In addition, we have also submitted an electronic copy of the MS Project file where other views may be examined or printed.

A roll-up of the main tasks is displayed below.



Exhibits for this section include:

- Exhibit A — Contract Year 1, Expanded Gantt Chart
- Exhibit B — Resource List
- Exhibit C — Resource List with Task Assignments
- Exhibit D — Gantt with Expanded Fields Displayed

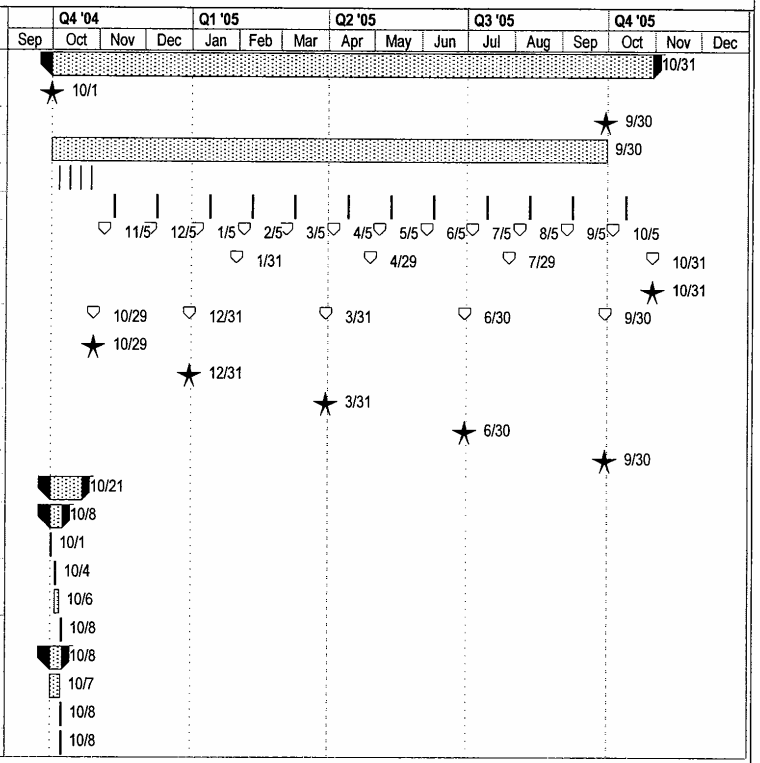
Exhibit A - Contract Year 1, Expanded Gantt Chart

Note: The following MS Project Schedule does not reflect the timeframes for inpatient audits as required in the bidder's questions and answers posted August 20th, 2004. Upon award of the contract, the timeframe for conducting these audits will be revised so that they take place monthly instead of quarterly.

MPRO

Michigan Statewide Hospital Admissions Certification and Review Program
Draft Workplan Subject to MDCH Review and Approval

ID	WBS	Task Name	Resource Initials
1	**1**	**Contract Administration**	
2	1.1	Contract period begins	
3	1.2	End of contract year 1	
4	1.3	Project Management	MRM,RHIT
5	**1.4**	**Weekly meeting/teleconference**	
10	**1.5**	**Monthly meeting/teleconference**	
23	**1.6**	**Submit electronic monthly status report**	
36	**1.7**	**Submit Quarterly Report (electronically)**	
41	**1.8**	**Submit Annual Report**	
42	**1.9**	**Submit revised quarterly work plan**	
43	1.9.1	Submit revised quarterly work plan 1	
44	1.9.2	Submit revised quarterly work plan 2	
45	1.9.3	Submit revised quarterly work plan 3	
46	1.9.4	Submit revised quarterly work plan 4	
47	1.9.5	Submit revised quarterly work plan 5	
48	**2**	**Start-up Activities**	
49	**2.1**	**Staffing**	
50	2.1.1	Reassign Staff	MRM,RPM
51	2.1.2	Hire Staff (2 RNs recruited prior to contract start date)	MRM,RPM
52	2.1.3	Train new staff	MRM,RPM
53	2.1.4	Train staff on new LTC procedures	MRM,RPM
54	**2.2**	**Tools and Procedures**	
55	2.2.1	Develop new LTC review procedures	RPM
56	2.2.2	Develop tracking tool for LTC exception requests	IT
57	2.2.3	Design spreadsheet for LTC retrospective reviews	IT



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Task Progress Summary
Split Milestone Critical

File: MPRO 2004

Exhibit A

MPRO

Michigan Statewide Hospital Admissions Certification and Review Program
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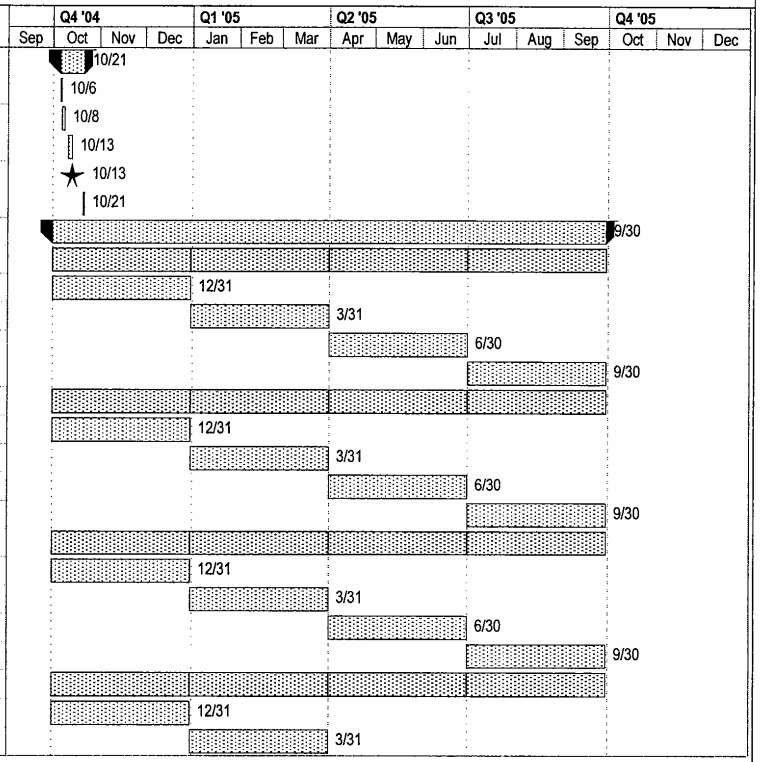
ID	WBS	Task Name	Resource Initials
58	**2.3**	**Report review**	
59	2.3.1	Review report formats with MDCH	MRM
60	2.3.2	Revise report formats if requested	IT
61	2.3.3	Test report modifications	IT
62	2.3.4	Submit revised report formats to MDCH	MRM
63	2.3.5	Receive approval for new report formats from MDCH	
64	**3**	**Part I - PACER Authorizations and Appeals**	
65	**3.1**	**Complete approx. 2700 FFS authorizations/quarter**	
66	3.1.1	Complete approx. 2700 FFS authorizations/quarter 1	PRC,PR,RPM
67	3.1.2	Complete approx. 2700 FFS authorizations/quarter 2	PRC,PR,RPM
68	3.1.3	Complete approx. 2700 FFS authorizations/quarter 3	PRC,PR,RPM
69	3.1.4	Complete approx. 2700 FFS authorizations/quarter 4	PRC,PR,RPM
70	**3.2**	**Complete approx. 500 LTC authorizations/quarter**	
71	3.2.1	Complete approx. 500 LTC authorizations/quarter 1	LTCEC,RPM,PR
72	3.2.2	Complete approx. 500 LTC authorizations/quarter 2	LTCEC,RPM,PR
73	3.2.3	Complete approx. 500 LTC authorizations/quarter 3	LTCEC,RPM,PR
74	3.2.4	Complete approx. 500 LTC authorizations/quarter 4	LTCEC,RPM,PR
75	**3.3**	**Complete approx. 25 FFS appeals/quarter**	
76	3.3.1	Complete approx. 25 FFS appeals/quarter 1	PR,RPM,PRC
77	3.3.2	Complete approx. 25 FFS appeals/quarter 2	PR,RPM,PRC
78	3.3.3	Complete approx. 25 FFS appeals/quarter 3	PR,RPM,PRC
79	3.3.4	Complete approx. 25 FFS appeals/quarter 4	PR,RPM,PRC
80	**3.4**	**Complete approx. 281 LTC appeals/quarter**	
81	3.4.1	Complete approx. 281 LTC appeals/quarter 1	LTCEC,PRLTC,F
82	3.4.2	Complete approx. 281 LTC appeals/quarter 2	LTCEC,PRLTC,F



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Task | Progress | Summary
Split | Milestone | Critical

File: MPRO 2004

Exhibit A

MPRO

Michigan Statewide Hospital Admissions Certification and Review Program
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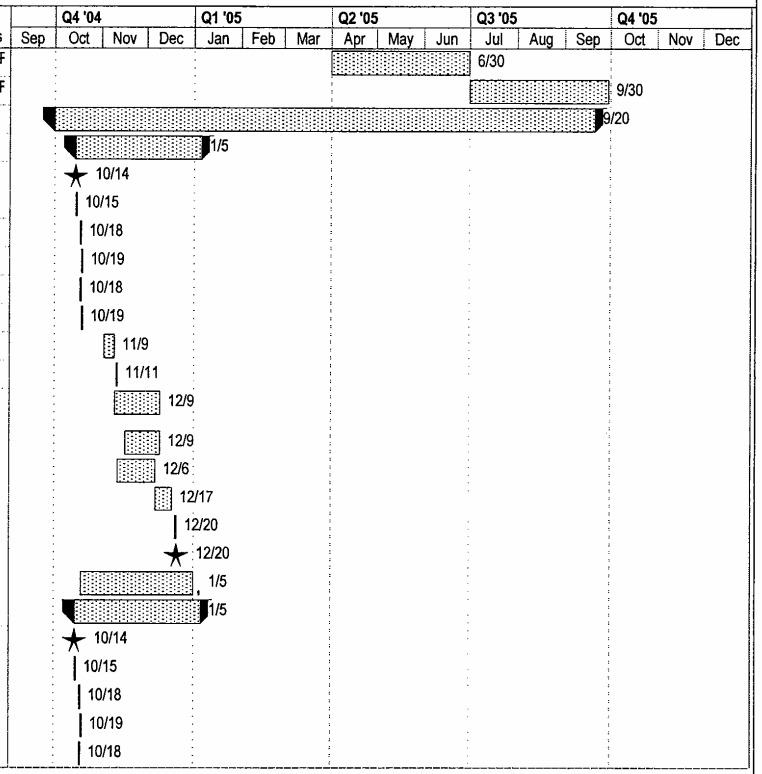
ID	WBS	Task Name	Resource Initials
83	3.4.3	Complete approx. 281 LTC appeals/quarter 3	LTCEC,PRLTC,F
84	3.4.4	Complete approx. 281 LTC appeals/quarter 4	LTCEC,PRLTC,F
85	**4**	**Part II - Audits**	
86	**4.1**	**Inpatient Audit 1**	
87	4.1.1	Receive inpatient audit list from MDCH	
88	4.1.2	Assign RN Audit Coordinator and RHIT	MRM
89	4.1.3	Assemble applicable Medicaid policy, codes, etc.	IAC
90	4.1.4	Send case listings to providers	IAC
91	4.1.5	Schedule appointment with provider to scan records	IAC
92	4.1.6	Send confirmation letter regarding appointment	IAC
93	4.1.7	Scan/copy records at provider location	IAC,RHIT,MRT
94	4.1.8	Request missing charts if applicable	IAC
95	4.1.9	Review records using audit criteria and document in workbook	RHIT,IAC
96	4.1.10	Request any missing information if applicable	IAC,RHIT
97	4.1.11	Determine if case needs physician review	IAC,RHIT,PR
98	4.1.12	RN compiles all information and writes report	IAC
99	4.1.13	Report is reviewed by management	MRM
100	4.1.14	Submit workbook and report to MDCH	IAC
101	4.1.15	Respond to appeals	IAC
102	**4.2**	**Inpatient Audit 2**	
103	4.2.1	Receive inpatient audit list from MDCH	
104	4.2.2	Assign RN Audit Coordinator and RHIT	MRM
105	4.2.3	Assemble applicable Medicaid policy, codes, etc.	IAC
106	4.2.4	Send case listings to providers	IAC
107	4.2.5	Schedule appointment with provider to scan records	IAC



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Task Progress Summary
Split Milestone Critical

File: MPRO 2004

Exhibit A

MPRO

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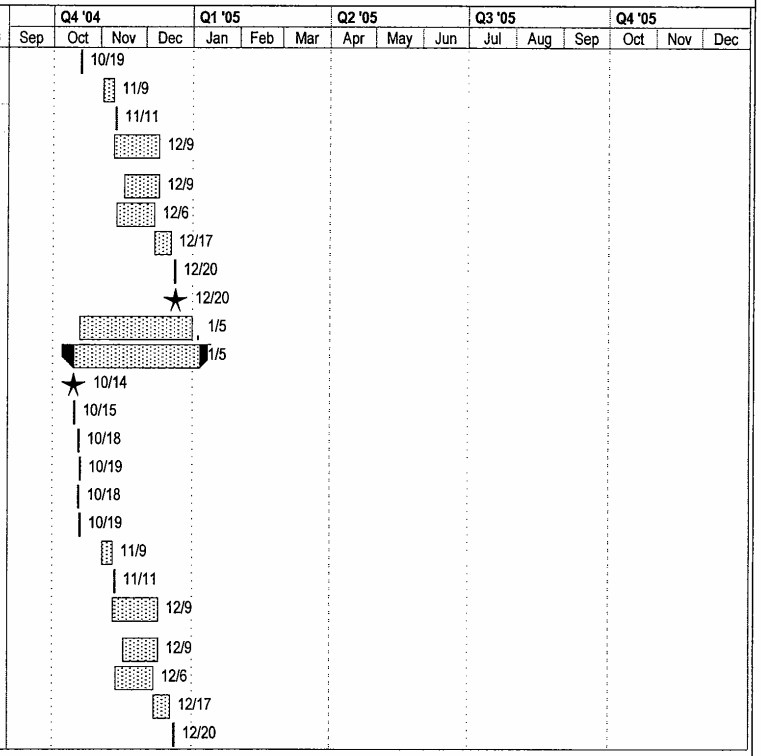
ID	WBS	Task Name	Resource Initials
108	4.2.6	Send confirmation letter regarding appointment	IAC
109	4.2.7	Scan/copy records at provider location	IAC,RHIT,MRT
110	4.2.8	Request missing charts if applicable	IAC
111	4.2.9	Review records using audit criteria and document in workbook	RHIT,IAC
112	4.2.10	Request any missing information if applicable	IAC,RHIT
113	4.2.11	Determine if case needs physician review	IAC,RHIT,PR
114	4.2.12	RN compiles all information and writes report	IAC
115	4.2.13	Report is reviewed by management	MRM
116	4.2.14	Submit workbook and report to MDCH	IAC
117	4.2.15	Respond to appeals	IAC
118	**4.3**	**Inpatient Audit 3**	
119	4.3.1	Receive inpatient audit list from MDCH	
120	4.3.2	Assign RN Audit Coordinator and RHIT	MRM
121	4.3.3	Assemble applicable Medicaid policy, codes, etc.	IAC
122	4.3.4	Send case listings to providers	IAC
123	4.3.5	Schedule appointment with provider to scan records	IAC
124	4.3.6	Send confirmation letter regarding appointment	IAC
125	4.3.7	Scan/copy records at provider location	IAC,RHIT,MRT
126	4.3.8	Request missing charts if applicable	IAC
127	4.3.9	Review records using audit criteria and document in workbook	RHIT,IAC
128	4.3.10	Request any missing information if applicable	IAC,RHIT
129	4.3.11	Determine if case needs physician review	IAC,RHIT,PR
130	4.3.12	RN compiles all information and writes report	IAC
131	4.3.13	Report is reviewed by management	MRM



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Task Progress Summary
Split Milestone Critical

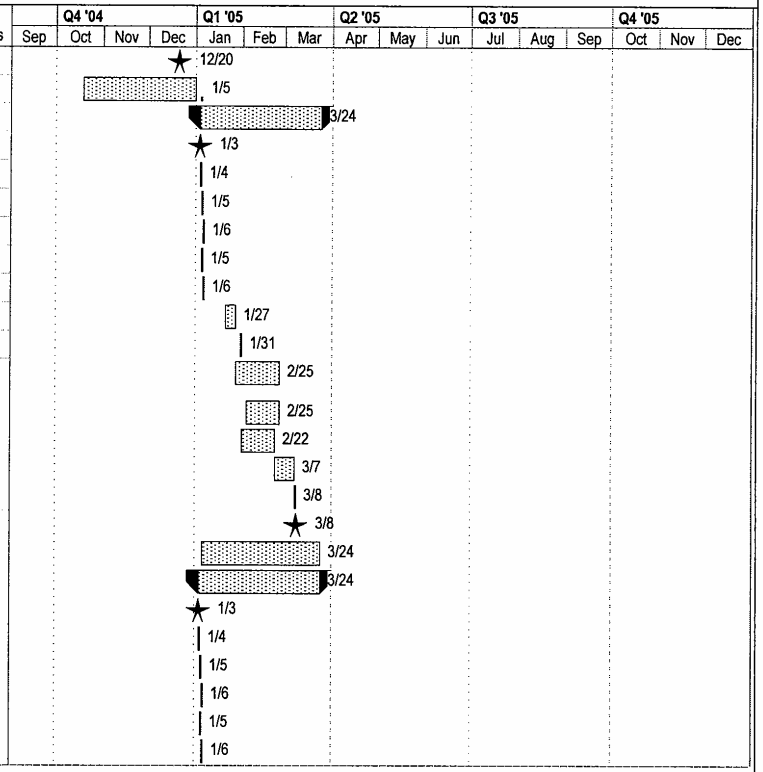
File: MPRO 2004

Exhibit A

MPRO

Michigan Statewide Hospital Admissions Certification and Review Program
Draft Workplan Subject to MDCH Review and Approval

ID	WBS	Task Name	Resource Initials
132	4.3.14	Submit workbook and report to MDCH	IAC
133	4.3.15	Respond to appeals	IAC
134	**4.4**	**Inpatient Audit 4**	
135	4.4.1	Receive inpatient audit list from MDCH	
136	4.4.2	Assign RN Audit Coordinator and RHIT	MRM
137	4.4.3	Assemble applicable Medicaid policy, codes, etc.	IAC
138	4.4.4	Send case listings to providers	IAC
139	4.4.5	Schedule appointment with provider to scan records	IAC
140	4.4.6	Send confirmation letter regarding appointment	IAC
141	4.4.7	Scan/copy records at provider location	IAC,RHIT,MRT
142	4.4.8	Request missing charts if applicable	IAC
143	4.4.9	Review records using audit criteria and document in workbook	RHIT,IAC
144	4.4.10	Request any missing information if applicable	IAC,RHIT
145	4.4.11	Determine if case needs physician review	IAC,RHIT,PR
146	4.4.12	RN compiles all information and writes report	IAC
147	4.4.13	Report is reviewed by management	MRM
148	4.4.14	Submit workbook and report to MDCH	IAC
149	4.4.15	Respond to appeals	IAC
150	**4.5**	**Inpatient Audit 5**	
151	4.5.1	Receive inpatient audit list from MDCH	
152	4.5.2	Assign RN Audit Coordinator and RHIT	MRM
153	4.5.3	Assemble applicable Medicaid policy, codes, etc.	IAC
154	4.5.4	Send case listings to providers	IAC
155	4.5.5	Schedule appointment with provider to scan records	IAC
156	4.5.6	Send confirmation letter regarding appointment	IAC



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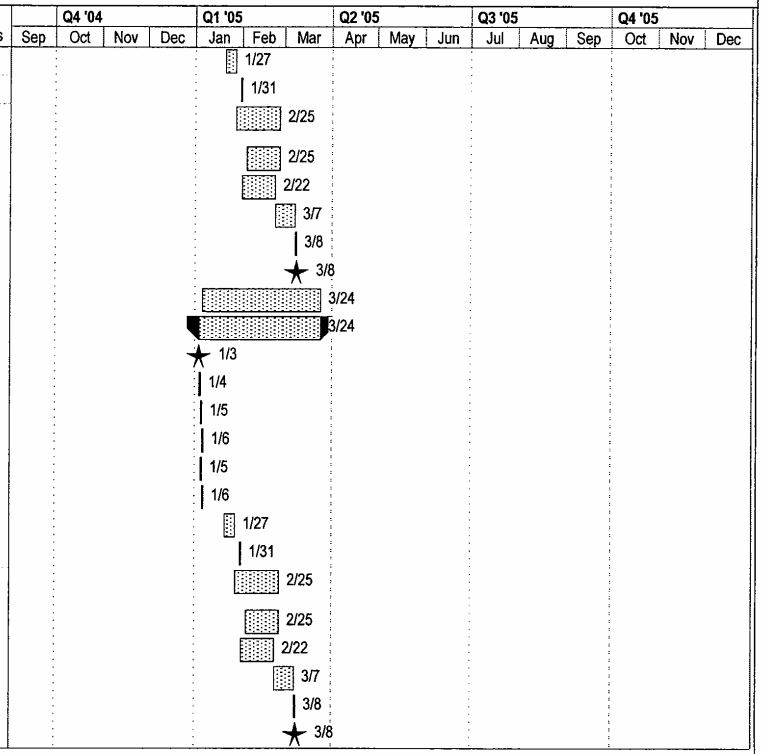
ID	WBS	Task Name	Resource Initials
157	4.5.7	Scan/copy records at provider location	IAC,RHIT,MRT
158	4.5.8	Request missing charts if applicable	IAC
159	4.5.9	Review records using audit criteria and document in workbook	RHIT,IAC
160	4.5.10	Request any missing information if applicable	IAC,RHIT
161	4.5.11	Determine if case needs physician review	IAC,RHIT,PR
162	4.5.12	RN compiles all information and writes report	IAC
163	4.5.13	Report is reviewed by management	MRM
164	4.5.14	Submit workbook and report to MDCH	IAC
165	4.5.15	Respond to appeals	IAC
166	**4.6**	**Inpatient Audit 6**	
167	4.6.1	Receive inpatient audit list from MDCH	
168	4.6.2	Assign RN Audit Coordinator and RHIT	MRM
169	4.6.3	Assemble applicable Medicaid policy, codes, etc.	IAC
170	4.6.4	Send case listings to providers	IAC
171	4.6.5	Schedule appointment with provider to scan records	IAC
172	4.6.6	Send confirmation letter regarding appointment	IAC
173	4.6.7	Scan/copy records at provider location	IAC,RHIT,MRT
174	4.6.8	Request missing charts if applicable	IAC
175	4.6.9	Review records using audit criteria and document in workbook	RHIT,IAC
176	4.6.10	Request any missing information if applicable	IAC,RHIT
177	4.6.11	Determine if case needs physician review	IAC,RHIT,PR
178	4.6.12	RN compiles all information and writes report	IAC
179	4.6.13	Report is reviewed by management	MRM
180	4.6.14	Submit workbook and report to MDCH	IAC



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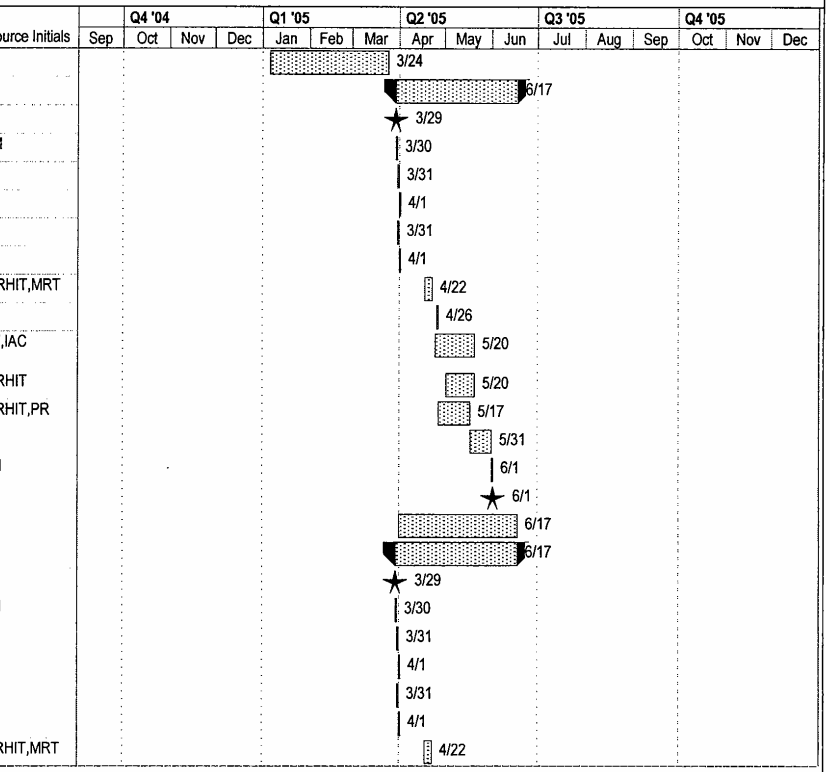
ID	WBS	Task Name	Resource Initials
181	4.6.15	Respond to appeals	IAC
182	**4.7**	**Inpatient Audit 7**	
183	4.7.1	Receive inpatient audit list from MDCH	
184	4.7.2	Assign RN Audit Coordinator and RHIT	MRM
185	4.7.3	Assemble applicable Medicaid policy, codes, etc.	IAC
186	4.7.4	Send case listings to providers	IAC
187	4.7.5	Schedule appointment with provider to scan records	IAC
188	4.7.6	Send confirmation letter regarding appointment	IAC
189	4.7.7	Scan/copy records at provider location	IAC,RHIT,MRT
190	4.7.8	Request missing charts if applicable	IAC
191	4.7.9	Review records using audit criteria and document in workbook	RHIT,IAC
192	4.7.10	Request any missing information if applicable	IAC,RHIT
193	4.7.11	Determine if case needs physician review	IAC,RHIT,PR
194	4.7.12	RN compiles all information and writes report	IAC
195	4.7.13	Report is reviewed by management	MRM
196	4.7.14	Submit workbook and report to MDCH	IAC
197	4.7.15	Respond to appeals	IAC
198	**4.8**	**Inpatient Audit 8**	
199	4.8.1	Receive inpatient audit list from MDCH	
200	4.8.2	Assign RN Audit Coordinator and RHIT	MRM
201	4.8.3	Assemble applicable Medicaid policy, codes, etc.	IAC
202	4.8.4	Send case listings to providers	IAC
203	4.8.5	Schedule appointment with provider to scan records	IAC
204	4.8.6	Send confirmation letter regarding appointment	IAC
205	4.8.7	Scan/copy records at provider location	IAC,RHIT,MRT



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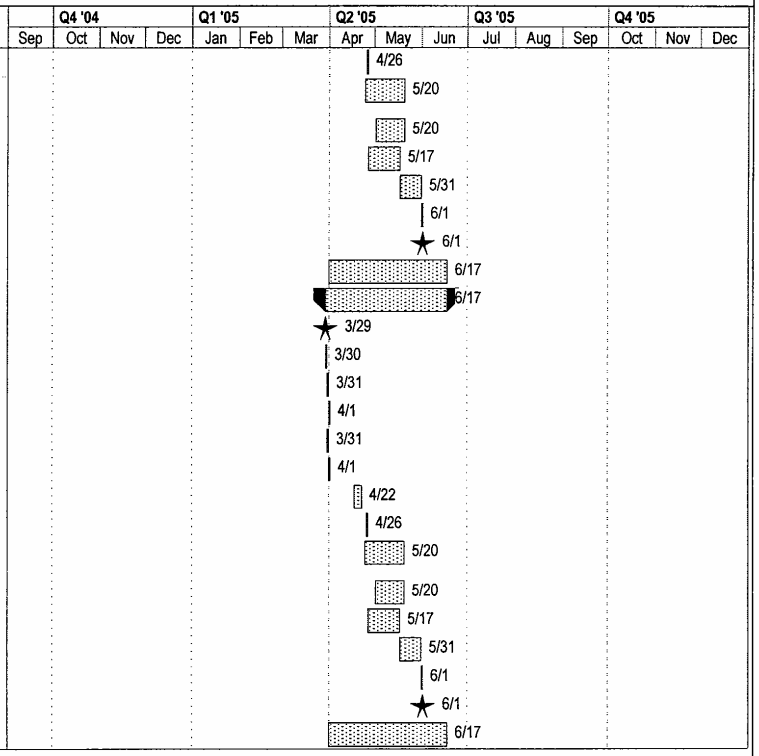
ID	WBS	Task Name	Resource Initials
206	4.8.8	Request missing charts if applicable	IAC
207	4.8.9	Review records using audit criteria and document in workbook	RHIT,IAC
208	4.8.10	Request any missing information if applicable	IAC,RHIT
209	4.8.11	Determine if case needs physician review	IAC,RHIT,PR
210	4.8.12	RN compiles all information and writes report	IAC
211	4.8.13	Report is reviewed by management	MRM
212	4.8.14	Submit workbook and report to MDCH	IAC
213	4.8.15	Respond to appeals	IAC
214	**4.9**	**Inpatient Audit 9**	
215	4.9.1	Receive inpatient audit list from MDCH	
216	4.9.2	Assign RN Audit Coordinator and RHIT	MRM
217	4.9.3	Assemble applicable Medicaid policy, codes, etc.	IAC
218	4.9.4	Send case listings to providers	IAC
219	4.9.5	Schedule appointment with provider to scan records	IAC
220	4.9.6	Send confirmation letter regarding appointment	IAC
221	4.9.7	Scan/copy records at provider location	IAC,RHIT,MRT
222	4.9.8	Request missing charts if applicable	IAC
223	4.9.9	Review records using audit criteria and document in workbook	RHIT,IAC
224	4.9.10	Request any missing information if applicable	IAC,RHIT
225	4.9.11	Determine if case needs physician review	IAC,RHIT,PR
226	4.9.12	RN compiles all information and writes report	IAC
227	4.9.13	Report is reviewed by management	MRM
228	4.9.14	Submit workbook and report to MDCH	IAC
229	4.9.15	Respond to appeals	IAC



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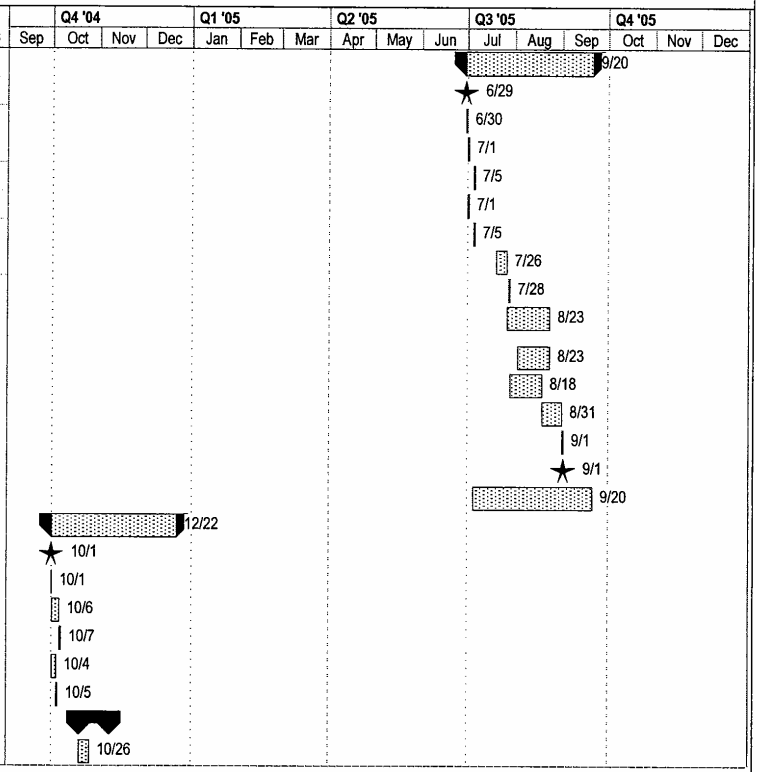
ID	WBS	Task Name	Resource Initials
230	**4.10**	**Inpatient Audit 10**	
231	4.10.1	Receive inpatient audit list from MDCH	
232	4.10.2	Assign RN Audit Coordinator and RHIT	MRM
233	4.10.3	Assemble applicable Medicaid policy, codes, etc.	IAC
234	4.10.4	Send case listings to providers	IAC
235	4.10.5	Schedule appointment with provider to scan records	IAC
236	4.10.6	Send confirmation letter regarding appointment	IAC
237	4.10.7	Scan/copy records at provider location	IAC,RHIT,MRT
238	4.10.8	Request missing charts if applicable	IAC
239	4.10.9	Review records using audit criteria and document in workbook	RHIT,IAC
240	4.10.10	Request any missing information if applicable	IAC,RHIT
241	4.10.11	Determine if case needs physician review	IAC,RHIT,PR
242	4.10.12	RN compiles all information and writes report	IAC
243	4.10.13	Report is reviewed by management	MRM
244	4.10.14	Submit workbook and report to MDCH	IAC
245	4.10.15	Respond to appeals	IAC
246	**4.11**	**Perform 3 ER/Outpatient Audits per Quarter**	
247	4.11.1	Receive ER/outpatient audit list from MDCH	
248	4.11.2	Assign RN Audit Coordinator and RHIT	MRM
249	4.11.3	Assemble applicable Medicaid policy, codes, etc.	OEAC
250	4.11.4	Send case listings to providers	OEAC
251	4.11.5	Schedule appointment with provider to scan records	OEAC
252	4.11.6	Send confirmation letter regarding appointment	OEAC
253	**4.11.7**	**Scan/copy records at provider location**	**MRT,OEAC**
254	4.11.7.1	Scan at Provider 1 location	MRT,OEAC



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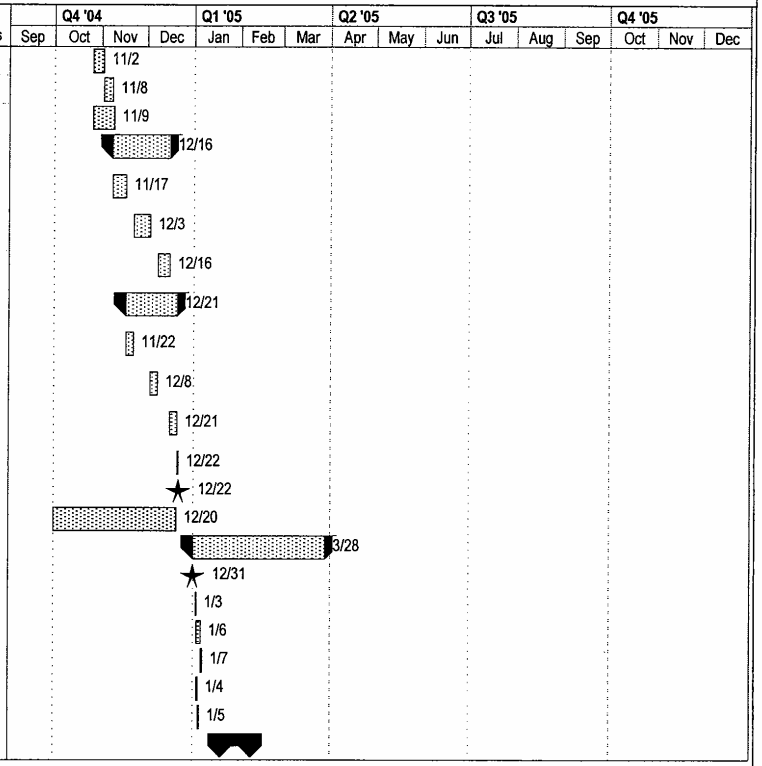
ID	WBS	Task Name	Resource Initials
255	4.11.7.2	Scan at Provider 2 location	MRT,OEAC
256	4.11.7.3	Scan at Provider 3 location	MRT,OEAC
257	4.11.8	Request missing charts if applicable	OEAC
258	**4.11.9**	**Review records using audit criteria and document in workbook**	
259	4.11.9.1	Review Provider 1 records using audit criteria and document in workbook	OEAC
260	4.11.9.2	Review Provider 2 records using audit criteria and document in workbook	OEAC
261	4.11.9.3	Review Provider 3 records using audit criteria and document in workbook	OEAC
262	**4.11.10**	**RN compiles all information and writes report**	
263	4.11.10.1	RN compiles all Provider 1 information and writes report	OEAC
264	4.11.10.2	RN compiles all Provider 2 information and writes report	OEAC
265	4.11.10.3	RN compiles all Provider 3 information and writes report	OEAC
266	4.11.11	Report is reviewed by management	MRM
267	4.11.12	Submit workbook and report to MDCH	OEAC
268	4.11.13	Respond to appeals	OEAC
269	**4.12**	**Perform 3 ER/Outpatient Audits per Quarter**	
270	4.12.1	Receive ER/outpatient audit list from MDCH	
271	4.12.2	Assign RN Audit Coordinator and RHIT	MRM
272	4.12.3	Assemble applicable Medicaid policy, codes, etc.	OEAC
273	4.12.4	Send case listings to providers	OEAC
274	4.12.5	Schedule appointment with provider to scan records	OEAC
275	4.12.6	Send confirmation letter regarding appointment	OEAC
276	**4.12.7**	**Scan/copy records at provider location**	



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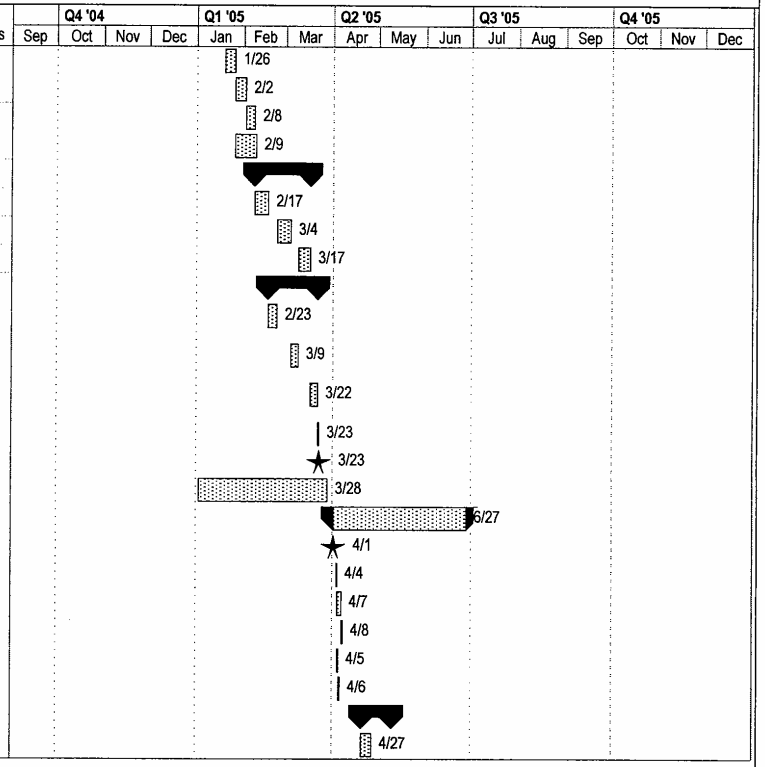
ID	WBS	Task Name	Resource Initials
277	4.12.7.1	Scan at Provider 4 location	MRT,OEAC
278	4.12.7.2	Scan at Provider 5 location	MRT,OEAC
279	4.12.7.3	Scan at Provider 6 location	MRT,OEAC
280	4.12.8	Request missing charts if applicable	OEAC
281	**4.12.9**	**Review records using audit criteria and document in w**	
282	4.12.9.1	Review Provider 4 records using audit criteria and do	OEAC
283	4.12.9.2	Review Provider 5 records using audit criteria and do	OEAC
284	4.12.9.3	Review Provider 6 records using audit criteria and do	OEAC
285	**4.12.10**	**RN compiles all information and writes report**	
286	4.12.10.1	RN compiles all Provider 4 information and writes report	OEAC
287	4.12.10.2	RN compiles all Provider 5 information and writes report	OEAC
288	4.12.10.3	RN compiles all Provider 6 information and writes report	OEAC
289	4.12.11	Report is reviewed by management	MRM
290	4.12.12	Submit workbook and report to MDCH	OEAC
291	4.12.13	Respond to appeals	OEAC
292	**4.13**	**Perform 3 ER/Outpatient Audits per Quarter**	
293	4.13.1	Receive ER/outpatient audit list from MDCH	
294	4.13.2	Assign RN Audit Coordinator and RHIT	MRM
295	4.13.3	Assemble applicable Medicaid policy, codes, etc.	OEAC
296	4.13.4	Send case listings to providers	OEAC
297	4.13.5	Schedule appointment with provider to scan records	OEAC
298	4.13.6	Send confirmation letter regarding appointment	OEAC
299	**4.13.7**	**Scan/copy records at provider location**	
300	4.13.7.1	Scan at Provider 7 location	MRT,OEAC



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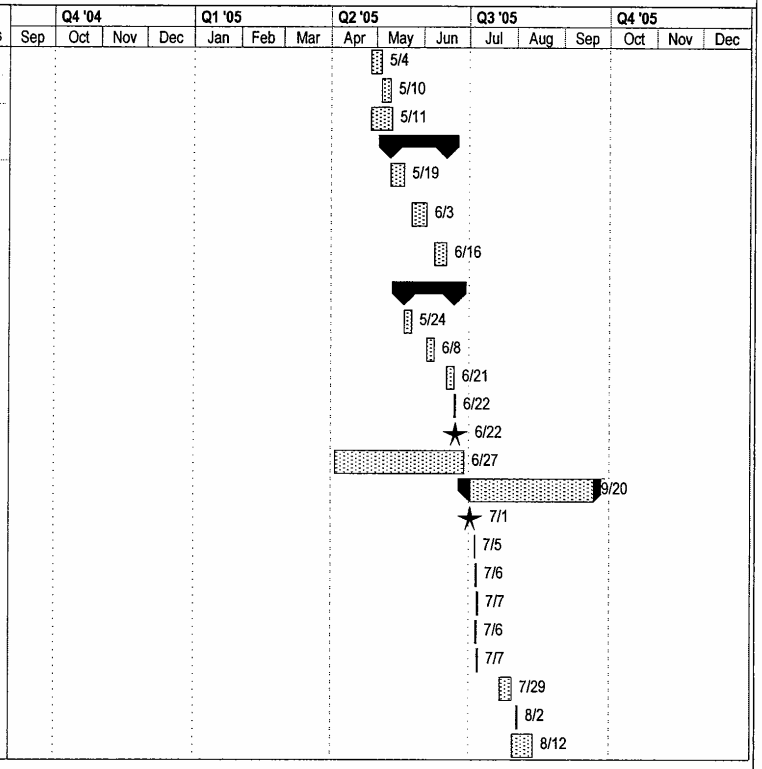
ID	WBS	Task Name	Resource Initials
301	4.13.7.2	Scan at Provider 8 location	MRT,OEAC
302	4.13.7.3	Scan at Provider 9 location	MRT,OEAC
303	4.13.8	Request missing charts if applicable	OEAC
304	**4.13.9**	**Review records using audit criteria and document in wo**	
305	4.13.9.1	Review Provider 7 records using audit criteria and document in workbook	OEAC
306	4.13.9.2	Review Provider 8 records using audit criteria and document in workbook	OEAC
307	4.13.9.3	Review Provider 9 records using audit criteria and document in workbook	OEAC
308	**4.13.10**	**RN compiles all information and writes report**	**OEAC**
309	4.13.10.1	RN compiles all Provider 7 information and writes rep	OEAC
310	4.13.10.2	RN compiles all Provider 8 information and writes rep	OEAC
311	4.13.10.3	RN compiles all Provider 9 information and writes rep	OEAC
312	4.13.11	Report is reviewed by management	MRM
313	4.13.12	Submit workbook and report to MDCH	OEAC
314	4.13.13	Respond to appeals	OEAC
315	**4.14**	**Perform 1 ER/Outpatient Audit in Quarter**	
316	4.14.1	Receive ER/outpatient audit list from MDCH	
317	4.14.2	Assign RN Audit Coordinator and RHIT	MRM
318	4.14.3	Assemble applicable Medicaid policy, codes, etc.	OEAC
319	4.14.4	Send case listing to 10th provider	OEAC
320	4.14.5	Schedule appointment with provider to scan records	OEAC
321	4.14.6	Send confirmation letter regarding appointment	OEAC
322	4.14.7	Scan/copy records at provider 10 location	MRT,OEAC
323	4.14.8	Request missing charts if applicable	OEAC
324	4.14.9	Review Provider 10 records using audit criteria and docume	OEAC



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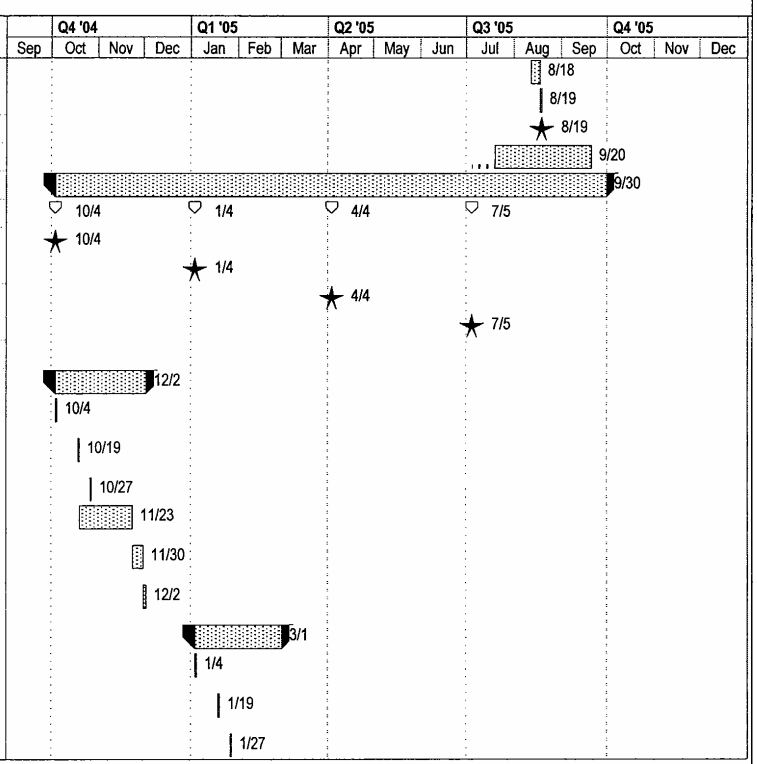
ID	WBS	Task Name	Resource Initials
325	4.14.10	RN compiles all Provider 10 information and writes report	OEAC
326	4.14.11	Report is reviewed by management	MRM
327	4.14.12	Submit workbook and report to MDCH	OEAC
328	4.14.13	Respond to appeals	OEAC
329	**5**	**Part II - LTC Retrospective Review**	
330	**5.1**	**Receive electronic listing of 250 cases for review**	
331	5.1.1	Receive electronic listing of 250 cases for review 1	
332	5.1.2	Receive electronic listing of 250 cases for review 2	
333	5.1.3	Receive electronic listing of 250 cases for review 3	
334	5.1.4	Receive electronic listing of 250 cases for review 4	
335	**5.2**	**Quarterly LTC retrospective Review**	
336	**5.2.1**	**Quarterly LTC retrospective Review 1**	
337	5.2.1.1	Prepare list and mail request to the appropriate provider(s)	MRT
338	5.2.1.2	Receive records from provider and identify missing records	MRT
339	5.2.1.3	Re-request any missing records	MRT
340	5.2.1.4	RN reviews case(s) and approves and records those meeting criteria	LTCRC
341	5.2.1.5	RN submits non-approved for Physician Review	PRLTC
342	5.2.1.6	RN sends initial negative action letter on non-approved cases	LTCRC
343	**5.2.2**	**Quarterly LTC retrospective Review 2**	
344	5.2.2.1	Prepare list and mail request to the appropriate provider(s)	MRT
345	5.2.2.2	Receive records from provider and identify missing records	MRT
346	5.2.2.3	Re-request any missing records	MRT



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ID	WBS	Task Name	Resource Initials
347	5.2.2.4	RN reviews case(s) and approves and records those meeting criteria	LTCRC
348	5.2.2.5	RN submits non-approved for Physician Review	PRLTC
349	5.2.2.6	RN sends initial negative action letter on non-approved cases	LTCRC
350	**5.2.3**	**Quarterly LTC retrospective Review 3**	
351	5.2.3.1	Prepare list and mail request to the appropriate provider(s)	MRT
352	5.2.3.2	Receive records from provider and identify missing records	MRT
353	5.2.3.3	Re-request any missing records	MRT
354	5.2.3.4	RN reviews case(s) and approves and records those meeting criteria	LTCRC
355	5.2.3.5	RN submits non-approved for Physician Review	PRLTC
356	5.2.3.6	RN sends initial negative action letter on non-approved cases	LTCRC
357	**5.2.4**	**Quarterly LTC retrospective Review 4**	
358	5.2.4.1	Prepare list and mail request to the appropriate provider(s)	MRT
359	5.2.4.2	Receive records from provider and identify missing records	MRT
360	5.2.4.3	Re-request any missing records	MRT
361	5.2.4.4	RN reviews case(s) and approves and records those meeting criteria	LTCRC
362	5.2.4.5	RN submits non-approved for Physician Review	PRLTC
363	5.2.4.6	RN sends initial negative action letter on non-approved cases	LTCRC
364	**5.3**	**LTC Retrospective Review Appeals**	
365	5.3.1	Respond to appeals as received using defined determination process	LTCRC,PRLTC

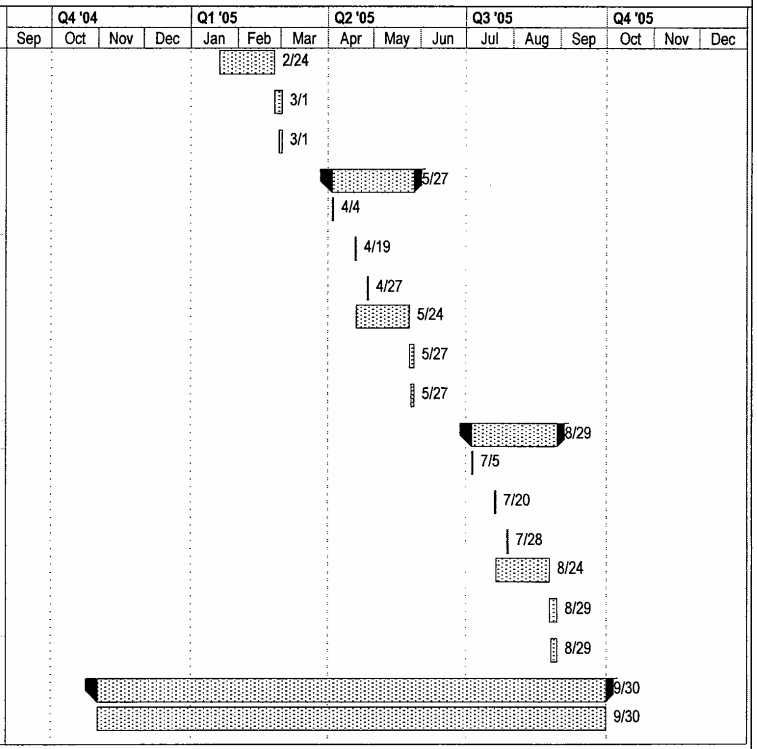

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Exhibit B – Resource List

MPRO Resource List
with Resource Initials Identified

ID	Resource Name	Initials
1	Sr Medical Review Manager	MRM
2	Outpatient/ER Audit Coordinator	OEAC
3	Inpatient Audit Coordinator	IAC
4	PACER Review Coordinator	PRC
5	Long Term Care Exception Coordinator	LTCEC
6	Physician Reviewer	PR
7	Physician Reviewer-LTC Exception	PRLTC
8	LTC Review Coordinator	LTCRC
9	Registered Health Information Technician	RHIT
10	Review Process Manager	RPM
11	Medical Records Technician	MRT
12	Information Technology staff	IT
13	MDCH	MDCH

Exhibit C – Resource List with Task Assignments

Note: The following MS Project Schedule does not reflect the timeframes for inpatient audits as required in the bidder's questions and answers posted August 20th, 2004. Upon award of the contract, the timeframe for conducting these audits will be revised so that they take place monthly instead of quarterly.

MPRO Resource List

with Task Assignments

ID	ID	Resource Name	Initials	Work	Details	2005			
						Qtr 4	Qtr 1	Qtr 2	Qtr 3
		Unassigned		0 hrs	Work				
1	1	**Sr Medical Review Manager**	**MRM**	**1,800 hrs**	Work	448.78h	462.4h	452.4h	434.4h
	4	*Project Management*	*MRM*	*1,578 hrs*	Work	346.78h	410.4h	410.4h	410.4h
	6	*Weekly meeting/teleconference 1*	*MRM*	*2 hrs*	Work	2h			
	7	*Weekly meeting/teleconference 2*	*MRM*	*2 hrs*	Work	2h			
	8	*Weekly meeting/teleconference 3*	*MRM*	*2 hrs*	Work	2h			
	9	*Weekly meeting/teleconference 4*	*MRM*	*2 hrs*	Work	2h			
	11	*Monthly meeting/teleconference 1*	*MRM*	*2 hrs*	Work	2h			
	12	*Monthly meeting/teleconference 2*	*MRM*	*2 hrs*	Work	2h			
	13	*Monthly meeting/teleconference 3*	*MRM*	*2 hrs*	Work		2h		
	14	*Monthly meeting/teleconference 4*	*MRM*	*2 hrs*	Work		2h		
	15	*Monthly meeting/teleconference 5*	*MRM*	*2 hrs*	Work		2h		
	16	*Monthly meeting/teleconference 6*	*MRM*	*2 hrs*	Work			2h	
	17	*Monthly meeting/teleconference 7*	*MRM*	*2 hrs*	Work			2h	
	18	*Monthly meeting/teleconference 8*	*MRM*	*2 hrs*	Work			2h	
	19	*Monthly meeting/teleconference 9*	*MRM*	*2 hrs*	Work				2h
	20	*Monthly meeting/teleconference 10*	*MRM*	*2 hrs*	Work				2h
	21	*Monthly meeting/teleconference 11*	*MRM*	*2 hrs*	Work				2h
	22	*Monthly meeting/teleconference 12*	*MRM*	*2 hrs*	Work				
	24	*Submit electronic monthly status report 1*	*MRM*	*0 hrs*	Work	0h			
	25	*Submit electronic monthly status report 2*	*MRM*	*0 hrs*	Work	0h			
	26	*Submit electronic monthly status report 3*	*MRM*	*0 hrs*	Work		0h		
	27	*Submit electronic monthly status report 4*	*MRM*	*0 hrs*	Work		0h		
	28	*Submit electronic monthly status report 5*	*MRM*	*0 hrs*	Work		0h		
	29	*Submit electronic monthly status report 6*	*MRM*	*0 hrs*	Work			0h	
	30	*Submit electronic monthly status report 7*	*MRM*	*0 hrs*	Work			0h	
	31	*Submit electronic monthly status report 8*	*MRM*	*0 hrs*	Work			0h	
	32	*Submit electronic monthly status report 9*	*MRM*	*0 hrs*	Work				0h
	33	*Submit electronic monthly status report 10*	*MRM*	*0 hrs*	Work				0h
	34	*Submit electronic monthly status report 11*	*MRM*	*0 hrs*	Work				0h
	35	*Submit electronic monthly status report 12*	*MRM*	*0 hrs*	Work				
	50	*Reassign Staff*	*MRM*	*8 hrs*	Work	8h			
	51	*Hire Staff (2 RNs recruited prior to contract start*	*MRM*	*8 hrs*	Work	8h			
	52	*Train new staff*	*MRM*	*24 hrs*	Work	24h			
	53	*Train staff on new LTC procedures*	*MRM*	*8 hrs*	Work	8h			
	59	*Review report formats with MDCH*	*MRM*	*2 hrs*	Work	2h			
	62	*Submit revised report formats to MDCH*	*MRM*	*0 hrs*	Work	0h			
	88	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work	2h			
	99	*Report is reviewed by management*	*MRM*	*8 hrs*	Work	8h			
	104	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work	2h			
	115	*Report is reviewed by management*	*MRM*	*8 hrs*	Work	8h			
	120	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work	2h			
	131	*Report is reviewed by management*	*MRM*	*8 hrs*	Work	8h			
	136	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work		2h		
	147	*Report is reviewed by management*	*MRM*	*8 hrs*	Work		8h		
	152	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work		2h		
	163	*Report is reviewed by management*	*MRM*	*8 hrs*	Work		8h		
	168	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work		2h		
	179	*Report is reviewed by management*	*MRM*	*8 hrs*	Work		8h		
	184	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work		2h		
	195	*Report is reviewed by management*	*MRM*	*8 hrs*	Work			8h	
	200	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work		2h		
	211	*Report is reviewed by management*	*MRM*	*8 hrs*	Work			8h	
	216	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work		2h		
	227	*Report is reviewed by management*	*MRM*	*8 hrs*	Work			8h	
	232	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work			2h	
	243	*Report is reviewed by management*	*MRM*	*8 hrs*	Work				8h
	248	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work	2h			
	266	*Report is reviewed by management*	*MRM*	*8 hrs*	Work	8h			
	271	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work		2h		
	289	*Report is reviewed by management*	*MRM*	*8 hrs*	Work		8h		
	294	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work			2h	
	312	*Report is reviewed by management*	*MRM*	*8 hrs*	Work			8h	

File: MPRO 2004

Exhibit C

MPRO Resource List

with Task Assignments

ID	ID	Resource Name	Initials	Work	Details	2005			
						Qtr 4	Qtr 1	Qtr 2	Qtr 3
	317	*Assign RN Audit Coordinator and RHIT*	*MRM*	*2 hrs*	Work				2h
	326	*Report is reviewed by management*	*MRM*	*8 hrs*	Work				8h
2	**2**	**Outpatient/ER Audit Coordinator**	**OEAC**	**2,368.33 hrs**	Work	717.85h	637.85h	735.63h	277h
	249	*Assemble applicable Medicaid policy, codes, etc.*	*OEAC*	*24 hrs*	Work	24h			
	250	*Send case listings to providers*	*OEAC*	*3 hrs*	Work	3h			
	251	*Schedule appointment with provider to scan reco*	*OEAC*	*3 hrs*	Work	3h			
	252	*Send confirmation letter regarding appointment*	*OEAC*	*3 hrs*	Work	3h			
	253	*Scan/copy records at provider location*	*OEAC*	*80 hrs*	Work	80h			
	254	*Scan at Provider 1 location*	*OEAC*	*27 hrs*	Work	27h			
	255	*Scan at Provider 2 location*	*OEAC*	*27 hrs*	Work	27h			
	256	*Scan at Provider 3 location*	*OEAC*	*26 hrs*	Work	26h			
	257	*Request missing charts if applicable*	*OEAC*	*2.85 hrs*	Work	2.85h			
	259	*Review Provider 1 records using audit criteria an*	*OEAC*	*110 hrs*	Work	110h			
	260	*Review Provider 2 records using audit criteria an*	*OEAC*	*110 hrs*	Work	110h			
	261	*Review Provider 3 records using audit criteria an*	*OEAC*	*110 hrs*	Work	110h			
	263	*RN compiles all Provider 1 information and writes*	*OEAC*	*40 hrs*	Work	40h			
	264	*RN compiles all Provider 2 information and writes*	*OEAC*	*40 hrs*	Work	40h			
	265	*RN compiles all Provider 3 information and writes*	*OEAC*	*40 hrs*	Work	40h			
	267	*Submit workbook and report to MDCH*	*OEAC*	*0 hrs*	Work	0h			
	268	*Respond to appeals*	*OEAC*	*72 hrs*	Work	72h			
	272	*Assemble applicable Medicaid policy, codes, etc.*	*OEAC*	*24 hrs*	Work		24h		
	273	*Send case listings to providers*	*OEAC*	*3 hrs*	Work		3h		
	274	*Schedule appointment with provider to scan reco*	*OEAC*	*3 hrs*	Work		3h		
	275	*Send confirmation letter regarding appointment*	*OEAC*	*3 hrs*	Work		3h		
	277	*Scan at Provider 4 location*	*OEAC*	*27 hrs*	Work		27h		
	278	*Scan at Provider 5 location*	*OEAC*	*27 hrs*	Work		27h		
	279	*Scan at Provider 6 location*	*OEAC*	*26 hrs*	Work		26h		
	280	*Request missing charts if applicable*	*OEAC*	*2.85 hrs*	Work		2.85h		
	282	*Review Provider 4 records using audit criteria an*	*OEAC*	*110 hrs*	Work		110h		
	283	*Review Provider 5 records using audit criteria an*	*OEAC*	*110 hrs*	Work		110h		
	284	*Review Provider 6 records using audit criteria an*	*OEAC*	*110 hrs*	Work		110h		
	286	*RN compiles all Provider 4 information and writes*	*OEAC*	*40 hrs*	Work		40h		
	287	*RN compiles all Provider 5 information and writes*	*OEAC*	*40 hrs*	Work		40h		
	288	*RN compiles all Provider 6 information and writes*	*OEAC*	*40 hrs*	Work		40h		
	290	*Submit workbook and report to MDCH*	*OEAC*	*0 hrs*	Work		0h		
	291	*Respond to appeals*	*OEAC*	*72 hrs*	Work		72h		
	295	*Assemble applicable Medicaid policy, codes, etc.*	*OEAC*	*24 hrs*	Work			24h	
	296	*Send case listings to providers*	*OEAC*	*3 hrs*	Work			3h	
	297	*Schedule appointment with provider to scan reco*	*OEAC*	*3 hrs*	Work			3h	
	298	*Send confirmation letter regarding appointment*	*OEAC*	*3 hrs*	Work			3h	
	300	*Scan at Provider 7 location*	*OEAC*	*27 hrs*	Work			27h	
	301	*Scan at Provider 8 location*	*OEAC*	*27 hrs*	Work			27h	
	302	*Scan at Provider 9 location*	*OEAC*	*26 hrs*	Work			26h	
	303	*Request missing charts if applicable*	*OEAC*	*2.85 hrs*	Work			2.85h	
	305	*Review Provider 7 records using audit criteria an*	*OEAC*	*110 hrs*	Work			110h	
	306	*Review Provider 8 records using audit criteria an*	*OEAC*	*110 hrs*	Work			110h	
	307	*Review Provider 9 records using audit criteria an*	*OEAC*	*110 hrs*	Work			110h	
	308	*RN compiles all information and writes report*	*OEAC*	*97.78 hrs*	Work			97.78h	
	309	*RN compiles all Provider 7 information and writes*	*OEAC*	*40 hrs*	Work			40h	
	310	*RN compiles all Provider 8 information and writes*	*OEAC*	*40 hrs*	Work			40h	
	311	*RN compiles all Provider 9 information and writes*	*OEAC*	*40 hrs*	Work			40h	
	313	*Submit workbook and report to MDCH*	*OEAC*	*0 hrs*	Work			0h	
	314	*Respond to appeals*	*OEAC*	*72 hrs*	Work			72h	
	318	*Assemble applicable Medicaid policy, codes, etc.*	*OEAC*	*16 hrs*	Work				16h
	319	*Send case listing to 10th provider*	*OEAC*	*1 hr*	Work				1h
	320	*Schedule appointment with provider to scan reco*	*OEAC*	*1 hr*	Work				1h
	321	*Send confirmation letter regarding appointment*	*OEAC*	*1 hr*	Work				1h
	322	*Scan/copy records at provider 10 location*	*OEAC*	*24 hrs*	Work				24h
	323	*Request missing charts if applicable*	*OEAC*	*2 hrs*	Work				2h
	324	*Review Provider 10 records using audit criteria a*	*OEAC*	*120 hrs*	Work				120h
	325	*RN compiles all Provider 10 information and write*	*OEAC*	*40 hrs*	Work				40h
	327	*Submit workbook and report to MDCH*	*OEAC*	*0 hrs*	Work				0h
	328	*Respond to appeals*	*OEAC*	*72 hrs*	Work				72h

File: MPRO 2004

Exhibit C

MPRO Resource List

with Task Assignments

ID	ID	Resource Name	Initials	Work	Details	2005			
						Qtr 4	Qtr 1	Qtr 2	Qtr 3
3	3	**Inpatient Audit Coordinator**	**IAC**	**2,585 hrs**	Work	774h	803h	748h	260h
	89	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work	8h			
	90	*Send case listings to providers*	*IAC*	*1 hr*	Work	1h			
	91	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work	1h			
	92	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work	1h			
	93	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work	32h			
	94	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work	2h			
	95	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work	124h			
	96	*Request any missing information if applicable*	*IAC*	*6 hrs*	Work	6h			
	97	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work	3h			
	98	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work	56h			
	100	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work	0h			
	101	*Respond to appeals*	*IAC*	*24 hrs*	Work	24h			
	105	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work	8h			
	106	*Send case listings to providers*	*IAC*	*1 hr*	Work	1h			
	107	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work	1h			
	108	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work	1h			
	109	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work	32h			
	110	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work	2h			
	111	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work	124h			
	112	*Request any missing information if applicable*	*IAC*	*6 hrs*	Work	6h			
	113	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work	3h			
	114	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work	56h			
	116	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work	0h			
	117	*Respond to appeals*	*IAC*	*24 hrs*	Work	24h			
	121	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work	8h			
	122	*Send case listings to providers*	*IAC*	*1 hr*	Work	1h			
	123	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work	1h			
	124	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work	1h			
	125	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work	32h			
	126	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work	2h			
	127	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work	124h			
	128	*Request any missing information if applicable*	*IAC*	*6 hrs*	Work	6h			
	129	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work	3h			
	130	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work	56h			
	132	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work	0h			
	133	*Respond to appeals*	*IAC*	*24 hrs*	Work	24h			
	137	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work		8h		
	138	*Send case listings to providers*	*IAC*	*1 hr*	Work		1h		
	139	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work		1h		
	140	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work		1h		
	141	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work		32h		
	142	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work		2h		
	143	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work		124h		
	144	*Request any missing information if applicable*	*IAC*	*8 hrs*	Work		8h		
	145	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work		3h		
	146	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work		56h		
	148	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work		0h		
	149	*Respond to appeals*	*IAC*	*24 hrs*	Work		24h		
	153	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work		8h		
	154	*Send case listings to providers*	*IAC*	*1 hr*	Work		1h		
	155	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work		1h		
	156	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work		1h		
	157	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work		32h		
	158	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work		2h		
	159	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work		124h		
	160	*Request any missing information if applicable*	*IAC*	*6 hrs*	Work		6h		
	161	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work		3h		
	162	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work		56h		
	164	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work		0h		
	165	*Respond to appeals*	*IAC*	*24 hrs*	Work		24h		
	169	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work		8h		
	170	*Send case listings to providers*	*IAC*	*1 hr*	Work		1h		

File: MPRO 2004

Exhibit C

MPRO Resource List

with Task Assignments

ID	ID	Resource Name	Initials	Work	Details	2005			
						Qtr 4	Qtr 1	Qtr 2	Qtr 3
	171	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work		1h		
	172	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work		1h		
	173	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work		32h		
	174	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work		2h		
	175	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work		124h		
	176	*Request any missing information if applicable*	*IAC*	*6 hrs*	Work		6h		
	177	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work		3h		
	178	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work		56h		
	180	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work		0h		
	181	*Respond to appeals*	*IAC*	*24 hrs*	Work		24h		
	185	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work		8h		
	186	*Send case listings to providers*	*IAC*	*1 hr*	Work			1h	
	187	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work		1h		
	188	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work			1h	
	189	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work			32h	
	190	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work			2h	
	191	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work			124h	
	192	*Request any missing information if applicable*	*IAC*	*6 hrs*	Work			6h	
	193	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work			3h	
	194	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work			56h	
	196	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work			0h	
	197	*Respond to appeals*	*IAC*	*24 hrs*	Work			24h	
	201	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work		8h		
	202	*Send case listings to providers*	*IAC*	*1 hr*	Work			1h	
	203	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work		1h		
	204	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work			1h	
	205	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work			32h	
	206	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work			2h	
	207	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work			124h	
	208	*Request any missing information if applicable*	*IAC*	*6 hrs*	Work			6h	
	209	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work			3h	
	210	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work			56h	
	212	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work			0h	
	213	*Respond to appeals*	*IAC*	*24 hrs*	Work			24h	
	217	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work		8h		
	218	*Send case listings to providers*	*IAC*	*1 hr*	Work			1h	
	219	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work		1h		
	220	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work			1h	
	221	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work			32h	
	222	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work			2h	
	223	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work			124h	
	224	*Request any missing information if applicable*	*IAC*	*7 hrs*	Work			7h	
	225	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work			3h	
	226	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work			56h	
	228	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work			0h	
	229	*Respond to appeals*	*IAC*	*24 hrs*	Work			24h	
	233	*Assemble applicable Medicaid policy, codes, etc.*	*IAC*	*8 hrs*	Work				8h
	234	*Send case listings to providers*	*IAC*	*1 hr*	Work				1h
	235	*Schedule appointment with provider to scan reco*	*IAC*	*1 hr*	Work				1h
	236	*Send confirmation letter regarding appointment*	*IAC*	*1 hr*	Work				1h
	237	*Scan/copy records at provider location*	*IAC*	*32 hrs*	Work				32h
	238	*Request missing charts if applicable*	*IAC*	*2 hrs*	Work				2h
	239	*Review records using audit criteria and documen*	*IAC*	*124 hrs*	Work				124h
	240	*Request any missing information if applicable*	*IAC*	*8 hrs*	Work				8h
	241	*Determine if case needs physician review*	*IAC*	*3 hrs*	Work				3h
	242	*RN compiles all information and writes report*	*IAC*	*56 hrs*	Work				56h
	244	*Submit workbook and report to MDCH*	*IAC*	*0 hrs*	Work				0h
	245	*Respond to appeals*	*IAC*	*24 hrs*	Work				24h
4	4	**PACER Review Coordinator**	PRC	3,808 hrs	Work	965.52h	941.53h	948.95h	952h
	66	*Complete approx. 2700 FFS authorizations/quart*	*PRC*	*927 hrs*	Work	927h			
	67	*Complete approx. 2700 FFS authorizations/quart*	*PRC*	*927 hrs*	Work	13.15h	913.85h		
	68	*Complete approx. 2700 FFS authorizations/quart*	*PRC*	*927 hrs*	Work		2.97h	924.03h	
	69	*Complete approx. 2700 FFS authorizations/quart*	*PRC*	*927 hrs*	Work				927h

File: MPRO 2004

Exhibit C

MPRO Resource List

with Task Assignments

ID	ID	Resource Name	Initials	Work	Details	2005			
						Qtr 4	Qtr 1	Qtr 2	Qtr 3
	76	*Complete approx. 25 FFS appeals/quarter 1*	*PRC*	*25 hrs*	Work	25h			
	77	*Complete approx. 25 FFS appeals/quarter 2*	*PRC*	*25 hrs*	Work	0.35h	24.65h		
	78	*Complete approx. 25 FFS appeals/quarter 3*	*PRC*	*25 hrs*	Work		0.08h	24.92h	
	79	*Complete approx. 25 FFS appeals/quarter 4*	*PRC*	*25 hrs*	Work				25h
5	5	**Long Term Care Exception Coordinator**	LTCEC	2,588 hrs	Work	656.18h	639.88h	644.93h	647h
	71	*Complete approx. 500 LTC authorizations/quarte*	*LTCEC*	*225 hrs*	Work	225h			
	72	*Complete approx. 500 LTC authorizations/quarte*	*LTCEC*	*225 hrs*	Work	3.2h	221.8h		
	73	*Complete approx. 500 LTC authorizations/quarte*	*LTCEC*	*225 hrs*	Work		0.72h	224.28h	
	74	*Complete approx. 500 LTC authorizations/quarte*	*LTCEC*	*225 hrs*	Work				225h
	81	*Complete approx. 281 LTC appeals/quarter 1*	*LTCEC*	*422 hrs*	Work	422h			
	82	*Complete approx. 281 LTC appeals/quarter 2*	*LTCEC*	*422 hrs*	Work	5.98h	416.02h		
	83	*Complete approx. 281 LTC appeals/quarter 3*	*LTCEC*	*422 hrs*	Work		1.35h	420.65h	
	84	*Complete approx. 281 LTC appeals/quarter 4*	*LTCEC*	*422 hrs*	Work				422h
6	6	**Physician Reviewer**	PR	1,125 hrs	Work	294.35h	288.73h	289.92h	252h
	66	*Complete approx. 2700 FFS authorizations/quart*	*PR*	*205 hrs*	Work	205h			
	67	*Complete approx. 2700 FFS authorizations/quart*	*PR*	*200 hrs*	Work	0h	200h		
	68	*Complete approx. 2700 FFS authorizations/quart*	*PR*	*200 hrs*	Work		0h	200h	
	69	*Complete approx. 2700 FFS authorizations/quart*	*PR*	*205 hrs*	Work				205h
	76	*Complete approx. 25 FFS appeals/quarter 1*	*PR*	*25 hrs*	Work	25h			
	77	*Complete approx. 25 FFS appeals/quarter 2*	*PR*	*25 hrs*	Work	0.35h	24.65h		
	78	*Complete approx. 25 FFS appeals/quarter 3*	*PR*	*25 hrs*	Work		0.08h	24.92h	
	79	*Complete approx. 25 FFS appeals/quarter 4*	*PR*	*25 hrs*	Work				25h
	97	*Determine if case needs physician review*	*PR*	*22 hrs*	Work	22h			
	113	*Determine if case needs physician review*	*PR*	*21 hrs*	Work	21h			
	129	*Determine if case needs physician review*	*PR*	*21 hrs*	Work	21h			
	145	*Determine if case needs physician review*	*PR*	*22 hrs*	Work		22h		
	161	*Determine if case needs physician review*	*PR*	*21 hrs*	Work		21h		
	177	*Determine if case needs physician review*	*PR*	*21 hrs*	Work		21h		
	193	*Determine if case needs physician review*	*PR*	*22 hrs*	Work			22h	
	209	*Determine if case needs physician review*	*PR*	*21 hrs*	Work			21h	
	225	*Determine if case needs physician review*	*PR*	*22 hrs*	Work			22h	
	241	*Determine if case needs physician review*	*PR*	*22 hrs*	Work				22h
7	7	**Physician Reviewer-LTC Exception**	**PRLTC**	**3,202 hrs**	Work	750.83h	811.17h	818h	822h
	71	*Complete approx. 500 LTC authorizations/quarte*	*PRLTC*	*175 hrs*	Work	175h			
	72	*Complete approx. 500 LTC authorizations/quarte*	*PRLTC*	*200 hrs*	Work	2.83h	197.17h		
	73	*Complete approx. 500 LTC authorizations/quarte*	*PRLTC*	*200 hrs*	Work		0.63h	199.37h	
	74	*Complete approx. 500 LTC authorizations/quarte*	*PRLTC*	*200 hrs*	Work				200h
	81	*Complete approx. 281 LTC appeals/quarter 1*	*PRLTC*	*422 hrs*	Work	422h			
	82	*Complete approx. 281 LTC appeals/quarter 2*	*PRLTC*	*422 hrs*	Work	5.98h	416.02h		
	83	*Complete approx. 281 LTC appeals/quarter 3*	*PRLTC*	*422 hrs*	Work		1.35h	420.65h	
	84	*Complete approx. 281 LTC appeals/quarter 4*	*PRLTC*	*422 hrs*	Work				422h
	341	*RN submits non-approved for Physician Review*	*PRLTC*	*55 hrs*	Work	55h			
	348	*RN submits non-approved for Physician Review*	*PRLTC*	*65 hrs*	Work		65h		
	355	*RN submits non-approved for Physician Review*	*PRLTC*	*65 hrs*	Work			65h	
	362	*RN submits non-approved for Physician Review*	*PRLTC*	*66 hrs*	Work				66h
	365	*Respond to appeals as received using defined de*	*PRLTC*	*488 hrs*	Work	90h	131h	133h	134h
8	8	**LTC Review Coordinator**	**LTCRC**	**900 hrs**	Work	191.4h	236.2h	236.2h	236.2h
	340	*RN reviews case(s) and approves and records th*	*LTCRC*	*90 hrs*	Work	90h			
	342	*RN sends initial negative action letter on non-app*	*LTCRC*	*16 hrs*	Work	16h			
	347	*RN reviews case(s) and approves and records th*	*LTCRC*	*86 hrs*	Work		86h		
	349	*RN sends initial negative action letter on non-app*	*LTCRC*	*16 hrs*	Work		16h		
	354	*RN reviews case(s) and approves and records th*	*LTCRC*	*86 hrs*	Work			86h	
	356	*RN sends initial negative action letter on non-app*	*LTCRC*	*16 hrs*	Work			16h	
	361	*RN reviews case(s) and approves and records th*	*LTCRC*	*86 hrs*	Work				86h
	363	*RN sends initial negative action letter on non-app*	*LTCRC*	*16 hrs*	Work				16h
	365	*Respond to appeals as received using defined de*	*LTCRC*	*488 hrs*	Work	85.4h	134.2h	134.2h	134.2h
9	9	**Registered Health Information Technician**	**RHIT**	**2,425 hrs**	Work	705.47h	701.58h	702.47h	315.47h
	4	*Project Management*	*RHIT*	*480 hrs*	Work	120.47h	118.58h	120.47h	120.47h
	93	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work	40h			
	95	*Review records using audit criteria and documen*	*RHIT*	*144 hrs*	Work	144h			
	96	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work	8h			
	97	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work	3h			

MPRO Resource List

with Task Assignments

ID	ID	Resource Name	Initials	Work	Details	2005			
						Qtr 4	Qtr 1	Qtr 2	Qtr 3
	109	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work	40h			
	111	*Review records using audit criteria and documen*	*RHIT*	*144 hrs*	Work	144h			
	112	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work	8h			
	113	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work	3h			
	125	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work	40h			
	127	*Review records using audit criteria and documen*	*RHIT*	*144 hrs*	Work	144h			
	128	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work	8h			
	129	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work	3h			
	141	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work		40h		
	143	*Review records using audit criteria and documen*	*RHIT*	*144 hrs*	Work		144h		
	144	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work		8h		
	145	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work		3h		
	157	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work		40h		
	159	*Review records using audit criteria and documen*	*RHIT*	*143 hrs*	Work		143h		
	160	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work		8h		
	161	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work		3h		
	173	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work		40h		
	175	*Review records using audit criteria and documen*	*RHIT*	*143 hrs*	Work		143h		
	176	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work		8h		
	177	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work		3h		
	189	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work			40h	
	191	*Review records using audit criteria and documen*	*RHIT*	*143 hrs*	Work			143h	
	192	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work			8h	
	193	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work			3h	
	205	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work			40h	
	207	*Review records using audit criteria and documen*	*RHIT*	*143 hrs*	Work			143h	
	208	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work			8h	
	209	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work			3h	
	221	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work			40h	
	223	*Review records using audit criteria and documen*	*RHIT*	*143 hrs*	Work			143h	
	224	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work			8h	
	225	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work			3h	
	237	*Scan/copy records at provider location*	*RHIT*	*40 hrs*	Work				40h
	239	*Review records using audit criteria and documen*	*RHIT*	*144 hrs*	Work				144h
	240	*Request any missing information if applicable*	*RHIT*	*8 hrs*	Work				8h
	241	*Determine if case needs physician review*	*RHIT*	*3 hrs*	Work				3h
10	**10**	**Review Process Manager**	**RPM**	**1,800 hrs**	Work	458.37h	444.08h	448.57h	449h
	50	*Reassign Staff*	*RPM*	*8 hrs*	Work	8h			
	51	*Hire Staff (2 RNs recruited prior to contract start*	*RPM*	*6 hrs*	Work	6h			
	52	*Train new staff*	*RPM*	*20 hrs*	Work	20h			
	53	*Train staff on new LTC procedures*	*RPM*	*7 hrs*	Work	7h			
	55	*Develop new LTC review procedures*	*RPM*	*40 hrs*	Work	40h			
	66	*Complete approx. 2700 FFS authorizations/quart*	*RPM*	*270 hrs*	Work	270h			
	67	*Complete approx. 2700 FFS authorizations/quart*	*RPM*	*270 hrs*	Work	3.83h	266.17h		
	68	*Complete approx. 2700 FFS authorizations/quart*	*RPM*	*270 hrs*	Work		0.87h	269.13h	
	69	*Complete approx. 2700 FFS authorizations/quart*	*RPM*	*270 hrs*	Work				270h
	71	*Complete approx. 500 LTC authorizations/quarte*	*RPM*	*75 hrs*	Work	75h			
	72	*Complete approx. 500 LTC authorizations/quarte*	*RPM*	*150 hrs*	Work	2.13h	147.87h		
	73	*Complete approx. 500 LTC authorizations/quarte*	*RPM*	*150 hrs*	Work		0.48h	149.52h	
	74	*Complete approx. 500 LTC authorizations/quarte*	*RPM*	*150 hrs*	Work				150h
	76	*Complete approx. 25 FFS appeals/quarter 1*	*RPM*	*1 hr*	Work	1h			
	77	*Complete approx. 25 FFS appeals/quarter 2*	*RPM*	*1 hr*	Work	0h	1h		
	78	*Complete approx. 25 FFS appeals/quarter 3*	*RPM*	*2 hrs*	Work		0h	2h	
	79	*Complete approx. 25 FFS appeals/quarter 4*	*RPM*	*1 hr*	Work				1h
	81	*Complete approx. 281 LTC appeals/quarter 1*	*RPM*	*25 hrs*	Work	25h			
	82	*Complete approx. 281 LTC appeals/quarter 2*	*RPM*	*28 hrs*	Work	0.4h	27.6h		
	83	*Complete approx. 281 LTC appeals/quarter 3*	*RPM*	*28 hrs*	Work		0.08h	27.92h	
	84	*Complete approx. 281 LTC appeals/quarter 4*	*RPM*	*28 hrs*	Work				28h
11	**11**	**Medical Records Technician**	**MRT**	**1,949 hrs**	Work	715h	523h	521h	190h
	93	*Scan/copy records at provider location*	*MRT*	*104 hrs*	Work	104h			
	109	*Scan/copy records at provider location*	*MRT*	*102 hrs*	Work	102h			
	125	*Scan/copy records at provider location*	*MRT*	*102 hrs*	Work	102h			
	141	*Scan/copy records at provider location*	*MRT*	*104 hrs*	Work		104h		

File: MPRO 2004

Exhibit C

MPRO Resource List

with Task Assignments

ID	ID	Resource Name	Initials	Work	Details	2005			
						Qtr 4	Qtr 1	Qtr 2	Qtr 3
	157	*Scan/copy records at provider location*	*MRT*	*102 hrs*	Work		102h		
	173	*Scan/copy records at provider location*	*MRT*	*102 hrs*	Work		102h		
	189	*Scan/copy records at provider location*	*MRT*	*102 hrs*	Work			102h	
	205	*Scan/copy records at provider location*	*MRT*	*102 hrs*	Work			102h	
	221	*Scan/copy records at provider location*	*MRT*	*102 hrs*	Work			102h	
	237	*Scan/copy records at provider location*	*MRT*	*102 hrs*	Work				102h
	253	*Scan/copy records at provider location*	*MRT*	*192 hrs*	Work	192h			
	254	*Scan at Provider 1 location*	*MRT*	*63 hrs*	Work	63h			
	255	*Scan at Provider 2 location*	*MRT*	*64 hrs*	Work	64h			
	256	*Scan at Provider 3 location*	*MRT*	*64 hrs*	Work	64h			
	277	*Scan at Provider 4 location*	*MRT*	*63 hrs*	Work		63h		
	278	*Scan at Provider 5 location*	*MRT*	*64 hrs*	Work		64h		
	279	*Scan at Provider 6 location*	*MRT*	*64 hrs*	Work		64h		
	300	*Scan at Provider 7 location*	*MRT*	*63 hrs*	Work			63h	
	301	*Scan at Provider 8 location*	*MRT*	*64 hrs*	Work			64h	
	302	*Scan at Provider 9 location*	*MRT*	*64 hrs*	Work			64h	
	322	*Scan/copy records at provider 10 location*	*MRT*	*64 hrs*	Work				64h
	337	*Prepare list and mail request to the appropriate p*	*MRT*	*8 hrs*	Work	8h			
	338	*Receive records from provider and identify missir*	*MRT*	*8 hrs*	Work	8h			
	339	*Re-request any missing records*	*MRT*	*8 hrs*	Work	8h			
	344	*Prepare list and mail request to the appropriate p*	*MRT*	*8 hrs*	Work		8h		
	345	*Receive records from provider and identify missir*	*MRT*	*8 hrs*	Work		8h		
	346	*Re-request any missing records*	*MRT*	*8 hrs*	Work		8h		
	351	*Prepare list and mail request to the appropriate p*	*MRT*	*8 hrs*	Work			8h	
	352	*Receive records from provider and identify missir*	*MRT*	*8 hrs*	Work			8h	
	353	*Re-request any missing records*	*MRT*	*8 hrs*	Work			8h	
	358	*Prepare list and mail request to the appropriate p*	*MRT*	*8 hrs*	Work				8h
	359	*Receive records from provider and identify missir*	*MRT*	*8 hrs*	Work				8h
	360	*Re-request any missing records*	*MRT*	*8 hrs*	Work				8h
12	**12**	**Information Technology staff**	**IT**	**38 hrs**	Work	38h			
	56	*Develop tracking tool for LTC exception requests*	*IT*	*8 hrs*	Work	8h			
	57	*Design spreadsheet for LTC retrospective review*	*IT*	*8 hrs*	Work	8h			
	60	*Revise report formats if requested*	*IT*	*16 hrs*	Work	16h			
	61	*Test report modifications*	*IT*	*6 hrs*	Work	6h			
13	13	**MDCH**	MDCH	20 hrs	Work	10h	3h	3h	3h
	6	*Weekly meeting/teleconference 1*	*MDCH*	*2 hrs*	Work	2h			
	7	*Weekly meeting/teleconference 2*	*MDCH*	*2 hrs*	Work	2h			
	8	*Weekly meeting/teleconference 3*	*MDCH*	*2 hrs*	Work	2h			
	9	*Weekly meeting/teleconference 4*	*MDCH*	*2 hrs*	Work	2h			
	11	*Monthly meeting/teleconference 1*	*MDCH*	*1 hr*	Work	1h			
	12	*Monthly meeting/teleconference 2*	*MDCH*	*1 hr*	Work	1h			
	13	*Monthly meeting/teleconference 3*	*MDCH*	*1 hr*	Work		1h		
	14	*Monthly meeting/teleconference 4*	*MDCH*	*1 hr*	Work		1h		
	15	*Monthly meeting/teleconference 5*	*MDCH*	*1 hr*	Work		1h		
	16	*Monthly meeting/teleconference 6*	*MDCH*	*1 hr*	Work			1h	
	17	*Monthly meeting/teleconference 7*	*MDCH*	*1 hr*	Work			1h	
	18	*Monthly meeting/teleconference 8*	*MDCH*	*1 hr*	Work			1h	
	19	*Monthly meeting/teleconference 9*	*MDCH*	*1 hr*	Work				1h
	20	*Monthly meeting/teleconference 10*	*MDCH*	*1 hr*	Work				1h
	21	*Monthly meeting/teleconference 11*	*MDCH*	*1 hr*	Work				1h
	22	*Monthly meeting/teleconference 12*	*MDCH*	*1 hr*	Work				

Exhibit D – Gantt with Expanded Fields Displayed

Note: The following MS Project Schedule does not reflect the timeframes for inpatient audits as required in the bidder's questions and answers posted August 20th, 2004. Upon award of the contract, the timeframe for conducting these audits will be revised so that they take place monthly instead of quarterly.

MPRO

Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
1	1	**Contract Administration**		**275 days**	**Fri 10/1/04**	**Mon 10/31/05**		**2,110 hrs**
2	1.1	Contract period begins		0 days	Fri 10/1/04	Fri 10/1/04		0 hrs
3	1.2	End of contract year 1		0 days	Fri 9/30/05	Fri 9/30/05		0 hrs
4	1.3	Project Management	MRM,RHIT	51 wks	Fri 10/1/04	Fri 9/30/05		2,058 hrs
5	**1.4**	**Weekly meeting/teleconference**		**15.25 days**	**Wed 10/6/04**	**Wed 10/27/04**		**16 hrs**
6	1.4.1	Weekly meeting/teleconference 1	MRM,MDCH	2 hrs	Wed 10/6/04	Wed 10/6/04		4 hrs
7	1.4.2	Weekly meeting/teleconference 2	MRM,MDCH	2 hrs	Wed 10/13/04	Wed 10/13/04		4 hrs
8	1.4.3	Weekly meeting/teleconference 3	MRM,MDCH	2 hrs	Wed 10/20/04	Wed 10/20/04		4 hrs
9	1.4.4	Weekly meeting/teleconference 4	MRM,MDCH	2 hrs	Wed 10/27/04	Wed 10/27/04		4 hrs
10	**1.5**	**Monthly meeting/teleconference**		**235 days**	**Thu 11/11/04**	**Thu 10/13/05**		**36 hrs**
11	1.5.1	Monthly meeting/teleconference 1	MRM,MDCH	1 day	Thu 11/11/04	Thu 11/11/04		3 hrs
12	1.5.2	Monthly meeting/teleconference 2	MRM,MDCH	1 day	Thu 12/9/04	Thu 12/9/04		3 hrs
13	1.5.3	Monthly meeting/teleconference 3	MRM,MDCH	1 day	Thu 1/13/05	Thu 1/13/05		3 hrs
14	1.5.4	Monthly meeting/teleconference 4	MRM,MDCH	1 day	Thu 2/10/05	Thu 2/10/05		3 hrs
15	1.5.5	Monthly meeting/teleconference 5	MRM,MDCH	1 day	Thu 3/10/05	Thu 3/10/05		3 hrs
16	1.5.6	Monthly meeting/teleconference 6	MRM,MDCH	1 day	Thu 4/14/05	Thu 4/14/05		3 hrs
17	1.5.7	Monthly meeting/teleconference 7	MRM,MDCH	1 day	Thu 5/12/05	Thu 5/12/05		3 hrs
18	1.5.8	Monthly meeting/teleconference 8	MRM,MDCH	1 day	Thu 6/9/05	Thu 6/9/05		3 hrs
19	1.5.9	Monthly meeting/teleconference 9	MRM,MDCH	1 day	Thu 7/14/05	Thu 7/14/05		3 hrs
20	1.5.10	Monthly meeting/teleconference 10	MRM,MDCH	1 day	Thu 8/11/05	Thu 8/11/05		3 hrs
21	1.5.11	Monthly meeting/teleconference 11	MRM,MDCH	1 day	Thu 9/8/05	Thu 9/8/05		3 hrs
22	1.5.12	Monthly meeting/teleconference 12	MRM,MDCH	1 day	Thu 10/13/05	Thu 10/13/05		3 hrs
23	**1.6**	**Submit electronic monthly status report**		**232 days**	**Fri 11/5/04**	**Wed 10/5/05**		**0 hrs**
24	1.6.1	Submit electronic monthly status report 1	MRM	0 days	Fri 11/5/04	Fri 11/5/04		0 hrs
25	1.6.2	Submit electronic monthly status report 2	MRM	0 days	Sun 12/5/04	Sun 12/5/04		0 hrs
26	1.6.3	Submit electronic monthly status report 3	MRM	0 days	Wed 1/5/05	Wed 1/5/05		0 hrs
27	1.6.4	Submit electronic monthly status report 4	MRM	0 days	Sat 2/5/05	Sat 2/5/05		0 hrs
28	1.6.5	Submit electronic monthly status report 5	MRM	0 days	Sat 3/5/05	Sat 3/5/05		0 hrs
29	1.6.6	Submit electronic monthly status report 6	MRM	0 days	Tue 4/5/05	Tue 4/5/05		0 hrs

File: MPRO 2004

Exhibit D

MPRO

Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
30	1.6.7	Submit electronic monthly status report 7	MRM	0 days	Thu 5/5/05	Thu 5/5/05		0 hrs
31	1.6.8	Submit electronic monthly status report 8	MRM	0 days	Sun 6/5/05	Sun 6/5/05		0 hrs
32	1.6.9	Submit electronic monthly status report 9	MRM	0 days	Tue 7/5/05	Tue 7/5/05		0 hrs
33	1.6.10	Submit electronic monthly status report 10	MRM	0 days	Fri 8/5/05	Fri 8/5/05		0 hrs
34	1.6.11	Submit electronic monthly status report 11	MRM	0 days	Mon 9/5/05	Mon 9/5/05		0 hrs
35	1.6.12	Submit electronic monthly status report 12	MRM	0 days	Wed 10/5/05	Wed 10/5/05		0 hrs
36	**1.7**	**Submit Quarterly Report (electronically)**		**191 days**	**Mon 1/31/05**	**Mon 10/31/05**		**0 hrs**
37	1.7.1	Submit Quarterly Report (electronically) 1		0 days	Mon 1/31/05	Mon 1/31/05		0 hrs
38	1.7.2	Submit Quarterly Report (electronically) 2		0 days	Fri 4/29/05	Fri 4/29/05		0 hrs
39	1.7.3	Submit Quarterly Report (electronically) 3		0 days	Fri 7/29/05	Fri 7/29/05		0 hrs
40	1.7.4	Submit Quarterly Report (electronically) 4		0 days	Mon 10/31/05	Mon 10/31/05		0 hrs
41	1.8	Submit Annual Report		0 days	Mon 10/31/05	Mon 10/31/05		0 hrs
42	**1.9**	**Submit revised quarterly work plan**		**234 days**	**Fri 10/29/04**	**Fri 9/30/05**		**0 hrs**
43	1.9.1	Submit revised quarterly work plan 1		0 days	Fri 10/29/04	Fri 10/29/04		0 hrs
44	1.9.2	Submit revised quarterly work plan 2		0 days	Fri 12/31/04	Fri 12/31/04		0 hrs
45	1.9.3	Submit revised quarterly work plan 3		0 days	Thu 3/31/05	Thu 3/31/05		0 hrs
46	1.9.4	Submit revised quarterly work plan 4		0 days	Thu 6/30/05	Thu 6/30/05		0 hrs
47	1.9.5	Submit revised quarterly work plan 5		0 days	Fri 9/30/05	Fri 9/30/05		0 hrs
48	**2**	**Start-up Activities**		**15 days**	**Fri 10/1/04**	**Thu 10/21/04**		**169 hrs**
49	**2.1**	**Staffing**		**6 days**	**Fri 10/1/04**	**Fri 10/8/04**		**89 hrs**
50	2.1.1	Reassign Staff	MRM,RPM	1 day	Fri 10/1/04	Fri 10/1/04		16 hrs
51	2.1.2	Hire Staff (2 RNs recruited prior to contract start date)	MRM,RPM	1 day	Mon 10/4/04	Mon 10/4/04	2FS+1 day	14 hrs
52	2.1.3	Train new staff	MRM,RPM	3 days	Mon 10/4/04	Wed 10/6/04	51SS	44 hrs
53	2.1.4	Train staff on new LTC procedures	MRM,RPM	1 day	Fri 10/8/04	Fri 10/8/04	55	15 hrs
54	**2.2**	**Tools and Procedures**		**6 days**	**Fri 10/1/04**	**Fri 10/8/04**		**56 hrs**
55	2.2.1	Develop new LTC review procedures	RPM	5 days	Fri 10/1/04	Thu 10/7/04		40 hrs
56	2.2.2	Develop tracking tool for LTC exception requests	IT	1 day	Fri 10/8/04	Fri 10/8/04	55	8 hrs
57	2.2.3	Design spreadsheet for LTC retrospective reviews	IT	1 day	Fri 10/8/04	Fri 10/8/04	55	8 hrs
58	**2.3**	**Report review**		**12 days**	**Wed 10/6/04**	**Thu 10/21/04**		**24 hrs**

File: MPRO 2004

Exhibit D

MPRO

Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
59	2.3.1	Review report formats with MDCH	MRM	1 day	Wed 10/6/04	Wed 10/6/04	2FS+3 days	2 hrs
60	2.3.2	Revise report formats if requested	IT	2 days	Thu 10/7/04	Fri 10/8/04	59	16 hrs
61	2.3.3	Test report modifications	IT	3 days	Mon 10/11/04	Wed 10/13/04	60	6 hrs
62	2.3.4	Submit revised report formats to MDCH	MRM	0 days	Wed 10/13/04	Wed 10/13/04	61	0 hrs
63	2.3.5	Receive approval for new report formats from MDCH		1 day	Thu 10/21/04	Thu 10/21/04	62FS+5 days	0 hrs
64	**3**	**Part I - PACER Authorizations and Appeals**		**254 days**	**Fri 10/1/04**	**Fri 9/30/05**		**11,488 hrs**
65	**3.1**	**Complete approx. 2700 FFS authorizations/quarter**		**254 days**	**Fri 10/1/04**	**Fri 9/30/05**		**5,598 hrs**
66	3.1.1	Complete approx. 2700 FFS authorizations/quarter 1	PRC,PR,RPM	13 ewks	Fri 10/1/04	Fri 12/31/04		1,402 hrs
67	3.1.2	Complete approx. 2700 FFS authorizations/quarter 2	PRC,PR,RPM	13 ewks	Thu 12/30/04	Thu 3/31/05		1,397 hrs
68	3.1.3	Complete approx. 2700 FFS authorizations/quarter 3	PRC,PR,RPM	13 ewks	Thu 3/31/05	Thu 6/30/05		1,397 hrs
69	3.1.4	Complete approx. 2700 FFS authorizations/quarter 4	PRC,PR,RPM	13 ewks	Fri 7/1/05	Fri 9/30/05	2	1,402 hrs
70	**3.2**	**Complete approx. 500 LTC authorizations/quarter**		**254 days**	**Fri 10/1/04**	**Fri 9/30/05**		**2,200 hrs**
71	3.2.1	Complete approx. 500 LTC authorizations/quarter 1	LTCEC,RPM,PRLTC	13 ewks	Fri 10/1/04	Fri 12/31/04		475 hrs
72	3.2.2	Complete approx. 500 LTC authorizations/quarter 2	LTCEC,RPM,PRLTC	13 ewks	Thu 12/30/04	Thu 3/31/05		575 hrs
73	3.2.3	Complete approx. 500 LTC authorizations/quarter 3	LTCEC,RPM,PRLTC	13 ewks	Thu 3/31/05	Thu 6/30/05		575 hrs
74	3.2.4	Complete approx. 500 LTC authorizations/quarter 4	LTCEC,RPM,PRLTC	13 ewks	Fri 7/1/05	Fri 9/30/05		575 hrs
75	**3.3**	**Complete approx. 25 FFS appeals/quarter**		**254 days**	**Fri 10/1/04**	**Fri 9/30/05**		**205 hrs**
76	3.3.1	Complete approx. 25 FFS appeals/quarter 1	PR,RPM,PRC	13 ewks	Fri 10/1/04	Fri 12/31/04		51 hrs
77	3.3.2	Complete approx. 25 FFS appeals/quarter 2	PR,RPM,PRC	13 ewks	Thu 12/30/04	Thu 3/31/05		51 hrs
78	3.3.3	Complete approx. 25 FFS appeals/quarter 3	PR,RPM,PRC	13 ewks	Thu 3/31/05	Thu 6/30/05		52 hrs
79	3.3.4	Complete approx. 25 FFS appeals/quarter 4	PR,RPM,PRC	13 ewks	Fri 7/1/05	Fri 9/30/05		51 hrs
80	**3.4**	**Complete approx. 281 LTC appeals/quarter**		**254 days**	**Fri 10/1/04**	**Fri 9/30/05**		**3,485 hrs**
81	3.4.1	Complete approx. 281 LTC appeals/quarter 1	LTCEC,PRLTC,RPM	13 ewks	Fri 10/1/04	Fri 12/31/04		869 hrs
82	3.4.2	Complete approx. 281 LTC appeals/quarter 2	LTCEC,PRLTC,RPM	13 ewks	Thu 12/30/04	Thu 3/31/05		872 hrs
83	3.4.3	Complete approx. 281 LTC appeals/quarter 3	LTCEC,PRLTC,RPM	13 ewks	Thu 3/31/05	Thu 6/30/05		872 hrs
84	3.4.4	Complete approx. 281 LTC appeals/quarter 4	LTCEC,PRLTC,RPM	13 ewks	Fri 7/1/05	Fri 9/30/05		872 hrs
85	**4**	**Part II - Audits**		**247 days**	**Fri 10/1/04**	**Tue 9/20/05**		**9,106.33 hrs**
86	**4.1**	**Inpatient Audit 1**		**57 days**	**Thu 10/14/04**	**Wed 1/5/05**		**589 hrs**
87	4.1.1	Receive inpatient audit list from MDCH		0 days	Thu 10/14/04	Thu 10/14/04	2SS+2 wks	0 hrs

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Exhibit D

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
88	4.1.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Fri 10/15/04	Fri 10/15/04	87	2 hrs
89	4.1.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Mon 10/18/04	Mon 10/18/04	88	8 hrs
90	4.1.4	Send case listings to providers	IAC	1 day	Tue 10/19/04	Tue 10/19/04	89	1 hr
91	4.1.5	Schedule appointment with provider to scan records	IAC	1 day	Mon 10/18/04	Mon 10/18/04	89SS	1 hr
92	4.1.6	Send confirmation letter regarding appointment	IAC	1 day	Tue 10/19/04	Tue 10/19/04	91	1 hr
93	4.1.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Wed 11/3/04	Tue 11/9/04	92FS+10 days	176 hrs
94	4.1.8	Request missing charts if applicable	IAC	1 day	Thu 11/11/04	Thu 11/11/04	93FS+1 day	2 hrs
95	4.1.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Wed 11/10/04	Thu 12/9/04	93	268 hrs
96	4.1.10	Request any missing information if applicable	IAC,RHIT	15 days	Wed 11/17/04	Thu 12/9/04	95SS+5 days	14 hrs
97	4.1.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Fri 11/12/04	Mon 12/6/04	95SS+2 days	28 hrs
98	4.1.12	RN compiles all information and writes report	IAC	9 days	Tue 12/7/04	Fri 12/17/04	97	56 hrs
99	4.1.13	Report is reviewed by management	MRM	1 day	Mon 12/20/04	Mon 12/20/04	98	8 hrs
100	4.1.14	Submit workbook and report to MDCH	IAC	0 days	Mon 12/20/04	Mon 12/20/04	99	0 hrs
101	4.1.15	Respond to appeals	IAC	11 wks	Tue 10/19/04	Wed 1/5/05	89	24 hrs
102	**4.2**	**Inpatient Audit 2**		**57 days**	**Thu 10/14/04**	**Wed 1/5/05**		**586 hrs**
103	4.2.1	Receive inpatient audit list from MDCH		0 days	Thu 10/14/04	Thu 10/14/04	2SS+2 wks	0 hrs
104	4.2.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Fri 10/15/04	Fri 10/15/04	103	2 hrs
105	4.2.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Mon 10/18/04	Mon 10/18/04	104	8 hrs
106	4.2.4	Send case listings to providers	IAC	1 day	Tue 10/19/04	Tue 10/19/04	105	1 hr
107	4.2.5	Schedule appointment with provider to scan records	IAC	1 day	Mon 10/18/04	Mon 10/18/04	105SS	1 hr
108	4.2.6	Send confirmation letter regarding appointment	IAC	1 day	Tue 10/19/04	Tue 10/19/04	107	1 hr
109	4.2.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Wed 11/3/04	Tue 11/9/04	108FS+10 days	174 hrs
110	4.2.8	Request missing charts if applicable	IAC	1 day	Thu 11/11/04	Thu 11/11/04	109FS+1 day	2 hrs
111	4.2.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Wed 11/10/04	Thu 12/9/04	109	268 hrs
112	4.2.10	Request any missing information if applicable	IAC,RHIT	15 days	Wed 11/17/04	Thu 12/9/04	111SS+5 days	14 hrs
113	4.2.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Fri 11/12/04	Mon 12/6/04	111SS+2 days	27 hrs
114	4.2.12	RN compiles all information and writes report	IAC	9 days	Tue 12/7/04	Fri 12/17/04	113	56 hrs
115	4.2.13	Report is reviewed by management	MRM	1 day	Mon 12/20/04	Mon 12/20/04	114	8 hrs
116	4.2.14	Submit workbook and report to MDCH	IAC	0 days	Mon 12/20/04	Mon 12/20/04	115	0 hrs

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
117	4.2.15	Respond to appeals	IAC	11 wks	Tue 10/19/04	Wed 1/5/05	105	24 hrs
118	**4.3**	**Inpatient Audit 3**		**57 days**	**Thu 10/14/04**	**Wed 1/5/05**		**586 hrs**
119	4.3.1	Receive inpatient audit list from MDCH		0 days	Thu 10/14/04	Thu 10/14/04	2SS+2 wks	0 hrs
120	4.3.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Fri 10/15/04	Fri 10/15/04	119	2 hrs
121	4.3.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Mon 10/18/04	Mon 10/18/04	120	8 hrs
122	4.3.4	Send case listings to providers	IAC	1 day	Tue 10/19/04	Tue 10/19/04	121	1 hr
123	4.3.5	Schedule appointment with provider to scan records	IAC	1 day	Mon 10/18/04	Mon 10/18/04	121SS	1 hr
124	4.3.6	Send confirmation letter regarding appointment	IAC	1 day	Tue 10/19/04	Tue 10/19/04	123	1 hr
125	4.3.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Wed 11/3/04	Tue 11/9/04	124FS+10 days	174 hrs
126	4.3.8	Request missing charts if applicable	IAC	1 day	Thu 11/11/04	Thu 11/11/04	125FS+1 day	2 hrs
127	4.3.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Wed 11/10/04	Thu 12/9/04	125	268 hrs
128	4.3.10	Request any missing information if applicable	IAC,RHIT	15 days	Wed 11/17/04	Thu 12/9/04	127SS+5 days	14 hrs
129	4.3.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Fri 11/12/04	Mon 12/6/04	127SS+2 days	27 hrs
130	4.3.12	RN compiles all information and writes report	IAC	9 days	Tue 12/7/04	Fri 12/17/04	129	56 hrs
131	4.3.13	Report is reviewed by management	MRM	1 day	Mon 12/20/04	Mon 12/20/04	130	8 hrs
132	4.3.14	Submit workbook and report to MDCH	IAC	0 days	Mon 12/20/04	Mon 12/20/04	131	0 hrs
133	4.3.15	Respond to appeals	IAC	11 wks	Tue 10/19/04	Wed 1/5/05	121	24 hrs
134	**4.4**	**Inpatient Audit 4**		**57 days**	**Mon 1/3/05**	**Thu 3/24/05**		**591 hrs**
135	4.4.1	Receive inpatient audit list from MDCH		0 days	Mon 1/3/05	Mon 1/3/05	87FS+11 wks	0 hrs
136	4.4.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Tue 1/4/05	Tue 1/4/05	135	2 hrs
137	4.4.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Wed 1/5/05	Wed 1/5/05	136	8 hrs
138	4.4.4	Send case listings to providers	IAC	1 day	Thu 1/6/05	Thu 1/6/05	137	1 hr
139	4.4.5	Schedule appointment with provider to scan records	IAC	1 day	Wed 1/5/05	Wed 1/5/05	137SS	1 hr
140	4.4.6	Send confirmation letter regarding appointment	IAC	1 day	Thu 1/6/05	Thu 1/6/05	139	1 hr
141	4.4.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Fri 1/21/05	Thu 1/27/05	140FS+10 days	176 hrs
142	4.4.8	Request missing charts if applicable	IAC	1 day	Mon 1/31/05	Mon 1/31/05	141FS+1 day	2 hrs
143	4.4.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Fri 1/28/05	Fri 2/25/05	141	268 hrs
144	4.4.10	Request any missing information if applicable	IAC,RHIT	15 days	Fri 2/4/05	Fri 2/25/05	143SS+5 days	16 hrs
145	4.4.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Tue 2/1/05	Tue 2/22/05	143SS+2 days	28 hrs

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
146	4.4.12	RN compiles all information and writes report	IAC	9 days	Wed 2/23/05	Mon 3/7/05	145	56 hrs
147	4.4.13	Report is reviewed by management	MRM	1 day	Tue 3/8/05	Tue 3/8/05	146	8 hrs
148	4.4.14	Submit workbook and report to MDCH	IAC	0 days	Tue 3/8/05	Tue 3/8/05	147	0 hrs
149	4.4.15	Respond to appeals	IAC	11 wks	Thu 1/6/05	Thu 3/24/05	137	24 hrs
150	**4.5**	**Inpatient Audit 5**		**57 days**	**Mon 1/3/05**	**Thu 3/24/05**		**585 hrs**
151	4.5.1	Receive inpatient audit list from MDCH		0 days	Mon 1/3/05	Mon 1/3/05	87FS+11 wks	0 hrs
152	4.5.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Tue 1/4/05	Tue 1/4/05	151	2 hrs
153	4.5.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Wed 1/5/05	Wed 1/5/05	152	8 hrs
154	4.5.4	Send case listings to providers	IAC	1 day	Thu 1/6/05	Thu 1/6/05	153	1 hr
155	4.5.5	Schedule appointment with provider to scan records	IAC	1 day	Wed 1/5/05	Wed 1/5/05	153SS	1 hr
156	4.5.6	Send confirmation letter regarding appointment	IAC	1 day	Thu 1/6/05	Thu 1/6/05	155	1 hr
157	4.5.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Fri 1/21/05	Thu 1/27/05	156FS+10 days	174 hrs
158	4.5.8	Request missing charts if applicable	IAC	1 day	Mon 1/31/05	Mon 1/31/05	157FS+1 day	2 hrs
159	4.5.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Fri 1/28/05	Fri 2/25/05	157	267 hrs
160	4.5.10	Request any missing information if applicable	IAC,RHIT	15 days	Fri 2/4/05	Fri 2/25/05	159SS+5 days	14 hrs
161	4.5.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Tue 2/1/05	Tue 2/22/05	159SS+2 days	27 hrs
162	4.5.12	RN compiles all information and writes report	IAC	9 days	Wed 2/23/05	Mon 3/7/05	161	56 hrs
163	4.5.13	Report is reviewed by management	MRM	1 day	Tue 3/8/05	Tue 3/8/05	162	8 hrs
164	4.5.14	Submit workbook and report to MDCH	IAC	0 days	Tue 3/8/05	Tue 3/8/05	163	0 hrs
165	4.5.15	Respond to appeals	IAC	11 wks	Thu 1/6/05	Thu 3/24/05	153	24 hrs
166	**4.6**	**Inpatient Audit 6**		**57 days**	**Mon 1/3/05**	**Thu 3/24/05**		**585 hrs**
167	4.6.1	Receive inpatient audit list from MDCH		0 days	Mon 1/3/05	Mon 1/3/05	87FS+11 wks	0 hrs
168	4.6.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Tue 1/4/05	Tue 1/4/05	167	2 hrs
169	4.6.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Wed 1/5/05	Wed 1/5/05	168	8 hrs
170	4.6.4	Send case listings to providers	IAC	1 day	Thu 1/6/05	Thu 1/6/05	169	1 hr
171	4.6.5	Schedule appointment with provider to scan records	IAC	1 day	Wed 1/5/05	Wed 1/5/05	169SS	1 hr
172	4.6.6	Send confirmation letter regarding appointment	IAC	1 day	Thu 1/6/05	Thu 1/6/05	171	1 hr
173	4.6.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Fri 1/21/05	Thu 1/27/05	172FS+10 days	174 hrs
174	4.6.8	Request missing charts if applicable	IAC	1 day	Mon 1/31/05	Mon 1/31/05	173FS+1 day	2 hrs

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
175	4.6.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Fri 1/28/05	Fri 2/25/05	173	267 hrs
176	4.6.10	Request any missing information if applicable	IAC,RHIT	15 days	Fri 2/4/05	Fri 2/25/05	175SS+5 days	14 hrs
177	4.6.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Tue 2/1/05	Tue 2/22/05	175SS+2 days	27 hrs
178	4.6.12	RN compiles all information and writes report	IAC	9 days	Wed 2/23/05	Mon 3/7/05	177	56 hrs
179	4.6.13	Report is reviewed by management	MRM	1 day	Tue 3/8/05	Tue 3/8/05	178	8 hrs
180	4.6.14	Submit workbook and report to MDCH	IAC	0 days	Tue 3/8/05	Tue 3/8/05	179	0 hrs
181	4.6.15	Respond to appeals	IAC	11 wks	Thu 1/6/05	Thu 3/24/05	169	24 hrs
182	**4.7**	**Inpatient Audit 7**		**57 days**	**Tue 3/29/05**	**Fri 6/17/05**		**586 hrs**
183	4.7.1	Receive inpatient audit list from MDCH		0 days	Tue 3/29/05	Tue 3/29/05	135FS+12 wks	0 hrs
184	4.7.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Wed 3/30/05	Wed 3/30/05	183	2 hrs
185	4.7.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Thu 3/31/05	Thu 3/31/05	184	8 hrs
186	4.7.4	Send case listings to providers	IAC	1 day	Fri 4/1/05	Fri 4/1/05	185	1 hr
187	4.7.5	Schedule appointment with provider to scan records	IAC	1 day	Thu 3/31/05	Thu 3/31/05	185SS	1 hr
188	4.7.6	Send confirmation letter regarding appointment	IAC	1 day	Fri 4/1/05	Fri 4/1/05	187	1 hr
189	4.7.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Mon 4/18/05	Fri 4/22/05	188FS+10 days	174 hrs
190	4.7.8	Request missing charts if applicable	IAC	1 day	Tue 4/26/05	Tue 4/26/05	189FS+1 day	2 hrs
191	4.7.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Mon 4/25/05	Fri 5/20/05	189	267 hrs
192	4.7.10	Request any missing information if applicable	IAC,RHIT	15 days	Mon 5/2/05	Fri 5/20/05	191SS+5 days	14 hrs
193	4.7.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Wed 4/27/05	Tue 5/17/05	191SS+2 days	28 hrs
194	4.7.12	RN compiles all information and writes report	IAC	9 days	Wed 5/18/05	Tue 5/31/05	193	56 hrs
195	4.7.13	Report is reviewed by management	MRM	1 day	Wed 6/1/05	Wed 6/1/05	194	8 hrs
196	4.7.14	Submit workbook and report to MDCH	IAC	0 days	Wed 6/1/05	Wed 6/1/05	195	0 hrs
197	4.7.15	Respond to appeals	IAC	11 wks	Fri 4/1/05	Fri 6/17/05	185	24 hrs
198	**4.8**	**Inpatient Audit 8**		**57 days**	**Tue 3/29/05**	**Fri 6/17/05**		**585 hrs**
199	4.8.1	Receive inpatient audit list from MDCH		0 days	Tue 3/29/05	Tue 3/29/05	135FS+12 wks	0 hrs
200	4.8.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Wed 3/30/05	Wed 3/30/05	199	2 hrs
201	4.8.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Thu 3/31/05	Thu 3/31/05	200	8 hrs
202	4.8.4	Send case listings to providers	IAC	1 day	Fri 4/1/05	Fri 4/1/05	201	1 hr
203	4.8.5	Schedule appointment with provider to scan records	IAC	1 day	Thu 3/31/05	Thu 3/31/05	201SS	1 hr

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
204	4.8.6	Send confirmation letter regarding appointment	IAC	1 day	Fri 4/1/05	Fri 4/1/05	203	1 hr
205	4.8.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Mon 4/18/05	Fri 4/22/05	204FS+10 days	174 hrs
206	4.8.8	Request missing charts if applicable	IAC	1 day	Tue 4/26/05	Tue 4/26/05	205FS+1 day	2 hrs
207	4.8.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Mon 4/25/05	Fri 5/20/05	205	267 hrs
208	4.8.10	Request any missing information if applicable	IAC,RHIT	15 days	Mon 5/2/05	Fri 5/20/05	207SS+5 days	14 hrs
209	4.8.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Wed 4/27/05	Tue 5/17/05	207SS+2 days	27 hrs
210	4.8.12	RN compiles all information and writes report	IAC	9 days	Wed 5/18/05	Tue 5/31/05	209	56 hrs
211	4.8.13	Report is reviewed by management	MRM	1 day	Wed 6/1/05	Wed 6/1/05	210	8 hrs
212	4.8.14	Submit workbook and report to MDCH	IAC	0 days	Wed 6/1/05	Wed 6/1/05	211	0 hrs
213	4.8.15	Respond to appeals	IAC	11 wks	Fri 4/1/05	Fri 6/17/05	201	24 hrs
214	**4.9**	**Inpatient Audit 9**		**57 days**	**Tue 3/29/05**	**Fri 6/17/05**		**587 hrs**
215	4.9.1	Receive inpatient audit list from MDCH		0 days	Tue 3/29/05	Tue 3/29/05	135FS+12 wks	0 hrs
216	4.9.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Wed 3/30/05	Wed 3/30/05	215	2 hrs
217	4.9.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Thu 3/31/05	Thu 3/31/05	216	8 hrs
218	4.9.4	Send case listings to providers	IAC	1 day	Fri 4/1/05	Fri 4/1/05	217	1 hr
219	4.9.5	Schedule appointment with provider to scan records	IAC	1 day	Thu 3/31/05	Thu 3/31/05	217SS	1 hr
220	4.9.6	Send confirmation letter regarding appointment	IAC	1 day	Fri 4/1/05	Fri 4/1/05	219	1 hr
221	4.9.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Mon 4/18/05	Fri 4/22/05	220FS+10 days	174 hrs
222	4.9.8	Request missing charts if applicable	IAC	1 day	Tue 4/26/05	Tue 4/26/05	221FS+1 day	2 hrs
223	4.9.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Mon 4/25/05	Fri 5/20/05	221	267 hrs
224	4.9.10	Request any missing information if applicable	IAC,RHIT	15 days	Mon 5/2/05	Fri 5/20/05	223SS+5 days	15 hrs
225	4.9.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Wed 4/27/05	Tue 5/17/05	223SS+2 days	28 hrs
226	4.9.12	RN compiles all information and writes report	IAC	9 days	Wed 5/18/05	Tue 5/31/05	225	56 hrs
227	4.9.13	Report is reviewed by management	MRM	1 day	Wed 6/1/05	Wed 6/1/05	226	8 hrs
228	4.9.14	Submit workbook and report to MDCH	IAC	0 days	Wed 6/1/05	Wed 6/1/05	227	0 hrs
229	4.9.15	Respond to appeals	IAC	11 wks	Fri 4/1/05	Fri 6/17/05	217	24 hrs
230	**4.10**	**Inpatient Audit 10**		**57 days**	**Wed 6/29/05**	**Tue 9/20/05**		**589 hrs**
231	4.10.1	Receive inpatient audit list from MDCH		0 days	Wed 6/29/05	Wed 6/29/05	215FS+13 wks	0 hrs
232	4.10.2	Assign RN Audit Coordinator and RHIT	MRM	8 hrs	Thu 6/30/05	Thu 6/30/05	231	2 hrs

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
233	4.10.3	Assemble applicable Medicaid policy, codes, etc.	IAC	1 day	Fri 7/1/05	Fri 7/1/05	232	8 hrs
234	4.10.4	Send case listings to providers	IAC	1 day	Tue 7/5/05	Tue 7/5/05	233	1 hr
235	4.10.5	Schedule appointment with provider to scan records	IAC	1 day	Fri 7/1/05	Fri 7/1/05	233SS	1 hr
236	4.10.6	Send confirmation letter regarding appointment	IAC	1 day	Tue 7/5/05	Tue 7/5/05	235	1 hr
237	4.10.7	Scan/copy records at provider location	IAC,RHIT,MRT	5 days	Wed 7/20/05	Tue 7/26/05	236FS+10 days	174 hrs
238	4.10.8	Request missing charts if applicable	IAC	1 day	Thu 7/28/05	Thu 7/28/05	237FS+1 day	2 hrs
239	4.10.9	Review records using audit criteria and document in workbook	RHIT,IAC	1 mon	Wed 7/27/05	Tue 8/23/05	237	268 hrs
240	4.10.10	Request any missing information if applicable	IAC,RHIT	15 days	Wed 8/3/05	Tue 8/23/05	239SS+5 days	16 hrs
241	4.10.11	Determine if case needs physician review	IAC,RHIT,PR	15 days	Fri 7/29/05	Thu 8/18/05	239SS+2 days	28 hrs
242	4.10.12	RN compiles all information and writes report	IAC	9 days	Fri 8/19/05	Wed 8/31/05	241	56 hrs
243	4.10.13	Report is reviewed by management	MRM	1 day	Thu 9/1/05	Thu 9/1/05	242	8 hrs
244	4.10.14	Submit workbook and report to MDCH	IAC	0 days	Thu 9/1/05	Thu 9/1/05	243	0 hrs
245	4.10.15	Respond to appeals	IAC	11 wks	Tue 7/5/05	Tue 9/20/05	233	24 hrs
246	**4.11**	**Perform 3 ER/Outpatient Audits per Quarter**		**56.25 days**	**Fri 10/1/04**	**Wed 12/22/04**		**1,110.85 hrs**
247	4.11.1	Receive ER/outpatient audit list from MDCH		0 days	Fri 10/1/04	Fri 10/1/04		0 hrs
248	4.11.2	Assign RN Audit Coordinator and RHIT	MRM	2 hrs	Fri 10/1/04	Fri 10/1/04	247	2 hrs
249	4.11.3	Assemble applicable Medicaid policy, codes, etc.	OEAC	3 days	Fri 10/1/04	Wed 10/6/04	248	24 hrs
250	4.11.4	Send case listings to providers	OEAC	1 day	Wed 10/6/04	Thu 10/7/04	249	3 hrs
251	4.11.5	Schedule appointment with provider to scan records	OEAC	1 day	Fri 10/1/04	Mon 10/4/04	249SS	3 hrs
252	4.11.6	Send confirmation letter regarding appointment	OEAC	1 day	Mon 10/4/04	Tue 10/5/04	251	3 hrs
253	**4.11.7**	**Scan/copy records at provider location**	**MRT,OEAC**	**14 days**	**Tue 10/19/04**	**Mon 11/8/04**	**252FS+10 days**	**543 hrs**
254	4.11.7.1	Scan at Provider 1 location	MRT,OEAC	5 days	Tue 10/19/04	Tue 10/26/04	252FS+10 days	90 hrs
255	4.11.7.2	Scan at Provider 2 location	MRT,OEAC	5 days	Tue 10/26/04	Tue 11/2/04	252FS+10 days,254	91 hrs
256	4.11.7.3	Scan at Provider 3 location	MRT,OEAC	4 days	Tue 11/2/04	Mon 11/8/04	252FS+10 days,255	90 hrs
257	4.11.8	Request missing charts if applicable	OEAC	10 days	Tue 10/26/04	Tue 11/9/04	256FF+1 day	2.85 hrs
258	**4.11.9**	**Review records using audit criteria and document in workbook**		**26 days**	**Mon 11/8/04**	**Thu 12/16/04**	**253**	**330 hrs**
259	4.11.9.1	Review Provider 1 records using audit criteria and document in workt	OEAC	7 days	Mon 11/8/04	Wed 11/17/04	253	110 hrs
260	4.11.9.2	Review Provider 2 records using audit criteria and document in workt	OEAC	7 days	Mon 11/22/04	Fri 12/3/04	263	110 hrs
261	4.11.9.3	Review Provider 3 records using audit criteria and document in workt	OEAC	6 days	Wed 12/8/04	Thu 12/16/04	264	110 hrs

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
262	**4.11.10**	**RN compiles all information and writes report**		**22 days**	**Wed 11/17/04**	**Tue 12/21/04**		**120 hrs**
263	4.11.10.1	RN compiles all Provider 1 information and writes report	OEAC	3 days	Wed 11/17/04	Mon 11/22/04	259	40 hrs
264	4.11.10.2	RN compiles all Provider 2 information and writes report	OEAC	3 days	Fri 12/3/04	Wed 12/8/04	260	40 hrs
265	4.11.10.3	RN compiles all Provider 3 information and writes report	OEAC	3 days	Thu 12/16/04	Tue 12/21/04	261	40 hrs
266	4.11.11	Report is reviewed by management	MRM	1 day	Tue 12/21/04	Wed 12/22/04	265	8 hrs
267	4.11.12	Submit workbook and report to MDCH	OEAC	0 days	Wed 12/22/04	Wed 12/22/04	266	0 hrs
268	4.11.13	Respond to appeals	OEAC	11 wks	Fri 10/1/04	Mon 12/20/04	247	72 hrs
269	**4.12**	**Perform 3 ER/Outpatient Audits per Quarter**		**60 days**	**Fri 12/31/04**	**Mon 3/28/05**		**838.85 hrs**
270	4.12.1	Receive ER/outpatient audit list from MDCH		0 days	Fri 12/31/04	Fri 12/31/04	246SS+64 days	0 hrs
271	4.12.2	Assign RN Audit Coordinator and RHIT	MRM	2 hrs	Mon 1/3/05	Mon 1/3/05	270	2 hrs
272	4.12.3	Assemble applicable Medicaid policy, codes, etc.	OEAC	3 days	Mon 1/3/05	Thu 1/6/05	271	24 hrs
273	4.12.4	Send case listings to providers	OEAC	1 day	Thu 1/6/05	Fri 1/7/05	272	3 hrs
274	4.12.5	Schedule appointment with provider to scan records	OEAC	1 day	Mon 1/3/05	Tue 1/4/05	272SS	3 hrs
275	4.12.6	Send confirmation letter regarding appointment	OEAC	1 day	Tue 1/4/05	Wed 1/5/05	274	3 hrs
276	**4.12.7**	**Scan/copy records at provider location**		**14 days**	**Wed 1/19/05**	**Tue 2/8/05**		**271 hrs**
277	4.12.7.1	Scan at Provider 4 location	MRT,OEAC	5 days	Wed 1/19/05	Wed 1/26/05	275FS+10 days	90 hrs
278	4.12.7.2	Scan at Provider 5 location	MRT,OEAC	5 days	Wed 1/26/05	Wed 2/2/05	277	91 hrs
279	4.12.7.3	Scan at Provider 6 location	MRT,OEAC	4 days	Wed 2/2/05	Tue 2/8/05	278	90 hrs
280	4.12.8	Request missing charts if applicable	OEAC	10 days	Wed 1/26/05	Wed 2/9/05	279FF+1 day	2.85 hrs
281	**4.12.9**	**Review records using audit criteria and document in workbook**		**26 days**	**Tue 2/8/05**	**Thu 3/17/05**		**330 hrs**
282	4.12.9.1	Review Provider 4 records using audit criteria and document in workbook	OEAC	7 days	Tue 2/8/05	Thu 2/17/05	276	110 hrs
283	4.12.9.2	Review Provider 5 records using audit criteria and document in workbook	OEAC	7 days	Wed 2/23/05	Fri 3/4/05	286	110 hrs
284	4.12.9.3	Review Provider 6 records using audit criteria and document in workbook	OEAC	6 days	Wed 3/9/05	Thu 3/17/05	287	110 hrs
285	**4.12.10**	**RN compiles all information and writes report**		**22 days**	**Thu 2/17/05**	**Tue 3/22/05**		**120 hrs**
286	4.12.10.1	RN compiles all Provider 4 information and writes report	OEAC	3 days	Thu 2/17/05	Wed 2/23/05	282	40 hrs
287	4.12.10.2	RN compiles all Provider 5 information and writes report	OEAC	3 days	Fri 3/4/05	Wed 3/9/05	283	40 hrs

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
288	4.12.10.3	RN compiles all Provider 6 information and writes report	OEAC	3 days	Thu 3/17/05	Tue 3/22/05	284	40 hrs
289	4.12.11	Report is reviewed by management	MRM	1 day	Tue 3/22/05	Wed 3/23/05	288	8 hrs
290	4.12.12	Submit workbook and report to MDCH	OEAC	0 days	Wed 3/23/05	Wed 3/23/05	289	0 hrs
291	4.12.13	Respond to appeals	OEAC	12 wks	Mon 1/3/05	Mon 3/28/05	270	72 hrs
292	**4.13**	**Perform 3 ER/Outpatient Audits per Quarter**		**60 days**	**Fri 4/1/05**	**Mon 6/27/05**		**936.63 hrs**
293	4.13.1	Receive ER/outpatient audit list from MDCH		0 days	Fri 4/1/05	Fri 4/1/05	269SS+64 days	0 hrs
294	4.13.2	Assign RN Audit Coordinator and RHIT	MRM	2 hrs	Mon 4/4/05	Mon 4/4/05	293	2 hrs
295	4.13.3	Assemble applicable Medicaid policy, codes, etc.	OEAC	3 days	Mon 4/4/05	Thu 4/7/05	294	24 hrs
296	4.13.4	Send case listings to providers	OEAC	1 day	Thu 4/7/05	Fri 4/8/05	295	3 hrs
297	4.13.5	Schedule appointment with provider to scan records	OEAC	1 day	Mon 4/4/05	Tue 4/5/05	295SS	3 hrs
298	4.13.6	Send confirmation letter regarding appointment	OEAC	1 day	Tue 4/5/05	Wed 4/6/05	297	3 hrs
299	**4.13.7**	**Scan/copy records at provider location**		**14 days**	**Wed 4/20/05**	**Tue 5/10/05**		**271 hrs**
300	4.13.7.1	Scan at Provider 7 location	MRT,OEAC	5 days	Wed 4/20/05	Wed 4/27/05	298FS+10 days	90 hrs
301	4.13.7.2	Scan at Provider 8 location	MRT,OEAC	5 days	Wed 4/27/05	Wed 5/4/05	300	91 hrs
302	4.13.7.3	Scan at Provider 9 location	MRT,OEAC	4 days	Wed 5/4/05	Tue 5/10/05	301	90 hrs
303	4.13.8	Request missing charts if applicable	OEAC	10 days	Wed 4/27/05	Wed 5/11/05	302FF+1 day	2.85 hrs
304	**4.13.9**	**Review records using audit criteria and document in workbook**		**26 days**	**Tue 5/10/05**	**Thu 6/16/05**		**330 hrs**
305	4.13.9.1	Review Provider 7 records using audit criteria and document in workbook	OEAC	7 days	Tue 5/10/05	Thu 5/19/05	299	110 hrs
306	4.13.9.2	Review Provider 8 records using audit criteria and document in workbook	OEAC	7 days	Tue 5/24/05	Fri 6/3/05	309	110 hrs
307	4.13.9.3	Review Provider 9 records using audit criteria and document in workbook	OEAC	6 days	Wed 6/8/05	Thu 6/16/05	310	110 hrs
308	**4.13.10**	**RN compiles all information and writes report**	**OEAC**	**22 days**	**Thu 5/19/05**	**Tue 6/21/05**		**217.78 hrs**
309	4.13.10.1	RN compiles all Provider 7 information and writes report	OEAC	3 days	Thu 5/19/05	Tue 5/24/05	305	40 hrs
310	4.13.10.2	RN compiles all Provider 8 information and writes report	OEAC	3 days	Fri 6/3/05	Wed 6/8/05	306	40 hrs
311	4.13.10.3	RN compiles all Provider 9 information and writes report	OEAC	3 days	Thu 6/16/05	Tue 6/21/05	307	40 hrs
312	4.13.11	Report is reviewed by management	MRM	1 day	Tue 6/21/05	Wed 6/22/05	311	8 hrs
313	4.13.12	Submit workbook and report to MDCH	OEAC	0 days	Wed 6/22/05	Wed 6/22/05	312	0 hrs

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Exhibit D

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
314	4.13.13	Respond to appeals	OEAC	12 wks	Mon 4/4/05	Mon 6/27/05	293	72 hrs
315	**4.14**	**Perform 1 ER/Outpatient Audit in Quarter**		**55 days**	**Fri 7/1/05**	**Tue 9/20/05**		**351 hrs**
316	4.14.1	Receive ER/outpatient audit list from MDCH		0 days	Fri 7/1/05	Fri 7/1/05	292SS+64 days	0 hrs
317	4.14.2	Assign RN Audit Coordinator and RHIT	MRM	2 hrs	Tue 7/5/05	Tue 7/5/05	316	2 hrs
318	4.14.3	Assemble applicable Medicaid policy, codes, etc.	OEAC	1 day	Tue 7/5/05	Wed 7/6/05	317	16 hrs
319	4.14.4	Send case listing to 10th provider	OEAC	1 day	Wed 7/6/05	Thu 7/7/05	318	1 hr
320	4.14.5	Schedule appointment with provider to scan records	OEAC	1 day	Tue 7/5/05	Wed 7/6/05	318SS	1 hr
321	4.14.6	Send confirmation letter regarding appointment	OEAC	1 day	Wed 7/6/05	Thu 7/7/05	320	1 hr
322	4.14.7	Scan/copy records at provider 10 location	MRT,OEAC	6 days	Thu 7/21/05	Fri 7/29/05	321FS+10 days	88 hrs
323	4.14.8	Request missing charts if applicable	OEAC	1 day	Mon 8/1/05	Tue 8/2/05	322FS+1 day	2 hrs
324	4.14.9	Review Provider 10 records using audit criteria and document in workbook	OEAC	2 wks	Fri 7/29/05	Fri 8/12/05	322	120 hrs
325	4.14.10	RN compiles all Provider 10 information and writes report	OEAC	4 days	Fri 8/12/05	Thu 8/18/05	324	40 hrs
326	4.14.11	Report is reviewed by management	MRM	1 day	Thu 8/18/05	Fri 8/19/05	325	8 hrs
327	4.14.12	Submit workbook and report to MDCH	OEAC	0 days	Fri 8/19/05	Fri 8/19/05	326	0 hrs
328	4.14.13	Respond to appeals	OEAC	11 wks	Tue 7/5/05	Tue 9/20/05	316	72 hrs
329	**5**	**Part II - LTC Retrospective Review**		**254 days**	**Mon 10/4/04**	**Fri 9/30/05**		**1,735 hrs**
330	**5.1**	**Receive electronic listing of 250 cases for review**		**191 days**	**Mon 10/4/04**	**Tue 7/5/05**		**0 hrs**
331	5.1.1	Receive electronic listing of 250 cases for review 1		0 days	Mon 10/4/04	Mon 10/4/04		0 hrs
332	5.1.2	Receive electronic listing of 250 cases for review 2		0 days	Tue 1/4/05	Tue 1/4/05		0 hrs
333	5.1.3	Receive electronic listing of 250 cases for review 3		0 days	Mon 4/4/05	Mon 4/4/05		0 hrs
334	5.1.4	Receive electronic listing of 250 cases for review 4		0 days	Tue 7/5/05	Tue 7/5/05		0 hrs
335	**5.2**	**Quarterly LTC retrospective Review**		**231 days**	**Mon 10/4/04**	**Mon 8/29/05**		**759 hrs**
336	**5.2.1**	**Quarterly LTC retrospective Review 1**		**42 days**	**Mon 10/4/04**	**Thu 12/2/04**	**331**	**185 hrs**
337	5.2.1.1	Prepare list and mail request to the appropriate provider(s)	MRT	1 day	Mon 10/4/04	Mon 10/4/04	331	8 hrs
338	5.2.1.2	Receive records from provider and identify missing records	MRT	1 day	Tue 10/19/04	Tue 10/19/04	337FS+10 days	8 hrs
339	5.2.1.3	Re-request any missing records	MRT	1 day	Wed 10/27/04	Wed 10/27/04	338FS+5 days	8 hrs
340	5.2.1.4	RN reviews case(s) and approves and records those meeting criteria	LTCRC	5 wks	Wed 10/20/04	Tue 11/23/04	338	90 hrs
341	5.2.1.5	RN submits non-approved for Physician Review	PRLTC	3 days	Wed 11/24/04	Tue 11/30/04	340	55 hrs
342	5.2.1.6	RN sends initial negative action letter on non-approved cases	LTCRC	2 days	Wed 12/1/04	Thu 12/2/04	341	16 hrs

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Gantt Chart with Expanded Fields

ID	WBS	Task Name	Resource Initials	Duration	Start	Finish	Predecessors	Work
343	**5.2.2**	**Quarterly LTC retrospective Review 2**		**40 days**	**Tue 1/4/05**	**Tue 3/1/05**	**332**	**191 hrs**
344	5.2.2.1	Prepare list and mail request to the appropriate provider(s)	MRT	1 day	Tue 1/4/05	Tue 1/4/05		8 hrs
345	5.2.2.2	Receive records from provider and identify missing records	MRT	1 day	Wed 1/19/05	Wed 1/19/05	344FS+10 days	8 hrs
346	5.2.2.3	Re-request any missing records	MRT	1 day	Thu 1/27/05	Thu 1/27/05	345FS+5 days	8 hrs
347	5.2.2.4	RN reviews case(s) and approves and records those meeting criteria	LTCRC	5 wks	Thu 1/20/05	Thu 2/24/05	345	86 hrs
348	5.2.2.5	RN submits non-approved for Physician Review	PRLTC	3 days	Fri 2/25/05	Tue 3/1/05	347	65 hrs
349	5.2.2.6	RN sends initial negative action letter on non-approved cases	LTCRC	2 days	Mon 2/28/05	Tue 3/1/05	348FF	16 hrs
350	**5.2.3**	**Quarterly LTC retrospective Review 3**		**40 days**	**Mon 4/4/05**	**Fri 5/27/05**	**333**	**191 hrs**
351	5.2.3.1	Prepare list and mail request to the appropriate provider(s)	MRT	1 day	Mon 4/4/05	Mon 4/4/05		8 hrs
352	5.2.3.2	Receive records from provider and identify missing records	MRT	1 day	Tue 4/19/05	Tue 4/19/05	351FS+10 days	8 hrs
353	5.2.3.3	Re-request any missing records	MRT	1 day	Wed 4/27/05	Wed 4/27/05	352FS+5 days	8 hrs
354	5.2.3.4	RN reviews case(s) and approves and records those meeting criteria	LTCRC	5 wks	Wed 4/20/05	Tue 5/24/05	352	86 hrs
355	5.2.3.5	RN submits non-approved for Physician Review	PRLTC	3 days	Wed 5/25/05	Fri 5/27/05	354	65 hrs
356	5.2.3.6	RN sends initial negative action letter on non-approved cases	LTCRC	2 days	Thu 5/26/05	Fri 5/27/05	355FF	16 hrs
357	**5.2.4**	**Quarterly LTC retrospective Review 4**		**40 days**	**Tue 7/5/05**	**Mon 8/29/05**	**334**	**192 hrs**
358	5.2.4.1	Prepare list and mail request to the appropriate provider(s)	MRT	1 day	Tue 7/5/05	Tue 7/5/05		8 hrs
359	5.2.4.2	Receive records from provider and identify missing records	MRT	1 day	Wed 7/20/05	Wed 7/20/05	358FS+10 days	8 hrs
360	5.2.4.3	Re-request any missing records	MRT	1 day	Thu 7/28/05	Thu 7/28/05	359FS+5 days	8 hrs
361	5.2.4.4	RN reviews case(s) and approves and records those meeting criteria	LTCRC	5 wks	Thu 7/21/05	Wed 8/24/05	359	86 hrs
362	5.2.4.5	RN submits non-approved for Physician Review	PRLTC	3 days	Thu 8/25/05	Mon 8/29/05	361	66 hrs
363	5.2.4.6	RN sends initial negative action letter on non-approved cases	LTCRC	2 days	Fri 8/26/05	Mon 8/29/05	362FF	16 hrs
364	**5.3**	**LTC Retrospective Review Appeals**		**234 days**	**Mon 11/1/04**	**Fri 9/30/05**		**976 hrs**
365	5.3.1	Respond to appeals as received using defined determination process	LTCRC,PRLTC	234 days	Mon 11/1/04	Fri 9/30/05		976 hrs

IV-D SECURITY

As a part of the pre-employment assessment efforts, our company verifies educational credentials, employment history and references. When MDCH background security checks are required, we will ensure that they are conducted on all staff that may need access to MDCH facilities. Star Systems Services, Inc., has been contracted to supply this service and all personnel who may attend meetings in Lansing have been checked. Star Systems Services is located at 37000 Grand River, Suite 390, Farmington Hills, Michigan. The background investigation consists of:

- County Criminal-Felony Including Related Misdemeanors (F&M);
- State Criminal (SC); and
- Federal Level SSN Trace (SSN).

Upon award of this contract, MPRO will provide to the State a letter certifying completion of the background checks and that the assigned staff members had "clean" backgrounds. We will also be prepared to provide individual results of background checks on request.

Our staff that access data at a customer's site are subject to corporate policies and procedures on data privacy, confidentiality and security. They are informed of and subject to the customer's policies and procedures to which we have agreed to be bound. This will include, as required, signing in as a visitor at any Michigan state facility and wearing their MPRO photo ID, and if requested by MDCH, wearing a state identification badge.

Currently, our employees have photo identification badges with their name and signature. These badges can serve as a proxy for a state-issued identification badge. MDCH will require that these badges be worn by all of our staff when attending meetings at a MDCH facility. For the convenience of the state, we can provide a list of individuals who will be attending each meeting to the MDCH Project Manager in advance of the scheduled meeting. This list also can be provided to State facility security personnel to verify with the MPRO issued badges. Our staff will comply with all security access requirements as set forth at individual State facilities.

We also maintain a detailed Data Privacy, Confidentiality and Security Policies and Procedures Manual, which is reviewed and updated periodically. More information on our data privacy and confidentiality policies is provided in Section IV-C Management Summary. All members of our Michigan contract support team are accountable for collecting, using, storing, disclosing and protecting data entrusted to us in accordance with these policies.

IV-E QUICK PAYMENT TERMS

We are interested in working with the State of Michigan to provide payment terms that reflects cost savings for the State based on an accelerated payment process.

Terms: net 30 upon receipt Discount: ½% net 15

IV-F BIDDER'S AUTHORIZED EXPEDITOR

The person authorized and designated by MPRO to expedite any proposed contract with the State is:

Debra L. Moss, MD, MBA
President and Chief Executive Officer
MPRO
22670 Haggerty Road, Suite 100
Farmington Hills, Michigan 48335-2611

Telephone: (248) 465-7400
Fax: (248) 465-7428
E-mail: dmoss@mpro.org

IV-G ADDITIONAL INFORMATION AND COMMENTS

SUBCONTRACTS WITH DISADVANTAGED BUSINESSES

We have served federal, state and private industry since 1984 and consistently strive to comply with all contract goals, whether for affirmative action or for small disadvantaged business utilization. While no specific goals are stated for this contract, we routinely seek to obtain services from small businesses, businesses owned and operated by women, minorities and persons with disabilities. We regularly file *Form 294 Subcontracting Report for Individual Contracts*, and *Form 295 Summary Subcontract Report* required by CMS. These filings document our use of small, women-owned, minority and small disadvantaged businesses.

DISCLOSURE OF LITIGATION

As referenced in Section 3.103 of Article 3 – Certifications and Representations, MPRO will notify the state if we, or any of our officers, directors, or key personnel under this contract, have ever been convicted of a felony, or any crime involving moral turpitude, including but not limited to fraud, misappropriation or deception. We will promptly notify the state of any criminal litigation, investigations or proceeding which may have arisen or may arise involving us or any of the foregoing entities' then current officers or directors during the term of this contract and three years thereafter.

Additionally, we will notify the State of any civil litigation, arbitration, proceeding or judgments that may have arisen against us during the five years preceding this bid proposal, or which may occur during the term of this contract or three years thereafter according to the specifications outlined in Section 3.103 of Article 3 – Certifications and Representations. All notices mentioned above will be provided in writing to the state within 15 business days after we learn about any such criminal or civil investigations and within 15 days after the commencement of any proceeding, litigation, or arbitration, as otherwise applicable.

IV-H PRICE PROPOSAL

INTRODUCTION

We are pleased to submit this price proposal to the Michigan Department of Community Health (MDCH) for the Medicaid Fee-For-Service Review contract. We have based our pricing model on the contract activities and projected volumes as described in the RFP. We have developed a specific cost model for each activity, in order to offer MDCH a pricing structure that is compliant with the payment terms outlined in both the RFP and the Bidder's Questions and Answers. The total contract price for the three-year term of the contract is $6,951,174.

We believe through staffing excellence, efficient and effective processes, and our long term relationship with the State of Michigan, we offer a reasonable and fair proposal price.

ISSUES AFFECTING PROPOSED RATES

There are several factors that impact our price determinations for each of the activities. These issues are briefly summarized below.

Increased Labor Costs

We have experienced increased labor costs as a result of the highly-competitive health care labor market, along with normal cost of living increases. This cost proposal reflects an increase to the labor rates for both the registered nurses and the coders. We believe that this rate increase will assist us in recruiting and retaining highly-qualified and experienced staff to perform the duties under this contract.

Changes to the FFS Review Program Structure

MDCH has established some new staffing requirements under this contract that limit our ability to cross-train and utilize review staff among multiple projects. First, there is a distinct separation between the PACER review staff and the audit staff. The registered nurses performing PACER authorizations are not able to participate in any of the PACER audit functions. Under our current contract with MDCH, we are able to use PACER review nurses to conduct audits during off-peak phone hours. The only restriction is that the nurses cannot audit cases in which they were involved in the initial determinations.

In addition, the audit model has changed significantly from the current inpatient retrospective review program. The focus on conducting provider-specific audits has necessitated the assignment of one review nurse to each provider for continuity and consistency. The prior model of random case selection allowed for multiple nurses to work on the inpatient retrospective reviews, depending upon volume and availability.

These changes impact the costs for the PACER Telephonic Reviews, as well as the Inpatient and Outpatient/ER Audits.

INCREASED STAFFING NEEDS FOR LONG TERM CARE REVIEW

Based upon the information in the RFP, we are anticipating that the long term care exception reviews and the long term care retrospective reviews will be a more labor-intensive effort than the current PACER reviews. This is primarily due to three factors:

- The anticipated high denial rate for these services;
- The volume of clinical information that is requested, especially for the long term care retrospective reviews; and
- The level of physician involvement in long term care exception process and the long term care retrospective reviews;

According to the RFP, we should expect 1,125 appeals for 2,000 long term care exception reviews. That implies a denial rate after reconsiderations of over 50%. The initial denial rate may even be higher since we anticipate some cases may be overturned upon reconsideration. It takes significantly more nurse and physician review time to deny a case than it does to approve a case. This will impact the cost per case for these services.

In addition, the RFP specifies a large volume of clinical information to be provided by the nursing facility to support the long term care retrospective review process, including PASARR evaluations, MDS data, nursing notes, care planning notes, skilled therapy notes and discharge plans. We anticipate that reviewing this information for the long term care retrospective reviews will take longer than completing an inpatient retrospective review.

Finally, due to the high denial rate, the long term care exception reviews and the long term care retrospective reviews involve a significant amount of physician reviewer time. The initial denial will require a physician review, as well as any reconsiderations. In addition, the 1,125 anticipated appeals also require a physician reviewer's participation.

The factors described above are the driving forces behind the significant cost differential between PACER reviews and long term care exception review program activities, including telephonic reviews, reconsiderations and appeals.

PRICING ASSUMPTIONS

We have made the following assumptions related to our pricing model. If MDCH provides information that is in conflict with any of these core assumptions, then we would be open to further discussions with MDCH regarding our pricing model.

1. With respect to the web-based tool for the long term care exception reviews, we have assumed that all of the development, implementation and ongoing maintenance of the web-based tool will be the responsibility of MDCH. We have not allocated any information technology development or support time related to this tool.

2. With respect to physician review time, we have assumed that all denials require the review of a physician. This means that for the long term care exception reviews, a physician will have to be involved in the initial denial and a second physician will be involved in the reconsideration. That physician will also participate in any appeals.

3. With respect to the labor for the appeals process, we are assuming that appeals hearings for the PACER reviews, long term care exception reviews and long term care retrospective reviews will take place via conference call and will not require a trip to Lansing for a face-to-face hearing.

4. With respect to the labor for the inpatient and outpatient/ER appeals, we are assuming that the bureau and administrative hearings will be held in Lansing and that our nurses and physicians will be required to drive to Lansing in order to participate.

5. With respect to pricing for the PACER appeals, we are assuming that MDCH would like us to propose a separate rate for each appeal case, as indicated on page 68 of the RFP. The payment schedule on page 32 of the RFP does not indicate that the PACER appeals are to be priced separately from the PACER reviews. If the payment for PACER appeals is to be included in the PACER telephonic review price, then we will need to adjust our rates accordingly.

6. With respect to the PACER authorization telephonic reviews, we are assuming that the contract does not include medical necessity reviews at the procedure level. We have priced the PACER authorizations to include medical necessity of the admission, but not the procedures. Under our current contract, we perform reviews at the procedure level for laminectomies, hysterectomies and spinal fusion. If MDCH desires for MPRO to continue with these three procedure-level reviews, the costs can be absorbed in our proposed rates. However, if procedure-level reviews are requested for additional procedures, then our proposed rates would have to be adjusted.

7. With respect to the PACER authorization process, our pricing model does not include the Adult Benefits Waiver (ABW) population.

PRICING ASSURANCES

We provide the following pricing assurances, as outlined in the RFP:

- All rates/prices quoted in this proposal are firm for the duration of the contract ending September 30, 2007, unless modified to the State's benefit by the mutual agreement of the parties to the contract.
- We acknowledge that MDCH or MPRO may propose price adjustments for any contract extension. These price adjustments must be submitted in writing to the State

Purchasing Director no later than 120 days prior to the proposed extension and must be no greater than the Detroit CPI. Any proposed changes are subject negotiation with MDCH and are subject to the approval of the State Purchasing Director before they become effective.

- We further acknowledge that if MPRO and the State cannot agree on pricing at least 30 days prior to the contract extension, then the contract will be cancelled.

INDEPENDENT PRICE DETERMINATION

We hereby attest that this cost and price analysis is submitted in full compliance with the provisions of the paragraph titled "Independent Price Determination" in Part III-H of the RFP to which this proposal is a response.

1. By submission of this proposal, MPRO certifies that:

   a. The prices in this proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition as to any matter relating to such prices with any other bidder or with any competitor; and

   b. Unless otherwise required by law, the prices which have been quoted in this proposal have not been knowingly disclosed by MPRO and will not knowingly be disclosed by MPRO prior to award directly or indirectly to any other bidder or to any competitor; and

   c. No attempt has been made or will be made by MPRO to induce any other person or firm to submit or not submit a proposal for the purpose of restricting competition.

2. Debra L. Moss, MD, MBA, President and Chief Executive Officer, certifies that she is the person at MPRO responsible for the decision as to the prices being offered in the proposal and has not participated (and will not participate) in any action contrary to Part IV-H, 1.a., b., and c. above.

3. MPRO understands that should we be awarded a contract resulting from this RFP, and be found to have failed to abide by the provisions set forth in this section, we will be in default of the contract. Consequences may include cancellation of the contract in accordance with Part I-U Cancellation.

PROJECT PRICING

We are providing the following pricing and rate information requested by MDCH related to each activity for the Michigan Fee-For-Service Review contract.

Table 31 - Part I – PACER/Long Term Care PACER Project Pricing

PACER	Program	Projected Volume/Month	Dollars/Review	Projected Annual Volume	Total Annual Per Program	Total Contract Per Program
	FFS	900/month	$ 55.25	10,800/year	$ 596,700	$1,790,100
	LTC Telephonic	167/month	65.00	2,000/year	130,000	390,000
	LTC NONC	68/month	123.50	816/year	100,776	302,328
	Subtotal				$ 827,476	$2,482,428
Appeals	FFS					
		RN	$ 26.40 per ½ hour	100/year	$ 3,960	$ 11,880
		MD	77.86 per ½ hour	100/year	11,679	35,037
	Subtotal				$ 15,639	$ 46,917
	LTC					
		RN	$ 26.40 per ½ hour	1,125/year	$ 44,550	$ 133,650
		MD	77.86 per ½ hour	120/year	14,015	42,045
	Subtotal				$58,565	$ 175,695
	Grand Total				$901,680	$ 2,705,040