MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Hospital 01-19
Medicaid Health Plans 01-17

Issued: October 15, 2001

Subject: Terms of Service and Payment Between Non-Contracting Hospitals and Medicaid Health Plans

Effective: December 1, 2001

Programs Affected: Medicaid

In its continuing efforts to assure all Medicaid beneficiaries have universal access to medically necessary covered hospital services, the Department of Community Health has been meeting with representatives from Hospitals and Medicaid Health Plans. As a result of these meetings, obligations for Hospitals, Health Plans, and the Department have been mutually identified and a process developed to assure these obligations are met.

The guiding principles in the identification of the obligations were:

1. The preferred relationship between Health Plans and Hospitals is a contract. A signed contract between a Health Plan and a Hospital supercedes the agreement described in this bulletin. It is essential to preserve the freedom to contract between Hospitals and Health Plans.

2. A Hospital will have the option to enter into the Agreement set forth in this bulletin, under which the Hospital agrees to provide services to Medicaid beneficiaries enrolled by Health Plans with which the Hospital does not have a contract.

3. Hospitals will be entitled to payment by Health Plans for all covered services provided in accordance with their obligations (see Attachment B).

4. The Department will enforce the Health Plans' guarantee of payment for covered hospital services provided in accordance with their obligations.

5. A rapid dispute resolution process will be available.

6. Where a Hospital does not have a contract with a Health Plan, the Hospital will be entitled to payment at Medicaid rates as reimbursement for services provided under the Agreement set forth in this bulletin. As set forth in this bulletin, the State will deduct from future health plan capitation and make payment to a Hospital if a Health Plan fails to make payment as required.

Principles 3 through 6 are only applicable to those hospitals that have signed a Hospital Access Agreement.

To acknowledge the responsibilities of health plans and hospitals in non-contracting circumstances, a Hospital Access Agreement (Attachment A) and Health Plan Obligations (Attachment B) have been developed. Each Hospital is encouraged to execute the Hospital Access Agreement. Although execution of this Agreement is voluntary on the part of each Hospital, the Department expects that substantially all Hospitals will sign and return the Agreement. (A copy of the Hospital Access Agreement is attached.) The Department requests that signed copies of the Hospital Access Agreement be submitted by Hospitals to the Department before November 1, 2001. The Hospital Access Agreement is not a contract with a health plan.

DISPUTE RESOLUTION

The Rapid Dispute Resolution Process was developed to provide a method for Hospitals and Health Plans to resolve disputed claims when the parties cannot reach an agreement. A copy of the Process is included in this document as Attachment C. The process will be included in both the Hospital Access Agreement and Health Plan contract with the State of Michigan.

DEFINITIONS

The definitions of terms used in this bulletin and attachments are included as the final attachment (Attachment D) to this bulletin.

MANUAL MAINTENANCE

Hospitals should retain this bulletin until its contents are incorporated into Chapter I of the Hospital Manual. Health Plans should retain this bulletin as an addendum to the Medicaid managed care contract until its contents are incorporated into the Medicaid Comprehensive Health Care Contract with the State of Michigan.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@state.mi.us. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVED

James K. Haveman, Jr.
Director

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Deputy Director for
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Hospital Access Agreement

This Agreement is made between the Michigan Department of Community Health ("Department"), and _____, a hospital licensed under the laws of the State of Michigan ("Hospital"). This Agreement shall apply where Hospital provides services to Medicaid beneficiaries who are enrolled in a Health Plan with which Hospital does not have a contract. Where Hospital and a Health Plan have a contract, the terms of that contract shall govern each relationship, and this Agreement shall not apply. When Hospital and a Health Plan have a limited services contract, the Agreement shall apply for all covered services outside the scope of the limited services contract. Since this is not a contract between hospitals and health plans, it is expected that health plans will continue to use network contracted providers where appropriate.

This Agreement is based on the following principles:

A. This Agreement is intended to provide access for all Covered Services that are available at Hospital for all Medicaid enrolled beneficiaries, and to provide for the payment and billing policies and procedures for those services, where Hospital and the Enrollee's Health Plan have not entered into a contract.

B. The parties believe that it is essential to encourage contracting as the preferred relationship between Health Plans and Hospitals, and to preserve the freedom of contract between Hospitals and Health Plans.

C. Hospital will be entitled to payment by a Health Plan for all Covered Services provided in accordance with this Agreement, at Medicaid Rates.

D. In the event a Health Plan does not make the payment to Hospital that is required under this Agreement, the Department will deduct the unpaid amount from future Health Plan capitation payments and shall make such payment to Hospital in accordance with this Agreement.

E. The Department shall cause the contracts between the State and each Health Plan to include a provision that each Health Plan will comply with the terms of this Agreement.

1.1 Provision of Covered Services. Hospital agrees to provide or arrange for Medically Necessary Covered Services to Medicaid beneficiaries who are enrolled in a Health Plan with which Hospital does not have a contract where:

i. Emergent services are required to be provided by the Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd ("EMTALA"); or

ii. Elective Admissions and Services (not required to be provided by EMTALA) have been arranged by a physician who has admitting privileges at Hospital, where beds, services and adequate resources are available, and Authorization for the Elective Admissions and Services have been obtained from the Health Plan.

In the case of Elective Admissions and Services, Health Plans will make efforts to utilize network contracted services where appropriate. It is the responsibility of the Health Plan to direct beneficiaries to network providers.

1.2 Health Plan Payment. Under this agreement Health Plans will pay Hospital at Medicaid Rates for all Covered Services provided by Hospital to Medicaid beneficiaries who are enrolled in Health Plans.

1.3 Department Payment. In the event that (i) a Health Plan does not pay to Hospital the full amount to which Hospital is entitled for services described in Section 1.1 above, and (ii) a final decision that Hospital is entitled to payment has been rendered through the Rapid Dispute Resolution Process, or through the OFIS appeal process, or through any other legal process, the Department will deduct the unpaid amount from future Health Plan capitation payments and pay it to Hospital. The Department will initiate the capitation deduction within 30 days after receipt of a final decision that payment was not made as required by this Agreement.

1.4 Authorization Requests—Post Stabilization. Hospital will make and document all post-stabilization authorization inquiries by telephone call to the Enrollee's Health Plan. The Health Plan will return all post-stabilization inquiries within one hour of receipt of the telephone call from Hospital and Hospital shall not be required to make more than one call provided that the "one phone call" included clinical information. **Authorization for admission and additional services shall be automatic should the Health Plan fail to respond within one hour.** Hospital agrees to provide the Health Plan with requested information obtained from a "medical screening examination," provided in accordance with EMTALA, in order to determine the emergent status for payment approval, prior to treatment and after stabilization. The Health Plan shall provide twenty-four (24) hour, seven (7) day a week availability for post-stabilization authorization requests.

1.5 Prior Authorization—Elective Admissions and Services. All Elective Admissions and Services must have Prior Authorization from the Health Plan. Prior Authorization by a Health Plan shall not prevent the Health Plan from a retrospective evaluation of medical services provided by Hospital. The granting of Prior Authorization for Covered Services by a Health Plan shall create a presumption that Medically Necessary services appropriate to the diagnosis presented at the time of Prior Authorization shall be paid pursuant to this Agreement. A Health Plan shall be required to support denial of payment for Prior Authorized services.

1.6 Data Coordination. Hospitals and Health Plans will share Enrollee information in order to support claims payment administration, to enable coordination of benefits, subrogation, verification of coverage, Prior Authorization and record keeping.

1.7 Quality, Utilization and Risk Management (Q/U/RM). Hospital and the Health Plan shall coordinate Q/U/RM services required in connection with patient care to the extent required by applicable state and federal law or accrediting entities. The Health Plan shall acknowledge that the information it receives as a result of participating in Q/U/RM activities with Hospital is and shall remain confidential as required by applicable law, and is furnished to the Health Plan solely to assist the Health Plan in conducting its own professional practice review. The Health Plan will reimburse Hospital for reasonable photocopy expenses incurred by Hospital in conducting the Q/U/RM review. The Health Plan may disclose confidential Q/U/RM information to third parties as necessary to (i) satisfy mandatory governmental or regulatory reporting requirements, (ii) for HEDIS reporting, (iii) for reporting required by applicable accrediting bodies.

1.8 Orderly Transfer. Hospital shall cooperate with the Health Plan in the orderly transfer of Enrollees being treated or evaluated to a contracted hospital provider, in the event that the Health Plan or physician elects to transfer the Enrollee to another hospital facility. In the event that services or care are required for any Enrollee while awaiting transfer, or within the context of

preparation for transfer, the Health Plan and Hospital agree to share such information as may be required. The Health Plan shall authorize payment for services, such as observation costs, in order to facilitate the orderly transfer and maintain the stability and health of the Enrollee. Transfers to other hospitals should occur within 24 hours of the request of the Health Plan to the extent practicable.

1.9 Claims.

1.9.1 Hospital shall provide claims in compliance with billing format UB-92 or other successor formats for Hospital services and billing format HCFA 1500 or other successor formats for professional services and as further outlined in Medicaid policies. Hospital will submit claims for Covered Services within 180 days from the date of service during the first year of this agreement and 120 days thereafter. The requirement shall not apply in the event of exceptions that extend the time period for the submission of claims. Exceptions granted by the Health Plans may be for changes in eligibility, coordination of benefits, other third party payer issues, internal Hospital risk management, or other valid reasons which may have delayed the submission of a claim. Under no circumstances will any claim be submitted later than 365 days from the date of service.

1.9.2 Hospital agrees to pursue other available resources, i.e., other insurance coverage, prior to submitting claims to a Health Plan. If Hospital has submitted a claim to another resource but has not received payment, and the billing deadline is near, Hospital agrees to contact the Health Plan to request a billing extension or to obtain approval from the Health Plan to submit a timely claim and a claim adjustment following adjudication by the other resource.

1.9.3 If Hospital is unable to comply with the billing time frame for another reason, e.g., an internal risk management issue, Hospital must contact the Health Plan to explain the circumstances and request a billing extension. Health Plan shall not unreasonably deny such an extension.

1.10 Disputed Claims.

1.10.1 Each Health Plan and Hospital that serves or has a contract to serve the same population of Medicaid beneficiaries will establish an Accounts Receivable Reconciliation Group (ARRG) comprised of persons empowered to make decisions regarding outstanding bills and payments. The ARRG shall reconcile accounts receivable of Hospital with accounts payable of the Health Plan. These groups will meet no less than every 90 days.

1.10.2 Claims in dispute by either Hospital or the Health Plan will be forwarded to the ARRG. The ARRG can table claims in question for no more than one 90-day period before either resolving the claim or referring it to the Rapid Dispute Resolution Process. If agreement cannot be reached on the payment after review by the ARRG, Hospital or the Health Plan may pursue dispute resolution pursuant to the Rapid Dispute Resolution Process. If either the Health Plan or Hospital pursues the Rapid Dispute Resolution Process, that determination is binding on the other party. The claims forwarded to the Rapid Dispute Resolution Process may either be a single claim or may be a group of similar claims. The determination of claim similarity will be made by the mediator during the Rapid Dispute Resolution Process.

1.10.3 Payment.

i. **Forty-Five Day Payment.** A Health Plan shall pay Hospital's Clean Claims within forty-five (45) days after receipt.

ii. **Thirty Day Denial / Additional Information Notice.** A Health Plan shall provide Hospital with a denial or written request for additional information within thirty days (30) after receipt of an inaccurate or insufficient claim. A Health Plan may either deny the claim or make payment in full to Hospital within thirty days (30) on a "corrected" claim**.**

iii. **Adjusted Payment.** A Health Plan may make an Adjusted Payment on a submitted claim within forty-five (45) days after receipt, where the totality of circumstances do not support the billing criteria for the level of service submitted on the claim, and may remit or recover such Adjusted Payment, providing a full and complete explanation and remittance advice. Where such Adjusted Payment is made, Hospital may dispute the adjustment, and pursue any and all remedies including the Rapid Dispute Resolution Process or OFIS appeal process, or other remedies of law**.**

1.11 Enrollee Hold Harmless. Hospital will not bill Medicaid beneficiaries enrolled in Health Plans for any Covered Services. Hospital shall look only to the Health Plan, other third party payers, and the Department to the extent provided under this Agreement, for compensation for Covered Services rendered to an Enrollee when the Health Plan covers such services, in accordance with Department policy and federal and state law.

1.12 Termination. Either party may cancel this Agreement without cause on 90 days' advance written notice.

1.13 Parties to This Agreement. The parties to this Agreement are Hospital and the Department. The Department agrees that it will enter into an agreement with each Health Plan and require the Health Plan to comply with the provisions of Attachment B of this bulletin. The Hospital Access Agreement is not a contract between a hospital and health plan.

1.14 Governing Law. This Agreement will be governed by the terms of Michigan Law.

1.15 Notice of Change. The Department shall provide advance notice to each Hospital that has signed the Hospital Access Agreement of any change to defined terms included as Attachment D to this bulletin. The advanced notice shall be consistent with the process and timeframe used for Medicaid policy promulgation, as outlined in MCL 400.111a and which is not otherwise prohibited under federal and state law.

This Agreement shall become effective on the signature of both parties to this Agreement or a facsimile copy of this Agreement.

For Hospital:

Hospital Name

Signature **Title**

Printed Name **Date**

For Department of Community Health:

Signature **Title**

Printed Name **Date**

HEALTH PLAN OBLIGATION

(To be included as an Amendment to the State's Medicaid Contract with Health Plans)

This obligation shall apply where a Health Plan does not have a contract with a Hospital to provide services to the Health Plan's Medicaid beneficiaries and where Hospital has signed a Hospital Access Agreement with the Michigan Department of Community Health ("Department").

The Health Plan will make efforts to utilize network-contracted services where appropriate.

The Health Plan may deny any claims submitted later than 180 days from the date of service for the first year of this agreement and 120 days the second year and thereafter. The submission requirement shall not apply in the event of exceptions that extend the time period. Exceptions granted by the Health Plan may be for changes in eligibility, coordination of benefits, other third party payer issues, internal Hospital risk management, or other valid reasons which may have delayed the submission of a claim.

When the Hospital requests a billing extension, the Health Plan agrees to evaluate the information supplied and provide the Hospital with an extension when appropriate based on exceptions noted above. Under no circumstances will the Health Plan accept any claim that is submitted more than 365 days from the date of service.

Authorization Requests—Post Stabilization

The Hospital will make and document all post-stabilization authorization inquiries by telephone call to the Enrollee's Health Plan. The Health Plan will return all post-stabilization inquiries within one hour of receipt of the telephone call from the Hospital and the Hospital shall not be required to make more than one call provided that the "one phone call" included clinical information. **Authorization for admission and additional services shall be automatic should the Health Plan fail to respond within one hour.** The Hospital agrees to provide the Health Plan with requested information obtained from a "medical screening examination," provided in accordance with EMTALA, in order to determine the emergent status for payment approval, prior to treatment and after stabilization. The Health Plan shall provide twenty-four (24) hour, seven (7) day a week availability for post-stabilization authorization requests.

Disputed Claims

Each Health Plan and Hospital that serves or has a contract to serve the same population of Medicaid beneficiaries will establish an Accounts Receivable Reconciliation Group (ARRG) comprised of persons empowered to make decisions regarding outstanding bills and payments. The ARRG shall reconcile accounts receivable of the Hospital with accounts payable of the Health Plan. These groups will minimally meet no less than every 90 days.

Claims in dispute by either the Hospital or the Health Plan will be forwarded to the Accounts Receivable Reconciliation Group. The group can table claims in question for one 90-day period before either resolving the claim or referring it to the Rapid Dispute Resolution Process. If agreement cannot be reached on the payment after review by the ARRG, the Hospital or Health Plan may pursue dispute resolution as set forth in the Rapid Dispute Resolution Process. If either the Hospital or Health Plan pursues Rapid Dispute Resolution Process, that determination is then binding on the other party. The claims forwarded to the Rapid Dispute Resolution Process may either be a single claim or may be a

group of similar claims. The determination of claim similarity will be made by the mediator during the Rapid Dispute Resolution Process.

Payment

- Forty-five Day Payment. The Health Plan shall pay Hospital's Clean Claims within forty-five (45) days after receipt.

- Thirty-Day Denial/Additional Information Notice. The Health Plan shall provide the Hospital with a denial or written request for additional information within thirty (30) days after receipt of an inaccurate or insufficient claim. The Health Plan may either deny the claim or make payment in full to the Hospital within thirty (30) days on a "corrected" claim.

- Adjusted Payment. The Health Plan may make an Adjusted Payment on a submitted claim within forty-five (45) days after receipt, where the totality of circumstances do not support the billing criteria for the level of service submitted on the claim, and may remit or recover such Adjusted Payment, providing a full and complete explanation and remittance advice. Where such Adjusted Payment is made, the Hospital may dispute the adjustment, and pursue any and all remedies, including the Rapid Dispute Resolution Process or OFIS appeal process, or other remedies of law.

- Payment and Remedies. Payment for services by a Health Plan shall be made as set forth in this document, and any disputed claim aged over 90 days shall give rise to the right of the Hospital to pursue the Rapid Dispute Resolution Process, OFIS appeal process, or other legal process. Any award rendered pursuant to the Rapid Dispute Resolution Process, OFIS appeal process, or other legal process shall be made by the Health Plan within 30 days after its receipt of a final decision, or withheld by the Department from the Health Plan's capitation and paid to the Hospital within 30 days after the Department's receipt of a final decision.

- Rates. The Health Plan shall pay the Hospital according to Medicaid Rates.

- Post Payment Review. The Health Plan may implement a post-payment claim review process in accordance with Department policies.

Department Payment

The Department will deduct from future capitations and make payment to the Hospital for provision of Covered Services under the following conditions:

- The Health Plan does not pay the Hospital the amount to which the Hospital is entitled for services described in "Provision of Covered Services" (Section 1.1 of Hospital Access Agreement, Attachment A) at the time such payment is required to be paid; and
- The disputed claim has been reviewed by the Accounts Receivable Reconciliation Group, (ARRG) described above, and the Hospital has either, (i) forwarded the disputed claim to the Rapid Dispute Resolution Process (Attachment C) mediator, (ii) initiated an OFIS appeal process, or (iii) initiated another applicable legal process; and
- A final decision that the Hospital is entitled to payment has been rendered through either the Rapid Dispute Resolution Process, the OFIS appeal process, or other applicable legal process; and

- The Health Plan does not pay the disputed claim within 30 days of its receipt of the final decision.

Data Coordination

The Health Plan and the Hospital will share enrollee information in order to support claims payment administration, to enable coordination of benefits, subrogation, verification of coverage, prior authorization and record keeping.

Quality, Utilization and Risk Management (Q/U/RM)

The Health Plan and Hospital shall coordinate Q/U/RM services required in connection with patient care to the extent required by applicable state and federal law or accrediting entities. The Health Plan shall acknowledge that the information it receives as a result of participating in Q/U/RM activities with the Hospital is, and shall remain, confidential as required by applicable law, and is furnished to the Health Plan solely to assist the Health Plan in conducting its own professional practice review. The Health Plan will reimburse the Hospital for reasonable photocopy expenses incurred by the Hospital in conducting the Q/U/RM review. The Health Plan may disclose confidential Q/U/RM information to third parties as necessary to (i) satisfy mandatory governmental or regulatory reporting requirements, (ii) for HEDIS reporting, (iii) for reporting required by applicable accrediting bodies.

Orderly Transfer

The Health Plan shall cooperate with the Hospital in the orderly transfer of Enrollees being treated or evaluated to a contracted Hospital provider, in the event that the Plan or physician elects to transfer the Enrollee to another Hospital facility. In the event that services or care are required for any Enrollee while awaiting transfer, or within the context of preparation for the transfer, the Health Plan and the Hospital agree to share such information as may be required. The Health Plan shall authorize payment for services, such as observation costs, in order to facilitate the orderly transfer and maintain the stability and health of the Enrollee. To the extent practicable, transfers to other hospitals should occur within 24 hours of the request of the Health Plan to the extent practicable.

RAPID DISPUTE RESOLUTION PROCESS

1. Hospitals and Health Plans agree to exhaust their efforts to achieve reconciliation solutions for outstanding accounts via internal means on a regular ongoing basis, including the use of an Accounts Receivable Reconciliation Group (ARRG), before pursuing the Rapid Dispute Resolution Process (RDRP).

2. Where a disputed claim, or group of similar claims, remains, either the Hospital or the Health Plan may submit a request to the Department for RDRP. Upon receipt of a request by either the Hospital or the Health Plan, the Department will advise the other party that the disputed claim or group of similar claims will be resolved in this manner.

3. The Department will contact a mediator, selecting one at random from the list of available mediators that it has prepared, within fifteen (15) calendar days of election/agreement by both parties to proceed. The mediator will schedule the mediation session within fifteen (15) calendar days of contact by the Department. The mediator will issue his/her decision within fifteen (15) calendar days of the mediation session. The mediators will be disinterested parties without conflict of interest with either the Health Plan or the Hospital.

4. Hospitals and Health Plans agree that, should a Hospital or a Health Plan elect this process, the outcome, including any monetary award, will be binding. Both parties agree to assume the burden of cost for presentation of their positions before the mediator. The cost of the mediator will be borne proportionally.

5. If the Hospital's position is granted, the Health Plan agrees to make payment for the disputed claim(s) within thirty (30) days. If the Health Plan fails to make payment within the required timeframe, the Department will enforce the decision through a withhold of the disputed amount from the Health Plan's capitation payment and direct payment to the Hospital.

6. If the Health Plan's position is granted and results in the Hospital obligated to reimburse the Health Plan, the Hospital agrees to make payment within thirty (30) days. If the Hospital fails to make payment within the required timeframe, the Department will enforce the decision through an adjustment of future Hospital payments and direct the disputed amount to the Health Plan.

DEFINITIONS

Authorization or Prior Authorization. Documented approval by a Health Plan for the medical services rendered to an Enrollee by a Hospital, based on clinical information provided to Health Plan and Pursuant to the Terms set forth in this bulletin.

Beneficiary. An individual who has been determined eligible for Medicaid.

Certificate of Coverage means the written document approved by OFIS, which explains the scope of benefits, limitations of coverage and exclusions governing the Enrollee's health care benefit coverage pursuant to the Health Plan's Medicaid Contract with the State of Michigan.

Clean Claims. Clean Claims as defined in *PA 187 OF 2000,* being MCL 400.111i and OFIS bulletin 2000/09.

Covered Services. All required services for Medicaid Enrollees as defined by a) Section 400.105 of the Michigan Compiled Laws, b) Title XIX of the federal Social Security Act, 42 USC 1395 et. seq.; c) MDCH Program Manuals and Bulletins; d) the Contract between Health Plans and the Michigan Department of Management and Budget for services rendered to Enrollees, and e) the Certificate of Coverage.

Department or MDCH means the Michigan Department of Community Health.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

EMTALA. The Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, that requires a Hospital to perform a medical screening examination of any individual presenting in its emergency department to determine if an emergency medical condition exists and to stabilize the individual's medical condition.

Enrollee. A Medicaid-eligible beneficiary who is enrolled in a Health Plan and who is either eligible at the time of service or determined retroactively eligible.

Health Plan means a Medicaid managed care plan that provides medical assistance through the delivery of Covered Services to Beneficiaries and that holds a Comprehensive Health Care Program Medicaid Contract with the State of Michigan.

Hospital means the licensed entity that executed the Hospital Access Agreement included in this bulletin and which has the inpatient capacity that is necessary to provide covered services.

Medically Necessary or Medical Necessity. Medical or surgical treatment that an Enrollee requires, as determined by a physician, in accordance with: 1) accepted medical and surgical standards; 2) professional and technical standards; and 3) applicable federal and state laws, rules and regulations, and the Department promulgated Medicaid policies.

Medicaid Rates. The entire amount payable by the Department to Hospitals for Covered Medical Services provided to Medicaid beneficiaries who are not enrolled in Health Plans. It includes, without limitation, Diagnosis Related Group (DRG) payments, Per Diem payments for exempt units, outpatient fee screen payments and applicable pass-through payments. Any other available resources, such as Medicare or other insurances, reduce the amount payable.

Non-Covered Service. A medical or health care service that is 1) not covered by the Medicaid program, 2) not medically necessary; 3) not described in a Health Plan's Certificate of Coverage, 4) provided before or after a beneficiary is an Enrollee in a Health Plan, or 5) non-emergency services for which the Hospital did not secure prior authorization.

OFIS means the Office of Financial and Insurance Services (OFIS) in the Michigan Department of Consumer and Industry Services.

Rapid Dispute Resolution Process. The process implemented by the Department to administer and resolve claim disputes according to the terms set forth in Attachment C of this bulletin.