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Provider Questions about HAP?
Special Features

Prior Authorization Requirement for Anesthesia Services for Outpatient Gastrointestinal Endoscopic Procedures - Delayed until 2017

In November 2015, HAP communicated our intent to implement a policy on monitored anesthesia care for elective endoscopy that was scheduled to be effective February 1, 2016 - and was subsequently postponed to April 1, 2016.

We have listened to feedback from anesthesiologists, gastroenterologists and other stakeholders and will postpone implementation until March 1, 2017. Thoughtful stakeholders will agree that the status quo is unsustainable: many patients who require endoscopy do not require monitored anesthesia care.

According to the “Guidelines for the Use of Deep Sedation and Anesthesia for GI Endoscopy,” Gastrointestinal Endoscopy, Volume 56, No. 5, 2002, p. 616:

"The routine assistance of an anesthesiologist for average risk patients undergoing standard upper and lower endoscopic procedures is not warranted and is cost prohibitive."

HAP’s policy is consistent with the joint guideline on the use of sedation for endoscopic procedures from the American College of Gastroenterology, the American Society of Gastrointestinal Endoscopy and the American Gastroenterological Society.

HAP recognizes that there is work to be done to achieve improved adherence to these specialty guidelines for some providers – others are already there. HAP will regularly monitor and report the rate of anesthesia consultation for elective scheduled uncomplicated endoscopies. HAP’s high volume providers with a rate lower than 50 percent for the use of monitored anesthesia with elective, uncomplicated endoscopies will be exempt from HAP’s prior authorization process for monitored anesthesia care when HAP’s policy goes into effect March 1, 2017.

Some providers have already completed the work required to adhere to evidence-based guidelines on monitored anesthesia care for routine endoscopies. We are confident that other providers will work to improve adherence to these guidelines if they have a desire to be exempt from HAP’s prior authorization process for monitored anesthesia care for routine endoscopies that goes into effect March 1, 2017.

Many parts of the country ranging from Minnesota to Alabama are ahead of Southeast Michigan in performance on specialty guidelines in this area. We hope that you will join the growing list of providers nationwide who are working to curb unsustainable practices and have already implemented policies related to monitored anesthesia care.

We listened to providers and postponed our planned prior authorization process in good faith. We urge providers who have not already addressed barriers to improved adherence with specialty guidelines to do so expeditiously.
Aloxi – Prior Authorization Required

Effective June 1, 2016, HAP will require prior authorization for Aloxi® (palonosetron); J2469 Injection, Palonosetron HCL, 25 mcg. Failure to obtain prior authorization may result in claims denial. To find complete coverage criteria online, log in at hap.org, select Benefit Administration Manual and search for Aloxi.

Newly established criteria for Aloxi® accounts for emetogenic potential of neoplastic agents and use of other intravenously administered 5-HT3 receptor antagonists, such as ondansetron and granisetron. Requests for administration of Aloxi will be approved for patients who are receiving highly emetogenic chemotherapy according to NCCN classification of risk and for whom ondansetron or granisetron therapy has failed.

Obtaining prior authorization
To request prior authorization for Aloxi, you can use our online prior authorization application, CareAffiliate. Simply follow these steps:
- Log in at hap.org
- Select Authorizations
- In the Request Type field, select the magnifying glass and in the Request Type Description field enter Drug-Aloxi®, then choose Office Administered or Infusion Center, depending on place of infusion

Contact Information
For questions regarding this policy, contact HAP’s Pharmacy Care Management at (313) 664-8940. For help with prior authorization requests, contact Provider Services at (866) 766-4708.

We appreciate your commitment to patient safety and quality of care.

Changes In Your Office/Facility?

Make sure that members have access to up-to-date information in our online provider directories. Please notify HAP immediately if you have any changes in your practice or facility. You can submit changes as follows:

<table>
<thead>
<tr>
<th>To Change or Update</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider name</td>
<td><a href="mailto:credentialing@hap.org">credentialing@hap.org</a></td>
</tr>
<tr>
<td>• Address</td>
<td></td>
</tr>
<tr>
<td>• Phone number and fax number</td>
<td></td>
</tr>
<tr>
<td>• Email address</td>
<td></td>
</tr>
<tr>
<td>• Practitioner area of practice and specialty changes</td>
<td></td>
</tr>
<tr>
<td>• Practitioner leave of absence updates</td>
<td></td>
</tr>
<tr>
<td>• NPI changes</td>
<td></td>
</tr>
<tr>
<td>• Changes to “accepting new patients” status</td>
<td></td>
</tr>
<tr>
<td>• Removal of a provider from the HAP provider directory</td>
<td></td>
</tr>
</tbody>
</table>

If you have changes in your W-9 name, W-9 billing address or Tax ID Number, you can
- Email: IS_BCT_vendor@hap.org
- Fax: (248) 443-7761
**Verify Member Eligibility – Change**

It is essential that you verify member eligibility. According to your HAP contract, you must verify the eligibility of your HAP patients at each visit before you deliver services. If you fail to obtain verification we may deny claims payment. You cannot balance-bill the member.

It’s also important to always make a copy of the front and back of the patient’s ID card. The back contains important contact and claims submission information.

Effective April 1, there will only be two options for verifying a member’s eligibility. Both options are available 24 hours a day, 365 days a year. There is no limit on the number of members you can verify.

To verify members, either:
- Call the Provider Automated Service line at (800) 801-1766
- Use the online application at hap.org
  - After you log in, select Member Eligibility
  - You can search for up to 10 members at a time
  - If you can’t find the member using his or her ID number, try searching by last name using the magnifying glass icon

**Important**

- If you are unable to retrieve the required benefit information and/ or have a discrepancy with the information provided, please send an email to: **PI_benefitdiscrepancy@hap.org** (available April 1, 2016)
- Allow up to 24 hours (one business day) for a response
- **Note:** If the patient is in the office, please mark your email “URGENT”
BRCA Testing Reminder

Effective February 1, 2016, Joint Venture Hospital Laboratories (JVHL) began coordinating BRCA testing for HAP HMO members (excluding members assigned to Genesys, Henry Ford Medical Group and U of M). MLabs™ Michigan Medical Genetics Laboratories (MMGL), part of the University of Michigan Health System and a JVHL partner, will perform testing. MMGL offers a full complement of BRCA procedures including the following test options:

<table>
<thead>
<tr>
<th>Test</th>
<th>Order Code</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRCA1 Gene Sequencing</td>
<td>BRCA1</td>
<td>81214</td>
</tr>
<tr>
<td>BRCA2 Gene Sequencing</td>
<td>BRCA2</td>
<td>81216</td>
</tr>
<tr>
<td>BRCA1 Deletion/Duplication Analysis</td>
<td>BRC1D</td>
<td>81213</td>
</tr>
<tr>
<td>BRCA2 Deletion/Duplication Analysis</td>
<td>BRC2D</td>
<td>81213</td>
</tr>
<tr>
<td>BRCA1 &amp; BRCA2 Gene Sequencing (Tier 1</td>
<td>BRC1</td>
<td>81211</td>
</tr>
<tr>
<td>BRCA1 &amp; BRCA2 Deletion/Duplication Analysis (Tier 2)</td>
<td>BRC2</td>
<td>81213</td>
</tr>
<tr>
<td>BRCA1 Targeted Sequencing, Familial</td>
<td>BR1F</td>
<td>81215</td>
</tr>
<tr>
<td>BRCA2 Targeted Sequencing, Familial</td>
<td>BR2F</td>
<td>81217</td>
</tr>
<tr>
<td>BRCA Ashkenazi Jewish Founder Mutations</td>
<td>BRAJ</td>
<td>81212</td>
</tr>
<tr>
<td>BRCP Panel (includes Tier 1 &amp; Tier 2)</td>
<td>BRCP1</td>
<td>81162</td>
</tr>
</tbody>
</table>

To better understand the scope of BRCA analysis provided by MMGL, the following information is included with this update.

- **Frequently Asked Questions**
- **Test description and collection guidelines**
- Specimen collection and handling guidelines are also available at [www.mlabs.umich.edu](http://www.mlabs.umich.edu)
- **Instructions for specimen transport**
  - [http://mlabs.umich.edu/customer-service/submit-specimens/](http://mlabs.umich.edu/customer-service/submit-specimens/)
- **Cover page for specimen transport**
- **Test requisition form**
  - [http://mlabs.umich.edu/customer-service/formsreqssupplies/test-requisitions/](http://mlabs.umich.edu/customer-service/formsreqssupplies/test-requisitions/)
- **Informed consent form**
  - [http://mlabs.umich.edu/files/pdfs/PCI-MMGL_InformedConsent.pdf](http://mlabs.umich.edu/files/pdfs/PCI-MMGL_InformedConsent.pdf)

If you have any questions regarding this information or to request collection kits, please call the MLabs Client Services Center at (800) 862-7284. Technical questions will be directed to Marwan Tayeh, Ph.D., FACMG, and Director of the Molecular Genetics Laboratory.

**Prior Authorization**

BRCA testing must be authorized for your HAP HMO patients prior to testing. Please submit authorization requests via CareAffiliate as outlined below.

- Log in at [hap.org](http://hap.org); select *Authorizations*
- Select the *Request Type* BRCA1/BRCA2
- Complete the information as prompted for patient demographics, HAP coverage information, family and clinical history

JVHL will process the BRCA requests and notify your office of the outcome decision.

If you have any questions or need assistance, please feel free to contact the JVHL Business Services team at (800) 445-4979.
Physical Exams

HAP members can have a physical once per calendar year with no out-of-pocket costs. This means that a member could potentially have a physical exam on December 31 and have another one on January 1 and both would be covered.

A member could have additional physical exams in a year but would incur out-of-pocket costs.

Covered Medicare Preventive Exams

HAP covers the Medicare preventive exams identified in the table below when billed with the appropriate code.

<table>
<thead>
<tr>
<th>Covered Exam</th>
<th>Appropriate Code to Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Preventive Physical Examination (IPPE)</strong></td>
<td>G0402</td>
</tr>
<tr>
<td>Also known as the “Welcome to Medicare” visit for new Medicare beneficiaries who are within the first 12 months of their Medicare Part B coverage. This is a one-time benefit.</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Wellness Visit</strong></td>
<td>G0438</td>
</tr>
<tr>
<td>With a personalized prevention plan of service (PPS), initial visit</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Wellness Visit</strong></td>
<td>G0439</td>
</tr>
<tr>
<td>With a personalized prevention plan of service (PPS), subsequent visit</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Routine examinations (CPT codes 99391-99397) are not covered or reimbursed by Medicare or HAP.

For more information about Medicare Preventive Services, visit [www.cms.gov](http://www.cms.gov).

Benefit Administration Manual Updates

The table below outlines the upcoming changes to HAP’s Benefit Administration Manual, effective April 1, 2016. To view the full policy, log in at [hap.org](http://hap.org) and select *Benefit Administration Manual*.

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Summary of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway clearance devices in the ambulatory setting</td>
<td>Policy revised based on Cigna review by clarifying title, description, codes, coverage criteria and exclusion language. Provides coverage for all product lines.</td>
</tr>
<tr>
<td>Deep brain, motor cortex and responsive cortical stimulation</td>
<td>Policy revised based on Cigna review by clarifying description, codes, coverage criteria and exclusion language. Provides coverage for all product lines.</td>
</tr>
</tbody>
</table>
Inpatient Hospital Readmissions-Reminder

HAP is committed to ensuring the best quality of care for its members when hospitalization is required.

Effective for dates of service January 1, 2016 forward, requests for hospital admissions for HAP members that were discharged within two (2) calendar days of a hospital admission will be reviewed by HAP. If it is determined that the member requires a new inpatient admission due to errors in care during their first hospital stay, the new request for admission will be denied. This means that the two hospital stays will be considered as one and only one payment will be made. This does not apply to requests for observation services.

Decisions can be appealed by following our Provider Appeals policy.

Future updates will be communicated through the provider monthly update and in the Provider Newsroom when you log in at hap.org.

Informed Patients can be Healthy Patients

How much time do you spend helping patients understand their treatment, coverage and costs? Now imagine being able to use that time on patient care instead.

Introducing HAP’s Health Care Cost Estimator

In early 2016, your patients will have access to our online Health Care Cost Estimator – a new transparency tool designed to help patients find:

- The average cost of treatment in their area—from diagnosis to final follow-up
- Out-of-pocket costs, based on their benefits
- Cost breakdown by treatment timeframe

Patients can also print out a treatment estimate and timeframe to discuss with you at an appointment. This allows you and your staff to work with empowered patients who can actively participate in their health care treatment plans.

Knowing what to expect before a treatment means no billing surprises or uncertainty about treatment coverage and costs. Encourage your patients to log in at hap.org and use HAP’s Health Care Cost Estimator. It will help you lower your administrative costs and free up more time to focus on patient care.

Watch for updates on HAP’s Health Care Cost Estimator in future monthly updates and in the Provider Newsroom when you log in at hap.org.
HAP Health Engagement

HAP’s Health Engagement Program rewards members for making healthy choices by saving them on their out-of-pocket costs. There are two separate programs under Health Engagement:

- **Aspire**: participation-based and rewards employees who make attempts to improve their health
- **Achieve**: outcomes-based and rewards employees who achieve specific health goals

Members in either option must see a HAP-affiliated primary care physician or approved specialist (Cardiologist, Endocrinologist, OB/GYN, Geriatric Specialist only) to complete and submit their Member Qualification Form (MQF) that attests to their healthy lifestyle or efforts to achieve this status.

Health Engagement Reminders

- We cannot fail participants for not meeting a wellness target identified on their MQF. For example:
  - If a member’s blood pressure was above the lifestyle target and they are taking medicine to help control it, they should receive points.
- We must offer reasonable alternatives to participants if they are unable to meet a wellness target identified on their MQF which includes:
  - Allowing the participants to work with their physicians to develop their own alternatives
  - Contacting HAP’s Customer Service to discuss all programs that are available
- There are no time restrictions for completing the treatment plan

Member Qualification Form (MQF)

- Information about reasonable alternatives is on the form
- Instructions for completing the form are on the back
- Online form submissions will receive $30 reimbursement
- Faxes are still acceptable but will not receive reimbursement
- Use code 99080 when billing

Need Help?

**For assistance in entering the MQF**

- Contact HAP’s Internet Application Team: (313) 664-8173
  Monday – Friday; 8:30 a.m. to 5:00 p.m.

**For MQF updates and corrections or general, non-technical questions**

- Email: hapmqf@hap.org (please do **not** put PHI in the subject line)
Billing & Claims

National Drug Code Billing Requirement for Outpatient Drugs—Reminder

Effective for claims with dates of service November 1, 2015 forward, all outpatient drug related HCPCS codes and CPT codes (revenue codes excluded) must be billed with the following:

- National Drug Code (NDC) qualifier
- NDC code
- Unit of measure
- Quantity

This information is required for:

- Medicare crossover claims
- CMS-1500 and UB-04 claim forms
- Electronic Data Interface (EDI) transactions
- Test strips (A4253, A4772 and A9275)

This applies to all HAP products. Any claim without a valid NDC code will be rejected. For a complete listing of affected codes, please see the Services that Require Prior Authorization List or the DME Services that Require Authorization List under Procedure Reference Lists when you log in at hap.org. NDC will be indicated in the Key column if it is required.

Format

NDCs must contain a valid 11-digit number in a 5-4-2 format. The first five digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The other digits, which are assigned by the manufacturer of the drug, identify the specific product and package size. Some packages will display fewer than 11 digits, but leading zeroes can be assumed and need to be used when billing.

Submitting the NDC

<table>
<thead>
<tr>
<th>Electronic claims</th>
<th>Follow the 5010 837 X12 standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-1500 claim form</td>
<td>In box 24A-24G – in the shaded portion</td>
</tr>
<tr>
<td></td>
<td>- Enter the NDC qualifier of N4</td>
</tr>
<tr>
<td></td>
<td>- Followed by the NDC number (see format above)</td>
</tr>
<tr>
<td></td>
<td>- Enter one space for separation</td>
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<tr>
<td></td>
<td>- Enter appropriate unit of measure (F2, GR, ML or UN)</td>
</tr>
<tr>
<td></td>
<td>- Enter the quantity</td>
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</table>

<table>
<thead>
<tr>
<th>24. A. DATES OF SERVICE</th>
<th>24. B. PLACE OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 01 13 01 11 J0744</td>
<td>1 17.94 6 N NH 12345678901</td>
</tr>
<tr>
<td>120</td>
<td>12345678909</td>
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</table>
Provider Refund Checks

If you discover an overpayment, please contact the Provider Inquiry department at (866) 766-4661. If HAP has not already identified the recovery, you may either request that HAP initiate the recovery or remit payment to HAP using the attached spreadsheet.

All refunds for HAP and Alliance Health and Life Insurance Company business can be sent to:

HAP
Attn: Accounts Receivable
2850 W. Grand Blvd.
Detroit, MI 48202

In the event of an overpayment, providers are expected to promptly refund HAP the amount overpaid or contact HAP to inquire if HAP has already identified the overpayment. By doing so, providers can avoid potential MSP demands, HAP initiated claim recoveries on future payments or other collection efforts. By law, providers are obligated to refund overpayments involving Medicare and other carriers.

Please forward this information to your billing department and/or billing company.

Note: For HAP Preferred business, please contact the TPA listed on your Explanation of Pricing.
# PROVIDER REFUND REPORT

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient HAP ID #</th>
<th>Date of Service</th>
<th>Claim #</th>
<th>Overpayment Amount</th>
<th>Reason for the Refund</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Return form to:**

HAP
Attn: Accounts Receivable
2850 West Grand Blvd.
Detroit, MI 48202
Change in Process for Claims Adjustments Reminder

Use HAP’s online claims application for claims adjustments. Simply:
1. Log in at hap.org
2. Select Claims
3. Search for the claim(s) that you wish to appeal
4. Select from one of three options:

<table>
<thead>
<tr>
<th>Option</th>
<th>Use when</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal-referral appeal</td>
<td>Claims and authorizations do not match</td>
</tr>
<tr>
<td>Payment Amount-Underpayment</td>
<td>You think HAP did not pay the appropriate amount for a claim based on your contracted rates</td>
</tr>
<tr>
<td>Payment Amount-Overpayment</td>
<td>You think HAP paid you too much for a claim per your contracted rates</td>
</tr>
</tbody>
</table>

Note:
- For any appeals that do not fall into one of the options above, please select option 2—Payment Amount-Underpayment
- If “Ineligible” displays in the column “Request Appeal,” contact Provider Inquiry at (866) 766-4661

5. Include the required information in the notes section:
   - Reason for submitting appeal/adjustment request
   - Contact name
   - Phone number
   - Email address (add this in the notes field)

Step-by-step instructions can be found in the Billing Manual and on the online Claims application under Need Help.

We appreciate your cooperation in adhering to this new process. We are confident this will eliminate duplication and ensure a more efficient, timely means of resolution.
Cigna

Cigna Claims Submissions Process Change Reminder

Cigna customers have access to the HAP Preferred network in 20 counties in Michigan. Currently, claims for your patients with Cigna coverage are sent directly to us.

Effective January 1, 2016, please submit all claims for these patients directly to Cigna.

How to submit claims electronically to Cigna

Cigna strongly encourages you to submit claims electronically, including coordination of benefits (COB) claims. Using Cigna Payer ID 62308, there are two options to submit claims electronically:

1. **Post-n-Track®** - The Post-n-Track Web service is available at no cost to health care professionals that participate in the Cigna network. To enroll in this Web service, call (860) 257-2030, or visit Post-n-Track.com/Cigna.

2. **Other EDI vendors** - A list of electronic data interchange (EDI) vendors and transactions that Cigna supports are available at Cigna.com/EDIvendors. If you have questions about transactions submitted through your EDI vendor, please contact the vendor directly.

How to submit paper claims to Cigna

Although electronic filing is recommended, Cigna will maintain a process for submitting paper claims. You can find the appropriate address to submit claims on the back of the Cigna customer’s ID card.

Please note that new ID cards for these Cigna customers will be issued in the coming months. Below is a sample copy of the new Cigna customer ID card.

We appreciate the care you provide to Cigna’s customers.
Utilization Management & Authorizations

CareAffiliate - Authorizations

HAP’s new online prior authorization platform, CareAffiliate, went live July 13, 2015. Since then, more than 60 percent of authorizations have been submitted through this application.

All provider offices should have the Authorizations link on their home page. If you haven’t submitted an authorization online yet, we encourage you to begin today.

CareAffiliate offers:
- Quicker approvals for prior authorization requests that meet evidenced-based criteria
- Pre-populated authorization requests that result in less data entry
- Expanded character limitations within each text box to capture more information needed to submit an authorization

Time Saving Reminders
- Is an authorization required? First check to see if the service/procedure needs an authorization. Log in at hap.org and select Procedure Reference Lists under Quick Links, then one of the lists under Prior Authorizations Lists. Be sure to review the “Key” at the top of the page for additional details related to the prior authorization request.
- Complete information. When submitting a request via Care Affiliate the more information you provide upfront, the better your chances of receiving a quick determination. Authorizations that are called in have a longer “pend” time because clinical information is not attached to the request.
- Assessments and Attachments. When completing an Assessment, in addition to the required green fields, add appropriate information in the white fields. You can also submit supporting clinical information via Attachments.

CareAffiliate Training Resources

You can find training manuals, tip sheets and short training videos when you log in at hap.org and select CareAffiliate under Quick Links, then link to Training Materials. Training tools are categorized by the type of user:
- Admission – Observation Services
- Behavioral Health – Chemical Dependency Services
- Medical – Surgical Services
- Pharmacy Services
Prior Authorization Decision Timeframes

With the implementation of CareAffiliate, prior authorization decisions have not changed and will be provided as follows:

- Non-urgent pre-service requests: A decision will be provided as quickly as the clinical condition warrants, not to exceed 15 calendar days, or 14 calendar days for Medicare Advantage members.
- Urgent pre-service requests: A decision will be provided within 72 hours of receipt of the request.
- Post-service decisions (retrospective review): A decision will be provided within 30 calendar days of the request.

Admissions and Observation Stay Process

Nurse Review Requirements

On June 1, 2015, HAP nurses began utilizing HAP-specific UM criteria instead of standard InterQual® UM criteria to review requests for observation stays and inpatient admissions for the following set of diagnoses:

- Acute kidney injury
- Abdominal pain
- Anemia
- Atrial Fibrillation
- Cellulitis
- COPD
- Deep vein thrombosis
- DKA
- Hyperglycemia
- Hypertension
- Infection
- Nephrolithiasis
- Osteomyelitis
- Sepsis and SIRS
- Syncope
- Vaginal bleeding

InterQual criteria are updated on a periodic basis. However, when HAP believes InterQual criteria can be modified to better align with available evidence, we adjust our criteria. McKesson invites feedback from users, and we will share our feedback for their consideration on future releases of InterQual criteria. You will find that HAP-specific UM criteria closely align with InterQual criteria. Details of the changes, including reference to the specific InterQual sections affected, can be found in the HAP Revised Interqual Guidelines – October 2015, which is posted in the Provider Newsroom.

Please note: if a nurse documents that a case is not meeting InterQual or HAP-specific criteria, the nurse must refer the case to a HAP medical director for further review.

If you have any questions, please contact our Admissions and Transfers team at (313) 664-8833, option 3.
## Utilization Management Staff Availability

For utilization management inquiries, HAP staff is available by telephone as follows:

<table>
<thead>
<tr>
<th>For</th>
<th>HAP Department</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Admissions</td>
<td>• Skilled Nursing Facility</td>
<td>Admissions Team</td>
</tr>
<tr>
<td>• Transfers</td>
<td>• Rehab</td>
<td>24/7; 7 days per week</td>
</tr>
<tr>
<td>• Inpatient Review</td>
<td></td>
<td>(313) 664-8833</td>
</tr>
<tr>
<td>• Outpatient authorizations and Services</td>
<td>• Homecare</td>
<td>Referral Management Team</td>
</tr>
<tr>
<td>• DME</td>
<td>• Home Infusion</td>
<td>Monday – Friday</td>
</tr>
<tr>
<td></td>
<td>• Hospice</td>
<td>8:00 a.m. – 4:30 p.m.</td>
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<tr>
<td></td>
<td></td>
<td>(313) 664-8950</td>
</tr>
<tr>
<td>Case management</td>
<td>Case Management</td>
<td>Monday – Friday</td>
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<tr>
<td></td>
<td></td>
<td>8 a.m. – 5 p.m.</td>
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<tr>
<td></td>
<td></td>
<td>(313) 664-8476</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Pharmacy</td>
<td>Monday – Friday</td>
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<tr>
<td></td>
<td></td>
<td>8:00 a.m. – 4:30 p.m.</td>
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<tr>
<td></td>
<td></td>
<td>(313) 664-8940</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>Coordinated Behavioral Health Management (CBHM)</td>
<td>Monday – Friday 8 a.m. – 5 p.m.</td>
</tr>
</tbody>
</table>
Prior Authorizations from eviCore

Cardiac imaging, musculoskeletal procedures, radiation therapy and high-tech radiology services

The above procedures require clinical review and prior authorization from eviCore. Prior authorization is **not** required for:

- Echocardiography, echo stress tests, radiation oncology and radiation therapy for HAP members who are under 18 years of age. Please see the Services that Require Prior Authorization List under Procedure Reference Lists when you log in at hap.org. A signifier of “AGE” will be next to the code.
- Certain add-on codes found in the cardiology, musculoskeletal management and radiation therapy programs. For updates, see the Services that Require Prior Authorization List under Procedure Reference Lists when you log in at hap.org.

Requesting Prior Authorization

The most efficient way to obtain authorization from eviCore is at evicore.com; then select CareCore. It’s important to have the patient’s chart available so that you can easily provide the following:

- Insurance information
- Member information (name, ID number, DOB)
- Ordering physician information (name, address, TIN/NPI)
- Servicing provider information (name, address where test is to be performed)
- CPT and ICD-10 codes
- Symptoms
- Results of previous studies
- Complete clinical information. This will minimize the need for further review by an eviCore clinical nurse or medical director.

You can also obtain prior authorization by phone at (888) 564-5487. Initial requests for authorization are no longer accepted by fax.

Notify HAP of the Admission and Discharge Date

You need to notify HAP of the admission and discharge dates or your claim could be rejected. You can easily enter this information online. Log in at hap.org and select Authorizations and then Status.

Following this process will help ensure efficient and timely processing of your prior authorization requests.
Prior Authorization for In-Home and Facility-Based Sleep Studies Programs via eviCore

Prior authorization is required for in-home and facility-based sleep studies for HAP HMO, HAP POS, Alliance Health and Life Insurance Company, and Medicare Advantage members. (Note: Genesys-assigned HAP HMO and POS members are excluded from this process).

Requesting a prior authorization

Both ordering physicians and rendering facilities can initiate a prior authorization request from eviCore. In-office procedures are not allowed. Ordering physicians may request studies to be performed only at HAP-contracted sleep study provider offices/facilities.

There are three ways to request an authorization:

- Fax: (888) 693-3210. Fax forms are available online or by calling the number below. Only MedSolutions fax forms are accepted.
- Phone: (855) 736-6284 Monday through Friday, 8 a.m. to 9 p.m. (EST)
- Online: [medsolutionsonline.com](http://medsolutionsonline.com)

Decisions on a routine prior authorization request will be processed within three (3) business days after receipt of the necessary information.

Resources and Questions

Criteria and request forms are available at [evicore.com](http://evicore.com). If you have any questions or need additional information, please contact the eviCore Customer Service department at (855) 736-6284.
HEDIS®

HEDIS Data Collection and Medical Record Reviews

Quality improvement and performance assessment continue to be important expectations in today’s health care environment. Health plans, physicians, hospitals and other health facilities are all linked by activities designed to improve care outcomes and facilitate patient and consumer decisions.

Data Collection
More than 90 percent of health plans measure performance on various aspects of care and service using the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS data collection and reporting are mandated by the federal Centers for Medicare & Medicaid Services. HEDIS incorporates standardized processes to capture medical record information combined with claims-based data elements.

Medical Record Review
HAP has contracted Public Health Sciences to perform HEDIS medical record data abstraction in physician offices. The abstraction process will begin in early January 2016 and continue through early May 2016.

Prior to the on-site review, PHS will contact your office to schedule a visit and distribute information to explain the data collection process. We may also ask your office to send copies of chart components via mail or fax for in-house review. The role of PHS is covered by HIPAA, which ensures that your patients’ protected health information will remain confidential and protected.

If you have any questions regarding the medical record review process, please contact HAP’s Provider Services department at (866) 766-4708.

HEDIS 2016 Frequently Asked Questions

What is HEDIS®?
HEDIS is a standardized set of performance measurements developed by the National Committee for Quality Assurance to evaluate how well a health plan is performing in key areas: quality of care, access to care and member satisfaction with the health plan and providers.

Does HIPAA allow me to release records to HAP’s contracted medical record reviewer?
Yes. As a HAP-contracted provider, you are permitted to disclose PHI to HAP’s medical record reviewer, Public Health Sciences. Under the HIPAA privacy rule, a signed consent from the member is not required for you to release the requested information.

Is my participation in HEDIS data collection mandatory?
Yes. Participating providers are contractually required to provide medical record information so that we can fulfill our regulatory obligations.
Should I allow a record review for a member who is no longer with HAP or for a member who is deceased?
Yes. Medical record reviews may require data collection on services obtained over multiple years.

What is my office’s responsibility regarding HEDIS data collection?
You and your office staff are responsible for responding in a timely manner to the PHS medical record reviewer’s request for medical record documentation. The reviewer will contact your office to establish a date for either on-site, fax or mail data collection. A patient list will be faxed to you so the requested medical records can be made available for the appointment or for submitting the documentation to PHS.

How should I provide the records to the PHS medical record reviewer?
The reviewer will schedule an on-site review at your location, access the medical records via remote access to your electronic medical record system (preferred) or ask that you fax or mail the information to them. The methodology chosen will depend on the volume of records being requested from your office.

Provider Questions about HAP?

You can always call us at (866) 766-4708 for more information. We also have the following information posted online at hap.org. If you prefer a hard copy, call the number listed above and we will mail it to you.

- Affirmative statement about UM incentives
- Clinical practice guidelines updates
- Complex case management
- Coordination of Care between Behavioral Health and Primary Care Providers
- Covered and non-covered benefits
- Credentialing information
- Disease management services
- Evaluation of medical technology
- HAP’s policy for making an appropriate practitioner reviewer available to discuss any utilization management denial decision and how to contact a reviewer
- Member rights and responsibilities
- Network limits
- Pharmacy procedures and formularies
- Privacy and HIPAA information
- Quality management program
- Utilization management criteria