



PROVIDER MANUAL

April 2009

SECTION 1
GENERAL INFORMATION

- Using the Health Plan of Michigan Primary Care Provider Manual.....
- HPM Medicaid HMO Definition
- Corporate Telephone Directory.....
- Provider Roles and Responsibilities.....

USING THE HEALTH PLAN OF MICHIGAN PRIMARY CARE PROVIDER MANUAL

The HPM Provider Manual is designed specifically for HPM Medicaid Providers. This manual will assist the provider in understanding the specific policies, procedures and protocols of the Health Maintenance Organization (HMO) contracted with the State of Michigan to deliver and manage health care for enrollees.

Use

This Manual is designed to be a user friendly informational tool.

HPM information is divided into sections.

To access information quickly, follow these simple steps:

- Locate the section or topic in the Table of Contents
- Identify the section's tab number
- Tab to the appropriate section's Table of Contents (page 1 of every section)
- Find the page number in that section associated with the topic of interest

Updates and Revisions

The Provider Manual is a dynamic tool and will evolve with HPM.

Minor updates and revisions will be communicated to the primary care physicians via *Bulletins*. Information given in bulletins replaces information found in the body of the Provider Manual.

Major revisions of the information in the Provider Manual will result in publication of a revised edition that will be distributed to all PCP's, in order to replace older versions of the manual.

HPM MEDICAID HMO DEFINITION

Health Plan of Michigan is a Health Maintenance Organization (HMO) contracted with the Michigan Department of Community Health to provide medical services to Medicaid members who are enrolled with HPM.

HPM is a plan that provides, arranges for, and manages all Medicaid covered services as defined by the Comprehensive Healthcare Program for Medicaid Eligible Persons.

CORPORATE TELEPHONE DIRECTORY	
CONTACT AND SERVICE FUNCTION	TELEPHONE NUMBER
HPM Care Management	
<ul style="list-style-type: none"> • Process referrals • Perform corporate pre-service review of select services • Collect supporting clinical information for select services • Conduct inpatient review and discharge planning activities • Coordinate case management services 	Region 1: 1-888-322-8843 Region 2: 1-800-845-8959 Region 3: 1-888-322-8844
HPM Customer Service	
<ul style="list-style-type: none"> • Verify member eligibility • Obtain member schedule of benefits • Obtain general information and assistance • Determine claims status • Encounter inquiry • Record member personal data change • Obtain member benefit interpretation • File complaints and grievances • Verify / record newborn coverage • Coordination of Benefit questions 	1-888-437-0606
Provider Services	
<ul style="list-style-type: none"> • Fee schedule assistance • Discuss recurring problems and concerns • Contractual issues • Provider education assistance • Primary care administration • Initiate physician affiliation, disaffiliation & transfer 	1-888-773-2647
Quality Management	
<ul style="list-style-type: none"> • Requests and questions about Clinical Practice Guidelines • Requests and questions about Preventive Healthcare Guidelines • Questions about Quality Initiatives • Questions about QI Regulatory requirements • Questions about Disease Management Programs 	1-888-437-0606 ask for QM
Contracted Partners	
CompCare Managed Behavioral Health Provider	
<ul style="list-style-type: none"> • Member may contact directly for services. No provider referral is necessary 	1-888-222-8041
RxAmerica Pharmacy Benefit Manager	
<ul style="list-style-type: none"> • Prior Authorize Non-Formulary Medications 	1-888-883-0699
Access2Care Transportation	
<ul style="list-style-type: none"> • Coordinate Non-Emergent Transportation 	1-800-821-9369

PROVIDER ROLES AND RESPONSIBILITIES

Primary Care Physician (PCP) Roles and Responsibilities

Each HPM Medicaid eligible member selects a PCP who is responsible for coordinating the member's total health care. Primary Care Physicians are required to work 20 hours per week per location, and be available 24 hours a day/seven days a week.

Except for required direct access benefits or self-referral services, all covered health services are either delivered by the PCP or are referred/approved by the PCP and/or HPM. Details are available in Section 4 –Prior Authorization and Referrals.

Specialty Care Physician Roles and Responsibilities

HPM recognizes that the specialty physician is a valuable team member in delivering care to HPM members. Some of the key specialty physician roles and responsibilities include:

- Rendering services requested by the PCP.
- Communicating with the PCP regarding the findings in writing.
- Obtaining prior-authorization from the PCP before rendering any additional services not specified on the original referral form.
- Confirming member eligibility and benefit level prior to rendering services.
- Providing a consultation report to the PCP within 60 days of the consult.
- Providing the lab or radiology provider with:
 - The PCP and/or Corporate prior-authorization number
 - The member's Medicaid ID number

Hospital Roles and Responsibilities

HPM recognizes that the hospital is a valuable team member in delivering care to HPM members. Some essential hospital responsibilities include:

- Coordination of discharge planning with HPM utilization management staff.
- Coordination of mental health/substance abuse care with the appropriate state agency or provider.
- Obtaining the required prior-authorization before rendering services.
- Communication of all pertinent patient information to HPM and to the PCP.
- Communication of all hospital admissions to the HPM utilization management staff within one business day of admission.

Ancillary / Organizational Provider Roles and Responsibilities

HPM recognizes that the ancillary provider is a valuable team member in delivering care to HPM members. Some critical ancillary provider responsibilities include:

- Confirming member eligibility and benefit level before rendering services.
- Being aware of any limitations, exceptions and/or benefit extensions applicable to HPM members.
- Obtaining the required prior-authorization before rendering services.
- Communication of all pertinent patient information to HPM and to the PCP.

SECTION 2

MEMBER RELATED INFORMATION

- The HPM Member Services Help Desk
- Member Rights and Responsibilities
- HPM Member Identification
- Eligibility Verification
- PCP Identification.....
- How to Change a Member’s PCP Location.....
- Member Enrollment and Disenrollment Procedures
- New HPM Member Information
- Durable Power of Attorney
- Notice of Privacy Practices
- Member Satisfaction
- Member Complaints & Grievances
- Language
- New Technology

THE HPM MEMBER SERVICES DEPARTMENT

The HPM Member Services Department exists for the benefit of our members and providers, to respond to any and all questions about HPM benefits, policies and procedures. Full-time professional Member Services Specialists (MSS) are available each business day from 8:00 AM to 5:30 PM to be of assistance in any respect possible.

HPM Member Services Department

Toll-Free: 1-888-437-0606

MEMBER RIGHTS AND RESPONSIBILITIES

Members have a right to receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.

- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to participate with practitioners in decision-making regarding their healthcare.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to voice complaints or appeals about the managed care organization or the care provided.
- Members have a right to make recommendations regarding the organization's members' rights and responsibilities policies.
- Members have a responsibility to provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them.
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Health Plan of Michigan staff and contracted providers will comply with all requirements concerning enrollee rights.

HPM MEMBER IDENTIFICATION

HPM members receive an HPM Membership Card that has health plan member services phone number and pharmacy contact information on it. If there are any questions about the member's State Medicaid Card or the HPM Member Identification Card, call HPM Member Services Department.

ELIGIBILITY VERIFICATION

How to Identify a Member's Eligibility

Member eligibility changes frequently, so it is important to verify eligibility prior to rendering services to a member.

To verify if a member is currently eligible to receive services as an HPM Medicaid member, the following steps must be followed:

1. Request that the member present his/her HPM card at each encounter.
2. If the member does not have his/her HPM card, you may request that the member present his/her **Green Plastic Medicaid ID Card**, which is generated at the time of enrollment, at each member encounter. HPM's Managed Care System may also be utilized with member's Medicaid ID number to validate health plan enrollment.
3. Review your PCP monthly eligibility report each time the member presents at your office for care or referrals.
4. Call the Member Services Department at 1-888-437-0606 for assistance with eligibility determinations.

If you find any discrepancies between a member's Medicaid ID card, an Eligibility Verification System and/or your monthly eligibility report, please contact the Member Services Department for further assistance.

PCP IDENTIFICATION

How to Identify a Member's Primary Care Provider

Call the Member Services Department at 1-888-437-0606 or utilize the HPM Managed Care System to identify a member's PCP location, if the member is not listed on your monthly eligibility report. To comply with HIPAA regulations, you must have a Medicaid ID number, name, and DOB to obtain any member information.

HOW TO CHANGE A MEMBER'S PCP LOCATION

The member must call the Member Services Department at 1-888-437-0606 to request a PCP location change. PCP location changes take effect on the first day of the following month if the request is after the 15th of the month. PCP's are notified by fax of all location changes, both additions and deletions on their monthly eligibility list.

MEMBER ENROLLMENT AND DISENROLLMENT PROCEDURES

HPM Member Enrollment

A State-contracted client enrollment broker processes member eligibility and enrollment. Once notified, HPM assigns the member to the PCP of his/her choice and provides the member with all new member information, including a member handbook and access to view the HPM provider network. The new member will be identified on their selected PCP's next monthly eligibility report and on each report thereafter as long as the member is still eligible for Medicaid services.

At times, members may temporarily lose eligibility. If they lose eligibility and then regain eligibility within a 3-month period of time, they will be re-assigned to HPM and the prior PCP site, unless they request otherwise.

NEW HPM MEMBER INFORMATION

New Member Information

The list below identifies some of the important information shared with new members when they join the Plan:

- Members may select a HPM doctor of their choice for each eligible family member. This doctor is called a Primary Care Provider (PCP). Members may change their PCP by calling the Member Services Department and requesting a PCP location change.
- Members should contact their PCP to provide or arrange for all medical care. Members cannot go to other doctors without a referral from their PCP (with the exception of self-referrals). If a member goes to another doctor without an appropriate referral and prior authorization from the PCP, the Plan may not pay for services rendered.
- If a member has been seeing a doctor that does not participate in HPM, he/she will probably not be able to continue to see this doctor unless the doctor elects to join the HPM provider network.
- If a non-participating doctor is treating a member for a serious health condition or pregnancy, the member must contact the Member Services Department immediately. HPM will work with the member to assure that the member's healthcare is not disrupted while transferring to an in-plan provider. HPM will review the medical records for continuity of care to determine a specific time frame for approval of out of network care and the transfer to a participating doctor.
- Members who have certain identified chronic illnesses may select a Specialty Physician from the HPM network to act as their PCP.
- If the member's Medicaid eligibility ends, so does his/her HPM coverage.

Additional details surrounding HPM coverage are described in the HPM Member Handbook, which is mailed to each new member. Members are invited to call the Member Services Department with any questions at 1-888-437-0606.

DURABLE POWER OF ATTORNEY

MICHIGAN NOTICE TO PATIENTS

*Required by the Patient Self-Determination Act: The State of Michigan has authorized the use of the **Medical Durable Power of Attorney** for health care. This allows you to choose another person to make decisions about your care, custody, and medical treatment if you cannot make these decisions for yourself. This way your desire to accept or refuse medical treatment is honored when you cannot participate in your medical treatment decisions.*

NOTICE OF PRIVACY PRACTICES

The following notice of Privacy Practices was written specifically for members. HPM PCP's must post the following information in their offices for members to read:

HEALTH PLAN OF MICHIGAN

NOTICE OF PRIVACY PRACTICES
(Combined Gramm Leach Bliley & HIPAA Notice)

Effective April 14, 2003
Revised January 2005

THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Information We Have. We have enrollment information about you which includes your date of birth, sex, identification number and other personal information. We also receive bills, physician reports and other information about your medical care.

Our Privacy Policy. We care about your privacy and we guard your information carefully whether it is in oral, written or electronic form. We are required by law to maintain the privacy of that information and to provide you with this notice of our legal duties and our privacy practices. We will not sell any information about you. Only people who have both the need and the legal right may see your information. Unless you give us a written authorization, we will only disclose your information for purposes of treatment, payment, business operations or when we are required by law to do so.

Treatment. We may disclose medical information about you for the purpose of coordinating your healthcare. For example, we may notify your personal doctor about treatment you receive in an emergency room.

Payment. We may use and disclose medical information about you so that the medical services you receive can be properly billed and paid for. For example, we may ask a hospital emergency department for details about your treatment before we pay the bill for your care.

Business Operations. We may need to use and disclose medical information about you in connection with our business operations. For example, we may use medical information about you to review the quality of services you receive.

As Required by Law. We will release information about you when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

Authorizations. If you give us a written authorization to do so, we may use and disclose your personal information. If you give us a written authorization, you have the right to change your mind and revoke that authorization.

Copies of this Notice. You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy.

Changes to this Notice. We reserve the right to revise this Privacy Notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published in our Member Newsletter.

Your Right to Inspect and Copy. You may request, in writing, the right to inspect the information we have about you and to get copies of that information. We can deny your request for certain, limited reasons, but we must give you a written reason for our denial. We may charge a fee for copying your records.

Your Right to Amend. If you feel that the information we have about you is incorrect or incomplete, you can make a written request to us to amend that information. We can deny your request for certain limited reasons, but we must give you a written reason for our denial.

Your Right to a List of Disclosures. Upon written request, you have a right to receive a list of our disclosures of your information, except when you have authorized those disclosures or if the disclosures are made for treatment, payment or healthcare operations. We are not required to give you a list of disclosures made before April 14, 2003.

Your Right to Request Restrictions on Our Use or Disclosure of Information. If you do so in writing, you have the right to request restrictions on the information we may use or disclose about you. We are not required to agree to such requests.

Your Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. For example, you can ask that we only contact you at home or only at a certain address or only by mail.

How to Use Your Rights Under this Notice. If you want to use your rights under this notice, you may call us or write to us. If your request to us must be in writing, we will help you prepare your written request, if you wish.

Complaints to the Federal Government. If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to: Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. You will not be penalized for filing a complaint with the federal government.

Complaints and Communications to Us. If you want to exercise your rights under this Notice or if you wish to communicate with us about privacy issues or if you wish to file a privacy related complaint, you can write to:

Chief Privacy Officer
Health Plan of Michigan, Inc.
777 Woodward Ave.
Suite 600
Detroit, MI 48226

You can also call us at 1-888-437-0606. You will not be penalized for filing a complaint.

You can view a copy of this notice on our website at www.hpmich.com.

MEMBER SATISFACTION

Member Services Program

HPM and its network providers are committed to providing and maintaining a consistently high level of member satisfaction. All PCP's and their staff are expected to maintain a friendly and professional image and office environment for members, the general public, physicians, and staff. PCP's must maintain adequate levels of staff to provide for timely and effective services for HPM members. Member Services functions are a requirement of the PCP initial orientation and on-going network provider education.

Member Satisfaction Surveys

The Michigan Department of Community Health (DCH) and the National Committee for Quality Assurance (NCQA) require that HPM conduct annual surveys to determine current levels of member satisfaction with the Plan and to identify areas of potential Plan improvement. HPM PCP's and their office staff are expected to cooperate with, and assist the Plan with obtaining data for these surveys. PCP's will be notified in advance of their required participation and the time frames in which the surveys will be conducted annually.

MEMBER COMPLAINTS & GRIEVANCES

The following is a summary of the grievance and appeal processes as written for HPM members.

Member Grievance

A grievance is when you are unhappy about anything other than a denied, reduced, or terminated service. A few examples of a grievance are:

- You cannot get an appointment with your doctor in a timely manner.
- You cannot get a referral from your doctor in a timely manner.
- You have been denied any of your rights as an HPM member.

If you have a grievance or concern with your health care services or HPM call HPM Member Services at 1-888-437-0606 and ask for the Grievance Coordinator. In most cases, we can resolve the problem over the phone. You can also file your grievance in writing. Your physician or a designated representative may file a grievance for you in writing. Please include a phone number where we can reach you. The address to file a grievance is:

**Health Plan of Michigan
Grievance Coordinator
777 Woodward Avenue, Suite 600
Detroit, MI 48226**

We will acknowledge your grievance by sending you or your representative a letter within five days of receiving the grievance. Your Level 1 Grievance will be resolved within 15 days. We will call you with the results and also send a response in writing.

If you are not happy with our resolution of your Level 1 Grievance, you may file a Level 2 Grievance with HPM. You must submit a Level 2 Grievance within five days of receiving the response to your Level 1 Grievance. Level 2 Grievances will be reviewed by the HPM Grievance Committee, which is the body designated by our Board of Directors.

You or your representative can appear in person or by phone before the Grievance Committee. You can also submit additional written information for the Grievance Committee to review. You or your representative will be notified of the resolution within three business days of the Committee's decision. We will call you with the results and also send a response in writing. The combined time frame for the Level 1 and Level 2 Grievance process will not be more than 30 days.

External Review of Grievances

If you are unhappy with HPM's resolution, you or your representative can submit a request for external review in writing to the Office of Financial and Insurance Regulation (OFIR). This must be submitted within 60 days of receipt of the final determination from HPM's internal grievance process.

Send your request for external review to the following address:

**OFIR
Health Plans Division - Appeals Section
PO Box 30220
Lansing, MI 48909-7720
Phone: 1-877-999-6442
Fax: (517) 241-4168**

At any time within 90 days of the date of the denial letter, you may request a fair hearing from the State Office of Administrative Hearings and Rules (SOAHR) for MDCH. Submit the request in writing to:

**State Office of Administrative Hearings and Rules (SOAHR)
Department of Community Health
PO Box 30763
Lansing, MI 48909-7695
Attention: Compliance/Appeals**

Member Appeal

A grievance/appeal is a request to change a decision about a denied, reduced or terminated service. A few examples of things you can appeal are:

- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for an authorized and covered service.
- When a request for services, medical supplies or prescriptions is denied.

How to File Grievance/Appeal

Your request for a grievance/appeal must be made within 90 days of receipt of HPM's denial letter. You can have someone else, such as a family member or a physician file the grievance/appeal for you. You must put in writing that you want the person to appeal for you. You must also give this person access to your health information.

To start a grievance/appeal, write a letter about the problem or use HPM's Internal Grievance/Appeal Form that is included with the initial denial letter. Send the grievance/appeal request to:

**Health Plan of Michigan
Grievance/Appeals Coordinator
777 Woodward Avenue, Suite 600
Detroit, MI, 48226
Fax: (313) 463-5259**

If you need help writing your grievance/appeal, the HPM Grievance/Appeals Coordinator will help you. Call us at 1-888-322-8843, extension 1302. Please send all paperwork and any other items related to the grievance/appeal. Please include a number where you can be reached so we can let you know that your grievance/appeal has been received.

HPM Internal Grievance/Appeal Process - Level 1

A doctor with the same or like specialty as your treating doctor will review your grievance/appeal. It will not be the same doctor who made the original decision. HPM will send you a letter notifying of the decision:

- Within 15 days if you are waiting to get the medical services
- Within 20 days if you already received the medical services

Health Plan of Michigan may need to take up to 10 more business days if we are waiting for information from your provider. If this happens we will send you a letter. If HPM does not completely approve your request during the Level 1 review, the letter will describe your further appeal rights.

HPM Internal Grievance/Appeal Process – Level 2

HPM's Grievance/Appeal Committee will review your grievance/appeal. HPM will let you know when the Level 2 hearing will be. You have the right to speak at the Level 2 hearing or someone else you authorize may speak for you. A final decision will be mailed to you within three days of the hearing date.

The combined time frame for the Level 1 and Level 2 Grievance/Appeal process shall not be more than 30 days.

Expedited Grievance/Appeal Review

Your problem may be so urgent that you need a decision about your care very quickly. If the usual 30-day time frame for a grievance/appeal would cause serious harm to your life or health, you or your representative can ask for an expedited grievance/appeal. Your doctor must support this request. You can ask for an expedited grievance/appeal 24 hours a day, 7 days a week. Health Plan of Michigan will make a decision about your care within 72 hours. Call the Grievance/Appeals Coordinator at 1-888-322-8843, extension 1302, during normal business hours of Monday through Friday from 8:00 AM to 5:00 PM. After hours, weekends and holidays you may call us at 1-888-437-0606.

External Review of Grievance/Appeals

If you or your authorized representative is unhappy with HPM's final decision, you may appeal the decision with the Commissioner of Financial and Insurance Regulation within 60 days of receiving HPM's final decision. You can write to them at the following address:

OFIR
Health Plans Division - Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Phone: (877) 999-6442
Fax: (517) 241-4168

You must complete the entire internal grievance/appeal process through Health Plan of Michigan before you are able to file an appeal with the Commissioner of Financial and Insurance Regulation.

You or your authorized representative have the right to request a Fair Hearing with the State of Michigan within 90 days of the denial letter if you disagree with an HPM decision. You can file a State Fair Hearing by writing to the Michigan Department of Community Health at the following address:

State Office of Administrative Hearings and Rules for
Michigan Department of Community Health
PO Box 30763
Lansing, MI 48909-7695

A physician or other representative of the enrollee such as family member, friend or attorney, may appeal on the enrollee's behalf with the enrollee's written permission. HPM must receive a copy of the enrollee's written permission prior to an appeal being processed.

LANGUAGE

We offer a language service to anyone speaking a non-English language. There is no charge to our members for these services. We also offer a Member Handbook in Spanish.

NEW TECHNOLOGY

HPM wants to make sure our members have quality access to new technologies and procedures. We do research on new technology before approving them for our members. Information of new technology/procedures is received from medical information, professional groups, Medicare and other sources of governmental and scientific groups. This information goes to an HPM group made up of doctors and HPM staff. HPM may also use specialists to review the information. The decision to approve or not approve a new technology or procedure is then made. Medicaid rules prevent authorization of experimental technology.

SECTION 3

MEMBER BENEFIT INFORMATION

- Member Benefits and Services
- Non-Covered HPM / Medicaid Services
- Medicaid Services Covered Outside HPM Benefit
- Pharmacy Benefit Management
- Member Self-Referrals
- Federally Qualified Health Centers
- Non-Emergency Transportation
- Advanced Directives.....

MEMBER BENEFITS AND SERVICES

HPM has a comprehensive benefit package available to all HPM members that are Medicaid eligible enrollees. Services for members are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, HPM will implement the changes consistent with the dates specified by the DCH.

Services Covered By HPM

The following services are covered under HPM:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid EPSDT policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services (benefit limit of 18 visits per year)
- Diagnostic lab, x-ray and other imaging services
- Durable Medical Equipment and supplies
- Emergency services
- End Stage Renal Disease services
- Family Planning services
- Health Education
- Hearing & Speech services
- Hearing aids
- Home Health services
- Hospice services
- Immunizations
- Inpatient and Outpatient Hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Maternal and Infant Health Program (MIHP)
- Medically necessary weight reduction services
- Mental Health Care – 20 outpatient visits per contract year
- Out-of-State services authorized by the Contractor
- Outreach for included services, especially pregnancy related and well-child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services
- Prosthetics & Orthotics
- School and Sports Physicals
- Therapies (speech, language, physical, occupational)
- Transplant services
- Transportation
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons up to the age of 21 years

NON-COVERED HPM / MEDICAID SERVICES

The following are services prohibited or excluded under Medicaid

- Elective abortions and related services
- Experimental or investigational drugs, procedures or equipment
- Elective cosmetic surgery
- Treatment for infertility

MEDICAID SERVICES COVERED OUTSIDE HPM BENEFIT

- Dental services
- Services provided by a school district and billed through the Intermediate School District
- Inpatient psychiatric services
- Outpatient partial hospitalization psychiatric care
- Mental health services in excess of 20 outpatient visits per contract year
- Substance abuse services through accredited providers including:
 - Screening and assessment
 - Detoxification
 - Intensive outpatient counseling and other outpatient services
 - Methadone treatment
- Services provided to persons with developmental disabilities and billed through Provider Type 21
- Custodial care in a nursing facility
- Home and Community based waiver programs services
- Personal care or home help services
- Transportation for services not covered in the Comprehensive Health Care Program (CHCP)
- Any service that is not medically necessary
- Any service that is not covered by your PCP, excluding emergencies, well woman care, mental health treatment, services at local health departments, immunizations, family planning, FQHC visits, pediatricians, and vision.

HPM providers are required to assist with and provide members with referrals for the above Medicaid covered services. Providers of the above Medicaid services **will bill the DCH directly** for payment of their services under their State specific contracts.

HPM providers should contact the MEMBER SERVICES HELP DESK at 1-888-437-0606 for assistance with making the above member referrals.

PHARMACY BENEFIT MANAGEMENT

Prescription Drug Plan Coverage

HPM utilizes RxAmerica to manage the member's pharmacy benefit. RxAmerica provides HPM with a pharmacy network, pharmacy claims management services, a drug formulary and pharmacy claims adjudication. Prior to authorizing any drug benefit, each member's eligibility is determined.

RxAmerica provides **Provider Support at 1-888-883-0699**. HPM providers may also speak with a clinical pharmacist regarding any pharmaceutical, medication administration or prescribing issues.

Each PCP will receive a copy of the HPM Pharmacy Drug Formulary. The Drug Formulary is also available on our website at www.hpmich.com or through epocrates.com. This drug formulary should be accessible and be referred to when prescribing medications for HPM members. Medicaid members have both prescription and specific over-the-counter medication coverage. All providers must prescribe from within the drug formulary unless a drug prior-authorization is obtained from RxAmerica. There are also a few specialized medications in the drug formulary identified as requiring a prior-authorization.

Obtaining a Drug Prior-Authorization

If a provider wishes to prescribe a drug that requires prior-authorization and/or a drug is not in the drug formulary, he/she must complete a Drug Prior Authorization Request Form. This form must be faxed to RxAmerica at **Prior Auth Desk fax #: 1-866-855-2678**.

In emergency situations, please phone RxAmerica at 1-888-883-0699.

Prior-authorizations must be obtained before providing the member with a written prescription. If a prior-authorization is not obtained in advance, the member will not be able to have the prescription filled at their pharmacy, causing a delay for the member in obtaining their medication.

Glucometers for Diabetic Members

Great Lakes Medical Supply provides glucometers for HPM members with diabetes. For a member to receive a glucometer the PCP must complete a Physician Order Form and forward it to Great Lakes Medical Supply at **Fax # 1-800-292-0677 or call 1-800-774-0788**

The initial glucometer will be shipped to the PCP within 24 hours of receipt of a completed request. The package received will include:

- Blood glucose monitor
- Check strip
- Carrying case
- Test strips (25)
- Normal control
- Lancing device
- User guide
- Patient record diary
- Instructional video
- Managed care letter of introduction

MEMBER SELF-REFERRALS

Family Planning

Family planning services are any medically approved means, including diagnostic evaluation, drugs, supplies, devices and related counseling for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of sexually transmitted diseases (STDs). These services are to be provided in a confidential manner to individuals of childbearing age, including minors who may be sexually active, who voluntarily choose not to risk initial pregnancy, or who wish to limit the number and spacing of their children.

Treatment for infertility is not included under the family planning benefit.

All HPM members have full freedom of choice of family planning providers, both in and out of the HPM network. The PCP should work with the member in providing for family planning services or assisting them in selecting a provider, as requested.

Members may also contact the Member Services Help Desk at 1-888-437-0606 for additional assistance with family planning referrals or family planning information.

Women's Health

Members sixteen years and older may self-refer to the network OB/GYN of her choice for routine annual exams and female cancer screens (pap smear and mammogram). She may also refer to the in-network OB/GYN of her choice for prenatal/perinatal care.

Children's Health

Members eighteen years and younger may seek treatment from the (in network) pediatrician of his/her choice without prior-authorization if the dependent minor is assigned to a PCP who is not a pediatrician.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

FQHC's are important community providers and all HPM members have access to them if the member resides in a community where FQHC services are available. The Member Handbook outlines the member's rights to access a FQHC in their service area, if they so desire.

For additional information and assistance in accessing a FQHC, members should be advised to contact the MEMBER SERVICES HELP DESK at 1-888-437-0606.

NON-EMERGENCY TRANSPORTATION

HPM will assure that non-emergency transportation and travel expenses determined to be necessary for members to secure medically necessary medical examinations and treatment are readily available and accessible.

This non-emergent transportation is available for all medical and health services deemed medically necessary by the member's primary care physician, including End Stage Renal Disease services (hemodialysis), prenatal care, preventive services, mental health services, obtaining prescription medicine and DME supplies.

HPM has contracted with a transportation agency that has a network that is capable of providing non-emergent transportation to the entire HPM member geographic coverage area. Information on how and when they can access non-emergent transportation is available in the Member Handbook or by calling the Member Services Help Desk at 1-888-437-0606.

Transportation Procedure

Any member that cannot access non-emergent transportation services through their own resources, family or friends, may contact their assigned PCP or the HPM Member Services Help Desk to arrange for these services.

To arrange for these services, the member, PCP or an HPM representative should call Access2Care Transportation at **1-800-821-9369**.

Access2Care will transport the following individuals:

- Members: All HPM members for all covered outpatient services.
- Parents and Guardians: Parents or legal guardians of minor or incompetent members when they accompany the member to their appointment.
- Others: Transportation of other family members, such as siblings, to the appointment may be allowed.

Transportation will be to and from participating providers, or if explicitly directed by HPM, to and from non-participating providers.

Appointment Scheduling Criteria / Process

Scheduling of transportation services usually requires a 3-4 day notice to assure service.

The transportation provider uses confidential eligibility information provided by HPM to verify member eligibility.

Members will be assigned to the most appropriate and cost effective means of transportation in the network web.

Appointments will be scheduled during business hours between 8:00 AM and 6:00 PM Monday – Friday.

Member complaints and grievances regarding non-emergent transportation issues will be handled through the HPM Complaints and Grievances Policy and Procedure.

Non-emergent transportation service abuse will be reported to HPM by Access2Care and investigated by HPM. HPM reserves the right to withhold non-emergent transportation services from members found to be abusing the service.

Examples of abuse of the service would include securing transportation for reasons outside of medical necessity and abusive behavior towards the transportation provider.

Members who must access non-emergent travel expenses outside of the HPM geographical area for medically necessary care, and incur costs for such services, may contact HPM Member Services Help Desk at 1-888-437-0606 for assistance. HPM will review the appropriateness of the request prior to the service being scheduled.

Reimbursement for reasonable and customary non-emergent transportation costs will be considered and made on an individual basis.

ADVANCED DIRECTIVES

Health Plan of Michigan's primary care physicians are responsible for educating members regarding Advanced Directives, providing members with Advance Directive forms and obtaining forms from members for the patient chart.

SECTION 4
CARE MANAGEMENT

- Referral Management.....
- Corporate Pre-service Review.....
- Specialty Network Access to Care
- Inpatient Review
- Denials & Provider Appeals.....
- Case Management

The objective of HPM's Care Management program is to ensure that medical services provided to members are medically necessary and/or appropriate, as well as in conformance with the benefits of the Plan. The program functions on consistently applied systematic evaluation of appropriateness criteria and by considering circumstances unique to the member.

Referral Management

Referral processing is the primary activity performed by our care management specialist staff. The specialists are assigned in teams by provider group and region. If you have a referral request or question, contact a member of your team. They will be glad to help you. If you do not know the team you are assigned to, you can call any of the numbers below for assistance.

Three easy ways to submit referrals:

1. Electronically
HPM's Managed Care System (MCS)
2. Fax
Refer to care management's regional team fax numbers. Please include pertinent clinical documentation with the request if indicated.
3. Phone
Urgent requests must always be submitted by calling your regional team. Make sure you identify the request as "urgent" to expedite the pre-service review process.

Please refer to the grid below to contact or send faxes to your regional team.

Teams	Coverage Counties	Phone #	Authorization Fax #
Region 1	Allegan, Alpena, Antrim, Barry, Berrien, Calhoun, Cass, Kalamazoo, Lapeer, Montmorency, Ottawa, St. Joseph and Van Buren	1-888-322-8843	313 463-5254
Region 2	Branch, Clinton, Crawford, Eaton, Hillsdale, Ingham, Jackson, Lake, Lenawee, Mason, Mecosta, Monroe, Osceola, Otsego, Shiawassee and Wayne	1-800-845-8959	313 463-5256
Region 3	Genesee, Huron, Kent, Livingston, Macomb, Manistee, Muskegon, Montcalm, Newaygo, Oakland, Oceana, Ogemaw, Oscoda, Roscommon, Saginaw, Sanilac, St. Clair, Tuscola and Washtenaw	1-888-322-8844	313 463-5258

Types of referrals:

The next table in this section provides HPM's referral requirements for the most commonly requested services. This list is not all inclusive and rarely requested services may require pre-service authorization. Should you have any questions please, contact the care management regional team for your coverage area.

Copies of the criteria utilized in decision-making are available upon request by calling the Care Management department at 1-888-322-8843.

No Prior Authorization (in or out of network)	PCP Notification to HPM (in or out of network)	Corporate Prior-Authorization (Pre-service review)
NO REFERRAL REQUIRED	REFERRAL NOTIFICATION ONLY	CLINICAL INFORMATION
Life-Threatening Emergencies – ER Screening Urgent Care Routine Lab Routine X-Ray including CT Scan, MRI, MRA, PET Scan DEXA, HIDA Scans Sleep Studies Obstetrical Observations Gastroenterology Diagnostics Ultrasounds Annual Vision / Glasses Audiology Services and Testing (excluding hearing aids) Chiropractic Services (18 Visits per Year) Annual Mammogram and Pap Colposcopy after an Abnormal Pap Myoview Stress Test Cardiac Stress Test Neurology and Neuromuscular Diagnostic Testing, including EEGs, 24 Hour EEG's and EMGs Bronchoscopy	*Specialist Office Services Specialist services to: 1) University of Michigan, 2) Hurley Hospital or 3) Michigan State University for central referral Maternity Care / Maternal Support Services Complex Outpatient Treatment <ul style="list-style-type: none"> • Dialysis • Outpatient Radiation Therapy • Chemotherapy PCP Notification is not necessary for claims payment. In-network or out-of-network practitioners will be reimbursed for consultations, evaluations and treatments provided within their offices, when the member is eligible and the service provided is a covered benefit under Michigan Medicaid and the Medicaid MCO Contract	Elective Inpatient Admissions/Surgeries/SNF admissions Elective Hospital Outpatient Surgery Elective Facility-Based Diagnostic Services DME / Prosthetics and Orthotics > \$1000 (*In Network Only) Home Health Care/Hospice/ Infusion Therapy Services Speech, Occupational and Physical Therapy Weight Management (prior to Bariatric Surgery) Bariatric Surgery Heredity blood testing, e.g., BRCA for Breast and Ovarian Cancer Any service request to an Out-of-State physician or facility Hearing Aids *All Emergency Inpatient Admissions, Surgeries and 23-Hour Observations require corporate authorization from Health Plan of Michigan. For emergency authorizations, HPM must be notified within the first 24 hours or the following business day.
DME / Prosthetics and Orthotics ≤ \$1000 (*In network only) EKG, Echocardiography Sigmoidoscopy or Colonoscopy Cardiograph Allergy Testing Bone Densitometry Studies	<p style="text-align: center;">* All DME Supplies and Services should be provided by an in-network provider</p>	
Barium Enema Non-Invasive Vascular Diagnostic Studies IVP, Intravenous Pyelography SPECT Pulmonary Diagnostic Testing Voiding Cysto-Urethrogram	<p style="text-align: center;">All Outpatient Mental Health Services must be authorized through CompCare by calling 1-888-222-8041</p>	
	<p style="text-align: center;">NON-COVERED BENEFITS</p> <p><i>The following services are not covered benefits under Medicaid and will not be reimbursed by Health Plan of Michigan:</i> Cosmetic Services, Cardiac/Pulmonary Rehab, Aqua Therapy, Children's Speech, Physical and Occupational Therapy covered under School Based Services, Erectile Dysfunction, Functional Capacity, Infertility Services, Community Mental Health Services, Convenience items and any other service otherwise not covered by Medicaid</p>	

**Accessing Specialty Care Services
at the University of Michigan, Hurley or Michigan State University**

Specialist referrals to the University of Michigan, Hurley Hospital or Michigan State University may be utilized when an in-network specialist is not available, or to seek another opinion subsequent to consultation/treatment with an in-network specialist.

As a primary care provider, you may request a referral to one of the three health care public entities via HPM's Managed Care System, Fax or calling HPM's Care Management department at 1-888-322-8843. HPM's care management staff will forward the information and authorization to central referral office of the public entities. HPM will fax you a copy of the approved referral notification form along with contact information to the public entity.

Corporate Pre-service Review

HPM must review and approve select services before they are provided. The primary reasons for clinical review are to determine whether the service is clinically appropriate, is performed in the appropriate setting and is a benefit. Clinical information is necessary for all services that require clinical review for medical necessity.

Care management clinical staff uses plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All Utilization Review decisions to deny coverage are made by HPM's medical directors. In certain circumstances, an external review of service requests are conducted by qualified, licensed physicians with the appropriate clinical expertise.

HPM's Medical Necessity Guidelines are based on current literature review, consultation with practicing physicians and medical experts in their particular field, government agency policies, and standards adopted by national accreditation organizations. It is the responsibility of the attending physician to make all clinical decisions regarding medical treatment. These decisions should be made consistent with generally accepted principles of professional medical practice and in consultation with the member.

Clinical information is required for all clinical review requests to ensure timely decisions by HPM. The decision time frame is based on the date we receive the supporting clinical information. To ensure a timely decision, make sure all supporting clinical information is included with the initial request. The preferred method of clinical review submission is via fax to your regional team. If clinical information is not received with the request HPM's care management staff will send a fax request for the information and/or contact the physician or specialist verbally to collect the necessary documentation.

Clinical information includes relevant information regarding the member's:

- History of presenting problem
- Physical assessment
- Diagnostic results
- Photographs
- Consultations

- Previous and current treatment
- Member's response to treatment

Clinical information should be provided at least 14 days prior to the service. The facility is responsible for ensuring authorization. HPM provides a reference number on all referrals.

TURN AROUND TIMES FOR REFERRAL PROCESSING

	Makes Decision	Fax/Phone Notification	Written Notification (Denials)
Non-Urgent pre-service review	Within 14 days of receipt of the request.	Within 14 days of receipt of the request	Within 14 days of receipt of the request.
Urgent pre-service review	Within 72 hours of receipt of the request.	Within 72 hours of the request.	Within 72 hours of the request.
Urgent Concurrent	Within 24 hours of receipt of the request. 48 hours if clinical is not included.	Within 24 hours of receipt of the request. 48 hours if clinical not included.	Within 72 hours of the decision.
Retrospective	Within 30 days of receipt of the request. N/A for members. HPM believes there are very few situations that justify requesting retrospective authorization and most often will be denied.	N/A	Within 30 days of receipt of the request.

Inpatient Review

Our nurse reviewers are assigned to follow members at specific acute care facilities to promote collaboration with the facility's review staff and management of the member across the continuum of care. HPM's nurse reviewers assess the care and services provided in inpatient setting and the member's response to the care by applying InterQual® criteria and HPM's Observation policy. Together with the facility's staff, care management's clinical staff coordinates the member's discharge needs.

All elective hospital admissions initiated by the PCP or specialist requires Corporate Pre-Service review. Call the appropriate regional care management team, enter the authorization request in HPM's Managed Care System, or Fax requests to the appropriate Care Management Team. Be sure to include documentation of medical necessity to facilitate the earliest possible turnaround time. The facility is responsible for ensuring authorization. HPM provides a reference number on all referrals.

Denials and Provider Appeals

All denial determinations are rendered by physician. A nurse reviewer contacts the provider telephonically to inform them of the denial decision, reason for the denial and contact information to discuss the denial with HPM's medical director. Written denial notification is sent via fax and mailed to the member. Treating physicians who would like to discuss a utilization review determination with the decision-making medical director may contact the Care Management Department at 1- 888-322-8843.

The written denial notification will include the reason for the denial, the reference to the benefit provision and/or clinical guideline on which the denial decision was based, and directions on how to obtain a copy of the reference. You may contact the Care Management Department any time at 1- 888-322-8843 to request a copy of HPM's medical necessity guidelines.

Expedited Appeal

An expedited appeal is a request to change a denial decision for urgent care. Urgent care is any request for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.

Inpatient services that are denied while a member is in the process of receiving the services are considered an urgent concurrent request and is therefore eligible for an expedited appeal.

Non-Urgent Pre-service Appeal

Providers may request an appeal of denial in advance of the member obtaining care or services. HPM will provide acknowledgement of your appeal within three days of receipt of the request. No physician will be involved in an appeal for which he/she made the original Adverse Determination. No physician will render an appeal decision who is a subordinate of the physician making the original decision to deny.

Refer to the Billing and Payment section for directions on Post-Service Appeals.

TURN AROUND TIMES FOR PROCESSING PROVIDER APPEALS

	Makes Decision	Fax/Phone Notification	Written Notification (Denials)
Expedited Appeal	<p>Completed as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of an expedited grievance.</p> <p>Inpatient admissions are eligible if the member is receiving services at the time of the denial</p>	Within 24 hours of the decision.	Within 72 hours of receipt of the request.
Pre-service appeals	Within 14 calendar days of receipt of the appeal.	Within 14 calendar days of receipt of the appeal.	Within 14 calendar days of receipt of the appeal.

Case Management

The HPM case management program provides patient-focused, individualized case management for those members with active disease processes, those who require extensive utilization of resources and those at high risk for health complications. The following case management programs are available to personally support the health care needs of your members: Asthma, Diabetes, Congestive heart failure, Cardiovascular disease, Complex/Catastrophic illness, and High emergency room use.

Our case managers will send you a report identifying the member's health status and identifying short-and-long term goals for case management.

Our case managers may contact you for other reasons:

- To coordinate a plan of care
- To confirm a diagnosis
- To verify appropriate follow-up such as cholesterol/LDL-C screening or HbA1c testing
- To identify compliance issues
- To discuss other problems and issues that may effect outcomes of care
- To inform you of a member's potential need for behavioral health follow-up

You may refer a member for case management via MCS "Notify CM" or calling the Care Management Department at 1- 888-322-8843

SECTION 5
BILLING & PAYMENT

- Billing and Claims Payment.....
- Coordination of Benefits.....
- Billing Procedure Code Requirements.....
- Explanation of Payments.....
- Grievance & Appeals Process for Denied Claims.....
- Rapid Dispute Resolution Process.....
- Electronic Claims Submission.....

BILLING AND CLAIMS PAYMENTS

Claims Billing Requirements

- The standard CMS 1500 Claim Form or UB 92 Claim Form is required for HPM billing.
- Specialty physician claims should include a referral form or prior-authorization number(s) for payment.
- Providers must use industry standard HCPCS, CPT, Revenue, and ICD-9 codes when billing HPM.

Claims Mailing Requirements

Submit all initial claims for payment to:

**Health Plan of Michigan, Inc.
777 Woodward Ave.
Suite 600
Detroit, MI 48226
Attn: Claims Department**

If you are re-submitting a claim for a status or a correction, please indicate *STATUS* or *CLAIMS CORRECTION* on the claim.

COORDINATION OF BENEFITS (COB)

It is important to remember that HPM is a Medicaid plan and is always the **final payer**. HPM is responsible only for the difference between what the primary insurance pays, and the allowable Medicaid fee screen. Please submit claims that have other insurance payers to HPM with an attached EOB payment or rejection.

BILLING PROCEDURE CODE REQUIREMENTS

HPM requires that providers use HCPCS, CPT, ICD-9, and revenue codes when billing HPM.

EXPLANATION OF PAYMENTS (EOP)

HPM sends its providers Remittance Vouchers as a method of explanation of benefits.

GRIEVANCE & APPEALS PROCESS FOR DENIED CLAIMS

Health Plan of Michigan offers a post-service claim appeal process for disputes related to denial of payment for services rendered to HPM members. This process is available to all providers, regardless of whether they are in or out of network.

What Types of Issues Can Providers Appeal?

The appeals process is in place for two main types of issues:

1. The provider disagrees with a determination made by HPM, such as combining two stays as a 15-day readmission. In this case, the provider should send additional information (such as medical records) that support the provider's position.
2. The provider is requesting an exception to an HPM policy, such as prior authorization requirements. In this case, the provider must give an explanation of the circumstances and why the provider feels an exception is warranted in that specific case.

Health Plan of Michigan's physician reviewer is available for a discussion with the treating physician or your physician reviewer prior to a post-service appeal decision. The physician may call for a peer to-peer discussion by calling 888-322-8843, ext 1311. If a specific time frame for the call is desired, a facility representative acting on behalf of the physician may call to schedule a peer-to-peer discussion.

A provider's lack of knowledge of a member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to member ineligible on the date of service or non-covered benefits.

How to File a Post-Service Claim Appeal

1. Please send a letter explaining the nature of your appeal and any special circumstances that you would like HPM to consider.
2. Attach a copy of the claim and documentation to support your position, such as medical records.
3. Send the appeal to the following address:

Health Plan of Michigan
Attention: Claims Appeals Department
777 Woodward Ave.
Suite 600
Detroit, MI 48226

Time Frame for Filing a Post Service Appeal

Appeals must be filed within one year from the date of service. HPM will allow an additional 120-day grace period from the date of the last claim denial, provided that the claim was submitted within one year of the date of service. Appeals submitted after the time frame has expired will not be reviewed.

Response to Post Service Claims Appeals

Health Plan of Michigan typically responds to a post-service claim appeal within 30 days from the date of receipt. If additional information is needed, such as medical records, then HPM will respond within 30 days of receiving the necessary information. Providers will receive a letter with HPM's decision and rationale.

There is only one level of appeal available within Health Plan of Michigan. All appeal determinations are final. If a provider disagrees with HPM's determination regarding an appeal, the in or out-of-network provider may pursue one of the following options:

- Binding Arbitration
 - A provider may initiate arbitration by making a written demand for arbitration to HPM. The Provider and HPM agree to mutually select an arbitrator and the process for resolution.
- DCH Rapid Dispute Resolution (Only applies to Out of Network Hospitals that have signed an Access Agreement through the State of Michigan)

If you have any questions about the post-service claim appeal process, please call HPM Provider Services at 1-888-773-2647 for more information.

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 basis before pursuing the *RAPID DISPUTE RESOLUTION PROCESS (RDRP)* including the use of an Accounts Receivable Reconciliation Group (ARRG).
2. Where a disputed claim remains either the Hospital or the Health Plan may submit a request to DCH for RDRP. Upon receipt of a request, DCH will contact the other party to obtain that party's agreement to pursue resolution of the disputed claim in this manner.
3. The DCH will contact a mediator, selecting one at random from the list of available mediators that it has prepared. The Mediator will schedule the mediation session within fifteen (15) calendar days of contact by DCH. The Mediator will issue his/her decision within fifteen (15) calendar days of the mediation session.
4. Hospitals and Health Plan agree that, should this process be elected/agreed to by both parties, the outcome, including any monetary award will be binding. Both parties agree to assume the burden of costs for presentation of their positions before the mediator. The cost of the mediation will be borne proportionally.

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

ELECTRONIC CLAIMS SUBMISSION

Health Plan of Michigan is currently accepting electronic claims from the following clearinghouses:

Netwerkes.com

EDI Support/Customer Service: 1-262-523-3600

Per Se'

EDI Support: 1-877-737-3773

Blue Cross Blue Shield of Michigan

EDI Support: (248) 486-2292

NDC

EDI Support: 1-800-942-3022

WebMD (Emdeon)

EDI Support: 1-800-845-6592

SECTION 6
SPECIAL PROGRAMS

- Special Programs.....

SPECIAL PROGRAMS

Health Plan of Michigan offers four special programs to members and providers:

The **Diabetes Self-Management Program** has a member component that includes a series of educational materials that are mailed to the member monthly for 12 months. The materials teach members about basic exams, tests and services they should receive annually, things to ask their doctors, and things they can do for themselves that will reduce diabetes-related health problems.

There is also a physician-education component to the **Diabetes Self-Management Program**. Continuing Medical Education credits will be offered to network practitioners for attendance at presentations. Your Provider Services representative will notify you when a Diabetes Education Program is scheduled in your area.

HPM is offering a similar program to members with Asthma. The **Asthma Focus Program** is a concentrated effort to improve the quality of life of the child, adolescent or adult with persistent asthma through education to self-care and appropriate medication administration and compliance.

Like the diabetes program, physician education is an integral component to the **Asthma Focus Program**. You will be invited to attend similar presentations in your area as they are scheduled.

Case Management of all high-risk members is an ongoing program at HPM. We are proactive in identification of members whose healthcare needs require intense monitoring, education and intervention for effectively reducing the complications of chronic diseases.

Women's and Children's Services provide intervention from the moment we become aware that the member is pregnant. The staff will assist the member in finding an OB/GYN provider, assisting with appointments, providing educational materials on numerous pregnancy related topics and also assist with transportation, if necessary. We follow them throughout the course of their pregnancy and provide support and assistance as needed to ensure the member follows through with their postpartum visit and incorporate educational materials to assist the member in experiencing a healthy and exciting time with their new baby. We include information to the new mother regarding well child visits to ensure that prevention and healthy habits are initiated.

Some of the materials provided include lead and pregnancy, smoking and pregnancy, breastfeeding, postpartum depression, nutritional information, Keeping Your Child Safe from Lead, Smoking around Children, information on SIDS and safe sleeping for babies, and many other topics.

HPM hopes that you, the Primary Care Physician, will support these programs and encourage your members to take advantage of this service. You can refer a member to any one of these special programs by calling Member Services at 1-888-437-0606.

SECTION 7
QUALITY IMPROVEMENT PROGRAM

- Mission
- History
- Structure.....
- Scope
- Objectives
- Program Description
- Confidentiality.....

Health Plan of Michigan 2009 Quality Improvement Program

Sections

- Mission
- History
- Structure
- Scope
- Objectives
- Program Description
- Confidentiality

MISSION

The Health Plan of Michigan (HPM) Quality Improvement Program (QIP) is designed to ensure HPM members receive high quality, medically appropriate and cost effective health care. It objectively and systematically monitors and evaluates the quality, appropriateness and outcome of care and services and the processes by which they are delivered and provides the framework to pursue opportunities for improvement and problem resolution.

The Quality Management (QM) department provides leadership and engages in the necessary activities to ensure continuous improvement in the areas of clinical care, safety and member services. Specifically the department:

- Develops, implements and evaluates improvement initiatives for:
 - Evidenced-based clinical quality (including behavioral health),
 - Patient safety
 - Practitioner availability, accessibility and satisfaction, and
 - Enrollee satisfaction
- Promotes enrollee wellness and safety through preventive health promotion and population/individual disease case management
- Supports provider practice improvement through education and the promotion of nationally accepted standards of care.
- Participates in Michigan Association of Health Plan (MAHP) quality improvement related activities.
- Continually seeks new opportunities for HPM improvements in the quality of care and services delivered to members.
- Collaborates with other HPM departments to achieve administrative and service quality improvements, ensure appropriate utilization of services and enhance continuity of care.

This program defines the methods incorporated by HPM to identify, research and review problems, take appropriate actions to improve quality of care and services and to provide follow-up evaluation.

HISTORY

The Quality Improvement Program has been an integral part of HPM since it began to operate as a full service health maintenance organization in February of 2000. As HPM has continued to expand and grow so has the QIP. From inception, HPM set high goals for performance. With the vision of accreditation, the QIP was designed to meet or exceed regulatory requirements including the submission of HEDIS data every year since inception. HPM achieved accreditation by the National Committee for Quality Assurance (NCQA) as a New Health Plan in March of 2002 and successfully achieved Full Accreditation from NCQA in 2005. HPM has maintained “Excellent” status since August 2005 with the most recent full accreditation in March 2008. The “Excellent” status was again achieved.

STRUCTURE

The organizational structure of the QIP is outlined below:

I. Board of Directors

The Health Plan of Michigan Board of Directors (BOD) is the governing body for Health Plan of Michigan. The BOD reviews, approves annually, and provides oversight to the Quality Improvement Program.

The BOD has delegated ongoing responsibility for the development, implementation and evaluation of the QIP to the HPM Medical Director. The HPM Medical Director chairs the Health Plan of Michigan Quality Improvement Committee and sub-committees.

The HPM Quality Improvement Committee (QIC) is a staff committee that serves both as an action body and as a coordinating committee where other committees are the action bodies.

The Health Plan of Michigan Board of Directors receives quarterly written reports from the HPM Quality Improvement Committee (QIC) delineating outcomes of current QI activities derived from monitoring and evaluation activities, improvement opportunities identified and the status of quality initiatives in the planning or implementation stage. The BOD annually reviews the Quality Improvement Work Plan and the QIP Evaluation.

The BOD meets quarterly.

II. Leadership

A. Chief Executive Officer (CEO)

The CEO reports directly to the Board of Directors on all aspects of the QIP including the impact on organizational goals and objectives, enrollee health and the quality of care and services delivered. The BOD makes recommendations and ensures that the necessary resources are available to maintain and/or enhance the Quality Improvement Program. The CEO communicates recommendations from the BOD directly to the Medical Director and QIC for review and appropriate implementation. The CEO provides executive leadership to the Medical Director through scheduled planning meetings and day-to-day operational encounters.

B. Chief Medical Officer/Medical Director

The Chief Medical Officer/Medical Director has organizational responsibility for the QI Program, is the designated physician with substantial involvement in the implementation of the HPM QIP and serves as the chairperson of the QIC. The Medical Director oversees program planning, development, implementation, monitoring and evaluation activities and communicates recommendations to the CEO for adequate staffing and resources to support the QIP. The Medical Director appoints Subcommittees and Task Forces as needed to address elements of the QIP that affect or are affected by other HPM Departments. The Medical Director serves as a chairperson of these Subcommittees and Taskforces. The Medical Director reports to the Chief Executive Officer.

C. Director of Quality Management

The Director of Quality Management provides leadership for the areas of Quality and Disease Management. The Director is designated and acts with the authority of the Medical Director in overseeing the planning, implementation, integration, monitoring and evaluation of all QIP activities. The Director reports to the Medical Director.

D. Manager of Quality Management

The Manager of Quality Management collaborates with the Director of Quality Management and the Medical Director in the planning and development of the QIP and related activities. The manager is then responsible for collaborating with the Medical Director, the QIC and plan management staff in implementing the QIP. The Manager monitors and analyzes internal and external data trends and patterns that affect the quality of care and service delivery and prepares quarterly and annual reports and recommendations for the QIC.

E. Chief Privacy Officer

The Chief Privacy Officer oversees all activities related to the development, implementation, maintenance of and adherence to all policies and procedures related to the privacy of, and access to, protected patient health information. The Privacy Officer attends the QIC as a member of the committee.

F. Corporate Compliance Officer/Fraud, Waste and Abuse

The Fraud, Waste and Abuse Compliance Officer oversees activities related to the development, maintenance of and adherence to all policies and procedures related to fraud, waste and abuse. The Compliance Officer reports directly to the CEO.

III. Quality Improvement Committee

Role:

The QI Committee is a working committee as well as one that performs a coordinating function where other Committees and Subcommittees are the action bodies.

Function:

The QI Committee:

- Reviews and approves all QI Policies and Procedures
- Reviews quality improvement activities and outcomes
- Recommends actions based on the evaluation of QI activities
- Monitors follow up as appropriate

- Reviews and approves the Annual QI Program Description, QI Program Evaluation and QI Work Plan
- Reviews and approves customer satisfaction initiatives and makes recommendation based on outcome evaluations.
- Review and makes recommendations on customer service issues
- Reviews and approves Member and Provider Satisfaction Surveys and makes recommendations based on the evaluation of those surveys.
- Reviews the results of HPM, State and National Surveys/Audits and makes recommendations
- Review and approves privacy and confidentiality processes and practices
- Reviews Complaints and Appeals reports and makes recommendations
- Reviews Continuous Monitor reports and makes recommendations

Meetings:

The QIC meets at least quarterly.

Board Oversight:

The Oversight Committee (OC) is a subcommittee of the Board of Directors and is comprised of organizational administrators external to the QIC. Prior to each board meeting, the OC reviews all quarterly QIC reports, materials and minutes and any applicable annual reports. The CEO presents a summary of the QI activities to the Board and the OC is present to provide further clarification, as necessary, on individual issues. The Oversight Committee is comprised of the Executive Vice President/Chief Information Officer (Board Member) and the Chief Financial Officer (Administration).

IV. The QIC Subcommittees

The following committees are all working subcommittees that report directly to the QIC.

Credentialing Committee

Role:

The Credentialing Committee (CC) ensures that the HPM provider network is comprised of providers and practitioners that deliver quality health care in a safe and sanitary environment, using medical record practices that are consistent with the critical elements set forth in the NCQA standards for medical records. The committee is comprised of permanent and ad hoc members, who are physicians within the network and /or of varying specialties capable of effectively advising on clinical issues.

Function:

The Credentialing Committee:

- Reviews and recommends the approval, pend or denial of applicants for inclusion in the HPM provider network.
- Reviews reports on quality of care or services issues relevant to an individual provider or practitioner and recommends remedial action, as necessary.
- Reviews the re-credentialing materials all Practitioners and Health Delivery Organizations at least every three (3) years, recommending continuation or severing

of the contractual relationship between HPM and the individual practitioner or provider.

- Reviews performance indicators of Primary Care Physicians, every three years as part of the re-credentialing process.
- Oversees HPM delegated credentialing activities (includes Behavioral Health Specialists through CompCare).

Meetings:

The CC meets at least quarterly at a date and time to be determined.

Pharmacy and Therapeutics Committee

Role:

The P&T Committee monitors the pharmacy utilization process and makes recommendations for improving the process in terms of quality of care, cost containment, and member and provider satisfaction. The committee is comprised of:

- HPM Physicians, Administration and Pharmacy
- RxAmerica Pharmacy
- HPM Network Physicians and Pharmacy

Function:

The P&T Committee analyzes statistical reports relative to pharmacy utilization both plan-wide and practitioner-specific.

- It monitors for over and under utilization
- It maintains a formulary consistent with the MPPL Guidelines.
- It makes recommendations, as indicated, to the QI Committee for improving the pharmacy management process.

Meetings:

The P&T Committee meets quarterly

Utilization Management Committee

Role:

The UM Committee continually monitors and takes the necessary actions to improve the UM process in terms of quality of care, cost containment, and member and provider satisfaction.

Function:

The UM Committee prepares and analyzes statistical utilization reports both plan-wide and practitioner-specific. It monitors for:

- Over and under utilization,
- Compliance with timeliness standards for appeals of adverse determinations,
- Denial overturn rates,
- Satisfaction with the UM process

The Committee makes recommendations to the QI Committee for improving the UM process based on the evaluation of monitoring activities.

Meetings: The UMC meets quarterly

Physician Advisory Committee

Role:

The PAC works to promote quality health care through compliance with standards set forth by HPM, the Department of Community Health and NCQA. The committee is comprised of permanent and ad hoc members, who are physicians within the network and/or of varying specialties, including behavioral health.

Function:

Reviews/approves and/or makes recommendations on issues of clinical importance:

- Clinical Practice Guidelines
- Preventive Healthcare Guidelines
- Criteria used in UM decision-making
- Peer Review activities
- Quality of Care issues
- Complaints and Appeals relative to individual providers
- Audit results relative to clinical issues

Meetings:

The PAC meets on an as-needed basis and the meetings are held in conjunction with the Credentialing Committee meeting.

Privacy and Security Committee

Role:

The Privacy and Security Committee oversees organizational compliance with the HIPAA Privacy Rule and the regulations that took effect on April 14, 2003, as well as the HIPAA Security Rule and the regulations that took effect on April 20, 2005.

Function:

The Privacy and Security Committee members are the organizational experts on the HIPAA Privacy and Security regulations. The Committee supports the Chief Privacy and Security Officer in the development, implementation and monitoring of those HPM policies and procedures that demonstrate compliance with HIPAA Privacy and Security Rules and MDCH regulations with respect to Privacy, Confidentiality and Security.

Meetings:

The Privacy and Security Committee meets at least quarterly but more frequently as needed to maintain organizational compliance.

Fraud, Waste and Abuse Compliance Committee (FACC):

Role:

The FACC assures the proper functioning of HPM operations for the detection and elimination of fraud, waste and abuse through data collection, analysis and recommendations for monitoring and detection. The Compliance Committee is composed of representatives from each of the operating departments.

Function:

The FACC:

- Reviews internal reports and audits to determine areas at risk for fraud, waste and abuse
- Provides data analysis and assessment to support fraud, waste and abuse investigations
- Recommends additional/alternative methodologies for monitoring/detecting fraud, waste and abuse
- Reports findings/suggestions to senior management and the HPM Quality Improvement Committee

Meeting:

The FACC meets quarterly or more often as needed to maintain compliance.

Grievance Committee

Role:

HPM's Grievance Committee is a body designated by the Board to review HPM's Level 2 internal grievances/appeals in a timely manner.

Function:

The Grievance Committee is responsible for the review of HPM's Level 2 internal grievances/appeals and is composed of the following:

- Chief Operating Officer
- Chief Medical Officer/Medical Director
- Director, Member Services
- Manager, Member Services
- Director, Care Management
- CM Grievance Coordinator

In addition to the regular membership, a physician reviewer who practices within the specialty area that is the subject of the grievance/appeal may join the Committee on an ad-hoc basis, as required by the Level 2 grievance/appeal process.

Meeting:

The Grievance Committee meets on an as-needed basis and is scheduled by the CM Grievance Coordinator as soon as possible and within no more than seven business days after request for a Level 2 grievance/appeal. A summary of the grievances/appeals reviewed by this Committee is presented to the QIC.

QIC Complaint Subcommittee

Role:

The complaint subcommittee is comprised of four members of the QIC. The committee meets prior to QIC quarterly meetings to review all member complaints. Based on analysis of the complaints and any subsequent investigation, the committee determines if further action is needed and prepares recommendations for the QIC.

QIC Policy and Procedure Subcommittee

Role:

The policy and procedure subcommittee is comprised of three members of the QIC. The committee reviews all policies and procedures to be presented at the next scheduled QIC meeting and makes recommendations to the QIC for approval or changes.

V. Quality Management Department

The Quality Management Department is responsible for planning, developing, implementing, supporting and evaluating the QIP and QI work plan. QM coordinates, performs and evaluates quality assessment, measurement and improvement activities. QM, including Disease Management, coordinates and supports QI activities throughout the HPM network. This may include but is not restricted to partnering with Member Services, Claims, Provider Services, Care Management and/or the Credentialing departments.

QM collaborates with Information Systems (IS) to develop data sources for measurement and evaluation of QI activities and HEDIS. QM is responsible for quality related collaborative initiatives and activities with MAHP and other community-based groups. Progress on collaborative activities is reported to the QIC on a regular basis for feedback and direction.

VI. Delegation

As of January 1, 2009, HPM delegated quality activities as they relate to Behavioral Health services for enrollees of HPM to CompCare, an NCQA accredited MBHO.

SCOPE

HPM is committed to continuous quality improvement in clinical care and service. HPM provides its physician community with evidence-based clinical guidelines and service standards. The QI Program is designed to encourage active, participating enrollees and support proactive practitioner practices. The QIP assesses, evaluates and acts on findings to continually improve the safety and quality of medical and behavioral health care and the quality of service provided at all sites and levels of care.

Specific clinical quality initiatives within the QIP and annual work plan are listed below:

- I. Quality Improvement:** Quality improvement programs include clinical and behavioral health (see delegated quality for behavioral health) quality improvement initiatives identified through analysis of HEDIS, EQR, CAHPS, internal data audits. These initiatives include but are not limited to: claims, enrollment, utilization, complaints, denials, appeals and historical data. The programs include practitioner and member education, provider profiling, targeted and general member reminders, and guideline implementation activities. Quality Initiatives are also often mandated by the State.

A. State Initiatives:

The External Quality Review (EQR) Performance Improvement Project for 2008 is “Improving the Rates of Cervical Cancer Screening and Reducing Disparities Among the African American Population.” The initial Quality Improvement Activity (QIA) was submitted January 5, 2008 with the second submitted in January 2009. Health Services Advisory Group (HSAG) is continuing the State contract for EQR and will be again conducting this section of the contract. Medicaid Health Plan Quality Improvement Initiatives implemented in 2005 and are continuing in 2008 are:

1. Blood lead testing
2. Access to Care (Adult, Adolescent, or Child), (addressed through the Outreach Program)
3. Behavioral Health Coordination of Care (addressed through continued involvement in CMH collaboration with various regions throughout the year). (All plans)

Additional Managed Care QI initiatives are as follows:

1. Disparity in Breast Cancer or Cervical Cancer Screening (PIP submitted to HSAG)
2. 2008 HEDIS data aggregation for Breast/Cervical Screening (Wayne County Plans)
3. HPM is continuing to participate in the Berrien County Project Breast/Cervical Screening Disparity project (was initiated with two other plans late 2007 within Berrien County Community Choice, Great Lakes Health Plan and HPM). A second grant was approved for Berrien County to continue this disparity project and HPM is continuing to provide all data and assistance needed.
4. Reducing Disparity at the Practice Site (begun in Oct. 2008)
5. Behavioral Health Coordination of Care: Participating in the PQIP 5 program in 2008 and continuing in 2009.
6. Assuring Better Child Development (ABCD Developmental Screening)-Three year plan written for submission.
7. Asthma Initiative (Genesee County plans)
8. Maternal Infant Health Program (MIHP)
9. Incorporation of Healthy Lifestyle Screening information into MCS for utilization purposes
10. HIT/HIE –initiation of educating providers and engagement for provider usage.

Three corrective action plans have been written relative to Well Child Visits 0-15 months (six visits), Well Child Visits 3-6 years and Lead screening due to HPM falling below the expected rate per MDCH. (Attached to QIP and in work plan).

Health Plan of Michigan wrote a descriptive summary of member incentive programs that address the following behaviors as part of the MDCH legislative mandate. HPM has updated and continued these incentive programs in the following areas:

- Health Risk Assessments (HRAs)
- Compliance with medical treatment
- Keeping appointments
- Smoking cessation
- Exercise
- Prenatal Visits
- Immunizations

B. Utilization of Enrollee Level Historical Data from DCH.

Historical data received from the State is entered into the MCS system and utilized in the following manner:

- New enrollees to HPM are identified and stratified into Disease Management programs within 30 days of enrollment.
- Enrollees with high ER encounters are added to the ER program
- High or poly pharmacy encounters are added to the Pharmacy program for potential pharmacy lock or other programs
- Case management, care management and quality management utilize data in planning clinical based initiatives.
- Primary Care Physicians are able to access data for assistance in planning and coordinating patient care activities.
- The Claims Department utilizes data for fraud, waste and abuse monitoring and coordination of payment.

C. Enrollee Outreach Program.

HPM achieved increased contact rates utilizing the auto dialer Touchstar calling system for enrollee. A dedicated Touchstar team initiated in 2007 continues to expand with campaigns specifically designed to reach a targeted group in a short period of time. HPM has added Televox campaigns to our Touchstar outreach in 2009 with the goal of increasing our preventive care outreach.

HPM utilizes three levels of member outreach. Case, Disease and Regional Management strategies are incorporated into enrollee contact programs.

1. Case management is the individually designed clinical support program to maximize continuity of care for enrollees with single or complex clinical issues. This program has four levels of care and is the most intensive enrollee contact program at HPM. The program is designed to be case specific and include a broad spectrum of contact activities directed at the enrollee, their PCP and others involved in the management of care. Contacts are designed to maximize enrollee quality and utilization of care. The program was expanded to incorporate a full case assessment by a Certified Case Manager to better determine the specific level of intervention needed. A Complex Case Management program initiated at the end of 2006 became fully operational in 2008. The overall Case Management program was re-engineered at the end of 2008 with the newly designed processes fully in place January 2009.
2. Disease management is comprised of a group of programs designed to target the chronic conditions of Diabetes, Asthma, Weight Management and Cardiovascular Disease (CVD) for enrollees who meet specific criteria. These programs have four levels of care and incorporate defined enrollee contact. Contact includes HRA completion, follow-up calls, education, newsletters, and support groups for enrollees. The programs also include education and support services for PCPs and other service providers. These services promote optimum utilization of resources and are designed to manage the progress of the identified condition. Scheduled contact with the enrollee is governed by the stratification level.
3. Regional management is a broad spectrum program that targets all HPM enrollees. This program has one level and enrollee contact is specific to defined campaigns or directed by identified enrollee issues. All member contact (not specifically related to Case or Disease management) is captured in regional management. Contacts include but are not limited to: Member Handbooks, Newsletters, Enrollee notices, scheduled calls (HEDIS, Welcome, Health Promotion, Inpatient Discharge), and Incoming calls (Questions, Grievances, etc).

The CAHPS vendor was utilized for 2007 and 2008 was again retained for 2009. Some of the CAHPS rates decreased in 2008 and new initiatives are already in place to ensure the highest level of customer satisfaction. New customer phone queues have been initiated to allow more departments the ability to immediately respond to customer issues, problems, questions or other needed assistance. Rather than having members be placed in voice mail or be transferred from one staff to another, the departmental queues provide immediate response with a live person. HPM is also conducting quarterly Patient Experience Surveys by mail and/or phone to further assess member satisfaction levels.

- II. **Disease Management (DM):** HPM has adopted a disease and population care model that aggressively pursues and engages all enrollees with chronic conditions through our outreach program (see above).

Chronic conditions identified for disease management have stratification levels and contact standards for each level. Prevalence analysis is utilized to identify any need for additional program development. No disease management programs have been discontinued at HPM. Two additional programs will be added in 2009 (CHF and COPD) to complement the existing DM programs.

DM is an opt-out program for identified enrollees. If an enrollee chooses to opt out, HPM will review the enrollee's known severity and move the member to either case or regional management.

Disease management programs are established for Diabetes and Asthma. HPM's implementation of the electronic HRA and deployment of HRA Outreach to the Diabetes, Asthma and Aging, Blind and Disabled (ABAD) populations significantly improved contact percentages and educational opportunities for the two programs. This continued in 2008 with Asthma redesigned based on the revised NHLBI asthma practice guidelines. The Diabetes DM program was also revised in 2008 based on recent HEDIS changes to promote better control of this condition.

Expansion of the Cardiovascular Disease (CVD) program in 2007 includes moving the population into the DM outreach campaigns as well as implementing enrollee and provider educational support will continue in 2009. The program will also be revised based on recent HEDIS changes related to hypercholesterolemia and the monitoring of statins.

HPM will continue the weight management programs of Medical Weight Loss Clinics, Healthy Roads, Mercy General Health Partners Heart Center initiated in 2007. No prevalence is utilized for this referral only program.

The DM Compliance program has been transferred to the Member Services department.

The High Risk Prenatal Screening Program initiated in 2008 is continuing this year. A High Risk Nurse has been added to assist with the management and coordination of high risk moms. Continuing efforts and additional staff are devoted to increasing the numbers of women who follow up with timely prenatal care and the postpartum exam within HEDIS and practitioner guidelines

- III. **Health Promotion:** Health promotion is the essence of HPM's outreach focus. HPM defines HEDIS Work as any preventive program necessary to promote excellent health and safety. HEDIS work has always been a major priority at Health Plan of Michigan (HPM). In the

past few years, every department has been challenged to identify specific initiatives to support the improvement of HEDIS rates. HPM developed HEDIS employee incentives to encourage and reward employee involvement and contributions. HPM has been very successful in these ventures and HEDIS rates demonstrated annual improvements. Historically, HPM utilized a HEDIS Committee (a sub-committee of the QIC) to identify, authorize, initiate and direct initiatives and efforts engaging all aspects of the company. It was through this committee that the Outreach Program was initiated in 2006.

HPM has made steady progress in improving HEDIS rates since 2000. Rates in most categories are now reaching levels that are demonstrating generalized initiative saturation. In order to continue to see growth it is necessary to further concentrate the direction of HEDIS efforts.

A new strategy for managing HEDIS was proposed in January 2008 and implemented in April 2008. This new HEDIS team is a high level working group. It was initially intended to meet quarterly to discuss progress and ideas and then more often during HEDIS season but has resulted in a biweekly meeting. The new team is comprised of members who have the ability and knowledge to make and implement changes. The members are able to analyze data and have a substantial understanding of HEDIS measures. The team has developed a HEDIS work plan which is updated at each meeting. This work plan identifies target dates, such as the HEDIS Roadmap deadline, audit dates, abstraction milestones, and other key targets. It also lists the progress of newly developed and ongoing interventions.

When action is needed, the team reaches out to coordinate efforts with an Ad Hoc group consisting of representatives from Care Management, Medical Management, Administration, Claims, Provider Services, Pharmacy, Finance and Information Services. This team can also respond to suggestions or new initiatives from these departments. Specifically, the HEDIS team is responsible for coordinating, designing, and implementing all HEDIS interventions. Tracking every task detail in one data source keeps the team organized. Additionally, this data source helps to identify outcomes for analysis.

A DCH sponsored statewide collaborative to stop smoking has been in place for a number of years. In 2006, DCH re-directed the stop smoking Quit Line to the American Cancer Association (ACA) program. The contract signed with ACA in 2006 continues in 2009 as the Tobacco Cessation Program.

IV. **Member Safety Promotion:** HPM encourages and supports practitioners in creating a safe practice environment. HPM demonstrates this support through:

- The development and implementation of clinical practice guidelines based on national standards or Michigan Association of Health Plans (MAHP) collaborations.
- Provider and member newsletters that convey new, revised, and/or updated initiatives and provide safety related information.
- The development and delivery of effective and on-going fraud, waste and abuse education and training for employees, enrollees and providers through various methods (i.e. member and provider websites, newsletters, member handbook, provider manual, HPM Network Development Specialist visits with providers and on-site training for all employees).
- The inclusion of provider office safety evaluations in the annual site visits for Quality.

A safety action plan continues in 2009 to ensure safety measures are assessed and incorporated in day to day operations.

Health Plan Safety Plan 2009

Objective	Strategies	Measurement	Responsible Department
PRACTITIONERS			
Support physician efforts by establishing standards and expectations for improvements in patient/enrollee safety	HPM formulary available on ePocrates with direct link updates to match website formulary	P&T Minutes for updates and usage reports	Pharmacy
	ePocrates usage monitoring		
	Encourage use of MCS capabilities for enrollee: Eligibility Service requests Prescriptions and services compliance history HRA results HEDIS preventive needs	Annual Practitioner Survey results on questions on use of MCS	PS
	Score, and analyze office safety practices on audit site visits as well as Safety Complaint site visits	QM Coordination of Care Initiative Med/Med	QM
		Tract both site visit and safety scores.	QM
Report results of safety initiatives to enrollees and practitioners	Collect and report patient perception of “medical mistakes” and harm	Monitor and report Quality of Care complaints to PAC.	QM MS PS
MEMBERS			
Educate enrollees to perform their appropriate role regarding safety	Include Safety articles in Member Newsletters, handbook and flyers when at all possible,		MS
	Design health plan products and website that encourage enrollees to self educate. <ul style="list-style-type: none"> • Information link on the HPM website regarding safety, (www.safemedicine.com) 	Website re-design	HPM
	Additional Safety and Risk Factor questions added to HRA.	Monitor viability of link	QM/DM
Provide educational support and		Report number of follow up educational support mailings for safety	QM

	feedback for enrollees engaged in preventive care and safety through participation in the HRA program	and risk factor answers to HRA.	
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Incorporated into the Quality Improvement Program is a strong emphasis on patient safety. The program ensures that individual practice sites have implemented appropriate safety practices before being considered for participation in the HPM Network. HPM also demonstrates a strong commitment to legal and ethical conduct through the prevention, detection and reporting of fraud, waste and abuse activities. Other safety related program components include:

- Information distributed to enrollees designed to improve their knowledge with respect to clinical safety in their own care, i.e. questions to ask surgeons prior to surgery.
- AskMe3 questions have been added to every member ID card that is sent.
- Collaborative activities with network practitioners targeting safe practices, i.e. improving medical record legibility.
- Analysis and actions on complaint and satisfaction data related to clinical safety.
- Mechanisms for pharmaceutical oversight that safeguard patient safety.
- Involvement by HPM's CEO in supporting and promoting the Leap Frog program and encouraging the participation of network providers.
- Written policies and procedures that identify specific areas of risk for fraud, waste and abuse.
- The designation of a Compliance Officer and Fraud, Waste and Abuse Compliance Committee to ensure the optimum functioning of HPM operations for the detection and elimination of fraud, waste and abuse.
- Comprehensive and on-going fraud, waste and abuse education and training programs to all Health Plan of Michigan employees, enrollees and providers.
- The development, implementation, review and evaluation of internal and external audits and other risk management tools intended to monitor compliance and assist in the identification of problem areas.

V. Monitoring and Audit Activities: HPM is responsible for evaluating the effectiveness of its services and initiatives. Monitoring and audit programs include:

- continuity of care
- access to care
- re-credentialing
- medical record
- member complaints for both clinical and behavioral health
- utilization review

Continuous reinforcement of privacy principles is maintained through mandatory education of employees and privacy monitoring. HPM has established a comprehensive Fraud, Waste and Abuse compliance program. This program provides a mechanism for the formulation of effective internal and external audits and other risk evaluation techniques to monitor compliance and assist in the identification of problem areas. Focus Record Reviews continue in 2009 in response to Fraud, Waste and Abuse Committee recommendations. The Focus Record Review is a method for determining the accuracy of claims submitted as compared to the level of service documented in the medical record. The focus record review substantiates services billed, reviews variances in utilization, identifies potential fraud, waste and abuse,

uncovers barriers to accurate billing of visit codes and objectively identifies opportunities for improvement.

VI. NCQA and State of Michigan Accreditation and Regulation: Accreditation and regulatory maintenance requirements include:

- meeting MDCH contractual requirements for performance
- preparation and submission of the HEDIS Roadmap (formerly known as the BAT)
- State Site Visit tools
- HEDIS data
- CAHPS database
- EQR data
- data resulting from collaborative initiatives.

OBJECTIVES

I. The objectives of the QIP are:

A. Continual improvement in the quality of care and services delivered to HPM enrollees through:

1. Implementing quality measures that are professionally current and are viewed as reliable and valid methods to detect trends and identify opportunities to improve quality of care and service to enrollees.
2. Assuring that the methods used to measure quality are appropriately related to the plan's population and will not only identify single important clinical and/or behavioral health events in the process or outcome of care or resource utilization, but will apply to the health care system as a whole.
3. Objectively measuring provider performance reflected in data systematically gathered from medical records, enrollee responses and assessments, and other sources and providing pertinent information about individual practitioners and other providers to review and renew credentialed privileges.
4. Using quality improvement methods to identify problems and opportunities for improvement in health services, identifying variance from performance goals and benchmarks, developing and testing improvement and evaluation plans, assuring that the plans are implemented and monitored, evaluating the effectiveness of improvement plans, and regularly re-evaluating quality improvement efforts.
5. Developing data-driven disease and condition management strategies to improve practitioner and member compliance with clinical and/or behavioral health guidelines and standards, thus enhancing enrollees' health.

B. Meeting or exceeding regulatory requirements, purchaser expectations and accreditation standards in the area of quality improvement.

C. Supporting continuous quality improvement through timely communication and reporting to enrollees, providers and employees.

D. Providing a supportive environment where analysis and decision making by health professional peers is fair, objective and in accordance with established standards of the medical community.

E. Promoting staff education

F. Promoting enrollee safety

PROGRAM DESCRIPTION

The QIP is an outcome driven initiative designed to continuously improve member and provider services for HPM and is accomplished through a combination of resources, and activities. QIC responsibilities, the work plan, and the annual program evaluation are essential components to accomplishing the objectives of the QIP.

I. Quality Improvement Committee Member Responsibilities

Member	Responsibilities
Chief Medical Officer/ Medical Director	Organizational responsibility for the QIP, including program implementation, function and results and recommendations for adequate staffing and resources to the Chief Executive Officer. The Chief Medical Officer/Medical Director is the designated physician with substantial involvement for the direction and the implementation of the HPM QI Program and is the chairperson for the QIC and all its subcommittees.
Legal Counsel Compliance Officer/Fraud, Waste and Abuse	Coordination of departments within HPM to ensure compliance with objectives of the QIP in general and as directed by minutes of QIC meetings. As Fraud, Waste and Abuse Compliance Officer, the Legal Counsel ensures compliance with all Federal and State laws and regulations with respect to Fraud, Waste and Abuse. Legal counsel reports directly to the CEO.
Director, Quality Management	Coordination of the QM and Disease Management areas within HPM for compliance with objectives of the QIP in general and as directed by minutes of the QIC meetings
Manager, Quality Management	QIC meeting coordination including: <ul style="list-style-type: none">• Scheduling of meetings• Agenda• Minutes• Oversight of action plans• Review of previous action plans Compliance with: <ul style="list-style-type: none">• Standards for QM and QI• QIP operations• Policies and Procedures for:<ul style="list-style-type: none">• Complaints and appeals• Preventive health services

	<ul style="list-style-type: none"> • Medical records • Continuity and coordination of care • Member satisfaction • Implements the multiple aspects of the disease management and health outreach program including: identification, research, development, implementation, evaluation and reporting of disease management and health outreach initiatives. <p>Maintaining all accreditation and regulatory standards related to quality</p>
NCQA Coordinator	The NCQA coordinator serves as the major resource and project manager related to all NCQA activities and regulatory requirements to ensure adherence with all standards. Reports directly to the Quality Manager.
Vice-President, Provider Services	<p>Compliance with:</p> <ul style="list-style-type: none"> • Health services contracting • Accessibility of services • Availability of practitioners • Credentialing and recredentialing. • Distribution of rights statement to practitioners • Maintaining all accreditation and regulatory standards related to provider services
Director, Member Services	<p>Compliance with:</p> <ul style="list-style-type: none"> • Standards for member rights & responsibilities • Subscriber information <p>Coordination of complaint procedures Maintaining all accreditation and regulatory standards related to member services</p>
Director, Care Management	<p>Compliance with:</p> <ul style="list-style-type: none"> • Standards for UM • Clinical Criteria for UM decisions • Policies for: <ul style="list-style-type: none"> Appropriate professionals Timeliness of UM decisions Clinical information Satisfaction with the UM process UM procedures for pharmaceutical management UM denial notices Appeals Appropriate handling of appeals Inter-rater reliability Evaluation of new technologies Emergency services <p>Maintaining all accreditation and regulatory</p>

	standards related to utilization.
Vice-President, Claims	Contributing insights to claims adjudication that improves QIC decision-making and the integrity of administrative data used for measurement activities.
Director, Pharmacy	Provides overall direction and guidance in the care and coordination for all covered Pharmacy services and maintains all accreditation and regulatory standards related to pharmacy services.
Ad Hoc Membership	PCPs and/or specialists from the HPM network, including behavioral health representation from the MBHO for input and advice regarding clinically specific issues.
Chief Privacy Officer	Compliance with HIPAA requirements for privacy and confidentiality and attends QIC as a member of the committee.

II. Work Plan

In coordination with the QIP, HPM develops an annual work plan based on the QIP objectives. The work plan describes in detail the individual quality improvement activities planned for the year. The work plan is a living document designed to be reviewed, revised, evaluated and updated concurrently throughout the year. The work plan is developed and implemented annually by QM, approved by the QIC and submitted for review to the BOD. It delineates who is responsible and the time frame in which planned activities will be achieved. The work plan for 2009 contains eight goals with associated objectives and very specific timelines and responsibilities. (See 2009 Work Plan)

III. Resources for Quality Improvement

MCS

Health Plan of Michigan is dedicated to the philosophy that each member of the workforce is responsible for quality. Responsibilities specific to each area are outlined below. To support that philosophy, HPM has devoted considerable resources to the development of a Managed Care Information System (MCS) developed in-house and designed to meet the unique needs of a Medicaid Health Plan. MCS houses data from multiple sources including claims, encounters, enrollment records, prior history data, HEDIS, CAHPS, member services, complaints and appeals. Having all of this data housed in one user friendly system significantly contributes to HPM's ability to engage in the level of analysis essential to the identification, development and delivery of quality based initiatives and to make data available in a secure environment to a wide variety of users. PCPs utilize the information available to them through MCS to determine eligibility, initiate referrals, review compliance history, access HRA results and identify preventive service needs.

HPM staff frequently utilize a component built into MCS that actively tracks and reports on the delivery of HEDIS and other health care related services to plan enrollees. Each time a Health Plan of Michigan staff member interacts with an enrollee or interacts with a provider about an enrollee, they check the MCS system and remind the enrollee or provider of any missing services.

Touchstar Auto Dialer

The Touchstar Auto Dialer is a software program that initiates a computer generated targeted member outreach call that once answered is directed to a specific staff member. This system has provided critical support for enrollee contact efforts and enhanced HPM's ability to evaluate quality improvement initiatives and improve HEDIS rates.

Campaigns designed for specific clinical conditions, HEDIS outreach efforts, New Member Welcome Calls, Health Risk Appraisals and Lost Member contact efforts rely on the Touchstar Auto Dialer and the data housed in MCS. These resources afford HPM the opportunity to engage in appropriate and timely member outreach programs at the point of initial enrollment and throughout the member's tenure with HPM. MCS and the Touchstar Auto Dialer have significantly contributed to the delivery of appropriate and timely services to enrollees, to the overall quality improvement efforts of the health plan and to the promotion of HPM's philosophy of teamwork as an essential component of success. As previously mentioned, a specific team dedicated to the Touchstar campaigns is continuing in 2009.

Director of Quality Management

The Director serves as the overall resource expert based on the coordination of all Quality areas within HPM. Provides the direction of the department within HPM for compliance and provides critical input to quality activities.

Manager, Quality Management

Serves as a member of the Quality Improvement Committee and other appropriate committees and provides the Quality Improvement Committee with reports of patterns or trends identified through quality improvement activities. The manager coordinates clinical studies to meet the regulatory requirements and the National Committee for Quality Assurance standards (NCQA) and develops, updates maintains and evaluates the Quality Improvement Plan (QIP), and QI Work plan.

Project Coordinator, Quality Management

Working closely with the Manager of Quality Management and the Quality Management Analyst the Project Coordinator supports the development, implementation, documentation and evaluation of quality improvement initiatives. Assists and supports all quality management functions including QI projects, disease management programs, HEDIS, CAHPS and NCQA Accreditation efforts. The project coordinator is the lead coordinator for the HEDIS workgroup activities.

Quality Management Analyst

Working closely with the Manager of QM, the Quality Analyst supports the data collection and analysis requirements for the quality improvement and disease management programs. This position coordinates all aspects of data management and analytical tactics for the quality and disease management departments including HEDIS data collection and analysis as well as other quality improvement data collection activities.

HPM utilizes IS and Financial analytical capabilities to compile, analyze and interpret data collected from monitoring activities. Data sources utilized for analysis may include but are not limited to: claims, encounter, enrollment, pharmacy, complaint and appeal, contact, utilization, and medical records.

Disease Management Coordinator

The coordinator develops the rationale for identification of potential disease management and health outreach program opportunities as well as the implementation strategies for programs, pilots and initiatives including resources, materials and plans of action. Coordinates health outreach efforts with providers, enrollees and other resources creating quality improvement opportunities while addressing identified population needs.

Regional Teams/Outreach

The regional teams support quality and disease management in the clinical areas. With the continuing Touchstar program, team members participate in outreach activities for HEDIS, discharge follow up calls, prevention outreach activities, Health Risk Appraisal, case management and participation in community programs. Staff is dedicated to specific regions within the state. Providers appreciate having to interact with only a few select team members leading to stronger relationships within the provider network. The teams are composed of UM specialists, Utilization Reviewers, Case Managers, Member Services and Provider Services staff members with a focus on excellent customer service and improved health status.

Special Projects Director

The Special Projects Director position supports special projects and assignments within the organization as determined by management and leadership. The Director also serves as the Privacy Officer for the organization. This position provides assistance to Quality in the form of analysis, review, and recommendations.

Provider Services

Network Development Specialists collaborate on all Quality Improvement initiatives including community based outreach activities. They consistently interact with and support provider efforts to meet HPM Quality and HEDIS expectations.

IV. Behavioral Health

The mental health coverage included in the health plan contract with the Michigan Department of Community Health is a limited benefit, both in terms of scope and duration, and is selective in regard to the types of conditions appropriate for this level of care. In general, the health plan is responsible to provide outpatient mental health care when the beneficiary has mild to moderate psychiatric signs and symptoms with minor or temporary functional limitations or impairments.

Effective January 1, 2009, HPM delegated the management and quality for behavioral health services to a NCQA accredited MBHO, CompCare. Authorization for the twenty outpatient visits per calendar year provided as a Medicaid benefit is completed through the MBHO. Transition to the Community Mental Health Services Program (CMHSP) does occur in the event that treatment, in addition to the 20-visit benefit, is necessary. For those enrollees diagnosed as Severely and Persistently Mentally Ill (SPMI as designated by state criteria) or the member's condition requires the services offered by the CMHSP prior to the exhaustion of the plan's 20-visit benefit, would be referred to the appropriate CMHSP.

HPM enrollees who are in need of substance abuse services access this care through the local Community Mental Health Services Programs. HPM works with the PCPs and the local CMHSP to ensure that the care settings and treatment plans are the most appropriate for the patient.

V. Annual Quality Improvement Program Evaluation

The QIP is evaluated in its entirety on an annual basis. This evaluation is a composite of reports encompassing all aspects of the QIP program. The annual evaluation includes but is not limited to the following reports:

2008 Quality Improvement Program

Member Services

- Grand Analysis Member Satisfaction
- CAHPS results analysis
- Member Newsletters

Provider Services

- Practitioner Grand Analysis
- Individual Provider Survey Results
- Geographical Access Reports

Care Management

- Care Management Executive Summary
- Strategic Plan 2008
- Continuous Monitor Report 2008
- Work Plan 2008
- Case Management Quarter Totals

Quality Management I

- Quality Management Executive Summary
- Physician Office Compliance Results
- After Hours Access Results
- PIP Lead
- Coordination of Care Medical Safety
- Coordination of Care Newborn Hospital to Home
- Continuity and Coordination of Care-Behavioral Health-Preventive Program and Management of Coexisting Medical and Behavioral Issues

Quality Management II

- HPM Diabetes Disease Management Program-2008
- HPM Asthma Disease Management Program-2008
- HPM CVD Disease Management Program-2008
- HPM Weight Management Program-2008
- Disease Management Quarter Totals
- DM Member Newsletters

Quality Management III

- Women's and Children's Services Quarter Totals

HEDIS

- HEDIS 2008 Summary Analysis
- HEDIS Comparative Measures

CONFIDENTIALITY

All members of the BOD and QIC and are required to sign a Workforce Confidentiality Form (WCF) annually. The signed copies are maintained on file by the Finance Department for Health Plan of Michigan. All peer review proceedings are confidential. External members of QIC subcommittees are required to sign a confidentiality agreement annually if they are not covered elsewhere (e.g. Business Associate Agreement). Any revisions to the form require updated signatures.

Approved by: _____ Date: _____
Medical Director

Reviewed and approved by Quality Improvement Committee Date: _____

SECTION 8

PROVIDER FUNCTIONS & RESPONSIBILITIES

- Primary Care / Managed Care Program.....
- 24 Hour PCP Member Responsibility / Accountability.....
- PCP Prior Authorization & Referral Procedures.....
- Corporate Reporting Requirements.....
- Encounter Reporting Requirements.....
- Physician Intent to Discharge Member from Care.....
- Member Waiting Time Surveys.....
- Mental Health / Substance Abuse Referrals.....
- Maternal Support Services / Infant Support Services.....
- Fraud, Waste and Abuse.....
- Provider Credentialing / Recredentialing.....
- Facility Site Reviews.....

PRIMARY CARE / MANAGED CARE PROGRAM

HPM utilizes a *Provider Primary Care (PCP) "Gate Keeper"* system. In this system the PCP is responsible for the comprehensive management of each member's health care. This may include, but not be limited to, ensuring that all medically necessary care is made available and delivered, facilitating the continuity of member health care, promoting and delivering the highest quality health care per HPM standards.

HPM providers are responsible for knowing and complying with all HPM network policies and procedures. Implementation of HPM policies will facilitate the Plan's periodic reporting of HMO data to DCH, the State, and the Federal agencies.

24 HOUR PCP MEMBER RESPONSIBILITY / ACCOUNTABILITY

HPM PCP's have 24-hour a day / seven day a week responsibility and accountability to their HPM member / patients through a legally executed written PCP contract.

Guidelines:

1. PCP's must be available to address member/patient medical needs on a **24-hours/day, seven (7) day** a week basis. The PCP may delegate this responsibility to another HPM physician or provider on a contractual basis for **AFTER-HOURS, HOLIDAY** and **VACATION COVERAGE**.
2. If the PCP site utilizes a different contact phone number for an on-call or after-hours service, the PCP site must provide HPM with the coverage information and the contact phone or beeper number. Please notify the Provider Services Specialist at HPM with any changes in PCP medical care coverage.
3. PCP's may employ other licensed physicians who meet the credentialing requirements of HPM for patient coverage as required and necessary. It is the responsibility of the PCP to notify HPM each time a new physician is added to a PCP's practice to assure that all physician providers are credentialed to HPM standards. PCP's may employ licensed/certified Physician's Assistants (PA) or Registered Nurse Practitioners (RNP) to assist in the care and management of their patient practice. If PAs or RNPs are utilized, the PCP or the designated and credentialed physician must be readily available for consultation via telephone or beeper, within a 15-minute call back time. They must also be able to reach the site where the PA or RNP is within 30 minutes.
4. Non-professional health care staff shall perform their functions under the direction of the licensed PCP, credentialed physician, or other appropriate health care professionals such as a licensed Physician's Assistant (PA) or a Registered Nurse Practitioner (RNP).
5. **REMINDER:** Failure to provide 24-hour medical coverage and/or make the appropriate arrangements for member/patient medical coverage constitutes a **BREACH OF THE HPM PROVIDER CONTRACT, placing the Provider at risk of due consequences.**

PCP PRIOR AUTHORIZATION & REFERRAL PROCEDURES

PCP's are responsible for initiating all necessary medical referrals for their assigned members. Details on the procedures for prior authorizations are located in Section 4 of this manual.

CORPORATE REPORTING REQUIREMENTS

PCP offices must provide the following information to HPM as requested:

- Referral logs documented with all pertinent information..... Weekly or daily if necessary
- Member Encounter Information..... Monthly

Member encounter information should be reported on submitted claims forms (CMS 1500; UB 92) by stamping or clearly designating on the claims form "ENCOUNTER".

Practices will be monitored for accurate and complete encounter reporting. The data that HPM submits to the State of Michigan requires your compliance with this requirement.

Other reporting requirements or data collection may be added, as data collection requirements are dynamic. PCP offices will be notified in writing of any additional reporting requirements.

ENCOUNTER REPORTING REQUIREMENTS

In order to assess the quality of care, determine utilization patterns and access to care for various health care services, qualified health plans are required to submit encounter data containing detail for each patient encounter reflecting all services provided by the providers of the health plan. The State will determine the minimum data elements of the encounter reporting. A format consistent with the formats and coding conventions of the CMS 1500 and UB92 will be used initially. PCPs will submit their encounter data monthly to the HPM, who must then submit it to the DCH via an electronic tape.

PHYSICIAN INTENT TO DISCHARGE MEMBER FROM CARE

PCP's must give reasonable notice to a member of his/her intent to discharge the member from his/her care. HPM considers ***reasonable notice to be at least a 30-day prior written notice***. This notice must be given by certified mail. HPM must also be notified of this process concurrently in writing. Failure to give reasonable notice may result in allegations of patient abandonment against the treating physician. PCP must provide 30 days of emergent care and referrals.

MEMBER WAITING TIME SURVEYS

In order to assure that members have *timely access to patient care and services*, HPM providers are expected to monitor waiting room times on a continual basis. PCP offices will be

surveyed periodically regarding this process. Member waiting room times should be less than 30 minutes.

MENTAL HEALTH / SUBSTANCE ABUSE REFERRALS

HPM members receive their mental health services (in excess of 20 visits annually) and substance abuse services through State-contracted vendors. DCH has contracted with local Community Mental Health (CMH) providers for these services. Members may access these services directly or through provider referrals. These providers will communicate directly with the PCP's with regard to the member's diagnoses, dispositions and other medical needs. PCP's must refer members to CMH and other community providers, as necessary. The member may choose to self-refer to any provider for mental health services for the first 20 visits.

MATERNAL INFANT HEALTH PROGRAM

HPM has coordination agreements with MIHP (Maternal Infant Health Program), service providers within its provider network. MIHP's provide preventive health services of a non-medical nature. Specifically these services are:

- Childbirth / parenting education
- Psychosocial and nutritional related assessments
- Psychosocial and nutritional related counseling
- Transportation

These preventive services are designed to be supportive to the woman / infant in coping with the pregnancy and supportive to the basic prenatal care provider in the care of the woman during the course of her pregnancy and needed services for the infant. These services are not meant to replace medical care or to replace the PCP's or OB/GYN's role. HPM will identify and refer each pregnant member to an MIHP provider to determine if the member qualifies for the MIHP Program.

FRAUD, WASTE AND ABUSE

Health care fraud, waste and abuse affects each and every one of us. It is estimated to account for between three and ten percent of the annual expenditures for healthcare in the U.S. Healthcare fraud is both a state and federal offense. As stated in the HIPAA Act of 1996: (18USC, Ch. 63, Sec. 1347), a dishonest provider or member is subject to fines or imprisonment of not more than 10 years or both.

Health Plan of Michigan asks that our participating providers and members, as our partners, report all cases of Fraud, Waste and Abuse. To help you identify Fraud, Waste and Abuse, the following is a list of definitions and examples:

42 CFR § 455.2 Definitions.

“Abuse” means 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 healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

“**Fraud**” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Examples of Fraud, Waste and Abuse:

- Billing more than once for the same service (double billing).
- Billing for services never performed or medical equipment/supplies never ordered/delivered.
- Performing inappropriate or unnecessary services.
- Providing lower cost or used equipment while billing for higher cost or new equipment.
- A Specialty or Ancillary provider completing an authorization log form or a PCP Authorization for a Primary Care Physician.
- Using someone else’s identity.
- An altered or false pharmacy prescription.

To report possible fraud, waste or abuse cases, please call the HPM Chief Operating Officer at (313) 324-3700 or 1-888-773-2647. Providers may also report potential Fraud, Waste and Abuse to HPM anonymously at the following address:

Health Plan of Michigan
777 Woodward Ave.
Suite 600
Detroit, MI 48226

Providers may also choose to report anonymously to the State of Michigan Program Investigation as follows:

Program Investigation Section
Capitol Commons Center Building
400 S. Pine Street, 6th Floor
Lansing, MI 48909
1-866-428-0005
www.michigan.gov/mdch

PROVIDER CREDENTIALING / RE-CREDENTIALING

The provider credentialing and re-credentialing processes require that all providers keep the HPM credentialing coordinator updated with changes in credentials. In conjunction with this, providers should respond promptly to any requests to update information so that all credentialing files can be maintained appropriately.

All providers shall be notified within 30 days of any substantial discrepancies between credentialing verification information obtained by HPM and information submitted by the provider. The applicant shall have 30 days to respond in writing to the Credentialing Coordinator regarding discrepancies.

All providers will be given 30 days to correct any erroneous information obtained by HPM during the credential verification process. The provider must inform HPM in writing of their intent to correct any erroneous information.

HPM re-credentials each provider in the network at least every three (3) years. Approximately six (6) months prior to the provider's three (3) year anniversary date, the provider will be notified of the intent to re-credential. All necessary forms will be sent for completion. In certain instances, a site visit will also be scheduled.

Additionally, the provider re-credentialing process includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data and member transfer rates.

Appeals Process

There is a formal method of appeal for a provider / applicant who is denied participation within the HPM Network. The request for reconsideration or appeal must be submitted to the credentialing coordinator in the Quality Improvement Department, who will submit it to the Credentialing Committee.

- A. The provider / applicant who is denied participation in the HPM Network may submit a request for reconsideration, within 21 days of the date of their participation denial, with additional supportive information or evidence of his/her professional qualifications or abilities to meet the accepted credentialing criteria.
- B. The request for reconsideration and the additional information will be submitted to the Credentialing Committee at the next scheduled meeting date.
- C. The Credentialing Committee will review the appeal request and additional information and will make a final determination of the appeal.
- D. The appealing provider / applicant will be notified of the appeal determination by the Credentialing Committee, through the Medical Director, by certified letter, within 5 working days of the Credentialing Committee meeting.
- E. If the denial is overturned, the applicant will continue with the new participation notification process outlined in this policy under section III-J.
- F. Denied applications are maintained in a confidential manner in Denied Participation file and are maintained for a period of four (4) years from the date of denial. Denials of participation are kept confidential except where reportable by HPM under federal or state regulation.

FACILITY SITE REVIEWS

As part of HPM's annual monitoring audits, provider office facilities will be evaluated against HPM's site review and medical record keeping requirements.

Guidelines for Facility Site Reviews

ACCESS TO SERVICE

- Is the next Adult Preventive Care appointment available within 30-45 days
- Is the next Child (< 18 months old) Preventive Care appointment available within 2 weeks
- Is the next Child (> 18 months old) Preventive Care appointment available within 4 weeks
- Is the next non-urgent sick visit available within two weeks
- Is the next urgent care appointment available within 24 hours
- Is each PCP available 20 hours per week
- Is the physician available 24 hrs/7 days a week
- Does the practitioner have mechanisms in place to meet HPM after hours access standards

PROVISIONS FOR PERSONS WITH DISABILITIES

- Are there designated handicap parking spaces close to building entrance
- Is the building entrance accessible by wheelchair, walker, etc.
- Are office hallways, doorways, and bathrooms accessible to wheelchairs, walkers, etc. (all hallways should have a minimum of 42 inches clearance)
- Are doors able to be operated by persons with physical limitations
- Are there accommodations for sight or hearing impaired patients

GENERAL OFFICE APPEARANCE

- Are NO SMOKING signs & Patient's Rights posted
- Is business conducted at the registration desk in a confidential manner (discussion, sign-in sheet, etc.) Staff is aware of the confidentiality policy of office
- Are restroom facilities available for waiting patients
- Are hours of operation posted
- Are all public and patient care areas clean, orderly and ample enough to accommodate patients
- Teaching literature is available for the patient

STAFF COMPETENCY

- Personnel file for each employee contains a copy of their current licensure, if applicable, or documentation of their formal training or certification.
- Each personnel file contains documentation of orientation to the facility, duties of their position, office medical equipment, and procedures.
- Each personnel file contains documentation of regular evaluations.
- There is documentation of on-going education for all staff. (Office in-services, staff meeting, conferences, etc.)
- There is documentation of annual OSHA training for Bloodborne Pathogens/Hazardous materials.
- Job descriptions are available for each position.
- Staff has current CPR Training.
- There is documentation of acceptance or denial of Hepatitis B Immunization.

DOCUMENTS

- Current Clia License
- Written Medical Waste Plan reviewed yearly

- Current Radiology Registration
- Written Emergency Preparedness and Disaster Plan with disaster drill documentation
- Copies of appropriate MSDS sheets for the office
- Bloodborne Pathogen Exposure Control Plan
- Manifests from Material Waste Processing Company
- Documented Quality Improvement Efforts
- Documentation of Well Water Safety if appropriate
- Documentation of Septic System Maintenance if appropriate
- Documentation of quarterly fire drills and yearly disaster drill

POLICIES

- Confidentiality
- Conflict Resolution
- Staff Competency & Orientation
- Medication storage and administration (include Narcotics and method to dispose of expired medication)
- Infection Control
- Radiology (pregnancy, safety apparel, maintenance of equipment, use of dosimeters, verification of proper technique, etc.)
- Maintenance of medical equipment (plan for broken equipment and routine maintenance and calibration – include Emergency Box if appropriate)
- Staffing plan (to include call-in vacation coverage and delegation of responsibilities)
- Purging and storing of records
- Sterilization/High Level Disinfectant
- Advance Directives
- Abuse and Neglect
- Policy for reporting communicable diseases to the state
- Sentinel Events
- Documentation of “no show” follow up and phone contacts

MEDICATIONS

- All stock and sample medications stored in a secure area away from patient access and in an appropriate (shelf, refig.)
- No oral and injectable medications stored together
- Documentation of regular review of all meds. for expiration dates
- A log is kept of all sample medications that are dispensed. (To include patient name, drug, lot#, and name of person giving the medication)
- Multi dose vials are marked with the initials of the person opening the vial and the date opened.
- Medications and laboratory specimens stored in separate refrigerators.
- All narcotics are stored under double lock system and the key is secure
- A narcotic log is maintained each working day. (To include current number of each item, name of drug and dosage given, name of patient given medication, date, medication given, and number remaining. All wastage should also be documented. Any count should be accomplished using two staff persons)
- No medication identified for an individual is stored with stock medication
- Medication is not stored in a refrigerator with food or drink and a temperature log for the fridge is maintained. (Staff should be aware of the proper temperature to be maintained.)
- The office participates in the Vaccines for Children Program and submits data to the MICR database.

DIAGNOSTIC MEDICAL EQUIPMENT

Thermometers
Pulse Oximetry
EKG Machine
Glucometer
Treadmill
Oxygen Tanks

Aerosol Machines
Cryocautery Machine
Colposcopy Equipment
Ultrasound Machine
Peak Flow Meter
Autoclave
Other

Equipment manuals are available for all medical equipment

SAFETY

- All Emergency exits are indicated. Emergency lights and electric exit signs are in working order
- Universal Precautions are always observed
- Fire Extinguishers are inspected at least yearly and have current markings
- Staff is aware of the location of fire pulls and fire extinguishers
- All fire exits are free of obstruction on both sides of the door. (Open all doors to check)
- Staff has been educated regarding the use and accessibility of MSDS sheets
- Appropriate staff has received annual Bloodborne Pathogen Training and is aware of the Exposure control plan
- Appropriate Protective Apparel is provided (gowns, masks, gloves, face shields, etc.)
- All gases are stored in an appropriate manner (intact tanks, upright & secured position). Staff is aware of the process for determining volume.
- Sharps Containers are used and discarded when $\frac{3}{4}$ full (disposed of with biohazard material) and not within reach of children.

LABORATORY

- Quality checks are done and documented on each Waived Lab Test each day used
- No food, drink or medication is ingested near or stored with collected lab specimens (lab reagents may be stored with them in a separate container)
- No lab reagent is kept or used beyond its expiration date. (Proper Disposal)
- All specimens are discarded in the proper manner after use
- All specimens should be labeled with the patient's name or ID# when multiple specimens are being tested

X-RAY

- Pregnancy Precautions for X-ray are posted
- Protective apparel is available and maintained including dosimeters
- Written plan for disposal of old films and developing agents
- X-ray room is identified with a system to protect other staff from exposure

STERILIZATION / HIGH LEVEL DISINFECTANT

- All items to be sterilized or disinfected are first cleaned with an enzymatic detergent, dried, and then processed maintaining a soiled to clean workflow
- Sterilized items are packaged appropriately, marked with a chemical test strip, the date processed, an expiration date, and then stored in the appropriate manner
- A log documenting each run and the chemical test strip is maintained including the date and the signature of the person processing the run
- A monthly spore check is done and documented
- All containers holding chemical solutions are marked with the name of the solution, date of expiration, and the date solution was mixed.
- Solution strength documentation exists for each day the solution is used
- The staff is aware of when sterilization with autoclave vs. high-level disinfectant should be done
- Glass thermometers are cleaned with alcohol and disposable probe covers are used for electronic thermometers

- Work surfaces soiled with biohazard materials are wiped down with commercial disinfectant material or a 10% bleach solution after the completion of testing
- There are sinks with soap and paper towels available in patient care areas. (Bar soap on the sink is not acceptable). Liquid hand disinfectants may be used in instances where the activity has taken place in an area not supplied with a sink and then hands are washed as soon as a sink is available.
- Hand washing is an expected practice before and after each patient encounter
- No food or beverage is consumed in any work area
- All equipment and surfaces cleaned appropriately after patient use
- The staff is aware of the process for reporting communicable diseases to the state
- Staff has been educated for the instance of TB and the screening process

EXAM ROOMS

- Each room assures patient privacy
- No medications, needles or syringes are stored in exam rooms unless in a locked cabinet
- Exam room is childproofed as appropriate (electrical outlet covers, no harmful solutions within reach, etc.)
- Area is clean and organized with opaque bags in wastebaskets.
- No patient care supplies or cardboard boxes stored on the floor or under the sinks
- There is an 18-inch clearance for sprinkler heads
- Clean laundry is covered
- No outdated material is stored

MEDICAL RECORDS

- The Medical Record is retrievable for review for six years.
- Patient information is kept confidential. Files are maintained away from accessibility of other patients, as are fax machines. Desktops do not have identifiable information in sight of other patients. Sign in sheet is not left in view of others.
- There is organization of the medical record, with dividers by type of service, i.e., Lab, X-ray, Consultations, discharge summaries, preventive services, progress notes, durable power of attorney/advance directives, informed consent, etc.
- All diagnostic and therapeutic services for which the practitioner referred the member are documented in the chart (Home Health Nursing Reports, Consults, Hospital discharges, Physical Therapy).
- There is a Problem List of significant illnesses and medical conditions with date of onset.
- Medication allergies and adverse reactions or NKDA as appropriate are prominently displayed in the medical record.
- A Past Medical History for patients seen more than three times that is easily identified and includes serious accidents, operations and illnesses. For children 18 and under, past medical history relates to prenatal care, birth, operations and childhood illnesses.
- The medical record is a unit record.
- There is an appropriately signed and dated Release of Information in the medical record.
- The entries in the Medical Record are legible.
- The entries in the Medical Record are signed and dated by the author.
- There is acknowledgement of receipt of privacy notice in record. (If not in individual records, there is a central file with acknowledgement of receipt of notice).

OSHA Training

Employee training and annual in-service education must include:

1. Universal precautions
2. Proper handling of blood spills
3. HBV and HIV transmission and prevention protocol

4. Needle stick exposure and management protocol
5. Bloodborne pathogen training
6. Sharps Handling
7. Proper disposal of contaminated materials
8. Information concerning each employees at-risk status

At-risk employees must be offered Hepatitis B vaccination free of charge. Each employee file of an at-risk employee must contain informed consent or informed refusals for Hepatitis B vaccines. Personal protective equipment must be provided to each at-risk employee.

Necessary equipment must be provided for the administration of mouth-to-mouth resuscitation.

Documents to be posted in the facility are:

1. Pharmacy Drug Control license issued by the State of Michigan, if dispensing drugs other than samples.
2. Section 17757a from the Board of Pharmacy (if dispensing drugs other than samples)
3. Controlled Substances License from State of Michigan and the Federal DEA
4. CLIA certificate or waiver
5. Medical Waste Management certificate
6. X-ray equipment registration
7. R-H 100 notice
8. Radiology protection rules
9. MIOSHA poster (#2010)

SECTION 9

HPM FORMULARIES

- RxAmerica Pharmacy Management Systems.....
 - Drug Formulary for Health Plan of Michigan
 - Drug Formulary Alternative List
 - Preferred Drug Reference Guide
 - HPM Over-The-Counter Drug List
 - HPM Step Therapy Protocols

USING THE HPM 2009 DRUG FORMULARY

Prescription Drug Plan Coverage

HPM employs, the pharmacy benefits manager (PBM), RxAmerica to assist in managing the member's ambulatory pharmacy benefit. RxAmerica provides HPM with a pharmacy network, pharmacy claims management services, drug formulary and pharmacy claims adjudication. Each HPM member's eligibility is verified prior to authorizing any drug benefit.

RxAmerica offers **Provider Support at: 1-888-883-0699**. A clinical pharmacist is available to speak with HPM providers regarding pharmaceutical, medication administration or prescribing concerns.

Each PCP will receive a copy of the HPM Pharmacy Drug Formulary. The HPM Formulary is also available on our website at: www.hpmich.com or through Epocrates.com. Please refer to the HPM formulary when prescribing medications for HPM members. Medicaid members have prescription and specific over-the-counter medication coverage. The HPM formulary is designed to cover the vast majority of therapeutic conditions, however in the advent a particular medication is required for a member, the medical necessity exceptions request is available through the prior authorization. Additionally, there are specialized medications on the drug formulary, identified as requiring a prior-authorization (PA).

Covered Benefits

- Federal legend drugs as identified on the formulary
- Select over-the-counter (OTC) items (require a written prescription from a licensed prescriber).
- Family planning devices:
 - Diaphragms
 - Male Condoms (maximum 12 per prescription, 36 per calendar year)
 - Depo-Provera Contraception Injection – 150 mg/ml (dispensing limited to one prescription per member every 75 days)

Non-Covered Benefits

- The following therapeutic classes are not eligible for reimbursement:
 - Agents used for cosmetic purposes
 - Diagnostic Prep Agents
 - Fertility Agents
- The program does not reimburse for drug products acquired for or administered in:
 - An inpatient hospital
 - An outpatient hospital emergency room or clinic
 - A physician's office or clinic (except Depo-Provera)

Prior Authorization Procedures

Although we ask that you prescribe within the formulary, we are aware that certain situations arise when a formulary alternative may not exist. Drugs requiring Prior Authorization are identified in the formulary with a PA designation. HPM requires that you

follow the Prior Authorization procedures detailed below for obtaining medically necessary non-formulary/non-covered drug products.

1. In order to receive a non-formulary/non-covered medication, the prescriber must submit a prior authorization request by fax to RxAmerica at **1-866-855-2678** using the designated HPM form available on this website.
2. RxAmerica may request that the prescriber submit additional clinical information by fax in order to process the request.
3. RxAmerica will respond by fax to the prescriber's request within 24 hours, Monday through Friday.
4. If the request is approved, RxAmerica will notify the provider via fax and enter the necessary authorization into the claims processing system for dispensing at a participating pharmacy network provider.
5. The prescriber may contact RxAmerica by telephone at **1-888-883-0699** with any questions or concerns. Representatives are available 24 hours a day, except major holidays.

HPM Prior Authorization Drug Request form and full formulary may be found on the HPM website www.hpmich.com

SECTION 10
CLINICAL PRACTICE GUIDELINES

- Clinical Practice Guidelines.....

Health Plan of Michigan Clinical Practice Guideline
 Routine Preventive Services for Infants and Children (Birth – 24 Months)

The following guideline provides recommendations for routine preventive services for children birth to 24 months.

Recommendation	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months
Health, developmental and risk assessments	x	x	x	x	x	x	x	x	x
Parental education and counseling: Immunizations, nutrition, breast-feeding [A], physical activity, dental health, child abuse, depression, alcohol/drug abuse, anxiety, stress reduction, coping skills Motor vehicle safety – Rear facing car seat when riding in a motor vehicle until 1 year and 20 pounds [B]. Poison prevention – Keep National Poison Control numbers readily accessible; use child resistant containers Burn prevention – Install smoke detectors and test bi-annually; carbon monoxide detectors, water heater temperature and fire prevention Injury prevention – Use of gates; never leave infant unattended on changing table; water safety; CPR training SIDS and infant sleeping positioning – Place infants on their back [B]	x	x	x	x	x	x	x	x	x
Tobacco Use Screening: Establish tobacco use and secondhand exposure	x	x	x	x	x	x	x	x	x
Neonatal Screening: Newborn metabolic screening prior to hospital discharge > 24 hours of age [D]	x, > 24 hours of age				x	x	x	x	x
Blood Lead Testing [B]						x			

Immunizations:

Consult the Advisory Committee on Immunization Practices (ACIP) website (www.cdc.gov/nip/acip/) for most updated immunization schedules for routine and high risk populations.
 Use combination vaccines to minimize the number of injections
 Update the Michigan Care Improvement Registry (MCIR)

DTaP [A]			x	x	x	x			
IPV			x	x		x			
MMR (MMRV) [A]						x			
Varicella [A]						x			
Pneumococcal (PCV7)			x	x	x	x			
Hib [A]			x	x	x	x			
Rotavirus			x	x	x				
Hep B [A] – Schedule 1	x	x				x			
Hep B [A] – Schedule 2		x		x		x			
Hep A						x	x		
Influenza [B]						x, 6-59 months annually			

Levels of Evidence for the most significant recommendations: A =randomized controlled trials; B =controlled trials, no randomization; C =observational studies; D =opinion of expert panel

This guideline lists core management steps. It is based on several sources, including: Preventive Services for Children and Adolescents, Institute for Clinical Systems Improvement, 2006 (www.icsi.org) Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Health Plan of Michigan Clinical Practice Guideline
 Routine Preventive Services for Children and Adolescents (Ages 2-18)

The following guideline provides recommendations for routine preventive services for children and adolescents ages 2-18 years.

Recommendation	2-6 years	7-12 years	13-18 years
Health, developmental and risk assessments	x	x	x
Parental/Child education and counseling: Nutrition, physical activity, dental health, violence and abuse, sexually transmitted infection (STI) prevention, depression, suicide threats, alcohol/drug abuse, anxiety, stress reduction, coping skills, immunizations Bicycle safety – helmet use when riding bicycle [B]. Motor vehicle safety – Car seat/booster seat/seat belt use [B]. Poison prevention – Keep National Poison Control numbers readily accessible; use child resistant containers; dispose expired/unused medications Burn prevention – Install smoke detectors and test bi-annually; carbon monoxide detectors, water heater temperature and fire prevention Injury prevention – Firearm safety; water safety; CPR training	x	x	x
Tobacco Use Screening: Establish tobacco use and secondhand exposure	x	x	x
Screening for overweight	Record height, weight and BMI annually		
Cholesterol Screening [A]	Over age 2 if increased risk for genetic forms of hypercholesterolemia		
Chlamydia Screening sexually transmitted infection (STI) [B]			All sexually active women 25 years and younger
Cervical Cancer Screening (Pap Smear) [B]			Beginning at age 21 or within three years after first sexual intercourse, whichever is earlier; every 3 years after 3 consecutive normal Pap smears over 5 years.
Preconception and Pregnancy Prevention Counseling		Preventive counseling beginning at age 12, or earlier if sexually active	
Vision Screening [A]	Children 4 years old and younger. By age 5, should be performed as part of preschool screening.		
Immunizations: <ul style="list-style-type: none"> Consult the Advisory Committee on Immunizations Practices (ACIP) website (www.cdc.gov/nip/acip/) for most updated immunization schedules for routine and high risk populations. Use combination vaccines to minimize the number of injections Update the Michigan Care Improvement Registry (MCIR) 	4-6 years	11-12 years	15-18 years
DTaP [A]	x	Tdap	
IPV	x		
MMR (MMRV) [A]	x		
Varicella [A]	x		
Meningococcal		x	
Influenza [B]	X 6-59 moths annually		
Human Papilloma Virus (females 9-26 years)		x dose series	x dose series

Levels of Evidence for the most significant recommendations: A =randomized controlled trials; B =controlled trials, no randomization; C =observational studies; D =opinion of expert panel

This guideline lists core management steps. It is based on several sources, including: Preventive Services for Children and Adolescents, Institute for Clinical Systems Improvement, 2006 (www.icsi.org) Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline

Adult Preventive Services (Ages 18-49)

The following guideline recommends clinical preventive services for adults.

Recommendation	18-39 Years	40-49 years
Health Assessment Screening, History and Counseling	One health maintenance exam (HME) every 1-5 years [D] according to risk status. Each HME should include: <ul style="list-style-type: none"> • Height, weight and Body Mass Index (BMI) • Risk evaluation & Counseling (Nutrition, obesity, physical activity, dental health. Tobacco use [A], immunizations, HIV prevention [B], sexually transmitted infections prevention [B] and sexual health, sexual abuse, preconception counseling for all women of reproductive age [B], polypharmacy including over-the-counter and herbal preparations when appropriate, sun exposure) • Safety (Domestic violence, seat belts [B], helmets, firearms, smoke and carbon monoxide detectors) • Behavioral Assessment (Depression, suicide threats, alcohol/drug use, anxiety, stress reduction coping skills) 	
Blood Pressure Monitoring [A]	At every office visit and at minimum every 2 years. If BP 120 – 139/80-89 or higher and/or presence of risk factors, more frequent monitoring is recommended.	
Cholesterol and Lipid Screening [B]	Measure a complete fasting lipoprotein profile, (i.e. total cholesterol, LDL-C, HDL-C) in men 35 years and older and women 45 years and older without other risk factors. Screen younger adults for lipid disorders if other risk factors for coronary heart disease (CHD) (i.e. diabetes, family history cardiovascular disease before age 50 in male relatives or age 60 in female relatives), multiple CHD risk factor [e.g. tobacco use, hypertension). Once screening begins, repeat every 5 years for low risk adults if initial test normal; consider more frequent screening in individuals at increased risk.	
Diabetes Mellitus Screening [D]	Screening may be indicated in patients with risk factors for diabetes (e.g. obesity, family history, high-risk ethnic groups [African Americans, Native Americans, Hispanics and Pacific Islanders], previously identified impaired fasting plasma glucose [FPG] or impaired glucose tolerance; history gestational diabetes, hypertension, HDL-C < 35 mg/dL and/or triglyceride > 250 mg/dL, polycystic ovarian disease, or history of vascular disease)	FPG every 3 years (especially if BMI>25) starting at age 45.
Colorectal Cancer Screening [B] for average risk adults	No requirement unless high risk (e.g. family history, history, history of colorectal polyps, chronic inflammatory bowel disease)	
Glaucoma Screening [C]	No requirement unless high risk (e.g. increased intraocular pressure, family history, African Americans, people who have diabetes, myopia, regular/long-term steroid use, previous eye injury)	Begin screening high risk patients annually at age 45
Cervical Cancer Screening [A] Pap Smear	At least every 3 years, more frequently if high risk (e.g. history of abnormal Pap results, sexually transmitted diseases or HIV; sexual activity before age 18 or multiple partners; vaginal spotting or bleeding between periods, after intercourse or after menopause; tobacco use) [Consider discontinuation for patients with surgical removal of cervix for benign conditions]	
Chlamydia Screening [B]	Recommended for all sexually active women age 24 and younger, and sexually active women age 25 and older if high risk (i.e. new or multiple sexual partners, history of sexually transmitted diseases, not using condoms consistently or correctly)	
Mammography with or without Clinical Breast Examination [C]	No requirement, unless high risk	Every 1-2 years

Immunizations (Consult ACIP website, www.cdc.gov/vaccines/recs/acip/ for up-to-date recommendations):

Tdap/Td [A]	Tdap once after age 11, then Td every 10 years	
HPV [D]	All females 26 years and younger should have full three vaccine series if not previously completed.	
MMR [C] , Varicella [C]	Ages 19 – 49 years: MMR 2 doses; Varicella as indicated by ACIP guidelines	
Influenza [B]	Every year if high risk; Optional for those who wish to avoid getting the flu	

Levels of Evidence for the most significant recommendations: A =randomized controlled trials; B =controlled trials, no randomization; C =observational studies; D =opinion of expert panel

This guideline lists core management steps. It is based on several sources, including: The Guide to Clinical Preventive Services 2009, Recommendations of the U.S. Preventive Services Task Force (www.preventiveservices.ahrq.gov) and the Advisory Committee on Immunization Practices (ACIP) 2006 Immunization Recommendations (www.cdc.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline
Adult Preventive Services (Ages 50-65+)

The following guideline recommends clinical preventive services for adults.

Recommendation	50-64 Years	65+ Years
Health Assessment Screening, History and Counseling	One health maintenance exam (HME) every 1-3 years according to risk status [D]. Each HME should include: <ul style="list-style-type: none"> • Height, weight and Body Mass Index (BMI) • Risk evaluation & Counseling (Nutrition, obesity, physical activity, dental health. Tobacco use [A], immunizations, HIV prevention [B], sexually transmitted disease prevention [B] and sexual health, sexual abuse, polypharmacy including over-the-counter and herbal preparations when appropriate, sun exposure) • Safety (Domestic violence, seat belts, helmets, firearms, smoke and carbon monoxide detectors) Behavioral Assessment (Depression, suicide threats, alcohol/drug use, anxiety, stress reduction coping skills)	One HME at least every 2 years
Blood Pressure Monitoring [A]	At every office visit and at minimum, every 2 years. If BP 120 – 139/80-89 or higher and/or presence of risk factors, more frequent monitoring is recommended.	
Cholesterol and Lipid Screening [B]	Measure a complete fasting lipoprotein profile, i.e. total cholesterol, LDL-C, HDL-C and triglycerides every 5 years if initial test is normal in low risk adults. If multiple risk factors are present, more frequent measurements are recommended	
Diabetes Mellitus Screening	Fasting plasma glucose (FPG) every 3 years beginning at age 45. FPG may be performed earlier in patients at increased risk of diabetes (e.g., those with BMI > 25, family history and high-risk ethnic groups – African Americans, Native Americans, Hispanics and Pacific Islanders)	
Colorectal Cancer Screening [B] for average risk adults	FOBT annually and/or sigmoidoscopy every 5 years; or double contrast barium enema every 5 years; or colonoscopy every 10 years	
Glaucoma Screening [C]	No requirement unless high risk (e.g. increased intraocular pressure, family history, African Americans, people who have diabetes, myopia, regular/long-term steroid use, previous eye injury)	Every 2 years; Screen annually if high risk
Osteoporosis Screening [C]	<ul style="list-style-type: none"> • Men or women on chronic glucocorticosteroids (prednisone > 7.5 mg/d, or equivalent, for > 6 months) and those who have received a solid organ transplant > 2 years ago should be screened. • Post-menopausal women with any of the following: personal history of fracture without substantial trauma > age 40; family history of fracture (hip, wrist or spine in first-degree relative > age 50); current smoking; weight in lowest quartile (< 127 lbs); and frailty. • Bone Mineral Density (BMD) test once for initial diagnosis. Do not repeat test more frequently than every 2 years (per MQIC Osteoporosis guideline). 	Women > age 65 regardless of risk factors
Cervical Cancer Screening [A] Pap Smear	At least every 3 years, more frequently if high risk (e.g. history of abnormal Pap results, sexually transmitted diseases or HIV; sexual activity before age 18 or multiple partners; vaginal spotting or bleeding between periods, after intercourse or after menopause; tobacco use) [Consider discontinuation for patients with surgical removal of cervix for benign conditions]	May discontinue after age 65, based on clinical judgment according to risk status
Mammography [A] and Clinical Breast Exam [C]	Every 1-2 years	Shared decision-making after age 70
Prostate Cancer Screening [D]	Age 50-65 years, shared decision-making for digital rectal examination (DRE) and/or prostate specific antigen (PSA) testing	
Immunizations (Consult ACIP website, www.cdc.gov/vaccines/recs/acip/ for up-to-date recommendations):		
Tdap/Td [A]	Tdap once after age 11, then Td every 10 years	Td every 10 years
Varicella [C]; Zoster [C]	Varicella as indicated by ACIP guidelines. Single dose zoster vaccine aged > 60 years	
Influenza [B]	Annually	
Pneumococcal vaccine [B]	No requirement, unless high risk	Once at age 65; booster may be needed after 5
Levels of Evidence for the most significant recommendations: A =randomized controlled trials; B =controlled trials, no randomization; C =observational studies; D =opinion of expert panel		
This guideline lists core management steps. It is based on several sources, including: The Guide to Clinical Preventive Services 2009, Recommendations of the U.S. Preventive Services Task Force (www.preventiveservices.ahrq.gov) and the Advisory Committee on Immunization Practices (ACIP) 2006 Immunization Recommendations (www.cdc.gov) Individual patient considerations and advances in medical science may supersede or modify these recommendations.		
Approved by MQIC Medical Directors September 2008		www.mqic.org

Health Plan of Michigan Clinical Practice Guideline
Routine Prenatal and Postnatal Care

The following guideline provides recommendations for routine prenatal and postnatal care.

Recommendation	6-8 Weeks	14-16 Weeks	24-28 Weeks	32 Weeks	36 Weeks	38 Weeks	39 Weeks	40 Weeks	41 Weeks	Post partum 4-6 Weeks After Delivery
Social and medical history (update at each visit)	x	x	x	x	x	x	x	x	x	x
Assessment (dental and nutritional health, weight, physical and sexual activity, alcohol and drug abuse, tobacco use [A], domestic violence, environment, genetic risk factors, medications, transportation, seatbelt use [B], infant car set use [A], childbirth education, adequate social support, coping skills, financial resources, knowledge of available resources, mental health, ability to comprehend information or care provided) (update at each visit)	x	x	x	x	x	x	x	x	x	x
General physical exam	x				x					x ¹
Pelvic exam	x					x	x	x	x	x
Blood pressure [B], weight, BMI	x	x	x	x	x	x	x	x	x	x
Fundal height, weeks gestation	x	x	x	x	x	x	x	x	x	
Urine for glucose and albumin	x	x	x	x	x	x	x	x	x	
Routine urinalysis, culture [A]		x								
Fetal position, fetal heart tones		x	x	x	x	x	x	x	x	
D (Rh) type, blood type, antibody screen [A]	x									
HIV counseling/testing [A] <i>*Repeat at 36 weeks if previous negative test in prenatal care or women who have never been tested</i>	x				x					
STD screening (GC, Chlamydia, VDRL [A]) for high-risk patient (e.g., new or multiple sexual partners, history of sexually transmitted diseases, not using condoms consistently or correctly) *Rescreen in third trimester if at continued risk.	x		x (28-36 weeks+)							
Hepatitis B[A] and rubella screening [B]	x									
Hemoglobin and hematocrit[B]	x		x		x					
Maternal serum alpha fetoprotein/multiple marker screening [B]		x (16-20 weeks+)								
Screening for gestational diabetes (test earlier if previous history gestational diabetes)			x							X ²
Influenza vaccine (second or third trimester during flu season)		x	x							
Group B strep culture (vaginal and rectal)					x (35-37 weeks+)					
Folic Acid (0.4-0.8 mg one month prior to conception through 1 st trimester)[A]	x	x								

¹Education and counseling for prevention of unintended pregnancy ²Arrange follow-up to screen for non-gestational diabetes six weeks after delivery and annually thereafter

Levels of Evidence for the most significant recommendations: A =randomized controlled trials; B =controlled trials, no randomization; C =observational studies; D =opinion of expert panel

This guideline lists core management steps. It is based on several sources, including: Routine Prenatal Care, Institute for Clinical Systems Improvement, 2005(www.icsi.org), individual patient considerations and advances in medical science may supersede or modify these recommendations.

Health Plan of Michigan Clinical Practice Guideline
Management of Adults with Wounds

The following guideline recommends diagnostic evaluation, education and treatment that support effective patient self-management

Eligible Population	<i>Key Components</i>	Recommendation and Level of Evidence
Adults with wounds	Initial evaluation	<p>Assessment should include:</p> <ul style="list-style-type: none"> • Thorough history and physical examination [C] including precipitating factors (post-operative, venous/arterial insufficiency, diabetic peripheral neuropathy, pressure ulcers, burns) • Perfusion tests (Doppler, flow studies, color scans, etc.) • Perfusion check (peripheral pulses, capillary refill, absence or presence of pain, color, temperature)[C] • Thorough description of wound(s) that include: location, size (measurements indicate length, width, depth), drainage(type, color, consistency, amount, odor), wound bed and wound edge appearance, tunneling/undermining presence[C] • Laboratory tests and other studies should include: CBC, serum electrolytes (including calcium, magnesium), BUN, serum creatinine, blood glucose, liver function tests, TSH, urinalysis [C]
Adults diagnosed: Venous insufficiency (stasis)	Treatment	<p><u>Measures to improve venous return:</u></p> <ul style="list-style-type: none"> • Elevation of legs • Compression therapy to provide at least 30mm/hg compression @ ankle • Surgical obliteration of damaged veins <p>OPTIONS:</p> <ul style="list-style-type: none"> • Short stretch bandages (i.e. Setopress, Surepress, Comprilan) • Therapeutic support stockings • Unna boot • Profore 4-layer wrap • Compression pumps <p><u>Topical Therapy</u></p> <ul style="list-style-type: none"> • Absorb exudates (use alginate, foam) • Maintain moist wound surface (i.e. hydrocolloids) <p><u>Measures to improve tissue perfusion:</u></p> <ul style="list-style-type: none"> • Medications that improve RBC transit through narrowed vessel • Lifestyle changes (avoid tobacco, caffeine, cold environments, constrictive/tight clothing, prevent trauma) [A] • Hydration • Revascularization if possible <p><u>Topical Therapy</u></p> <ul style="list-style-type: none"> • Dry uninfected necrotic wound: keep dry [A] • Dry infected wound: Immediate referral for surgical debridement and aggressive antibiotic therapy • Open wound: moist wound healing, non-occlusive dressings (i.e. solid hydrogels) and aggressive treatment of any infection
Arterial insufficiency	Education, counseling and risk factor modification	<p>Educate patient/family regarding:</p> <ul style="list-style-type: none"> • Daily self monitoring of wound progress and dressing/treatment changes • Recognition of symptoms of infection (local and systemic) and when to seek medical attention • Adequate nutrition to encourage wound healing • Risk factor modification (smoking cessation; control of weight, BP, DM, lipids, wear appropriate footwear at all times, etc.) • Avoid excessive alcohol intake, illicit drug use, and the use of NSAIDS

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline represents core management steps. It is based on the 2000 APIC Guideline Committee, Wound, Ostomy and Continence Nurses Society (WOCN) position statement: Clean vs. sterile: Management of chronic wounds (available at <http://www.wocn.org/publications/posstate/pdf/clvst.pdf>). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Health Plan of Michigan Clinical Practice Guideline

Appropriate Treatment for Children with Upper Respiratory Infection

The following guideline are to provide recommendations for the accurate diagnosis and optimal treatment of Upper Respiratory Infection in children 3 mos - 18 years of age.

	Key Components	Recommendation and Level of Evidence	Frequency
<p>Eligible Population</p> <p>Children 3 mos – 18 years of age</p>	<ul style="list-style-type: none"> Antimicrobial agents should not be given for the common cold.³ Mucopurulent rhinitis (thick, opaque or discolored nasal discharge) frequently accompanies the common cold. It is not an indication for antimicrobial treatment unless it persists for > 10 to 14 days.³ 	<ul style="list-style-type: none"> Antibiotics should not be given for viral rhinosinusitis Cough illness/bronchitis in children rarely warrants antibiotic treatment Antibiotics should not be routinely prescribed for uncomplicated acute bronchitis unless the cough persisted for more than 10 days. Antimicrobial therapy does not significantly improve symptoms or outcomes of acute bronchitis.⁴ Classify episodes of otitis media as acute otitis media (AOM) or otitis media with effusion (OME). Only treat proven AOM. antibiotics are indicated for treatment of AOM, however, diagnosis requires: <ul style="list-style-type: none"> documented middle ear infection signs or symptoms of acute local or systemic illness.⁴ <p>Codes to Identify URI:</p> <ul style="list-style-type: none"> Acute nasopharyngitis (common cold) ICD-9 – 460 and URI unspecified site ICD-9 – 465 <p>Cold Symptoms: Nasal discharge, obstruction of nasal breathing, swelling of the sinus membranes Sneezing, sore throat, cough, headache and fever</p>	
	Treatment	<ul style="list-style-type: none"> Only symptomatic treatment is available for uncomplicated cases of the common cold² <ul style="list-style-type: none"> Bed rest Plenty of fluids Gargling with warm salt water Petroleum jelly for a raw nose Antitussives Vaporizer Aspirin or acetaminophen to relieve headache or fever, (caution when prescribing aspirin. Several studies have linked the use of aspirin to the development of Reye’s syndrome recovering from influenza or chickenpox) 	
	Patient Education and counseling	<ul style="list-style-type: none"> Avoid close contact with people who have a cold¹ Wash hands after touching someone who has a cold, after touching an object they have touched, and after blowing your own nose Discuss with patient, lack of benefit of antibiotics and risks related to antibiotic use Pamphlets, posters and fact sheets¹ 	Reinforce at each visit
	Medical recommended	Symptomatic treatment for uncomplicated cases of the common cold ² .	

References:

- Guidelines for the prevention and treatment of Influenza and the common cold, American Lung Association.
- National Institute of Health, U.S. Department of Health and Human Services, March 2001.
- Rosenstein, R., Phillips, WI, Gerber, M., et. All, Pediatrics vol. 101 No. 1 supplement January 1998, pp 181-184, The common cold-Principles of Judicious Use of antimicrobial Agents.
- Dowell SF, Editor, Principals of judicious use of antimicrobial agents for children’s upper respiratory tract infections Pediatrics. Vol 1 January 1998 supplement.

The clinical guidelines and information are intended as an analytical framework for the evaluation and treatment of patients. These guidelines are not intended to replace your best clinical judgment or establish a protocol for all patients.

Health Plan of Michigan Clinical Practice Guideline
Prevention of Unintended Pregnancy in Adults 18 Years and Older

The following guideline recommends specific interventions for assessing and counseling to lower the risk of unintended pregnancies.

Eligible Population	<i>Key Components</i>	Recommendation and Level of Evidence	Frequency
Males and Females	Assessment for risk of unintended pregnancy	<p>Ask about:</p> <ul style="list-style-type: none"> • Sexual activity/involvement, past pregnancy and outcome • Abuse (e.g. Were you pressured or forced to have sex when you did not want?) • Consistent use of birth control or protection (e.g. Does it ever happen that you have sex without using birth control or protection?) <ul style="list-style-type: none"> ○ If contraception used, assess type • Intent to become pregnant or father a child (e.g. Are you trying to get pregnant? Are you trying to father a child?) • If currently pregnant, discuss postpartum contraception. 	At annual health exam; more frequently at the discretion of the health care provider [D]
	Interventions to prevent unintended pregnancies	<p>Advise and discuss:</p> <ul style="list-style-type: none"> • Patient’s risk of pregnancy or contributing to an unintended pregnancy • Risks and adverse outcomes associated with unintended pregnancies <p>Assess:</p> <ul style="list-style-type: none"> • Patients understanding of risks and readiness to make behavior changes. <p>Assist patients in preventing unintended pregnancy by:</p> <ul style="list-style-type: none"> • Discussing all contraceptive methods • Offering prescriptions • Encouraging consistent latex condom use for sexually transmitted infection prevention • Referring to primary care provider, local health department, family planning clinic, Pan First, federally qualified health center or hotline <p>Arrange follow-up</p>	

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline lists core management steps. It is based on several sources including the Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report: Recommendations to Improve Preconception Health and Health Care – United States, 06-Apr-2006; 55(RR-6). (www.cdc.gov) Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Health Plan of Michigan Clinical Practice Guideline
Tobacco Control

The following guidelines recommend specific interventions for cessation services for current smokers and tobacco users.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
All patients 12 years of age and older (regardless of prior use status)	Identification of tobacco use status (never, former, current) and type (all forms, including smokeless tobacco, pipe, snuff, and cigars, hookah [water pipe] and second-hand smoke)	<ul style="list-style-type: none"> • Ask and document tobacco use status in the medical record and/or problem list [A] 	At each outpatient visit and inpatient admission
All patients identified as current smokers/tobacco users	Intervention to promote cessation of tobacco use	<ul style="list-style-type: none"> • Advise to quit [A]/avoid second hand smoke • Assess patient willingness to attempt to quit [C] • Assist patients who are ready to quit by: <ul style="list-style-type: none"> ○ Establishing a quit date ○ Providing self-help materials (e.g. free Quit kits; see www.michigan.gov/tobacco) ○ Offering nicotine replacement therapy (adults only) and/or withdrawal medications e.g., sustained release bupropion [A] (adolescents and adults) ○ Offering referral into smoking cessation program (e.g. MI Quit Line 1-800-480-7848) ○ The combination of nicotine replacement therapy and/or withdrawal medications plus a smoking cessation program is more effective than either alone. • Arrange follow-up contact, either in person or by telephone [D]: First week after quit date First month after quit date 	At each periodic health exam, more frequently at the discretion of the physician

SPECIAL CIRCUMSTANCES

- **Pregnant Smokers:** Due to the serious risks to the mother and fetus, pregnant smokers should be offered interventions such as referral to a smoking cessation program.
- **Hospitalized Smokers:** Clinicians should provide appropriate pharmacotherapy and counseling during hospitalization to reduce nicotine withdrawal symptoms and assist smokers in quitting.
- **Smokers with Psychiatric Comorbidity:** Nicotine withdrawal symptoms may exacerbate depression among patients with a prior history of affective disorder. Stopping smoking may affect the pharmacokinetics of certain psychiatric agents. Clinicians should monitor closely the actions or side effects of psychiatric medications in smokers/tobacco users who are attempting to quit.

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline lists core management steps. It is based on the Clinical Practice Guideline for the Management of Tobacco Use, Veterans Health Administration/Department of Defense, 2004(www.oqp.med.va.gov)
Individual patient considerations and advances in medical science may supercede these recommendations.

Health Plan of Michigan Clinical Practice Guideline
Screening, Diagnosis and Referral for Substance Use Disorders

The following guideline recommends detection, diagnosis, treatment and referral considerations for substance use disorders

Eligible Population	<i>Key Components</i>	Recommendation and Level of Evidence		
Adolescents and adults	Detection/Screening	<ul style="list-style-type: none"> • Screen by history for substance use at every health maintenance exam or initial pregnancy visit (repeat as indicated), using a validated screening tool (improves accuracy of detecting alcohol abuse or dependence)¹ [D] • Maintain high index of concern for substance use in persons with: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> • Family history of substance abuse disorder [B] • Recent stressful life events and lack of social supports • Chronic pain or illness, trauma • Mental illness </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> • Drug seeking behaviors • Physical and cognitive disabilities • Alcohol before age 15 • Medical conditions associated with substance abuse </td> </tr> </table> 	<ul style="list-style-type: none"> • Family history of substance abuse disorder [B] • Recent stressful life events and lack of social supports • Chronic pain or illness, trauma • Mental illness 	<ul style="list-style-type: none"> • Drug seeking behaviors • Physical and cognitive disabilities • Alcohol before age 15 • Medical conditions associated with substance abuse
	<ul style="list-style-type: none"> • Family history of substance abuse disorder [B] • Recent stressful life events and lack of social supports • Chronic pain or illness, trauma • Mental illness 	<ul style="list-style-type: none"> • Drug seeking behaviors • Physical and cognitive disabilities • Alcohol before age 15 • Medical conditions associated with substance abuse 		
<p>Substance dependence or abuse indicates a maladaptive pattern of substance use resulting in clinically significant impairment of distress. Relevant issues include:</p> <ul style="list-style-type: none"> • Recurrent substance use resulting in a failure to fulfill major role obligations • Recurrent substance use in situations that are physically hazardous • Recurrent substance-related legal problems • Substance use despite having persistent or recurrent social or interpersonal problems • Tolerance, withdrawal, use in larger amounts or over a longer period than intended • Persistent desire or unsuccessful efforts to cut down • Great deal of time spent in obtaining, using or recovering from use of the substance • Reduction in social, occupational or recreational activities because of substance use • Substance use continues despite knowledge of problems 				
Patients with Substance Use Disorder	Patient Education and Brief Intervention by PCP or Trained Staff (e.g. RN, MSW, etc.) [A]	<ul style="list-style-type: none"> ▪ Discuss the relationship to presenting medical concerns or psychosocial problems ▪ Assess the patient's readiness to change ▪ Negotiate goals and strategies for reducing consumption and other change ▪ Involve family members as appropriate ▪ 		
	Referral Considerations	<ul style="list-style-type: none"> • Consider referral to community-based services (e.g., Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) or Employee Assistance Program, or (especially if substance dependent) a substance abuse or behavioral health specialist. [D] • Pharmacologic management should be conducted by or in collaboration with physicians who have expertise in the area of substance abuse disorders [D] • Schedule follow-up at least 2 visits within 30 days to re-assess and support behavior change 		

¹Validated tools include: Alcohol Use Disorders Identification Test (AUDIT), TWEAC (for pregnant women), Michigan Alcohol Screening Test (MAST, MAST-G), CAGE Survey, Substance Abuse Subtle Screening Inventory (SASSI)

²At risk substance use is defined as any illicit drugs; >3 drinks/day or >7drinks/week in women; >4 drinks/day or >14 drinks/week in men, >1 drink/day if age >65

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline lists core management steps for non-behavioral health specialists. It is based on several sources including, Practice Guideline for the Treatment of Patients with Substance Use Disorders, American Psychiatric Association, August 2006 (www.psych.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline
Management of Overweight and Obesity in the Adult

The following guideline recommends specific interventions for treatment of overweight and obese conditions in adults.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Adults 18 years or older	Assessment of Body Mass Index (BMI)	<ul style="list-style-type: none"> ▪ Measure weight, waist circumference and calculate patient's BMI¹ to determine if patient is overweight or obese and pattern of weight change [C] ▪ If overweight, assess for complicating risk factors: <ul style="list-style-type: none"> ○ Established CHD or stroke ○ Other atherosclerotic disease ○ Type 2 diabetes ○ Sleep Apnea ○ Smoking ○ High triglycerides ○ Hypertension ○ High LDL ○ Low HDL ○ Impaired fasting glucose ○ Family history of premature CHD ▪ Assess current eating, exercise behaviors, history of weight loss attempts and psychological factors contributing to weight gain 	At each periodic health exam; more frequently at the discretion of the physician
Patients with BMI >25	Interventions to promote weight management	<ul style="list-style-type: none"> ▪ Ask patients how their weight impacts their health ▪ Advise and discuss patient's associated disease risks and importance of weight management ▪ Assess and discuss patient's readiness to make positive behavior changes. ▪ Assist patients who are ready to make behavior changes related to food intake and physical activity: <ul style="list-style-type: none"> ○ Work with your patients to establish realistic treatment goals² ○ Collaborate on strategies for reducing calories and adjusting as needed to maintain gradual weight loss [A] (reduce calories as needed to maintain 1 to 2 pound weight loss per week) and improving dietary quality ○ Recommend weight loss strategies and resources as needed (see www.michigan.gov/surgeongeneral) ○ Collaborate on strategies for increasing daily physical activity (ideally 30 minutes of moderate physical activity most days of the week)[A] ▪ Arrange follow-up with your patients to monitor progress and provide support. 	At each periodic health exam; more frequently at the discretion of the physician.
Patients with BMI >30 or >27 with other risk factors or diseases	Interventions to promote weight management	<p>All of the above plus:</p> <ul style="list-style-type: none"> ▪ Consider referral to a program that provides guidance on nutrition, physical activity and psychosocial concerns ▪ Consider pharmacotherapy only for patients with increased medical risk because of their weight with co-existing risk factors or comorbidities (monitor for weight loss and medication side effects; periodically review need for medication) ▪ Insurance coverage for weight loss medication varies; consult health plan for eligibility 	
BMI ≥ 40 or BMI ≥ 35 and uncontrolled comorbid conditions ³	Surgical Treatment	<ul style="list-style-type: none"> ▪ Weight loss surgery should be considered only for patients in whom other methods of treatment have failed and who have clinically severe obesity, i.e., BMI ≥ 40 or BMI ≥ 35 with life-threatening co morbid conditions³ [B] ▪ Evaluate for psychological factors that adversely affect surgical outcomes ▪ Insurance coverage for bariatric surgery varies; consult health plan for eligibility 	

¹BMI is an accurate proxy for body fat in average adults but may be misleading in muscular individuals.

²Avoid weight gain or maintain weight loss, initial goal of 10% weight loss and reassess after goal achieved, maximum weight loss of ½ pound per week if overweight and 1-2 pounds per week if BMI > 30

³Comorbidities: Severe cardiac disease (CHD, pulmonary hypertension, congestive heart failure, and cardiomyopathy); Type 2 diabetes, obstructive sleep apnea and other respiratory disease (chronic asthma, hypoventilation syndrome, Pickwickian syndrome); end-organ damage; pseudo-tumor cerebri; gastroesophageal reflux disease; hypertension; hyperlipidemia; severe joint or disc disease if interferes with daily functioning

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline represents core management steps. It is based on the Prevention and Management of Obesity (Mature Adolescents and Adults), Institute for Clinical Systems Improvement, 2005 and the National Institutes of Health, National Heart, Lung and Blood Institute (NHLBI) Obesity Education Initiative. The Practical Guide: Identification, Evaluation and Treatment of Overweight and Obesity in Adults, 2000 (www.nhlbi.nih.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline
Management and Prevention of Osteoporosis

The following guideline recommends assessment and management of patients with osteopenia and osteoporosis.

Eligible Population	<i>Key Components</i>	Recommendation and Level of Evidence	Frequency		
Patients at high risk for osteoporosis	Assessment	<ul style="list-style-type: none"> Assess for loss of height (> 1.5 inches) and back pain Assess other risk factors: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <u>Modifiable:</u> <ul style="list-style-type: none"> Current cigarette smoking Low body weight (< 127 lbs. or BMI < 20) Endocrine disorders <ul style="list-style-type: none"> Premature or surgical menopause Chronic corticosteroid therapy Estrogen or testosterone deficiency Excessive thyroid hormone replacement Calcium or vitamin D deficiency Excessive alcohol intake (more than two drinks per day) Inadequate physical activity </td> <td style="width: 50%; vertical-align: top;"> <u>Non-Modifiable:</u> <ul style="list-style-type: none"> Family history of osteoporosis Caucasian or Asian race Advanced Age (> age 65) Female Gender History of atraumatic fracture </td> </tr> </table> 	<u>Modifiable:</u> <ul style="list-style-type: none"> Current cigarette smoking Low body weight (< 127 lbs. or BMI < 20) Endocrine disorders <ul style="list-style-type: none"> Premature or surgical menopause Chronic corticosteroid therapy Estrogen or testosterone deficiency Excessive thyroid hormone replacement Calcium or vitamin D deficiency Excessive alcohol intake (more than two drinks per day) Inadequate physical activity 	<u>Non-Modifiable:</u> <ul style="list-style-type: none"> Family history of osteoporosis Caucasian or Asian race Advanced Age (> age 65) Female Gender History of atraumatic fracture 	<ul style="list-style-type: none"> Adult height assessments at periodic well exams BMD test for initial diagnosis [D]
	<u>Modifiable:</u> <ul style="list-style-type: none"> Current cigarette smoking Low body weight (< 127 lbs. or BMI < 20) Endocrine disorders <ul style="list-style-type: none"> Premature or surgical menopause Chronic corticosteroid therapy Estrogen or testosterone deficiency Excessive thyroid hormone replacement Calcium or vitamin D deficiency Excessive alcohol intake (more than two drinks per day) Inadequate physical activity 	<u>Non-Modifiable:</u> <ul style="list-style-type: none"> Family history of osteoporosis Caucasian or Asian race Advanced Age (> age 65) Female Gender History of atraumatic fracture 			
Core Principles of Treatment and Prevention	<u>Regardless of risk factors:</u> <ul style="list-style-type: none"> Dietary calcium 1200 mg/d and 800 – 1000 IU vitamin D₃ [B] Weight-bearing exercise [A] Address modifiable risk factors above 	<ul style="list-style-type: none"> BMD testing more often than every two years is generally not useful Consider rechecking BMD after at least two years of pharmacologic treatment to monitor effectiveness [D] 			
Patients requiring therapy to reduce high risk of fracture	Patient Selection for Pharmacological Management Based on DEXA	<ul style="list-style-type: none"> Treatment to prevent fractures in osteopenia [T-score between -1 and -2.0] without risk factors is not useful [D] Treat patients on corticosteroid therapy with a T-score \leq -1.0 [A] Treat patients with osteopenia and a T-score between -2.0 and -2.5 at increased risk [D] Patients with osteoporosis [T-score < -2.5] (Osteopenia associated with atraumatic fracture should be treated as osteoporosis [D]) 			

¹ Use Caution in patients with active upper GI disorders. Take medication on an empty stomach with water, remain upright, no food or beverage for 30 minutes. (60 minutes for Ibandronate)

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline represents core management steps. It is based on The Guide to Clinical Preventive Services 2009, Recommendations of the U.S. Preventive Services Task Force (www.preventiveservices.ahrq.gov) and the Diagnosis and Treatment of Osteoporosis Guideline, Institute for Clinical Systems Improvement, 2006 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Health Plan of Michigan Clinical Practice Guideline
Medical Management of Adults with Osteoarthritis

The following guideline recommends initial evaluation, nonpharmacologic and pharmacologic interventions for the management of osteoarthritis.

Eligible Population	<i>Key Components</i>	Recommendation and Level of Evidence		
Adults 18 years or older with clinical suspicion or confirmed diagnosis of osteoarthritis.	Initial evaluation	<ul style="list-style-type: none"> • Detailed history (aspirin use, pain control with over-the-counter medications, activity tolerance and limitations) • Physical examination. • <u>Assess gastrointestinal (GI) risk:</u> <ul style="list-style-type: none"> ○ History of GI bleeding ○ Concomitant use of corticosteroids and/or warfarin ○ High dose, chronic, or multiple NSAIDs including aspirin ○ Age > 60 yrs <p style="text-align: center;">[A]</p>		
	Nonpharmacologic modalities	Treatment plan should include: <ul style="list-style-type: none"> ▪ Education and counseling regarding weight reduction, joint protection ▪ Range-of-motion [B], aerobic and muscle strengthening exercises <ul style="list-style-type: none"> ○ For patients with functional limitations, consider physical and occupational therapy ▪ Self-management resources (e.g., American Arthritis Foundation self help course and book) For Select Patients <ul style="list-style-type: none"> ▪ Assistive devices for ambulation and activities of daily living ▪ Appropriate footwear, orthotics (e.g., wedged insoles) 		
	Pharmacologic Therapy			
	Therapies other than NSAID	<ul style="list-style-type: none"> ▪ Initial Drug of Choice: Acetaminophen 4g/day, modify dose for patients at risk for toxicity (Note patients with hepatic toxicity risk factors, especially those on aspirin. Reassess and taper as tolerated.) ▪ Topical capsaicin 		
	NSAID analgesics	No or low NSAID GI risk	NSAID GI risk	
	<ul style="list-style-type: none"> ▪ No cardiovascular risk ▪ Cardiovascular risk 	<ul style="list-style-type: none"> ▪ NSAID ▪ Add PPI¹ if on aspirin, plus risk warrants GI protection ▪ Naproxen^{2,3} ▪ Add PPI¹ if GI risk of aspirin /NSAID combination warrants GI protection 	<ul style="list-style-type: none"> ▪ NSAID plus PPI¹ ▪ If NSAID not tolerated, Cyclo-oxygenase-2 (COX-2) selective inhibitor ▪ For those with prior GI bleed avoid all NSAIDs/COX-2, if must use, then COX-2 plus PPI¹ [D] ▪ Naproxen^{2,3} plus PPI¹ if cardiovascular risk > GI risk ▪ COX-2 plus PPI¹ if GI risk > cardiovascular risk 	
Other pharmacologic agents	Nonacetylated salicylate, tramadol, opioids, intra-articular glucocorticoids or hyaluronate, topical capsaicin or methylsalicylate			

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline lists core management steps and is based on the following sources: The ICSI Diagnosis and Treatment of Adult Degenerative Joint Disease (DJD)/Osteoarthritis (OA) of the Knee, Institute for Clinical Systems Improvement, 2009 (www.isci.org) and Scheiman JM. Summing the Risk of NSAID Therapy. Lancet 2009; 369:1580-1 Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline
Management of Adults with Major Depression

The following guideline recommends being alert to depressive symptoms and risk for suicide, following diagnostic criteria, using pharmacologic treatment, when indicated, in adequate dose and for appropriate duration, and when to refer to Behavioral Health Specialists.

Eligible Population	<i>Key Components</i>	Recommendation and Level of Evidence	Frequency
Adults 18 years or older with high risk for major depressive disorder including prenatal and postpartum populations	Detection and Diagnosis	<ul style="list-style-type: none"> ▪ Assess if DSM-IV-TR criteria for major depression are met [A]: Must have a total of five symptoms for at least two weeks. One of the symptoms must be depressed mood or loss of interest: <ul style="list-style-type: none"> ▪ Depressed mood ▪ Markedly diminished interest or pleasure in all or almost all activities ▪ Significant weight loss or gain (> 5% body weight), or increase or decrease in appetite ▪ Insomnia/hypersomnia ▪ Psychomotor agitation or retardation ▪ Fatigue/loss of energy ▪ Feeling of worthlessness or inappropriate guilt ▪ Diminished concentration or indecisiveness ▪ Recurrent thoughts of death or suicide (Recognition may be increased with the use of a validated screening tool, (e.g., PHQ-9, HANDS, CES-D Revised, Zung, PRIME-MD) ▪ Assess whether patients have symptoms suggesting bipolar disorder [C] 	<ul style="list-style-type: none"> ▪ At each evaluation where the patient's high-risk status, symptoms or signs raise suspicion of current or uncontrolled depression ▪ At the first prenatal care visit through end of first post-partum year
Individuals diagnosed with significant mood symptoms, particularly those meeting criteria for major depression	Screening for Suicide Risk	Assess risk of suicide by direct questioning about suicidal ideation, and if present, suicidal planning, potential means, and personal/family history of suicidal attempts. [D]	At each encounter addressing depression until patient is treated to remission, is stable and has not expressed suicidal thinking in previous visits.
	Management of patients who are prescribed antidepressant medication	<ul style="list-style-type: none"> • Initiate antidepressant medication following manufacturer's recommended doses. [A] • Referral to, and coordination with, Behavioral Health Specialist when [D]: <ul style="list-style-type: none"> • Identified or suspected risk of suicide • Additional counseling as desired • Primary physician not comfortable managing patient's depression • Diagnosis is uncertain or complicated by other psychiatric factors • Complex social situation • Management is complex, response to medication at therapeutic dosage is not optimal, or considering prescribing multiple agents. • Monitor medication frequently and adjust to a therapeutic level as assessed by clinical data not to exceed the highest recommended dose. [D] Medication should not be abruptly discontinued. • If no response after 2 – 3 weeks on therapeutic dosage increase dosage as tolerated and begin new observation period. If no response after 2 – 3 weeks on maximal dosage then switch antidepressant. If partial response after 2 – 3 weeks on maximal dosage then switch antidepressant or augment with additional agent. • For patients with recurrent major depression, continue medication for at least one year or longer at effective dosage. [B] 	Medication for at least 9 – 12 months after acute symptoms resolve [A] Schedule at least 3 follow-up office visits in first 12 weeks one of which can be telephonic [D]

Levels of Evidence for the most significant recommendations: A =randomized controlled trials; B =controlled trials, no randomization; C =observational studies; D =opinion of expert panel

This guideline lists core management steps for non-behavioral health specialists. It is based on several sources including: Major Depression in Adults in Primary Care Health Care Guideline. Institute for Clinical Systems Improvement, 2009 (www.icsi.org). Individual patient considerations and advances in medical science may supercede or modify these recommendations.

**Michigan Quality Improvement Consortium Guideline
Medical Management of Adults with Hypertension**

The following guideline recommends diagnostic evaluation, education and pharmacologic treatment that support effective patient self-management

Eligible Population	Key Components	Recommendation and Level of Evidence
<p>Adult patients ≥ 18 years of age. Not pregnant.</p> <p>Classification based on mean of 2 or more seated BP readings on each of 2 or more office visits.</p> <p>Normal BP < 120/<80</p> <p>Prehypertension 120-139/80-89</p> <p>Hypertension</p> <p><i>Stage 1</i> 140-159/90-99</p> <p><i>Stage 2</i> ≥ 160/≥ 100</p>	<p>Initial assessment</p> <p>Patient education and nonpharmacologic interventions</p> <p>Goals of Therapy</p> <p>Pharmacologic interventions</p> <p>Monitoring and adjustment of therapy [D]</p>	<ul style="list-style-type: none"> The objectives of the initial evaluation are to assess lifestyle, cardiovascular risk factors, concomitant disorders, reveal identifiable causes of hypertension and check for target organ damage and cardiovascular disease. Physical examination: 2 or more BP measurements using regularly calibrated equipment with the appropriate sized cuff and separated by at least 2 minutes, verification in contralateral arm, funduscopic exam, neck exam (bruits), heart and lung exam, abdominal exam for bruits or aortic aneurysm, extremity pulses [A] Laboratory tests prior to initiating therapy: Potassium, creatinine, glucose, hematocrit, calcium, urinalysis, lipid panel, EKG [D] <ul style="list-style-type: none"> Lifestyle modification: weight reduction (BMI goal <25), reduction of dietary sodium to less than 2.4 gm/day, DASH diet [A] (i.e. diet high in fruits and vegetables, reduced saturated and total fat), aerobic physical activity >30 minutes most days of the week, tobacco avoidance, increased dietary potassium and calcium, moderation of alcohol consumption¹ [A] Use of self BP monitoring. Home measurement device should be checked regularly for accuracy. Mean self measured BP>135/85 generally considered to be hypertensive <p>Adjust therapy to achieve target BP <140/90 (<130/80 for patients with diabetes or kidney disease)</p> <ul style="list-style-type: none"> Prehypertension (120-139/80-89): none unless compelling indications (e.g., diabetes, renal failure, CHF, post-MI, stroke arteriosclerotic cardiovascular disease) Hypertension, Stage 1 (140-159/90-99): thiazide-type diuretics alone or in combination with angiotensin converting enzyme inhibitor (ACEI), beta blocker or calcium channel blocker (extended /sustained release or long acting)² Angiotensin receptor blocker (ARB) if ACEI not tolerated Hypertension, Stage 2 (≥ 160/ ≥ 100): two-drug combination (thiazide-type diuretic plus ACEI, beta blocker or calcium channel blocker (extended/sustained release or long acting); use ARB if ACEI not tolerated ACEI (ARB if ACEI not tolerated) are recommended in patients with diabetes or heart failure [A] Beta-blockers are recommended in patients with ischemic heart disease or heart failure 3 or more drugs may be necessary for some patients to achieve goal BP <ul style="list-style-type: none"> Prehypertension without medication: annual BP check with lifestyle modification counseling Hypertension, Stage 1: initiate therapy and recheck at monthly intervals until goal is reached Hypertension, Stage 2: initiate therapy and recheck weekly or more often if indicated. Symptomatic Stage 2 may require hospital monitoring and treatment Modify antihypertensive therapy as needed if adverse effects become intolerable One BP controlled with medication: recheck every 3-6 months Serum potassium and creatinine should be monitored at least 1-2 times/year for patients on medication

¹Moderate alcohol consumption is defined as up to two drinks per day for men, one drink per day for women and older people.

²Avoid use of short-acting nonsustained release calcium channel blockers [A]

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline represents core management steps. It is based on several sources including: Hypertension Diagnosis and Treatment, Institute for Clinical Systems Improvement, 2006 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline
Screening and Management of Hyperlipidemia

The following guideline recommends risk assessment, stratification, education, counseling and pharmacological interventions for the management of low density lipoprotein cholesterol (LDL-C)

Eligible Population	Key Components	Recommendation and Level of Evidence						
Age ≥ 18 years	Risk Assessment	<ul style="list-style-type: none"> Screening: Initial fasting lipid profile (i.e., total, LDL-C, HDL-C, triglycerides); If normal repeat at least every five years [D] Treatment is based on LDL-C, major risk factors and presence of CHD or equivalent. 						
		<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <p>Major Risk Factors:</p> <ul style="list-style-type: none"> Cigarette smoking *Hypertension (BP ≥ 140/90) On antihypertensives, regardless of current BP levels HDL-C: < 40 (HDL-C ≥ 60 = negative risk factor) Family history (first degree) of premature CHD (men < 55 years; women < 65 years) Age (men ≥ 45 years; women ≥ 55 years) </td> <td style="width: 50%; border: none; vertical-align: top;"> <p>CHD Risk Equivalents:</p> <ul style="list-style-type: none"> Other clinical forms of atherosclerotic disease (e.g., peripheral arterial disease, abnormal aortic aneurysm, and/or symptomatic carotid artery disease) Diabetes Multiple risk factors confer a 10-year risk for CHD > 20% CHD and CHD risk equivalents give a >20% risk of CHD event within 10 years </td> </tr> </table>	<p>Major Risk Factors:</p> <ul style="list-style-type: none"> Cigarette smoking *Hypertension (BP ≥ 140/90) On antihypertensives, regardless of current BP levels HDL-C: < 40 (HDL-C ≥ 60 = negative risk factor) Family history (first degree) of premature CHD (men < 55 years; women < 65 years) Age (men ≥ 45 years; women ≥ 55 years) 	<p>CHD Risk Equivalents:</p> <ul style="list-style-type: none"> Other clinical forms of atherosclerotic disease (e.g., peripheral arterial disease, abnormal aortic aneurysm, and/or symptomatic carotid artery disease) Diabetes Multiple risk factors confer a 10-year risk for CHD > 20% CHD and CHD risk equivalents give a >20% risk of CHD event within 10 years 				
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LDL > 100	Risk Stratification	<ul style="list-style-type: none"> Calculate short-term risk for patients with 2+ risk factors using Framingham projection of 10-year absolute risk [D]: 						
		<table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left; border: none;">Categorical Risk</th> <th style="text-align: left; border: none;">Goal for LDL-C</th> </tr> </thead> <tbody> <tr> <td style="border: none;"> <ul style="list-style-type: none"> CHD or CHD risk equivalents 10-year risk: > 20% </td> <td style="border: none;">< 100 mg/dL</td> </tr> <tr> <td style="border: none;"> <ul style="list-style-type: none"> 2+ risk factors 10-year risk: ≤ 20% </td> <td style="border: none;">< 130 mg/dL</td> </tr> <tr> <td style="border: none;"> <ul style="list-style-type: none"> 0 – 1 risk factor </td> <td style="border: none;">< 160 mg/dL</td> </tr> </tbody> </table>	Categorical Risk	Goal for LDL-C	<ul style="list-style-type: none"> CHD or CHD risk equivalents 10-year risk: > 20% 	< 100 mg/dL	<ul style="list-style-type: none"> 2+ risk factors 10-year risk: ≤ 20% 	< 130 mg/dL
Categorical Risk	Goal for LDL-C							
<ul style="list-style-type: none"> CHD or CHD risk equivalents 10-year risk: > 20% 	< 100 mg/dL							
<ul style="list-style-type: none"> 2+ risk factors 10-year risk: ≤ 20% 	< 130 mg/dL							
<ul style="list-style-type: none"> 0 – 1 risk factor 	< 160 mg/dL							
	Education and risk factor modification	<p>Educate patient/family regarding Therapeutic Lifestyle Changes (TLC):</p> <ul style="list-style-type: none"> Reduce saturated fats and cholesterol [A], increase plant stanols/sterol (e.g. cholesterol-lowering margarines), increase viscous soluble fiber (e.g. oats, barley, lentils, beans) Decrease weight and increase exercise to moderate level of activity for 30 minutes, most days of the week [A]. 						
	Pharmacologic interventions	<ul style="list-style-type: none"> TLC and/or drug therapy may be initiated based on the LDL-C level and/or presence of CHD risk or CHD risk factors. Initiate statin therapy for patients with atherosclerotic CHD or when the LDL-C is not at goal by 6-8 weeks after TLC have begun in earnest. Statin are the most commonly used lipid-lowering agents. Liver function test monitoring is recommended for 12 weeks following treatment initiation, or dosage increases, of any statin. Evaluate and adjust drug therapy at 6 – 8 week intervals. For patients who do not reach LDL-C goal, consider referral to lipid specialist. 						

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline represents core management steps. It is based on several sources, including: Lipid Management in Adults, Institute for Clinical Systems Improvement, 2006 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Health Plan of Michigan Clinical Practice Guideline
Management of Adults Systolic Heart Failure

The following guideline recommends diagnostic evaluation, education and pharmacologic treatment and education that support effective patient self-management

Eligible Population	<i>Key Components</i>	Recommendation and Level of Evidence
Adults with suspicion of left-ventricular systolic dysfunction, including heart failure	Evaluation	<p>Initial assessment should include:</p> <ul style="list-style-type: none"> • Thorough history and physical examination [C] including consideration of obstructive sleep apnea • Chest x-ray [C] • 12 lead electrocardiogram [C] • Laboratory tests and other studies should include: CBC, serum electrolytes (including calcium, magnesium), BUN, serum creatinine, blood glucose, liver function tests, TSH, urinalysis [C] • Two-dimensional echocardiography with Doppler or radionuclide ventriculography [C] • Assessment for coronary artery disease risk factors • Serial monitoring should include: weight, volume status, electrolytes, renal function and activity tolerance
Adults diagnosed with left-ventricular systolic dysfunction, including heart failure	Pharmacological Management	<p>Drugs recommended for routine use:</p> <ul style="list-style-type: none"> • ACE inhibitors in all patients, unless contraindicated¹ [A] • Recommend beta-blockers (carvedilol, sustained-release metoprolol, bisoprolol) in all stable patients, unless contraindicated^{1,2} [A] <p>Drugs recommended for use in select patients:</p> <ul style="list-style-type: none"> • Diuretics and sodium restriction for evidence of fluid retention [A] • Spironolactone for patients with recent or current symptoms of heart failure, normal renal function & potassium concentration [B] • In patients who cannot tolerate ACE inhibitors due to cough or angioedema, angiotensin receptor blockers (ARBs) are recommended [A] • In patients who cannot tolerate ACE inhibitors or ARBs due to angioedema, hypotension or renal insufficiency, hydralazine and nitrate combination is recommended [B] • African-American patients may be candidates for adding the combination of hydralazine and isosorbide dinitrite [A]
	Education, counseling and risk factor modification	<p>Educate patient/family regarding:</p> <ul style="list-style-type: none"> • Daily self monitoring of weight and adherence to recommended patient action plan • Recognition of symptoms and when to seek medical attention • Moderate dietary sodium restriction (e.g., 2000-2500 mg sodium/day) • Risk factor modification (regular exercise 3 times per week as tolerated [B] ; smoking cessation; control of BP, DM, lipids, etc.) • Avoid excessive alcohol intake, illicit drug use, and the use of NSAIDS • Vaccination against influenza and pneumococcal disease

¹Contraindications include: life-threatening adverse reactions (angioedema or anuric renal failure), pregnancy, hypotensive patients at immediate risk of cardiogenic shock, systolic blood pressure < 80 mm Hg, serum creatinine >3 mg/dL, bilateral renal artery stenosis, or serum potassium > 5.5 mmol/L

²Contraindications include: patients with current or recent fluid retention history, unstable or poorly controlled reactive airway disease, symptomatic bradycardia or advanced heart block (unless treated with a pacemaker), or recent treatment with an intravenous positive inotropic agent.

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline represents core management steps. It is based on the ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult: A Report of the American College of Cardiology/American Heart Association Task Force on Practice guidelines (www.acc.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Health Plan of Michigan Clinical Practice Guideline
Outpatient Management of Uncomplicated Deep Venous Thrombosis

Eligible Population	Key Components	Recommendation and Level of Evidence
<p>Adult patients ≥ 18 years of age</p> <p>Diagnosis of acute DVT, confirmed by duplex ultra sonography or venography. [A]</p> <p>No contraindications to anticoagulation or use of low molecular weight heparin (LMWH)</p>	Initial Assessment	<ul style="list-style-type: none"> Perform initial comprehensive history and physical examination; consider conditions predisposing to DVT. Assess risk factors and contraindications to outpatient anticoagulation therapy. Assess patient/caregiver ability and compliance for outpatient therapy, and need for home care resources. <p>Contraindications to initiating anticoagulation therapy in the outpatient setting:</p> <ul style="list-style-type: none"> Pulmonary embolism Extensive iliofemoral thrombus Known potential for non-compliance Recent surgery/trauma Active bleeding Severe HTN Pregnancy Known hypercoagulable state Catheter-associated DVT Renal clearance <30mL/min or creatine >2.5 mg/DL Thrombocytopenia <100,000 History of heparin induced thrombocytopenia Childbearing age w/o contraception
	Pharmacologic interventions	<ul style="list-style-type: none"> Outpatient therapy is preferred if no contraindications Contraindications to warfarin therapy: <ul style="list-style-type: none"> Absolute: Pregnancy Relative: dementia, and certain psychoses Begin warfarin after 1st dose of LMWH [A], on the same day, titrate to INR range of 2.0-3.0 Continue LMWH until INR range 2.0-3.0 for 2 consecutive days (usually LMWH 5-7 days). [A] Maintain warfarin therapy at least 3 months in therapeutic INR range. [A] longer if risk of recurrence Ask about any changes in diet, medications and compliance before and dosage adjustment
	Testing/Monitoring	<ul style="list-style-type: none"> Obtain baseline lab values:aPTT, PT/INR, CBC with platelet count. Consider platelet count 3 to 5 day s into anticoagulation therapy. Monitor warfarin therapy using INR; no lab monitoring required for Enoxaprin unless special circumstances such as renal insufficiency or extremes of body weight. Frequent INR monitoring is necessary at the onset of therapy (e.g. at least 2 checks in the first week of therapy); than at least 2-3 times per week for the next 1-2 weeks. When stable, monitor every 4-8 weeks. Maintain an Antiocoagulant Monitoring Log (or dose adjustment system) for each patient treated with warfarin Monitor common bleeding sites; gums, nose, GI, GU and skin Monitor for signs/symptoms of pulmonary embolism, risk factors and side effects. Management through a specialized program for anticoagulation monitoring, if available.
	Patient Education	<ul style="list-style-type: none"> Inform patient/caregiver of the reasons and benefits of therapy, potential side effects, importance of follow-up monitoring warfarin dosage adjustment, compliance, dietary recommendations (i.e. a diet that is constant in vitamin K), the potential for drug interactions, safety precautions, and recognizing internal bleeding. Instruct patient/caregiver on symptoms of pulmonary embolism, extension of DVT and self-injection of LMWH. The patient should be encouraged to be ambulatory after an appropriate weight-based dose of LMWH. [D] Compression stockings should be used routinely to prevent postthrombotic syndrome [A], beginning within 1 month of diagnosis of proximal DVT and continuing for a minimum of 1 year.
Emergency plan	The physician should be available to address serious side effects or increasing behavioral problems.	

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline represents core management steps. It is based on several sources, including: Management of Venous Thromboembolism: AI Clinical Practice Guideline from the American College of Physicians and the American Academy of Family Physicians. Ann Intern Med. 2009; 146:204-210. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

*Michigan Quality Improvement Consortium Guideline
Diagnosis and Management of Adults with Chronic Kidney Disease*

The following guideline recommends diagnosis and aggressive management of chronic kidney disease by clinical stage.

<i>Eligible Population</i>	Key Components	Recommendation and Level of Evidence	Frequency
All adults at increased risk for CKD	Screening & Diagnosis	For patients at increased risk for CKD (e.g., diabetes, hypertension, family history of kidney failure, kidney stones, etc.) assess for markers of kidney damage: <ul style="list-style-type: none"> • Measure blood pressure [A] • Obtain estimated GFR¹ (serum creatinine levers should <u>not</u> be used as sole means to assess renal function) • Protein-to-creatinine ratio or albumin-to-creatinine ration (first morning or random spot urine specimen) • Urinalysis, fasting lipid profile, electrolytes, BUN 	<ul style="list-style-type: none"> • Semi-annual blood pressure monitoring; more frequent monitoring if indicated • Monitor GFR every 1-2 years
	Risk Factor Management & Patient Education	<ul style="list-style-type: none"> • Evaluation and management of comorbid conditions (e.g. diabetes, hypertension, urinary tract obstruction, cardiovascular disease)² • Review medications for dose adjustment, drug interactions, adverse effects, therapeutic levels • Educate on therapeutic lifestyle changes: dietary sodium intake < 2.4g/d recommended for patients with CKD and hypertension [A], weight maintenance if BMI < 25, weight loss if BMI ≥ 25, exercise and physical activity, moderation of alcohol intake, smoking cessation 	At each routine health exam
Adults with CKD		<u>All of the above plus:</u> <ul style="list-style-type: none"> • Develop clinical action plan for each patient, based on disease stage as defined by the National Kidney Foundation, Kidney Disease Outcomes Quality Initiative (K/DOQI) [B] • Incorporate self-management behaviors into treatment plan at all stages of CKD [B] 	
	Core Principles of Treatment	<ul style="list-style-type: none"> • Stage 1 (GFR ≥ 90): Monitor GFR annually, smoking cessation, consider ASA, consider ACE and/or ARB therapy, BP goal <130/80, LDL-C goal < 100 • Stage 2 (GFR 60-89): Nephrology referral if GFR decline > 4ml/min/yr, maintain BP and lipid goals as above • Stage 3 (GFR 30-59): Consult Nephrologist and Renal Dietician; Suppress PTH with Vit D to level appropriate for CKD stage; Phosphorus lowering treatment if > 4.6 mg/dl; Correct iron deficiency before start of erythropoiesis stimulating agent (ESA); ESA if Hgb (Hct) < 10 (30%); Renal-specific vitamins; Update vaccines: HBV, influenza, Tdap and Pneumovax • Stage 4 (GFR 15-29): Nephrology and vascular access surgery referrals, ESA if Hgb < 10 g/dL, Optimize Ca x P product to < 55 with specific agents, update vaccines as indicated, CKD education classes • Stage 5 (GFR <15): Renal replacement therapy 	As indicated

¹If not calculated by lab, refer to National Kidney Foundation website for GFR calculator (<http://www.kidney.org/professionals/tools/>)

²Reference MQIC guidelines on diabetes, hypertension, hyperlipidemia and obesity (www.mqic.org)

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the Henry Ford Health System, Divisions of Nephrology & Hypertension and General Internal Medicine Chronic Kidney Disease (CKD) Clinical Practice Recommendations for Primary Care Physicians and Healthcare Providers, Edition 5.0 (www.ghsrenal.com). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Health Plan of Michigan Clinical Practice Guideline
Management of ADHD

The following guidelines apply to the management and pharmacologic treatment of Attention Deficit and Hyperactivity Disorder.

Eligible Population	<i>Key Components</i>	Recommendation and Level of Evidence	Frequency
Children up to age 18, diagnosed with ADHD and receiving a psychostimulant. Diagnosis is based on criteria from DSM-IV-TR™.	Initial and Follow up Assessment (Initiation phase and continuation and maintenance phase)	Patients assessment should include: <ul style="list-style-type: none"> • Patient's and family's ability to cooperate with treatment [D] • Reasonableness of dosing regimen [D] • Medication side effects [D] • Coexisting medical or psychiatric disorders [D] • Risk of drug diversion [D] • School evaluations [D] 	<ul style="list-style-type: none"> • At onset of treatment patient should be seen within 30 days after initiation of medication prescription. • During continuation and maintenance phase, patient should be seen for at least two additional follow up visits within 9months of initiation phase ending.
	Medication selection: Psychostimulants (see addendum)	<ul style="list-style-type: none"> • Start standard immediate release of psychostimulant; give at dosages recommended by the manufacturer. [A] [B] [C] • Titrate immediate release of medication up to the minimally effective dose before converting to a long-acting formulation such as Concerta, Metadate CD, or Adderrall XR. [B] [D] • Augmentation therapy with clonidine may be indicated when a patient does not respond to stimulant drug, alone. [A] [B] 	Evaluate at each visit until treatment goals are reached.
	Referral to psychiatrist	Psychiatric referral is indicated for patients with serious psychiatric symptoms, serious concurrent medical illnesses, failure to respond to standard dose of psycho-stimulant. [D]	Referrals ordered as needed.
	Education and/or professional counseling	Physician counseling may be beneficial to family and patient in helping them understand ADHD causes, treatment options, medication compliance, treatment side effects.	Recommended <i>at least</i> biannually as indicated.
	Emergency plan	The physician should be available to address serious side effects or increasing behavioral problems.	The physician must be readily available if contacted by the patient or family to address emergency follow-up care.

Sources:

1. Diagnosis and Treatment of ADHD. National Institute of Health. Consensus Statement 16(2): 1998, Nov 16-18
2. American Academy of Pediatrics, Clinical Practice Guideline: Treatment of the school-aged child with ADHD. Pediatrics 2001; 108:1033-44
3. Institute for Clinical Systems Improvement. Diagnosis and Management of ADHD in Primary Care for School Age Children and Adolescents, March 2003
4. National Institute of Neurological Disorders and Stroke 4/02. Methylphenidate and Clonidine Help Children with ADHD and Tics.

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline represents core management steps. Individual patient considerations and advances in medical science may supercede or modify these recommendations.

Reviewed by HPM PAC November 2007

Health Plan of Michigan Clinical Practice Guideline: Acute Pharyngitis in Children

The following guideline recommends assessment, diagnosis and treatment interventions for the management of acute pharyngitis in children and adolescents.

<i>Eligible Population</i>	Key Components	Recommendation and Level of Evidence		
Children 2 – 18 years of age	Assessment	Assess past history of rheumatic fever (especially carditis/vulvular disease) or household contact with a history of rheumatic fever to identify high-risk patients. Assess the likelihood of strep pharyngitis using the following items <ul style="list-style-type: none"> • Sudden onset • History of exposure • Sore throat • Fever • Patchy discrete exudate • Presentation in winter or early spring • Headache • Nausea, vomiting and abdominal pain <ul style="list-style-type: none"> • Inflammation of pharynx and tonsils • Tender anterior cervical nodes <ul style="list-style-type: none"> • Patient aged 5-15 years 		
Not high-risk	Diagnosis	<u>Probability of GABHS</u> Low	<u>Testing</u> None	<u>Treatment</u> Symptomatic treatment only. Avoid antibiotics.
		Intermediate or High	Throat Culture OR	If TC Positive use Antibiotics If TC Negative use Symptomatic treatment only. Avoid antibiotics. If Treatment is started and culture result is negative, stop antibiotics.
			Rapid Screen	If Rapid Screen Positive use Antibiotics If Rapid Screen Negative, culture ¹ and only use antibiotic if throat culture is positive.
High-risk (history of rheumatic fever or household contact)		Start antibiotics immediately. If throat culture is obtained and is negative, stop antibiotics.		
	Treatment	<u>Preferred Treatment for Strep Pharyngitis:</u> <ol style="list-style-type: none"> 1. Penicillin VK: 250-500 mg bid-tid x 10 days 2. Amoxicillin: 20-40 mg/kg/day divided tid x 10 days [A] 3. Benzathine Penicillin G IM x 1: 600,000 units for weight <60 lbs; 1.2 million units for weight > 60 lbs. 4. If Penicillin allergic: Erythromycin Ehtyl Succinate (EES): 40 mg/kg/day bid-qid (max 1 gm/day) x 10 days 5. With oral antibiotics, a full 10 day course is required <u>Alternative Treatment for Strep Pharyngitis:</u> <ol style="list-style-type: none"> 6. Cephalixin 15-50 mg/kg/day divided bid or tid x 10 days 		
	Re-evaluate/ referral	<ol style="list-style-type: none"> 1. If failure to respond clinically after 48 hours of treatment, rule out peritonsillar or retropharyngeal abscess. If present, prompt ENT evaluation is recommended. 2. Assess the potential for a compliance problem. 		

¹Culture optional for age 16 and over

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources including, the ICSI Acute Pharyngitis Guideline, Institute for Clinical Systems Improvement, 2005 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

*Michigan Quality Improvement Consortium Guideline
Management of Acute Low Back Pain*

The following guideline recommends assessment, diagnosis and treatment interventions for the management of acute low back pain in adults.

<i>Eligible Population</i>	Key Components	Recommendation and Level of Evidence
Adults with low back pain or back-related leg symptoms for < 6 weeks	Patients with low risk of serious pathology (no red flags)	<p>Reassure patient that 90% of episodes resolve within six weeks regardless of treatment [C]. Advise that minor flare-ups may occur in the subsequent year.</p> <p><u>Therapy:</u></p> <ul style="list-style-type: none"> Stay active and continue ordinary activity within the limits permitted by pain. Avoid bedrest [A]. Early return to work is associated with less disability. Injury prevention (e.g. use of proper body mechanics, safe back exercises) Recommend ice for painful areas and stretching exercises [D]. McKenzie exercises [A] are helpful for pain radiating below the knee. <p><u>Referral:</u></p> <ul style="list-style-type: none"> If no improvement at 1-2 weeks, refer for goal-directed manual physical therapy, not modalities such as heat, traction, ultrasound, TENS. Surgical referral usually not required if no “red flags.” <p><u>Medication Strategies:</u></p> <ul style="list-style-type: none"> Medication treatment depending on pain severity with acetaminophen or NSAIDS [A] COX-2 inhibitors and muscle relaxants have not been shown to be more effective than NSAIDS [A]. Opiate analgesics have not been shown to be more effective than NSAIDS in acute low back pain. <p><u>Testing</u></p> <ul style="list-style-type: none"> Diagnostic tests or imaging usually not required. If no improvement after 6 --, consider imaging.
	Assessment to identify potential serious pathology	<p>Assess for “red flag” indications of serious disease:</p> <p>Cauda Equina</p> <ul style="list-style-type: none"> Severe or progressive neurologic deficit Recent bowel or bladder dysfunction Saddle anesthesia <p>Cancer</p> <ul style="list-style-type: none"> Men and women age > 50 Cancer history Insidious onset No relief at bedtime or worsening when supine Constitutional symptoms (e.g. fever, weight loss) Male with diffuse osteoporosis or compression fracture <p>Fracture</p> <ul style="list-style-type: none"> Traumatic injury or onset, cumulative trauma Steroid use history Women age > 50 <p>Infection</p> <ul style="list-style-type: none"> Steroid use history Diabetes Mellitus Immune suppression History UTI or other infection Constitutional symptoms (e.g. fever, weight loss) No relief at bedtime or worsening when supine <ul style="list-style-type: none"> HIV Previous surgery Insidious onset IV drug use
	Patients with high risk of serious pathology (red flags)	<ul style="list-style-type: none"> Cauda Equina syndrome or severe or progressive neurologic deficit – Refer for emergency studies and definitive care [C] Spinal fracture or compressions - Plain LS spine X-ray [B]. After 10 days, if fracture still suspected or multiple sites of pain, consider either bone scan [C] or referral [D] before considering CT or MRI. Cancer or infection – CBC, urinalysis, ESR [C]. If still suspicious consider referral or seek further evidence (e.g. bone scan [C], other labs – negative plain film X-ray does not rule out disease).

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources, including the ICSI Adult Low Back Pain Guideline, Institute for Clinical Systems Improvement, 2006 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

*Michigan Quality Improvement Consortium Guideline
Management of Uncomplicated Acute Bronchitis in Adults*

The following guideline recommends assessment, diagnosis and treatment interventions for the management of acute low back pain in adults.

<i>Eligible Population</i>	Key Components	Recommendation and Level of Evidence
Adults 18 years or older with clinical suspicion of uncomplicated acute bronchitis	Assessment	<ul style="list-style-type: none"> • Perform thorough history (including tobacco use status [A]) and physical exam • Assess the likelihood of uncomplicated acute bronchitis using the following items: <ul style="list-style-type: none"> ○ Acute respiratory infection (ARI) manifested predominantly by cough, with or without sputum production lasting no more than 3 weeks ○ No clinical evidence of pneumonia ○ Common cold, acute asthma, or exacerbation of COPD have been ruled out as cause of cough ○ Consider other diagnoses if cough persists greater than 3 weeks.
	Diagnosis	<p><u>Clinical Information and Testing:</u></p> <ul style="list-style-type: none"> • Presumed diagnosis of acute bronchitis: <ul style="list-style-type: none"> ○ ARI and cough with or without sputum production lasting no more than 3 weeks ○ No clinical evidence of pneumonia ▪ Viral cultures, serologic assays and sputum production lasting no more than 3 weeks ▪ Chest x-ray is not indicated if all of the following are present [B]: <ul style="list-style-type: none"> ○ Acute cough and sputum production suggestive of acute bronchitis ○ Heart rate < 100 beats/min ○ Respiratory rate < 24 breaths/min ○ Oral temperature < 38° C (100.4° F) ○ Chest exam lacks findings of focal consolidation, egophony or fremitus
	Treatment	<ul style="list-style-type: none"> • Condition is a self-limited respiratory disorder. Symptomatic treatment only. Routine treatment with antibiotics is not justified and should not be offered. Avoid antibiotics [A] • Beta₂agonist bronchodilators should not be routinely used to alleviate cough. In select patients with wheezing, treatment with beta₂agonists bronchodilators may be useful [C] • Antitussive agents can be offered for short-term symptomatic relief of coughing [C] • Mucokinetic (mucolytic) agents are not recommended (no consistent favorable effect) [D]
	Education and Counseling	<p><u>Educate patient/family regarding:</u></p> <ul style="list-style-type: none"> • Condition often does not require medical treatment • Inform patient that cough may last for 3 weeks • Routine use of antibiotics is not recommended [A] • Use the term “chest cold” which is associated with less patient belief that antibiotics are needed • Rest and increasing fluid intake • Smoking cessation and second-hand smoke avoidance [C] (See also MQIC Tobacco Control Guideline)

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources including the American College of Chest Physicians Chronic Cough Due to Acute Bronchitis: ACCP Evidence-Based Clinical Practice Guidelines, 2006 (www.chestjournal.org). Individual patient considerations and advances in medical science