# Ingham Health Plan

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INTRODUCTION

The Ingham County community is using an innovative approach to providing health care benefits to persons in need. The Ingham Health Plan is serving as a vehicle to access organized systems of healthcare for low income, uninsured residents, who otherwise would not have basic, medically needed health and dental services, at little to no cost. We’ve helped more than 70,000 low income uninsured Ingham County residents since the plan’s creation in 1998. And our impact goes beyond the uninsured.

We also help:

- Provide a safety net for Ingham County’s uninsured
- Save emergency room services for real emergencies
- Reduce uncompensated care for Ingham County’s two hospital systems
- Control health insurance costs for all insured workers, families, and employers

This “coverage” model has been widely used throughout Michigan. Typically, a not-for-profit organization is formed in each of the communities where plans exist. The plan contracts with providers and hospitals to provide care to enrollees. Residents of the county are determined eligible by a local enrollment sites and enrolled in the Ingham Health Plan.

This manual is an instruction handbook and reference guide. It is intended to offer additional detail to areas covered in the contract between the Ingham Health Plan and the participating provider. It is also intended to provide instruction to staff when managing the care of Ingham Health Plan members.
Section 1
MEMBER ENROLLMENT AND DISENROLLMENT

Medical Coverage

Subject to enrollment limitations, persons must meet the following criteria established by Ingham Health Plan (IHP) to be eligible for coverage:

- Be a resident of Ingham County

- Be ineligible for Medicaid, Healthy Michigan Plan (HMP), Medicare Part B, Healthy Kids, MIChild, or any other public health insurance or medical benefit. Exceptions to this are Medicare Part A, Medicaid Spend-down, and Emergency Services Only Medicaid.

- Have a yearly household income equal to or below 240 percent of the Federal Poverty Level. For a one person household this is $28,000 per year.

Eligibility Determinations

- All eligibility determinations for IHP are done by IHP. Applicants unable to meet IHP’s eligibility criteria are classified as ineligible.

Eligibility Limitations

- IHP reserves the right to determine whether a person meets the eligibility criteria established by the plan.

- If funds are limited, IHP may limit enrollment.

DISENROLLMENT

The member may cancel his/her membership at any time by contacting Ingham Health Plan (IHP). A member may be disenrolled by IHP for any of the following reasons:

- IHP limits enrollment and must terminate memberships or terminates its operation for any reason

- The member fails to meet the eligibility criteria established by the plan

- The member’s actions are inconsistent with IHP membership including non-compliance, fraud, or violent or life threatening behavior

In the event that a member is disenrolled, the plan may decide to allow the member to re-enroll in the IHP. If a member disenrolled for failure to meet eligibility guidelines, the member will be eligible to reenroll at any time if he/she meets the eligibility criteria and enrollment limitations have not been enforced. Members disenrolled any other reason shall have the right to appeal.
IHP members will receive a permanent plastic Ingham Health Plan (IHP) identification card that will arrive approximately ten (10) days after the member has been determined eligible. The member will use the IHP card each month he/she is eligible.

IHP Members covered under the Ingham County Health Services Millage will receive an additional identification card from Delta Dental of Michigan which will be used for dental services only.

**Medical Identification card - Ingham Health Plan**

- **Line 1**: Member’s full name - One family member per card
- **Line 2**: Member’s identification number – The letters “HPMS” followed by a six (6) digit number
- **Line 3**: Member’s group number and plan - This is a five (5) digit number and the letter “B”. It represents the member’s assigned primary care provider practice. The member’s group number is followed by the plan letter
- **Line 4**: Assigned office – This is the primary care office the member has been assigned to. It coordinates with the group number
- **Line 5**: Copay amount - The member’s financial responsibility for each visit, procedure or prescription

**Important information about a member’s IHP ID card**

- It will take ten (10) working days after the person is determined eligible before he/she receives a permanent IHP ID card. Providers can verify coverage online at [www.ihpmi.org](http://www.ihpmi.org) or by calling Customer Service at 1-866-291-8691
• A member's IHP ID card and member information are mailed to his/her mailing address unless specified otherwise

• The IHP ID card must be carried by the member at all times

• The member should not throw his/her card away. The member will use the IHP card each month he/she is eligible

• The member should notify IHP Customer Service by calling 1-866-291-8691 when a card is lost, stolen, or damaged. Lost, stolen, or damaged cards are replaced at no cost to the member

• If a card is mailed to a member and is returned to IHP due to an insufficient or incorrect address, the card will be returned to Customer Service

• The identification card is the property of IHP. The member is responsible for returning his/her card upon request.

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**Dental Identification card**

![Dental Identification card image]

• Line 1: Member Identification number. This is a randomly assigned 9 digit number. This is not the member’s social security number or HPMS ID number.

• Line 2: This is the Ingham Health Plan Delta Dental client number. All Dental members have the same client number.
Section 3
ELIGIBILITY VERIFICATION

Member eligibility changes frequently, so it is important to verify eligibility prior to rendering services to a member each time they present for care.

Health providers should request that the member present his/her Ingham Health Plan ID card at each visit. Dental providers should request that the member present his/her Delta Dental ID card at each visit. These ID cards are not a guarantee of eligibility.

To verify if a member is currently eligible to receive services through IHP, the following steps should be:

- Health provider should verify coverage online at [www.ihpmi.org](http://www.ihpmi.org). Provider may also call the IHP Customer Service Department at 866-291-8691 Monday through Friday 8:00am-12:00pm and 1:00pm – 5:00pm.

- Dental providers should verify coverage online at [www.deltadentalmi.com](http://www.deltadentalmi.com) or by calling Delta Dental at 800-870-9988. Customer Service agents are available Monday through Friday 8:30am-8:00pm.

When verifying eligibility, it is necessary to provide the following information:

- Members Name
- Member Identification number as written on the card
- Member’s date of birth or social security number.

If a practitioner provides health or dental care services to an individual and it is later to be determined that the individual is not a member at the time health services were rendered, those services will not be eligible for payment.
Ingham Health Plan provides dental coverage through Delta Dental of Michigan’s EPO plan for some eligible members. Eligible IHP members include those covered under the Ingham County Health Services Mileage. Members should call IHP Customer Service for eligibility details.

Members who are eligible for the dental benefit will receive a new member packet directly from Delta Dental. Coverage begins the first day of the next month following enrollment. All benefits are rendered on the calendar year of January through December. Benefits will cease on the last day of the month in which the member qualifies for coverage.

Covered services are listed under the Covered Services section of this manual.

For dental services, members must go a Delta Dental EPO dentist. When seeking care from a Delta EPO dentist, Delta will pay the dentist for covered services. Members need to pay for any copayment for covered services. EPO is an exclusive provider organization dental plan managed by Delta Dental of Michigan.

Members can switch to another Delta EPO dentist at any time. A list of for EPO dentists is available by calling 800-870-9988 OR by using the online Delta Dentist Directory at www.deltadentalmi.com.

If a member has a dental emergency, they can see any dentist. However, if they do not see an EPO dentist, members will have to pay for the emergency dental care. Delta Dental will then pay the member back up to $125.00 in any calendar year. Members can ask Delta for payment within one year of the emergency dental care being rendered.

Members may be referred to a specialist or another dentist by their EPO general dentist if he/she decides it is necessary. No referral form is required; however, specialist care will only be covered if treatment is received by a participating EPO dentist.
A primary care physician/practitioner (PCP) is responsible for providing and coordinating the care of each member with other physicians. Members enrolled in IHP must use an in network participating PCP. The member’s assigned PCP is listed on the front of his/her IHP card.

Members are assigned to a participating primary care practice by IHP according to the following guidelines:

- At the time of enrollment, the member is assigned to a participating primary care practice based on the provider’s location in relation to the member’s home address and the provider’s ability to accept new patients

- If the IHP is aware of the member’s present primary care practice, all reasonable attempts are made to assign a member to this practice; however, due to capacity and contractual issues, this may not be possible

- If a member has been seeing a primary care doctor that does not participate with IHP, he/she may not be able to continue to see this doctor unless the doctor elects to join the IHP provider network.

If a non-participating doctor is treating a member for a serious health condition, the member must contact the IHP Customer Service Department immediately. The IHP will work with the member to assure that the member’s healthcare is not disrupted while transferring to an in-plan provider.

Members seeking PCP care outside of their assigned IHP PCP are considered self-pay patients. Providers should notify the IHP member of this information at the time of the service. Services rendered by a non-participating provider may not be reimbursed by the IHP.

All reporting to participating primary care practices (PCP) is broken down by the practice's identifying group numbers. Each practice is given a unique group number. Each Ingham Health Plan (IHP) member assigned to a practice will have the corresponding group number. The group number appears on the IHP identification card directly above the member’s name. Group numbers are a five (5) digit number and the letter “B”.

Section 5
PRIMARY CARE PROVIDER ASSIGNMENTS
An Ingham Health Plan (IHP) member may request, in writing or by telephone, a transfer or reassignment to another participating primary care practice (PCP), if other participating practices are accepting members. A member may request a transfer at any time during the year. IHP may limit the number of transfer requests.

The member may make the request by calling Customer Service at 1-866-291-8691. If approved, the member is responsible for transferring his/her medical records.

A PCP may call Customer Service at 1-866-291-8691 or use the Member Information Change Form to request that a member be assigned to their location or reassigned to another primary care practice.

IHP may reassign a member at any time due to provider network issues.

**PCP DISCHARGES**

A participating PCP may request a member be discharged from the practice. The participating PCP should inform IHP of the request to discharge and provide supporting documentation upon request. If an office discharges a member due to the member’s behavior, a copy of the discharge letter or other documentation should accompany the request for reassignment.

To assist in the decision of reassignment or disenrollment from IHP, IHP may request additional documentation such as:

- Police report
- Incident report
- Broken narcotic contract
- Documentation of non-compliant behavior
- Forged or altered prescriptions
- Medical records documenting behavioral issue
- Reports or notes on counseling regarding inappropriate emergency room use
- Counseling or treatment attempts to correct behavior
- Summary of Michigan Automated Prescription System (MAPS) report.
PRIMARY CARE PHYSICIAN ROLES

Each Ingham Health Plan (IHP) primary care physician (PCP) is responsible for coordinating the member’s total health care. All covered health services are either delivered by the PCP or are referred/approved by the PCP and/or the IHP. In addition, the PCP is responsible for initiating referrals for specialty care, maintaining continuity of care, maintaining the member’s medical records, and for assuring that the services provided are of appropriate quality and intensity for the member’s condition.

SPECIALITY PHYSICIAN ROLES

Specialty physicians are valuable members in delivering care to our members. Specialty physicians are responsible for services requested by the PCP, communicating with the PCP regarding medical findings, and obtaining prior-authorization before rendering any services not specified on the original authorization or outside of an office visit.

PROVIDER RESPONSIBILITIES

Participating IHP providers rendering services are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in the Medicaid provider manual. Participating providers are required to accept IHP’s rates for payment for covered services as payment in full. Providers should not bill the member for any amount other than copays and services not covered under the member’s benefit.

Participating providers are required to give IHP access to provider’s records, data, and reports related to services rendered to members, as permitted by law.

Participating providers may discuss treatment options with members that may not reflect IHP’s position or may not be covered by IHP.

Participating providers may not intentionally or unlawfully discriminate in the acceptance or treatment of a member because of the member’s religion, race, color, national origin, age sex, income level, health status, marital status, disability or such other categories of unlawful discrimination as are or may be defined by federal or state law.

Participating providers may advocate on behalf of the member in any grievance, appeal, or utilization review process, or individual authorization process to obtain covered services.
ADDITIONAL PCP RESPONSIBILITIES

PCPs must cooperate with IHP’s quality improvement and utilization review activities.

PCPs should have an established dispute resolution procedure which describes a method for receiving and responding appropriately to member complaints regarding office policies and procedures. Members should have the opportunity to file a complaint and be assured it will be reviewed by someone who is not subject to the complaint.

PCPs should have an ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services to members and to pursue opportunities for improvement.

MEDICAL RECORDS

Participating IHP providers shall maintain medical records of all services provided to IHP members. The medical record must be maintained in a detailed, comprehensive manner that allows for effective professional medical review, medical audit processes, and facilitates an adequate system for follow up treatment. All medical records shall be signed and dated.

Medical records must be retained for no less than seven (7) years from the date of the last visit.

Participating IHP providers shall afford prompt access of all IHP medical records to MDCH and/or the Centers for Medicare and Medicaid Services.

When an IHP member changes PCP, the former PCP must forward his or her medical records or copies of medical records to the new PCP within ten (10) working days from receipt of a written request.

PCP CARE ACCESS GOALS

In order to assure that members have timely access to patient care and services, IHP participating PCPs will be asked to monitor waiting room times, appointment scheduling, and after hours care access on a continual basis. PCPs will be surveyed periodically regarding this process. IHP may also elect to conduct a survey of the office’s patient care access.
Section 8
PROVIDER QUALIFICATIONS AND REGISTRATION

PROVIDER QUALIFICATIONS

Participating providers shall continuously meet all of the following standards:

- Possess an unrestricted license to practice in Michigan and experience no revocation, corrective action, suspension or other related disciplinary action or sanction under federal or state law

- Be authorized under federal and Michigan law to prescribe all drugs and biologicals required to be administered in providing covered Services

- To the extent the participating provider is practicing in a particular field or specialty other than a primary care specialty, the participating provider shall be board certified or board eligible in that field or specialty

- Experience no debarment or suspension by any federal or state agency or experience no suspension, termination or exclusion from participating in Medicare, Medicaid, Blue Cross/Blue Shield or any other federal or state health care program or private third party payer program

- Experience no criminal convictions related to federal health care programs

- Adhere to professional standards of practice and ethics.

PROVIDER REGISTRATION

The registration processes requires all providers to complete the IHP Provider Registration form on behalf of the office and all the corresponding practitioners rendering services to IHP members. Offices requiring an IRS 1099 should also submit a W-9. The Provider Registration form can be obtained at www.ihpmi.org Click on “Provider”. Under the “Provider Tools” menu select “Claims Services”. On the Claims Services home page select “Forms” from the menu.

Providers administering laboratory services in their office must also provide IHP with a copy of its Clinical Laboratory Improvement Amendments (CLIA) Accreditation certificate upon request.

Providers should keep the IHP updated with changes in credentials, office information including telephone number, tax ID number, payee address, office physical address, office hours, open/closed status regarding new members, and physicians/practitioners joining or leaving the practice location. In conjunction with this, providers should respond promptly to any IHP requests to update information so that all credentialing files can be maintained appropriately and clean claims can be processed quickly. Failure to provide IHP with updated with your information may result in slower claim payments.
Health care fraud, waste, and abuse hurts everyone including members, providers, the community, and Ingham Health Plan. IHP asks that participating providers and members report all cases of fraud, waste and abuse.

To help identify fraud and abuse, the following is a list of definitions and examples:

DEFINITION OF TERMS

Fraud — Is defined as “An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).”

Abuse — Is defined as “Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to IHP, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the IHP program.”

EXAMPLES OF MEMBER FRAUD AND/OR ABUSE

- Doctor shopping for controlled substances
- Prescription forging or prescription modification to obtain controlled substances, other medications or more medication than prescribed
- Members sharing their IHP ID cards with nonmembers
- Nondisclosed other health insurance coverage.

EXAMPLES OF PROVIDER FRAUD AND/ABUSE

- Lack of medical necessity for medical services and prescription drugs billed
- Services not provided but billed
- Up-coding of CPT codes to obtain a higher rate of reimbursement
- Inappropriate use of CPT codes and/or modifiers to seek higher reimbursement
- Prescription drugs that were not dispensed as written
• Scheduling more frequent return visits than are needed to increase reimbursement

• Billing for services outside of your medical qualifications

• Balance billing of members for any remaining balance after IHP has reimbursed for the service

**REPORTING FRAUD AND ABUSE**

To report possible fraud or abuse cases, please call Customer Service department at 1-866-291-8691. Potential fraud and abuse may also be reported to IHP at the following address:

Ingham Health Plan  
PO Box 30125  
Lansing, MI 48909

Members and providers may also choose to report to the State of Michigan Medicaid Integrity Section as follows:

Medicaid Integrity Section  
Capitol Commons Center Building  
400 S. Pine Street, 6th Floor  
Lansing, MI 48909  
1-866-428-0005

When reporting fraud or abuse to either IHP or the State of Michigan, the caller should give as many details as he/she can, including names and phone numbers. Callers may remain anonymous.
Advance directives are legal documents that allow members to convey their decisions about end of life care ahead of time. They provide a way for members to communicate their wishes to family, friends, and health care professionals if they are unable to do so themselves.

Members are responsible to tell the PCP if they have an Advance Directive and provide him/her with a copy to keep in their medical record. If an advance directive is not on file, physicians should provide information to the member on how to obtain the appropriate forms. If there are any questions about Advance Directives or a member needs help finding an advance directive form, please call Customer Services at 1-866-291-8691.

There are two types of advance directives:

**LIVING WILL**

A living will tells how a person feels about care intended to sustain life. They can accept or refuse medical care. There are many issues to address including:

- The use of dialysis and breathing machines
- Tube feeding
- Organ or tissue donation
- If the person wants the doctors to try to save them if breathing or heartbeat stops

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

A Durable Power of Attorney for Health Care is a document that names another person to make decisions for the individual if they are not able to do so. This is called a health care proxy. The proxy should be given to someone that they trust to follow their wishes.
Section 11
COVERED SERVICES

PLAN B COVERAGE

Physician, Physician Assistant, and Nurse Practitioner Services
Office visit Copay: $5.00
Covered when provided by the member’s Primary Care Provider (PCP) or by a specialty medical provider to whom the enrollee is appropriately referred for medically necessary services. Services must be provided in an office or outpatient setting. Medicaid covered CPT’s only.

- Office visits
- Annual physical exams, including breast exams, pap smears, and screening tests
- Immunizations
- Administration of allergy extract
- Anesthesia services
- Injectable medications (limited benefit – see additional information)
- Diagnostic and treatment services
- Oral Surgery (Medical services only. Dental related services covered per Delta EPO)
- Ophthalmology services provided by an Ophthalmologist or Optometrist (must be related acute or chronic medical condition)
- Podiatry services
- Preventive Services
- Surgery

Outpatient Hospital Services
Copay: $0.00
Covered when ordered by the member’s PCP or specialty provider to whom the enrollee is appropriately referred and medically necessary. Medicaid covered CPT’s only.

- Physical or Occupational therapy- maximum of 12 visits per calendar year
- Radiation therapy
- Colonoscopies and sigmoidoscopies
- Diagnostic and treatment services (limited benefit)
- Surgeries

Urgent Care Services
Copay: $5.00
Covered for after-hours, non-emergency medical conditions that need to be treated before a PCP appointment can be scheduled. Medicaid covered CPT’s only.

- Urgent care visits
- Immunizations
- Injectable medications and administration.
Laboratory Services
Copay: $0.00
Covered when ordered and/or authorized in advance by the enrollee’s PCP or a specialist physician to whom the enrollee is appropriately referred and medically necessary. Medicaid covered CPT’s only. Genetic testing requires review for medical necessity and prior authorization.

Radiology Services
Copay: $0.00
Covered for diagnosis and treatment purposes when ordered and/or authorized in advance by the enrollee’s PCP or a specialist physician to whom the enrollee is appropriately referred and medically necessary. Medicaid covered CPT’s only.

- Diagnostic X-rays
- CT scans
- Mammograms (women over 40 should be referred to authorized Title XV BCCCP program)
- MRI scans
- PET scans

Ambulatory Surgical Center Services
Copay: $0.00
Covered when services ordered by the member’s PCP or specialist physician to whom the enrollee is appropriately referred and medically necessary. Medicaid covered CPT’s only.

- Practitioner charges for diagnostic and treatment services
- Practitioner charges for surgery

Pharmacy
Copay: $5.00 (Generic)/$10.00 (Brand)

- County Health Plan formulary medications filled at a IHP participating pharmacy
- Diabetic supplies (insulin syringes, lancets, and test strips, quantity limits apply)
- Glucose monitors – Available through Bayer Diagnostics only. Call Bayer at 877-229-3777

Medical Supplies
Copay: $0.00
Covered with a valid prescription when ordered by the member’s PCP or specialist physician and medically necessary.

- Glucose monitors – Available through Bayer Diagnostics only. Call Bayer at 877-229-3777
- Medical supplies other than gradient surgical garments, formulas and feeding supplies, oxygen and related supplies, incontinence supplies, and supplies related to any non-covered durable medical equipment item
- Syringes, test strips, and lancets – Available through member’s Pharmacy Benefit. (See Section 17 for details). Any pharmacy that participates with IHP can fill these prescriptions
- Limited knee and wrist orthotics
**Dental Services**
Dental coverage is available Ingham Health Plan members covered under the Ingham County Health Services Millage only. Not all Ingham Health Plan will receive dental coverage.

**Copay: $0.00** for preventive services, x-rays, and routine fillings. Copayment amounts for all other services such as crowns, root canals, extractions, bridges, and dentures vary depending on service. Services must be performed by Delta Dental EPO provider.

- Cleaning and Preventive exams
- X-Rays
- Filings
- Crown
- Root Canals
- Bridges
- Dentures
- Extractions

The following items have benefit restrictions:

- Oral exams (including evaluations by a specialist) are payable twice per calendar year
- Prophylaxes (cleanings) are payable twice per calendar year
- People with specific at risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment.
- Fluoride treatments are payable twice per calendar year for members up to age 19
- Bitewing X-rays are payable once per calendar year and full mouth x-rays are payable once in any five year period
- Sealants are payable once per tooth per lifetime for the occlusal surface of first permanent molar to age once and second per permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite Resin (white) restorations covered services on posterior teeth
- Porcelain and resin facings on crowns are optional treatment on posterior teeth
- Implants and related services are not covered services.
- Occlusal guards and occlusal adjustments are not covered services.

**Injectable Medications**

**Copay: $0.00** Injection administration is a covered benefit which does not require a prior authorization. However, not all injectable medications are a covered benefit. The purpose of the benefit is to cover common, routine injectable medicine given in the office or outpatient surgery setting. Providers should contact the Plan to verify coverage prior to administration with any questions.

- Infusion therapy is a covered benefit which requires prior authorization. The medication administered by infusion also requires prior authorization, and may not be covered by the Plan.
- Chemotherapy is not a covered benefit.
- Emergency Department and Inpatient Services are not a covered benefit.
- Medicaid payable Vaccines and TB skin testing, as indicated by the CDC, are a covered benefit. Children should qualify for the Vaccines for Children (VFC) program.
IHP members may be eligible for manufacturer PDAP (Patient Drug Assistance Program) or the Michigan AIDS Drug Assistance Program (MIDAP). IHP will not cover any injectable medication, or medication given by infusion, available to the member via a PDAP or MIDAP. Residency and citizenship status may be a barrier for some programs. In the case that a member’s application is rejected the Plan will cover injectable medications included in the Covered Categories below.

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<td>Synovial fluid supplement/joint injections for osteoarthritis J7321, J7323 Available via PDAP: J7324, J7325, J7327,</td>
<td></td>
</tr>
<tr>
<td>Vitamins and Minerals</td>
<td></td>
</tr>
</tbody>
</table>

**Any medication available through PDAP or MIDAP not covered.**

Some injections will require review for medical necessity and will not be paid without a Prior Authorization. These include all botox injections and all unclassified injection codes.

<table>
<thead>
<tr>
<th>NOT COVERED CATEGORIES FOR INJECTION OR INFUSION</th>
<th>ADDITIONAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy drugs</td>
<td></td>
</tr>
<tr>
<td>Drugs to treat complex, chronic conditions Biologies, Immunomodulators, Drugs for Inborn Errors of Metabolisms or Blood Disorders, Treatment for Hepatitis, Treatment for complex Endocrine or Gastrointestinal Disease</td>
<td></td>
</tr>
<tr>
<td>Infertility treatment</td>
<td></td>
</tr>
<tr>
<td>Parenteral nutritional therapies</td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs not listed under Covered Categories</td>
<td></td>
</tr>
<tr>
<td>Drugs related to transplant procedures Immunosuppressants, Antirejection drugs</td>
<td></td>
</tr>
<tr>
<td>Treatment for HIV infection MIDAP available</td>
<td></td>
</tr>
</tbody>
</table>

Specialty Drugs are prescription medications that require special handling, administration, monitoring and significant degree of patient education. These drugs may be oral or injectable and are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis and hemophilia.
Section 12
NON-COVERED SERVICES

The following services are prohibited or not covered under the Ingham Health Plan (IHP)

- Any condition for which the member is eligible to receive health care services or benefits through a public or private health care benefit, program, or insurance plan (e.g. Healthy Kids for pregnant women and infants and Breast and Cervical Cancer Control Program)
- Any covered service not deemed medically necessary
- Any experimental or investigational treatment, supplies, devices, drugs, or any treatment not considered to be reasonable and effective for the specific medical condition
- Any service provided by the assigned primary care provider or specialist not specifically listed as a covered primary care or specialty care service
- Cardiac rehabilitation
- Medications not on the list of covered drugs
- Chiropractic care or services
- Chemotherapy services
- Contraceptive devices or aides and fertility drugs or sterilization (exceptions apply)
- Custodial care, rest therapy, and care in a nursing or rest home facility
- Dental work and treatment (covered by Delta Dental EPO plan)
- Diagnosis and/or treatment of an injury, illness, or disability which occurs or arises from an act of war, declared or undeclared, or from the member’s actions in conjunction with the commission of a felony, an attempt to commit a felony, or an illegal business or occupation
- Dialysis
- Educational classes - exceptions may apply (diabetes education covered)
- Emergency transportation by air or water to a hospital or emergency room and all other non-emergent transportation
- Emergency room services (both professional and facility charges)
- Examinations, preparation, fitting, or procurement of hearing aids
- Eyeglasses, contact lenses, and other vision care
- Home health care services
- Hospice care
- Infertility treatment
- Inpatient hospitalization, both professional and facility
- Items for personal comfort or convenience
- Lodging or transportation expenses
- Medical equipment and some supplies, including but not limited to prosthetics, orthotics, corrective shoes, wigs, bandages, braces, and canes (note: insulin, syringes, lancets, and blood glucose strips are listed on the drug formulary, covered as a pharmacy benefit)
- Medical services provided to any person incarcerated in a local, city, state, or federal penal institution
• Medical or hospital services needed as a result or related to an accident involving a motor vehicle
• Mental health or substance abuse services other than those provided during a primary care provider visit
• Respiratory, and speech therapy
• Office visits, exams/tests, treatments, and reports related to requirements or documentation of health medical status for employment, SSI certification, insurance, travel, surrogate parenting arrangements, school, sports participation, citizenship, or for legal proceedings and court
• Organ transplants
• Oral surgery for dental related procedures (see also Delta Dental EPO plan coverage)
• Oxygen, oxygen related supplies, and CPAP machines
• Services considered to be cosmetic
• Services for sickness or injury to the extent that are covered under No-Fault Law, Workers’ Compensation, Occupational Disease Law, or similar legislation
• Services or supplies related to a sex change
• Services provided outside of Michigan
• Services received before the effective date of coverage or after termination of coverage
• Services not covered by Michigan Medicaid
• Sleep apnea treatment
• Smoking cessation counseling other than through designated providers
• Services to pregnant women whether or not such services are pregnancy-related
• Substance abuse treatment services
• Travel shots
• Visits to a psychiatrist, psychologist, or social worker
• Weight reduction services and procedures.

Section 13
HEALTH CARE SERVICES PROVIDED IN THE COMMUNITY

Some services are available free of charge to Ingham Health Plan (IHP) members through local programs.

FAMILY PLANNING

The Family Planning Program provides services such as pelvic exams, pap smears, breast exams, birth control information and contraceptive supplies, STD counseling, testing and treatment, diagnosis and treatment of gynecological problems, and sterilization referrals to women of childbearing years. Services must be provided at an authorized family planning clinic and are provided on a sliding fee scale based on the number of people in the household and household income. For local program contact information see the directory located in this manual.

Some contraceptive medications are covered. See formulary for details.

BREAST AND CERVICAL CANCER SCREENING SERVICES (BCCCP)
Breast and Cervical Cancer Screening Program is available to women age 40 and over. The program provides screening services including a pelvic exam, Pap smears, clinical breast exam, and mammogram. Follow-up services are also available to women with abnormal findings. Services must be provided by an authorized BCCCP provider. For local program contact information see the directory located in this manual.

Section 14
MEMBER HEALTH EDUCATION

The Ingham Health Plan (IHP) provides general health education for members with active chronic disease processes such as diabetes, obesity, migraine, asthma to assist your patients in better understanding their condition, knowing plan benefits related to the disease, and providing them with assistance in self management of their condition. The information is designed to reinforce your treatment plans for the patient.

Health education materials are available under “Members” on the IHP web site at www.ihpmi.org. Click on the member’s health plan, then “Managing Your Health”. Members may also contact Customer Service at 866-291-8691 to request information be mailed to their home. IHP may periodically mail newsletters to members with general information regarding their disease, ways to self-manage their symptoms, and how to access care through the IHP.

Section 15
AUTHORIZATION FOR MEDICAL SERVICES

The following describes the authorization process for those services that are covered by Ingham Health Plan (IHP)

A primary care physician (PCP) may refer IHP members to any physician specialist in the state of Michigan who will accept persons enrolled in IHP. An authorization is not necessary for the referral; however, a provider must obtain authorization to perform a procedure or testing in the office or outpatient hospital setting.

An authorization is verification and approval that a specific service is covered by IHP. Authorizations for covered services must be obtained prior to the service being rendered. Retroactive authorizations are not given. Failure to follow the existing process may lead to nonpayment of services.

An authorization number is assigned at the time of request. However, payment for a covered service is contingent on the member being eligible on the date of service and procedure code being payable according to Medicaid guidelines.
All test results and reports should be sent to the ordering provider, not IHP.

MEDICAL SERVICES REQUIRING AN AUTHORIZATION

- Procedures or diagnostic testing
- Outpatient hospital procedures or diagnostic tests (other than routine diagnostic lab or radiology services)
- Cancer treatment services such as radiation treatment
- Genetic Testing

MEDICAL SERVICES NOT REQUIRING AN AUTHORIZATION

- Office Visits (CPT codes 99201-99215, 99241-99245, and 99381-99397)
- Laboratory tests (CPT codes 80000-89999 (excluding genetic testing))
- Radiology procedures (CPT codes 70010-76999 and 78000-79999)
- Visits to an urgent care center/clinic

AUTHORIZATION SUBMISSION

Electronically submit your request using the online automated authorization system. This system is located at www.ihpmi.org. Providers may receive an immediate authorization on some services. A response will be faxed back within two (2) business days for services requiring further review.

Call Customer Service at 1-866-291-8691 for same day requests.

MEDICAL REVIEW

IHP may limit covered services to those that are medically necessary and appropriate, and that conform to professionally accepted standards of care. Clinical documentation is not required for authorization unless requested by IHP.

Review for medical necessity may be required for some services. Surgical services should not be scheduled for the member until this review is concluded by IHP and an authorization is granted. For medical review requests, the provider should send clinical documentation to support medical necessity to:

Ingham Health Plan
ATTN: Medical Review
P.O. Box 30125
Lansing, MI 48909
Fax: 517-394-4549
Medical review cases are reviewed per the following time frames:

- Non-urgent pre-service decisions within 14 calendar days of receipt of request
- Urgent pre-service decisions within 3 working days

The IHP will notify the provider and/or member in writing of the decision. The “decision notice” will include the decision, reason for the decision if denied, and the right to appeal a denied request. Please see the Appeal Procedures section of this manual for information on how to file an appeal. The requesting provider has the right to discuss the decision with a person familiar with the case. Call IHP for more information.

**AUTHORIZATION REQUEST FORM- ONLINE INSTRUCTIONS**

Providers submitting an online authorization request must have a login and password to IHP’s member management system.

To access the online authorization form, go to [www.ihpmi.org](http://www.ihpmi.org). Once logged in, search for the member under “Eligibility Search”. Click “View” next to the member’s name and then click on the “Authorization Request” tab listed at the top of the member’s eligibility details window. Please complete all fields requested. Some fields have auto fill capabilities.

Requesting and rendering providers or facilities should be selected from the IHP provider database. Type in the NPI or use the drop down menu to choose the city in which the provider is located. If your provider is not listed, click on the box indicating the provider is not found. You will then be able to type in your provider information.

If the member is no longer covered by the plan the system will not allow the request to be submitted.

Sample form:
AUTHORIZATION REQUEST FORM

REQUESTING PCP / SPECIALIST OFFICE

Date of Request: ____________
Request Submitted By: ____________

Search for a Requesting Provider or Facility by using one of the methods below

Provider NPI: ____________
Provider's City: ____________
Facility: ____________

☐ If Provider not found, check here to enter Provider Information

SEARCHING PROVIDER / FACILITY

Search for a Rendering Provider or Facility by using one of the methods below

☐ Same As Above

Provider NPI: ____________
Provider's City: ____________
Facility: ____________

☐ If Provider not found, check here to enter Provider Information

SERVICES REQUESTED

*Note: Inpatient services are not a covered benefit

Date of Service: ____________

Primary Diagnosis
ICD9 Code: ____________
Primary Diag Desc: ____________
Secondary Diagnosis
ICD9 Code: ____________
Secondary Diag Desc: ____________

Procedure
Description: ____________

Form Completed By: ____________
Contact Number: ____________
Contact E-mail: ____________

Submit
Ingham Health Plan's (IHP’s) prescription benefit is subject to a limited formulary. The most current formulary is available on the internet at www.ihpmi.org. Only the medication form(s) and doses listed on the formulary are covered. Prescriptions are filled with a generic medication, unless one is not available. There are very few brand name medications available on the formulary.

Prescriptions can be written for up to a 30-day supply. Some medications have monthly quantity limits. The blood glucose test strip quantity limit may be over-ridden from 50 to 100 strips per month, upon submission of a Prior Authorization request.

Diabetic supplies such as test strips, lancets, and insulin syringes are on the formulary as a pharmacy benefit. Quantity limits and brand restrictions apply.

Members enrolled in IHP are subject to prescription copays. Copays are expected to be paid at the time the prescription is dispensed. Members are responsible for covering the cost of any medication dispensed at a nonparticipating pharmacy or not covered by the plan. Members are responsible to pay 100% of the cost of the medication if it is less than the copay amount (when copays apply).

Section 17
APPEAL PROCEDURE

Ingham Health Plan monitors member and provider appeals. The following is a summary of the appeal processes as written for IHP members.

An Ingham Health Plan (IHP) member, member’s representative or medical provider shall have the right to file an appeal with IHP for actions consistent with the definition of an appeal.

An appeal is a request for review of the IHP’s decision that resulted in any of the following actions:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a properly authorized Covered Service
- The failure of IHP to act within the established timeframes for grievance and appeal disposition.
Appeals must be in writing and addressed to:

Ingham Health Plan
Attn: Appeals
P.O. Box 30125
Lansing, MI 48909

**ADMINISTRATIVE AND MEDICAL SERVICE APPEALS**

IHP shall mail a notice to the member, at his/her last known address, informing of a denial, reduction, suspension or termination of a requested covered service, reason for the action, effective date of the action, and the right to an appeal.

The member, member’s representative, or medical provider, may request an internal appeal with IHP. The appeal must be received by IHP within 45 days from the effective date the action.

**CLAIM APPEALS**

IHP shall mail an explanation of benefits to the provider informing him/her of each claim determination. The member or provider disagreeing with an adverse determination made on a clean claim may request an Internal Claim Reconsideration Review.

Internal Claim Reconsideration Review requests can be submitted either in writing or verbally to the Claim Services Department within 12 months from the date the claim was denied. Appeals related to timely filing must be received within 16 months from the date of service, provided the claim was originally submitted within 12 months of the date of service.

Members or providers disagreeing with the Internal Claim Reconsideration Review decision may submit a written Level I Internal appeal. These appeals must be received within 60 calendar days after the claim reconsideration review decision. Members or providers disagreeing with Level I decision may submit a written Level 2 Internal appeal. These appeals must be received within 30 calendar days after the Level I decision.

**DISENROLLMENT APPEALS**

IHP shall notify the member in writing if IHP intends to disenroll. The notice will include information on how the member can appeal the action to IHP. Disenrollment by IHP may occur for the reasons stated in the Member Enrollment and Disenrollment section and are subject to appeal. Some reasons are not subject to appeal.
The Ingham Health Plan (IHP) adjudicates claims according to the State of Michigan Medical Services Administration (MSA) policies and procedures. Reference the Uniform Billing Guidelines, ICD-9 Diagnosis, CPT and HCPCs code books, and Michigan Department of Community Health (MDCH) website www.michigan.gov when submitting a claim.

**PROVIDER REQUIREMENTS**

Providers rendering services to IHP members must comply with all Medicaid provider requirements outlined in the Medicaid provider manuals however; they do not need to be a Medicaid enrolled provider.

**CLAIM SUBMISSION**

The standard CMS 1500 Claim Form or UB 04 Claim Form is required for paper claim submission. Providers must use industry standard HCPCS, CPT, Revenue and ICD-9 codes when billing the IHP.

Claims require valid and complete diagnosis coding relative to the date of service listed in the International Classification of Diseases, Clinical Modification (ICD-9-CM) publication. Diagnosis codes should be reported to the highest degree of specificity. If applicable, 4th and 5th digit level descriptions are mandatory for claims reimbursement.

Claims submitted with incorrect member information, such as the member identification number, date of birth, or spelling of member’s first and last name, will be returned to the office unprocessed. Claims submitted with incorrect or unregistered provider and payee information will be returned to the office unprocessed.

**NATIONAL DRUG CODE (NDC) REQUIREMENTS**

The IHP requires the billing of drug codes along with the appropriate NDC code for reimbursement. Providers should reference the Michigan Department of Community Health’s MSA 10-15 and MSA 10-26 Bulletins for more information. Submitting claims with a missing or invalid NDC drug code will result in delay of payment or denied claim. Please refer to newest NDC coding guidelines for direction regarding appropriate codes.

**PAPER CLAIMS**

Paper claims are scanned into the claim processing system and converted to an EDI format. Paper claims may be prepared using a computer or typewriter. To enhance the speed of processing claims, the following “DOs” and “DON’Ts” should be observed:

- Do use clean typewriters
- Do use black ribbon/ink
- Do use care in proper alignment of claim form
- Do avoid small font. Use font size between 10-14 points
- Do try to prevent shadows
- Do adjust printer to insure character clarity side to side, top to bottom
- Don’t use script or slant type
- Don’t highlight information on claim form
- Don’t type over preprinted numbers and words
- Don’t use special characters (i.e. #, $).

Paper claims should be submitted to:

Ingham Health Plan
P.O. Box 30125
Lansing, Michigan 48909

**CMS 1500 FORM REQUIREMENTS**

When completing the CMS 1500 form, the following form locators must be completed or the claim will be denied:

<table>
<thead>
<tr>
<th>FIELD</th>
<th>STATUS</th>
<th>INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>OPTIONAL</td>
<td>Insurance</td>
</tr>
<tr>
<td>1a</td>
<td>MANDATORY</td>
<td>BHJHP I.D. Number (Format: HPMS + 6 digits. Medicaid Recipient number is not accepted)</td>
</tr>
<tr>
<td>2</td>
<td>MANDATORY</td>
<td>Patient's Name</td>
</tr>
<tr>
<td>3</td>
<td>MANDATORY</td>
<td>Patient's Birth Date And Sex</td>
</tr>
<tr>
<td>4</td>
<td>MANDATORY</td>
<td>Insured's Name</td>
</tr>
<tr>
<td>5</td>
<td>MANDATORY</td>
<td>Patient's Address</td>
</tr>
<tr>
<td>6</td>
<td>MANDATORY</td>
<td>Patient Relationship To Insured</td>
</tr>
<tr>
<td>7</td>
<td>MANDATORY</td>
<td>Insured's Address</td>
</tr>
<tr>
<td>8</td>
<td>OPTIONAL</td>
<td>Patient Status</td>
</tr>
<tr>
<td>9</td>
<td>OPTIONAL</td>
<td>Other Insured's Name</td>
</tr>
<tr>
<td>9a</td>
<td>OPTIONAL</td>
<td>Other Insured's Policy Or Group Number</td>
</tr>
<tr>
<td>9b</td>
<td>OPTIONAL</td>
<td>Other Insured's Date Of Birth And Sex</td>
</tr>
<tr>
<td>9c</td>
<td>OPTIONAL</td>
<td>Employer's Name Or School Name</td>
</tr>
<tr>
<td>9d</td>
<td>OPTIONAL</td>
<td>Insurance Plan Name Or Program Name</td>
</tr>
<tr>
<td>10a</td>
<td>OPTIONAL</td>
<td>Is Patient's Condition Related To Employment?</td>
</tr>
<tr>
<td>10b</td>
<td>OPTIONAL</td>
<td>Is Patient's Condition Related To Auto Accident?</td>
</tr>
<tr>
<td>10c</td>
<td>OPTIONAL</td>
<td>Is Patient's Condition Related To Other Accident?</td>
</tr>
<tr>
<td>10d</td>
<td>OPTIONAL</td>
<td>Reserved For Location Use</td>
</tr>
<tr>
<td>11</td>
<td>OPTIONAL</td>
<td>Insured's Policy Group Or Federal Employee Compensation Act (FECA) Number</td>
</tr>
<tr>
<td>11a</td>
<td>OPTIONAL</td>
<td>Insured's Date Of Birth</td>
</tr>
<tr>
<td>11b</td>
<td>OPTIONAL</td>
<td>Employer's Name Or School Name</td>
</tr>
<tr>
<td>11c</td>
<td>OPTIONAL</td>
<td>Insurance Plan Name Or Program Name</td>
</tr>
<tr>
<td>11d</td>
<td>OPTIONAL</td>
<td>Is There Another Health Benefit Plan?</td>
</tr>
<tr>
<td>12</td>
<td>MANDATORY</td>
<td>Patient's Or Authorized Person's Signature</td>
</tr>
<tr>
<td>13</td>
<td>MANDATORY</td>
<td>Insured's Or Authorized Person's Signature</td>
</tr>
<tr>
<td>14</td>
<td>OPTIONAL</td>
<td>Date Of Current Illness, Injury Or Pregnancy</td>
</tr>
<tr>
<td>15</td>
<td>OPTIONAL</td>
<td>If Patient Has Had A Same Or Similar Illness, Give First Date</td>
</tr>
<tr>
<td>16</td>
<td>OPTIONAL</td>
<td>Dates Patient Unable To Work In Current Occupation</td>
</tr>
<tr>
<td>17</td>
<td>MANDATORY</td>
<td>Name Of Referring Physician Or Other Source</td>
</tr>
<tr>
<td>FIELD</td>
<td>STATUS</td>
<td>INFORMATION</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>MANDATORY</td>
<td>Company Name as registered with the IRS, Address and Telephone Number. Must be a street address. No Po Boxes or lockbox addresses.</td>
</tr>
<tr>
<td>2</td>
<td>MANDATORY</td>
<td>Payment Name, Address</td>
</tr>
<tr>
<td>3</td>
<td>MANDATORY</td>
<td>Patient Control Number</td>
</tr>
<tr>
<td>4</td>
<td>MANDATORY</td>
<td>Type of Bill</td>
</tr>
<tr>
<td>5</td>
<td>MANDATORY</td>
<td>Federal Tax Number</td>
</tr>
</tbody>
</table>

**UB 04 FORM REQUIREMENTS**

When completing the UB04CMS 1500 form, the following form locators must be completed or the claim will be denied:
<table>
<thead>
<tr>
<th></th>
<th>MANDATORY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Statement Covers Period</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8a</td>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>9a-d</td>
<td>Patient Address</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Patient Date of Birth</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Patient Sex</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Admission Start of Care Date</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour (for inpatient only)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Type of Admission</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Source of Admission (SRC)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Patient Status (Discharge Status)</td>
<td></td>
</tr>
<tr>
<td>18-28</td>
<td>Condition Codes (if applicable)</td>
<td></td>
</tr>
<tr>
<td>29-30</td>
<td>ACDT State</td>
<td></td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence Codes and Dates (if applicable)</td>
<td></td>
</tr>
<tr>
<td>35-37</td>
<td>Occurrence span code</td>
<td></td>
</tr>
<tr>
<td>38a-d</td>
<td>Name and Address of the party responsible for the bill</td>
<td></td>
</tr>
<tr>
<td>39-41</td>
<td>Value Codes and Amounts (if applicable)</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Revenue Codes</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Revenue Description plus (NDC &amp; its supplemental information)</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>HCPCS Code/Rates (if applicable)</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Date of Service for the Line Item</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Units of Service (if more than 1)</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Total Charges (by Revenue Code/HCPCS)</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Dollar Amount for Any Non-covered Services</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Payer Identification</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Assigned Release For Insurance Benefit</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Assignment Of Benefits</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Prior Payments (if applicable)</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Estimated Amount Due From Payer</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Billing Provider NPI#. Must Be Register with the BHJSHP</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>Name Of Insured</td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Patient’s Relationship To Insured</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Members IHP ID Number (Format: HPMS + 6 digits. Medicaid Recipient number is not accepted).</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Group Policy Number</td>
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<tr>
<td>63</td>
<td>Authorization Number</td>
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<td>Document Control Number</td>
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<tr>
<td>65</td>
<td>Name Of Employer</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>ICD-9 Principle Diagnosis</td>
<td></td>
</tr>
<tr>
<td>67a-q</td>
<td>Other Diagnosis Codes (if applicable)</td>
<td></td>
</tr>
<tr>
<td>68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis (for Inpatient only)</td>
<td></td>
</tr>
<tr>
<td>70a-c</td>
<td>Patient Reason Diagnosis</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>72</td>
<td>External Cause Of Injury ICD-9 Diagnosis Code</td>
<td></td>
</tr>
<tr>
<td>73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Principle Procedure Code and Date</td>
<td></td>
</tr>
<tr>
<td>74a-c</td>
<td>Other Procedure Codes and Dates</td>
<td></td>
</tr>
</tbody>
</table>
ELECTRONIC CLAIMS

IHP also accepts professional and institutional electronic claims from the Emdeon clearinghouse. The IHP Payer ID is 38343. Claims can be sent directly to Emdeon or sent by your clearinghouse. To send claims directly to Emdeon, you must be a customer of Emdeon. To enroll in Emdeon, call 1-800-845-6592. To send claims from your clearinghouse, the clearinghouse must have a forwarding agreement with Emdeon. This arrangement allows your clearinghouse to pass the claim on to Emdeon so IHP can receive them. Contact your Clearinghouse to see if this arrangement exists.

Hospital providers must use the ASCX12N 837 4010A1 institutional format when submitting electronic claims. Practitioners must use the ASC X12N 837 4010 A1 professional format.

<table>
<thead>
<tr>
<th>FIELD</th>
<th>REQUIREMENT/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer Identification number</td>
<td>38343</td>
</tr>
<tr>
<td>Billing Provider</td>
<td>85</td>
</tr>
<tr>
<td>Billing Provider Name</td>
<td>Individual Provider - Enter each part of name in separate fields using the format shown below. Do not use any punctuation. (LASTNAME FIRSTNAME MIDDLEINITIAL)</td>
</tr>
<tr>
<td></td>
<td>Group Practices/Companies - Enter as much of the full name as possible in last name field using the format shown below. Do not use any punctuation (GROUPNAME).</td>
</tr>
<tr>
<td>Billing Provider Address</td>
<td>Use standard US Post Office street abbreviations (ex. N, E, S, SW, NE) in the format shown below. Do not use any punctuation. (999 S Healthcare ST or PO BOX 123)</td>
</tr>
<tr>
<td>City, State, and ZIP</td>
<td>Use full city name and standard Post Office two-digit state abbreviations. Use the five digit zip code.</td>
</tr>
<tr>
<td>Billing Provider Identification Number:</td>
<td>A required field. Enter your billing provider NPI number. Incorrect provider identification numbers will cause the claim to be rejected</td>
</tr>
<tr>
<td>Billing Provider Secondary Identifier</td>
<td>Tax ID</td>
</tr>
<tr>
<td>Member Group Number</td>
<td>Loop: 2000B, Segment: SBR03. A required field but can be defaulted to 999999 if number unknown.</td>
</tr>
<tr>
<td>Member Name</td>
<td>A required field. Enter each part of the name into a separate field using the format shown below. Incorrect spelling of a member’s name will cause the claim to be rejected. The spelling must mirror the spelling on the member’s IHP card. (LASTNAME FIRSTNAME MIDDLEINITIAL)</td>
</tr>
</tbody>
</table>
### Member Identification Number

(Loop: 2000B, Segment: SBR03): A required field. **An incorrect identification number will cause the claim to be rejected.** The identification number will be HPMS plus 6 or seven digits. There is a hyphen after the HPMS. This is not the member’s Medicaid, Social Security, or group number. *(HPMS-012345)*

### Members Address:

Street- Use standard US Post Office street abbreviations (ex. N, E, S, SW, NE) in the format shown below. Do not use any punctuation. *(999 S Healthcare ST or PO BOX 123)*

### City, State, and ZIP

Use full city name and standard Post Office two-digit state abbreviations. Use the five digit zip code.

### Member’s Date of Birth and all other Date Fields

Enter each part of the date in the format shown below. Do not use any punctuation. **An incorrect date of birth will cause the claim to be rejected.** *(CCYYMMDD)*

### Units


---

If you have questions about the set up instructions above contact IHP’s third party administrator at 1-800-634-0173.

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**ELECTRONIC CLAIMS DATA VALIDATION**

EDI claims will be validated at several points before they are loaded into the claims payment system.

- Your clearinghouse validates the claim data. You should be provided with rejection reports by your clearinghouse for claims that we do not receive. IHP does not receive a copy of those reports and has no control over the validation your clearinghouse performs. Positive submission status received from the clearinghouse does not guarantee claims were received by IHP. Clearinghouse edits may differ from IHP claim requirements.

- Emdeon Envoy validates the claim data. If you have problems with claim rejections **received from the clearinghouse:** Contact Emdeon Transaction Division/Envoy Customer Solutions at 1-800-845-6592.

- IHP’s claim system validates the claim data. The member’s name, ID number, and date of birth must be correct for the claim to be processed. The rendering and billing provider identification number (NPI) must also be correct. If any of these fields are incorrect, a copy of the original claim will be returned with a cover letter explaining the rejection. These rejections may also appear on an explanation of benefits (EOB) with a rejection code stating the patient/provider could not be identified.
CLAIM FILING LIMIT

Providers may submit an initial claim up to 365 days from the date of service to be considered for payment. The IHP will allow an additional 120 day grace period if documentation is attached showing the office attempted to submit an initial claim to IHP within 365 days from the date of service.

CLAIM STATURING

Claims can be statused by phone at 1-866-291-8691, by fax at 1-517-394-4590, or by email at claimsservices@ingham.org. IHP recommends waiting a minimum of 30 days after submission before checking status.

Claims can also be statused any time online at www.communityhealthplans.org. Click on “Providers” and under the “Provider Tools” menu; select the “Claim Services” option. On the left hand side of the screen, select “Online Claim Status”. The claim provider portal provides real time access to claim history, status, payment information, and explanation of benefits. Providers must obtain a password and login prior to use. Offices can obtain an application for a login by clicking on the “I am a new Provider” option. A temporary password will be emailed within five (5) to ten (10) working days. Offices should register each individual practitioner rendering services to IHP members.

CLAIM ADJUSTMENTS/RESUBMISSIONS

If a provider notices an error on a claim once it has already been processed for payment and a correction needs to be made in one or more of the following fields: charge amount, units, diagnosis, procedure code, or modifier, a claim adjustment should be submitted. Providers should send a copy of the corrected claim and a cover sheet or IHP Claim Adjustment-Appeal form describing the correction made. These documents must be faxed to the claims services department at 517-394-4590. Failure to follow this step could result in the corrected claim denying as a duplicate submission. Prior IHP payments should be refunded.

CLAIM APPEALS

If a provider receives an adverse claim determination, an appeal for the service may be submitted using IHP’s internal appeal mechanism. Internal Claim Reconsideration Review requests can be submitted either in writing or verbally to the HPMS Claim Services Department within 12 months from the date the claim was denied. Appeals related to timely filing must be received within 16 months from the date of service, provided the claim was originally submitted within 12 months of the date of service.

Providers disagreeing with the Internal Claim Reconsideration Review decision may submit a written Level I Internal appeal. These appeals must be received within 60 calendar days after the claim reconsideration review decision. Members or providers disagreeing with Level I decision may submit a written Level 2 Internal appeal. These appeals must be received within 30 calendar days after the Level I decision.
Appeals should be submitted to:

Ingham Health Plan  
Attn: Claim Services Appeal  
PO Box 30125  
Lansing, MI 48909  
Fax: 517-394-4590

IHP 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 IHP respond within 30 days of receiving the necessary information. Providers will receive an EOP or letter with IHP’s decision and rationale.

**REIMBURSEMENT**

For practitioner covered services, IHP will reimburse at 8% above the Michigan Medicaid fee schedule rates or the provider’s usual and customary charge, whichever is less, minus the required copay amount. For facility charges, IHP reimburses at Michigan Medicaid rates. Find the Medicaid fee screens at the Michigan Department of Community Health website at [www.michigan.gov/mdch](http://www.michigan.gov/mdch). Click on Providers and proceed to information for Medicaid providers. By accepting payment from IHP, the provider is choosing to accept the patient as an IHP member and the member should not be billed for covered services.

Offices visits and immunization administrative services rendered by PCPs and Specialist are reimbursed at rates similar to the 2014 Medicare rates.

Members are financially responsible for copayments, services not a contract covered benefit, and services provided before and after the effective date of eligibility. Members are also financially responsible for services if they choose to obtain services from an out-of-network or non-participating provider. It is recommended that the provider obtain the member’s acknowledgement of payment responsibility in writing for the specific services to be provided.

IHP is financially responsible for assuring timely and accurate payment for covered services rendered by the provider to a covered member. Such payments will usually be made to the provider within 45 days following receipt of a complete and undisputed claim. Claims will not appear on an EOB prior to being adjudicated. Common reasons claims may be considered incomplete include incorrect provider and/or member information, or the claim form is missing required information.

Members **should not be billed** for the following:

- Difference between the provider’s charge and IHP reimbursement
- IHP denied services because of improper billing or failure to obtain authorization (if required),
- A procedure code not listed on the Medicaid fee schedule and member was not informed that it was non-covered prior to the service being performed.
REFUNDS

Providers may send refund or voided checks to IHP when the paid amount needs to be returned due to overpayment, either from a primary insurance or processing error. A copy of the IHP EOP and, if applicable, the primary insurance’s EOP, with a check made out to IHP should be sent to the following address:

Ingham Health Plan
Attn: Refunds
P.O. Box 30125
Lansing, Michigan 48909

Occasionally IHP receives notice from the State of Michigan that they are retroactively terminating a member’s benefit through the health plan. Usually this is a result of the member being enrolled in another State program, such as Medicaid or Healthy Michigan Plan. For provider reimbursements made during this period, IHP will recover those payments. Providers will receive a refund request for these overpayments. Refunds not received will be deducted from the provider’s future checks.
An EOP will be sent to each provider once the claim has been processed. If multiple claims are processed under the same provider, a bulk payment will be made. Claim information will be listed alphabetically below the check.

When posting the EOP, each patient’s identifying information appears in the shaded box above the service line information. If a service line is rejected, a two or three character code appears next to the ineligible dollar amount. Explanation codes for rejected claims appear at the end of the remittance advice.

The following is a list of the most common Explanation Codes that may appear on a provider’s EOP. For codes not appearing on this list, please refer to the end of the EOP for a detailed description.

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>The Member has no eligibility effective during the Date(s) of Service.</td>
</tr>
<tr>
<td>002</td>
<td>The From date of service is after the termination date of an existing coverage eligibility entry.</td>
</tr>
<tr>
<td>003</td>
<td>A duplicate claim was found for this charge based on the member, provider, service dates, place of service, procedure code, and modifier.</td>
</tr>
<tr>
<td>005</td>
<td>The received date on the claim is outside of the timely claims filing limit.</td>
</tr>
<tr>
<td>006</td>
<td>The Utilization Review referral listed on the claim has a maximum visits limit. This claim would exceed that limit.</td>
</tr>
<tr>
<td>008</td>
<td>The referral listed on the claim is not valid for the claim, or no referral was listed. A valid referral that would cover the service has been found and is listed in the EOB information for the claim.</td>
</tr>
<tr>
<td>009</td>
<td>No Approved referral matched the claim information for Member ID, Referred to Provider ID, Facility ID, Effective and Service Dates, Diagnosis and Procedure Code.</td>
</tr>
<tr>
<td>019</td>
<td>The referral listed on the claim has an approved quantity limit for this procedure. This claim would exceed that limit.</td>
</tr>
<tr>
<td>020</td>
<td>The services (procedure and diagnosis) were not found in any Code Group of any effective Benefit Plan under the Benefit Contract.</td>
</tr>
<tr>
<td>022</td>
<td>The Member has no Benefit Contract effective during the Date(s) of Service.</td>
</tr>
<tr>
<td>024</td>
<td>The provider does not belong to a network for which this service is covered.</td>
</tr>
<tr>
<td>025</td>
<td>The member's eligibility coverage level does not include any Benefit Type specified on the Benefit Class.</td>
</tr>
<tr>
<td>028</td>
<td>The place of service designated on the claim is restricted from coverage in this Benefit Class/Exception.</td>
</tr>
<tr>
<td>036</td>
<td>The procedure has been performed multiple times during the same service date(s)</td>
</tr>
<tr>
<td>037</td>
<td>Prior Authorization on claim is not valid and no valid Referral is on file for this service.</td>
</tr>
<tr>
<td>050</td>
<td>The Benefit Class or Exception for this service specifies that the service is not covered.</td>
</tr>
<tr>
<td>072</td>
<td>Paid patient responsibility.</td>
</tr>
<tr>
<td>074</td>
<td>Deducted Member Share of Cost.</td>
</tr>
<tr>
<td>076</td>
<td>Secondary payment information not received.</td>
</tr>
<tr>
<td>1039</td>
<td>The DOS is after the end of the extended benefit period.</td>
</tr>
<tr>
<td>1124</td>
<td>The Fixed Period accumulator maximum has been reached.</td>
</tr>
<tr>
<td>1143</td>
<td>The per individual maximum number of visits set by the Visit accumulator has been reached.</td>
</tr>
<tr>
<td>1153</td>
<td>Provider payment is being reduced by the amount of insured/patient's overpayment.</td>
</tr>
<tr>
<td>1154</td>
<td>Refund amount due to subscriber/patient as a result of subscriber/patient overpayment.</td>
</tr>
<tr>
<td>1168</td>
<td>An ICD-9 Code may not be used with a Date of Service on or after the ICD-10 implementation date.</td>
</tr>
<tr>
<td>1169</td>
<td>An ICD-10 Code may not be used with a Date of Service earlier than the ICD-10 implementation date.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>1170</td>
<td>Claims may not be submitted with both ICD-9 and ICD-10 diagnosis codes.</td>
</tr>
<tr>
<td>1171</td>
<td>Claims may not be submitted with both ICD-9 and ICD-10 procedure codes.</td>
</tr>
<tr>
<td>1172</td>
<td>An ICD-9 Code may not be used with this Bill Type is not usable on/after ICD10 implementation date.</td>
</tr>
<tr>
<td>1173</td>
<td>Claims with this Bill Type may not span the ICD-10 implementation date and must be split into two separate claims that don't span both periods.</td>
</tr>
<tr>
<td>122</td>
<td>The Provider's fee for service Vendor ID could not be found so the Provider's Default Vendor ID has been assigned.</td>
</tr>
<tr>
<td>123</td>
<td>The Provider's capitation Vendor ID could not be found so the Provider's Default Vendor ID has been assigned.</td>
</tr>
<tr>
<td>300</td>
<td>This service was paid in error and requires a retroactive adjustment. The line has been negated.</td>
</tr>
<tr>
<td>310</td>
<td>This service was processed in error and requires a retroactive adjustment. The line has been added.</td>
</tr>
<tr>
<td>406</td>
<td>The member has Medicare, Medicaid, CHAMPUS, etc., or other insured information that indicates coordination of benefits.</td>
</tr>
<tr>
<td>408</td>
<td>The provider does not have a Default Vendor assigned.</td>
</tr>
<tr>
<td>409</td>
<td>The provider has multiple Default Vendors which cover the dates of service.</td>
</tr>
<tr>
<td>410</td>
<td>One or more diagnosis codes on this claim line are not coded to the highest level of specificity.</td>
</tr>
<tr>
<td>413</td>
<td>One or more diagnosis codes on this claim line are invalid.</td>
</tr>
<tr>
<td>460</td>
<td>Netpay reduced by Covered Amount Fee Schedule</td>
</tr>
<tr>
<td>502</td>
<td>The 'from date of service' is after the 'to date of service'.</td>
</tr>
<tr>
<td>504</td>
<td>No procedure code is specified on the claim detail line.</td>
</tr>
<tr>
<td>505</td>
<td>The net pay amount on the claim detail line is missing or set to 0.</td>
</tr>
<tr>
<td>506</td>
<td>The place of service on the claim detail line is missing or not recognized by the system.</td>
</tr>
<tr>
<td>507</td>
<td>No diagnosis code is specified on the claim detail line.</td>
</tr>
<tr>
<td>508</td>
<td>The units on the claim detail line is missing or set to 0.</td>
</tr>
<tr>
<td>624</td>
<td>The per individual maximum number of units defined in the Benefit Class or Exception for this set of services has been reached.</td>
</tr>
<tr>
<td>638</td>
<td>The limit of procedures listed in the Exception that can be performed in the period defined by the frequency on the Exception has been reached.</td>
</tr>
<tr>
<td>684</td>
<td>The diagnosis code is listed in the Fee Schedule Selector of the payment contract with Allowed set to No.</td>
</tr>
<tr>
<td>685</td>
<td>The procedure code is not listed in the Fee Schedule of the payment contract.</td>
</tr>
<tr>
<td>688</td>
<td>The submitted charges are less than the amount in the Payment Contract.</td>
</tr>
<tr>
<td>772</td>
<td>Net pay calculation rule used when contracted amount is greater than Coordination of Benefits amount.</td>
</tr>
<tr>
<td>773</td>
<td>Net pay calculation rule used when contracted amount is less than Coordination of Benefits amount.</td>
</tr>
<tr>
<td>774</td>
<td>Other carrier's COB amount, deductible and coinsurance are required on the COB Entry form when the Calculate Net Pay Due Based on Medicare COB Amount calculation rule is used.</td>
</tr>
<tr>
<td>901</td>
<td>A previous charge has been found for this service using a conflicting modifier (00, 26, 27, or TC).</td>
</tr>
<tr>
<td>920</td>
<td>The procedure code is listed in the Fee Schedule with a payment type of capitated.</td>
</tr>
<tr>
<td>926</td>
<td>The procedure code is not listed in the pricing table appropriate for the payment parameter given in the Fee Schedule (e.g. RBRVS table).</td>
</tr>
<tr>
<td>928</td>
<td>Evaluation and Management procedure codes may not have a professional/Technical modifier using the Std. Medicare payment type.</td>
</tr>
<tr>
<td>935</td>
<td>This procedure code requires a specific modifier to compute the RVUs and/or to compute the pricing.</td>
</tr>
</tbody>
</table>

**APC** Pricing Applied

**APC70** Cost Outlier-adjust compensate addtn'l costs

**N17** Charges are bundled into significant services. Incidental services not separately reimbursable

---

If a claim does not appear on an EOB within 60 days of submission, the claim should be statused or resubmitted. Prior to resubmittal, providers should verify that the correct IHP member ID number (*not Medicaid ID or Social Security Number*), date of birth, and spelling of member’s first and last name was used on the claim.
# PAYMENT REPORT

<table>
<thead>
<tr>
<th>No.</th>
<th>Date(s) of Service</th>
<th>Procedure Code</th>
<th>Description of Service</th>
<th>Total Charges</th>
<th>Allowed Amount</th>
<th>Co-Payment</th>
<th>Benefit Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>06/05/2011</td>
<td>0300</td>
<td>Laboratory</td>
<td>$10.00</td>
<td>$10.00</td>
<td>0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2</td>
<td>06/05/2011</td>
<td>0300</td>
<td>Laboratory</td>
<td>$17.00</td>
<td>$17.00</td>
<td>0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$27.00</td>
<td>$27.00</td>
<td>0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

- **Payment To:**
- **Check Date:** 06/15/2011
- **Check Number:** 21038
- **Amount:** $37.15

---

**EOP SAMPLE**

**GROUP NAME:**

**Provider TIN:**

**Check #:**

**Date Paid:**

---

**Health Plan**

P.O. Box 30125
Lansing, MI 48909
(866) 201-8691

---

**Health Plan**

P.O. Box 30125
Lansing, MI 48909
(866) 201-8691

---

**ABC CLINIC**

PO BOX 123
HEALTH, MI

---

**Payment To:**

**Check Date:** 06/15/2011

**Check Number:** 21038

**Amount:** $37.15
Section 20
COORDINATION OF BENEFITS

IHP shall be the payer of last resort in all cases when private or commercial insurance, including either health or automobile insurance to a member. All other coverages are considered primary.

In situations when the member has other health coverage, the provider should collect any payments available from health insurances. The provider should report any such payments to IHP. Claims submitted to IHP must include the primary carrier’s EOB. IHP’s payment is the lesser of the member’s liability (including coinsurance, co-payment, or deductibles), the provider’s charge, or the maximum IHP fee screen minus the insurance payment and contractual adjustments.

IHP does not coordinate benefits. Some exceptions may apply such as Emergency Services Only and Medicaid Spend-down. If another payer (including Medicaid) can reimburse a provider for services that IHP has already made a payment on, a refund should be sent to IHP for the entire amount paid by IHP.

If a is found to have active medical coverage under another policy other than Emergency Services Only Medicaid, Medicare Part A, or Medicaid Spend-down, members will be disenrolled from the health plan the day prior to the primary insurance becoming effective.

Section 21
SPECIAL CLAIM INSTRUCTIONS

Anesthesia services must be reported with the five (5) digit CPT anesthesia codes (ASA). Only one anesthesia service should be reported for a surgical session. The code for the major surgery should be used. Every anesthesia service must have the appropriate anesthesia modifier reported on the service line. Providers should report time units on line 24G of the HCFA 1500 form for each minute of anesthesia time. Do not include base units.

Outpatient hospital services are processed in accordance with MDCH Outpatient Prospective Payment System (OPPS) guidelines. Many of these are modeled after the Centers of Medicaid and Medicare Services (CMS) OPPS guidelines. The OPPS payment calculations are dependent on CPT/HCPCS procedure codes and modifiers reported at the claim line level.

Ambulatory Surgical Center claims are processed in accordance with MDCH Ambulatory Surgical center guidelines. Many of these are modeled after the Centers of Medicaid and Medicare Services (CMS) ASC guidelines. Facility charges should be billed on a CMS 1500 form and TC modifiers should be reported on each CPT/HCPCS

IHP follows Medicare’s observation care services coverage, claim submission, and reimbursement policies.
Attending emergency room physician services submitted for a denial need to be billed with the modifier UD or UA in conjunction with the appropriate E/M procedure code. UD is used to designate that the member was treated and released from the emergency room. UA is used to designate that the member was admitted to the hospital following treatment.

**ADMINISTRATION**
For questions related to primary care site administration, recurring problems or concerns, or payment of services, contact:
Ingham Health Plan Corporation
3425 Belle Chase Way, Ste. 1
Lansing, Michigan 48911
1-866-291-91
Fax: 1-517-394-4590

**AUTHORIZATION**
To authorize procedures performed by a physician in an office or outpatient hospital setting (other than primary care office visits or routine diagnostic outpatient laboratory or radiology services), submit a request online at [www.ihpmi.org](http://www.ihpmi.org). For same day requests contact Customer Service at 1-866-291-8691.

**BREAST AND CERVICAL CANCER SCREENING SERVICES (BCCCP)**
To refer women age 40 and over to an authorized breast and cervical cancer screening site, call:
Ingham County Health Department BCCCP at 1-517-887-4364 or 1-877-221-6505, ext 1

**CLAIM SERVICES**
To obtain claim status or information regarding a claim rejection, contact:
Ingham Health Plan
P.O. Box 30125
Lansing, MI 48909
1-866-291-8691- Monday - Friday, 8:00am to 12:00 and 1:00 to 5:00pm.
Fax: 1-517-394-4590
Email: claimsservices@ingham.org

**COMMUNITY MENTAL HEALTH**
Clinton-Eaton-Ingham Community Mental Health Authority at 1-517-346-8318 or 1-888-800-1559

**CUSTOMER SERVICE**
To obtain information about eligibility, policies and procedures, enrollment verification, member copayments and primary care site assignment, covered services, authorizations, assistance with Prescription authorizations, to request a member special disenrollment, and to resolve clinical issues call:
Ingham Health Plan
PO Box 30125
Lansing, MI 48909
1-866-291-8691 (toll free) - Monday - Friday, 8:00am to 12:00 and 1:00 to 5:00pm.
ELIGIBILITY VERIFICATION
To verify IHP eligibility, contact Customer Service at 1-866-291-8691. Enrolled IHP providers can access www.ihpmi.org to verify eligibility.

FAMILY PLANNING SERVICES
To refer a member for family planning services, including contraceptives, call:
Ingham County Health Department at 1-517-887-4320
Planned Parenthood- Lansing Center at 517-351-0550

HIV/AIDS SERVICES
To refer a member for HIV/AIDS testing and services, contact:
Ingham County Health Department at 1-517-887-4424

MATERIALS
To order IHP member or provider materials, or schedule trainings, call or fax your request to:
Ingham Health Plan
Claim Services
1-866-291-8691 (toll free)
Fax: 1-517-394-4590

MI-HEALTH
For questions related to services covered under Michigan Medicaid member’s mihealth card contact Provider Inquiry, Department of Community Health at 1-800-292-2550 or e-mail ProviderSupport@michigan.gov.

PHARMACY
To obtain an IHP drug formulary or for assistance with filling medications covered by IHP, visit www.ihpmi.org or contact Customer Service at 1-866-291-8691.

SMOKING CESSATION
For smoking cessation assistance, call:
Michigan Department of Community Health “I Can Quit” program at 1-800-480-7848
Ingham County Health Department at 1-517-887-4315

SUBSTANCE ABUSE SERVICES
To refer a member for substance abuse services, contact:
Clinton- Eaton-Ingham Community Mental Health Authority at 1-517-346-8318 or 1-888-800-1559
Or Mid-State Health Network 1-844-405-3095

TUBERCULOSIS SERVICES
To refer a member with a positive PPD, call:
Ingham County Health Department at 1-517-887-4308

WEB SITE
www.ihpmi.org
MEMBER INFORMATION CHANGE FORM

Member Information Change Form

Phone (toll free): 1-866-291-8691* Fax: (517) 349-4590 * Email: claimsservices@ingham.org

REQUESTING OFFICE: Today’s Date: ________________
Office Name:__________________________________ Group #: __________________
Staff person completing form:____________________ Phone: __________________

MEMBER INFORMATION:
Last Name: ____________________ First Name: ___________ M.I.: _______
Date of Birth: ________________ ID #: HPMS _______ _______ or Soc. Sec. #: XXX – XX – _______
Email: _______________________

MEMBER CHANGE/REQUEST:
PCP Changes are effective the date of the request. Changes may take up to 5 days to appear in the system.
☐ Change Primary Care Provider Office: (must be a participating provider in the same CHP)
Transfer from: __________________________ Transfer to: __________________________
Group #: __________________________ Group #: __________________________
☐ Deceased/Date: ______________________
☐ Discharged from Office (attach discharge letter)
☐ Member Address Change: (member signature required)*
   Street Address: __________________________ City: __________________________
   State: _______ Zip: ___________ Phone: ( ) __________________________
☐ Moved out of County: (must complete member address change above)
☐ Order New Card
☐ Other Medical Coverage:
   Insurance Name: __________________________ Contract #: __________________________
   Group #: __________________________ Policy Effective Date: _________
☐ Pregnant/Due Date: ______________________
☐ Other (briefly explain): __________________________

* Member Signature: I verify that the above information is correct and authorize Health Plan Management Services on behalf of the County Health Plan to update my records.

Member’s Signature: __________________________ Date: __________________________

This electronic message, including any attachments, is confidential and intended solely for use of the intended recipient(s). This message may contain information that is privileged or otherwise protected from disclosure by applicable law, including Health Plan member protected health information (PHI), and is being sent under circumstances where member authorization is not required. Member PHI shall only be disclosed to permitted recipients for purposes of treatment, payment, or health care operations for the member. The disclosure or request for PHI shall be limited to the PHI that is the minimum amount necessary to achieve the intended purpose of the use, disclosure, or receipt. Any unauthorized disclosure, dissemination, use or reproduction is strictly prohibited. If you have received this message in error, please destroy it and notify the sender.

(DD/MM/YYYY)
Completing the Member Information Change Form

All information should be *printed* on the form. Failure to complete all pertinent information may delay the change process. Forms can be faxed to Customer Service. The fax number is located at the top of the form.

The requesting office should complete the date, office name and/or group number, staff person completing the form and phone. It is important to include staff person and phone if more information is needed to process the request. Complete the County Health Plan name, last name and first name of member and date of birth. Select the change/request you are completing the form for. If the change is a Member Address Change the member’s signature is required to process the change. If the member’s signature cannot be obtained, include the member’s phone number to verify the change.