Summer 2014

Totally Connected.....

Inside this issue:

Provider Services

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Provider Relations - Growing to Serve you Better!

Good news for our provider offices! If you haven't already had a visit from one of our Provider Relations staff, you soon will! THC has added to our team and is committed to working with you to improve the healthcare of our members. But don't feel you need to wait; call us at ***844-THC-DOCS*** to initiate an appointment. PCPs offices are in the first wave of visits; specialists will be visited in 2015.

Member Engagement & Access

As a participating provider with THC, we need to work together to best service the needs of our patients. THC is committed to ensuring our members have access to the right care at the right place and in a timely manner, which is defined as within 30 days for a routine office appointment or well visit, within 7 days for a routine non-urgent but symptomatic appointment and within 24 hours for an urgent need. Additionally, Healthy Michigan members need to be appointed with their PCP for the first visit within 60 days of enrollment, and seen within 150 days.

PCP offices should access and review eligibility rosters (available through the Provider Portal) every month to determine newly assigned patients and reach out to them to come into the office for a visit. We ideally want all our members to obtain an initial assessment of their health status within 90 days of enrollment with the plan. Establishing the doctor-patient relationship is essential to health management and encouraging patients to take responsibility for their own health. However, we recognize that not all members will take that initiative, so we ask that you put forth your best efforts to reach out to your assigned members. So, what's the pay off?

- Improved HEDIS Scores
- Increased Pay for Performance Dollars
- Improved Patient Satisfaction
- Increased Revenue

PCPs need to see a minimum of 75% of assigned patients in each calendar year and submit an associated patient encounter for all patient visits to be in good standing with THC. This will allow you to keep your panels open to new member assignment to grow your business. The Provider Relations team is available to work with your office to reach these goals. Together we can achieve success and improve healthcare for our members.

Our Mission:
To be the industry leader in providing quality, cost effective health care for our members

Pharmacy - Updates Effective 10/1/2014

NEW PBM

Effective October 1, 2014, Total Health Care's prescription drug benefit will be managed by EnvisionRxOptions. Total Health Care will no longer be contracted with Catamaran for this service. For questions about the pharmacy benefits or the pharmacy network, you may call EnvisionRxOptions' Pharmacy Help Desk at **844-222-5584**.

Mail Order: Commercial Members Only

Total Health Care offers a ninety (90) day prescription home delivery service for certain maintenance medications through a mail order program administered by EnvisionRxOptions' affiliate company, Orchard Pharmaceutical Services. Commercial members can sign up for mail order service at www.orchardrx.com.

Specialty Program

Effective October 1st, Total Health Care will transition its Specialty Pharmacy to Diplomat Specialty Pharmacy. To request specialty medications for a Total Health Care member, you may call Diplomat at **1-877-977-9118**.

Diabetic Supplies

Effective September 1st, Total Health Care contracted with J&B Medical Supply to manage distribution of diabetic supplies. For questions about diabetic supplies, you may contact J&B Medical Supply at **844-236-7933.**

Prior Authorization forms for EnvisionRxOptions, Diplomat Specialty Pharmacy and J&B Medical Supply are attached, and can be found on our website at www.THCmi.com.

THC will issue new ID cards to members with the updated pharmacy logo.

Pharmacy Help Desk:	**844-222-5584**
Mail Order Pharmacy:	**866-909-5170**
Specialty Pharmacy:	**877-977-9118**
J&B Medical Supply:	**844-236-7933**

TOTAL HEALTH CARE
TOTALLY THERE FOR YOU

ENVISION RX OPTIONS

2181 E Aurora Rd, Ste 201
Twinsburg, OH 44087
Customer Services Phone: 1-844-222-5584

PRIOR AUTHORIZATION FORM

****Please include relevant medical records including laboratory results for review.****

COMPLETE AND FAX TO ENVISION RX OPTIONS AT 1-877-503-7231

Patient Information		Prescriber Information	
Contact Person:		Date Faxed:	
Patient Name:		Prescriber Name and Specialty:	
Date of Birth:		NPI:	
Member ID:		Office Phone:	
Group Number:		Office Fax:	
Requested Medication and Diagnosis			
Medication:	Strength:	Frequency:	Quantity:
Diagnosis:		Expected Length of Therapy:	

Medical History and Rationale for Prior Authorization Request

Clinical Rationale for Prior Authorization Request: (e.g. history of present utilization, past medical history, etc.)

_____

_____

_____

List all medications tried and failed, including dose, duration, and outcome of each therapy:		
Medication:	Date:	Reason for failure:

DIPLOMAT

TOTAL HEALTH CARE
TOTALLY THERE FOR YOU

ENVISION Rx OPTIONS

Customer Services Phone: 1-844-222-5584

Specialty Drug Prior Authorization Request Form

COMPLETE AND FAX TO ENVISION RX OPTIONS 1-877-503-7231

PHYSICIAN INFORMATION			
Contact Person		**Date Faxed**	
Physician Name		**Physician Specialty**	
Phone Number		**Fax Number**	
NPI or DEA #		**Pharmacy Fax**	

MEMBER INFORMATION			
First Name		**Last Name**	
Plan	**TOTAL HEALTH CARE**		
Member ID		Date of Birth	

Drug requested and directions for use (e.g. mg/day):	Diagnosis:

Is patient currently taking drug (yes, no)? _____ If yes, for how long? _____

Other drugs previously tried:

Name of drug, dose and date	**Outcome** (reason why it failed or was not tolerated)
_____	_____
_____	_____
_____	_____

Other reason(s) why this particular drug was selected *(attach chart notes, pertinent laboratory tests or procedures and results, letter or supporting literature as appropriate)*

DRUG/CLINICAL INFORMATION

¨ Initial request ¨ Renewal Drug requested: _____ Proposed duration of therapy: _____

Strength/Quantity: _____ Daily dose: _____ Height: _____ Weight: _____

Sig. _____

¨ Supplies package (no charge): sharps disposal unit (regular or large), alcohol wipes (100 per box), and syringes as necessary

Prescriberôs Name _____ Date _____

Print Name

Signature _____ _____

_____

20496 W Pontiac Trail
Wixom, MI 48393
Customer Service Phone # 1-844-236-7933

PRIOR AUTHORIZATION FORM

****Please include relevant medical records including laboratory results for review.****

COMPLETE AND FAX TO J&B MEDICAL SUPPLY AT 1-800-737-0012

Patient Information	Prescriber Information
Contact Person:	Date Faxed:
Patient Name:	Prescriber Name and Specialty:
Date of Birth:	NPI:
Member ID:	Office Phone:
Group Number:	Office Fax:

Requested Diabetic Supplies and Diagnosis		
Diabetic Supply Requested:	Quantity:	Testing Frequency:
Diagnosis Code:	Duration of Need:	

Medical History and Rationale for Prior Authorization Request

Rationale for Prior Authorization Request: (e.g. history of present utilization, past medical history, etc.)

_____

_____

Patientôs A1C Result: _____ Date of Test_____

Is the patient treated with insulin injections? _____YES _____NO

How many times per day does the patient inject insulin? _____ per day _____N/A

Expected delivery date if applicable:_____ _____N/A

Medicals Records Submitted for Review: _____YES _____NO

Prescriber Signature:	Date Signed:

Pharmacy Drug Formulary Updates

Drug Formulary Updates ~ Effec□ve July 2014

MEDICATION	UPDATE	Formulary Affected		
		Medicaid	Commercial	QHP (Exchange)
Pulmicort 0.25mg/2mL and **0.5mg/2mL respules**	While this medication will remain a formulary agent for patients age 4 and under moving forward, THC encourages the use of the Qvar, a corticosteroid inhaler that is FDA approved for the treatment of asthma in patients age 5 and over. THC also covers spacers and masks, which can be utilized should administration issues arise.	X	X	X
Nexium OTC **Breo Ellipta** **Tudorza**	Added	X	X	X
Spiriva **Combivent**	**Removed** (evaluate members with new covered alternatives **Breo Ellipta and Tudorza**)	X	X	Move to tier 3
Amphetamine Extended Release	Added with step therapy following trial of **Amphetamine immediate release (60 Day Trial)**		X	X
Vyvanse	Added with step therapy following trial of **Amphetamine Extended Release (60 Day Trial)**		X	
Guanfacine Immediate Release	Added as the covered non-stimulant medication for the treatment of Attention Deficit Disorder/Attention Deficit Hyperactive Disorder		X	

Please call the Total Health Care Pharmacy Department at 313-871-2000, extension 3300 for any claims processing questions. You may view the complete drug formularies on THC's website at http://www.THCmi.com

IMPORTANT: Prescribing Changes for Hydrocodone

EFFECTIVE OCTOBER 6, 2014

On August 22, 2014 the DEA announced that Hydrocodone combination products will be placed under Schedule II of the Controlled Substances Act (CSA). Currently Hydrocodone combination products are under Schedule III of the CSA.

Formulary Change Effective 1/1/2015

Covered Agents	Agents Affected
Breo Ellipta (One inhaler per month)	**Spiriva**
Tudorza (One inhaler per month)	**Combivent**

Please evaluate your members for use with Breo Ellipta or Tudorza. Members will no longer be able to receive Spiriva or Combivent effective 1/1/2015.

Pharmaceutical Management Procedures

Please visit THC's web site at www.THCmi.com to view the Drug Formularies specific to the following members:

- Commercial
- Health Insurance Marketplace
- Medicaid
- CSHCS
- MIChild

Each formulary includes information regarding pharmaceutical management procedures regarding generic substitution, step therapy, quantity limits, age limits and prior authorization requirement.

If you would like a copy of the formularies or pharmaceutical management procedures, you may call the Pharmacy Department at 313-871-2000, and press extension 3300.

Envision is THC's Pharmacy Benefit Manager. Prior authorization requests can be faxed to 877-503-7231 or you may call with questions to 844-222-5584.

Drug Prior Authorization Criteria

Prior Authorization Criteria for prescription drugs is available upon request by contacting the Pharmacy Department in writing or call 313-871-2000, and press extension 3300.

Referral & Authorizations

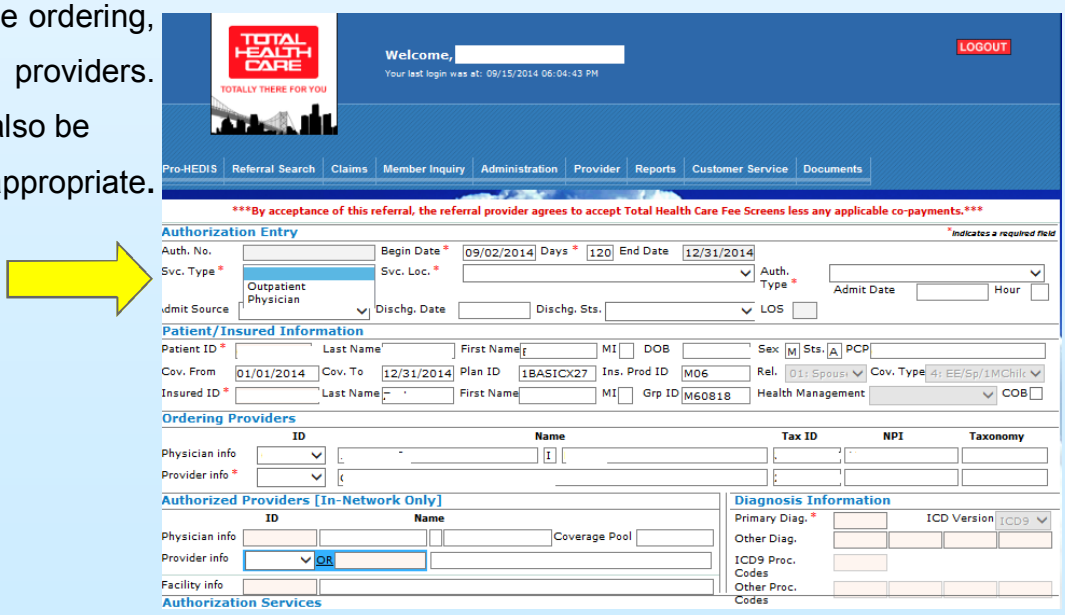
In-Network Providers & THC Provider Portal

You may have noticed some changes when attempting to process a referral through the Provider Portal. Effective August 18, PCPs are unable to create a referral to a non-participating provider.

THC is adhering to network guidelines, which requires members to see participating providers only. In the event that there is a continuity of care need, or a provider is unavailable in the network, a PCP must contact THC to request the out of network service, following the Prior Authorization Process.

Total Health Care continues to update the network with new providers and services. While we continue to grow, other providers leave the network. It is important to be aware of these changes to avoid sending patients to out of network facilities and providers. Please use the Provider Directory at www.THCmi.com > Find a Doctor to validate if a provider is in the network.

We are continuing to work to enhance our portal and make is easier for providers to do business with us. Another change we implemented was to change the verbiage when selecting a referral. Your options are now limited to Outpatient or Physician as the Service Type. **This is to emphasize the fact that all inpatient services require prior authorization and should not be entered into the portal.** The portal is for referrals that a PCP may authorize. PCPs cannot authorize services that require prior authorization from THC, such as inpatient admissions or foot surgeries. ***Services that require clinical review and approval from THC must be requested via fax.*** Only upon review and approval/denial will the THC nurse enter the decision with comments into the portal for viewing by the ordering, rendering and facility providers. The Service Type will also be noted as Inpatient if appropriate.



Please refer to the Authorization Grid online: wwwTHCmi.com > Providers / Referral & Authorizations.

Additional enhancements are underway to let providers know a service is pended if it is incorrectly entered into the portal. We will continue to update you with these changes.

Quality Improvement Program

Quality Improvement Program

Total Health Care's (THC) Quality Improvement Program (QIP) is based on the principles of continuous quality improvement. The QI Program's purpose is to provide a framework that enables THC to ensure Plan members have access to and receive high quality health care and preventive services that promote wellness. THC's Board of Directors recognizes that achieving optimal health outcomes requires the collaboration of the Plan, the provider network, and the membership. The QI Program is designed to meet state and federal requirements and is structured to meet accreditation standards. The Program along with THC's policies and procedures are evaluated at least annually, and revised as necessary. Information about the QI Program, including a summary description of the Program and a report on the Plan's progress toward achievement of annual goals, is available on our website at www.THCmi.com. Click on the Providers box, under the *More Information* box click on the *Documents & Additional Info* link, then *Documents & Information*. Look for the Quality Improvement section.

Clinical Practice Guidelines

The following CPGs developed by MQIC (Michigan Quality Improvement Consortium) were approved for use at the February meeting of Total Health Care's Quality Improvement Committee :

- **Advance Care Planning**
- **Primary Care Diagnosis & Management of Adults with Depression**
- **Management and Prevention of Osteoporosis**

Visit the THC Website at www.THCmi.com for more information.

Primary Care Services

All PCPs are contracted to provide the following services to members without the need to refer outside of the office:

- Well physical examinations and sick visits
- Immunizations based on ESPDT guidelines (Pediatrics and Family Medicine)
- ECG
- Spirometry
- Noninvasive ear or pulse oximetry
- Allergy shots (excluding provision of toxin)
- 1st Degree Burn treatment
- Skin lesion removal
- Foreign body removal, cerumen removal
- Labs, including urinalysis, pregnancy test, blood occult, glucose, TB skin test, microbiology smears and urine testing

Healthy Michigan Plan

We are providing this information again to make you aware of the requirements to receive credit for completion of the HRA for Healthy Michigan Members. Identify Healthy Michigan Members by their Group number on the THC ID card roster: M1001 or M1501

You will be paid for the incentive when reporting 99420 on your claim and the completed HRA has been received by THC.

Health Risk Assessment (HRA) Process ~ How it will Work

THC wants to make it easy for our members and physicians to complete the required HRA for Healthy Michigan Plan Enrollees. We have partnered with **Health Integrated** to work with enrollees to complete Sections I, II & III of the HRA prior to their PCP visit. Here's how the process will

What THC/Health Integrated Does:

- THC provides Health Integrated with an eligibility list of all Healthy Michigan Plan new enrollees
- Health Integrated contacts each member to telephonically complete Sections I, II, III of the HRA, which includes nine questions. This process is expected to take approximately 10 minutes.
- Upon completion of the HRA and within 60 days of enrollment, arrange for the initial PCP appointment to be completed within 150 days of enrollment.
- Arrange transportation, as needed.
- Fax completed HRA to PCP office.
- THC will also make the HRA form available through the Provider Portal.
- Reimburse PCP for completion of HRA.
- Incentivize member for HRA completion.

What the PCP Does:

- Educate office staff about the requirements of Healthy Michigan Plan.
- Accommodate appointment requests for Healthy Michigan Plan members. Providers should leave open slots to accommodate timely visits.
- Arrange for the faxed HRA to be available for a patient's appointment.
- Complete Section IV of HRA and review in detail with patient, discussing appropriate interventions.
- Sign HRA form and fax to Health Integrated at **877-872-3163.**
- Bill 99420 on a HCFA 1500 or 837P claim to report completion of the HRA within 30 days of completion.

Navant - Rehabilitation Vendor

- Navant authorizes therapy treatment for Physical, Occupational and Speech Therapy
- PCPs MUST enter a referral for evaluation for the services before any authorization can occur
- Do not refer patients for services with a prescription or a doctor's order. All services must be initiated through a PCP referral for evaluation. Navant will not authorize therapy without the evaluation referral.

Coding Corner

The Proper Use of Modifier 59

The *CPT Manual* defines modifier 59 as follows: "Distinct Procedural Service: CPT modifier -59 represents a procedure or service that is distinct or independent from other services performed on that same day. Modifier -59 identifies procedures or services, other than E&M services, that are not normally reported together but are appropriate under the circumstances."

"Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

Modifier 59 is a "default modifier" and should be used only when no other established modifier is appropriate to the situation. When applying modifier 59, the documentation in the medical record must support and substantiate the use of this modifier.

This modifier should never to be used for the purpose of bypassing the procedure to procedure edits in the system. Because of the potential for misuse, THC may request medical records to determine if the 59 modifier is being appropriately used.

Appropriate Usage

- Documentation indicates two separate procedures performed on the same day by the same physician
    - For example, a different session or patient encounter, different procedure or surgery, different site, or separate injury (or area of injury)
- Append Modifier 59 to the secondary, additional or lesser procedure of combinations listed in National Correct Coding Initiative (NCCI) edits.
- Use Modifier 59 on the second initial injection procedure code when the IV protocol requires two separate IV sites or when the patient has to come back for a separately identifiable service.
- Use Modifier 59 when there is **NO** other appropriate modifier.

Inappropriate Usage

- Code combination not appearing in the NCCI edits
- Submission of E/M Codes
- The NCCI tables lists the procedure code listed with a modifier indicator of "0"
- Documentation does not support the separate and distinct status
- Exact same procedure code performed twice on the same day
- Multiple administration of injections of the same drug
- If a valid modifier exists to identify the services

Documentation Requirements

- Providers must maintain adequate documentation in the medical record to support the use of modifier 59.
- Using modifier 59 to indicate different procedures or surgeries does not require a different diagnosis for each HCPCS/CPT-coded procedure/surgery. Different diagnoses are not adequate criteria for use of modifier 59.

The Proper Use of Modifier 59, continued

Claims Processing

- Although modifier 59 may be appended to a claim line on first submission, this does not guarantee reimbursement of these services.
- If a claim line is denied due to a clinical edit and you submit a corrected claim using modifier 59 for that claim line, we will require medical records in order to process the corrected claim.
- Amendments to the documentation will not be accepted after a claim has been denied.

Make sure when applying the 59 modifier, it is for appropriate reasons and the documentation in the medical record supports the use of the modifier.

For more information regarding modifier 59, please visit http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/modifier59.pdf

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1418.pdf

Billing Medicaid Patients for Co-Insurance and Deductible

A provider may not collect any applicable deductible or co-insurance from a patient who has both Medicare and Medicaid. When Medicare approves a service, Medicare pays the physician 80% and the patient is responsible for the remaining 20%. In addition, Medicare will apply the appropriate deductible amounts for the allowed services. Patients are generally responsible for payment of the deductible and co-insurance; however, when a patient has additional coverage through Medicaid, the patient is not responsible for any applied deductible or the co-insurance. The provider's enrollment status with Medicaid does not change this requirement. If you have further questions, please access the CMS MLN Matters Article, Prohibition of Balance Billing Qualified Medicare Beneficiaries (QMBS) (SE 1128).

Do you MEAT Coding for Accuracy?

Accurate diagnosis coding plays a fundamental role in population health management. As a health plan, THC relies on accurate diagnosis coding to (1) **risk stratify** our membership to report on Medicare, Medicaid and ACA Healthcare Exchange membership, (2) **allocate needed resources**, such as case and disease management; (3) report **HEDIS®/quality measures**, (4) **assess** physician efficiency and (5) **award incentives**.

To support accurate diagnosis coding it is necessary to provide complete and accurate documentation. Each progress note must contain documentation that supports **every diagnosis** for the date of service. To determine if your note substantiates the diagnosis code, follow the **MEAT** process:

- **M**anage: Indicate any lab work, diagnostic radiology or other tests.
- **E**valuate: Document review of lab, X-ray or test results, as well as exam findings.
- **A**ssess and **A**ddress: Describe the status of a patient's condition (stable, worsening or improved).
- **T**reat: Indicate if medications are prescribed or refilled, and surgical treatments or therapy services.

* ***Link a treatment plan to each condition noted in the progress note and link medications to a specific diagnosis***

* ***Document and code to the highest level of specificity***

* ***Remember to document and code ostomies & amputations at least once yearly***

* ***Do not code with "history of" if the disease or illness is active and being treated***

* ***Never use "rule out" in an office setting; code for known signs and symptoms***

CMS Launches Road to 10 Webcast Series

The Centers for Medicare & Medicaid Services (CMS) has released a new webcast introducing the "Road to 10" tool. Accessible through the "Road to 10" link on the CMS website, the webcast covers the history of the International Classification of Diseases (ICD) and the benefits of ICD-10. This is the first in the new "Road to 10" webcast series. Five more webcasts will follow—all aimed at helping small practices get ready for ICD-10 by the October 1, 2015, compliance date.

Also available now is a brief video introduction to the "Road to 10" tool. Developed in collaboration with physicians, the "Road to 10" tool offers:

- Clinical documentation tips
- Coding concepts
- Clinical scenarios
- Training calendar

Go to the CMS website (http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html) to access this information.

Network Updates

Effective 9/1/2014, Oakland Regional Medical Center is no longer a contracted provider with Total Health Care. No referrals should be processed to this facility. Please redirect patients to in-network providers for services.

Laboratory Providers:
To help members save on out-of-pocket costs, please refer members to the following labs for services;

- Quest—which includes BRCA 1 and BRCA 2
- LabCorp
- Contracted Hospital laboratories

No other laboratories are contracted with THC at this time. Please direct patients to in-network laboratories only. Providers who continue to send specimens to out of network labs will be notified and corrective action will be implemented to alleviate this issue.

Did you know that our Find a Doctor search tool has more information than just physicians?

Advanced Search

The Advanced Search allows you to refine your search parameters for either a Professional or Facility. You can

- Choose a doctor based on a foreign language, particular hospital affiliation or Practice Name
- Locate a facility based on a particular service such as mammography or endoscopy.

Use the Advanced Search to keep patients in the network to help avoid unnecessary out of pocket expenses for your members

Value Options—our Behavioral Health Provider Network

ALERT: Medicare Advantage and Part D Contractors and Subcontractors

As you know, CMS (Centers for Medicare and Medicaid Services) requires FDRs (First Tier, Downstream, and Related Entities) associated with the administration of any Medicare Advantage and Prescription Drug line of business to complete certain regulatory compliance requirements. Accordingly, the following actions must be completed within 30 days of receiving this alert and may be audited for compliance. Those FDR actions/ obligations include but are not limited to the following:

- **Receive FWA (Fraud Waste and Abuse) and Compliance Training**
- **Provide Total Health Care with FWA and Compliance Training Attestations (upon request)**
- **Provide Total Health Care with Conflict of Interest Disclosure Statements**
- **Provide Total Health Care with Offshore Subcontracting Attestations Associated with the Protection of Beneficiary PHI (Protected Health Information) – (only when you contract with off-shore subcontractors)**

Total Health Care's Medicare Advantage and Prescription Drug internet site contains the training links and forms that support your obligations bulleted above. Our website address is:

www.TotalMedicarePlus.com

Click on the "**FDRs**" link on the main page (top of page). On the FDR page, click on the following links:

Compliance and FWA Training **Offshore Subcontracting**

Call (313) 871-7886 with questions. Thank you for your cooperation.

Medicare Quality Improvement Organization (QIO) Replaced by new Organization

Effective August, 1, 2014, Medicare restructured its QIO to improve patient care and health outcomes as well as to save money. This restructuring resulted in the creation of Beneficiary and Family-Centered Care (BFCC QIO) contractors; for Michigan, this organization is KEPRO:

* KEPRO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with THC. Providers need to allow KEPRO access to patient / physician medical records.

Members are urged to contract KEPRO if they have a compliant about the quality of their care, if they think their hospital stay, SNF, rehab or any other service ended too soon.

KEPRO: 5201 W Kennedy Blvd, Ste 900, Tampa FL 33609; phone: 855-408-8557; fax 844-834-7130

Member Rights & Responsibilities

Member Rights and Responsibilities

All contracted THC providers are required to comply with the following Rights & Responsibilities for all THC members. If a THC member fails to follow this code of conduct, please notify Customer Services at 313-871-6596.

Members have the right:

To get information about Total Health Care, its services, its providers and member rights and responsibilities.
To make recommendations regarding Total Health Care's member rights and responsibilities policy.
To be treated with respect and dignity.
To have privacy while receiving care.
To take part with doctors in decision-making about their health care, including the right to refuse treatment.
To talk openly about treatment options regardless of cost or benefit coverage.
To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
To be free to exercise their rights without adversely treatment.
To be free from other discriminations prohibited by State and Federal regulations.
To receive healthcare services consistent with their contract, State and Federal regulations.
To voice their complaints or grievance/appeals about Total Health Care or the care provided.

Members have the responsibility:

To receive all their health care services through Total Health Care.
To understand their healthcare benefits.
To provide THC and its providers with the information needed for their care.
To help their doctor decide what treatment will work best.
To follow the care plan and instructions agreed upon with their doctor.
To respect the rights of other patients, doctors and staff of Total Health Care.

Advanced Directives

The Patient Self Determination Act 1990 allows competent adults the right to make decisions concerning medical care, including the right to accept or refuse any medical or surgical treatment and the right to formulate Advance Directives. Advance Directives are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity.

PCPs are asked to encourage members, as appropriate, to plan for medical care in the event of loss of decision-making ability by developing a Living Will or Durable Power of Attorney for Health Care. A copy of the directive should be maintained in the patient's medical record.

A copy of the Advance Directive Michigan Notice to Patient can be found at **wwwTHCmi.com** / Members; More Options, or contact the Provider Relations Department at 844-THC-DOCS.

Language Interpretation Services Available

Total Health Care will make language interpretation services (either written or spoken) available to members in any setting (ambulatory, inpatient and outpatient). If one of your patients requires services, contact us at 800-826-2862.

Race/Ethnicity/Language Proficiency for Network Providers

THC collects and reports on R/E/L and will publish practitioner language information in our provider directory.