Partners In Health

Spring 2022

McLaren HEALTH PLAN

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"Partners in Health" is the newsletter for McLaren Health Plan physicians, office staff and ancillary providers. It is published twice per year by McLaren Health Plan Inc., who shall be referred to as "MHP" throughout this newsletter.

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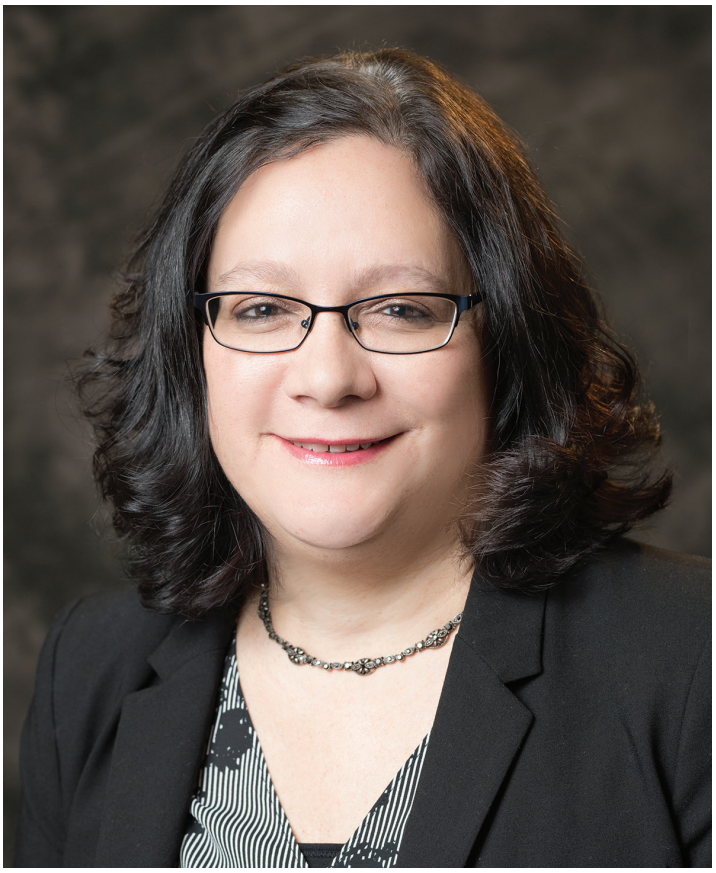

FROM JODY LANDON

Vice President, Customer & Provider Services

Here we are, in the second year of a global pandemic. I want to thank you — our provider partners – for working through the challenges to make sure your McLaren Health Plan patients received the right care, in the right setting. I know it isn't easy, having to adapt many of your processes to meet new protocols due to COVID-19 restrictions, so please know how much we appreciate what you do.

We continue to put forth our best efforts to encourage our members to get vaccinated and boosted. We embarked on a robust media campaign, addressed hesitancy with facts via our website, sent direct mail reminders and have continued to promote our free COVID-19 vaccine drive-through clinics and speak to our members directly at every opportunity.

We know that getting the vaccine will contribute to a member's good health. It's important for our members to know we support other healthy habits like eating right and getting regular exercise. One of the ways we actively provide support in this manner is our statewide partnership with a number of farmers markets. Let your patients who receive Supplemental Nutrition Assistance Program (SNAP) benefits know about the *Double Up Food Bucks* program, which matches fruit and vegetable purchases up to $20/day. Send your eligible patients who are interested to www.doubleupfoodbucks.org to put in their ZIP code to find a location near them.

We value our provider partnerships and continue to look forward to working together to improve the health status of the members we collectively serve.

Sincerely,

Jody Landon

Vice President, Customer & Provider Services
McLaren Integrated HMO Group

CONTACT US

General Information About MHP's Departments and Services

Customer Service

Monday through Friday, 9 a.m. to 5 p.m.

888-327-0671 (TTY: 711)

Fax: 833-540-8648

Customer Service is responsible for assisting physicians, office staff, providers and members with questions. Representatives are available Monday through Friday from 9 a.m. to 6 p.m. Call if you have questions about:

- Transportation for MHP Medicaid and Healthy Michigan plan members
- Referrals
- Claims

MHP has FREE interpretation and translation services for members in any setting – ambulatory, outpatient, inpatient, office, etc. If MHP members need help understanding written materials or need interpretation services, call Customer Service.

McLaren CONNECT

If you have not yet registered for McLaren CONNECT, the provider portal, click here: https://www.mclarenhealthplan.org/mhp/mclaren-connect.aspx.

McLaren CONNECT replaces the Health Edge portal and FACTSWeb. McLaren CONNECT is a secure web-based system for all MHP lines of business that allows you to:

- Verify member eligibility
- View member claims and EOPs
- View and print member eligibility rosters*
- View and print member benefit information
- View a member's demographic information
- Contact the MHP provider team

Your provider TIN and NPI are required for the login process. Logins require your username and password each time, for your security.

**Member eligibility rosters are no longer mailed to primary care offices. Using McLaren CONNECT provides access to an up-to-date roster while eliminating the delay of sending a printed roster mid-month.*

McLarenHealthPlan.org

MHP's website contains information about the plan's policies, procedures and general operations. You'll find information about quality programs, preauthorization processes, health management programs, clinical and preventive practice guidelines, pharmaceutical management procedures, the pharmacy formulary, member rights and responsibilities, the provider appeal process and provider newsletters. Visit often for the most up-to-date news and information. If you would like a printed copy of anything on our website, please call Customer Service.

Interpretation and translation services are FREE to MHP members in any setting – ambulatory, outpatient, inpatient, etc. Oral interpretation services are available for people who are deaf, hard of hearing or have speech problems. If McLaren Health Plan members need help understanding MHP's written materials or need interpretation services, call 888-327-0671 (TTY: 711)

GetHelp.McLaren.org

Do you have patients who need help with food, education, housing, jobs or other "quality of life" situations? McLaren Health Plan offers an online program to assist members who need community-based services. Simply put in a ZIP code, and categories are listed with programs and services by location. There are thousands of resources to choose from, such as advocacy and legal aid, how to help pay for school, adoption and foster care services, tax preparation, mental health care, housing assistance and skills and training to enter or reenter the workforce, among much more! Let your patients know about www.gethelp.mclaren.org.

Network Development

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7979

The Network Development team is responsible for physician- and provider-related issues and requests, including contracting.

Network Development coordinators are assigned to physician or provider practices by county. Their services include:

- Orientations for you and/or your office staff to learn about MHP – how to submit claims, obtaining member eligibility or claims via the MHP CONNECT provider portal
- Reviewing provider incentives, quality initiatives and program updates

If you have changes to your practice such as a new federal tax identification number, a payment address change or a name change, a new W-9 is required.

Current participating primary care physicians who wish to open their practices to new MHP patients can do so at any time. Simply submit your request in writing, on office letterhead, to your Network Development coordinator, requesting to open your practice to new MHP members, and your coordinator will make the change.

For other changes, such as hospital staff privileges, office hours or services, address or phone number or on-call coverage, please contact your Network Development coordinator. Notification at least 30 days prior to any change is requested to allow time to make system changes.

If you are uncertain of whom to contact, call us for the name of your coordinator.

Outreach Team

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7985

The MHP Outreach team is available to assist your office with scheduling your MHP commercial and Medicaid patients for preventive care visits and ancillary tests. The Outreach Team can come to your office during the HEDIS® measurement year to provide chart review to assist in closing gaps in care.

Using Gaps in Care reports provided by MHP or by your office, the team can assist your staff by contacting and scheduling patients for these important visits.

By working together, we strive to achieve:

- Increased incentive payments
- Better patient outcomes when preventive services are provided
- Improved relationships among you, your patients and MHP

The MHP Outreach team is trained in several electronic scheduling systems and can assist with in-office or off-site scheduling. During patient contacts, the Outreach team can assist your patients by:

- Discussing the importance of preventive care services
- Determining barriers to care and assisting with barriers, such as transportation

Call us and ask to speak to an Outreach representative if you are interested in working with the Outreach team. If you have medical records you want to send to the Outreach Team for gap closure, fax directly to **810-600-7985**.

Medical Management

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7959

Medical Management supports the needs of both MHP providers and members. Medical Management coordinates members' care and facilitates access to appropriate services through the resources of our nurse case managers.

Through case management services, nurses promote the health management of MHP members by focusing on early assessment for chronic disease and special needs and by providing education regarding preventive services. Nurses also assist the physician and provider network with health care delivery to MHP members. Nurses are available 24 hours a day, seven days a week and work under the direction of MHP's Chief Medical Officer.

Call the Medical Management team for information and support with situations about:

- Preauthorization requests: https://www.mclarenhealthplan.org/mhp/referral-request-form-mhp1
- Inpatient hospital care (elective, urgent and emergent)
- Medically necessary determinations of any care, including the criteria used in decision-making
- Case management services
- Complex case management for members who qualify
- Disease management – diabetes, asthma, maternity care
- Preventive health education and community outreach support
- Children's Special Health Care Services (CSHCS)

You may get voicemail when you call the Medical Management team due to the volume of calls received. Voicemail is checked frequently throughout the day and all calls are returned within one business day.

Through its utilization management process, Medical Management is structured to deliver fair, impartial and consistent decisions that affect the health care of MHP members. Medical Management coordinates covered services and assists members, physicians and providers to ensure that appropriate care is received. Nationally

recognized, evidence-based criteria is used when determining the necessity of medical or behavioral health services. The criteria are available to you upon request by calling the Medical Management team.

If there is a utilization denial, the member and physician will be provided with written notification – which will include the specific reason for the denial – as well as all appeal rights. MHP's Chief Medical Officer, or an appropriate practitioner, will be available by telephone to discuss utilization issues and the criteria used to make the decision.

Utilization decision-making is based solely on appropriateness of care and service and existence of coverage. MHP does not specifically reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives for utilization decision-makers to encourage decisions that would result in underutilization.

Case Management

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7965

Case management is offered to all MHP members. A case management nurse is assigned to each primary care office to assist you with managing your MHP members. The MHP nurses help manage medical situations and are a resource for identified issues. This enables a circle of communication that promotes continuity of care, the member's understanding of his or her health care, support for the Primary Care Physician and the PCP office as the medical home.

MHP members are referred for case management services by physicians who identify at-risk patients. Complete a Referral to Case Management form at https://www.mclarenhealthplan.org/community-provider/case-management-mhp. When MHP receives the form, a nurse begins an assessment of the member and identifies a proactive approach to managing the totality of the member's health care needs. The program focuses on preventive health management, disease management, general and complex case management and Children's Special Health Care Services (CSHCS) case management.

Program goals are:

- Empower members to understand and manage their condition
- Support your treatment plan
- Encourage patient compliance

Preventive health management helps by:

- Informing members of preventive testing and good health practices
- Mailing reminders to members about immunizations, well-child visits and lead screenings
- Highlighting ways to stay healthy and fit in member newsletters
- Identifying members who are due for annual checkups and screenings and notifying PCPs of these patients
- Initiating call programs to assist members with scheduling annual checkups and screenings

If you do not know who your case management nurse is, please call Customer Service at **888-327-0671 (TTY: 711)**.

Complex Case Management

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7965

MHP has nurses trained in Complex Case Management (CCM). Members considered for CCM have complex care needs including:

- Those listed for a transplant
- Ones who have frequent hospitalizations or ER visits
- Are part of the Children's Special Health Care Services (CSHCS)

Virtual Case Management

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7965

The Medical Management team at McLaren Health Plan has virtual case management services available for members. Using the "ZOOM for Healthcare" platform, case managers can connect with members on a personal level with face-to-face conversations while maintaining social distancing and the need for privacy.

Conversations about health maintenance, missed services – or services that are due – and other important health discussions can take place during these visits. Members currently receiving case management services, or those who would like to, are eligible to participate.

Please call MHP at **888-327-0671 (TTY: 711)** if you have an MHP patient you would like to refer for case management services.

How to Help Manage Your Patients' Mental Health

There's no outward symbol to show the world when someone is dealing with mental health issues. People might be more accepting if they could "see" the condition and understand the person may be working with a doctor or behavioral health provider to improve his or her mental health.

Mental health includes emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.[1]

People from racial and ethnic minority groups are less likely to receive care for mental health. Among adults with mental illness, 48% of whites received care compared with 31% of Blacks and Hispanics, and 22% of Asians.[2] Suicide was the second-leading cause of death for Blacks and Hispanics ages 15-24.[3]

People who are hospitalized for a mental health issue are more at risk for relapse, readmission and poor outcomes after being discharged. It's critical to have your patients follow up with you and a mental health provider within seven days of discharge.

Mental health resources are available for McLaren Health Plan members. Please have your patients call customer service at 888-327-0671 (TTY: 711) for assistance or if they have barriers to receiving care.

[1]*www.cdc.gov/mentalhealth*

[2]*2017, www.Psychiatry.org, Division of Diversity and Health Equity and Division of Communications*

[3]*2021, U.S. Department of Health and Human Services Office of Minority Health, Mental and Behavioral Health*

Learn About the Michigan Child Collaborative Care Program

The Michigan Child Collaborative Care (MC3) program provides psychiatry support to primary care providers in Michigan who are managing patients with behavioral problems. This includes children, adolescents and young adults through age 26. It also includes women who are contemplating pregnancy, or who are pregnant or postpartum with children up to a year. Psychiatrists are available to offer guidance on diagnoses, medications and psychotherapy interventions so that primary care providers can better manage patients in their practices. Support is available through same-day phone consultations to referring providers. Remote psychiatric evaluation through video telepsychiatry is also available.For more information, go to mc3.depressioncenter.org.

Improving the Quality of Kidney Care

About 37 million adults in the United States have chronic kidney disease (CKD) and 9 out of 10 people with CKD are unaware they are living with the disease. Early identification, regular monitoring and ongoing management of CKD are critical to slow disease progression and avoid kidney failure.

The National Committee for Quality Assurance (NCQA) created the **Kidney Health Toolkit** for use in improving the quality of care for patients with and at risk of CKD. This toolkit will help equip you with tools that guide and facilitate strategies to promote kidney health.

The toolkit includes the following tools to help patients and their care teams navigate CKD diagnosis, monitoring and management:

Let's Talk About Diabetes and Kidney Health: Ready-Set-Test

Provider guide on diabetes and CKD testing.

Are Your Kidneys at Risk?

Patient infographic on CKD risk factors and testing.

You've Been Diagnosed With Kidney Disease. Now What?

Patient pamphlet on understanding a CKD diagnosis and next steps.

Chronic Kidney Disease: Talk, Listen, Learn

Patient and provider poster on how to talk about CKD.

Scan the code to download the Kidney Health Toolkit

Help Available for Internet, Laptop Purchase for Your MHP Medicaid Patients

The Affordable Connectivity Program (ACP) is a government benefit program. It helps make sure certain households can afford the internet service they need for work, school, health care and more.

Eligible households get a discount of up to $30 per month toward internet service. There's also a one-time discount of up to $100 to purchase a laptop.

Who Is Eligible for the ACP?

A household is eligible if a member of the household meets at least one of the following:

- Has an income at or below 200% of the **federal poverty guideline**
- Enrolled in programs like SNAP, Medicaid, federal public housing assistance, SSI, WIC or **Lifeline**
- Participates in Tribal-specific programs, such as Bureau of Indian Affairs General Assistance, Tribal TANF or food distribution program on Indian Reservations
- Receives free or reduced-price school breakfast or lunch
- Received a Federal Pell Grant during the current award year
- Is eligible for a participating provider's existing low-income program

If you think you have patients who qualify, have them visit https://www.fcc.gov/acp for more information.

Member Language Needs and Resources

McLaren Health Plan (MHP) uses census data to track and monitor the language needs of its enrolled members – as well as the language of the population in its geographical area – to ensure appropriate language assistance.

The top languages spoken by MHP members as of March 31, 2022 are:

- English – 99.2%
- Spanish – 0.4%
- Arabic – 0.3%
- Swahili – 0.1%

MHP offers providers detailed reports on service area language needs and the language needs of assigned members. Language assistance resources are made available to providers and staff, along with training to identify needs and services available.

Please contact customer service at 888-327-0671 (TTY: 711) to obtain a list of language needs of assigned members in your practice or to request training about language services.

Care Coordination And the Importance of Communicating With the PCP

The coordination of medical care is essential to a patient's overall state of health. MHP encourages physicians to communicate with each other when co-treating a patient, including for behavioral health issues. It is the responsibility of every treating provider to adequately inform the patient's PCP of all recommendations and medical treatment being proposed.

Communication among physicians and providers is one of the best ways to successfully treat a patient. The patient's primary care provider is the medical home for all health information regarding the patient's care. Consider this question: What does the PCP need to know to treat this patient in the safest and most efficient manner?

It's critical to have medical information relayed to the PCP by:

- Prompting patients to return to their PCP after a consultation or hospital stay

- Having specialists send summaries of recommendations to PCPs
- Providing communication from pharmacy data identifying polypharmacy to PCPs
- Notifying members of PCP terminations
- Improving the process for members to authorize sharing of behavioral health information with their PCPs
- Promoting the sharing of information by the PCP to the behavioral health specialists when coexisting medical and behavioral health conditions exist
- Providing behavioral health services in the primary care home

Credentialing With MHP

Here's how to avoid delays in the credentialing and recredentialing process with McLaren Health Plan:

- Update and/or reattest to your CAQH application at least every 120 days.
- Update your Authorization for Release of Information at least every 12 months and upload to CAQH.
- Ensure the address and contact information is correct for all practice locations.
- Leave no gaps in your most recent five years of work history section. If gaps greater than six months exist, document the reason, including the month or years and reason, e.g., leaves of absence, maternity leave, moves, etc.
- Ensure a current copy of your liability license is attached to your CAQH. After uploading a new copy to CAQH, check after three days to make sure it wasn't rejected.
- Provide a credentialing contact in case outreach is needed.

IMPORTANT: *Failure to respond to requests from the MHP credentialing team could result in termination from the network due to incomplete documentation.*

Provider Appeals and When to Submit a Request

Please allow McLaren Health Plan the opportunity to resolve issues before submitting an appeal. Contact Customer Service at 888-327-0671 (TTY: 711) and ask for the Provider Team when a dispute occurs. If you continue to disagree with an action taken by MHP after informally attempting to resolve the dispute through a verbal contact or a provider claims adjustment, then a formal, written appeal may be submitted.

Supporting information (not previously submitted) regarding the reason and rationale for the appeal must be included with the appeal request. This could include:

- Additional medical records and or office notes
- Diagnostic reports
- Operative notes or surgery reports
- Other information as applicable to the appeal request

You must have submitted a claim for the service in question and/or received a denial or reduction in payment from MHP before an appeal will be considered. An appeal form must be received within 90 calendar days of the disputed action. Disputed action dates are from the latter of the:

- Explanation of Payment (EOP)
- Original claim date of service
- Adjusted EOP
- Authorization decision

The right to appeal is forfeited if you do not submit a written request for an appeal within the 90-day time frame and any changes in dispute must be written off.

To submit a provider appeal request or provide appeal-related information, send to MHPAppeals@mclaren.org or fax to 810-600-7984.

Details about the provider appeals process can be found at https://www.mclarenhealthplan.org/Uploads/Public/Documents/HealthAdvantage/documents/HA%20Documents/Provider%20Appeal%20Process%20with%20.Form.pdf.

Lab Service Info for MHP Providers

If you perform lab tests in your office, you must demonstrate that you have a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. MHP has developed a list of laboratory services that are billable when performed in the office by both primary care and specialist. Please see the MHP In-Office Laboratory Billable Procedures form here (make hyperlink) for a list of CPT codes that are billable when performed in an office setting.

MHP uses Joint Venture Hospital Laboratories (JVHL) as our provider for laboratory services. JVHL has more than 400 phlebotomy locations, full-time courier service and 24/7 client support. For service center locations, the JVHL provider directory or other information, go to www.jvhl.org.

Clinical Practice Guidelines Available to Assist With Decision-Making

McLaren Health Plan uses **Clinical Practice Guidelines** to assist practitioners and members with decision-making about appropriate health care for specific clinical circumstances. New and revised guidelines are developed and updated through collaborative efforts of the Michigan Quality Improvement Consortium (MQIC) and other evidence-based resources.

Clinical Practice Guidelines are distributed to practitioners to improve health care quality and reduce unnecessary variation in care. Documentation in your medical records should indicate you used the appropriate guideline in your practice decisions.

The Clinical Practice Guidelines were reviewed, updated and approved in September 2021 by our Quality Improvement committee.

Please review the guidelines found at www.MQIC.org.

Contact Medical Management at **888-327-0671 (TTY: 711)** if you have questions or would like a copy of the guidelines mailed to you.

The Importance of Communicating With Your Patients

Explaining things in a way that is easy for a patient to understand isn't always easy. It's especially important now that everyone is wearing masks. It's imperative that patients understand what you and your staff are telling them.

The annual Consumer Assessment of Health Plans Survey (CAHPS®) measures a member's overall satisfaction with his or her treating physician. Recent survey results reveal "How well doctors communicate" falls below the 75th percentile set forth by the National Committee for Quality Assurance (NCQA).

Here are some tips to follow during the service encounter when communicating with your patients:

- Speak slowly
- Speak loudly enough to be heard through a mask
- Use plain language
- Make eye contact
- Use the patient's name during conversation
- Use pictures, if necessary
- Encourage your patients to ask questions
- Repeat the information back
- Always ask, "Do you understand?"
- Ask if the patient has been to an ER or urgent care or has seen a specialist since his or her last visit. Counsel if necessary.

Screen Your Patients for Hepatitis C

The Michigan Department of Health and Human Services (MDHHS) recommends screening for hepatitis C at least once in a lifetime for people ages 18-79. McLaren Health Plan covers the drugs used to treat Hep C.

Please make sure your eligible patients are screened for this contagious infection.

MedImpact: PBM for All MHP Lines of Business

MedImpact is the Pharmacy Benefits Manager for all McLaren Health Plan lines of business.

Pharmacy Prior Authorization
The appropriate pharmacy PA request forms are located at https://www.mclarenhealthplan.org/mhp/referral-request-form-mhp1. There are certain drugs that have their own PA form. All new PA requests should be submitted directly to MedImpact. Please use the following dedicated MHP PA information below when inquiring about and submitting PA requests:

MedImpact Prior Authorization Department
Electronic PA: https://surescripts.com/enhance-prescribing/prior-authorization

Phone: 888-274-9689

Retail/Specialty/Mail-Order Pharmacy Network
CVS and Target pharmacies are out-of-network. For a complete list of our in-network pharmacies, go to https://www.mclarenhealthplan.org/community-provider/find-a-provider-community or call Customer Service at 888-327-0671 (TTY: 711).

The MHP preferred specialty pharmacy vendor is AllianceRX Walgreens Prime. All specialty drugs will need to be obtained through this pharmacy.

AllianceRX Walgreens Prime
Phone: 888-282-5166

The MHP preferred mail-order pharmacy is MedImpact Direct. Contact MedImpact Direct if a patient expresses interest in having medications mailed to them.

MedImpact Direct
Phone: 855-873-8739

To contact a MedImpact representative, please call 888-274-9689.

PCPs and Your Acceptance Status With MHP

MHP Community HMO, POS, Medicaid and Healthy Michigan members are assigned to a primary care provider upon enrollment. Every contracted PCP is listed as having an "open" acceptance status – accepting new patients – unless a request to close the practice has been made and approved.

Changing the accepting status of a practice requires six steps, completed in the following order:

1. If you are requesting an acceptance status change with MHP, you also must be changing the acceptance status of your practice with all other health plans.
2. Create a letter on office letterhead that includes the following:
   - » The reason for the request to limit members
   - » Attestation that your practice is being closed to all other health plans
   - » Anticipated time frame new enrollment is being limited
   - » Signature of physician making the request
3. Mail the letter to your MHP Network Development coordinator

   ATTN: <NAME OF NETWORK DEVELOPMENT COORDINATOR>

   McLaren Health Plan
   G-3245 Beecher Road
   Flint, MI 48532
4. The request is reviewed by the Network Development manager following verification of assigned membership to the PCP.
5. The Network Development manager will respond in writing to the PCP's request within two weeks, indicating approval or denial.
6. If approved, the request for the acceptance status change is effective 30 days from the date of approval and changes your acceptance status to "conversion only."

Once your acceptance status is "conversion only," PCPs are required to accept new MHP members whose enrollment was in process at the time of the acceptance status change and accept existing patients who switch from other plans to MHP.

There are exceptions to MHP's acceptance status policy, which are reviewed on a case-by-case basis. Special consideration may be made under the following circumstances:

- Exit of a partner in the practice
- Total volume of patient base in direct comparison with office space
- Leave of absence
- Provider agreement language

If a request for acceptance status change is approved by MHP, the length of the status change is limited to six months from the date of approval. After six months, the acceptance status will revert to "open" to accepting new MHP members.

Why It's Important to Refer to In-Network Providers

MHP Medicaid and MHP Community members must use providers who participate or are in-network with McLaren Health Plan for their health care needs. Go to https://www.mclarenhealthplan.org/community-provider/find-a-provider-community or call Customer Service at 888-327-0671 (TTY: 711) if you need information about in-network providers when referring a member.

MHP members with Point-of-Service (POS) plans have an Option B benefit that allows self-referral and the use of nonparticipating/out-of-network providers. These members will have higher copays and/or deductibles and will be responsible for any balance bill from a nonparticipating/out-of-network provider. Some Option B benefits require plan preauthorization regardless of the network status of the provider. Call Customer Service if you have referral, authorization or benefit questions.

Understanding the MHP Referral Process

Authorization or referral? Outpatient or inpatient? In-network or out-of-network? How do you know which CPT codes require an authorization from McLaren Health Plan, and when?

You can view a list of CPT codes that require an authorization when provided in the outpatient setting at McLarenHealthPlan.org/ or https://www.mclarenhealthplan.org/Uploads/Public/Documents/HealthPlan/documents/MHP%20Documents/referral_catagories.pdf. The list is reviewed quarterly and may be revised and updated as appropriate.

These codes also require an authorization when performed in the inpatient setting or an at out-of-network facility. All services and/or procedures billed to MHP must be both medically necessary and coded appropriately. MHP reviews paid claims to ensure compliance and accuracy.

All genetic testing codes require Medical Director review and preauthorization. Authorization is not required for pregnant women over the age of 40 and if services are provided in-network. For MHP Medicaid members only — authorization is not required for 81222 and 81223.

We have two versions of the MHP Request for Preauthorization form. The fillable PDF form is available for you to download, print and return to us by mail or fax and is located on our website at McLarenHealthPlan.org/ or https://www.mclarenhealthplan.org/medicaid-provider/referral-request-mhp .If you'd like to scan it and email it to us, send it to MHPAuthandCharts@mclaren.org. There's also an option to complete the form and submit it directly from our website. Go to https://www.mclarenhealthplan.org/community-provider/referral-guidelines-mhp. Print a copy of the completed request for your patient's records.

MHP is committed to the philosophy of the primary care provider as the patient's care coordinator and the medical home for its members. Ongoing coordination of care remains the responsibility of the PCP. MHP continues to educate its members about the importance of discussing all health care needs with their PCPs.

ARE YOU USING MCIR?

The Michigan Care Improvement Registry, or MCIR, is an important tool that records and tracks immunization history and can help ensure that vaccines are not missed.

The secure website, www.MCIR.org, includes immediate patient immunization history, due dates, future dose dates, reminder and recall notices for due or overdue immunizations, printable official immunization records and batch reports. All MHP providers are required to submit vaccination information to MCIR.

MHP and MCIR sends reminder notices to your patients encouraging them to receive immunizations. Among the reminders being sent are ones for the 11-, 12- and 13-year-olds in your practice who may be easy to overlook when it comes time to think about immunizations. The CDC recommends all preteens need HPV vaccination, so they can be protected from HPV infections that cause cancer. Encourage your patients to receive these important immunizations, and then submit the information to MCIR.

VACCINE	AGE
Human Papillomavirus Vaccine (HPV)	11-13 years old (3 doses) Or 2 doses at least 6 months apart
Meningococcal (MCV)	11-13 years old
Tetanus, Diphtheria, Pertussis (Tdap)	11-13 years old

AGE	NEW PATIENT	ESTABLISHED PATIENT
Early Childhood (1-4 years)	99382	99392
Late Childhood (5-11 years)	99383	99393
Adolescent (12-17 years)	99384	99394

Turn a 'Sick Visit' Into a 'Well-Child' Visit and Increase Your Reimbursement

Health screenings play an important part in a child's life. MHP encourages parents of young children to schedule well-child visits to make sure their kids are up to date on immunizations and are meeting milestones for growth and development.

Families get busy and many times see the doctor only for sick visits. But did you know you can easily turn a sick visit into a well-child visit?

When you have an MHP member in your office for a sick visit who also is due for a well-child visit, simply incorporate the elements of a well-child exam into the visit and bill MHP for both the sick and well-child services performed. You can do this by adding modifier -25 to the sick visit and you will be reimbursed for both services.

Telehealth visits are a covered benefit and can be used for gap closure for well visits.

Well-child visits must include physical, mental, developmental, hearing and vision components and other tests to detect potential problems.

Bill age-appropriate well-child codes as indicated below. When these services are provided to an MHP Medicaid member, MHP reimburses you at a higher rate than the Medicaid fee schedule. MHP will reimburse you for one well-child visit per patient each calendar year. You do not have to wait a full calendar year to perform a well-child visit.

HOW TO GET FREE LEAD TESTING SUPPLIES FOR YOUR OFFICE

PCPS CAN EARN AN INCENTIVE WHEN PERFORMING A LEAD TEST FOR MHP MEDICAID MEMBERS

Lead is a poison that affects virtually every system in the body. It is particularly harmful to young children. Very severe lead exposure in children (blood lead >= 70 ×g/dL) can cause coma, convulsions and even death. Lower levels can cause adverse effects on the central nervous system, kidney and hematopoetic system. Blood lead levels as low as 5 ×g/dL are associated with decreased intelligence and impaired neurobehavioral development. Other effects begin at these low blood lead levels, including decreased growth, decreased hearing acuity and decreased ability to maintain a steady posture.

All children should be lead tested by the second birthday. PCPs can perform an in-office blood lead screening during a well-child visit and are eligible to receive FREE lead testing supplies from the State of Michigan. The kits are to be used for children receiving Medicaid benefits. MHP will assist you in obtaining the free kits.

You'll get:

- All the supplies and instructions needed to complete the lead screen test
- Prepaid envelopes to mail test samples

For MHP Medicaid members:

When using the lead screening kits from MDHHS, submit a claim to MHP with CPT code 36416 – which indicates the lead sample was obtained and sent for testing – and you'll earn a $15 incentive.

Of if you have the capability to perform the actual lead test and receive an immediate result, submit a claim to MHP with CPT code 83655 – which indicates the lead sample was obtained and tested – and you'll earn a $25 incentive.

Call your MHP Outreach Representative at **888-327-0671 (TTY: 711)** if you need information about obtaining the lead testing kits or if you would be interested in hosting a lead clinic.

FLINTREGISTRY
Get Connected. Get Supported. Get Counted.

The Flint Registry is a project that connects people to services and programs to promote health and wellness. It was created to help understand how the Flint water crisis has affected the Flint community. If you have patients who lived, worked or attended school or day care between April 25, 2014, and Oct. 15, 2015, at any address serviced by the Flint water system, have them register at www.flintregistry.org/how-to-join or call 833-go-flint.

Assuring Better Child Health and Development (ABCD)

CPT CODE	ICD CODE	CATEGORY	NOTES	INCENTIVE FOR MEDICAID MEMBERS (AGE 0-3 YRS.)
96110	Z13.4	Developmental Screenings	Screening tool completed by parent or non-physician staff and reviewed by the physician	$20 (one per member per year)

Developmental screening should be included at every well-child visit and can be billed in addition to the well-child visit (see below.) It is recommended that standardized developmental screening tests be administered at the nine-, 18-, and 24- or 30-month visits.

The Michigan Medicaid Early and Periodic Screening, Diagnostic and treatment (EPSDT) policy requires developmental surveillance and screening and recommends providers use a tool, such as the PEDS, PEDS: DM or Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire Social-Emotional (ASQSE). You are encouraged to implement developmental surveillance and screening into your office to be compliant.

For our contracted MHP network practitioners, MHP purchased the rights to the ASQ screening tool. If you would like a copy of this material, please contact your network development coordinator at **888-327-0671 (TTY: 711)**.

Suggestions for successful practice implementation include the following:

- Use a standardized screening tool, such as ASQ.
- Communicate with office staff, colleagues and parents about the importance of developmental surveillance and screening.
- Screen all children during well-child checks at the nine-, 18-, and 24- or 30-month visits.
- Discuss any developmental concerns with the child's parents.
- Refer children to Michigan's Early On program if developmental delays* are found. You can make the referral at www.1800earlyon.org or the statewide line at (800) EARLY ON (327-5966.)

**Should the screening indicate developmental delays, additional objective development testing may be performed by the physician at an outpatient office visit using CPT code 96111.*

HEDIS® MEASURING THE QUALITY OF CARE

McLaren Health Plan supports care that keeps members at optimum levels of health while also controlling costs and meeting government and purchaser requirements. MHP is accredited by the National Committee for Quality Assurance (NCQA) Health Plan Accreditation, which builds upon more than 25 years of experience to provide a current, rigorous and comprehensive framework for essential quality improvement and measurement. It bases results on consumer experience and clinical performance, which is HEDIS® (Healthcare Effectiveness Data and Information Set), the most widely used set of performance measures in the managed care industry. HEDIS measures performance in health care where improvements can make a meaningful difference in people's lives.

Key Impact Areas for 2022

MHP's team of dedicated professionals will work with you to educate members about resources available to them to improve key impact areas in the HEDIS measures for 2022:

- Preventive screenings
- Medication management
- Use of services
- Behavioral health
- Respiratory conditions
- Cardiovascular
- Access and availability of care
- Diabetes
- Musculoskeletal

To become accredited, MHP submits claims and medical review data to NCQA. Many HEDIS measures may include only a small number of your patients due to a continuous enrollment requirement of the specifications and a sampling of the eligible population.

Other measures can be calculated only by administrative results (claims data submitted by you, the practitioner), and some measures are calculated through a hybrid method of a combination of claim submissions and medical record review.

A summary table and the HEDIS provider manual can be found at https://www.mclarenhealthplan.org/community-provider/hedis-information-mhp.aspx, or call MHP's Quality Management team at 888-327-0671 (TTY: 711) for more information.

The following conditions serve as reminders for services that are HEDIS measures for 2022.

MEASURE: Low Back Pain

For adults between the ages of 18 and 75 with the primary diagnosis of low back pain, the expectation is no imaging studies (X-ray, MRI, CT scan) within 28 days of diagnosis. Exclusions include for cancer, recent trauma, IV drug use or neurological impairment.

MEASURE: Upper Respiratory Tract Infections

McLaren Health Plan annually measures the rate at which our members are diagnosed with an upper respiratory infection (URI), diagnosis codes J00, J06.0 and J06.9, indicative of a viral URI and are not prescribed antibiotics. Coding or billing a viral URI diagnosis (code J00) or acute nasopharyngitis (common cold) diagnosis (code J06.9) where antibiotics are prescribed is inconsistent with evidence-based medicine or correct coding. Sneezing, running nose, nasal congestion and headache are the common symptoms of viral URIs. A viral URI (common cold) occurs with great frequency.

While there is no curative treatment for this type of URI, numerous over-the-counter cold remedies provide symptomatic relief. A bacterial URI also can develop. Many factors, including duration and severity of symptoms, as well as underlying respiratory diseases, are considered when deciding whether to prescribe antibiotics in the treatment of URI. In contrast to viral URIs, prescription antibiotics do provide effective treatment for bacterial URIs.

When a patient presents with a bacterial URI that requires prescription antibiotics, please ensure you are documenting the appropriate diagnosis for the bacterial URI and your billing staff is submitting appropriate codes on claims to MHP.

MEASURE: Patients With Acute Bronchitis

Avoiding antibiotic treatment for patients with acute bronchitis looks at patients ages 3 months and older who have had a diagnosis of acute bronchitis and were not dispensed an antibiotic prescription within three days of the date of the office visit.

Prescribing antibiotics for acute bronchitis (diagnosis codes J20.3-J20.9) is inconsistent with evidence-based medicine unless a comorbid diagnosis or other bacterial infection exists.

Keep in mind:

- Less than 10 percent of acute cough/bronchitis is bacterial.
- Use antibiotics wisely to prevent antibiotic resistance.
- Encourage smoking cessation and avoidance of secondhand smoke.
- If no relief, encourage a follow-up in three days.
- Educate patients on self-help measures, such as drinking extra fluids, getting rest, using antitussive agents for cough and proper hand-washing techniques.

MEASURE: Obesity and BMI Documentation

During the annual HEDIS chart review, MHP will look to see if obesity issues were addressed; BMI was calculated and documented, and healthy lifestyle habits were encouraged.

Children – For MHP members 3 to 17 years old who have had an office visit with a PCP or OB-GYN during the measurement year, the following should be documented:

BMI percentile: Simply recording the member's height and weight or BMI number will not meet the criteria. BMI percentiles must be used as BMI norms will vary with age and gender for children.

Counseling for nutrition: Documentation with the date of the visit should include one of the following:

- Discussion of eating habits
- Counseling or referral regarding nutrition education
- Providing anticipatory guidance for nutrition

Counseling for physical activity: Documentation with the date of the visit should include one of the following:

- Discussion of current physical activity behaviors
- Counseling or referral regarding physical activity
- Providing anticipatory guidance for physical activity

Resource material for children, including growth charts, training modules and a BMI calculator for children and teens, is available at www.cdc.gov/growthcharts.

MEASURE: Access to Care

The National Committee for Quality Assurance and the Michigan Department of Health and Human Services monitor the access rates of health plans. This may consist of both well and/or sick visits. The measurement requires:

- Adults age 20 and older have at least one outpatient ambulatory visit per year

McLaren Health Plan can help you identify your MHP members who have not received services and help you schedule them for an appointment.

- Our Outreach Team can assist you in contacting and scheduling patients for preventive care services. We also can contact patients (according to claims submission) who have not been seen by the PCP during the calendar year and encourage them to contact your office for an appointment. Call 888-327-0671 (TTY: 711) if you are interested in this service.
- MHP Customer Service can help you with address and telephone numbers of patients who have not yet established a relationship with your office. Call 888-327-0671 (TTY: 711) for assistance.

MEASURE: Diabetes Care

The greatest number of people with diabetes are those patients in your practice between the ages of 40 and 59. Several tests are recommended annually that may reduce the risk of diabetes-related health problems:

- Hemoglobin A1c
- Dilated eye exam
- Urine microalbumin and estimated glomerular filtration rate
- Physical examination, including a foot exam at least twice per year

MEASURE: Adolescent Immunization

It's not only infants who need regular immunizations. You and your office staff can be an advocate to your patients and their parents about the safety and effectiveness of immunizations for adolescents. A fully immunized 13-year-old patient will have received the following:

- One meningococcal vaccine between ages 11 and 13
- One TD or Tdap on or between ages 10 and 13
- Two or three doses of the HPV vaccine by age 13
- For two doses, must be administered at least 146 days apart

Be sure to update MCIR after administering all patient immunizations.

MEASURE: Women's Preventive Health

Breast and cervical cancer screenings continue to save lives when performed on time, in the right setting and for the right patient.

- Screen women patients ages 21 to 64 for cervical cancer every year.
- Screen women patients ages 50 to 74 for breast cancer every year.

MEASURE: Chlamydia Screening

The ability to screen for chlamydia using a urine sample has simplified the recommended preventive screening; however, less than 50 percent of women receive this important test.

- All sexually active women 16 to 24 years old and men 16 to 18 years old should be screened for chlamydia every year.

Include chlamydia screening as part of the adolescent well exam – and for women as part of the annual Pap exam.

When your patients test positive for chlamydia, have them inform previous and current sexual partners. Expedited Partner Therapy should be provided for the partners of patients with a clinical or laboratory diagnosis of chlamydia. Information on Expedited Partner Therapy can be found at https://www.michigan.gov/documents/mdhhs/Expedited_Partner_Therapy_Information_Sheet_for_Patients_and_Partners_721277_7.pdf.

PLAN	BAYER BRAND TEST STRIPS/LANCETS	INSULIN PUMP SUPPLIES
MHP Community With Pharmacy Coverage	Pharmacy Benefit	DME Supplier
MHP Community Without Pharmacy Coverage	DME Supplier	DME Supplier
MHP Medicaid HMO **MHP Healthy Michigan**	Pharmacy Benefit	DME Supplier
McLaren Health Advantage	Pharmacy Benefit	DME Supplier

PCPs: Review Your 'Gaps in Care' Reports

Gaps in Care reports are sent to MHP primary care physicians (PCPs) to identify services that have not been completed for assigned membership based on current HEDIS specifications. Rates are now measured using race and ethnicity. Eliminating health disparities is essential for providing equitable care to all members.

Reports are closed when a member receives the service and a claim has been billed to MHP. If you find you've billed a service, but your report shows it outstanding, please contact the MHP Quality Management team at MHPOutreach@mclaren.org to confirm receipt of claims or to discuss why the claim(s) didn't meet the gap closure.

You can supplement claims data by faxing medical records for the following measures to MHP at **810-600-7985**.

- Child BMI and nutrition and physical activity counseling
- Diabetes care – HbA1c testing, nephropathy testing and eye exams
- Chlamydia testing
- Breast cancer screening and any possible exclusion
- Cervical cancer screening and any possible exclusion

If you have any questions, call Customer Service at **888-327-0671 (TTY: 711)** and ask for the Quality Outreach team.

Report Social Determinants of Health When Identified During Patient Visits

Social determinants of health (SDoH) are conditions in the places where people are born, live, learn, work, worship and play that affect a wide range of health risks and health outcomes.[1]

There are ICD-10 codes that can be submitted with claims to help MHP identify members who have SDoH. Either submit SDoH codes with claims or make a referral to MHP's case management program. These code categories include:[2]

Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

[1]*Office of Disease Prevention and Health Promotion, October 11, 2018, Healthy People 2020 – Social Determinants of Health, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health*

[2]*ICD-10 Data, 2018, Factors Influencing Health Status and Contact With Health Services*

How to Increase Colorectal Screening Rates in Your Practice

Created by clinicians for clinicians, the toolbox linked below can help improve colorectal cancer screening in actual practice. It provides state-of-the-science information, advice to help make screening practices more efficient and tools for use in the practice. Available at http://nccrt.org/resource/crc-clinicians-guide/.

A shorter version of the toolbox above, this brief guide pulls together the most important material from the full action plan, including charts, templates and sample materials that clinicians can use. As the guide above, the tools are applicable to all types of clinical screening. Go to www.cancer.org/content/cancer/en/health-care-professionals/colon-md.html.

MHP Aims to Improve Members' Health With Free Programs and Services

McLaren Health Plan has the following programs available in which you can enroll members by calling **888-327-0671 (TTY: 711)**. Members may also self-refer and can exit the programs at any time.

Upon enrollment, members receive educational mailings, ongoing nurse contacts and pharmacy management, where applicable.

Taking It Off – MHP nurses help both adults and children who want to lose weight. Members receive:

- Educational materials mailed to their home upon request
- Phone calls to offer support
- Coordination with their PCP

McLaren Moms – Upon enrollment, pregnant members receive a $10 gift card and are entered into a quarterly drawing for an iPad or a Pack 'n Play if they receive timely care after their baby is born. A nurse talks to members and members receive information about pregnancy self-care, including how to take care of the baby and the baby's growth and development. Other topics covered include:

- A flu shot is the best protection from illness for mother and baby.
- Quit smoking and do not drink alcohol.
- Check with your doctor to make sure you can take your current medications while pregnant.
- Go to all your prenatal visits; these are very important to track the health of you and your baby.
- See your doctor within six weeks after having a baby.
- Dental coverage is available during pregnancy and up to three months after delivery.

Stop Smoking Quit Line – MHP members can call **800-784-8669** for free counseling. You also can counsel and bill for stop-smoking services as the PCP using 99406 – Smoking and tobacco-use cessation counseling, Intermediate > 3-10 minutes or 99407 – Smoking and tobacco-use cessation counseling – Intensive > 10 minutes.

Communicate the hazards of smoking, vaping and tobacco use at each visit. There are several prescription medications available that are covered benefits for MHP members. Call **888-327-0671 (TTY: 711)** for details.

Diabetes and Asthma Management Programs – MHP has nurses who understand diabetes and asthma. They work with members to help them understand their diabetes or asthma and provide them with support. These nurses will keep you informed of your members who are enrolled in the programs. Members receive:

- Support from a nurse so they know the best ways to manage their condition and assess their health status
- Newsletters with the most up-to-date information about diabetes or asthma
- Materials that will help them understand and manage their medicine and plan visits to their doctor

Down With Hypertension – Members are enrolled if their doctor diagnoses them with high blood pressure. All identified members will be mailed information about the program. MHP's pharmacists and nurses offer support by phone.

Quarterly iPad Drawing – Every quarter, MHP randomly chooses an entry form from all eligible participants age 50 or older who get a mammogram.

Case Management/ Complex Case Management – Every MHP member has a case management nurse who helps coordinate the care and services necessary to stay healthy and improve health. This nurse helps with difficult health problems and connects members with community support services.

Help Prevent Fraud, Waste and Abuse

McLaren Health Plan works hard to prevent fraud, waste and abuse. We follow state and federal laws about fraud, waste and abuse. Examples of fraud, waste and abuse by a **member** include:

- Changing a prescription form
- Changing medical records
- Changing referral forms
- Letting someone else use his or her MHP ID card to get health care benefits
- Resale of prescriptions

Examples of fraud, waste and abuse by a **doctor** include:

- Falsifying his or her credentials
- Billing for care not given
- Billing more than once for the same service
- Performing services that are not needed
- Not ordering services that are medically necessary
- Prescribing medicine that is not needed

Call **MHP's Fraud and Abuse Line** at **866-866-2135** if you think a doctor, other health care provider or member might be committing fraud, waste or abuse. You can email MHP's Compliance Department at MHPcompliance@McLaren.org. You also can write to MHP at:

McLaren Health Plan Inc.
Attn: Compliance
P.O. Box 1511
Flint, MI 48501-1511

Contact the **State of Michigan** if you think a member has committed fraud, waste or abuse. Here's how:

- Fill out a fraud referral form at https://mdhhs.michigan.gov/Fraud OR
- Call the MDHHS office in the county where you think the fraud, waste or abuse took place OR
- Call the MDHHS office in the county where the member lives

Contact the **Michigan Department of Health and Human Services Office of Inspector General** if you think a doctor or other health care provider has committed fraud, waste or abuse. Here's how:

- Call them at **855-MI-FRAUD (855-643-7283)** OR
- Send an email to MDHHS-OIG@michigan.gov OR
- Write to them at Office of Inspector General, P.O. Box 30062, Lansing, MI 48909

Here's What MHP Tells Its Members

You might be the target of a fraud scheme if you receive medical supplies that you or your doctor did not order.

Take Action to Protect Your Benefits:

- Refuse medical supplies you did not order.
- Return unordered medical supplies that are shipped to your home.
- Report companies that send you these items.

Identity theft can lead to higher health care costs and personal financial loss. Don't let anybody steal your identity.

Current fraud schemes to be on the lookout for include:

- People using your health plan number for reimbursement of services you never received
- People calling you to ask for your health plan numbers
- People trying to bribe you to use a doctor you don't know to get services you may not need

You are one of the first lines of defense against fraud. Do your part and report services or items that you have been billed for but did not receive.

- Review your plan explanations of benefits (EOBs) and bills from physicians.
- Make sure you received the services or items billed.
- Check the number of services billed.
- Ensure the same service has not been billed more than once.

Do Your Part!

- Never give out your Social Security number, health plan numbers or banking information to someone you do not know.
- Carefully review your MHPExplanation of Benefits (EOB) to ensure the information is correct.
- Know that free services DO NOT require you to give your MHP ID number to anyone.

McLaren
HEALTH PLAN

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