Partners In Health

Spring 2024

McLaren HEALTH PLAN

INDIVIDUAL
MEDICAID
MEDICARE

"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 is referred to as "MHP" throughout this newsletter.

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CONTACT US

General Information About MHP's Departments and Services

Customer Service

Phone: 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 your MHP patients needs help understanding written materials or need interpretation services in their preferred language, call Customer Service at the number above.

McLaren CONNECT

If you have not yet registered for access to our McLaren CONNECT, provider portal, click: 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 user name 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; skills and training to enter or re-enter the workforce, among much more! Let your patients know about www.gethelp.mclaren.org.

Provider Relations

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7979

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

Provider relations representatives are assigned to physician or provider practices by county. Their services include:

- Orientations for you or your office staff to learn about MHP – how to submit claims, obtaining member eligibility or claims statuses through 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 Provider Relations representative, requesting to open your practice to new MHP members and your representative will make the change.

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

If you are uncertain of who to contact, call us for the name of your representative.

Provider Relations Representative Territory POD Assignments

ORANGE POD
REP II Stephanie Anderson
Work Cell: 231-342-2012
Stephanie.Anderson2@mclaren.org

REP I Bev Hude (light orange)
Work Cell: 517-803-7509
Beverly.Hude@mclaren.org

REP I Kylie Weidenhammer (dark orange)
Work Cell: 810-845-4782
Kylie.Weidenhammer1@mclaren.org

BLUE POD
REP II Aimee Arseneault
Work Cell: 810-931-1948
Aimee.Arseneault@mclaren.org

REP I Darrian Colborne (light blue)
Work Cell: 248-804-7871
Darrian.Colborne@mclaren.org

REP I Jessica Kline (dark blue)
Work Cell: **810-493-1044**
Jessica.Kline@mclaren.org

GREEN POD
REP II Ken Axtell
Work Cell: 517-490-2626
Ken.Axtell@mclaren.org

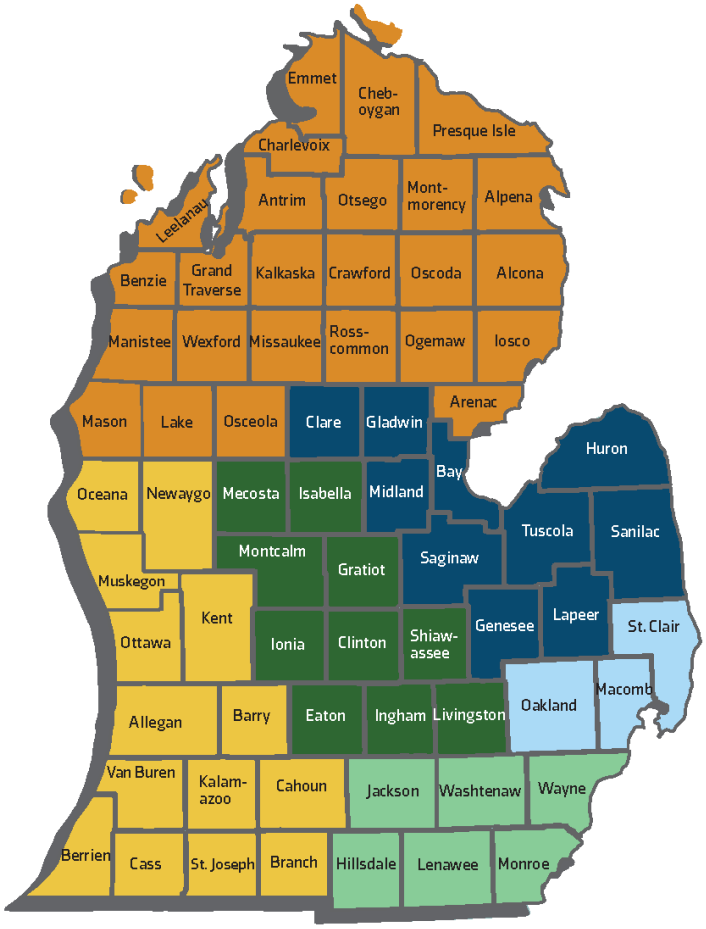
REP I Dawn Dunn (light green)
Work Cell: 810-701-2182
Dawn.Dunn@mclaren.org

REP I Shantell Moore (dark green)
Work Cell: 517-512-5465
Shantell.moore@mclaren.org

PROVIDER RELATIONS

Phone: 888-327-0671
Fax: 810-600-7979

Visit the McLaren CONNECT provider portal at mclarenhealthplan.org to view your claim status and verify member eligibility.



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 or email MHPQuality@mclaren.org.

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 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
- 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)

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 which would result in under-utilization.

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 promotes 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** found here. 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, but not limited to:

- Those listed for a transplant
- Ones who have frequent hospitalizations or ER visits
- Members with multiple health care conditions
- 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 (MHP) 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 which 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.

MDHHS Doula Initiative Announced

Michigan Medicaid began reimbursing for doula services provided to individuals covered by or eligible for Medicaid effective January 1, 2023 (MMP 22-47).

Doula providers seeking reimbursement for their professional services to Medicaid beneficiaries are required to be on the MDHHS Doula Registry and enrolled in CHAMPS.

- Doulas are non-clinical providers who typically offer physical, emotional, and educational support services to pregnant individuals during the prenatal, labor and delivery, and postpartum periods.
- Evidence indicates doula services are associated with improved birth outcomes.
- Doula services have been shown to positively impact social determinants of health, support birth equity, and decrease existing health and racial disparities.
- Medicaid covers different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas.

Doula services must be recommended by a licensed healthcare provider, including but not limited to licensed practical nurse, registered nurse, social worker, midwife, nurse practitioner, physician assistant, certified nurse midwife or physician.

Licensed healthcare providers recommending doula services are not required to be part of the beneficiary's healthcare team, but collaboration is highly encouraged.

- Beginner Guide for Doula Providers
- Doula 101
- Doula-Billing-Guidance
- Doula Fee Schedule

Doulas must submit claims to McLaren Health Plan for services rendered to MHP members with Medicaid.

- Claims and Encounters (michigan.gov)
- CHAMPS claim status instructions

Provider Data Attestation: Better Doctor

McLaren Health Plan has partnered with Better Doctor (Quest Analytics) to gather data attestations quarterly as required by MDHHS, CMS, NCQA and other governing bodies. This process also helps ensure our directory information is accurate. Providers and offices will receive a communication every 90 days from Better Doctor asking to have a representative visit verify.betterdoctor.com and use the access code provided to confirm the demographic information MHP currently has in our systems for each practice. The process is simple and required for continuing participation with MHP.

The easiest way to attest is by sharing your provider roster each quarter with McLaren Health Plan at mhpproviderservices@mclaren.org and Better Doctor at rosters@questanalytics.com.

When providing a roster to your Provider Relations representative, please copy Better Doctor in your email message and add rosters@questanalytics.com to your distribution list. Attesting or sharing your roster each quarter allows MHP to keep your information up-to-date in our records, systems and provider directories while also properly documenting information for compliance and reporting purposes.

Prior Authorization Changes

For upcoming and current prior authorization requirements, visit: **Prior Authorization Codes List**

For current Medicare prior authorization requirements, visit: **Medicare Prior Authorization Information**

UPDATING AND CERTIFYING PROVIDER DATA IN NPPES

To ensure accuracy, Medicare providers are legally required to keep their information up-to-date, including National Provider Identifiers (NPI) and corresponding data in the National Plan & Provider Enumeration System (NPPES).

The Centers for Medicare & Medicaid Services (CMS) encourages Medicare Advantage Organizations such as MHP to use NPPES as a resource for online provider directories.

Using NPPES and keeping it current provides more reliable information to Medicare beneficiaries. When reviewing your provider data in NPPES, update any inaccurate information in modifiable fields, including provider name, mailing address, telephone and fax numbers and specialty.

- Be sure to include all addresses where you practice and actively see patients. This is the same location where a member may call and schedule an appointment.
- Do not include addresses where you could see a patient, but don't actively practice.
- Remove any practice locations no longer in use.

Once you update your information, confirm accuracy by certifying it in NPPES. Remember, NPPES has no bearing on billing Medicare.

If you have any questions pertaining to NPPES, reference NPPES help here. Direct general questions about this notice to your MHP Provider Relations representative.

Psychiatry Support for Providers

The majority of children and women who have depression or anxiety do not receive treatment. That is where MC3 comes in.

ABOUTMC3

MC3 offers no-cost psychiatry support to pediatric and perinatal providers in Michigan through same-day phone consultations to offer guidance on diagnostic questions, safe medications, and appropriate psychotherapy.

CONSULTATION PROCESS

- Consult requests can be initiated by anyone in your practice with knowledge about the patient.
- Requests can be submitted either by phone using regional phone numbers or online via a secure form.
- A psychiatrist will call the prescribing provider with recommendations.
- An MC3 Behavioral Health Consultant (BHC) can provide consultations on local resources.
- Consult summary will be sent to provider.

ADDITIONAL SERVICES

In addition to provider consultations, MC3 also offers:

- Telepsychiatry patient evaluations
- Trainings
- Workflow analysis to better integrate screening, care coordination, and MC3 services
- Local and regional behavioral health resource and referral navigation
- Group case consultations with MC3 psychiatrist
- Perinatal patient care in select counties

LEARN MORE

Request a Clinic Presentation

If you'd like to learn more about MC3 services, please contact us to set up a time for a group presentation for your clinic. MC3-admin@med.umich.edu

Sign Up Online

To sign up for MC3, visit the sign-up page on our website: MC2Michigan.org

Sickle Cell

McLaren Health Plan's Sickle Cell management program is a comprehensive program that begins with early identification of members with Sickle Cell Disease, and through patient education and monitoring, promotes improved outcomes. The emphasis of the program is on self-management and coordination with the primary care physician (PCP) and hematologist and assisting with getting needed testing and treatment.

Program goals include emphasis on self-management, follow-up with health care providers, adherence to prescribed medications, and getting recommended testing to prevent Sickle Cell Disease complications. Ongoing individualized contacts with the member are conducted on an as needed basis to ensure understanding of treatment plans, promotion of the preventive measures and prevention of disease complications.

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.

Chronic Kidney Disease (CKD) and Your Patients

Chronic Kidney Disease (CKD) is permanent kidney damage or decreased level of kidney function for three months or more. Left untreated, CKD can lead to kidney failure. The National Kidney Foundation of Michigan (NKFM) reports 33% of adults or 1 in 3 people in the United States are at risk for kidney disease. According to the Michigan Department of Health and Human Services, more than 1 million adults over age 20 in Michigan are living with CKD.

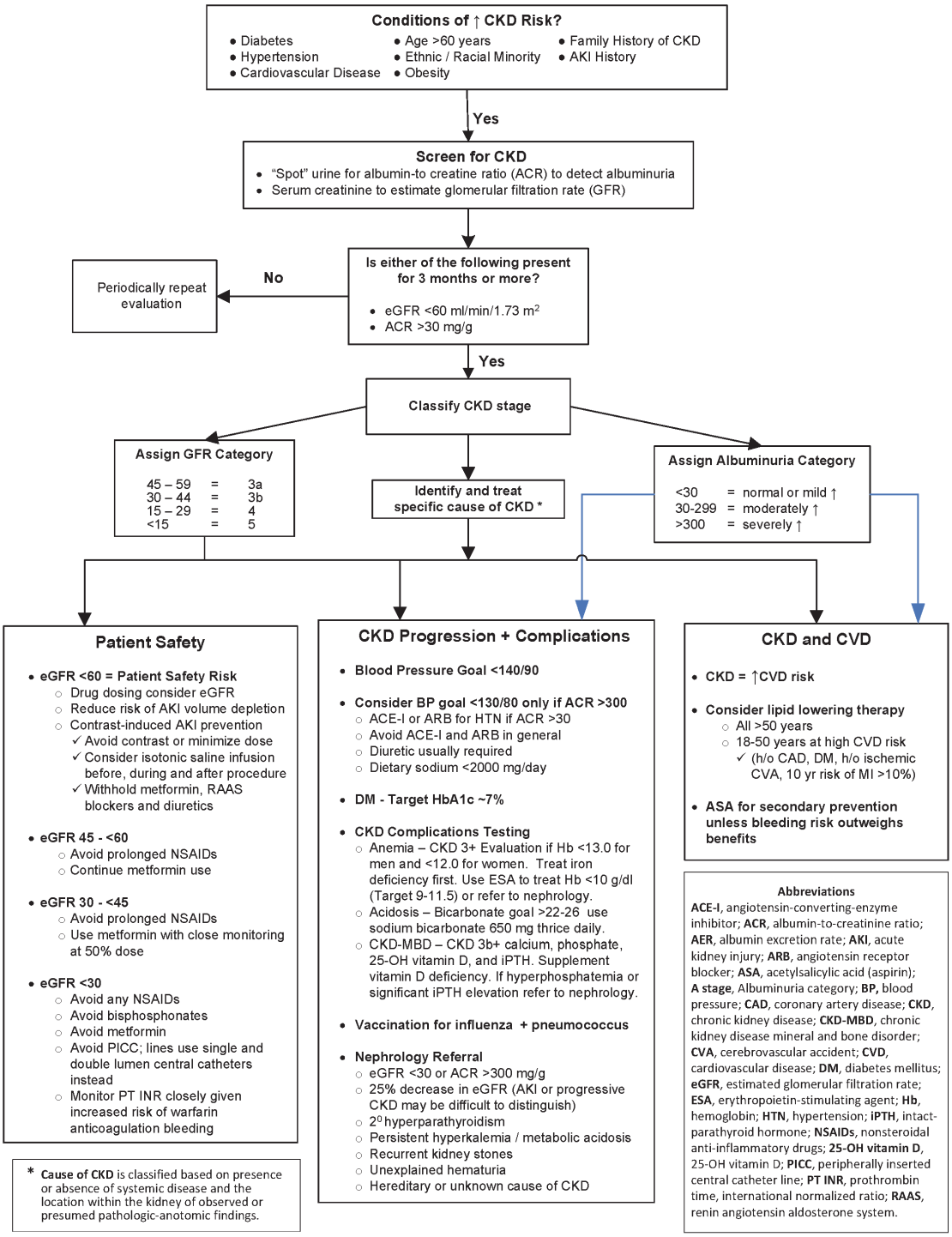
MDHHS has collaborated with the NKFM to raise awareness about the prevalence of kidney disease. McLaren Health Plan is also collaborating with the NKFM on multiple outreach initiatives to educate members about chronic kidney disease.

Visit www.mclarenhealthplan.org for details.

The latest MDHHS/NKFM plan focuses on kidney disease prevention, early detection, management and control efforts across Michigan. Review the MDHHS/NKFM Michigan CKD Prevention Strategy at Michigan.gov.

National Kidney Foundation®

How to Manage Your CKD Patients



Reference: Inker LA, Astor BC, Fox CH, et al. KDOQI US commentary on the 2012 KDIGO clinical practice guideline for the evaluation and management of CKD. *Am J Kidney Dis.* 2014:63(5):713-735.

Quality Quick Tips
CHILDREN'S HEALTH

Each year brings the opportunity to keep your patients on track with their well visits, immunizations and preventive screenings. You can turn a sick visit into a well visit by incorporating the elements of a well child exam into the visit. You will be able to bill MHP for services performed for both the sick and well child. You can do this by adding modifier 25 to the sick visit and you will be reimbursed for both services.

A sports physical can also become a well child visit by adding anticipatory guidance (nutrition, health and social/behavior) to the sports physical's medical history and physical exam. Visit must include the following:

- Physical growth and development assessment
- Mental developmental history
- Complete physical exam
- Hearing and vision screening
- Anticipatory guidance

LOB	Measure	Incentive
Medicaid	Lead	36416 = $15 83655 = $25
Medicaid & Commercial	Chlamydia Screening	$25 per eligible member
Medicaid & Commercial	Weight Assessment and Counseling for Nutrition and Physical Activity	$15 Total ($5 each completed component)
Medicaid	Developmental Screening	$20 members 0-3
Medicaid & Commercial	Vaccines for Children and Adolescents	CIS Combo3 - $50 Combo10 - $100 IMA Combo2 - $50
Medicaid	Club 101 – Well Child Visits Ages 1-14	$101

Child and Adolescent Provider Incentives

MHP will reimburse you for one well child visit each calendar year. You do not have to wait a full 12 months to perform a well child visit.

Dental health and physical health are so intrinsically connected, Well Child visits are also an excellent time to inquire if your patient has a dental home or receives routine dental exams!

CERVICAL CANCER

Make sure to check in with your female members who have not already obtained this important screening. Half of women in the U.S. between the ages of 21 and 60 don't know how often they should be screened for cervical cancer.

Cervical cancer screening is recommended every 1-5 years for women 21 - 64 years of age.

For patients with a cervix and who are not at high risk for cervical cancer, this can be achieved by the following:

Population	Recommendation
Aged 21-29 years	Cytology alone every 3 years
Aged 30-65 years	Any of the following: • Cytology alone every 3 years • hrHPV testing alone every 5 years • Cotesting HrHPV and cytology every 5 years

Health Screening Measure	Medicaid MY22 Rates	Medicaid MY23 Rates	NCQA 75th%
Cervical Cancer Screening	55%	52%	61.80%

Don't forget! McLaren Health Plan wants to recognize and reward you for your excellent quality care and offers an incentive opportunity for Primary Care Providers. Based on your cervical cancer screening overall compliance for your assigned membership you will earn a per member incentive noted below:

Line of Business	NCQA 75th Percentile	NCQA 90th Percentile
Medicaid	61.80%	66.48%
Incentive Opportunity	$25 Per Screened Member	$50 Per Screened Member

We look forward to working in partnership with you to assist our members in achieving optimal health. If you would like a list of your assigned patients who need these services or if you have questions or would like more information, please email us at MHPQuality@mclaren.org.

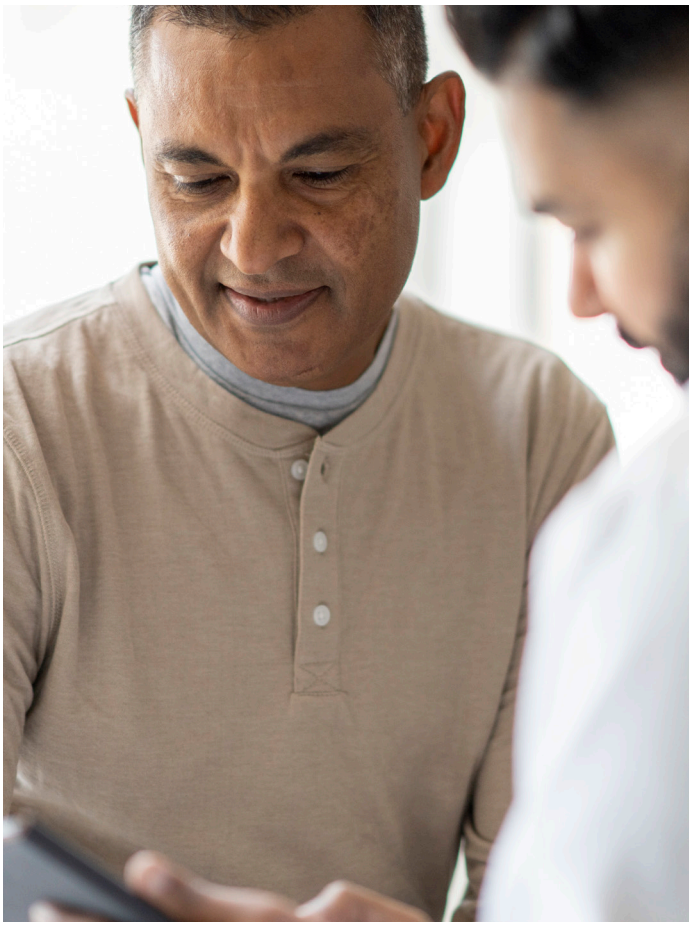
HYPERTENSION

Now is a great time to connect with your patients who have hypertension and ensure they have received or are scheduled to receive their hypertensive disease management appointment.

Known as the "silent killer," hypertension increases the risk of heart disease and stroke, which are the leading causes of death in the United States. While BP lowering interventions can be used to prevent CVD events and mortality, this can only be achieved by preventing high BP and recognizing, treating, and controlling hypertension. You play an important role in diagnosing and supporting your patients to prevent complications. McLaren Health Plan wants to support you and your practices with educating and caring for these patients.

The HEDIS® Controlling High Blood Pressure (CBP) assesses adults 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

Controlling High Blood Pressure	MY2020	MY2021	MY2022	Current	NCQA 75%
Medicaid-Adult	47.20%	45.26%	46.47%	41.22%	62.53%
Commercial	54.26%	52.80%	49.27%	39.83%	64.48%
Marketplace	57.24%	54.94%	59.17%	41.97%	64.48%



TIPS TO IMPROVE HYPERTENSION

- Take 2 or more BP measurements if initial BP is >140/90.
- Ensure that the patient has feet flat, sitting in upright position and the appropriate size cuff is used.
- Rest in between measurements for at lease two minutes with the patient seated.
- Use equipment that is the appropriate size for the patient and that has been regularly calibrated.
- Encourage out of office BP measurements with communication of results, frequent checks for accuracy and lifestyle and medication adjustments. Home readings are often 5 mm Hg lower than in the office.

Health care providers can help patients manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity and smoking cessation.

ORAL HEALTH

Oral health is inextricably linked to overall health and is essential for healthy development and healthy aging. Children who have poor oral health often miss more school and have lower grades than children who have good oral health. As many as 90% of common diseases have oral symptoms and can be detected by a dentist during a routine exam. More than 120 symptoms of nondental disease can be detected through a routine oral exam. It's important to encourage your patients to obtain routine oral health care by their first birthday and then regularly thereafter in order to improve and maintain their overall health.

Who has dental coverage?

- Healthy Michigan Plan – MHP Healthy Michigan Plan members over the age of 21 have expanded dental coverage through Delta Dental at no out-of-pocket cost.
- Healthy Kids Dental – MHP Medicaid members under the age of 21 qualify for Healthy Kids Dental through MDHHS.
- Pregnant Women's Dental – MHP's pregnant members have dental coverage through Delta Dental during their entire pregnancy and three months post-partum at no out-of-pocket cost.

What's covered?

Here is a list of some – but not all – of the covered dental services:

- Oral exams
- X-rays
- Screenings and assessments
- Extractions
- Root canals
- Teeth cleanings
- Deep teeth cleanings
- Crowns
- Fillings
- Emergency treatment
- Fillings
- Dentures
- Sealants

Some health conditions, such as diabetes, pregnancy, eating disorders and medications, can impact the patient's oral health. Please encourage your patients to take care of their oral health and obtain preventive oral screenings and treatments. Your McLaren Health Plan patients can seek transportation assistance and get help finding a dental provider by calling 888-327-0671 (TTY: 711), Monday-Friday, 8a.m. - 6p.m.

March is Kidney Health Awareness Month

Diabetes and hypertension are the leading causes of Chronic Kidney Disease (CKD). Other risk factors include obesity, family history of CKD, history of acute kidney injury, patients over the age of 60 and being a member of a minority race or ethnicity.

- Because CKD is often asymptomatic, many patients are unaware they have the disease until it has progressed to later stages.
- Early identification of CKD in your at-risk patients creates the opportunity to slow or prevent the progression of this disease and can result in decreased hospitalizations and costs.
- Understanding who has CKD allows you to provide education, develop treatment plans and goals or refer outside your practice as needed to help facilitate better outcomes for these patients.

The American Diabetes Association and the National Kidney Foundation recommend annual screening for patients with diabetes using both the eGFR and uACR lab tests. (Patients with diabetes can have changes in either their eGFR, uACR or both, so it is important to track both tests). Together the two tests, also known as the Kidney Profile, provide key information about kidney health, including determining CKD stage and risk of progression.

eGFR-Estimated Glomerular Filtration rate measures kidney function through filtration rate and is determined via a blood test.

- Creatinine Blood- CPT Code 82565 or
- Any of the Blood Panels which contain this test: 80047, 80048, 80050, 80053, 80069

uACR-Urine Albumin Creatinine Ratio measures kidney damage through albuminuria levels found in the urine, however, there is not one CPT code for this measurement it is a combination of 2 separate tests:

- Quantitative Urine Albumin Test – CPT Code 82043 and
- Urine Creatinine Test – CPT Code 82570

Resources for Patients and Providers: Are You the 33% Campaign is a strategic digital campaign from NKF focused on reaching, educating, and empowering those most at risk for CKD to take control of their kidney health is available at www.nkm.org/areyouthe33

CONTROLLING HIGH BLOOD PRESSURE (CBP)

The Controlling High Blood Pressure (CBP) measure is defined by HEDIS as assessing your patients aged 18-85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year (most recent blood pressure is used for this measure). Your patients are included in this measure if they had two or more visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.

Use Correct Billing Codes:
It is important to use correct billing codes to capture this measure in your encounter

DESCRIPTION	ICD-10 CODE
Hypertension	I10

Codes to Identify Blood Pressure include:
(Note: include a code for both diastolic and systolic blood pressures in order to be compliant for HEDIS)

DESCRIPTION	CPT II CODE
Diastolic = 80-89	3079F
Diastolic >= 90	3080F
Diastolic < 80	3078F
Systolic >= 140	3077F
Systolic < 130	3074F
Systolic 130-139	3075F
History of Kidney Transplant	ICD-10 Z94.0

TIPS TO IMPROVE HEDIS SCORES

- Take two or more BP measurements if initial BP is >140/90.
- Ensure that the patient has feet flat, sitting in upright position and the appropriate size cuff is used.
- Rest in between measurements for at least two minutes with the patient seated.
- Use equipment that is the appropriate size for the patient and that has been regularly calibrated.
- Review hypertensive medication history and patient compliance and consider modifying treatment plans for uncontrolled blood pressure as needed. Have patient return in three months for follow-up.
- Encourage out of office BP measurements with communication of results, frequent checks for accuracy and lifestyle and medication adjustments. Home readings are often 5 mm Hg lower than in the office.

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 2023 by our Quality, Safety, and Satisfaction Improvement Committee.

Please review the guidelines found at www.MQIC.org. There is also a link on our website.

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

HELP PREVENT FRAUD, WASTE AND ABUSE

MHP is committed to preventing health care fraud, waste and abuse, as well as complying with applicable state and federal laws governing fraud and abuse.

Examples of fraud and abuse by a member include:

- Altering or forging a prescription
- Altering medical records
- Changing or forging referral forms
- Allowing someone else to use his or her member ID card to obtain health care services

Examples of fraud and abuse by a provider include:

- Falsifying his or her credentials
- Billing for services not performed
- Billing more than once for same services
- Upcoding and unbundling procedure codes
- Over-utilization: performing inappropriate or unnecessary services
- Under-utilization: not ordering services that are medically necessary
- Collusion among providers

Examples of fraud and abuse by an MHP employee include:

- Altering provider contracts or forging signatures
- Collusion with providers or members
- Inappropriate incentive plans for providers
- Embezzlement or theft
- Intentionally denying services or benefits that are normally covered

Federal law prohibits an employer from discriminating against an employee in the terms and conditions of his or her employment because the employee reports or otherwise assists in a false claims action.

To report a possible violation, contact MHP's Compliance Officer:

- Mail: McLaren Health Plan, Attn: Compliance Officer, G-3245 Beecher Road, Flint, MI 48532
- Email: MHPCompliance@mclaren.org
- Phone: Compliance Hotline at 866-866-2135

To report Medicaid fraud, waste and abuse, contact MHP as above or:

- **Mail**:

  Department of Attorney General
  Health Care Fraud Division
  P.O. Box 30218
  Lansing, MI 48909

- **Online:** https://www.michigan.gov/ag/about/faqs/senior/who-do-i-call-report-welfare-medicaid-fraud
- **Phone:** 800-24-ABUSE (800-242-2873)

To report Medicare fraud, waste and abuse, contact MHP as above or:

- Mail: U.S. Department of Health and Human Services, Attn: Hotline, P.O. Box 23489, Washington, D.C. 20026
- Online: www.oig.hhs.gov/fraud/report-fraud
- Phone: Hotline at 800-HHS-TIPS (800-447-8477)

Information provided will be kept confidential. You can remain anonymous by calling the hotline numbers or through the U.S. mail.

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 MHP Explanation of Benefits (EOBs) to ensure the information is correct
- Know that free services DO NOT require you to give your MHP ID number to anyone

Medical Record Standards and Maintenance

MHP's participating providers are required to maintain accurate and timely medical records for MHP members for at least 10 years in accordance with federal and state laws. Providers must also ensure the confidentiality of those records and allow access to medical records by authorized representatives of MHP, regulatory agencies, accrediting bodies and appropriate governmental agencies at no cost.

Each provider contracting with MHP is required to maintain a medical record for each member served while enrolled in MHP. Medical records of members must be in English and should be sufficient enough to fully disclose and document the extent of services provided.

Medical records must be signed, dated and legible. Failure to maintain legible and complete records will result in a denial of payment.

As a reminder, medical records must include:

A. A record of outpatient and emergency care
B. Specialist referrals
C. Ancillary care
D. Diagnostic test findings, including all laboratory and radiology
E. Therapeutic services
F. Prescriptions for medications
G. Inpatient discharge summaries
H. Histories and physicals
I. Allergies and adverse reactions
J. Problem list
K. Immunization records
L. Documentation of clinical findings and evaluations for each visit
M. Preventive services-risk screening
N. All other documentation sufficient to fully disclose the quantity, quality, appropriateness and timeliness of services rendered by provider.

Medical records must be maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates a system for follow-up treatment.

Providers are required to store medical records securely and maintain written policies and procedures that:

- Ensure access by authorized personnel only
- Preserve the confidentiality of all medical records
- Maintain medical records that are documented accurately and in a timely manner, readily accessible and permit prompt, systematic retrieval of information.
- Train staff periodically on proper maintenance of patient information confidentiality

For more information on MHP medical record standards, see Medical Record Maintenance in the MHP Provider Manual.

Member Language Needs and Resources

McLaren Health Plan 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:

- English
- Spanish
- Arabic
- Swahili

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.

Learn More About MHP Member Rights & Responsibilities

McLaren Health Plan members have rights and responsibilities. Providers have a responsibility to recognize a member's needs and treat members in a mutually respectful manner. Understanding member rights and responsibilities ultimately helps your patients get the most from their health care benefits.

MHP Members Have:

- The right to confidentiality.
- The right to be treated with respect and dignity, including to be free from restraint and seclusion.
- The right to a primary care provider at all times.
- The right to receive culturally and linguistically appropriate services.
- The right to receive covered benefits consistent with McLaren's contract with the State of Michigan, and state and federal regulations.
- The right to a current listing of network providers and access to a choice of specialists within the network who can treat chronic problems.
- The right to get covered routine and preventive OB-GYN and pediatric covered services without a referral, if the OB-GYN or pediatric specialist is a participating provider.
- The right to receive Federally Qualified Health Clinic (FQHC) and Rural Health Clinic (RHC) services.
- The right to be free from any form of restraint or seclusions used as a means of coercion, discipline, convenience or retaliation.
- The right to continue receiving services from a specialty provider who is no longer in the MHP network, if it is medically necessary.
- The right for female members who are pregnant to continue coverage with a provider who is no longer in the MHP network (that includes up to six weeks after they have their baby).
- The right to no "gag rules" from MHP. Doctors are free to discuss all medical treatment even if they are not covered services.
- The right to participate in decision-making regarding their health care.
- The right to refuse treatment, to get a second opinion and express preferences about treatment options.
- The right to receive a copy of their medical record upon request, & request amendments or corrections.
- The right to know how MHP pays its providers, including incentive arrangements or financial risk.
- The right to be provided with a telephone number and address to obtain additional information about payment methods, if desired.
- The right to tell MHP if they have a complaint, the care provided and the right to appeal a decision to deny or limit coverage.
- The right to know that they or a provider cannot be penalized for filing a complaint or appeal about care.
- The right to receive beneficiary information and information about the structure and operation of MHP, including the services, providers of care and member rights and responsibilities.
- The right to make suggestions regarding MHP members' rights and responsibilities.
- The right to have their medical record kept confidential by MHP and their provider.
- The right to be free from other discrimination prohibited by state and federal regulations.
- The right to be free to exercise their rights without adversely affecting the way McLaren, providers or the state treats them.

MHP Members Have the Following Responsibilities:

- To schedule appointments in advance and be on time. If a member needs to cancel an appointment with any doctor's office, call as soon as possible.
- To use the hospital emergency room only for emergency care. If possible, a member should call his/her doctor before going to the emergency room.
- To give all the information that the member can to his or her providers and MHP so they can be cared for in the best way.
- To ask questions if the member doesn't understand the care he or she is getting.
- To talk about their care and help their doctors plan what they will be receiving.
- To complete the treatments that the member has agreed to and follow all plans of care.
- To tell the MDHHS and MHP Customer Service right away with any change in address or telephone number.
- To help MHP assist with the member's health care by telling us of any problems he/she has with services.
- To tell MHP suggestions in writing or by contacting Customer Service for assistance.
- To carry the MHP Member ID card at all times.

If you have questions or need more information, contact Provider Services at 888-327-0671 (TTY: 711) or your McLaren Health Plan provider representative.