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I - Introduction

McLaren Health Plan (MHP) offers a variety of products and benefits designed to meet the health care needs of each member. To this end, our mission is to partner with providers that offer high quality, accessible and cost-effective health services throughout our service area.

MHP products include:

- McLaren Medicaid (Medicaid Managed Care Plan)
- McLaren Health Plan Healthy Michigan
- McLaren Community Health Maintenance Organization (Commercial HMO)
- McLaren Point Of Service (POS) Managed Care Plan
- McLaren Fully-insured Preferred Provider Organization (PPO) Plan
- McLaren Advantage (HMO) (Medicare Advantage HMO)

MHP also has a subsidiary that functions as third party administrator (TPA) for self-insured products which include:

- McLaren Health Advantage (Self-Insured PPO Plan)

MHP combines the resources of independent physicians, multi-specialty groups, ambulatory care centers, ancillary providers, and hospitals to offer members access to a comprehensive array of high quality health care providers. The member's ID card identifies which type of plan they have (see page 12-13 for examples). MHP will provide you with updated information through mailings and on our websites, at McLarenHealthPlan.org, McLarenHealthAdvantage.org and McLarenAdvantage.org.

About Managed Care

The objective of managed care is to form effective links between patients and providers, thereby improving access to appropriate health services while containing costs. However, the specific strategies for accomplishing this goal vary widely from one managed care company to another. MHP’s philosophy is to assign as few “rules” as possible so that health care providers can do what they do best - practice medicine. Our Managed Care products, McLaren Medicaid, McLaren POS, McLaren HMO and McLaren Advantage (HMO) require members to select a Primary Care Provider (PCP) at the time of enrollment. Our PCPs will provide both primary care services and act as care coordinators, guiding members to the full range of health services. Staff at MHP will assist the health care providers in navigating the service delivery system.

About McLaren Advantage (HMO)

McLaren Advantage (HMO) is committed to helping members get the care they need. McLaren Advantage (HMO) is a Coordinated Care Plan with a Medicare Advantage contract. It is available to those who are eligible for Medicare Part A and enrolled in Medicare Part B.

The Centers for Medicare and Medicaid Services (CMS) determines eligibility for Medicare. MHP verifies a Member’s eligibility for Medicare Part A, and enrollment in Medicare Part B, before the applicant can be enrolled in McLaren Advantage (HMO). New members are effective on the first day of the month following receipt of a valid application for membership.
To be eligible to receive services through McLaren Advantage (HMO), a person must:

- Be entitled to Medicare Part A and enrolled in Part B;
- Not have end-stage renal disease (ESRD);
- Live in the McLaren Advantage (HMO) service area;
- Choose McLaren Advantage (HMO) during a valid election period;
- Agree to the rules of the McLaren Advantage (HMO) plan; and
- Continue to pay Medicare Part B premiums if not paid by another third party.

Quick Reference Guides

This Provider Manual contains detailed information regarding MHP’s operations and business practices that are important for you and your staff to be aware of. We have also summarized this information on Quick Reference Guides, (Section XVIII) to provide you with an easy references.

Website

MHP maintains a website that provides an array of information regarding the health plan’s policies, procedures, and general operations. Such information includes the Quality programs, preauthorization process, health management programs, clinical and preventive practice guidelines, pharmaceutical management procedures, the formulary, member rights and responsibilities, the provider appeal process and provider newsletters. Providers can also verify member eligibility and benefit coverage, as well as status claims that are submitted for payment, through both FACTSWeb site and provider portal. Utilizing FACTSWeb and the provider portal is discussed further in Section XII, “Checking the Status of Your Claims”. Please visit our websites at McLarenHealthPlan.org, McLarenHealthAdvantage.org or McLarenAdvantage.org frequently for the latest updates and new information. In addition, a hard copy of any information on the website can be obtained by calling Customer Service at (888) 327-0671.

Using This Manual

This Provider Manual (“Manual”) is a guidebook for providers that includes general information and instructions on operational and administrative procedures, which may be revised from time to time. The provisions in this Manual are intended to supplement the terms of the provider agreement (“Agreement”) you entered into with McLaren. In the event of a direct conflict between a provision in this Manual and the Agreement between you and McLaren, the provision in this Manual will control unless it conflicts with a term required by law, regulation or a regulatory agency.
McLaren Health Plan Service Area - Maps

Approved Medicare Service Area – January 2017

Key
- McLaren Advantage service areas in Michigan

McLaren Health Advantage 2017 Approved Service Areas

Key
- McLaren Advantage service areas in Michigan
MHP has several departments that are available to assist providers and provider staff with their MHP membership. The following information provides a brief description of the departments that will be utilized most frequently by your practice.

MHP’s 24-hour toll free number is (888) 327-0671 (TTY call 711). All departments can be accessed through this number. Normal business hours are 8:30 a.m. to 5 p.m., Monday – Friday.

Network Development

The Network Development Department is responsible for all provider related issues and requests, including contracting. The Network Development Coordinators are assigned to provider practices based on the county location of the practice. Coordinators act as a liaison between the provider and MHP. They are available to assist with any of the following:

- In-services or orientations for you or your staff to learn how best to work with MHP, including submitting claims, statusing member eligibility or claims via our website, or to discuss any issues you or your office staff may have

- Providing office materials:
  - Referral forms
  - Pharmacy formularies

- Reporting changes in your practice such as:
  - Hospital staff privileges
  - Office hours
  - Office address or phone number
  - Office services
  - Call coverage

- A new W-9 form is required to notify us of a change to your:
  - Federal Tax Identification Number
  - Payment address change
  - Name change

- To discuss any questions regarding your participation in MHP

If you are not certain of how to contact your assigned Network Development Coordinator, please call (888) 327-0671 to request the correct contact information.

Customer Service

The Customer Service Department is responsible for assisting all providers and members with any questions they may have regarding MHP. Customer Service Representatives are available from 8 a.m. to 6 p.m., Monday – Friday. Providers and members are encouraged to call (888) 327-0671 (TTY call 711) for assistance with any of the following:
• Verify member eligibility
• Confirm member PCP assignment
• Arrange for member transportation (Medicaid and Healthy Michigan Plan only)
• Inquire about referrals
• Claims questions

Medical Management

Medical Management supports the needs of both the membership and the provider network. Medical Management offers support to coordinate our members’ care and to facilitate access to appropriate services through the resources of our Nurse Case Managers.

Through our Case Management Services, the nurses promote health management of our members by focusing on early assessment for chronic disease and special needs, and by providing education regarding preventive services. In addition to this member focus, the nurses are available to assist our provider network with health care delivery to our members. The nurses are available for members 24 hours per day, seven days a week and work under the direction of MHP’s Chief Medical Officer.

The Medical Management Department can be reached by calling (888) 327-0671 and following the prompts. Medical Management’s business hours are from 8:30 a.m. to 5 p.m. Monday - Friday. Please be aware, you may get voice mail when you call direct numbers due to the large volume of incoming calls. Voice messages are checked frequently throughout the day and all calls are returned within one business day. Call Medical Management for information and support with situations such as:

• Preauthorization requests: see Section X Referral and Authorization Requirements
• Inpatient hospital care (elective, urgent, and emergent)
• Medically necessary determinations of any care, including the criteria utilized in decision making
• Case Management Services
• Complex Case Management for members who qualify
• Disease Management: Diabetes, Asthma, Maternity Care and others
• Preventive health education and community outreach support
• Children’s Special Healthcare Services (CSHCS)

Utilization Management

Medical Management, through its utilization management processes, is structured to deliver fair, impartial, and consistent decisions that affect the health care of our members. Medical Management coordinates services between the members Medicare and Medicaid benefits when applicable. There is nationally recognized, evidence-based criteria that is used when determining the necessity of medical or behavioral health services. The criteria are available to you upon request by calling Medical Management at (888) 327-0671.
If there is a utilization denial, they will be provided with written notification and the specific reason for the denial, as well as your appeal rights. In addition, MHP’s Chief Medical Officer or an appropriate practitioner, will be available by phone to discuss any utilization issues and the criteria utilized in making the decision.

Please call Medical Management at (888) 327-0671 for more information, or to schedule a time to speak with the Chief Medical Officer about a utilization denial or any utilization issue.

In addition, regarding incentives, utilization decision-making is based solely on appropriateness of care and service and existence of coverage. We do 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 result in under-utilization.

**Case Management Services**

MHP offers case management to all members. A Case Management Nurse is assigned to each PCP’s office to assist the physician and staff in managing their MHP patients. Nurses are available to all members, PCP’s and specialty care physicians for management of complex problems or as a resource for any identified issues. Call Case Management toll free at (888) 327-0671.

Complex Case Management (CCM) are specially trained nurses who are available to MHP members who have complex care needs. Members considered for CCM include but are not limited to:

- Members listed for a transplant
- Frequent hospitalizations
- Frequent ER visits
- Children’s Special Healthcare Services (CSHCS)

**Community Outreach**

MHP provides community outreach with a focus on support services, such as food programs, special family services, clothing needs and more. Both Customer Service and Medical Management work in tandem to provide outreach, education and ongoing support to our membership.

Many community outreach programs are operational for members such as expectant mothers, breast cancer patients, Asthmatic and Diabetic members, members needing preventive screening reminders and much more. For more information about the literature and services that are available, call our toll free number at (888) 327-0671 or for correspondence in writing, send request to:

ATT: Customer Service
McLaren Health Plan
P.O. Box 1511
Flint, MI 48501-1511
Interpretation and Translation Services - I

Interpretation and translation services are FREE to MHP Medicaid, MHP Healthy Michigan and McLaren Advantage (HMO) members in any setting (ambulatory, outpatient, inpatient, etc.). If these members need help understanding MHP’s written material or need interpretation services, they can call Customer Service at (888) 327-0671.

If a member is deaf, hard of hearing or has speech problems, oral interpretation services are available to MHP Medicaid, MHP Healthy Michigan and McLaren Advantage (HMO) members that require this service. Please call Customer Service at (888) 327-0671 for assistance. If the member can access a TTY line, the number is 711. The Michigan Relay line is available 24 hours a day.

Member materials are available in other languages, if needed. Please call Customer Service at (888) 327-0671 to request copies.
## III - Contact Information

<table>
<thead>
<tr>
<th>Department</th>
<th>Telephone No.</th>
<th>Fax No.</th>
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<tbody>
<tr>
<td><strong>Customer Service/Provider Inquiry</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available to assist they with claims, benefits, eligibility, authorizations and coordination of benefit inquiries. Hours: 8 a.m. - 6 p.m., Monday-Friday.</td>
<td>(888) 327-0671</td>
<td>Toll Free: (877) 502-1567</td>
</tr>
<tr>
<td><strong>Network Development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please contact an MHP Network Development representative for the most up-to-date Network Development Service Area Map.</td>
<td>(888) 327-0671</td>
<td>(888) 327-0671</td>
</tr>
<tr>
<td><strong>Medical Management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral requests can be submitted electronically via the following link: <a href="http://www.mclaren.org/mhp/referral-request-form-mhp1.aspx">www.mclaren.org/mhp/referral-request-form-mhp1.aspx</a></td>
<td></td>
<td>(888) 327-0671</td>
</tr>
<tr>
<td><strong>Quality Management/Member Outreach</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available to assist they with Gaps in Care reports, HEDIS reports, quality incentives, member outreach</td>
<td>(888) 327-0671</td>
<td>Flint: (810) 733-9653</td>
</tr>
<tr>
<td><strong>Sales Department</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>(888) 327-0671</td>
<td>Flint: (810) 733-9596</td>
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### Other Information

| Administrative | McLaren Health Plan  
<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>G-3245 Beecher Rd.</td>
</tr>
<tr>
<td></td>
<td>Flint, MI 48532</td>
</tr>
</tbody>
</table>
| Pharmacy Services | For formulary information or medication prior authorization request forms.  
|                  | E-prescribing is available for all lines of business through SureScripts®.  |
| Provider Demographic Changes | Contact Network Development at (888) 327-0671 8:30 a.m.-5 p.m.  |
| Provider Portal | The MHP Provider Portal is available to all contracted MHP providers. On the MHP Provider Portal, they can check the status of claims, check member eligibility and get their monthly member roster. If they are not currently registered, call Network Development today.  |
| Claims | MHP receives EDI claims from our clearinghouse, ENS Optum Insight. Our Payer IDs for electronic claims are:  
|        | • MHP Medicaid/Healthy Michigan - 3883C  
|        | • MHP Community (Commercial HMO) - 38338  
|        | • McLaren Health Advantage (PPO) - 3833A  
|        | • McLaren Advantage (Medicare HMO) - 3833R  
|        | • **You are expected to submit your MHP claims electronically if you are able.**  
|        | [www.enshealth.com](http://www.enshealth.com)  |
| Laboratory | For Medicaid and Commercial HMO -  
|            | Required lab vendor is Joint Venture Hospital Lab (JVHL) - (800) 445-4979.  |
IV - McLaren Health Plan – Plan Definitions

MHP offers a variety of plans designed specifically to meet the needs of our customers and their communities. Our diverse plans offer employer groups and members varying levels of flexibility in benefit coverage and provider access. An overview of each plan is presented below. For additional information, contact MHP’s Network Development Department at (888) 327-0671, Monday - Friday, 8:30 am. – 5 p.m.

MHP Community HMO

MHP Community HMO covers a comprehensive set of health care services obtained through a designated provider network. MHP Community HMO members have plans with varying levels of copayments, deductibles and out-of-pocket maximums that are chosen by the employer group. McLaren Rewards: Each MHP Community HMO member selects a PCP who is responsible for coordinating the member’s health care. The PCP provides the member with a medical home.

McLaren POS

McLaren POS offers the member the most flexibility in obtaining care. Although the member must still select a PCP, for each episode of medical care, the member determines his/her level of coverage based on the “point” from which the member receives the “service.” Medical care is PCP coordinated (HMO-like) care within the network, or self-referred care within or outside the network with greater out-of-pocket expenses.

MHP Medicaid

MHP is contracted with the Michigan Department of Health and Human Services (MDHHS) to provide medical services to eligible Medicaid recipients. MHP provides administrative services and arranges for the provision of all MHP covered services, offering some additional benefits, including transportation. Each MHP Medicaid member selects a PCP, which provides the member with a medical home. Medicaid recipients are entitled to a second opinion from in or out of network qualified health care professionals. Special requirements apply for out of network second opinions, please contact Medical Management for assistance.

McLaren Health Plan Healthy Michigan

MHP is contracted with the MDHHS to provide medical services to members eligible for Medicaid expansion. MHP administers the benefits for Healthy Michigan members and arranges for the provision of all eligible covered services. The benefit design of the Healthy Michigan Plan ensures member access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors. Healthy Michigan Plan members select a PCP which provides the member with a medical home.

McLaren PPO

McLaren PPO is a fully insured product. Members do not have to select a PCP or obtain specialty care referrals. This is not a managed care product. This product is targeted towards employer groups with 50 or more employees. The majority of employees must be based in Michigan, but coverage is available for employees throughout the United States. Reimbursement is fee-for-service (FFS) with rates that are competitive with other local payers.
McLaren Health Advantage

McLaren Health Advantage (MHA) is a self-funded PPO that is utilized by McLaren Health Care Corporation for employee health care benefits. Reimbursement is FFS with rates that are competitive with other local payers.

McLaren Advantage (HMO)

McLaren Advantage (HMO) is a Medicare Advantage HMO. Members must select a PCP. Reimbursement is based on the rates established and published by CMS. Covered services and exclusions for Medicare Advantage members are listed in the Evidence of Coverage (EOC). The EOC is located at McLarenAdvantage.org.

| Possession of a MHP or MHA member ID card does not guarantee eligibility. Members should be cross-referenced with the monthly Member Eligibility Report, if appropriate, or they can verify eligibility by calling Customer Service at (888) 327-0671 (TTY call 711). |

MHP Member Handbook

All enrolled members are given a member handbook as a guide for using the Plan. The member handbook contains information on emergency and urgent care procedures, out-of-area coverage, benefit limitations and exclusions, the enrollment process, PCP selection, Member Rights and Responsibilities and the complaint and grievance procedures. If they have questions, please contact Customer Service at (888) 327-0671.
V - Sample Member Identification Cards

McLaren Community

Toll-free Phone
(888) 327-0671
McLarenHealthPlan.org

<table>
<thead>
<tr>
<th>Enrollee Name</th>
<th>圈</th>
<th>Contract No.</th>
<th>Group No.</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>JANE DOE</td>
<td>123-4567</td>
<td>123-4567</td>
<td>1234</td>
<td></td>
</tr>
</tbody>
</table>

Provider Information

Eligibility and Benefits
For customer service, verification of benefits, hospital admission authorization and eligibility, call McLaren Health Plan at:
(888) 327-0671

Pharmacy Billing Information:
4D Pharmacy Management
BIN: 600428
PCN: 01990000
Pharmacy Help Desk: (800) 522-7487
Person Code Billing Required

Available Secondary Networks for Urgent and Emergency Use Only

McLaren POS

Toll-free Phone
(888) 327-0671
McLarenHealthPlan.org

<table>
<thead>
<tr>
<th>Enrollee Name</th>
<th>圈</th>
<th>Contract No.</th>
<th>Group No.</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOHN DOE</td>
<td>123-4567</td>
<td>123-4567</td>
<td>1234</td>
<td></td>
</tr>
</tbody>
</table>

Provider Information

Eligibility and Benefits
For customer service, verification of benefits, hospital admission authorization and eligibility, call McLaren Health Plan at:
(888) 327-0671

Pharmacy Billing Information:
4D Pharmacy Management
BIN: 600428
PCN: 01990000
Pharmacy Help Desk: (800) 522-7487
Person Code Billing Required

Available Secondary Networks for Urgent and Emergency Use Only

McLaren Health Advantage

Toll-free Phone
(888) 327-0671
McLarenHealthPlan.org

<table>
<thead>
<tr>
<th>Enrollee Name</th>
<th>圈</th>
<th>Contract No.</th>
<th>Group No.</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOHN DOE</td>
<td>123-4567</td>
<td>123-4567</td>
<td>1234</td>
<td></td>
</tr>
</tbody>
</table>

Provider Information

Eligibility and Benefits
For customer service, verification of benefits, hospital admission authorization and eligibility, call McLaren Health Advantage at:
(888) 327-0671

Pharmacy Billing Information:
4D Pharmacy Management
BIN: 600428
PCN: 01990000
Pharmacy Help Desk: (800) 522-7487
Person Code Billing Required

Available Secondary Networks for Urgent and Emergency Use Only

McLaren Medicaid

24 Hour #
(888) 327-0671
McLarenHealthPlan.org

Provider Information

Eligibility and Benefits
For customer service, verification of benefits, hospital admission authorization and eligibility, call McLaren Health Plan at:
(888) 327-0671

Pharmacy Billing Information:
4D Pharmacy Management
BIN: 600428
PCN: 01990000
Pharmacy Help Desk: (800) 522-7487
Person Code Billing Required

Available Secondary Networks for Urgent and Emergency Use Only

Submit all medical claims to:
McLaren Health Plan
P.O. Box 1511
Flint, MI 48501-1511

Pharmacy benefits are administered by
4D Pharmacy Management Systems.

This card is only valid if member maintains McLaren Health Plan eligibility. Eligibility should be verified before rendering services.
McLaren Healthy Michigan

MEMBER NAME: JANE DOE
Member ID: 0123456789
PCP NAME: JANE DEER MD
PCP Phone: 517-111-2222

Please show this card each time you get health care services.

Submit all medical claims to:
McLaren Health Plan
P.O. Box 1511
Flint, MI 48501-1511

Pharmacy benefits are administered by
4D Pharmacy Management Systems.

This card is only valid if member maintains McLaren Health Plan eligibility. Eligibility should be verified before rendering services.
VI - Provider Network

National Provider Identifier (NPI)

All providers must bill MHP using their unique rendering and billing (if applicable) NPI for claims to be accepted for processing. Providers can apply for their NPI at the CMS website, https://nppes.cms.hhs.gov.

Participating (Contracted) Providers

MHP has contracted with an extensive network of quality providers to deliver health care to its members. Unless the member’s benefit allows, members must receive health care services from providers in the MHP network who are listed in the Provider Directory. The Provider Directory for McLaren Medicaid, Healthy Michigan Plan, McLaren HMO, McLaren PPO, McLaren POS, McLaren Rewards and McLaren Advantage (HMO) can be found on our website McLarenHealthPlan.org. The Provider Directory for McLaren Health Advantage and McLaren Select can be found at McLarenHealthAdvantage.org. The directory for McLaren Advantage (HMO) can be found at McLarenAdvantage.org. For example, if a MHP member needs to be hospitalized for an elective inpatient procedure, a MHP network hospital must be used (in addition, inpatient hospital care would require preauthorization).

Non-Participating Providers

McLaren Community HMO, McLaren Medicaid, Healthy Michigan and McLaren Advantage (HMO)

Preauthorization for services from a non-participating provider must be obtained from MHP’s Medical Management Department prior to services being rendered. Preauthorization will be considered in the following situations:

- When a covered service is needed, but not available within the network
- When the member needs emergent care while outside the MHP service area and travel back to the service area is not feasible
- When a member has begun an episode of care previous to becoming a MHP member (continuity of care)

McLaren PPO, McLaren Health Advantage, McLaren POS and McLaren Select

Members are able to seek services both in and out of the network of contracted providers. Members seeking service from out of network providers may be responsible for coinsurance and/or deductible. Please refer to Section X, Referral and Authorization Requirements for more detail.
VII - Role of the PCP

McLaren HMO, McLaren POS, McLaren Medicaid, Healthy Michigan and McLaren Advantage (HMO) members select a PCP at the time of enrollment. If a member does not choose a PCP, MHP will assign a PCP to that member. A PCP is a MHP participating physician who has contracted to provide primary care services and to coordinate and manage the member’s access to all health services. Each family member must select a PCP and members have the right to change PCPs.

MHP recognizes the following groups of providers as PCP’s*:

- Family Practice Physicians
- General Practice Physicians
- Internal Medicine Physicians
- Pediatricians
- Nurse Practitioners*
- Physician Assistants*

*Under certain circumstances a member can request primary care services be provided by a participating specialty care physician. For further information, Contact Customer Service at (888) 327-0671.

*Physician Assistants (PAs) and Nurse Practitioners (NPs)

Except in an emergency situation, PAs and NPs shall provide medical care services only under the supervision of physician or properly designated alternative physician, and only if those medical care services are within the scope of practice of the supervising physician and are delegated by the supervising physician.

PAs and NPs shall conform to the minimal standards of acceptable and prevailing practice for the supervising physician.

The supervising physician must be a contracted in-network provider of MHP and credentialed by MHP.

PAs and NPs shall only prescribe drugs as a delegate of a supervising physician in accordance with applicable laws, regulations and rules.

PAs and NPs must comply with all other applicable laws, regulations and rules.

Primary care services should be provided to a member by his/her designated PCP or physician designated to cover for that PCP. Examples of primary care services are:

- Annual physical exams
- EPSDT visits (Medicaid only)
- Preventive care and screenings
- Sudden onset of illness
- Management of chronic conditions
- Laboratory and diagnostic tests performed routinely in an ambulatory care setting
Each PCP will receive a monthly Member Eligibility Report listing for these products with all members assigned to the PCP for that month (see sample Eligibility Report in Section XVII). Office staff can also verify member eligibility by accessing FACTSWeb or provider portal. Contact your Network Development Coordinator for information on accessing and utilizing the portals.

**PCP as the Care Coordinator**

When required, the PCP is the member’s care coordinator. As such, the PCP is expected to coordinate and manage the member’s utilization of specialty care, ancillary services, and inpatient services. When a member needs non-emergent inpatient care, MHP recommends that the PCP coordinates the entire episode of care (i.e., initiate the admission or collaborate with the admitting specialist/hospitalist) to ensure timely initiation and appropriate utilization of health services. Case Management Nursing staff can assist in this process and can be reached at (888) 327-0671 or direct at (810) 733-9522.

**Children’s Special Health Care Services (CSHCS) PCP**

MHP, through its contract with the MDHHS, is responsible for working with our provider network to coordinate care for all CSHCS eligible members. To ensure that MHP has PCPs available to handle the complex needs of CSHCS enrollees, MHP PCPs are eligible to receive a care management fee for all MHP CSHCS members assigned to their panel. To become a CSHCS PCP, they must complete a CSHCS readiness survey. This brief survey is required by the MDHHS to ensure that primary care requirements necessary for CSHCS members can be met. If they would like to become a CSHCS PCP, please contact your Network Development Coordinator at (888) 327-0671.

**PCP Case Management Program**

Case management is a collaborative process that assists the member in accessing care. MHP’s Case Management Program includes the PCP. MHP proactively assigns a Nurse Case Manager to each PCP to assist the PCP and/or office staff with any member issues (i.e. arranging community services, assisting patients in keeping their appointments, etc.).

The goal of this program is for MHP to be the physician’s advocate. The program has proven successful in many ways, as the PCP has additional resources that can support the management of his/her caseload and at the same time helps to resolve the individual member’s concerns.

Please involve Case Management with the care management of your patients. If you need further assistance, please contact the Medical Management Department at (888) 327-0671. If you have a member that would benefit from a contact by a Nurse Case Manager, please complete a Referral to Case Management form. Forms are available on our website and can also be obtained by contacting your Network Development Coordinator.
## Accessibility of Care

The established monitoring standards are set as minimum guidelines of measurement. The following are the MHP Commercial, Marketplace and Medicaid standards for PCP accessibility to members:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Routine / Regular Care</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Preventive Care (i.e. physical)</td>
<td>Within 45 days</td>
</tr>
<tr>
<td>In-Office Wait Time</td>
<td>Patient seen within 30 minutes of appointment time</td>
</tr>
<tr>
<td>After Hours Coverage</td>
<td>100%</td>
</tr>
</tbody>
</table>

The following are the MHP Commercial, Marketplace and Medicaid monitoring standards for high-volume and high impact provider accessibility to members:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Visit</td>
<td>Within 45-60 working days</td>
</tr>
<tr>
<td>Follow-up Care</td>
<td>Within 30-60 working days</td>
</tr>
</tbody>
</table>

The following are the MHP Commercial, Marketplace and Medicaid monitoring standards for Behavioral Health provider accessibility to members:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Life Threatening Emergency</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Initial Visit for Routine Care</td>
<td>Within 10 working days</td>
</tr>
<tr>
<td>Routine</td>
<td>Within 30-45 working days</td>
</tr>
</tbody>
</table>

An annual evaluation and analysis is conducted by Quality Improvement Staff on the following:

- Primary care appointment availability for regular, routine and urgent care appointments
- Primary care after hours availability
- Behavioral Health care appointment availability (a separate analysis is performed for Behavioral Health care providers who prescribe medication and those who do not prescribe medication).

Results are reported to the Quality Improvement Committee. MHP requires an 80 percent compliance rate for all access measures. Those practitioners that do not meet the 80 percent requirement will be notified and requested to submit a corrective action plan to MHP within 30 days. Failure to comply with this requirement may result in departicipation.
Coverage Responsibilities

All PCPs are contractually committed to provide coverage to MHP members 24 hours a day, 7 days a week.

Acceptable after-hours access methods include:

- An answering service
- On-call paging system
- Call forwarded to physician’s cell phone or other contact phone
- Recorded message with instructions directing the member to another provider

There must be a method to talk to a physician 24/7 regarding after hours care for urgent or non-life threatening conditions. There must also be instructions to call 911 or go to the emergency department for life threatening situations.

The message should not direct members to seek after hours care at the nearest emergency department for non-life threatening situations.

In the event the provider utilizes covering physician(s), we recommend the covering physician also be a participating MHP physician. It is the PCP’s responsibility to ensure that his/her members have access to a covering physician when the PCP is not available. If the PCP is paid on a per member per month basis (capitation), financial reimbursement for services rendered by the covering physician is also the responsibility of the PCP.

MHP expects the PCP to maintain ultimate responsibility for managing the member’s care, even when a covering physician provides a portion of the care.

Non-contracted physicians who are covering a contracted physician must receive preauthorization before non-capitated services can be rendered to a member.

Accepting Status of Primary Care Practices

The MHP Community HMO, POS, Medicaid, Healthy Michigan Plan and Medicare Advantage products assign members to a PCP upon enrollment. Each contracted PCP is designated to have an open practice, unless a request to close a practice has been made and approved.

Changing the Accepting Status of a Practice

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

1. The PCP requesting to change the accepting status of the practice to no longer accept new MHP members must also be changing their accepting status with other health plans.
2. The PCP submits a letter, on office letterhead, to their MHP Network Development Coordinator with the following:
   a. The reason for requesting limitation of members
   b. Attestation that the practice is being closed to other health plans
   c. Anticipated period of time new enrollment is to be limited
   d. Provider’s signature making the request
3. The PCP must send the letter to:
   ATT: Network Development
   McLaren Health Plan
   G-3245 Beecher Road
   Flint, MI  48532

4. The request is reviewed and approved by the Network Development Manager following verification of membership assigned to the PCP.

5. The Network Development Coordinator will respond in writing to the provider’s request within two weeks, indicating approval or disapproval.

6. If approved, the request to limit membership is effective 30 days from the date of approval.

After changing accepting status of the practice to a Conversion Only Status, PCPs are required to accept new MHP members whose enrollment was in process at the time of the closure and existing members who moved from other health plans into MHP.

Exceptions

Exceptions to MHP’s accepting status policy are reviewed on a case-by-case basis. Special consideration may be made in the following cases:

- Loss of a partner
- Total volume of patient base in direct comparison to office space
- Leave of absence
- Provider agreement language
- If a request for accepting status change is approved by MHP, the length of the status change is limited to six months from the date of approval. After the six month time period, the PCP will be changed to a status of “Open” to accepting new MHP members.

Opening a Practice

A participating PCP may open a practice at any time by submitting a letter, on office letterhead to their Network Development Coordinator, requesting that the practice be open to new MHP members.

Data Reporting

All providers must submit claims to MHP for every encounter or consultation provided to a member. MHP encourages providers to submit claims within 60 days of the date of service in order to document service utilization. MHP needs encounter data to document the amount of work health care providers perform on a member’s behalf. This data is used to track utilization (the content, type, and timing of services) to monitor over-utilization and under-utilization of services and for required documentation to state regulators, the Health Effectiveness Data Information Set (HEDIS), and accrediting bodies. If MHP does not receive encounter data, it will be assumed that no visit or consultation has taken place, which could have a negative impact on your future reimbursement rates.

MHP expects all providers to submit claims even when MHP is the secondary payer and no reimbursement is due from MHP.
Professional services should be reported on a standard CMS 1500 form to report all encounters and billable services provided.

Please refer to Submitting a Claim in Section XII of this Provider Manual for further details on the data elements required for billing.

**McLaren Advantage (HMO) Disenrollment**

A McLaren Advantage (HMO) member may request disenrollment at any time, for any reason, by notifying McLaren Advantage (HMO). Refer members to McLaren Advantage (HMO) Customer Service at (888) 327-0671 (TTY call 711) if they need information on disenrollment. The member’s termination of enrollment will take effect on the first of the month following the receipt of this written request by McLaren Advantage (HMO). Members are advised to continue to use their McLaren Advantage (HMO) ID card and to coordinate all services through their PCP until their disenrollment becomes effective.

If you learn that a member plans to disenroll, you may avoid payment delays by reminding the member to notify McLaren Advantage (HMO), and validating eligibility with McLaren Advantage (HMO) on the date of each visit.

**McLaren Advantage (HMO) Involuntary Termination**

Each member’s enrollment is generally in effect as long as the member retains eligibility and chooses to stay with McLaren Advantage (HMO). The Plan cannot and will not terminate a member because of the amount or cost of services.

McLaren Advantage (HMO) can terminate members with CMS approval for the following:

- If the member loses entitlement to Medicare Part B coverage
- If the member loses entitlement to Medicare Part A coverage
- If the member permanently moves or resides outside the service area for more than six consecutive months
- If the member has committed fraud
- If the member has abused the McLaren Advantage (HMO) Plan Beneficiary ID card and/or benefits
- If the member has or demonstrated disruptive behavior that interfered with care for the Member or others

Please notify McLaren Advantage (HMO) if any of the situations listed above occurs, so we can discuss the disenrollment request with the Member and if necessary, initiate a request to CMS for member disenrollment. CMS will review all cases and determine whether or not the Member should be disenrolled from McLaren Advantage (HMO), but members have the right to appeal the cancellation of coverage.
Procedures for Dismissing Members for Disruptive Behavior or Fraud and Abuse

Participating health care providers can request that a MHP Member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include non-compliance with medication schedules, no-show office policies or failure to modify behavior as requested. Any time a member misses three or more consecutive appointments, providers are expected to notify our Customer Service Department for assistance.

Providers shall not discriminate against members when terminating from their practice. Involuntary dismissal policies must be designed and implemented in a neutral non-discriminatory manner.

We strongly recommend that your office make at least three attempts to educate the member about non-compliant behavior and document them in the patient’s record. Please remember that MHP can assist you in educating the member. After three attempts, providers may initiate the dismissal by following the guidelines below:

- The provider office must notify the member of the dismissal by certified letter
- A copy of the letter must be sent to MHP at the following address:
  ATT: Customer Service Manager
  McLaren Health Plan
  G-3245 Beecher Road
  Flint, MI  48532

You can also fax the dismissal letter to: (877) 502-1567

For PCPs only, the letter must contain specific language stating that:

- The Member must contact MHP to choose another PCP
- The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal

When a Member changes to a new PCP, the provider must forward the Member’s medical records or copies of medical records to the new PCP at no cost within ten (10) working days from receipt of a written request.

Provider Marketing

It is common for health care providers to inform their patients about their contracted managed care plans. Advocating enrollment in a specific health plan, however, is unacceptable according to the CMS Medicare Marketing Guidelines. CMS allows providers to discuss participation under specified circumstances.

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers may not be fully aware of plan benefits and costs, and it’s important that beneficiaries receive the right information needed to make an informed decision about their health care options. Therefore, it is inappropriate for providers to be involved in any of the following actions:
• Offering sales/appointment forms
• Accepting enrollment applications for MA/MA-PD or PDPs
• Making phone calls or directing, urging or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
• Mailing marketing materials on behalf of plan sponsors
• Offering anything of value to induce plan enrollees to select them as their provider
• Offering inducements to persuade beneficiaries to enroll in a particular plan or organization
• Health screening is a prohibited marketing activity
• Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities
• Distribute materials/applications within an exam room setting

Providers contracted with plan sponsors (and their contractors) are permitted to do the following:

• Provide the names of plan sponsors with which you contract and/or participate
• Provide information and assistance in applying for the low income subsidy
• Make available and/or distribute plan marketing material including provider affiliation materials for a subset of contracted Plans only as long as providers offer the option of making available and/or distributing marketing materials from all plans with which you participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials. Rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted Plans, it should do so knowing it must accept future requests from other Plan sponsors with which it participates. To that end, providers are permitted to:
  • Provide objective information on plan sponsors’ specific Plan formularies, based on a particular patient’s medications and health care needs
  • Provide objective information regarding plan sponsors’ Plans, including information, such as covered benefits, cost sharing and utilization management tools
  • Make available and/or distribute PDP enrollment applications, but not MA or MA-PD enrollment applications, for all plans with which the provider participates
  • Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their state Medicaid Office, local Social Security Office, CMS’s website at [http://medicare.gov](http://medicare.gov) or [1-800-MEDICARE](tel:1-800-MEDICARE).
  • The “Medicare and You” handbook or “Medicare Options Compare” (from [http://medicare.gov](http://medicare.gov)), may be distributed by providers without additional approvals.

NOTE: A provider should not attempt to switch or steer plan enrollees or potential plan enrollees to a specific plan or group of plans to further the financial or other interests of the provider.
VIII - Immunizations

Michigan Care Improvement Registry (MCIR)

The Michigan Public Health Code and Communicable Disease Rules require that immunization providers report vaccines administered to children born after 12/31/93. Registering with MCIR facilitates meeting this reporting requirement. MHP encourages providers to register with MCIR by calling (888) 217-3900 or online at http://mcir.org. In addition, all vaccines administered to Medicaid members must be reported to MCIR.

Vaccines Available Through Local Health Department

Michigan physicians may obtain many childhood vaccines and some vaccines for adults, through the public health system for patients meeting specific eligibility requirements. Health care professionals should check with their local health department regarding the availability of these vaccines for both children and adults.

Vaccines for Children (VFC) Programs

Protecting children from diseases that can be prevented by vaccination is a primary goal of MHP and the MDHHS. The federally funded Vaccines for Children Basic (VFC-Basic) and Vaccines for Children Expanded (VFC-Expanded) Programs are cooperatively run by local and state public health departments. These programs provide free vaccines for children, who are enrolled in Medicaid, have no insurance, are American Indian or Alaskan Native, or are underinsured.

Vaccines are covered for all MHP Medicaid members through the VFC Program. MHP reimburses practitioners for vaccine administration. However, you may want to consider participating in this program to ensure that all children in your practice, regardless of their insurance status, have access to appropriate immunizations as recommended by MHP’s Pediatric Preventive Care Guidelines and the Alliance for Immunizations in Michigan (AIM).

If you are not already a VFC provider and you want to learn more about VFC, contact the immunization program at your local health department, or the MDHHS, Communicable Disease and Immunization service at (517) 335-8159.

Michigan Vaccine Replacement Program (MI-VRP)

The MI-VRP program provides certain vaccines for qualifying adults, 19 years of age or older at the local health department and, under certain circumstances, at private providers’ offices.
Champs Enrollment

MHP Medicaid contracted providers must enroll and attest to their information within the CHAMPS System. Enrolling in CHAMPS does not require you to be a medicaid FFS provider.

Seven easy steps to enroll in CHAMPS:

1. Go to www.michigan.gov/MDHHS
2. Click on “Doing Business with MDHHS” Icon (top of page)
3. Click on “Health Care Providers” icon (right side of page)
4. Click on “Providers” (middle of page)
5. Click on “Single Sign-ON (SSO)” icon
6. Click “Register” button under “Sign Up”)

If you have not done so already, please enroll and attest today.
IX - Emergency and Urgent Care

Patients often find it difficult to distinguish between an urgent health care need and a medical emergency. Therefore, MHP members are instructed to contact their PCP if a medical problem or question arises which the member believes should be taken care of right away.

Definitions

Emergency care is defined as a sudden and/or unexpected sickness or injury that could result in a serious problem or death if not treated right away. Examples of emergency conditions include:

- Serious bleeding
- Fracture
- Loss of consciousness
- Chest pain
- Convulsions or seizures
- Sudden high fever in a child
- Severe breathing problems
- Sudden high fever in a child

Urgent health problems are not life threatening, but they may require immediate attention. Members are encouraged to contact their PCP if they experience a health problem they believe requires immediate attention. Examples of common urgent health problems include:

- Severe sore throat
- Minor cuts and bruises associated with trauma
- Sprains
- Rashes
- Severe headache
- High fevers
- Earache

A PCP or covering physician must be available 24 hours a day/seven days a week to provide or arrange for coverage of services.

Emergency Care Program

MHP has developed an Emergency Room Program that identifies high utilizers and provides member education and support. The relationship between PCPs and their patients is an important one. The PCP is contracted to coordinate the care of MHP members 24 hours a day, seven days a week. At MHP, we realize this is not always easy or convenient, but caring for a patient’s urgent medical problems instead of automatically referring a member to the Emergency Department, fosters your relationship with your patient, reduces member anxiety and provides continuity of care.

Members who have multiple visits to the Emergency Department within a six month period are contacted by their MHP Case Manager. They work collaboratively with the member and the PCP to identify needs the member may have, which contribute to high utilization of the Emergency Department. Case Managers ensure the member has established a relationship with their PCP and educate members on appropriate use of the Emergency Department.

Please contact Medical Management at (888) 327-0671 for more details.
PCP’s Role in Urgent and Emergency Care

Members must contact their PCP prior to an Emergency Department visit unless the member has what he or she believes to be a life-threatening emergency. If the PCP is contacted, an assessment of the situation for severity should determine the appropriate course of action (i.e., STAT office visit, Urgent Care visit, Emergency Department visit or regular office visit). If an Urgent Care or Emergency Department visit is required, authorization is not needed. However, when a member notifies his/her PCP of an intended Emergency Department visit, the PCP should call the Emergency Department to alert them on the member’s behalf. The PCP should notify MHP no later than the next day of the Emergency Department visit.

If the member self-refers for emergent care, the Emergency Department staff will evaluate the member’s condition. The member will be treated, stabilized and the PCP contacted. If the condition is non-life threatening, the PCP is contacted by the Emergency Department staff allowing him/her the option of caring for their patient at this point or authorizing Emergency Department treatment. The PCP must arrange for all follow up care.

The PCP or covering physician is responsible for coordination of urgent problems 24 hours a day/ 7 days a week.

Out-of-Area Emergent Care

When a MHP member presents to an out-of-area facility for emergency care, the institution providing this emergency care (or emergency admission) must notify MHP no later than the next business day.

Out-of-Area Non-Emergent Care

MHP’s members may be eligible to receive non-emergent or routine covered services while outside the MHP service area (with prior approval from the Plan) under the following circumstances:

- When travel back to the service area is not possible or is impractical
- When preauthorization is obtained from MHP

Member Responsibility

If the member feels they have an emergent medical condition and does not have time to call the PCP, they are instructed to go to a MHP participating hospital Emergency Department, the nearest Emergency Department, or call 911.

Members who go to an Urgent Care or Emergency Department are instructed to identify themselves as MHP members and present their MHP member identification card.

Members are encouraged to notify their PCP within 24 hours, or the next business day, of an Urgent Care or Emergency Department visit to ensure that appropriate and immediate follow-up care may be arranged.
X - Referral and Authorization Requirements

MHP promotes the traditional primary care relationship between physicians and their patients. PCPs are generally responsible to issue referrals for care outside of the PCP office setting. MHP recommends that the PCP coordinates the entire episode of care to ensure the timely initiation and appropriate utilization of health services. We do recognize that there are certain situations and circumstances in which the specialist provider would be more appropriate to request services. Therefore, referrals and request for preauthorization are also accepted from the specialist provider.

The Provider Referral Form is utilized by MHP to obtain preauthorization when certain services outside of the PCP office setting are requested. The Provider Referral Form is available in electronic submission format completion and submission to MHP at McLarenHealthPlan.org or McLarenAdvantage.org. Electronic clinical notes may be attached. An electronic preauthorization request can be submitted. This submission form can be accessed by selecting the Referral Form quick link via the provider tab drop down. The preauthorization request form can also be printed from the same webpage and submitted via fax to (877) 502-1567.

Use of the electronic form is secure and is the preferred method of submitting requests for preauthorization of services to MHP. Urgent requests for preauthorization may be made by contacting the Medical Management Department at (888) 327-0671. MHP Medical Management strives to respond to provider requests for preauthorization of services in an efficient and prompt manner. MHP utilizes the following time frames for timeliness of non-behavioral healthcare utilization management decision making:

- For non-urgent pre-service decisions, MHP makes decisions within 14 calendar days of receipt of the request
- For urgent, pre-service decisions, MHP makes decisions within 72 hours of receipt of the request
- For urgent concurrent review, MHP makes decisions within 24 hours of the request
- For post-service decisions, MHP makes decisions within 30 calendar days of receipt of the request

Providers will be notified by fax of the utilization management decision.

As a reference guide, there is a complete listing of service codes requiring preauthorization for each line of business. There is also a complete list, by CPT code, of procedures that do and do not require preauthorization on the website in the same location as the Provider Referral Form.

MHP does not require any authorization for in-network (contracted) specialty consultations, or for care provided in the specialist office. However, preauthorization is required, regardless of the contracted status of the physician for:

- Certain injections given in a specialist office
In summary, a completed Provider Referral Form and preauthorization are required for:

- Any care that is referred to an out-of-network (non-contracted) physician
- Any service listed on the back of the Provider Referral Form
- Certain injections (please call Medical Management for clarification)

In addition, any health care provider who is not a participating provider with MHP must obtain preauthorization for all non-emergency services provided.

Please note that preauthorization requirements are subject to change. Please refer to McLarenHealthPlan.org or McLarenAdvantage.org for the most current information on services that require preauthorization and the preauthorization process.

**Preauthorization** requests are subject to a medical review by MHP and may require additional information and/or documentation before a service can be approved.

When completing the **Provider Referral Form**:

- There is an option of requesting an office consult with or without follow up visits
- Provider must contact MHP to add any testing, outpatient procedures, or additional consults to other specialists, to the original office consult referral
- An in-network specialist can complete the Provider Referral Form to request authorization for services in the non-office setting, such as:
  - Outpatient surgery
  - MRI
  - Physical Therapy

The following fields are required on the **Provider Referral Form**:

- Request date
- Member’s plan
- Patient information
- Requestor information
- Referred to information
- Diagnosis/Procedure Code
- Facility information
- Requested Service

If these fields are not appropriately completed, the referral will be returned to the requesting office and will not be processed by MHP.

Referrals are valid for the duration of the episode of care, not to exceed one year. The provider may request follow-up or subsequent visits on the same referral form. If the episode of care exceeds one year, a new referral will need to be generated.

MHP will return the form to the requesting provider authorized, redirected, pended or not authorized. If the referral is authorized, MHP will complete the Authorization Request Response Form with the authorization number and FAX the referral back to the requestor. The authorization number is automatically activated upon receipt and remains subject to member eligibility on the date of service.
McLaren Advantage (HMO) members may go to non-participating providers for:

- Emergency care
- Out-of-area dialysis care
- Out-of-area urgently needed care

McLaren Advantage (HMO) members may be sent to out-of-plan providers if the member needs medical care that can only be received from a doctor or other health care provider who is not participating with our health plan. PCPs must obtain preauthorization from our health plan before sending a member to an out-of-plan provider. You can request a preauthorization by calling Medical Management at (888) 327-0671.

McLaren Advantage (HMO) members, or their health care providers may request a second opinion for surgery or other medical services, at no cost to the member other than applicable copayments, coinsurance and deductibles. The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, a preauthorization must be obtained to send the member to the non-participating provider.
- The provider must not be affiliated with the member’s PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

**Inpatient Hospital Services: Provider**

All patient hospital admissions require preauthorization (except in emergency situations). For Inpatient elective or urgent admissions the provider must contact MHP’s Medical Management department by calling (888) 327-0671 toll-free or by calling your Case Management Nurse directly. For **elective admissions** notify MHP at least 7 business days in advance and for **urgent admissions** notify MHP prior to admission or within 24 hours (or next business day), including the clinical information that supports the need for inpatient care.

All elective and urgent hospitalizations must be made to a MHP network hospital unless **prior** approval from our Medical Management Department has been obtained.

**Inpatient Hospital Services: Facility**

Contracted facilities must notify MHP of all admissions and provide clinical information within one business day of the admission. Timely facility notification allows us to ensure our members are receiving care in the most appropriate setting, that our Medical Management Nurses are involved in the members care, including discharge planning, and that case management is initiated when appropriate.

Notify us of admissions by telephone or fax:

**Telephone:** (888) 327-0671 (toll free)  |  **Fax:** (877) 502-1567 (toll free)  |  (810) 733-9645 (direct)
If the clinical information meets MHP’s criteria for admission, an authorization will be given. If additional information is needed to verify the level of care for any admission, an Authorization Process is faxed to the hospital. After medical review the form is returned with the final authorization number for reimbursement purposes. In addition, for all inpatient admissions, the Medical Management Department will conduct concurrent reviews. Concurrent review of inpatient admissions requires frequent and comprehensive updates to verify need for continued stay and to aid in discharge planning. If adequate and timely information is not received during concurrent review, the status of the authorization may be adversely affected. In addition, notification of the inpatient admission is required prior to a member’s discharge. This also includes a required notification to MHP of a member’s date of discharge. Failure to supply the information necessary may result in non-payment of a hospital admission. The member’s Case Management nurse will work with the hospital staff in managing the stay and assist with the planning and determining discharge needs.

When an admission occurs through the emergency room, we ask that the hospital contact the PCP prior to admission to discuss the member’s medical condition and to coordinate care prior to admitting.

For inpatient obstetrical admissions, MHP requires that hospitals provide both admission and discharge information for all deliveries. The following information must be provided within 48 hours of delivery:

- Admission date
- Delivery date
- Discharge date
- Type of delivery
- Status of the mother and baby

Newborns discharged home with their mothers from the newborn nursery do not require a separate authorization from their mother. However, we do require a separate authorization within 24 hours when the newborn requires extended services. Examples include when a newborn:

- Is admitted directly into the NICU or Special Care Nursery from the delivery room
- Is transferred to an NICU or Special Care Nursery from the newborn nursery
- Remains in the nursery after the mother is discharged

If questions arise regarding the appropriateness of any inpatient admission or the course of treatment, a concurrent review nurse, or MHP’s Chief Medical Officer, will contact the hospital utilization review staff and/or the admitting physician to discuss the case. Please contact Medical Management at (888) 327-0671 for further details.

**Outpatient/Observation Stay: Facility**

Sometimes a facility may request Inpatient Authorization for an episode of care when an Outpatient Authorization is more appropriate. MHP considers an episode of care to be more appropriately authorized as outpatient when medical documentation reveals that a patient’s presenting symptoms have been stabilized or resolved with emergency room treatment, but additional time is needed for continued short term treatment and/or observation.

In addition to the evaluation of the emergency room treatment results, many other factors are also considered, such as patient’s medical history, medical predictability of adverse outcomes with presenting signs and symptoms, and the expectation that the episode of care may be resolved in a short period.
Also, to help identify outpatient stays, system edits will identify an episode of care lasting less than 48 hours and members with a specific presenting diagnosis. Examples of diagnoses (not all inclusive) that may be reviewed for reimbursement as an outpatient include:

- Asthma
- Bronchitis/bronchiolitis
- Cellulitis
- Chest pain
- Closed-head injury without loss of consciousness
- Dehydration (gastroenteritis)
- Overdose/alcohol intoxication
- Pain: e.g., abdominal, head, back
- Pneumonia
- Pyelonephritis
- Syncope

If the clinical information suggests that the admission requires outpatient authorization and the hospital is pursuing an inpatient authorization, additional clinical information will be required. The Authorization Process form will be faxed to the hospital to aid in the determination of the final authorization for reimbursement. After medical review the form is returned with the final authorization number for reimbursement purposes.

MHP will respond to a non-contracted facilities request for approval of post-stabilization services within one (1) hour. If MHP does not respond within one (1) hour, the post-stabilization services (hospitalization or other health care services) will be prior authorized for payment. Payment and authorization for an inpatient hospitalization in this instance will be for inpatient DRG, not as observation payment.

Additionally, outpatient reimbursement for observation care is not payable in the following situations:

- After outpatient surgery -- Reimbursement for recovery room care is included in the outpatient surgical fees
- For monitoring of pregnancy related conditions such as preterm labor, hyperemesis gravidarum, and gestational diabetes. These services are billable in the outpatient setting using the labor room/delivery room revenue code only

**Readmissions: Facility**

MHP reviews all inpatient readmissions when readmission occurs within 14 days after a member is discharged. We review cases to determine if the readmission is related to the first admission for reasons such as:

- Premature discharge or a continuity of care issue
- Lack of, or inadequate, discharge planning
- A planned readmission
- Complications from surgery performed on first admission

The outcome of the review may impact the hospital’s reimbursement. When providing clinical review for members readmitted to the same hospital within 14 days, please provide a clinical review for the last two days of the first admission, and an admission review for the second, when calling in the second admission. If readmission involves a different facility, MHP will seek the clinical information from the first admission to determine if either hospital’s reimbursement is impacted.
Emergency Care Requires Outpatient Surgery

When a member is transferred from the emergency room for any outpatient surgical procedures, the hospital must call Medical Management to obtain authorization for the services. Please call (888) 327-0671 for authorization.
XI - General Information

Physician Office Laboratory Services

MHP providers who perform laboratory tests in their office must demonstrate that they have either 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 for a complete list of CPT codes that are billable when performed in an office setting.

MQIC Guidelines

MHP has adopted the Michigan Quality Consortium’s (MQIC) Clinical Practice Guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances and behavioral healthcare services. These guidelines may be found at http://mqic.org and www.McLarenHealthPlan.org/medicaid-provider/provider-guidelines-mhp.aspx. The MQIC guidelines are evidence-based and include both physical conditions such as asthma and diabetes, and behavioral health conditions such as depression and attention-deficit/hyperactivity disorder for children and adolescents. The guidelines are reviewed every two years for needed updates.

Joint Venture Hospital Laboratories (JVHL)

MHP utilizes JVHL as our provider for laboratory services. JVHL will provide you and your patients with responsive, convenient, high quality services. JVHL specializes in outreach laboratory services with more than 400 phlebotomy locations, full-time courier services and 24 hour/7 day client service support. You may contact JVHL at (800) 445-4979 or visit www.jvhl.org for additional information, including:

- Service Center Locations
- JVHL Provider Directory

Reference Lab Billing Requirements

As laboratory testing continues to become increasingly specialized, hospital laboratories may find it necessary to refer specimens to reference laboratories for testing if they lack the capability to process the specimens in-house. This information pertains to covered laboratory procedures performed by reference laboratories that are under contractual arrangements with MHP contracted hospitals. This would include any laboratory procedure covered by CPT codes 80000 – 89999, or any applicable HCPCS codes. See Reference Guide “H” for more information on Reference Lab Billing Requirements.

Diabetic Monitors and Supplies

MHP utilizes Bayer HealthCare as our sole supplier for diabetic monitors and diabetic monitor supplies for all lines of business. To request a monitor for a member, contact Customer Service (888) 327-0671. There are a few exceptions to the requirement to utilize Bayer for monitors and supplies. They include:

- Children 18 years and younger coming to one of our health plans already trained on another meter
• Blind or serious vision impairments requiring the use of a talking meter
• Insulin Pump users coming to the health plan with a meter that speaks to their pump

If you have any questions, please call Customer Service at (888) 327-0671.

Medical Record Maintenance

State regulations require MHP’s participating practitioners and other providers to maintain accurate patient medical records regarding treatment and diagnostic procedures provided to MHP members for at least six (6) years. CMS requires that records related to McLaren Advantage (HMO) or Medicare Advantage members must be maintained for ten (10) years.

Each provider contracting with MHP is required to maintain a medical record for each member served while enrolled in MHP. These records are to be made available to authorized representatives of MHP, regulatory agencies, accrediting bodies and appropriate state and federal agencies.

Medical records of members shall be sufficiently complete and legible to permit subsequent peer review or medical audit.

MHP requires participating providers to release medical records, as may be directed by the member, or by authorized representatives of appropriate state and federal agencies.

Provider must maintain medical records of all medical services received by members. Medical records include, but are not limited to the following: a) a record of outpatient and emergency care, b) specialist referrals, c) ancillary care, d) diagnostic test findings including all laboratory and radiology, e) prescriptions for medications, f) inpatient discharge summaries, g) histories and physicals, h) immunization records, and i) all other documentation sufficient to fully disclose the quantity, quality, appropriateness and timelines of services provided 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. Medical records must be legible, signed and dated. All medical records must be kept in the time periods required by applicable regulatory agencies. Medical records will be made promptly available, at no cost to the MDHHS or CMS upon request. When a member changes PCP, the former PCP must forward copies of the member’s medical records to the new PCP within ten (10) working days from receipt of a written request from the new PCP or the member. Medical records must be stored in a matter that ensures compliance with federal and state privacy and security requirements and must be stored securely so that only authorized personnel have access to the records. If provider is a hospital, provider must comply with all medical record requirements contained within 42 CFR 456.101-145. Provider will comply with any additional medical record standards established in MHP’s policies, which are available upon request.
Confidentiality

MHP guarantees its members the right to privacy of information through the policies, procedures and the MHP Confidentiality Program. A privacy notice is available to all members. In addition, every MHP employee signs a statement when they are hired that states they are required to keep member information private. Employees are trained every year on keeping information private and only allow employees who are authorized with a password have access to electronic information.

Providers must assure that all information relating to, or identifying specific patients, shall be kept strictly confidential. Each MHP participating provider is responsible for maintaining the confidentiality of medical, social, and economic information contained in the member’s medical record. Storage of medical and confidential files shall be subject to physical security measures during non-working hours.

Quality Improvement Activities

MHP’s contracted Provider Network is obligated to comply with all MHP quality improvement activities. These activities include utilization review, quality management, care coordination, peer review and other such programs as established by MHP to promote the provision of quality health care and cost containment.

Performance data collected by MHP’s Provider Network is utilized in quality improvement activities. This data is collected through, but not limited to, claims history and HEDIS chart review. This data is utilized in a variety of ways. Individual provider performance is reported as well as compiled into the Plan’s performance overall. From this data, work plans, opportunities for action, and provider incentives are developed to help increase quality outcomes and member satisfaction.

Non-Discrimination

In connection with the performance of services under the contract between MHP and the provider, the provider agrees to comply with the American’s Disability Act, 42 USLA 12112 (ADA). Additionally, the provider agrees with the Civil Rights Act of 1964 (78 stat. 252).

Discussing Treatment Options

MHP providers may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations. Providers shall not be prohibited from advocating on behalf of a member in any grievance or utilization review process or individual authorization process to obtain necessary health care services.
In-Office Laboratory Procedures

McLaren Health Plan (MHP) contracts with Joint Venture Hospital Laboratories (JVHL) to provide all outpatient laboratory services. In order to better serve our members, MHP allows physicians to perform and submit claims for specific laboratory services performed in their offices.

The **in-office** laboratory procedures listed below are billable by Primary Care Physicians and Specialists.

<table>
<thead>
<tr>
<th>CPT-4 Code</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80048</td>
<td>BASIC METABOLIC PANEL</td>
</tr>
<tr>
<td>80051</td>
<td>ELECTROLYTE PANEL</td>
</tr>
<tr>
<td>81000</td>
<td>URINALYSIS; NON-AUTOMATED, WITH MICROSCOPY</td>
</tr>
<tr>
<td>81001</td>
<td>URINALYSIS; AUTOMATED, WITH MICROSCOPY</td>
</tr>
<tr>
<td>81002</td>
<td>URINALYSIS; NON-AUTOMATED, WITHOUT MICROSCOPY</td>
</tr>
<tr>
<td>81003</td>
<td>URINALYSIS; AUTOMATED, WITHOUT MICROSCOPY</td>
</tr>
<tr>
<td>81007QW</td>
<td>URINALYSIS SCREEN FOR BACTERIA, EXCEPT BY CULTURE OR DIPSTICK</td>
</tr>
<tr>
<td>81015</td>
<td>URINANLYSIS; MICROSCOPIC ONLY</td>
</tr>
<tr>
<td>81025</td>
<td>URINE PREGNANCY TEST, BY VISUAL COLOR COMPARISON METHODS</td>
</tr>
<tr>
<td>82044</td>
<td>URINARY MICROALBUMIN</td>
</tr>
<tr>
<td>82270</td>
<td>BLOOD, OCCULT; FEces SCREENING BY PEROXIDASE ACTIVITY, 1-3 SIMULTANEOUS DETERMINATIONS</td>
</tr>
<tr>
<td>82272</td>
<td>BLOOD, OCCULT; FEces SCREENING BY PEROXIDASE ACTIVITY, SINGLE SPECIMEN (E.G., FROM DIGITAL RECTAL EXAM)</td>
</tr>
<tr>
<td>82274QW</td>
<td>BLOOD, OCCULT; FECAL HEMOGLOBIN SCREENING BY IMMUNOASSAY, 1-3 SIMULTANEOUS DETERMINATIONS</td>
</tr>
<tr>
<td>82310</td>
<td>CALCIUM; TOTAL</td>
</tr>
<tr>
<td>82374</td>
<td>CARBON DIOXIDE (BICARBONATE)</td>
</tr>
<tr>
<td>82435</td>
<td>CHLORIDE; BLOOD</td>
</tr>
<tr>
<td>82565</td>
<td>CREATININE; BLOOD</td>
</tr>
<tr>
<td>82670</td>
<td>ESTRADIOL</td>
</tr>
<tr>
<td>82947QW</td>
<td>GLUCOSE; QUANTITATIVE</td>
</tr>
<tr>
<td>82948</td>
<td>GLUCOSE; BLOOD, REAGENT STRIP</td>
</tr>
<tr>
<td>83001QW</td>
<td>GONADOTROPIN; FOLLICLE STIMULATING HORMONE (FSH)</td>
</tr>
<tr>
<td>83002</td>
<td>GONADOTROPIN; LUTEINIZING HORMONE (LH)</td>
</tr>
<tr>
<td>83036</td>
<td>HEMOGLOBIN, GLYCATED</td>
</tr>
<tr>
<td>83037</td>
<td>GLYCOSYLATED HEMOGLOBIN TEST</td>
</tr>
<tr>
<td>83655</td>
<td>LEAD</td>
</tr>
<tr>
<td>84144</td>
<td>PROGESTERONE</td>
</tr>
<tr>
<td>84146</td>
<td>PROLACTIN</td>
</tr>
<tr>
<td>84295</td>
<td>SODIUM; SERUM, PLASMA OR WHOLE BLOOD</td>
</tr>
</tbody>
</table>
### MHP In-Office Laboratory Billable Procedures

<table>
<thead>
<tr>
<th>CPT-4 Code</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>84520</td>
<td>UREA NITROGEN; QUANTITATIVE</td>
</tr>
<tr>
<td>84703QW</td>
<td>GONADOTROPIN, CHORIONIC (HCG); QUALITATIVE</td>
</tr>
<tr>
<td>85007</td>
<td>BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL DIFFERENTIAL WBC COUNT</td>
</tr>
<tr>
<td>85013</td>
<td>BLOOD COUNT; SPUN MICROHEMATOCRIT</td>
</tr>
<tr>
<td>85014QW</td>
<td>BLOOD SMEAR; HEMATOCRIT (HCT)</td>
</tr>
<tr>
<td>85018QW</td>
<td>BLOOD SMEAR; HEMOGLOBIN (HGB)</td>
</tr>
<tr>
<td>85025</td>
<td>COMPLETE BLOOD CT (CBC-HGB, HCT, RBC, WBC, AND PLT) AND DIFF, AUTOMATED</td>
</tr>
<tr>
<td>855027</td>
<td>BLOOD COUNT; COMPLETE (CBC) AUTOMATED (HGB, HCT, RBC, WBC, PLAT)</td>
</tr>
<tr>
<td>85048</td>
<td>BLOOD COUNT; LEUKOCYTE (WBC), AUTOMATED</td>
</tr>
<tr>
<td>85097</td>
<td>BONE MARROW; SMEAR INTERPRETATION ONLY, W/OR W/O DIFF.CELL CNT</td>
</tr>
<tr>
<td>85610</td>
<td>PROTHROMBIN TIME</td>
</tr>
<tr>
<td>85651</td>
<td>SEDIMENTATION RATE, ERYTHROCYTE; NON-AUTOMATED</td>
</tr>
<tr>
<td>86308QW</td>
<td>HETEROPHILE ANTIBODIES; SCREENING</td>
</tr>
<tr>
<td>86403</td>
<td>PARTICLE AGGLUTINATION (SCREENING EACH ANTIBODY) RAPID STREP TEST</td>
</tr>
<tr>
<td>86580</td>
<td>SKIN TEST; TUBERCULOSIS, INTRADERMAL</td>
</tr>
<tr>
<td>87081</td>
<td>CULTURE, BACTERIAL, SCREENING ONLY; FOR SINGLE ORGANISMS</td>
</tr>
<tr>
<td>87210</td>
<td>SMEAR, PRIMARY SOURCE, W/INTERP; WET MOUNT SIMPLE STAIN</td>
</tr>
<tr>
<td>87220</td>
<td>TISSUE EXAMINATION BY KOH SLIDE FOR FUNGI</td>
</tr>
<tr>
<td>87650</td>
<td>STREPTOCOCCUS, GROUP A, DIRECT PROBE TECHNIQUE</td>
</tr>
<tr>
<td>87880QW</td>
<td>INFECTIOUS AGENT DETECTION IMMUNOASSAY OBS, STREPT GROUP A</td>
</tr>
<tr>
<td>89050</td>
<td>CELL COUNT, MISCELLANEOUS BODY FLUIDS, EXCEPT BLOOD</td>
</tr>
<tr>
<td>89190</td>
<td>NASAL SMEAR FOR EOSINOPHILS</td>
</tr>
<tr>
<td>89300/G0027</td>
<td>SEMEN ANALYSIS; PRESENCE AND/OR MOTILITY OF SPERM</td>
</tr>
<tr>
<td>89310</td>
<td>SEMEN ANALYSIS; MOTILITY AND COUNT (NOT INC. HUHNER TEST)</td>
</tr>
<tr>
<td>89320</td>
<td>SEMEN ANALYSIS; COMPLETE (VOLUME, COUNT, MOTILITY, DIFFERENTIAL)</td>
</tr>
</tbody>
</table>

*Only Specialists may perform these services.*
Allowable Amount

MHP reimburses all providers of care, for all lines of business, at applicable facility and professional fee schedule rates and methodologies. Reimbursement is provided as payment in full at the lesser of billed charges or 100 percent of the allowed amount less any deductible, copayments or coinsurance amounts that are the responsibility of the Member.

Mid-Level Providers

MHP reimburses mid-level providers according to industry standard methodology. Mid-level providers are reimbursed at 85 percent of the standard professional fee schedule, applicable to each line of business, less any deductibles, copayments or coinsurance amounts that are the responsibility of the Member. Mid-level providers are classified as:

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)
- Certified Nurse Specialist (CNS)
XII - Submitting a Claim

In general, MHP follows the claims reimbursement policies and procedures set forth by the MDHHS and CMS. Reimbursement for Medicaid and Medicare is based on the prevailing state of Michigan Medicaid or Medicare fee schedule.

MHP accepts both paper (CMS 1500 and UB-04 claim forms) and electronic claims. All claims must be submitted and received by MHP no later than one (1) year from the date of service to be eligible for reimbursement. Claims received that exceed this filing limit may be denied.

<table>
<thead>
<tr>
<th>Use a CMS 1500 Form for:</th>
<th>Use a UB-04 Form for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services provided by physicians, behavioral health providers, DME providers, laboratories, ambulances, etc.</td>
<td>Services provided by hospitals (inpatient/outpatient), ambulatory surgery centers, hospices, home health care companies, skilled nursing facilities and dialysis facilities.</td>
</tr>
</tbody>
</table>

Billing Reminders

- Prenatal visits may be billed using the global code, but prenatal individual dates **MUST** be listed on the claim form.
- DME claims must have appropriate modifiers listed (refer to HCPC’s reference book).
- Anesthesia is to be billed listing the total number of minutes. **DO NOT** include base units. Example: total anesthesia time is two (2) hours, units would equal 120 (minutes). Total time in minutes should be provided in box 24G, in the unshaded area. The procedure base units will be added to the total number of units by MHP. See Reference Guide “D” for more information on Anesthesia billing.
- Industry standard HCPCS, CPT, Revenue and ICD codes must be used.
- **DO NOT** include the MHP Provider Identification Number (PIN) on claims.
- Hospital based clinics/providers will be reimbursed for professional services. See Reference Guide “E” for more information on Hospital Based billing.

Paper Claims

Although we prefer receiving claims electronically, if you do submit them on paper, all paper claims should be mailed to:

McLaren Health Plan  
P.O. Box 1511  
Flint, MI 48501-1511

**Handwritten claims will not be accepted.** Paper claims must be typed and mailed to the address provided above.

Paper claim submission must be done using the most current form version as designated by the CMS and the National Uniform Claim Committee (NUCC).
Please note: You must submit your appropriate NPI on the claim form. If you have any questions, contact Network Development or access McLarenHealthPlan.org.

Electronic Claims Submission

For claims filed electronically through MHP’s Electronic Data Interchange (EDI) vendors, the claims payment process does not differ from paper claim submissions. However, electronic claims may require providers to put the information in different “fields” or “loops”. Refer to the Clearinghouse Information section for detailed instructions for submitting electronic claims.

Our Payer IDs for electronic claims are:

- McLaren Medicaid / Healthy Michigan Plan – 3833C
- McLaren Commercial HMO – 38338
- McLaren Health Advantage – 3833A
- McLaren Advantage (HMO) – 3833R

Clearinghouse Information (both Professional and Facility)

MHP receives EDI claims from our clearinghouse, ENS Optum Insight. Since you may choose to contract with a different clearinghouse, you must ask whether your clearinghouse has a forwarding arrangement with ENS Optum Insight. A forwarding arrangement allows your clearinghouse to pass your claims on to ours so that we will receive them. Please visit McLarenHealthPlan.org for an updated listing of ENS Optum Insight affiliated clearinghouses.

Claims Data Validation

EDI claims that you submit to us will be validated at several points before they are loaded into our claims payment system for review by a claims analyst.

- Your clearinghouse validates your data
- Our clearinghouse validates your data
- Pre-Edit: Our system validates the subscriber and billing provider

The following suggestions will improve your ability to submit a claim for processing:

Your Clearinghouse

You should be provided with rejection reports by your clearinghouse for claims that we do not receive. We do not receive a copy of your rejection reports. Please understand that we have no control over or knowledge of the validation that your clearinghouse performs.

Pre-Edit

Your claim must contain the rendering and the billing NPI in order to be processed.
Subscriber Identification

We will not process a claim that contains an invalid subscriber/member ID. The correct subscriber ID can be found on the MHP member ID card. If you are unsure of the number, call Customer Services at (888) 327-0671.

Billing Provider Identification:

We will not process a claim that contains an invalid billing NPI. Be sure to also submit the rendering provider’s NPI as assigned by CMS. The Tax ID number is not acceptable in lieu of this field. This must be included as the “Billing Provider Secondary Identifier”. The billing address cannot contain a P.O. Box or Department Number for electronic claims, as specified by 5010 billing requirements.

EDI Contacts

If you have questions about becoming a customer at ENS Optum Insight or have problems with claim rejections that were received by ENS Optum Insight, contact: http://enshealth.com; (866) 367-9778

If you have questions about the instructions in this document or would like the status of a claim that you have submitted to us:

• Access our provider portal at McLarenHealthPlan.org - Provider/Medicaid/Provider Information/Provider Portal -
• Contact Customer Service at (888) 327-0671; TTY call 711

Clean Claims

MHP is required to process your clean claims within forty-five (45) days of MHP receiving the claim. Clean claims not processed in this time period are eligible for interest payments at twelve percent (12%) per annum in compliance with Michigan’s prompt payment legislation (Public Act 28 of 2004).

Public Act 28 defines a clean claim when the following information is present on the claim:

• Identifies the provider of service, including any provider identification number and Federal Tax Identification number
• Lists the patient name and their ID numbers
• Lists the date(s) and place of service
• The claim is a bill for covered services for an eligible member
• The claim is a bill for medically necessary and appropriate care
• The claim contains preauthorization or pre-certification information, if required
• The claim identifies the services rendered by using proper procedure and diagnosis codes
• The claim includes additional information when required by MHP
Non-Clean Claims

When MHP is unable to process a submitted claim, notification will be provided identifying the reason for rejection. Common reasons include:

- Valid NPI is missing or incorrect
- Unable to identify the provider (using your NPI)
- Unable to identify the member (copy the name and member number from the MHP ID card)
- Provider did not complete form correctly

MHP’s Ineligible (Reason) Codes and their definitions are listed in the Forms Section XVII.

Billing for Physician Administered Drugs and NDC Reporting

Providers are required to report the National Drug Code (NDC) supplemental information in addition to the procedure code (CPT or HCPCS) when billing for a physician administered drug on the electronic and paper claim formats. This requirement is mandated to ensure the MDHHS’s compliance with the Patient Protection and Affordable Care Act (PPACA). The PPACA requires Medicaid to collect rebates for certain drugs.

When billing MHP for physician administered drugs, in addition to the appropriate CPT or HCPCS codes, the following must be reported on the claim:

- 11-digit NDC number
- Unit price (EDI only)
- 2-digit unit of measure code, e.g. GM (gram), ML (milliliter), UN (unit)
- Quantity dispensed
- The prescription number

Due to the implementation of the HIPAA X12 version 5010, only one LIN segment is used to report the supplemental NDC information along with the HCPCS Code. For electronic and DDE claims, the prescription number must be reported to link multiple service lines together for the same procedure code.

If billing multiple lines for the same injectable medication due to different NDC numbers, a 59 modifier is required.

Coordination of Benefits (COB)

MHP does not pay a claim when it is unclear as to whether MHP is the primary or secondary payer. We recommend that you always ask patients when they register if they have coverage from more than one insurance carrier or if their injury is the result of an accident.

When MHP is secondary, be sure to submit a copy of the primary carrier’s Explanation of Benefits (EOB) along with your claim and indicate in the “Remarks” section that an EOB is attached.
COB claims should be submitted on paper since the EOB received from the primary payer must accompany the claim. COB claims must be submitted to MHP within twelve (12) months from the date of service or 90 days from the date of the primary payer's EOB.

Submit all claims to:

McLaren Health Plan  
PO Box 1511  
Flint, MI  48501-1511

COB Provider Payment Reports (PPR)

When a claim is submitted to MHP for coordination of benefits, the primary payer may have been paid more than the plan's allowable amount. When this happens, the provider will see a provider discount amount on the PPR, but no ineligible code. This is explained by subtracting the discounted amount from the charged amount, giving you the plan’s allowed amount. The primary payer’s amount will be listed in the “Other Carrier” column of the PPR. This amount will be more than the Plan’s allowed amount.

Checking the Status of Your Claims or Requesting a Claims Adjustment

All claim inquiries and adjustments must be submitted to MHP within 90 calendar days of the administrative action, excluding COB/subrogation claims. Inquiries and requests for adjustments after 90 calendar days will not be given consideration.

You can status your claim in our system by accessing FACTSWeb or provider portal.

Both portals are HIPAA compliant and will allow:

- You, or anyone you designate, to status claims submitted by you, and also to verify member eligibility and coverage
  - You will need to apply for access and will be given a password
  - FACTSWeb allows one password per Federal Tax Identification number
  - Application forms are included in Forms Section XVII of this manual.

You can also status a claim by completing the Provider Claims Status Fax Form and faxing it to Customer Service at (877) 502-1567. For a Provider Claims Status Fax Form, see Forms Section XVII or visit McLarenHealthPlan.org.

Please remember, just as MHP must pay simple interest on clean claims not processed within 45 days, providers can be fined for re-submitting duplicate claims during this same time period. Also, your claim will not be statused within this time period.

Providers who wish to request a claims adjustment to correct a previously submitted claim, believe a service was denied inappropriately or a claim did not pay correctly, are encouraged to do one of the following:
• Complete the Provider Claim Adjustment Form, see Forms Section XVIII or McLarenHealthPlan.org, attaching a **paper** copy of the corrected claim or the claim in dispute, and supporting documentation for the adjustment, and fax it to Customer Service at (877) 502-1567 for processing.
• Contact Customer Service at (888) 327-0671 to request a claim adjustment.

Requests for claim adjustments cannot be submitted electronically. The completed Provider Claim Adjustment Form must accompany a **paper claim** to avoid it from being automatically denied as a duplicate claim.

### Submitting a Claim

In general, MHP follows the claim reimbursement policies and procedures set forth by the MDHHS for Medicaid and the CMS for Medicare, its Commercial business and Health Advantage. Provider shall comply with MHP’s payment policies. Please contact MHP for details.

### Claims Recovery

MHP identifies opportunities to recover payments made to providers.

The claims recovery process will include adjustments on the following types of previously paid claims including, but not limited to:

- COB
- Subrogation
- Clinical Inpatient Review
- Overpayments due to billing, clerical error and termination of a member’s coverage

COB includes the following:

- MHP paid primary and then found out at a later date the MHP should have paid secondary or tertiary
- MHP paid primary/secondary and then found out at a later date that MHP should not have paid at all

The following table outlines the timeframes for MHP to request funds or do take-backs.
<table>
<thead>
<tr>
<th>Type of Corrective Adjustment</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>COB</td>
<td>The longer of 12 months from the Date of Service or 90 days after MHP’s receipt of information confirming the primary carrier</td>
</tr>
<tr>
<td>Subrogation</td>
<td>24 months from the initial Date of Reimbursement</td>
</tr>
<tr>
<td>Inpatient Clinical Review</td>
<td>24 months from the initial Date of Reimbursement</td>
</tr>
<tr>
<td>Gross Negligence, Billing Errors, Fraud by Provider</td>
<td>No time limit</td>
</tr>
<tr>
<td>Clerical Overpayments by MHP</td>
<td>No time limit</td>
</tr>
<tr>
<td>Termination of Member’s Coverage</td>
<td>12 months from the Date of Service</td>
</tr>
</tbody>
</table>

**Corrective Adjustments**

MHP (or a contracted representative) will notify the provider of the corrective adjustment. The provider has 30 days from the date of the notice to reimburse MHP or object to the proposed corrective adjustment. Any disagreements to the proposed corrective adjustment shall be communicated to MHP and be supported in writing. If the provider does not object in writing within the required time period, MHP will offset the amounts against future claims. Appeals, if any, will be handled in accordance with the appeals section (see Provider Administrative Appeals, section XIV).

**Termination of a Member’s Coverage**

At times, MHP receives notice from an employer, including the State of Michigan for Medicaid members, that they are retroactively terminating their benefits through MHP. For any services provided and payments made during this period, MHP shall recover those payments.

Payments will be recovered up to twelve (12) months from the date of service. Providers may bill the terminated member or another insurance carrier as appropriate for services provided during the retroactive period.

**Understanding the Remittance Advice**

The goal at MHP is to use a Provider Payment Report (PPR) format that makes our claims processing information understandable. Please review the information on the following sample PPR form to better understand the information and features of our PPR.

**835 and EFT Options**

To add efficiency and speed to the payment of claims, MHP offers several payment options available through Pay Plus Solutions, Inc.®. 835 remittance delivery options are also available. To update your payment, remittance delivery or notification options, please call Pay Plus Customer Service at (877) 828-8770.
**Sample Provider Payment Report**

MHP Commercial - McLaren Health Advantage - McLaren Advantage

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**Claim #: 21417166-01**

**Patient Account #: ABC-123**

**Insured Name: John Doe**

**Insured ID: 999-99-999**

<table>
<thead>
<tr>
<th>No.</th>
<th>Date(s) of Service</th>
<th>Proc Code</th>
<th>Description of Services</th>
<th>Total Charges</th>
<th>Provider Discount</th>
<th>Ineligible Amount</th>
<th>Ineligible Code</th>
<th>Deductible</th>
<th>Copay Co-Ins</th>
<th>Other Carrier</th>
<th>Benefits Paid</th>
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<td>08/01/2018</td>
<td>36415</td>
<td>Office Visit</td>
<td>40.00</td>
<td>0.00</td>
<td>10.00</td>
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<td>20.58</td>
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<tr>
<td>2</td>
<td>08/01/2018</td>
<td>84015</td>
<td>Injection</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td></td>
<td></td>
<td></td>
<td><strong>75.00</strong></td>
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<td><strong>0.00</strong></td>
<td><strong>0.00</strong></td>
<td><strong>0.00</strong></td>
<td><strong>20.58</strong></td>
</tr>
</tbody>
</table>

**Reason Code Description**

10 CHARGES PREVIOUSLY CONSIDERED

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**STATEMENT TOTALS**

<table>
<thead>
<tr>
<th>Total Charges</th>
<th>Provider Discount</th>
<th>Ineligible Amount</th>
<th>Deductible</th>
<th>Copay Co-Ins</th>
<th>Other Carrier</th>
<th>Benefits</th>
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</thead>
<tbody>
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<td>0.00</td>
<td>0.00</td>
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<td>20.58</td>
</tr>
</tbody>
</table>

Other Credits or Adjustments: 0.00

Total Net Payment: 20.58

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Questions, call us at (888) 327-0671
XIII - Pharmaceutical Management - Commercial and Medicaid

Commercial Pharmaceutical Management

Introduction

Pharmaceutical Management promotes the use of the most clinically appropriate, safe and cost effective medications. MHP works together with a Pharmacy Benefits Manager to administer drug formularies, which fit industry standards and meet all required regulations. MHP offers two Commercial drug formularies:

- Standard Commercial Drug Formulary: Used by Large Groups with 50 or more employees.
- On/Off the Marketplace Drug Formulary: Used by Individuals and Small Groups with less than 50 employees.

Both MHP Commercial Drug Formularies include one or more medications in each therapeutic class covered under a member’s pharmacy benefit. The drug formularies can be found at McLarenHealthPlan.org or through the Epocrates system.

In addition to the full drug formularies, MHP has created Quick Formulary Guides for each commercial formulary. The Quick Guide is a list of commonly prescribed medications, which are covered under MHP. The Quick Guide is sorted by drug class and can be obtained in new member packets, on the website or by calling our Customer Service Department at (888) 327-0671.

Prescription Drug Rider

Coverage and applicable copayment amounts for medications are based on a member’s specific Drug Rider. The member must have a Drug Rider to have pharmacy benefit coverage. A copy of the member specific Drug Rider is included in each new member packet. Please contact our Customer Service Department at (888) 327-0671 for Drug Rider related questions.

Covered Benefits

- Federal legend drugs identified on a MHP Commercial Drug Formulary.
- Select over-the-counter (OTC) items, identified on the drug formulary, prescribed by a prescribing provider.
- Diabetic supplies limited to needles, syringes, lancets and Bayer® manufactured test strips.

Non-Covered Benefits

- Cosmetic medications or medications prescribed for cosmetic purposes.
- Medications used for investigational or unproven uses.
- Medical foods or agents that are not regulated by the Food and Drug Administration.
- OTC medications not listed on the drug formulary.
- Vaccines.

In addition, the drug benefit does not reimburse for drug products acquired for or administered in an inpatient hospital, outpatient hospital, emergency room or clinic, physician’s office or clinic.
Medication Copayment Tiers

Pharmacy copayments are determined per the member specific Drug Rider and by the placement of medications into copayment levels, also known as Tiers, on the drug formulary. The MHP Commercial formularies have the following tiers:

- Formulary Generic: Formulary preferred generic medications, lowest copay.
- Formulary Brand Name: Formulary preferred brand name medications, medium copay.
- Non-Preferred Brand Name or Generic: Brand name and generic medications which have been designated as non-preferred, highest copay.
- Preventive: Zero copay.
- Specialty.

Dispense as Written (DAW) and Generic Mandate Policy

There is automatic generic substitution required on all prescriptions covered by MHP.

If a prescribing provider requests a brand name when a generic version is available (DAW-1), reimbursement to the pharmacy will be at the established Maximum Allowable Cost (MAC) limits. The member will be charged the difference in price between the brand name product and the generic product, plus any applicable copay, unless a prior authorization request, see Forms section XVII, has been approved by the health plan.

If a member requests a brand name medication when a generic version is available, DAW-2 designated on the prescription, reimbursement will be at the established MAC limit. The member will be responsible for the difference in price between the brand name product and the generic product, plus any applicable copay.

If a pharmacy is out of stock of a generic medication and chooses to dispense the brand name product, reimbursement to the pharmacy will be at the MAC limit. The member has the option of obtaining the generic drug, covered in full, at another pharmacy within MHP’s pharmacy network.

Step Therapy (ST) Edits

Step Therapy Edits allow MHP to define a logical sequence of therapeutic alternatives. MHP provides coverage for medications indicated as “ST” (Step Therapy restricted) after a predetermined previous or concurrent drug therapy sequence has been met.

Prior Authorization/Drug Exception Request

MHP has placed a Prior Authorization (PA) restriction on certain medications within the drug formularies. PA means the medication requires special approval before it will be considered for coverage under MHP. A medication may require a prior authorization due to safety concerns or to ensure a more cost-effective formulary alternative cannot be used.

If a prescribing provider feels a medication which requires prior authorization is medically necessary,
then a prior authorization form, found in the Forms section XVII, should be completed by the prescribing provider and faxed to the number indicated on the form. Please contact MHP at (888) 327-0671, if they should have questions regarding the PA process or the status of a PA request.

Note: If the member is in need of an emergency supply of a medication that requires prior authorization, please contact our Customer Service Department at (888) 327-0671 for assistance.

**Compounded Medications**

All compounded medications require PA. Upon approval, the medication must be obtained via an in-network compounding pharmacy. Paper claims submitted by an out-of-network compounding pharmacy will not be accepted.

**Mail Order Pharmacy**

MHP has contracted mail order pharmacies. Our members can fill up to a 90-day supply of brand name medications through the mail order after a 30-day trial has been completed. Mail order brochures are available at McLarenHealthPlan.org or by calling our Customer Service Department. Note: Generic medications cannot be obtained via the mail order.

**Specialty Pharmacy Medications**

Medications on a drug formulary identified with a Specialty Pharmacy (SP) restriction, must be obtained via a MHP approved specialty pharmacy. The specialty pharmacy will mail the specialty pharmacy medication to the member’s home or to the prescribing provider’s office. All specialty pharmacy medications are limited to no more than a 30-day supply. Medications used to treat cancer, endometriosis, Hepatitis C, multiple sclerosis, osteoporosis and rheumatoid arthritis are some examples of specialty pharmacy required agents.

**Dose Optimization and Quantity Limits**

Quantity limits (QL) are used to ensure patient safety, increase patient compliance and decrease pharmacy costs. Medications with quantity limits are identified on a drug formulary with a QL restriction. The health plan may limit the quantity of a medication to:

- A specified quantity per day, month or year.
- A specified quantity per lifetime.
- A specified quantity across a drug class.

Note: If a prescribing provider feels a different quantity is medically necessary for a member, a request for PA (see Forms section XVII) should be submitted to the health plan for review.

**Drug Formulary Review and Modification**

A committee of health professionals (doctors, pharmacists and nurses) meets throughout the year and maintains the MHP Commercial Drug Formularies. The following changes have an impact on the Commercial Drug Formularies:
• Drug recalls.
• Marketplace withdrawals/product discontinuation.
• New generic availability.
• New medication releases.

Prescribing providers may ask for a modification to any drug formulary by contacting our Pharmacy Administration Department at (810) 244-1660 or by faxing in a written request to (810) 213-0290. Requests for formulary modification will be reviewed by our Pharmacy Administration Department and taken to the formulary committee for determination.

**Medicaid Pharmaceutical Management**

**Introduction**

Pharmaceutical Management promotes the use of the most clinically appropriate, safe and cost effective medications. MHP’s Medicaid Drug Formulary is based upon the Michigan Medicaid Common Drug Formulary (Common Formulary). The use of the Common Formulary is a requirement of all Medicaid health plans in the state of Michigan. One or more medications are available in all required drug classes. The drug formulary can be found at [McLarenHealthPlan.org](http://McLarenHealthPlan.org) or through the Epocrates system.

In addition to the drug formulary, MHP has a Quick Formulary Guide (Quick Guide). The Quick Guide is a list of commonly prescribed medications which are covered by MHP. The Quick Guide is sorted by drug class and can be found in new member packets, on the website or by calling our Customer Service Department at (888) 327-0671.

**Covered Benefits**

- Medications listed on the Common Formulary.
- Federal legend drugs identified on the MHP-Medicaid Drug Formulary.
- Select over-the-counter (OTC) items, identified on the Medicaid Pharmaceutical Product List (MPPL), prescribed by a prescribing provider.
- Diabetic supplies limited to needles, syringes, alcohol swabs, lancets and Bayer® manufactured test strips.

**Non-Covered Benefits**

- Medications that are not listed on the MPPL.
- Medications prescribed for cosmetic or convenience purposes.
- Experimental or unproven use of medications.
- Medications which are excluded from coverage under Michigan Medicaid, including but not limited to the following:
  - Diet aids
  - Cough and cold medications
  - Sexual enhancement or Erectile Dysfunction Medications
  - Medications used to promote fertility
• Medical foods or agents that are not regulated by the Food and Drug Administration

In addition, the drug benefit does not reimburse for drug products acquired for or administered in an inpatient hospital, an outpatient hospital emergency room or clinic, a physician’s office or clinic.

**Michigan Department of Health and Human Services (MDHHS) Carve Out Program**

MDHHS has created a list of medications that are not reimbursable under MHP. These medications are identified on the drug formulary as “Carved Out.” Any medication listed as Carved Out should be billed to straight FFS Medicaid. For questions regarding a medication identified as Carved Out, please contact the Magellan Medicaid Beneficiary Help Line at (877) 681-7540.

**Dispense as Written (DAW) and Generic Mandate Policy**

Automatic generic substitution is required on all prescriptions. If a generic form of a medication is available and a provider feels the brand name is medically necessary, the prior authorization process can be used (see Prior Authorization/Drug Exception Request section below).

**Prior Authorization/Drug Exception Request**

Certain medications are identified as having a prior authorization (PA) restriction. PA means special approval must be given by MHP before the medication will be covered through a pharmacy. A medication may require a PA due to safety concerns or to ensure a more cost effective formulary alternative can be used.

If a prescribing provider feels a medication which requires PA is medically necessary than the Prior Authorization form (see Forms section XVII), should be completed by the prescribing provider and faxed to the number indicated on the form. Please contact MHP at (888) 327-0671 if they have questions regarding the PA process or the status of a PA request.

Note: If the member is in need of an emergency supply of a medication that requires PA, please contact our Customer Service Department at (888) 327-0671 for assistance.

**Step Therapy Edits**

Step therapy (ST) edits allow MHP to define a sequence of medication alternatives. MHP provides coverage for medications indicated as ST required after a list of formulary alternatives have been tried and failed.

**Compounded Medications**

All compounded medications require prior authorization. Upon approval the medication must be obtained through an in-network compounding pharmacy and billed to MHP electronically. Paper claims submitted by an out-of-network compounding pharmacy will not be accepted.

**Specialty Pharmacy Medications**

Specialty Pharmacy (SP) medications are used to treat complex medical conditions and may require special storage and handling. Medications on the drug formulary identified with a Specialty Pharmacy (SP) restriction, upon prior authorization approval, must be obtained via an MHP approved specialty pharmacy.
The specialty pharmacy will mail the specialty pharmacy medication to the member’s home or to the prescribing provider’s office. Some examples of specialty pharmacy agents are medications used to treat cancer, endometriosis, Hepatitis C, multiple sclerosis, osteoporosis and rheumatoid arthritis.

**Dose Optimization and Quantity Limits**

Quantity limits are used to ensure patient safety, increase patient compliance and decrease pharmacy costs. Medications with quantity limits are identified on the drug formulary with a Quantity Limit (QL) restriction. MHP may limit the quantity of a medication to:

- A specified quantity per day, month or year.
- A specified quantity per lifetime.
- A specified quantity across a drug class.

Note: If a prescribing provider feels a different quantity is medically necessary for a patient, a request for prior authorization should be submitted to MHP for review.

**Drug Formulary Review and Modification**

A committee of health professionals (doctors and pharmacists) maintains the Common Drug Formulary. This committee meets a minimum of four times per year to review changes in the market which may effect the drug formulary. Changes in the market may include, but are not limited to:

- Drug recalls.
- Marketplace withdrawals or product discontinuation.
- New generic availability.
- New medication releases.

Prescribing providers may ask for a modification to the drug formulary by contacting our Pharmacy Administration Department at (810) 244-1660 or by faxing a written request to (810) 213-0290. Requests for formulary modification will be reviewed by our Pharmacy Administration Department and then taken to the formulary committee for determination.
XIV - Provider Administrative Appeals

It is the goal of MHP to resolve provider issues before reaching an appeal level. MHP encourages providers to first contact Customer Service when a dispute occurs. If, after informally attempting to resolve the dispute through a verbal contact or a Provider Claims Adjustment, a provider continues to disagree with an administrative action taken by MHP, a written formal appeal may be filed.

Appeals Process: Investigation and Result

A provider may appeal an administrative action by MHP by submitting the following:

- Within 90 calendar days of the administrative action by MHP, the provider must complete and submit a Provider Request for Appeal (PRA) form and attach a copy of the claim in paper form. For a PRA form, see Forms Section XVIII or visit our website at McLarenHealthPlan.org. These two items and any additional information should be sent to:
  
  ATT: Appeals
  McLaren Health Plan
  G-3245 Beecher Road
  Flint, MI 48532

- Supporting documentation must be included with the PRA form. This would include information not previously submitted regarding the reason and rational for the appeal.

- The paper claim must be attached to the PRA form (cannot submit EDI).

MHP staff will research the necessary contractual, benefit, claims, medical record information, and other pertinent clinical documentation to reassess the appropriateness of the initial decision and make a new determination.

Appeal Time Frames

PRA form must be received within 90 calendar days of the disputed action. Disputed actions dates are from the latter of the:

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

The right to appeal is forfeited if the provider does not submit a written request for an appeal within this 90 calendar day time frame, and any charges in dispute must be written off.

What Disputed Actions Can Be Appealed

Providers may appeal such administrative actions taken by MHP related to:

- Denial of inpatient days or other services;
- Denial of authorization;
- Place of service authorization (inpatient versus outpatient);
• Payment issues;
• Clinical claim edits; or
• Denial of a claim.

**Appeal Response Time Frame**

The provider will receive a decision in writing, which may be either a letter or a new EOP. The response should come within 60 (calendar) days of MHP’s receipt of the written appeal request.

MHP’s decision is final and binding for all products except Medicaid. The Claims Adjustment process is not available to a provider if the Appeal Process is used and the provider is not satisfied with the outcome.

**Appeal Process Reminders**

The provider 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.

A written request to MHP’s Appeals Department through completion of the PRA form and the attachment of a paper claim must be submitted to begin the appeal process.

A cover letter outlining the reason and rationale for the appealed request must accompany the PRA.

The written request should include any new information, such as:

• Documentation from the medical record.
• An explanation of payment.
• Other applicable documentation supporting the request for appeal.

**Appeals Process for Adverse Compliance Audit Findings**

As part of the MHP Compliance Program, routine auditing and monitoring as well as data mining activities are performed. Providers are notified that they are part of one of these activities at the conclusion of the audit and if there are any findings that result in billing education, corrective action or recoupment of claims payments.

Within 30 calendar days of the date written on the audit results notice, the provider must complete and submit an appeal with supporting documentation. The provider must attach a copy of the audit results notice letter.

The right to appeal is forfeited if the provider does not submit a written request for an appeal within 30-day time frame and payment for amounts owed to MHP are due immediately upon expiration of the 30-day time period. Notwithstanding the foregoing, MHP may, in its sole discretion, offset against future claims.

McLaren staff that did not participate in the audit or are not subordinates of those that conducted the audit will review the documentation submitted by the provider. MHP will make a decision on the appeal within 30 calendar days of its receipt of the appeal. MHP will provide a written decision to the provider. If MHP upholds the decision (in full or in part), the provider must remit payment of the amounts owed to
MHP immediately, but in no case later than 30 calendar days of the date of the letter. In cases of fraud, waste or abuse, MHP may offset claims immediately. For all other cases, if payment is not received within 30 days of the date on the letter, MHP will offset against future claims.

**Medicaid Appeals**

Non-contracted hospitals providing services to MHP members through the MDHHS Hospital Access Agreement are eligible to request a Rapid Dispute Resolution Process in compliance with the Medicaid Provider Manual, after the hospital has first exhausted its efforts to achieve a resolution through MHP’s Administrative Appeals Process.

Non-contracted hospitals that have not signed a Hospital Access Agreement, or non-contracted, non-hospital providers do not have access to the Rapid Dispute Resolution Process. These providers serving MHP Medicaid members are entitled to initiate a binding arbitration process, after the provider has first exhausted their efforts to achieve a resolution through MHP’s Administrative Appeals Process. To initiate binding arbitration, call MHP to obtain a list of arbitrators. Arbitrators are selected by the MDHHS. The decision of the arbitrator is final. If the arbitrator does not reverse the decision, the provider is responsible for the arbitrator’s charges.

Providers, who are appealing a professional clinical care review, or a Credentialing or Recredentialing action taken by MHP’s Quality Improvement Committee, must pursue a different type of appeal, which is governed by separate policies. Call Customer Service for more information at (888) 327-0671. Providers can access the PRA form in Section XVIII in this manual or go to McLarenHealthPlan.org.

**McLaren Advantage (HMO) Medicare Appeals**

*Note: Appeals procedures are distinctly different for Medicaid and Medicare members. This section outlines the process for McLaren Advantage (HMO) Medicare appeals only.*

**Level 1 Appeal – Reconsideration**

A member starts the appeal process by making an appeal. It is called the first level of appeal of a Level 1 Appeal.

The member contacts McLaren Advantage (HMO) and makes the appeal. If their health requires a quick response, they must ask for a fast appeal. To start an appeal, the member, their representative or in some cases their provider must contact McLaren Advantage (HMO). Appeal requests must be within 60 (calendar) days from the date on the written notice sent concerning a coverage decision. If the member wishes, their provider may give additional information to support the appeal.

A standard appeal must be in writing and completed within 30 calendar days after being received by McLaren Advantage (HMO).

A fast appeal is also called an expedited appeal. An expedited appeal can be a verbal or written request and must be completed within 72 hours after being received by McLaren Advantage (HMO).
Level 2: Independent Review Entity – IRE

If McLaren Advantage (HMO) says no to the Level 1 Appeal, the case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision made during the first appeal. This organization decides whether the decision made should be changed.

The Independent Review Organization is an outside independent organization that is hired by Medicare. This organization is not connected with McLaren Advantage (HMO) and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work. McLaren Advantage (HMO) will send information about the appeal to this organization. This information is called the “case file.” The member has the right to ask for a copy of the case file. The member has a right to give the Independent Review Organization additional information to support their appeal. Reviewers at the Independent Review Organization will take a careful look at all of the information related to the appeal. If there is a “fast” appeal at Level 1, there will also be a “fast” appeal at Level 2.

Level 3: Administrative Law Judge - ALJ

The notice received from the Independent Review Organization will tell the member in writing if the case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage being requested must meet a certain minimum. If the dollar value of the coverage being requested is too low, the member cannot make another appeal, which means that the decision at Level 2 is final.

Level 4: The Medicare Appeals Council

The Medicare Appeals Council will review the member’s appeal and give the member an answer. The Medicare Appeals Council works for the federal government.

If the member’s Level 4 appeal is approved, or if the Medicare Appeals Council denies McLaren Advantage’s (HMO) request to review a favorable Level 3 appeal decision, the appeals process may or may not be over. McLaren Advantage (HMO) has the right to appeal a Level 4 decision that is favorable to the member. If McLaren Advantage (HMO) decides not to appeal the decision, McLaren Advantage (HMO) must authorize or provide the member with the service within 60 days after receiving the Medicare Appeals Council’s decision. If McLaren Advantage (HMO) decides to appeal the decision, McLaren Advantage will let the member know in writing.

If the member’s Level 4 appeal is denied or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over. If the member decides to accept this decision, the appeals process is over. If the member does not want to accept the decision, the member might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to the member’s appeal, the notice the member receives will tell the member whether the rules allow the member to go on to a Level 5 appeal. If the rules allow the member to go on, the written notice will also tell the member who to contact and what to do next if the member chooses to continue with the next level of review.
Level 5: A Judge at the Federal District Court

A judge at the Federal District Court will review the member’s appeal if permitted based on the Level 4 response. This is the last stage of the appeals process.
XV - Fraud, Waste and Abuse

Health care fraud and abuse is both a state and federal offense. The HIPAA Act of 1996 indicates a dishonest provider or member is subject to fines or imprisonment of not more than ten years, or both.

MHP asks that providers and members partner with us to identify and eliminate fraud, waste and abuse.

**Fraud** is intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal and state law (42 CFR § 455.2).

**Waste** is the overuse of services or other practices that directly or indirectly, result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.

**Abuse** is provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or commercial health care program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR § 455.2), or commercial health care program.

Examples of fraud, waste and abuse include, but are not limited to:

- Billing more than once for the same service
- Billing for services never performed or provided
- Performing inappropriate or unnecessary services
- Providing lower cost or used equipment and billing for higher cost or new equipment
- Using someone else’s identity
- Altering or falsifying pharmacy prescriptions

**Reporting Commercial Fraud, Waste and Abuse**

To report Fraud, Waste and Abuse, please contact MHP at (866) 866-2135. This can be done anonymously. Additionally, a Fraud, Waste and Abuse claim can be made in writing to:

ATT: Compliance Officer  
McLaren Health Plan  
G-3245 Beecher Road  
Flint, MI 48532  
MHPcompliance@mclaren.org

**Reporting Medicaid Fraud, Waste and Abuse**

To report Fraud, Waste and Abuse via phone, please contact the Medicaid Fraud Hotline at (855) MI-FRAUD (643-7283) or MHP at (866) 866-2135. Reports can be made online at [http://michigan.gov/fraud](http://michigan.gov/fraud). This can be done anonymously. Additionally, a fraud, waste and abuse claim can be made in writing to:
Reporting Medicare Fraud, Waste and Abuse

Via phone: 1-800-HHS-TIPS (447-8477)
Online: http://oig.hhs.gov/report-fraud
Fax: 1-800-223-8164
TTY: 1-800-377-4950

Mail:
ATT: Hotline
Office of Inspector General
U.S. Department of Health and Human Services
P.O. Box 23489
Washington, D.C. 20026

A Roadmap to Avoid Medicare and Medicaid Fraud, Waste and Abuse

The Office of Inspector General (OIG) has created free materials for providers to assist them in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse. This brochure can be found on the Office of Inspector General’s website at: http://oig.hhs.gov/compliance/physician-education/index.asp

False Claims Act

The Deficit Reduction Act of 2005 requires information about both the federal False Claims Act and other laws including state laws dealing with fraud, waste and abuse and whistleblower protection for reporting those issues.

Federal law prohibits an employer from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. To report a possible violation, please inform your employees that they can contact MHP at:

Compliance Hotline – (866) 866-2135
Compliance Officer – (888) 327-0671
By mail:
McLaren Health Plan
G-3245 Beecher Rd.
Flint, Michigan  48532

**For Medicaid Only**

Office of Inspector General – (855) MI-FRAUD (643-7283)

By mail:
Office of Inspector General
P.O. Box 30062
Lansing, Michigan  48909
XVI - Member Rights and Responsibilities

MHP Members have:

- The right to confidentiality and privacy.
- 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 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 routine OB-GYN and pediatric services without a referral, if the OB-GYN or pediatric specialist is a participating provider.
- The right to choose a participating pediatrician as the PCP for a minor member.
- The right to receive Federally Qualified Health Clinic (FQHC) Services.
- 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 to receive a copy of their medical record upon request.
- The right to know how MHP pays its providers.
- 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, about care provided or 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 information about MHP, including the services, providers of care and member rights and duties.
- The right to make suggestions regarding MHP member’s rights and duties.
- The right to have their medical record kept confidential by MHP and their PCP.
- The right to be free from other discrimination prohibited by state and federal regulations.

Members of MHP 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/her providers and MHP so they can care for the member in the best way.
• To ask questions if the member does not understand the care he/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 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.

McLaren Advantage Member Rights and Responsibilities

McLaren Advantage Medicare members’ rights and responsibilities as stated in the Evidence of Coverage are:

“The MHP plan must honor members rights as a member of the Plan”

We must provide information in a way that works for the member (in languages other than English that are spoken in the Plan service area, in Braille, in large print or other alternate formats, etc.)

To get information from MHP in a way that works for the member, please call Customer Service. MHP has people and translation services available to answer questions from non-English speaking members. We can also give information in Braille, in large print or other alternate formats if needed.

If a member is eligible for Medicare because of a disability, MHP is required to give information about the Plan’s benefits that is accessible and appropriate. If there is any trouble getting information from MHP because of problems related to language or disability, call Medicare at 1-800-MEDICARE ((800) 633-4227), 24 hours a day, seven days a week to file a complaint. TTY users call (877) 486-2048.

“MHP must treat members with fairness and respect at all times”

MHP must obey laws that protect members from discrimination or unfair treatment. MHP does not discriminate based on a person’s race, disability, religion, sex, health, ethnicity, creed (beliefs), age or national origin.

For more information, concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights at (800) 368-1019 (TTY: (800) 537-7697) or the local Office for Civil Rights. If the member has a disability and needs help with access to care, they can call Customer Service. If a member has a complaint, such as a problem with wheelchair access, Customer Service can help.
MHP must ensure timely access to members covered services and drugs”

Members have the right to choose a PCP in the Plan’s network to provide and arrange for members covered services. Call Customer Service to learn which doctors are accepting new members. Members also have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members, they have the right to get appointments and covered services from the Plan’s network of providers within a reasonable amount of time. This includes the right to get timely services from specialists. Members have the right to get their prescriptions filled or refilled at any of our network pharmacies without long delays. If they think that they are not getting medical care or Part D drugs within a reasonable amount of time, please refer to the Evidence of Coverage.

“MHP must protect the privacy of personal health information”

Federal and state laws protect the privacy of medical records and personal health information. MHP protects personal health information as required by these laws:

- “Personal health information” includes the personal information members gave MHP when they enrolled in the plan, as well as medical records and other medical and health information.
- The laws that protect privacy give members rights related to getting information and controlling how their health information is used.
- MHP will give they a written notice, called a “Notice of Privacy Practice” that tells about these rights and explains how we protect the privacy of health information.

“How does MHP protect the privacy of health information?”

- We make sure that unauthorized people don’t see or change member records.
- In most situations, if MHP gives health information to anyone, MHP is required to get written permission from they first. Written permission can be given by the member or by someone they have given legal power to make decisions for them.
- There are certain exceptions that do not require us to get written permission first. These exceptions are allowed or required by law:
  - For example, MHP is required to release health information to government agencies that are checking on quality of care.
  - MHP is required to give Medicare health information including information about Part D prescription drugs. If Medicare releases information for research or other uses, this will be done according to federal statutes and regulations.

“Members see the information in their records and know how it has been shared with others.”

- Members have the right to look at their medical records held at the Plan, and to get a copy of their records. We are allowed to charge a fee for making copies. Members also have the right to ask MHP to make additions or corrections to their medical records. If asked to do this, we will consider the request and decide whether the changes should be made.
- Members have the right to know how their health information has been shared with others for any purposes that are not routine.
- If a member has questions or concerns about the privacy of their personal health information, they can call Customer Service.
“MHP must give members information about the Plan, its network of providers and covered services”

Members have the right to get several kinds of information from MHP. This includes getting the information in languages other than English, in large print or other alternate formats. If a member wants any of the following kinds of information, they can call Customer Service:

- **Information about our Plan.** This includes, for example, information about the Plan’s financial condition. It also includes information about the number of appeals made by members and the Plan’s performance ratings, including how it has been rated by members and how it compares to other Medicare Advantage Health Plans.

- **Information about network providers, including network pharmacies.**
  - For example, members have the right to get information from MHP about the qualifications of the providers and pharmacies in network and how MHP pays the providers in network.
  - For a list of the providers in the Plan’s network, see the Provider Directory.
  - For a list of the pharmacies in the Plan’s network, see the Pharmacy Directory.
  - For more detailed information about providers or pharmacies, contact Customer Service or visit McLarenAdvantage.org

- **Information about coverage and rules members must follow in using their coverage:**
  - The Evidence of Coverage explains what medical services are covered, any restrictions to coverage, and what rules must be followed to get covered medical services.
  - To get the details on Part D prescription drug coverage, see the Evidence of Coverage plus the plan’s List of Covered Drugs (Formulary).
  - These documents tell what drugs are covered, explain the rules that must be followed and the restrictions to coverage for certain drugs.
  - Any questions about the rules or restrictions, contact Customer Service.

- **Information about why something is not covered and what can be done.**
  - If a medical service or Part D drug is not covered, or if coverage is restricted in some way, members can ask MHP for a written explanation. Members have the right to this explanation even if they received the medical service or drug from an out-of-network provider or pharmacy.
  - If a member disagrees with a decision MHP makes about what medical care or Part D drug is covered, they have the right to ask MHP to change the decision. For details on what to do if something is not covered in the way a member thinks it should be covered, see the Evidence of Coverage. It gives details about how to ask the Plan for a decision about coverage and how to make an appeal if they want MHP to change the decision. (The Evidence of Coverage also tells about how to make a complaint about quality of care, waiting times and other concerns.)
  - If a member wants to ask our Plan to pay our share of a bill they received for medical care or a Part D prescription drug, see the Evidence of Coverage.
“MHP must support a members right to make decisions about their care”

Members have the right to know their treatment options and participate in decisions about their health care. Members have the right to get full information from their doctors and other health care providers when they go for medical care. Providers must explain a members medical condition and their treatment choices in a way they can understand.

Members also have the right to participate fully in decisions about their health care. To help members make decisions with their doctors about what treatment is best; their rights include the following:

- **To know about all choices.** This means that they have the right to be told about all of the treatment options that are recommended for their condition, no matter the cost or whether they are covered by MHP. It also includes being told about programs our Plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** They have the right to be told about any risks involved in their care. They must be told in advance if any proposed medical care or treatment is part of a research experiment. They always have the choice to refuse any experimental treatments.

- **The right to say “no.”** They have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if the doctor advises them not to leave. They also have the right to stop taking their medication. Of course, if they refuse treatment or stop taking medication, they accept full responsibility for what happens to their body as a result.

- **To receive an explanation if denied coverage for care.** Members have the right to receive an explanation from MHP if a provider has denied care that they believe they should receive. To receive this explanation, members will need to ask MHP for a coverage decision. The Evidence of Coverage tells how to ask the Plan for a coverage decision. Members have the right to give instructions about what is to be done if they are not able to make medical decisions for themselves. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness.

Members have the right to say what they want to happen if they are in this situation. This means they can:

- Fill out a written form to give someone the legal authority to make medical decisions for them if they ever become unable to make decisions for themselves.

- Give doctors written instructions about how they want them to handle medical care if a member become unable to make decisions for themselves.

The legal documents that can be used to give directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If a member wants to use an “advance directive” to give instructions, here is what to do:

- **Get the form.** If a member wants to have an advance directive, they can get a form from a lawyer, a social worker or an office supply stores. Members can sometimes get advance directive forms from organizations that give people information about Medicare.

- **Fill it out and sign it.** Regardless of where a member obtains this form, keep in mind that it is a legal document. Members should consider having a lawyer to help prepare it.
• **Give copies to appropriate people.** Members should give a copy of the form to their doctor and to the person named on the form as the one to make decisions for the member. The member may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If a member knows ahead of time they are going to be hospitalized, and have signed an advance directive, they should take a copy with them to the hospital:

• If a member is admitted to the hospital, they will ask whether the member has signed an advance directive form and whether they have it with them.

• If they have not signed an advance directive form, the hospital has forms available and will ask if they want to sign one.

Remember, it is their choice whether they want to fill out an advance directive (including whether they want to sign one if they are in the hospital). According to law, no one can deny them care or discriminate against them based on whether or not they have signed an advance directive.

“**What if the instructions are not followed?**”

If a member has signed an advance directive, and they believe that a doctor or hospital hasn’t followed the instructions in it, they may file a complaint with the Michigan Bureau of Health Professions.

“**Members have the right to make complaints and to ask MHP to reconsider decisions we have made**”

If a member has any problems or concerns about their covered services or care, the Evidence of Coverage tells what they can do. It gives the details about how to deal with all types of problems and complaints.

As explained in the Evidence of Coverage, what they need to do to follow up on a problem or concern depends on the situation. They might need to ask our Plan to make a coverage decision for them, make an appeal to us to change a coverage decision, or make a complaint. Whatever they do — ask for a coverage decision, make an appeal or make a complaint — MHP is required to treat them fairly.

They have the right to get a summary of information about the appeals and complaints that other members have filed against our Plan in the past. To get this information, please call Member Services.

“**What can they do if they think they are being treated unfairly or their rights are not being respected?**”

If it is about discrimination, call the Office for Civil Rights. If they think they have been treated unfairly or their rights have not been respected due to their race, disability, religion, sex, health, ethnicity, creed (beliefs), age or national origin, they should call the Department of Health and Human Services’ (DHHS) Office for Civil Rights at (800) 368-1019 or TTY (800) 537-7697 or call their local Office for Civil Rights.

“**Is it about something else?**”

If they think they have been treated unfairly or their rights have not been respected, and it’s not about discrimination, they can get help dealing with the problem they are having:
• They can call Customer Service.
• They can call the State Health Insurance Assistance Program.

For details about this organization and how to contact it, go to the Evidence of Coverage.

“How to get more information about their rights”

There are several places where they can get more information about their rights:

• They can call Customer Service.
• They can call the State Health Insurance Assistance Program.
• They can contact Medicare.
  • They can visit the Medicare website (www.medicare.gov) to read or download the publication “Their Medicare Rights & Protections.”
  • Or, they can call 1-800-MEDICARE ((800) 633-4227), 24 hours a day, seven days a week. TTY users should call (877) 486-2048.

“They have some responsibilities as a member of the Plan”

What are their responsibilities?

Things they need to do as a Member of the plan are listed below. If they have any questions, please call Customer Service. We’re here to help.

• Get familiar with their covered services and the rules they must follow to get these covered services. Use the Evidence of Coverage booklet to learn what is covered for them and the rules they need to follow to get their covered services.
  • The Evidence of Coverage gives the details about their medical services, including what is covered, what is not covered, rules to follow and what they pay.
  • The Evidence of Coverage gives the details about their coverage for Part D prescription drugs.
  • If they have any other health insurance coverage or prescription drug coverage in addition to our Plan, they are required to tell us. Please call Customer Service to let us know.
  • We are required to follow rules set by Medicare to make sure that they are using all of their coverage in combination when they get their covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits they get from our plan with any other health and drug benefits available to them. We’ll help them with it.

• Tell their doctor and other health care providers that they are enrolled in our plan. Show their plan membership card and Medicaid card whenever they get medical care or Part D prescription drugs.
• Help their doctors and other providers help them by giving them information, asking questions and following through on their care.
• To help their doctors and other health providers give them the best care, learn as much as they are able to about their health problems and give them the information they need about the members health. Follow the treatment plans and instructions that they and their doctors agree upon.

• If they have any questions, be sure to ask. Their doctors and other health care providers are supposed to explain things in a way they can understand. If they ask a question and they don’t understand the answer they are given, ask again.

• Be considerate. We expect all our members to respect the rights of other patients. We also expect they to act in a way that helps the smooth running of their doctor’s office, hospitals and other offices.

• Pay what they owe. As a plan Member, they are responsible for these payments:
  - In order to be eligible for our Plan, they must maintain their eligibility for Medicare Part A and Part B. For that reason, some Plan members must pay a premium for Medicare Part A, and most plan members must pay a premium for Medicare Part B to remain a Member of the Plan.
  - For some of their medical services or drugs covered by the Plan, they must pay their share of the cost when they get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The Evidence of Coverage tells what they must pay for their medical services. The Evidence of Coverage tells what they must pay for their Part D prescription drugs.
  - If they get any medical services or drugs that are not covered by our Plan or by other insurance they may have, they must pay the full cost.

• Tell us if they move. If they are going to move, it’s important to tell us right away by calling Customer Service.
  - **If they move outside of our Plan service area, they cannot remain a Member of our Plan.** We can help they figure out whether they are moving outside our service area. If they are leaving our service area, we can let them know if we have a Plan in their new area.
  - **If they move within our service area, we still need to know** so we can keep their membership record up-to-date and know how to contact they.

• Call Customer Service for help if they have questions or concerns. We also welcome any suggestions they may have for improving our Plan.
  - Phone numbers and calling hours for Customer Service are on the front page of the Evidence of Coverage.
  - For more information on how to reach us, including our mailing address, please see the Evidence of Coverage.
XVII - HIPAA Notice of Privacy Practices

Members are notified of privacy practices as required by HIPAA. This notice includes a description of how and when medical information about members is used or disclosed and how members can access it. We take measures across our organization internally to protect oral, written and electronic personal health information of members.

Please remember that disclosures of a patient’s personal health information are permitted for treatment, payment or health care operations in compliance with the regulation 45 CFR 164. For example, health care providers may disclose patient information to us for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others. Thank they for your assistance in providing requested information to us in a timely manner.
FORMS SECTION
XVIII
## XVIII - FORMS SECTION

### McLaren Health Plan
Member Eligibility List for 2017
Commercial

**SMITH (1234567)**

<table>
<thead>
<tr>
<th>Commercial ID</th>
<th>Dependent</th>
<th>Member Name</th>
<th>Sex</th>
<th>DOB</th>
<th>Age</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>1234567</td>
<td>3</td>
<td>DOE, JANE</td>
<td>F</td>
<td>2/3/2004</td>
<td>11</td>
<td>3/1/2017</td>
</tr>
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<td>7654321</td>
<td>0</td>
<td>JONES, BOB</td>
<td>M</td>
<td>6/1/1950</td>
<td>64</td>
<td>3/1/2017</td>
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### McLaren Health Plan
Member Eligibility List for 2017
Medicaid

**SMITH (1234567)**

<table>
<thead>
<tr>
<th>Medicaid ID</th>
<th>Member Name</th>
<th>Sex</th>
<th>DOB</th>
<th>Age</th>
<th>Effective Date</th>
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<tr>
<td>912345678</td>
<td>PATIENT, IMA</td>
<td>F</td>
<td>5/6/1978</td>
<td>36</td>
<td>3/1/2017</td>
</tr>
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</table>
CMS 1500 Claim Form

The following section is intended for paper claim submitters only. Providers billing electronic
claims must refer to the ANSI 837 electronic claims file guide for proper field requirements.
To become an electronic submitter, contact ENS Optum Insight, our preferred vendor for

<table>
<thead>
<tr>
<th>Field Location CMS 1500</th>
<th>Field Name</th>
<th>Field Description</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MEDICARE</td>
<td>MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER</td>
<td>Place an “X” in the appropriate box for the type of health insurance applicable to this claim. If the “other” box contains an “X”, complete field 1a with the primary coverage identification number. If secondary coverage, refer to field 9. Mark only one box.</td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s I.D. number</td>
<td>Enter insured’s ID number as shown on insured’s ID card for the payer to whom the claim is being submitted. For Medicaid – 9-digit numeric ID number (NOT SSN) For Commercial – 7-digit numeric ID number (NOT SSN)</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s name</td>
<td>Enter the patient’s last name, first name and middle initial as it appears on the ID card.</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s birth date Sex</td>
<td>Enter the patient’s eight-digit date of birth in (MM</td>
<td>DD</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s name</td>
<td>Enter insured’s last name, first name and middle initial.</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s address</td>
<td>Enter the patient’s address, city, state, zip code and phone number. If the patient’s phone number is unknown leave blank. Do not use punctuation. Use two-digit state code and, if available, nine-digit zip code.</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Patient relationship to insured</td>
<td>Place an “X” in the box for “self” if the patient is the insured, “spouse” if the patient is the insured’s husband or wife. If none of the above applies, place an “X” to indicate “child” or “other” as applicable. Mark only one box.</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s address</td>
<td>Enter the insured’s address, city, state, zip code and phone number. Do not use punctuation. If insured’s address or telephone number is unknown, leave blank. Use two-digit state code and, if available, nine-digit zip code.</td>
<td>Yes, if known</td>
</tr>
<tr>
<td>8</td>
<td>Patient status</td>
<td>Place an “X” in the appropriate boxes. If the patient is a full-time student, complete field 11b if the information is available.</td>
<td>Yes, if applicable</td>
</tr>
<tr>
<td>9</td>
<td>Other insured’s name</td>
<td>When additional group health coverage exists, enter other insured’s last name, first name and middle initial.</td>
<td>Yes, if applicable</td>
</tr>
<tr>
<td>9a</td>
<td>Other insured’s policy or group number</td>
<td>Enter the policy or group number of the other insured as indicated.</td>
<td>Yes, if applicable</td>
</tr>
<tr>
<td>9b</td>
<td>Other insured’s date of birth Sex</td>
<td>Enter the other insured’s eight-digit date of birth in (MM</td>
<td>DD</td>
</tr>
<tr>
<td>9c</td>
<td>Employer’s name or school name</td>
<td>Enter the name of the other insured’s employer or school.</td>
<td>Yes, if applicable</td>
</tr>
</tbody>
</table>
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the patient has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If there is no complete patient's signature authorized to use the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain Affiliations with the United States Services. Information on the patient's sponsor should be provided in those items captioned in "Insured," i.e., Items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form are medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by the Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his employee; 2) they must be an integral, although incidental part of a covered physician's service; 3) they must be of kinds commonly furnished in physician's offices; and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that (1) any employee who rendered services is not an active duty member of the United Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5508). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No benefits under Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may on conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS, and OWCP to ask for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424(a) (8), and 44 Part 9101 et seq and 10 USC 1079 and 1086, 5 USC 8101 et seq, and 30 USC 901 et seq, 36 USC 913, 13 C.F.R. 907.

The information we obtain from claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used at a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.


FOR CHAMPUS CLAIMS: PRINCIPAL PURPOSES: To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USES: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and Congressional Offices in response to a request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjustment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services to the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0933-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, NY 24-28, 6330 Security Boulevard, Baltimore, Maryland 21204-1830.

McLarenHealthPlan.org
(888) 327-0671
## UB-04 Data Field Requirements

<table>
<thead>
<tr>
<th>Field Location</th>
<th>Description</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name and Address</td>
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<td>Pay-To Name and Address</td>
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<td>31-34</td>
<td>Occurrence Code and Dates</td>
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<td>35-36</td>
<td>Occurrence Span Codes and Dates</td>
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<td>Value Codes and Amounts</td>
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<td>Total Charges (By Rev. Code)</td>
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<td>Non-Covered Charges</td>
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<td>Assignment of Benefit Certification</td>
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<td>Prior Payments</td>
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<td>Outpatient</td>
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<td>58</td>
<td>Insured's Name</td>
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<td><strong>For Medicaid – 9-digit ID (NOT SSN)</strong></td>
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<td>Insured Group Number</td>
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<td>Treatment Authorization Codes as assigned by payer</td>
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<td>Remarks</td>
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<td>*B3</td>
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</table>
Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured/beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.

5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.

6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary Information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.

9. For TRICARE Purposes:

(a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

(b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

(c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;

(d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;

(e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts;

(f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

(g) Based on 42 United States Code 1395ccc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and

(h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.
### MOST COMMONLY USED INELIGIBLE CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Loss prior to effective date of coverage</td>
<td>PTP</td>
<td>PT covered only when billed by PT for continuous PT</td>
</tr>
<tr>
<td>002</td>
<td>Loss after termination date of coverage</td>
<td>RPC</td>
<td>Report CPT or CCPCS when billing this revenue code</td>
</tr>
<tr>
<td>01</td>
<td>Covered by other insurance (see COB)</td>
<td>TKB</td>
<td>Payment reduced due to previous payment</td>
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<tr>
<td>02</td>
<td>Service is not reimbursable</td>
<td>UER</td>
<td>Additional documentation required</td>
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<td>05</td>
<td>Maximum benefit reached</td>
<td>WH</td>
<td>Withhold on provider</td>
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<td>10</td>
<td>Duplicate charges previously considered</td>
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<td>11</td>
<td>Adjustment of previously processed claim</td>
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<td>Services paid under fee schedule or other prospectively determined rate</td>
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<td>34</td>
<td>Claim not submitted timely basis</td>
<td>AA</td>
<td>Ambulance fee schedule item</td>
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<td>ADX</td>
<td>Invalid admitting diagnosis</td>
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<td>DMEPOS fee schedule item</td>
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<td>ANT</td>
<td>Resubmit total anesthesia time units in minutes</td>
<td>AL</td>
<td>Clinical laboratory fee schedule item</td>
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<td>ASC</td>
<td>Procedure typically performed as an outpatient</td>
<td>AM</td>
<td>National fee schedule item</td>
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<td>AST</td>
<td>Assistant surgeons reimbursed at 16% MHP allowable</td>
<td>AR</td>
<td>Physician fee schedule item</td>
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<td>ATH</td>
<td>Authorization required</td>
<td>AX</td>
<td>Other fee schedule item</td>
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<td>BEN</td>
<td>Procedure/service is not a covered benefit</td>
<td>B</td>
<td>Service not allowed under OPPS on hospital outpatient claim</td>
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<td>CAP</td>
<td>Services are capitated</td>
<td>C</td>
<td>Inpatient serve, not paid under OPPS</td>
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<td>CLB</td>
<td>Lab services capitated through Joint Venture Hospital Laboratories (JVHL)</td>
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<td>Non-covered service, not paid under OPPS</td>
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<td>Procedure code does not exist or invalid</td>
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<td>Corneal, CRNA and Hepatitis B</td>
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<td>ICD</td>
<td>ICD-9 diagnostic code does not exist or invalid</td>
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<td>Drug/biological pass-through</td>
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<td>IDX</td>
<td>Incomplete diagnostic code 4th &amp; 5th digit required</td>
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<tr>
<td>IWH</td>
<td>IPHN withhold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDF</td>
<td>Correct modifier missing or invalid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCB</td>
<td>Procedure not a covered benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSR</td>
<td>Procedure not separately reimbursable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT</td>
<td>Provider terminated from plan prior to/after date of service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POS</td>
<td>Procedure not typically performed in the POS noted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPC</td>
<td>Payment reduced to previously processed claim</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OPPS PAYMENT STATUS CODES

- **A**: Services paid under fee schedule or other prospectively determined rate
- **AA**: Ambulance fee schedule item
- **AD**: DMEPOS fee schedule item
- **AL**: Clinical laboratory fee schedule item
- **AM**: National fee schedule item
- **AR**: Physician fee schedule item
- **AX**: Other fee schedule item
- **B**: Service not allowed under OPPS on hospital outpatient claim
- **C**: Inpatient serve, not paid under OPPS
- **E**: Non-covered service, not paid under OPPS
- **F**: Corneal, CRNA and Hepatitis B
- **G**: Drug/biological pass-through
EDI CLAIM FILE INSTRUCTIONS

MHP utilizes ENS Optum Insight as its preferred vendor for EDI claims submissions. To become a customer of ENS Optum Insight, or if they are already a customer and are having difficulty submitting claims electronically, please contact the ENS Optum Insight’s Payer Services team at inform@optum.com. ENS Optum Insight has affiliations with various clearinghouses and uses them as “channel partners” to submit claims. Some of those clearinghouses include:

<table>
<thead>
<tr>
<th>Relay Health (McKesson)</th>
<th>Gateway EDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>MedAvant</td>
<td>Payerpath / MYSIS</td>
</tr>
<tr>
<td>ClaimLynx</td>
<td>PerSe</td>
</tr>
<tr>
<td>Claim Logic</td>
<td>SSI Group</td>
</tr>
<tr>
<td>CPSI</td>
<td>ZirMed</td>
</tr>
</tbody>
</table>

If they are using one of ENS Optum Insight’s channel partners, their claims will be received by MHP.

MHP accepts the standard ANSI 837 professional and institutional file formats for claims billed electronically. In addition to the ANSI 837 data requirements, below are some key points to consider when submitting claims electronically to ensure the quickest and most accurate results:

**Individual Providers**
- Enter each part of name in separate fields
- Use format: LASTNAME FIRSTNAME MIDDLE INITIAL (not required) TITLE (not recommended)
- No punctuation (example: EDI with NPI: NM1*85*1* SMITH*JOHN*A***XX*12345)
- If their software does not allow name separation, contact Network Development at (888) 327-0671 to discuss options

**Companies/Groups** – Enter as much of full name as possible in last name field
- Use format: GROUPNAME
- No punctuation (see example above)

**Billing Provider Street Address (ALL Providers)**
- 999 S ANYWHERE ST (PO Box not accepted)
- No punctuation (such as periods or commas)
- No additional address information required or processed for street

**Billing Provider City, State, Zip**
- Full city name as space allows and standard USPS 2-digit state abbreviation
- IMPORTANT: use 9-digit Zip Code
- Each in a separate field

**Member Group Number**: must be filled in. Can be a default of 999999

**MEMBER – IL**: (same for QC dependent as applicable)
- **Member Name**: Enter each part of name in separate fields
- Use format: LASTNAME FIRSTNAME MIDDLEINITIAL
- Note: incorrect spelling of name can cause rejection

**Member Identification #**:
- Medicaid - Member Identification # - MI – All must be exactly 9 digits or will be REJECTED
- Commercial - Member Identification # - MI – All must be exactly 7 digits or will be REJECTED

**Address**: Member Street, City, State, Zip (same format as billing provider)

**Member Date of Birth** (and any other date)
- CCYYMMDD – no punctuation (example: 20030114)

**Claims Detail**
- Units value cannot be 0

**Alternate Providers Info**
- Individual Providers – enter each part of name in separate fields
- Format: LASTNAME FIRSTNAME MIDDLEINITIAL (not required) TITLE (not recommended)
- No punctuation
- Alternate Provider Street Address – where applicable

For assistance in submitting an electronic claim file, please contact ENS Optum Insight at http://enshealth.com or their current clearinghouse. For claims status, visit FACTSWeb, Provider Portal or call Customer Service at (888) 327-0671.
FACTS Web Application Request Form

Your Privacy is Important. McLaren Health Plan has a strict Privacy Policy, we will not share your account information with others.

All fields must be completed

<table>
<thead>
<tr>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Manager/Authorized Contact:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Tax Id:</td>
</tr>
</tbody>
</table>

| Type of Access Requested: | □ Eligibility Inquiry | □ Claim Status and Eligibility Inquiry* |
|---------------------------|-----------------------|
| User Name:                |
| Position/Title:           |
| Address                   |
| City, State Zip           |
| Phone Number:             |
| E-mail                    |

*Only 1 person per Tax ID will have ability to request access for claims status inquiry

I hereby state that the information provide on this application is correct and pertains to my practice/facility only.

On behalf of the requesting provider/facility, signer agrees to:

2. To use data obtained only in the manner specified by McLaren Health Plan/McLaren Health Advantage.
3. To assure information obtained shall be kept confidential and only used for purposes related to transactions of McLaren Health Plan/McLaren Health Advantage.
4. Adhere to all confidentiality provisions of McLaren Health Plan/McLaren Health Advantage participation agreements, which are applicable to the individual user granted access to member and claim information via FACTSWeb.
5. If the User named on this request is no longer employed or does not require access to FACTSWeb, it is your responsibility to notify us immediately so access can be terminated.
6. Ensure that the individual designated by Provider to access FACTSWeb complies with paragraphs 1-5.

<table>
<thead>
<tr>
<th>Office Manager/Authorized Contact Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>User Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

Fax completed form to: (810) 733-9651

<table>
<thead>
<tr>
<th>McLaren Health Plan Staff Use Only</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receipt Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completion Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Provider Referral Form - Request for Preauthorization

### Member’s Plan
- Medicaid
- Healthy Michigan
- MIChild
- HMO Commercial
- POS Commercial
- Health Advantage
- Select
- Medicare SNP
- Medicare HMO

### Ordering Provider Information
- Name: [Name]
- Specialty: [Specialty]
- Address: [Address]
- Phone: [Phone]
- Fax: [Fax]

### Member is being referred to:
- Service Provider: [Service Provider]
- Specialty: [Specialty]
- Address: [Address]
- Phone: [Phone]
- Fax: [Fax]

### Member Information
- First Name: [First Name]
- Last Name: [Last Name]
- DOB: [DOB]
- Member ID: [Member ID]

### Service Category
<table>
<thead>
<tr>
<th>Service Category</th>
<th>Specialty</th>
<th># of visits</th>
<th>Diagnosis Codes</th>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network Consult</td>
<td>[Specialty]</td>
<td>[# of visits]</td>
<td>[Diagnosis Codes]</td>
<td>[Procedure Codes]</td>
</tr>
<tr>
<td>Outpatient Ambulatory Procedure**</td>
<td>[Facility Name]</td>
<td>[Date of Procedure]</td>
<td>[Diagnosis Codes]</td>
<td>[Procedure Codes]</td>
</tr>
<tr>
<td>Inpatient Procedure</td>
<td>[Facility Name]</td>
<td>[Date of Procedure]</td>
<td>[Diagnosis Codes]</td>
<td>[Procedure Codes]</td>
</tr>
<tr>
<td>Therapy</td>
<td>[PT: # of visits]</td>
<td>[Diagnosis Codes]</td>
<td>[SN: # of visits]</td>
<td>[Diagnosis Codes]</td>
</tr>
<tr>
<td>DME (Attach Medical Necessity)</td>
<td>Purchase</td>
<td>[Diagnosis Codes]</td>
<td>Rental</td>
<td>[DME Codes]</td>
</tr>
<tr>
<td>Acupuncture (MIChild only)</td>
<td>Diagnosis Codes</td>
<td>Inpatient Mental Health Care</td>
<td>Inpatient Mental Health Outpatient for McLaren Advantage HMO &amp; SNP Only</td>
<td>Consults &amp; Management</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Diagnosis Codes</td>
<td>Inpatient Mental Health Outpatient for McLaren Advantage HMO &amp; SNP Only</td>
<td>Consults &amp; Management</td>
<td>Eating Disorders</td>
</tr>
<tr>
<td>Hospice</td>
<td>[Soc]</td>
<td>Diagnosis Codes:</td>
<td>Notes:</td>
<td>Diagnosis Codes:</td>
</tr>
<tr>
<td>Injectable/IV Therapy</td>
<td>See Referral Category “Specialty Medications/Injections”</td>
<td>Diagnosis Codes:</td>
<td>J-Codes:</td>
<td></td>
</tr>
</tbody>
</table>

### Other Requests
- Start Date:
- Diagnosis/Procedure Codes:

### Decision
- Incomplete Request
- Not Authorized
- Authorization Approved
- Directed to In-Network
- No Pre-Auth required
- Pended for more info
- Start Date
- End Date
- Staff Note
- Staff Initials

---

1. *Please see back of form for a detailed listing of services requiring pre-authorization by product
2. For Medicaid, McLaren HMO/POS, McLaren Advantage (HMO SNP): If a specialist is completing this form, you must notify the PCP of services requested.
3. This authorization is for the services requested. The actual procedure codes billed may require additional documentation for reimbursement.
4. **List of outpatient codes requiring pre-authorization may be found on MclarenHealthPlan.org
5. This pre-authorization is not guarantee of payment. Please contact McLaren Health Plan to verify eligibility and covered benefits.

All information, including any attachments are confidential and intended solely for the use of the intended recipient(s). All information is privileged or otherwise protected from disclosure by applicable law. Any unauthorized disclosure, dissemination, use or reproduction is strictly prohibited. If you receive in error, please notify the sender immediately and destroy the information.
### Require Pre-Authorization (Varies by Product)

#### Medical Health Services*

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid</th>
<th>Healthy Michigan</th>
<th>MiChild</th>
<th>HMO Commercial</th>
<th>POS Commercial</th>
<th>McLaren Health Advantage</th>
<th>McLaren Select</th>
<th>Medicare McLaren Advantage HMO SNP &amp; HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accupuncture</td>
<td>NC</td>
<td>NC</td>
<td>X</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
</tr>
<tr>
<td>All Inpatient Services (Medicaid, Healthy Michigan, MiChild see below)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>All Inpatient Services for Medicaid, Healthy Michigan, MiChild-obtained by admitting facility. Exception - Routine Delivery without sterilization requires notification only.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Inpatient Mental Health (MH)-obtained by admitting facility</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>All Out of Network Services (non-contracted providers)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ambulance: Non-Urgent Transportation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cosmetic Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dialysis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>MEDICAID DME Purchase</strong> (allowable line by line as per Medicaid fee schedule)</td>
<td>&gt;$250</td>
<td>&gt;$250</td>
<td>&gt;$250</td>
<td>&gt;$250</td>
<td>&gt;$250</td>
<td>&gt;$250</td>
<td>&gt;$250</td>
<td>&gt;$250</td>
</tr>
<tr>
<td><strong>MEDICAID DME Rental</strong> (allowable line by line as per Medicaid fee schedule)</td>
<td>&gt;$100/Mth</td>
<td>&gt;$100/Mth</td>
<td>&gt;$100/Mth</td>
<td>&gt;$100/Mth</td>
<td>&gt;$100/Mth</td>
<td>&gt;$100/Mth</td>
<td>&gt;$100/Mth</td>
<td>&gt;$100/Mth</td>
</tr>
<tr>
<td>DME Purchase - (allowable line by line)</td>
<td></td>
<td>&gt;$3000</td>
<td>&gt;$3000</td>
<td>&gt;$5000</td>
<td>&gt;$5000</td>
<td>&gt;$750</td>
<td>&gt;$750</td>
<td>&gt;$750</td>
</tr>
<tr>
<td>DME Rentals - (allowable line by line)</td>
<td></td>
<td>&gt;$3000</td>
<td>&gt;$3000</td>
<td>&gt;$5000</td>
<td>&gt;$5000</td>
<td>&gt;$750</td>
<td>&gt;$750</td>
<td>&gt;$750</td>
</tr>
<tr>
<td>Emergency Medical Response System</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>X</td>
</tr>
<tr>
<td>Genetic Testing, Counseling, Diagnosis and Treatment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hearing Aids (Requires rider) (Medicaid under age 21 only)</td>
<td>&gt;21 yrs</td>
<td></td>
<td>NC</td>
<td>X</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>X</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospice</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Interfacility Testing and Services</td>
<td>X</td>
<td>X</td>
<td>NC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Injectable/IV Therapy (See J Code List)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Insulin Pumps/Supplies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maternity Services-Out of Network</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mental Health Outpatient Services Including:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Network Consultations and Management</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Network Eating Disorders</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Network Substance Abuse</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication nonformulary drug requests &amp; some Part B &amp; D drugs (see formulary) **</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral procedures including TMJ and orthognathic</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Outpatient Selected Procedures: Visit our website, McLarenHealthPlan.org. or McLarenAdvantage.org for a listing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Podiatry Office Visits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>&gt;$500</td>
<td>&gt;$500</td>
<td>&gt;$500</td>
<td>&gt;$3000</td>
<td>&gt;$5000</td>
<td>&gt;$5000</td>
<td>&gt;$5000</td>
<td>&gt;$5000</td>
</tr>
<tr>
<td>Proton Beam Therapy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Provider Portal Authorization Form

Provider and Location Information

| Practice Name: ___________________________ | TAX ID: ___________________________ |
| Address: _________________________________ | GROUP NPI: ___________________________ |
| _________________________________________ | PROVIDER ID: _________________________ |
| _________________________________________ | LOCATION ID: _________________________ |

Authorized Representative

I hereby certify that the information provided on this form is correct. As an Authorized Representative, I agree to 1) adhere to and enforce all confidentiality provisions of McLaren Health Plan participation agreements, and 2) notify MHP immediately by calling Customer Service at (888) 327-0671 if the User listed on this form is no longer employed or does not require access to the Portal.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature Date

Authorized Users

List all Users authorized to access eligibility and claims information for the above named provider location.

<table>
<thead>
<tr>
<th>First and Last Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please return this form to MHP via fax at (810) 733-9651

If additional space is required, please copy form.
Provider Claims Status Fax Form

Please complete form and fax to McLaren Health Plan (MHP) or McLaren Health Advantage (MHA) and we will fax back a status response.

<table>
<thead>
<tr>
<th>Date:</th>
<th>From:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Number:</td>
<td>Fax Number:</td>
</tr>
</tbody>
</table>

- Please allow 15 days for MHP/MHA to process and/or respond to all claims status fax forms
- Claims will not be reviewed if status is requested less than 30 days from the date MHP/MHA received the original claim
- Attach a copy of the original claim

Please complete the following information (required for each claim)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Member ID #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHP/MHA Claim Number:</td>
<td>Date of Service:</td>
</tr>
<tr>
<td>Provider name:</td>
<td>Provider NPI#:</td>
</tr>
<tr>
<td>Procedure Code:</td>
<td>Charges:</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

| MIHP/MHA Status Response (for MHP/HA use only) |
| --- | --- | --- | --- |
| Claim Processed | EOB Date: | Check #: | Amount: |
| Claim Denied | Reason: |
| Corrected Claim Needed | Correction Needed: |
| Comments: |

If you have any questions, please contact Customer Service at (888) 327-0671.

**Important:** This message, including any attachments, is confidential and intended solely for the use of the intended recipient(s). This message may contain information that is privileged or otherwise protected from disclosure by applicable law. Any unauthorized disclosure, dissemination, use, or reproduction is strictly prohibited. If you have received this message in error, please destroy it and notify the sender immediately.

MHP41061071

McLarenHealthPlan.org
(888) 327-0671
Provider Claim Adjustment

McLaren Health Plan and McLaren Health Advantage
Provider Claim Adjustments

It is the goal of McLaren Health Plan (MHP) and McLaren Health Advantage (MHA) to adjudicate all provider claims in a timely and accurate manner. Providers who need to correct a claim should complete a Provider Claim Adjustment Form.

The following summarizes the Provider Claim Adjustment Form process:

<table>
<thead>
<tr>
<th>When To Use the Provider Claim Adjustment Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>A provider may submit a Provider Claim Adjustment Form if you believe a claim has been adjudicated incorrectly or a service denied inappropriately.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Adjustment Process</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 90 calendar days from the administrative action by MHP and MHA, the provider must complete and submit a Provider Claim Adjustment Form.</td>
<td>Claim Adjustment Form must be received within 90 calendar days of the most recent McLaren Health Plan Explanation of Payment (EOP), excluding COB/subrogation claims</td>
</tr>
<tr>
<td>Provider must complete the Claim Adjustment Form and attach a paper copy of the corrected claim or the claim dispute, and any supporting documentation for the adjustment.</td>
<td></td>
</tr>
<tr>
<td>Mail to: McLaren Health Plan or McLaren Health Advantage Attn: Customer Service P.O. Box 1511 Flint, MI 48501-1511</td>
<td></td>
</tr>
</tbody>
</table>

Process Clarification

The Claims Adjustment process is not available to a provider if the Appeals Process has been used and the provider was not satisfied with the outcome.

For questions regarding the Provider Claims Adjustment Process, call Customer Service at (888) 327-0671.

The Provider Claims Adjustment Request Form is available on our website at: MclarenHealthPlan.org or MclarenHealthAdvantage.org.
Provider Claim Adjustment Request Form

McLaren Health Plan and McLaren Health Advantage

WHEN TO USE THIS FORM:

A Claim Adjustment - is a request for payment reconsideration for a paid or denied claim. Any claim for which an Explanation of Payment (EOP) was issued that was paid inappropriately, or was denied, must be resubmitted on a paper claim (not EDI) with supporting documentation as an adjustment.

Claim Adjustment Request Time Frame - All claim adjustment inquiries and requests must be made to McLaren Health Plan (MHP) or Health Advantage (MHA) within 90 calendar days of the most current MHP/MHA EOP. Any inquiry or request made after 90 calendar days will not be given consideration. The acknowledgement of receipt date will only be considered when a completed request form and supporting documentation is received by MHP/MHA.

COMPLETE THE FOLLOWING REQUIRED INFORMATION:

| Member Name: ______________________ | ID #: ______________________ |
| MHP/MHA Claim #: ____________________ | DOS: ____________________ |
| Provider Name: ______________________ | Tax ID #: ____________________ |
| Office Contact: ______________________ | NPI #: ____________________ |
| Date Provider Claim Adjustment Request Form Submitted: ______________________ | Phone #: ____________________ |
| Fax #: ____________________ |

Reason for Request (please check appropriate box):

For a correction to a previously submitted claim:
- Anesthesia Time
- Date of Service
- Diagnosis Code
- Modifier
- MS DRG
- Place of Service
- Procedure Code
- Provider/Tax ID
- Other

For reconsideration: (supporting documentation required)
- Service denied for lack of authorization
  (attach copy of referral)
- Service denied as other insurance primary (COB)
  (attach copy of primary EOB)
- Service denied as a duplicate
  (attach documentation)

Send this completed Provider Claim Adjustment Request form along with the paper claim form (not EDI) and supporting documentation to:
McLaren Health Plan or McLaren Health Advantage
Attention: Customer Service
P.O. Box 1511
Flint, MI 48501-1511
Or Fax to: (877) 502-1567

For questions regarding the Provider Claims Adjustment Process, call Customer Service at (888) 327-0671.
The Provider Claims Adjustment Request form is available on our websites at MclarenHealthPlan.org or MclarenHealthAdvantage.org.

MHP Response:

MHP42721074F Rev. 4/2015
Provider Request for Appeal (PRA) Form

A formal Provider Appeal process is made available to any provider who challenges administrative action taken by McLaren Health Plan (MHP) or Health Advantage (HA).

Appeal Time Frame – A PRA must be made to MHP or HA within 90 calendar days of the administrative action. The PRA form must be complete and supporting documentation must be included.

The right to appeal is forfeited if the provider does not submit a completed PRA form with supporting documentation (within the 90 calendar day timeframe), and any charges in dispute must be written off.

Please complete the REQUIRED information below:

Member name: ___________________________ ID #: ___________________________
DOS: ___________________________ MHP/HA Claim #: ___________________________
Provider name: ___________________________ Tax ID #: ___________________________
Service being appealed: ___________________________
Reason for appeal: ___________________________

REQUIRED ATTACHMENTS:
• Letter documenting the rationale for the appeal request
• Supporting documentation
• Paper claim for the services being appealed

Name of person submitting appeal: ___________________________
Phone #: ___________________________ Date submitted: ___________________________
Address to send response: ___________________________

Mail to: McLaren Health Plan or McLaren Health Advantage
Attention: Provider Appeals
P.O. Box 1511
Flint, MI 48501-1511

For questions regarding the Provider Request for Appeal Process, call Customer Service at (888) 327-0671

The Provider Request for Appeal Form is available online at McLarenHealthPlan.org or McLarenHealthAdvantage.org.
Provider Request for Prior Authorization

Medication Prior Authorization Request Form

Your request cannot be processed without complete information which includes provider specialty.

Member Information

<table>
<thead>
<tr>
<th>Member name:</th>
<th>Member ID:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of birth:</th>
<th>Sex:</th>
<th>□ Female</th>
<th>□ Male</th>
</tr>
</thead>
</table>

**Expedited/Urgent**

By checking this box, I certify applying the standard review time frame may jeopardize the health of the member or the member's ability to regain maximum function.

Provider Information

<table>
<thead>
<tr>
<th>Provider name:</th>
<th>Provider NPI#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
<th>Fax:</th>
<th>Specialty:</th>
</tr>
</thead>
</table>

Name & title of person completing form:

Medication Information

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Strength</th>
<th>Administration schedule</th>
<th>Length of therapy</th>
<th>Quantity required</th>
</tr>
</thead>
</table>

Patient diagnosis for use of medication

Previous history of a medical condition, allergies or other pertinent medical information that necessitates use of this medication:

Has the patient been seen by any other provider for this condition?  □ Yes  □ No

If so, what was the prescriber's specialty:

Previous non-prior authorized and prior authorized medications tried and failed for this condition:

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Reason for failure</th>
<th>Date</th>
</tr>
</thead>
</table>

Pertinent laboratory test or procedure (if applicable)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Findings</th>
<th>Date</th>
</tr>
</thead>
</table>

Other Information:

To Prescriber- Complete ENTIRE form and send to:

Magellan Rx Prior Authorization Department
2520 Industrial Row Dr, Troy, MI 48084
Phone: 1-248-540-6686
Fax: 1-888-656-3604

The fax number is only for prior authorization requests.
Pharmacy will only accept original prescription orders from patients.
Fax-only prescriptions can be accepted if faxed to the member’s pharmacy by the prescribing physician.
Request for Medicare Prescription Drug Coverage Determination

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

<table>
<thead>
<tr>
<th>Address:</th>
<th>Fax Number:</th>
</tr>
</thead>
</table>
| 4D Pharmacy Management  
2520 Industrial Row Drive  
Troy, Michigan 48084 | (248) 341-8133 |

You may also ask us for a coverage determination by phone at (888) 274-2031 or through our website at www.MclarenAdvantage.org.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee’s Information

<table>
<thead>
<tr>
<th>Enrollee’s Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrollee’s Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Enrollee’s Member ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

<table>
<thead>
<tr>
<th>Requestor’s Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requestor’s Relationship to Enrollee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Representation documentation for requests made by someone other than enrollee or the enrollee’s prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or (800) Medicare.
**Name of prescription drug you are requesting** (if known, include strength and quantity requested per month):


**Type of Coverage Determination Request**

- ☐ I need a drug that is not on the plan’s list of covered drugs (formulary exception).*
- ☐ I have been using a drug that was previously included on the plan’s list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*
- ☐ I request prior authorization for the drug my prescriber has prescribed.*
- ☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*
- ☐ I request an exception to the plan’s limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*
- ☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
- ☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
- ☐ My drug plan charged me a higher copayment for a drug than it should have.
- ☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

*NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached “Supporting Information for an Exception Request or Prior Authorization” to support your request.

Additional information we should consider (attach any supporting documents):

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H0141_MIMHMO178

CMS Approval: 2/4/2014
Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber’s support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).

Signature: Date:

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber’s supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

Prescriber’s Information

Name

Address

City State Zip Code

Office Phone Fax

Prescriber’s Signature Date

Diagnosis and Medical Information

Medication: Strength and Route of Administration: Frequency:

New Prescription OR Date Therapy Initiated: Expected Length of Therapy: Quantity:
### McLaren Advantage (HMO)

<table>
<thead>
<tr>
<th>Height/Weight:</th>
<th>Drug Allergies:</th>
<th>Diagnosis:</th>
</tr>
</thead>
</table>

#### Rationale for Request

- **☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]

- **☐ Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome]

- **☐ Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason]

- **☐ Request for formulary tier exception** [Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome]

- **☐ Other (explain below)**

#### Required Explanation

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*McLaren Advantage (HMO) is an HMO plan with a Medicare Advantage contract. Enrollment in McLaren Advantage (HMO) depends on contract renewal.*

*The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year.*
QUICK REFERENCE

SECTION

XIX
Emergency and Urgent Care Guidelines

Members must contact their PCP prior to an Urgent Care or Emergency Department (ED) visit unless the member has what he or she believes to be a life-threatening emergency.

**Emergency Care**
Emergency care is defined as a sudden and/or unexpected sickness or injury that could result in a serious problem or death, if not treated right away. Examples of emergency conditions include:

- Serious bleeding
- Loss of consciousness
- Convulsions or seizures
- Severe breathing problems

If an ED visit is required, authorization is not needed, but the PCP should alert the hospital of the member’s pending arrival. Whenever possible, the PCP should serve as the admitting physician or consult with the ED physician to promote the quality and continuity of care delivered to the member.

**Urgent Care**
Urgent health problems are not life threatening, but they may require immediate attention. Members are encouraged to contact their PCP if they experience a health problem they believe requires immediate attention. Examples of common urgent health problems include:

- Severe sore throat
- Sprains
- Severe headache
- Earache

If an urgent care visit is needed, authorization is not needed.

A PCP or covering physician must be available 24 hours a day/7 days a week to coordinate MHP member’s access to care.

**Emergency Care Reminders**
If the member feels he or she has an emergent medical condition and does not have time to call the PCP, he or she is instructed to go to a MHP participating hospital emergency department, the nearest ED or call 911.

Members who present to an ED are instructed to identify themselves as MHP members and present their MHP member identification card. Members are encouraged to notify their PCP within 24 hours, or the next business day, of an ED visit to ensure that appropriate and immediate follow-up care may be arranged. Please contact Medical Management at (888) 327-0671 or (810) 733-9522 for more details.
Referral Guidelines

Provider Referral Form
When a member needs care that the PCP cannot provide, a Provider Referral Form needs to be completed.

A completed Provider Referral Form and preauthorization are required for:
- Any care that is referred to an Out-of-Network (non-contracted) physician.
- Any service listed on the back of the Provider Referral Form (see Section XVIII Forms Section).
- Certain injections (please call Medical Management for clarification).

Preauthorization requests are subject to a medical review by MHP and may require additional information and/or documentation before a service can be approved.

When completing the Provider Referral Form:
- PCP has the option of requesting an office consult with or without follow up visits.
- PCP must contact MHP to add any testing, outpatient procedures, or additional consults to other specialists, to the original office consult referral.
- Referrals are valid for the duration of the episode of care, not to exceed one year.
- A new referral form will be required if the episode of care exceeds one year.
- The Provider Referral Form must be completed appropriately or it will be returned to the requesting office and will not be processed by MHP.

Authorization Number
- The authorization number is located in the body of the Authorization Request Response Form.
- For preauthorization: after medical review occurs, the referral decision will be returned as either authorized, redirected, pended or not authorized.

Referral Time and Scope
- Referrals are valid for the episode of care, but not to exceed one year.
- The PCP can request an “Office Consult”, with or without follow up visits.
- A contact must be made to MHP by the specialist or PCP to add services to the original referral.
- Any addition to an original referral that is to an Out-of-Network provider requires preauthorization, without exception.
- Whenever possible, the treatment plan should be delivered by the PCP in conjunction with the specialist.
- Each referral is for the testing and the treatment of the current diagnosis and said diagnosis.
- The referral is invalid if the member is not eligible.

The Provider Referral Form Request for Preauthorization may be completed and submitted electronically, including any clinical attachments, by using the form available on the MHP website, McLarenHealthPlan.org, under the Provider tab.

Please call Medical Management at (888) 327-0671 with questions about our referral process.
Pharmaceutical Management

The MHP Formulary is utilized as a resource for pharmacy management with quality and cost effectiveness as the primary goals. MHP Formularies, Commercial and Medicaid consist of:

- Introduction
- Prescribing Protocols
- Full Positive Listings and Quick Formulary Reference Guide
- Request for Prior-Authorization Procedure and Form

To facilitate the member’s access to needed medications, consult our Quick Formulary Reference Guide per product. This useful tool directs the prescribing practitioner to high quality, cost effective medications. The first-line of medication is listed by Therapeutic Class. The second-line of medication is provided, if available. In addition, some of the non-formulary medications are also listed by Therapeutic Class.

Any specific prescribing restriction is listed by code per the medication. At the bottom of each page the codes are described for your convenience. In addition, the complete Positive Drug List is available on the website at McLarenHealthPlan.org or you can request a hard copy by calling Customer Service at (888) 327-0671.

When prescribing a medication:

- Consult the Quick Formulary Reference or the complete Positive Drug List
- Review by Therapeutic Class for the Preferred or Generic Medications that are available
- Note any prescribing restriction codes listed by the medication
- If the medication needed is listed as Preferred or Generic, the member can proceed to the pharmacy with their prescription
- If, per the Quick Reference or the Positive Drug List, the medication is not a Preferred or Generic Medication, please review the formulary for a suitable alternative. If one cannot be found, you may request an exception to the formulary by completing a Request for Prior Authorization
- If, per the Quick Reference or the Positive Drug List, the medication has a prescribing restriction of Prior Authorization Required, please complete a Request for Prior Authorization
- If, per the Quick Reference or the Positive Drug List, the medication has any other prescribing restriction, and you wish to seek an override, please complete a Request for Prior Authorization and follow the directions for this request
Reminders:

- Contact Medical Management with specific questions regarding the formulary at (888) 327-0671
- To obtain an exception to the formulary, submit a Request for Prior Authorization to our Pharmacy Benefit Manager, 4D by fax, at (248) 540-9811
- Detailed instructions are on the form, which is included in the Forms Section XVIII of this manual
- Do not send the request to MHP
- MHP Formularies are product specific
- E-Prescribing: You can access all MHP, McLaren Health Advantage, and McLaren Advantage formulary information and prescribe through Sure Scripts®.
Anesthesia

Billing for Anesthesia Services

McLaren Health Plan requires providers to bill anesthesia services with the total number of minutes provided. The number of minutes is to be recorded in the units field. Do not add the base number of units for the procedure, as that is automatically added by McLaren Health Plan’s claim system.

Modifiers are required in order to administer payment appropriately. Failure to provide the modifier will result in the claim being denied. Secondary modifiers should also be billed, as applicable.

Payment Calculation

For payment purposes, McLaren Health Plan calculates the units by dividing the actual minutes by 15 and rounding to the nearest full unit. Anesthesia services are based on the following calculation:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>MHP’s Commercial Payment % of Allowable</th>
<th>MHP’s Medicaid Payment % of Allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Physician personally directs the entire case</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>AD</td>
<td>Physician supervising more than 4 concurrent cases</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>GC</td>
<td>Physician supervising up to two anesthesia residents</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>QK</td>
<td>Physician directing 2, 3, or 4 concurrent cases involving CRNA’s or anesthesia assistants</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>QY</td>
<td>Physician is medically directing one CRNA</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA’s and anesthesia assistants, when medically directed by an anesthesiologist</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>QZ</td>
<td>Services performed by CRNA’s without the medical direction of an anesthesiologist</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Secondary Modifier

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS</td>
<td>Monitored anesthesia care</td>
</tr>
<tr>
<td>G8</td>
<td>Monitored anesthesia care for complex complicated procedure</td>
</tr>
<tr>
<td>G9</td>
<td>Monitored anesthesia care for patient with history of cardiopulmonary condition</td>
</tr>
<tr>
<td>52</td>
<td>Reduced services</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued procedure, started but discontinued</td>
</tr>
<tr>
<td>23</td>
<td>Unusual services</td>
</tr>
</tbody>
</table>

Hospital Based Billing

McLaren Health Plan reimburses professional services rendered in a hospital based or facility setting when performed by a contracted provider. Facility charges associated with evaluation and management (E&M) services in these settings are not reimbursed.

Revenue Code 510

All charges for professional services must be billed on a CMS-1500. Revenue Code 510 is billed on a UB-04 and is used to report the technical charge associated with a physician/practitioner service. Facility charges billed in addition to professional charges with Revenue Code 510 will be denied as charges included in professional fee. The member is not liable for these charges. Providers are contracted based on the professional fee schedule and E&M services reimburse at a global rate that includes facility and professional services.
Newborn Billing Requirement

McLaren Health Plan, in accordance with the Michigan Department of Community Health Provider Bulletin MSA 14-34, is instituting the following Hospital claim requirements for newborns:

- **Reporting Newborn Priority (Type) of Admission or Visit** – Providers are required to report the appropriate priority (type) of admission or visit in accordance with NUBC guidelines. For instance, a newborn admission should be reported as type of admission of “4” (newborn). When billing with type of admission of “4”, providers must report special point of origin code “5” (born inside this hospital) or “6” (born outside of this hospital).

- **Reporting Newborn Birth Weight** – NUBC value code “54” (newborn birth weight in grams) is required on all claims with type of admission “4”. Birth weight should be reported as a whole number. For example, if the birth weights is 2764.5 grams, then value code “54” amount should be reported as “2765”.

- **Reporting Cesarean Sections or Inductions Related to Gestational Age** – Providers are expected to report the following NUBC condition codes for cesarean sections or inductions related to gestational age, as appropriate:
  - **Condition Code “81”** – C-Sections or inductions performed at less than 39 weeks gestation for medical necessity
  - **Condition Code “82”** – C-Sections or inductions performed at less than 39 weeks gestation electively
  - **Condition Code “83”** – C-Sections or inductions performed at 39 weeks gestation or greater

Currently, MHP is reviewing these claim for informational edits, as of January 1, 2015, any claim received without this required information will be denied.
Healthy Michigan Plan Beneficiary Notification of Copays

In accordance with the Michigan Department of Community Health L-Letter (L 14-52, date October 28, 2014), McLaren Health Plan is reminding you of the requirement to notify all Healthy Michigan Plan beneficiaries of their potential co-pay information when they receive services. The document below, titled “Information About Healthy Michigan Plan Copays” is to be given to each Healthy Michigan Plan beneficiary when they receive health care services. You may copy the information below, it is also available online at www.michigan.gov/healthymichiganplan.

As a reminder, McLaren Health Plan Healthy Michigan Plan beneficiaries are not responsible for the payment of copays at the point of service as long as the service is covered by McLaren Health Plan.

--------------------------------------------------------------------------------------------------------------------------------

Information About Healthy Michigan Plan Co-Pays

Healthy Michigan Plan members enrolled in a health plan pay most co-pays through their MI Health Account at a later time. Below is a table that shows how much you could pay for health care services.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits (including Free-Standing Urgent Care Centers)</td>
<td>$2</td>
</tr>
<tr>
<td>Outpatient Hospital Visit</td>
<td>$1</td>
</tr>
<tr>
<td>Emergency Room Visit for Non-Emergency Services:</td>
<td>$3</td>
</tr>
<tr>
<td>· Co-payment ONLY applies to non-emergency services</td>
<td></td>
</tr>
<tr>
<td>· There is no co-payment for true emergency services</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Stay (with the exception of emergency admissions)</td>
<td>$50</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$1 generic</td>
</tr>
<tr>
<td></td>
<td>$3 brand</td>
</tr>
<tr>
<td>Chiropractic Visits</td>
<td>$1</td>
</tr>
<tr>
<td>Dental Visits</td>
<td>$3</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>$3 per aid</td>
</tr>
<tr>
<td>Podiatric Visits</td>
<td>$2</td>
</tr>
<tr>
<td>Vision Visits</td>
<td>$2</td>
</tr>
</tbody>
</table>

Not all services have co-pays and not all people are required to pay co-pays. For example, services that help you get or stay healthy, like preventive services or certain services or medications that help you manage a chronic condition, may have no co-pays. Also, some people don’t have to pay co-pays at all, like those who are under 21.

The amount you owe could be different than what is shown in the table. These amounts are for informational purposes only. Your MI Health Account Statement will tell you what you have to pay and how the amounts were figure.

If you would like more information on copayment requirements, visit www.healthymichiganplan.org, or call (800) 642-3195.
Reference Lab Billing Requirements

As laboratory testing continues to become increasingly specialized, hospital laboratories may find it necessary to refer specimens to reference laboratories for testing if they lack the capability to process the specimens in-house. This information pertains to covered laboratory procedures performed by reference laboratories that are under contractual arrangements with McLaren Health Plan contracted Hospitals. This would include any laboratory procedure covered by CPT codes 80000 – 89999, or any applicable HCPCS codes.

Definitions of reference and referring laboratories are as follows:

- **Reference laboratory** – A laboratory that receives a specimen from another, referring laboratory for testing and that actually performs the test.
- **Referring laboratory** – A laboratory that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.

Following Medicare and Medicaid guidelines and applicable State and Federal laws, in situations where a contracted hospital laboratory must refer a specimen to a reference laboratory, the contracted laboratory will be allowed to bill MHP for the services provided by the reference laboratory under the following conditions:

- The reference laboratory holds the required Clinical Laboratory Improvement Amendments (CLIA) certification and State licensure, if required, to perform the test;
- The contracted hospital laboratory and the reference laboratory have a contractual agreement to provide such services with the hospital laboratory responsible for reimbursing the reference laboratory for the services; and
- If the service requires pre-authorization, the contracted hospital laboratory must request and receive preauthorization from MHP for the services to be performed by the reference laboratory. The preauthorization number must be included on the claim.

For a list of laboratory services that require preauthorization, please visit McLarenHealthPlan.org. Follow the links to Providers/Referrals and Requests for Preauthorization/Preauthorization Program Guidelines.

MHP Contracted Hospitals who are the JVHL Provider network will continue to submit all laboratory claims through their JVHL agreement.