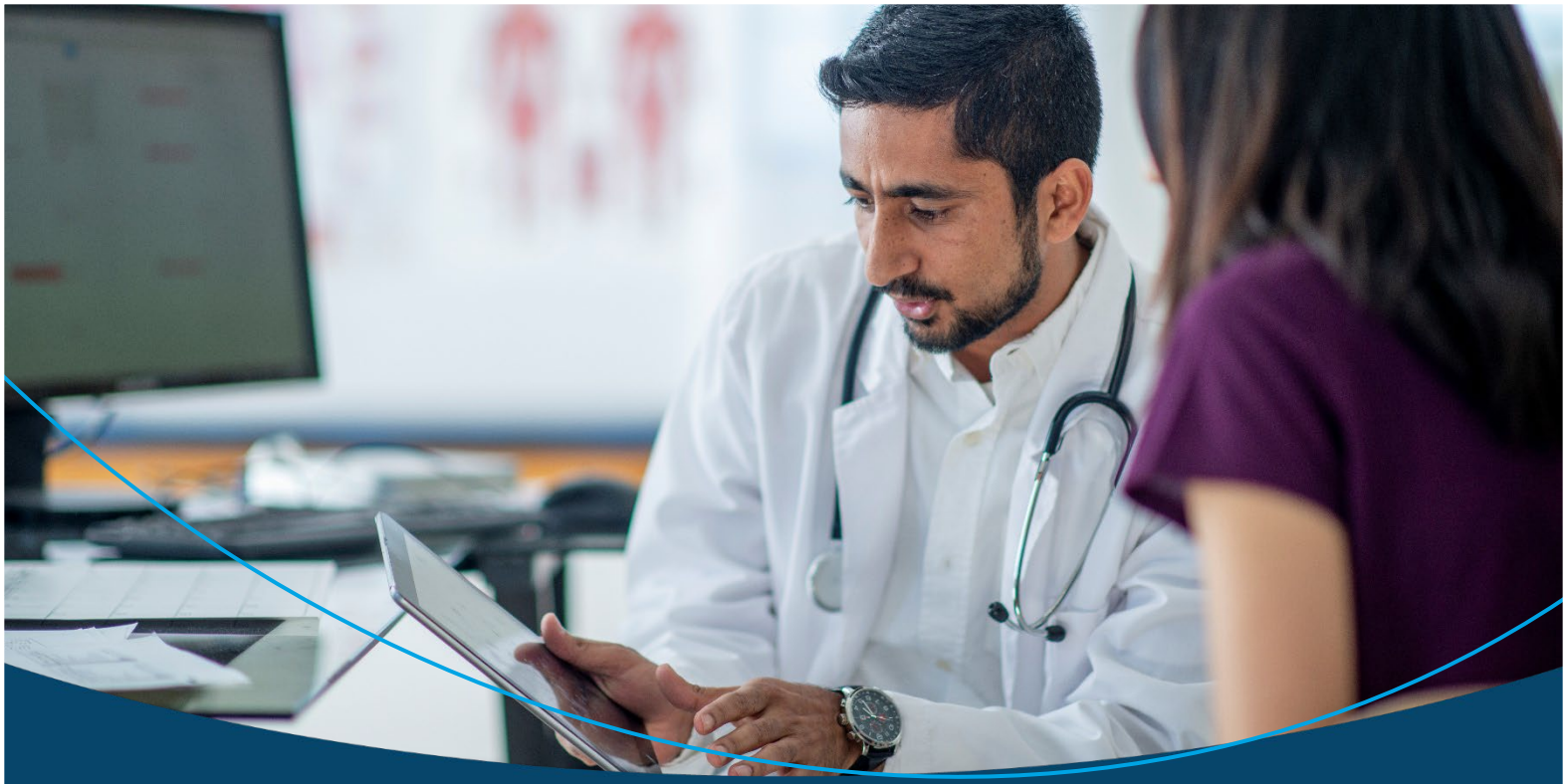


Provider Manual

McLaren HEALTH PLAN

mclarenhealthplan.org

McLaren HEALTH PLAN

Table of Contents

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 who 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 Health Plan Community – Health Maintenance Organization (Commercial HMO)
- McLaren Medicare Supplement
- McLaren Medicare (Medicare Advantage HMO/HMO-POS)

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

- McLaren Health Advantage (Self-Insured PPO Plan)

MHP combines the resources of independent physicians, multispecialty 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 pages 22 for examples). MHP will provide you with updated information through mailings and on our website, at McLarenHealthPlan.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/Healthy Michigan Plan, McLaren HMO and McLaren Medicare, 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.

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 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 processes, 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 also can verify member eligibility and benefit coverage, as well as status claims that are submitted for payment, through the McLaren Connect provider portal. Please visit McLarenHealthPlan.org frequently for the latest updates and new information. A printed hard copy of any information on the website can be obtained by calling Customer Service at 888-327-0671.

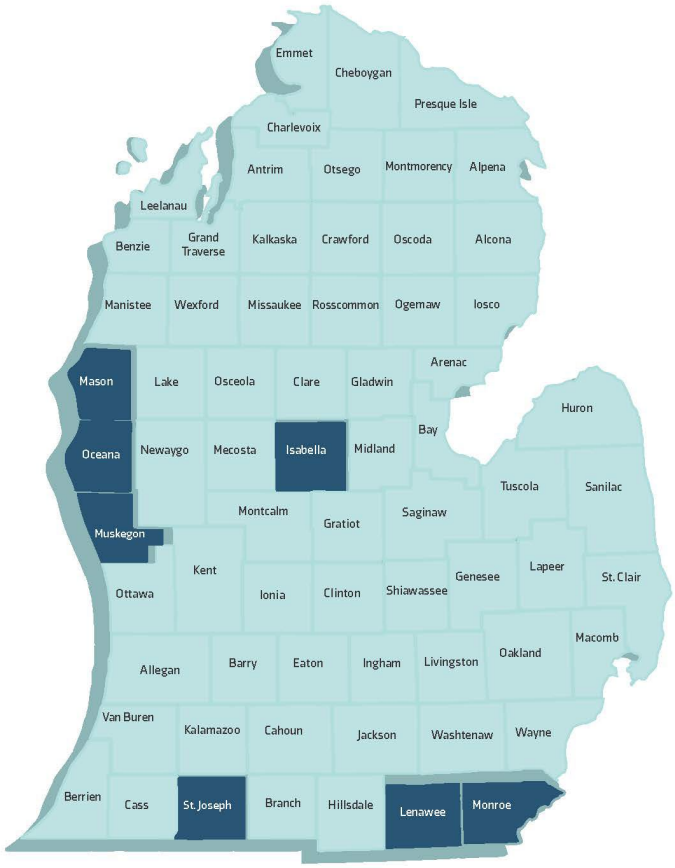
Using this Manual

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 dates of review and/or revisions are on the last page of the manual. The provisions in this manual are intended to supplement the terms of the provider agreement ("Agreement") you entered into with McLaren Health Plan. In the event of a direct conflict between a provision in this manual and the Agreement between you and McLaren Health Plan, the provision in this manual will control unless it conflicts with a term required by law, regulation or a regulatory agency, or if your Agreement otherwise specifies that it controls.

Provider Maps

Medicaid

McLaren Medicare



Community

Approved Counties

Alcona
Allegan
Alpena
Antrim
Arenac
Barry
Bay
Benzie
Calhoun
Charlevoix
Cheboygan
Clare
Clinton
Crawford
Eaton
Emmet
Genesee
Gladwin
Grand Traverse
Gratiot
Hillsdale
Huron
Ingham
Ionia
Iosco
Isabella
Jackson
Kalamazoo
Kalkaska
Kent
Lake
Lapeer
Leelanau
Livingston
Macomb
Manistee
Mason
Mecosta
Midland
Missaukee
Montcalm
Montmorency
Newaygo
Oakland
Ogemaw
Osceola
Oscoda
Otsego
Ottawa
Presque Isle
Roscommon
Saginaw
Sanilac
Shiawassee
St. Clair
St. Joseph
Tuscola
Washtenaw
Wayne
Wexford

Partially Approved Counties

Livingston

Non-Approved Counties

Berrien
Branch
Cass
Lenawee
Monroe
Muskegon
Oceana
Van Buren

Key

Approved Areas

Partially Approved Areas

Non-Approved Areas

McLaren HEALTH PLAN | INDIVIDUAL MEDICAID MEDICARE

Department Services

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 used 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.

Provider Relations

The Provider Relations department is responsible for all provider-related issues and requests, including provider enrollment and contracting. The Provider Relations Representatives 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 the McLaren CONNECT provider portal, or to discuss any issues you or your office staff may have.
- Providing office materials:
    - Referral and preauthorization 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
  - Name
- To discuss any questions regarding your participation in MHP.

If you have questions about how to become a McLaren Health Plan provider or other questions, contact a Provider Relations Representative by calling 888-327-0671.

Customer Service

The Customer Service department is responsible for assisting providers and members with any questions they may have regarding MHP Medicaid, Community, and Health Advantage. 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:

- Arrange for member transportation (Medicaid and Healthy Michigan Plan only)
- Inquire about referrals
- Ask claims questions

Use the McLaren CONNECT provider portal to:

- Verify member eligibility
- Review status of claims
- View/print provider explanation of payments (EOP)

McLaren Medicare Member Services is available to assist McLaren Medicare members and can be reached at 833-358-2404 (TTY 711). McLaren Medicare Member Services is open April 1-Sept. 30: Monday through Friday, 8 a.m. to 8 p.m. Oct. 1-March 31: Seven days a week, 8 a.m. to 8 p.m. (except Thanksgiving and Christmas day).

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 voicemail 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 Preauthorization Requirements
- Inpatient hospital care (elective, urgent and emergent)
- Medically-necessary determinations of any care, including the criteria used in decision-making
- Case management services
- Complex case management for members who qualify
- Disease management: diabetes, asthma, maternity care and others
- Preventive health education and community outreach support
- Children's Special Health Care 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 covered services and assists members and providers in ensuring that appropriate care is received. There are nationally recognized, evidence-based criteria 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, you 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 used 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.

Regarding incentives, utilization decision-making is based solely on the appropriateness of care and service, and the 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 that result in under-utilization.

Case Management

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, PCPs 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) nurses are specially-trained nurses who are available to MHP members who have complex care needs. Members considered for CCM include those who:

- Are listed for a transplant;
- Have frequent hospitalizations;
- Have frequent ER visits;
- Are Children's Special Health Care Services (CSHCS) members

Community Outreach

MHP provides community outreach with a focus on support services such as food programs, housing and utilities, special family services, clothing needs and more. 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, members with asthma and diabetes, 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 a request to:

McLaren Health Plan
Attn: Customer Service
P.O. Box 1511
Flint, MI 48501-1511

Interpretation and Translation

Interpretation and translation services are FREE to MHP Medicaid, Healthy Michigan Plan, MHP Community (Marketplace) and McLaren Medicare 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. McLaren Medicare members should call 833-358-2404 (TTY:711).

If a member is deaf or hard of hearing or has speech problems, oral interpretation services are available to MHP Medicaid, Healthy Michigan Plan, MHP Community (Marketplace) and McLaren Medicare members who require this service. Please call Customer Service at 888-327-0671 for assistance. McLaren Medicare members should call 833-358-2404. 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. McLaren Medicare members should call 833-358-2404 (TTY:711).

Pregnancy Resources

McLaren Miracles: a program for pregnant McLaren Health Plan members with special nurses who will send information on what to expect throughout pregnancy. Participants receive information on healthy habits and the nurse can help members with any questions or problems. McLaren Miracles also covers breast pumps with a prescription.

Members identified as currently pregnant are automatically enrolled in the McLaren Miracles program. Members can become ineligible if they are incorrectly identified as being pregnant, are no longer an MHP member (termed/expired) or if the member chooses to opt out of the program. For questions or to opt out of this program, contact Customer Service toll free at 1-888-327-0671 (TTY: 711).

Maternal Mortality Prevention: Health care professionals play a critical role in eliminating preventable maternal mortality. Listening goes a long way when engaging patients in their care. Really hear your patient's concerns during and after pregnancy to facilitate open conversation and ensure any issues are addressed. Help your patients recognize urgent warning signs and when to seek medical attention right away. Take steps to make pregnant patients feel understood and valued during their visit. The following resources may make a difference:

- HEAR HER Michigan MDHHS' Hear Her Michigan Campaign aims to empower women and their support networks to recognize urgent maternal warning signs and speak up when they have concerns. The campaign is also dedicated to encouraging everyone – including providers, caregivers, friends, and family – to listen and act.
- McLaren Health Plan pregnancy information: www.mclarenhealthplan.org/mclaren-health-plan/pregnancy-health-information
- Centers for Disease Control HEAR HER Campaign resources for health care providers - www.cdc.gov/hearher/healthcare-providers/index.html

Maternal Infant Health Program (MIHP): This is a program for women who may need extra help when they are pregnant. MIHP providers are special people trained to help patients understand what is happening to them and they can help new moms get supplies they may need.

- After the baby is born, members must call their McLaren Health Plan caseworker to register their newborn with McLaren Medicaid. After the baby is registered with McLaren Health Plan, members will get a new McLaren Health Plan ID card for their baby to receive MIHP services.

Doula (supportive pregnancy) services

A doula is a non-clinical person who typically provides physical, emotional, and educational support services to pregnant individuals during the prenatal, labor and delivery, and postpartum periods. Evidence indicates doula services are associated with improved birth outcomes. Doula services have been shown to positively impact social determinants of health, support birth equity, and decrease existing health and racial disparities.

Medicaid covers different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas. Doula services must be recommended by any licensed healthcare provider, including a: licensed practical nurse, registered nurse, social worker, midwife, nurse practitioner, physician assistant, certified nurse midwife or physician.

Pregnant members with Medicaid are covered for doula services from Medicaid-enrolled doulas, registered with McLaren Health Plan. Doula services may include a maximum of six total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery. All prenatal and postpartum visits must be at least 20 minutes in duration to be considered eligible for reimbursement.

Doula providers seeking reimbursement for services rendered to Medicaid beneficiaries are required to be registered and approved on the MDHHS Doula Registry and enrolled in CHAMPS. For information on how to enroll with McLaren Health Plan as a doula, providers should send a request to MHPProviderServices@mclaren.org or call MHP Customer Service at 888-327-0671. Providers should refer to the MDHHS Medicaid Provider Manual for additional information on requirements, coverage and reimbursement.

Contact Information

Department	Telephone No.	Fax No.
Customer Service/Provider Inquiry Available to assist with claims, benefits, authorizations and coordination of benefit inquiries. Hours: 8 a.m. – 6 p.m., Monday-Friday.	888-327-0671	Toll Free: 833-540-8648

Medicare Member Services **April 1-Sept. 30: Monday through Friday, 8 a.m. to 8 p.m.** Oct. 1-March 31: Seven days a week, 8 a.m. to 8 p.m. (except Thanksgiving and Christmas days)	833-358-2404 (TTY: 711)	810-600-7971
Provider Relations Available to assist with contracting, provider education and incentive opportunities.	888-327-0671	Flint: 810-600-7979
Medical Management Referral requests can be submitted electronically via the following link: www.mclarenhealthplan.org/mclaren-health-plan/provider-preauthorization-form	888-327-0671	Preauthorization Requests – 810-600-7959 Inpatient Authorization Requests – 810- 600-7960
Quality Management/Member Outreach Available to assist with Gaps in Care reports, HEDIS reports, quality incentives, member outreach	888-327-0671	Flint: 810-600-7985
Sales Department	888-327-0671	Flint: 810-600-7931

Other Information	
Administrative	McLaren Health Plan G-3245 Beecher Road Flint, MI 48532
Pharmacy Services	For formulary information or medication prior authorization request forms, please visit:

Other Information	
	McLarenHealthPlan.org/mclaren-health-plan/pharmacy-mhp-providers. E-prescribing is available for all lines of business. For McLaren Medicare formularies, visit: https://www.mclarenhealthplan.org/medicare/formulary-ma. To submit a McLaren Medicare prior authorization request electronically, visit: https://mp.medimpact.com/webtocase/W2CWizMain.aspx For a McLaren Medicare prior authorization form, visit:
Provider Demographic Changes	Submit changes online at: mclarenhealthplan.org/mclaren-health-plan/documents-and- links/provider-change-form-8051, via email at MHPProviderServices@mclaren.org or via McLaren CONNECT provider portal.
Provider Portal	The McLaren CONNECT provider portal is available to all contracted MHP providers. On McLaren CONNECT, you can check the status of claims, check member eligibility and view/print EOPs. If you are not currently registered, contact Customer Service today at 888-327-0671.
Claims	MHP receives EDI claims from our clearinghouse, ENS Optum Insight. Our Payer IDs for electronic claims are: • MHP Medicaid/Healthy Michigan Plan – 3883C • MHP Community (Commercial HMO) – 38338 • McLaren Health Advantage (PPO) – 3833A • McLaren Medicare –3833R • McLaren Medicare Supplemental – 3833S

Other Information	
	• You are expected to submit your MHP claims electronically. • Secondary claims are also able to be submitted electronically. • Medicare secondary claims are received by MHP from the CMS Coordination of Benefits System. If you are billing Medicare primary, CMS will forward the claims to MHP for secondary adjudication.
Laboratory	For Medicaid/Healthy Michigan Plan, Commercial HMO/POS and McLaren Health Advantage, required lab vendor is Joint Venture Hospital Lab (JVHL) – 800-445-4979.

McLaren Health Plan – Plan Definitions

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

MHP Medicaid

MHP is contracted with the Michigan Department of Health and Human Services (MDHHS) to provide medical services to eligible Medicaid recipients.

Medicaid Eligibility: The Medical Services Administration administers the Medicaid program in Michigan. Eligibility is determined by the state with the sole authority to determine whether individuals or families meet eligibility requirements as specified for enrollment in the Comprehensive Health Care Program (CHCP) and other state assistance programs.

Children's Special Health Care Services (CSHCS) Eligibility: Eligibility for CSHCS (authorized by Title V of the Social Security Act) is determined by the state with the sole authority to determine whether individuals meet eligibility requirements. Individuals eligible for both CSHCS and Medicaid are a mandatorily enrolled Medicaid-Eligible Group (see II-C (1)(c)).

Medicaid-Eligible Groups

Within the Medicaid-eligible population, there are groups who are mandatorily enrolled in the CHCP; groups who may voluntarily enroll, and groups excluded from enrollment. Those groups are as follows:

1. Medicaid-Eligible Groups Mandatorily Enrolled in the CHCP:
   a. Children in foster care
   b. Families with children receiving assistance under the Financial Independence Program (FIP)
   c. Persons enrolled in Children's Special Health Care Services (CSHCS)
   d. Persons under age 21 who receive Medicaid
   e. Persons enrolled in the MIChild program
   f. Persons receiving Medicaid for the aged
   g. Persons receiving Medicaid for the blind or disabled
   h. Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
   i. Pregnant women
   j. Medicaid-eligible persons enrolled under the Healthy Michigan Plan (HMP)
   k. Supplemental Security Income (SSI) beneficiaries who do not receive Medicare

2. Medicaid-Eligible Groups Who May Voluntarily Enroll in the CHCP:
   a. Migrants
   b. American Indian/Alaska Native
   c. Persons with both Medicare and Medicaid eligibility

3. Medicaid-Eligible Groups Excluded from Enrollment in the CHCP:
   a. Children in childcare institutions
   b. Deductible clients (also known as Spenddown)
   c. Persons without full Medicaid coverage
   d. Persons with Medicaid who reside in Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID) or a state psychiatric hospital
   e. Persons receiving long-term care (custodial care) in a nursing facility
   f. Persons authorized to receive private-duty nursing services
   g. Persons being served under the Home & Community Based Elderly Waiver
   h. Persons with commercial HMO/PPO coverage
   i. Persons in PACE (Program for All-inclusive Care for the Elderly)
   j. Persons in the Refugee Assistance Program
   k. Persons in the Repatriate Assistance Program
   l. Persons in the Traumatic Brain Injury Program
   m. Persons diagnosed with inherited disease of metabolism who are authorized to receive metabolic formula
   n. Persons disenrolled due to Special Disenrollment or Medical Exception for the time period covered by the Disenrollment or Medical Exception

o. Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the contractor's plan
p. Persons incarcerated in a city, county, state or federal correctional facility.
q. Persons participating in the MI Health Link Demonstration

MHP provides administrative services and arranges for the provision of all MHP covered services, offering some additional benefits including transportation, dental, mental health, prescription, vision and other services. Each MHP Medicaid member selects a PCP within thirty (30) days of enrollment, who 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.

Medicaid Service Area – Regions/ Counties

McLaren Health Plan is contracted to service members in Regions 2-10 below.

- Region 2. Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford
- Region 3. Alcona, Alpena, Cheboygan, Crawford, Iosco, Ogemaw, Oscoda, Otsego, Presque Isle, Montmorency, Roscommon
- Region 4. Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm, Newaygo, Oceana, Osceola, Ottawa
- Region 5. Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw
- Region 6. Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola
- Region 7. Clinton, Eaton, Ingham
- Region 8. Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
- Region 9. Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw
- Region 10. Macomb, Oakland, Wayne

Healthy Michigan Plan

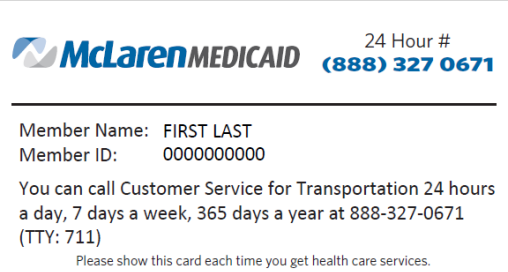
MHP is contracted with the MDHHS to provide medical services to members eligible for Medicaid expansion. MHP administers the benefits for Healthy Michigan members and arranges for the provision of all eligible covered services. The benefit design of the Healthy Michigan Plan ensures member access to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

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 complaint and grievance procedures. MHP handbooks are also available at McLarenHealthPlan.org. If you or your MHP members have any questions, please contact Customer Service at 888-327-0671.

Sample Member Identification Cards

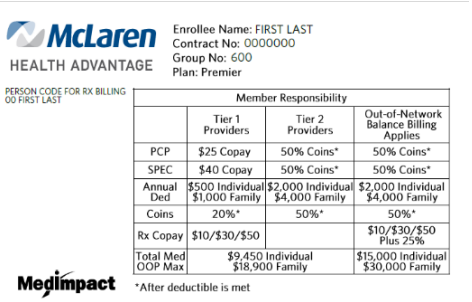

McLaren MEDICAID

24 Hour # (888) 327 0671

Member Name: FIRST LAST
Member ID: 0000000000

You can call Customer Service for Transportation 24 hours a day, 7 days a week, 365 days a year at 888-327-0671 (TTY: 711)

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


McLaren HEALTH ADVANTAGE

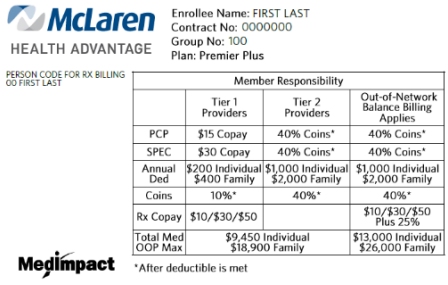
Enrollee Name: FIRST LAST
Contract No: 0000000
Group No: 600
Plan: Premier

PERSON CODE FOR RX BILLING
00 FIRST LAST

	Member Responsibility		
	Tier 1 Providers	Tier 2 Providers	Out-of-Network Balance Billing Applies
PCP	$25 Copay	50% Coins*	50% Coins*
SPEC	$40 Copay	50% Coins*	50% Coins*
Annual Ded	$500 Individual $1,000 Family	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Coins	20%*	50%*	50%*
Rx Copay	$10/$30/$50		$10/$30/$50 Plus 25%
Total Med OOP Max	$9,450 Individual $18,900 Family		$15,000 Individual $30,000 Family

Medimpact

*After deductible is met


McLaren HEALTH ADVANTAGE

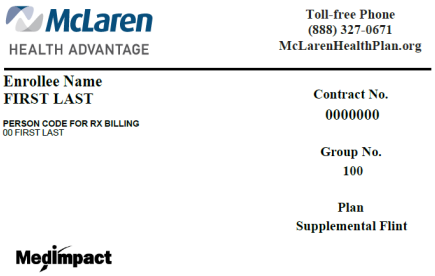
Enrollee Name: FIRST LAST
Contract No: 0000000
Group No: 100
Plan: Premier Plus

PERSON CODE FOR RX BILLING
00 FIRST LAST

	Member Responsibility		
	Tier 1 Providers	Tier 2 Providers	Out-of-Network Balance Billing Applies
PCP	$15 Copay	40% Coins*	40% Coins*
SPEC	$30 Copay	40% Coins*	40% Coins*
Annual Ded	$200 Individual $400 Family	$1,000 Individual $2,000 Family	$1,000 Individual $2,000 Family
Coins	10%*	40%*	40%*
Rx Copay	$10/$30/$50		$10/$30/$50 Plus 25%
Total Med OOP Max	$9,450 Individual $18,900 Family		$13,000 Individual $26,000 Family

Medimpact

*After deductible is met


McLaren HEALTH ADVANTAGE

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

Enrollee Name
FIRST LAST

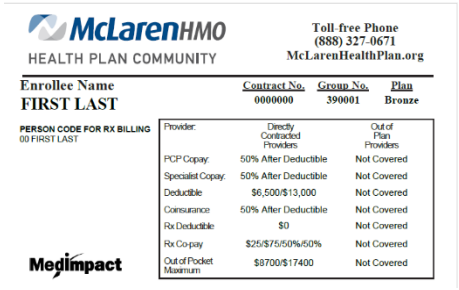
PERSON CODE FOR RX BILLING
00 FIRST LAST

Contract No.
0000000

Group No.
100

Plan
Supplemental Flint

Medimpact


McLaren HMO
HEALTH PLAN COMMUNITY

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

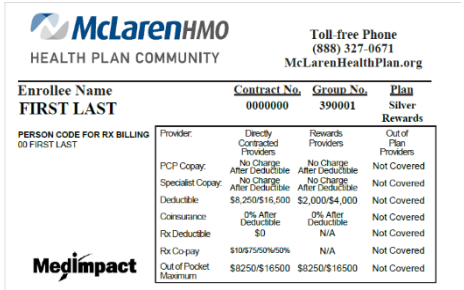
Enrollee Name
FIRST LAST

Contract No.	Group No.	Plan
0000000	390001	Bronze

PERSON CODE FOR RX BILLING
00 FIRST LAST

Provider:	Directly Contracted Providers	Out of Plan Providers
PCP Copay:	50% After Deductible	Not Covered
Specialist Copay:	50% After Deductible	Not Covered
Deductible	$6,500/$13,000	Not Covered
Coinsurance	50% After Deductible	Not Covered
Rx Deductible	$0	Not Covered
Rx Co-pay	$25/$75/50%/50%	Not Covered
Out of Pocket Maximum	$8700/$17400	Not Covered

Medimpact


McLaren HMO
HEALTH PLAN COMMUNITY

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

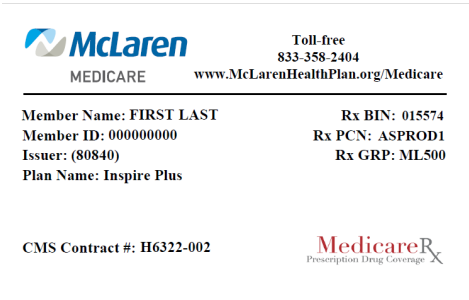
Enrollee Name
FIRST LAST

Contract No.	Group No.	Plan
0000000	390001	Silver Rewards

PERSON CODE FOR RX BILLING
00 FIRST LAST

Provider:	Directly Contracted Providers	Rewards Providers	Out of Plan Providers
PCP Copay:	No Charge After Deductible	No Charge After Deductible	Not Covered
Specialist Copay:	No Charge After Deductible	No Charge After Deductible	Not Covered
Deductible	$8,250/$16,500	$2,000/$4,000	Not Covered
Coinsurance	0% After Deductible	0% After Deductible	Not Covered
Rx Deductible	$0	N/A	Not Covered
Rx Co-pay	$10/$75/50%/50%	N/A	Not Covered
Out of Pocket Maximum	$8250/$16500	$8250/$16500	Not Covered

Medimpact


McLaren MEDICARE

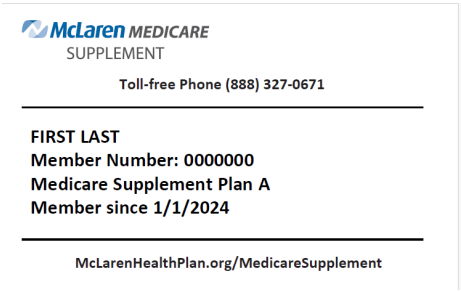
Toll-free
833-358-2404
www.McLarenHealthPlan.org/Medicare

Member Name: FIRST LAST
Member ID: 000000000
Issuer: (80840)
Plan Name: Inspire Plus

Rx BIN: 015574
Rx PCN: ASPROD1
Rx GRP: ML500

CMS Contract #: H6322-002

MedicareRx
Prescription Drug Coverage


McLaren MEDICARE SUPPLEMENT

Toll-free Phone (888) 327-0671

FIRST LAST
Member Number: 0000000
Medicare Supplement Plan A
Member since 1/1/2024

McLarenHealthPlan.org/MedicareSupplement

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, 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 directories for McLaren Medicaid, Healthy Michigan Plan, McLaren HMO, McLaren Rewards, McLaren Medicare and McLaren Health Advantage can be found at McLarenHealthPlan.org. For example, if an MHP member needs to be hospitalized for an elective inpatient procedure, an MHP network hospital must be used (in addition, inpatient hospital care requires preauthorization).

Background Checks

Upon request, McLaren Health Plan must perform background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the state and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The state, in its sole discretion, may also perform background checks.

Culturally and Linguistically Appropriate Services (CLAS) Training Requirement

CLAS is a way to improve the quality of services provided to all individuals. By tailoring services to an individual's culture and language preference, health professionals can bring about positive health outcomes for diverse populations.

CLAS training is an NCQA requirement for all providers and staff. McLaren Health Plan is pleased to offer CLAS training online at www.mclarenhealthplan.org. The training provides an overview of CLAS standards, legal requirements, communication standards, continuous improvement recommendations and member diversity.

We request each provider location complete the CLAS training online and sign the attestation included in the presentation (one per office location). Fax your completed attestation to 810-733-9651.

If you have completed CLAS training with another health plan, we will accept their signed attestation.

Nonparticipating Providers

Preauthorization for services from a nonparticipating provider must be obtained from Medical Management 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 prior to becoming an MHP member (continuity of care)

Exceptions For Medicaid:

- Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) can be accessed in or out of network without preauthorization.
- Children in Foster Care and Children Special Health Care Services are allowed to maintain a primary care provider who is out-of-network when medically necessary.
- Mental Health services are covered in or out-of-network

Role of the PCP

McLaren Community HMO, McLaren Medicaid, Healthy Michigan Plan and McLaren Medicare members must select a PCP at the time of enrollment. If a member does not choose a PCP, MHP will assign a PCP to the member. A PCP is an MHP participating physician who has contracted to provide primary care services and to coordinate and manage the member's access to all health services. Provider must arrange for or make Covered Services available 24 hours a day, 7 days a week when medically necessary. Providers are expected to ensure members have access to emergency and urgent care services 24 hours a day, seven days a week. PCPs must be available to see members 20 hours per week at each practice location. PCPs must reinforce appropriate use of the health care delivery system with all members. Office visits must be available during regular and scheduled office hours. Each family member must select a PCP and members have the right to change PCPs. Medicaid members in CSHCS or foster care benefit plans can remain with their established PCP even if the physician is out-of-network.

MHP recognizes the following groups of providers as PCPs:*

- Family Medicine 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 a 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

Eligibility can be verified on the McLaren CONNECT provider portal. Contact Customer Service at 888-327-0671 for information on accessing and using McLaren CONNECT.

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 use of specialty care, ancillary services and inpatient services. When a member needs non-emergent inpatient care, MHP recommends 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 use of health services. Case Management nursing staff can assist in this process and can be reached at 888-327-0671.

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, you 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 you would like to become a CSHCS PCP, please contact your Provider Relations Representative 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 (e.g., 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 proved successful, as the PCP has additional resources that can support the management of his or her caseload and 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 Medical Management at 888-327-0671. If you have a member who would benefit from a contact by a nurse case manager, please complete a Referral to Case Management form.

Forms are available at McLarenHealthPlan.org and can also be obtained by contacting your Provider Relations Representative.

Gaps in Care Reports

Gaps in Care reports are sent to MHP PCPs. These reports identify a PCP's assigned membership and services that have not been completed for the member based on current Healthcare Effectiveness Data and Information Set (HEDIS®) specifications. Reports are closed when a member receives the service and a claim has been billed to MHP. It is necessary for all MHP PCPs to review their Gaps in Care reports and ensure all services provided have been submitted to MHP. If you find that you have billed a service but your report still shows it as outstanding, please contact MHP's Quality Management department at 810-733-9524 to confirm receipt of the claim or to discuss why the claim did not meet the gap closure.

You can supplement your claim data by faxing medical records to MHP at 810-733-9653. Supplemental medical records can be sent to MHP for the following measures:

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

If you have questions, please contact MHP Customer Service at 888-327-0671 and ask for the Quality department.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Accessibility of Care

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

Type of Service	Standard
Emergency Services	Immediately 24 hours per day / 7 days per week
Urgent Care	Within 48 hours
Routine/Regular Care including preventive services (physicals)	Within 30 business days of request
Non-Urgent Symptomatic Care	Within 7 business days of request
In Office Wait Time	Patient seen within 30 minutes of time of their appointment
After-Hours Coverage (Information/advice is given to patients when medical care is needed after regular office hours)	100%
MHP Customer Service Line – Speed to Answer	80% of calls are answered within 30 seconds
MHP Customer Service Line – Abandonment Rate	5% or less

The following are the McLaren Health Plan Commercial, Marketplace, Medicaid and Medicare monitoring standards for high-volume and high impact specialty care provider accessibility to members:

Type of Service	Standard
Routine Specialty Care (non-urgent)	Within 6 weeks of request
Acute Specialty Care	Within 5 business days of request

The following are the McLaren Health Plan Commercial, Marketplace Medicaid and Medicare monitoring standards for mental health (MH) provider accessibility to members:

Type of Service	Standard
MH Non-Life-Threatening Emergency	Within 6 hours of request
MH Urgent	Within 48 hours of request
MH Initial Visit for Routine Care	Within 10 business days of request
MH Follow-up for Routine Care	Within 45 business days of request

The following are the McLaren Health Plan Commercial, Marketplace, and Medicaid monitoring standards for prenatal care provider accessibility to pregnant members:

Type of Service	Standard
Initial prenatal appointment (Obstetrician, OB-GYN, PCP, certified nurse midwife, or other advanced practice registered nurse with experience, training and demonstrated competence in prenatal care)	If member is in first or second trimester: Within 7 business days of member being identified as pregnant.
	If member is in third trimester: Within 3 business days of member being identified as pregnant.

	If there's any indication of the pregnancy being high-risk (regardless of trimester): Within 3 business days.

The following are the McLaren Health Plan Medicaid monitoring standards for dental provider accessibility to members, as monitored and managed by Delta Dental:

Type of Service	Standard
Emergency Dental Services	Immediately 24 hours per day, 7 days per week
Urgent Dental Care	Within 48 hours
Routine Dental Care	Within 21 business days of request
Preventive Dental Services	Within 6 weeks of request
Initial Appointment	Within 8 weeks of request

An annual evaluation and analysis is conducted by Provider Relations staff on the following:

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

Providers must offer hours of operation that are no less than the hours of operation offered to commercial members, or hours of operation must be comparable to Medicaid fee-for-service office hours if the provider serves only Medicaid enrollees. Results are reported to the Quality Improvement committee. MHP requires an 80 percent compliance rate for all access measures. Those providers who 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

The hours of operation that practitioners offer to Medicaid members must be no less than those offered to commercial members. All services are available 24 hours a day, seven days a week when medically necessary.

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. Members with non-life-threatening behavioral health emergencies should be directed to the nearest emergency room or behavioral health crisis units.

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 uses covering physician(s), we recommend the covering physician also be a participating MHP physician. It is the PCP's responsibility to ensure his or 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 services can be rendered to a member.

Accepting Status of Primary Care Practices

The MHP Community HMO, POS and Medicaid/Healthy Michigan Plan 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

The MHP Community HMO, POS and Medicaid/Healthy Michigan Plan 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 requires the following six steps, completed in the following order:

1. If you are requesting an accepting status change with MHP, you also must be changing the accepting status of your practice with all other health plans.
2. Create a letter on office letterhead that includes the following:
    a. The reason for the request to limit members
    b. Attestation that your practice is being closed to all other health plans
    c. Anticipated time frame new enrollment is to be limited
    d. Signature of physician making the request
3. Mail the letter to your MHP Provider Relations Representative:
   McLaren Health Plan
   Attn: <Name of Provider Relations Representative>
   G-3245 Beecher Road
   Flint, MI 48532
4. The request is reviewed and approved by the Provider Relations Manager following verification of membership assigned to the PCP.
5. The Provider Relations Representative will respond in writing to the provider's request within two weeks, indicating approval or denial.
6. If approved, the request for the accepting status change is effective 30 days from the date of approval and changes your accepting status to "conversion only."

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

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

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

If a request for accepting status change is approved by MHP, the length of the status change is limited to six months from the date of approval. After six months, the accepting status will revert to "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 Provider Relations Representative or by calling 888-327-0671, requesting that the practice be open to new MHP members.

Immunizations

Michigan Care Improvement Registry (MCIR)

The Michigan Public Health Code and Communicable Disease Rules require immunization providers report vaccines administered to children born after 12/31/93. Registering with MCIR facilitates meeting this reporting requirement. MHP providers must register with MCIR at 888-217-3900 or mcir.org. Vaccines administered to all MHP 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 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 Diseases 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.

Emergency and Urgent Care

Patients often find it difficult to distinguish between an urgent health care need and a medical emergency. MHP members are instructed to contact their PCP if a medical problem or question arises that 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
- Loss of consciousness
- Convulsions or seizures
- Severe breathing problems
- Fracture
- Chest pain
- 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 that 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 (e.g., 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 or 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 or 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, seven days a week.

Out-of-Area Emergent Care

When an 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 doesn't have time to call the PCP, they're instructed to go to an MHP participating hospital emergency department or 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.

Referral and Preauthorization 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 having the PCP coordinate the entire episode of care to ensure the timely initiation and appropriate utilization of health services. We do recognize 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 and Preauthorization form is used by MHP to obtain preauthorization when certain services outside of the PCP office setting are requested. The Provider Referral and Preauthorization form is available electronically for completion and submission to MHP at McLarenHealthPlan.org. Electronic clinical notes should be attached. An electronic preauthorization request can be submitted. The electronic form can be accessed at McLarenHealthPlan.org > Providers > Medical Management and Authorization > Provider Preauthorization Form. The form also can be printed from the same webpage and submitted via fax to 810-600-7959. For Medicare members, please select the Medicare Preauthorization Form.

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 Medical Management at 888-327-0671. MHP Medical Management strives to respond to provider requests for preauthorization of services in an efficient and prompt manner. MHP uses the following time frames for timeliness of non-behavioral health care 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 72 hours of the request
- For post-service decisions, MHP makes decisions within 30 calendar days of receipt of the request
- For Part B drugs (Medicare only), MHP makes decisions within 72 hours receipt of the non-urgent request or within 24 hours of receipt of the urgent request.

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

As a reference guide, there is a complete list of service codes requiring preauthorization for each line of business. There also is 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 preauthorization 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 and Preauthorization 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 for the most current information on services that require preauthorization and the preauthorization process. MHP's list of service codes requiring preauthorization is available on our website. Updates, changes and clarifications to authorization requirements will be completed on a quarterly basis. Any updates, changes or clarifications will be effective January, April, July and October of each year.

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 and Preauthorization 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 and Preauthorization form:

- Request date
- Member's plan
- Patient information
- Requestor information
- Referred to information including NPI

- 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.

Inpatient Hospital Services: Provider

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

All elective and urgent hospitalizations must be made to an MHP network hospital unless prior approval from Medical Management 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 member's 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: 810-600-7960 | 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, Medical Management 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. Also, notification of the inpatient admission is required prior to a member's discharge.

This includes a required notification to MHP of a member's date of discharge. Failure to supply the information necessary may result in nonpayment 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 the hospital to 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 hospitals to 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 the 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 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 facility's 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 review all inpatient admissions when a readmission occurs as follows:

- Within 15 days after a Medicaid member is discharged
- Within 30 days after a Medicare 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 15 days, please provide a clinical review for the last two days of the first admission and an admission review 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 at 888-327-0671 to obtain authorization for the services.

General Information

Clinical Practice Guidelines (MQIC)

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 health care services. These guidelines may be found at www.mqic.org and https://www.mclarenhealthplan.org/mclaren-health-plan/clinical-practice-guidelines. The MQIC guidelines are evidence-based and include 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.

Physician Office Laboratory Services

MHP providers who perform laboratory tests in their office must demonstrate 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 PCPs and specialists. 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.

Joint Venture Hospital Laboratories (JVHL)

MHP uses JVHL as our exclusive vendor 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 24/7 client service

support. Outpatient laboratory services should be received at a JVHL location when available to prevent additional out-of-pocket costs for members. You may contact JVHL at 800-445-4979 or visit jvhl.org for additional information, including:

- Service center locations
- JVHL provider directory (select McLaren Health Plan as your insurance provider)

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 Community and Health Advantage

MHP uses Abbott as our sole supplier for diabetic monitors and diabetic monitor supplies for MHP Community and Health Advantage members. To request a monitor for a member, give your patient a prescription for one of the following diabetic meters or test strips:

- FreeStyle Lite meter
- FreeStyle Freedom Lite meter
- Precision Xtra meter
- FreeStyle Lite test strips
- Precision Xtra test strips
- Precision Xtra Beta Ketone test strips

The member can take the prescription to their local pharmacy to receive the meter and test strips. The exception to the requirement to use Abbott for monitors and supplies is:

- 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.

Diabetic Monitors and Supplies – MHP Medicaid/Healthy Michigan Plan and Marketplace

MHP uses Bayer as our sole supplier for diabetic monitors and diabetic monitor supplies for MHP Medicaid/Healthy Michigan Plan and Marketplace members. To request a monitor for a member, give your patient a prescription for the Bayer Contour meter and test strips.

The member can take the prescription to their local pharmacy to receive the meter and test strips. There are a few exceptions to the requirement to use Bayer for monitors and supplies:

- 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 ten (10) years. CMS requires that records related to McLaren Medicare members 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 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.

Providers must maintain in English and in a legible manner written or electronic records necessary to fully disclose and document the extent of services provided to members. Failure to maintain legible and complete records will result in a denial of payment.

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 MHP, MDHHS or CMS, upon request.

When a member changes a 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 manner 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.

Medical Record Review Standards

MHP requires provider's medical records to be maintained in a manner that is current, detailed and organized and which permits effective and confidential patient care and quality review.

MHP Medical Record Review Standards apply to:

- All services provided directly by a practitioner who provides primary care services
- All ancillary services and diagnostic tests ordered by a practitioner
- All diagnostic and therapeutic services for which a member was referred by a practitioner

MHP annually chooses two medical record standards (e.g., patient identification, record content, and continuity and coordination of care) to be assessed through a medical record audit at 50 percent of our PCPs with more than 50 members.

The medical record shall pass at a minimum of 80 percent for passing for the entire review and for each section. If any section is below 80 percent, a corrective action plan (CAP) is required to be submitted within 30 days. If the medical record score is below 80 percent, a CAP is required within 30 days as well as re-visit or re-audit in 60 days.

The following documentation should be in each patient's medical record:

A. PATIENT IDENTIFICATION

Identification sheet or demographic data documented and current.

1. An identification sheet, which includes all of the following information pertaining to the patient/enrollee:
   a. Name
   b. Address
   c. Date of birth or age
   d. Gender (except obstetrics and gynecology)
   e. Emergency contact person
   f. Home and work telephone numbers
   g. Employer

h. Marital status

B. RECORD CONTENT

The following documentation should be in each patient's medical record:

1. ALLERGIES AND ADVERSE REACTIONS TO MEDICATIONS PROMINENTLY DISPLAYED

   May be on front cover, inside cover, medication sheet, patient information sheet.

2. ALL ENTRIES IN MEDICAL RECORD CONTAIN THE WRITER'S ID (INCLUDING FLOW SHEETS)

   All writers in the patient record (including flow sheet) must be identified. If initials or signature stamp is used, a signature list is available. A written policy and procedure is needed for use of the signature stamp and the stamp must be locked or kept with the practitioner at all times.

3. ALL PAGES CONTAIN PATIENT ID

   If pages are not secured in the record, each page must have an ID# (e.g., DOB, MR#, etc.) in addition to the name.

4. RECORD LEGIBLE

   Can be read by at least two people other than the writer.

5. ALL ENTRIES DATED

6. UPDATED PROBLEM LIST

   Pediatric records should include any acute or recurrent problems.

7. UPDATED MEDICATION LIST

   Must be separate from progress notes.

8. IMMUNIZATION RECORD PRESENT

   Is there a centralized form in record for recording all immunizations?

9. ADVANCE DIRECTIVES

   The Michigan Legislature authorized the use of Durable Power of Attorney for Health Care in our state. The member can appoint another individual to make decisions concerning his/her care, custody and medical treatment when member is unable to participate in medical

treatment decisions. Need to have evidence of inquiry of Advance Directives prominently located. (Adults age 18 and older.)

10. APPROPRIATE MEASURES TAKEN TO ENSURE CONFIDENTIALITY OF PATIENT MEDICAL RECORDS

    Includes storage, accessibility of records (must not be accessible to patients), release of information, a written policy and procedure, and a signed confidentiality statement.

11. MEDICAL/TREATMENT RECORD ORGANIZED IN A CONSISTENT MANNER

    All labs, X-ray reports, consults, etc., organized in the record in a consistent manner.

C. HEALTH HISTORY

Comprehensive health assessment completed or offered. If patient refuses to complete the form, documentation should be present. Checklists are acceptable as long as they include the following:

1. MEDICAL HISTORY DOCUMENTED (UPDATED WITH A PHYSICAL)

   Patient can complete, but practitioner must review, date and sign. Include delivery data for children.

2. FAMILY HISTORY DOCUMENTED (UPDATED WITH A PHYSICAL)

   As above. For children, if in foster care or adopted, it must be documented.

3. SOCIAL HISTORY DOCUMENTED

   Marital status, number of children, sexual activity and contraceptive usage.

4. SUBSTANCE USE DOCUMENTED

   Includes documentation of smoking habits and history of patient alcohol use, according to Plan's preventive guidelines.

5. SAFETY EDUCATION

   Evidence of inquiry regarding use of seat belts, helmets, smoke detectors, etc.

6. COMPLETE PHYSICAL EXAMINATION

   A completed physical exam should be documented or offered, in time frames according to Plan's preventive guidelines.

7. ABUSE INQUIRY

   Evidence of inquiry regarding present or previous mental, physical, sexual abuse.

D. PROGRESS NOTES

1. REASON FOR VISIT

The reason patient came to see the practitioner.

2. OBJECTIVE PHYSICAL FINDINGS

What physical findings are found according to patient presenting complaints.

3. DIAGNOSIS/PHYSICAL FINDINGS

4. TREATMENT RENDERED

What was done for the patient relative to the patient's presenting complaints.

5. FOLLOW-UP PLANS

Next visit, return as needed, etc.

6. PREVIOUS UNRESOLVED PROBLEMS ADDRESSED

E. REFERRALS/CONSULTANTS

1. REPORT DATED UPON REVIEW BY PHYSICIAN

2. SIGNED OR INITIALED UPON REVIEW BY PHYSICIAN

3. CONSULTANT/REFERRAL REPORTS IN RECORD

4. REFERRALS ISSUED APPROPRIATELY

F. LAB/X-RAY REPORTS

1. DATED UPON REVIEW BY PHYSICIAN (CAP required if not passed)

2. SIGNED OR INITIALED UPON REVIEW BY PHYSICIAN (CAP required if not passed)

3. FOLLOW-UP TO ABNORMAL FINDINGS

Need documentation of patient notification of abnormal findings and plan to address findings (CAP required if not passed).

G. PREVENTIVE SERVICES

Preventive health care services should be offered and documented accordingly.

1. IMMUNIZATIONS APPROPRIATE FOR AGE
   Evidence of immunizations, according to the Plan's preventive guidelines.

2. BREAST CANCER SCREENING

3. CERVICAL CANCER SCREENING

4. PSA

   Performed in accordance with the Plan's preventive guidelines.

5. COLORECTAL CANCER SCREENING

6. PATIENT EDUCATION

   Based on diagnosis and Plan's preventive guidelines.

7. SMOKING INQUIRY ON EACH VISIT

   Recommended to be done on each visit; may be noted on vital signs sheet.

8. SMOKING COUNSELING ON EACH VISIT (if required)

H. CONTINUITY AND COORDINATION OF CARE

1. IS THERE EVIDENCE OF CONTINUITY AND COORDINATION OF CARE BETWEEN PRIMARY AND SPECIALTY PHYSICIANS?

   Exchange information in an effective, timely and confidential manner, including patient-approved communications between medical practitioners, behavioral health practitioners and other specialist providers.

2. EVIDENCE OF DISCHARGE SUMMARIES FROM HOSPITALS

3. EVIDENCE OF DISCHARGE SUMMARIES OR PROGRESS NOTES FROM SKILLED NURSING FACILITIES/HOME HEALTH PROVIDERS

Medical Record Review Standards for Mental Health and Substance Use Disorder Practitioners

The following MHP Medical Record Review Standards apply to:

- All services provided directly by a practitioner who provides mental health or substance use disorder services
- All ancillary services and diagnostic tests ordered by a practitioner

- All diagnostic and therapeutic services for which a member was referred by a practitioner

MHP annually chooses two medical record standards (e.g., patient identification, record content, and continuity and coordination of care) to be assessed through desk audits of up to 100 providers and /or facilities selected as a random sample.

The Medical Record shall pass at a minimum of 80% for passing for the entire review and for each section. If any section is below 80%, a corrective action plan (CAP) is required to be submitted within 30 days. If the medical record score is below 80%, a CAP is required within 30 days as well as an additional desk audit within 60 days.

The following documentation should be in each patient Mental Health and Substance Use Disorder Practitioners medical record:

A. PATIENT INFORMATION

Identification sheet or demographic data documented and current.
AN IDENTIFICATION SHEET, WHICH INCLUDES ALL OF THE FOLLOWING INFORMATION PERTAINING TO THE ENROLLEE IS DOCUMENTED AND CURRENT:

1. Name
2. Address
3. Date of Birth or Age
4. Gender
5. Emergency contact person
6. Home and work telephone numbers
7. Employer
8. Marital status

B. RECORD CONTENT

1. The following documentation should be in each patient medical record: All pages contain patient name or ID#
2. Problem List
    a. Significant illnesses and medical conditions are indicated on the problem list
3. Medication List
    Long term medications are listed in the Medication Section of the Problem List and updated as necessary
4. Medication Allergies and Adverse Reactions are Prominently Displayed
    a. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record. May be on front cover, inside cover, medication sheet, and patient information sheet
5. Evidence of documentation of individual, family or guardian consent for admission, treatment, evaluation, continuing care, or research

6. Evidence of continuity and coordination of care between primary and behavioral health practitioner – Summaries of recommendations for behavioral health care (including but not limited to prescribed medications) are sent to the patient's primary care physician
    a. Reports sent to the PCP are dated and signed by the practitioner
    b. Reports received from the PCP are reviewed, dated and signed by practitioner
7. All diagnostic and therapeutic procedures, tests, orders and results;
    a. Are dated and signed or initialed by the practitioner.
        (CAP REQUIRED IF NOT PASSED)
    b. Abnormal studies have appropriate follow up and notations
        (CAP REQUIRED IF NOT PASSED)
8. Practitioner identification on each entry – All writers in the patient record must be identified. If initials or signature stamp is used a signature list must be available. A written policy and procedure are needed for use of the stamp and the stamp must be locked or kept with the practitioners at all times.
    a. All entries must be dated
    b. All records must be legible. Legibility is defines as being read and understood by at least two people other than the writer.

C. PATIENT ASSESSMENT/HISTORY

An initial screening and/or assessment of each individual's physical, psychological, and social status is conducted to determine the need for care, the type of care to be provided, and the need for any further assessment. Reassessments are performed as necessary. (CAP REQUIRED IF NOT PASSED)

1. EMOTIONAL AND BEHAVIORAL ASSESSMENT DOCUMENTED
   An emotional and behavioral assessment of each individual is completed and entered in the clinical record. The assessment includes at least a history of emotional, behavioral, and substance-abuse problems, their co-occurrence or treatment, including:
    a. Use of alcohol and other drugs by individual or by family members;
        1. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances;
    b. Current emotional and behavioral functioning;
    c. Maladaptive or problem behaviors;
    d. When indicated, a psychiatric evaluation;
    e. When indicated, a mental status examination appropriate to the individual's age;
    f. When indicated, a psychological assessment, including intellectual, projective, neuropsychological, and personality testing; and
    g. When indicated, other functional evaluations of language, self-care, visual-motor-, and cognitive functioning.
    h. Services provided to a child or an adolescent include assessing the individual's growth and development including physical, emotional, cognitive, educational, nutritional, and social development.
    i. Services provided to a child or an adolescent include assessing the individual's play and daily activities needs.

j. Services provided to individuals with mental retardation or other developmental disabilities include a comprehensive assessment of the presenting problems, disabilities, needs, and when possible their causes.

2. PSYCHOSOCIAL ASSESSMENT DOCUMENTED

A psychosocial assessment is completed and entered in the clinical record for each individual's:

a. Environment and home;
b. Leisure and recreation;
c. Religion and spiritual orientation;
d. Childhood history;
e. Military service history;
f. Financial status;
g. Usual social, peer-group, and environmental setting;
h. Sexual history and orientation; and
i. Family circumstances;
j. The psychosocial assessment includes determining the appropriateness and level of need for the family's participation.
k. When the bereavement process is a significant factor in the individual's need for treatment, care, or services, the psychosocial assessment includes the social, spiritual, and cultural variables that influence the perceptions and expressions of grief by the individual or family.
l. When appropriate, a vocational assessment is completed and entered in the clinical record.
m. When appropriate, an educational assessment is entered in the clinical record.
n. When appropriate, a legal assessment is completed and entered in the clinical record.
    1. Services provided to children and adolescents include assessing the individual's legal custody status, when applicable.

3. Possible victims of abuse or neglect are identified and/or referred to the appropriate setting; assessment includes notification of the proper authorities and release of information, as required by law.

4. ADDITIONAL ASSESSMENT OF INDIVIDUALS IN ADDICTION PROGRAMS
    a. History or alcohol, nicotine, and other drug use, and other addictive behaviors, including age of onset, duration, patterns of use and consequences of use;
    b. History of emotional, behavioral, legal and social consequences of dependence or addiction;
    c. History of physical problems associated with substance abuse, dependence, and other addictive behaviors;
    d. Family history of substance abuse, dependence, or other addictive behaviors;
    e. Religion and spiritual orientation;

f. Types of previous treatment and relapse history; and
g. Any history of abuse.

5. The facility has a screening procedure for the early detection of life-threatening behavior, to assess if an individual is a danger to themselves or others.

6. DISCHARGE PLANNING NEEDS ARE ASSESSED
   a. Assessment data are analyzed and integrated to identify and prioritize the individual's care needs.
   b. Each individual is reassessed to evaluate his or her response to treatment.
   c. Individuals are reassessed when significant changes occur in their condition or diagnosis.

7. ALL OF THE ABOVE ARE SIGNED AND DATED BY PRACTITIONER
   Refer to Record content above, B(8).

A. <u>PROGRESS NOTES</u>

General charting practices should be followed.

1. Diagnosis or Diagnostic Impression;
2. The Reason(s) for Admission or Treatment;
3. Clinical Observations
4. The Response to Care and Services Provided;
5. Every Medical Ordered or Prescribed; Every Dose of Medication Administered and any Adverse Drug Reaction – Prescribed medication's effect on the individual is monitored continuously. Effects of medication are assessed based on information maintained in the individual's clinical record and medication profile and observations by staff the individual.
6. Documentation of Individual, and, as Appropriate Family Involvement in the Treatment Program – When appropriate, a separate record is maintained on each family member involved in treatment;
7. Treatment Plan is Consistent with Diagnosis – A preliminary treatment plan is developed based on an initial screening and is refined in response to additional clinical information.
   a. Justification is documented when identified needs are not addressed.
   b. Treatment plan contains specific goals for achieving emotional and/or physical health as well as maximum growth and adaptive capabilities.
   c. Treatment plan specifies the frequency of treatment procedures.
   d. When indicated to meet a specified objective, the individual program plan addresses the issue of behavior-management procedures and describes:
      i. The reason for such procedures;
      ii. The methods to be used;
      iii. How often or under what circumstances they will be used; and
      iv. Any restriction on the individual's rights.

e. Treatment plan stipulates specific criteria for discharge or terminating treatment.

B. CONTINUITY AND COORDINATION OF CARE

1. TREATMENT-PLAN GOALS LISTED
    a. The treatment-plan goals include specific objectives for the goals identified in the plan.
    b. Rehabilitation plans include a description of facilitating factors and possible barriers to using rehabilitation services or reaching rehabilitation goals.
    c. The treatment plan specifies the interventions and approaches necessary to meet the individual's needs and goals.
2. DOCUMENTED DATE FOR RETURN VISIT OR OTHER FOLLOW-UP PLAN
3. DISCHARGE SUMMARY
    a. A discharge summary that summarizes the reason for treatment or services, the significant findings, the procedures performed treatment or services provided the individual condition on discharge, and any specific instructions given to the individual and/or family, as appropriate.

C. ALL ENTRIES ARE DATED AND SIGNED BY PRACTITIONERS

1. Refer to record content above, B(8).

Confidentiality

MHP guarantees its members the right to privacy of information through the policies and procedures. 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 employees who are authorized with a password have access to electronic information.

Providers must ensure 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 claims history, HEDIS® chart review and other means. This data is used 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.

Gag Clause Prohibition

The Consolidated Appropriations Act (CAA) prohibits group health plans and health insurance issuers from entering into an agreement with providers that include certain gag clauses related to costs and quality. As required by the CAA, your Agreement with MHP and its subsidiaries does not directly or indirectly restrict MHP or a group health plan from:

1. Providing provider-specific cost or quality of care information or date to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individual eligible to become participants, beneficiaries, or enrollees of the plan or coverage.

2. Electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee.

3. Sharing such information, consistent with applicable privacy regulations.

Non-Discrimination

In connection with the performance of services under the contract between MHP and the provider, the provider agrees to comply with the Americans with Disability Act, 42 USLA 12112 (ADA) and Section 1557. 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.

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)

Multiple Surgical Procedures

When submitting claims for multiple surgical procedures performed during the same surgical session – for both professional and facility charges – report the primary surgery on the first service line with no modifier. Report the subsequent procedures performed during the same surgical session with modifier -51.

The multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician or physicians of the same specialty in the same group practice. MHP reimburses up to 100 percent of the fee screen for the most complex surgical procedure, and up to 50 percent of the fee screens for the second through fifth surgical procedures. If more than five procedures are performed, an operative report must be provided with the claim.

Telemedicine

MHP has made available the use of telemedicine to enhance access to care for our members. Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location. It allows real-time interaction at both the originating and distant sites between the patient and health care professional via the telecommunication system. Telemedicine should be used primarily when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services. Telemedicine is most often limited to specialty consults with an ED physician or visits that are of low complexity and when it is not anticipated that a follow-up encounter will be required. It is never to be used for physician convenience.

Providers must ensure the privacy of the member and the security of any information shared via telemedicine. The technology used must comply with current regulations and industry standards for audio and visual equipment and software.

There are no preauthorization requirements when in-network providers provide telemedicine services to MHP members.

All allowable telemedicine services must be submitted with the appropriate telemedicine modifier, -GT. For services that can be billed only via telemedicine, the -GT modifier must always be used. Failure to include the -GT modifier for these services will result in denial of the service.

DME, Prosthetics and Orthotics Benefits

As a reminder, MHP members in any line of business have benefits for DME, prosthetics and orthotics.* Certain authorization requirements apply and are different for specific lines of business. (Please see the authorization requirements listed by service code at McLarenHealthPlan.org). In addition to authorization requirements, there are quantity limits, age parameters and rental caps that MHP applies when considering reimbursement of medically necessary, covered services. If you have any questions, please contact Customer Service at 888-327-0671.

*Orthotics are covered only by providers who have facility accreditation through the American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., to furnish and bill for custom-fabricated P&O appliances. Providers must maintain their ABC accreditation and be able to provide accreditation proof upon request. Coverage for orthotics is not available when received from a podiatrist.

Clinical Editing System (CES) Implementation

MHP implemented a CES in 2019. The implementation of the CES focused on professional claims and is designed to automatically check each claim, on a pre-payment basis, for errors, omissions and questionable coding relationships by testing the data against industry rules, regulations and policies governing health care claims. The CES also detects coding errors, including errors relating to unbundling, incidental procedures, modifier appropriateness, diagnoses and duplicate claims.

Healthy Michigan Plan Program Changes

The MI Health Account for Healthy Michigan Plan beneficiaries has gone away. There are no copays for services for MHP Healthy Michigan Plan members.

The Healthy Michigan Plan Certificate of Coverage and other benefit information can be found at https://www.mclarenhealthplan.org/mclaren-health-plan/healthy-michigan-members-mhp

Dental Services are covered through Delta Dental. For questions about coverage, please contact Delta Dental at 866-558-0280.

Transportation Services

Non-Emergency Transportation Services

McLaren Health Plan provides benefits for non-emergency transportation to McLaren Health Plan Medicaid and Healthy Michigan Plan members. McLaren Health Plan has partnered with ModivCare to provide transportation benefits.

Transportation for McLaren Health Plan and Healthy Michigan Plan Members is free of charge for McLaren Health Plan and MDHHS covered benefits, including but not limited to, doctor’s visits, lab

visits, non-emergency hospital services, prescription pick-up, dental services, and other covered services, whether those are provided by McLaren Health Plan or through MDHHS directly.

Transportation assistance is available 24 hours a day, 7 days a week, 365 days a year. There is a review process if the member needs transportation outside the county they live in. Transportation assistance is available by calling Customer Service at 888-327-0671 (TTY: 711) for more information and to schedule a ride. ModivCare will ask the member or the member's representative whether there are any special transport needs at the time of scheduling. ModivCare will determine the most appropriate mode of transportation to meet the member's medical needs and based on individual circumstances. In some cases, bus tokens may be provided. If a member has their own vehicle or someone else to drive them, they can request mileage reimbursement. This includes, but is not limited to, special transport requirements for members who are medically fragile, members with physical or mental health needs, members with an Intellectual and/or Developmental Disability (I/DD), pregnant members, infants, members with children, and additional riders needed to accompany the member. ModivCare also considers the need for car seats, whether housing status may affect pick-up and drop-off location(s), and any circumstances where the appointment(s) need to be kept confidential. Special transport includes but is not limited to, medically necessary wheelchair lift-equipped vehicles, Medi-Van vehicles, medically necessary attendants, and other transportation related needs supported by medical documentation and/or safety protocols.

ModivCare provides transportation to ongoing services, such as dialysis, chemotherapy, substance use disorder (SUD) services, physical therapy, speech therapy, and occupational therapy. Additionally, to Maternal Infant Health Programs (MIHP) or other MDHHS approved evidence-based home-visiting program, enrolled pregnant and infant beneficiaries to access health care and pregnancy-related appointments and for a mother to visit their hospitalized infant. Pregnancy related appointments include those for oral health services, WIC services, mental and substance use disorder treatment services, and childbirth and parenting education classes. Medically necessary, nonemergency ambulance transportation to Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services (CMHSP) related services. The following lists the non-emergency transportation scheduling guidelines:

- Members should call Customer Service at 888-327-0671 (TTY: 711) for more information and to schedule a ride
- Members should call 2-3 business days before an appointment
- Members can request same-day or next day transportation for an urgent non-emergency appointment
- Transportation can be scheduled up to 30 days in advance of an appointment for ongoing prescheduled appointments for services such, but not limited to, dialysis, chemotherapy or physical therapy, or substance use disorder (SUD) services
- Members should have this information ready when they call:

- Name, Medicaid ID number and date of birth
- The address and phone number of where they will be picked up
- The address and phone number of where they are going
- The appointment date and time
- The name of the provider and provider specialty
- Inform ModivCare of any special needs (wheelchair accommodations, oxygen resources, car seats, etc.) and if there is a need for additional riders
- Members should call as soon as possible to cancel a trip if applicable
- Members should call 911 for Emergency Transportation
- Door-to-door service is available upon request and we comply with paratransit via the Americans with Transportation Services Disabilities Act (ADA).

Mileage/Gas Reimbursement is also available to McLaren Health Plan Medicaid and Healthy Michigan Plan Members. The process for Members who need to request Mileage Reimbursement is listed below:

- Members should call ModivCare at 855-251-7100 and report the driver and their trip details to obtain a trip # for their ModivCare Trip Log, aka Mileage Reimbursement form
- Once the Trip # is obtained, it needs to be logged on the ModivCare Trip Log (ModivCare link below)
- After the Mileage Reimbursement form is completed by the member & signed by their provider, it needs to be submitted to one of the following:
  - By Mail: ModivCare Billing, 798 Park Avenue NW, Norton, VA 24273
  - By Fax: 866-528-0462
  - By Email: virginia.billingoperations@modivcare.com ModivCare Trip Log Form & Trip Log Instructions found here: https://www.modivcare.com/facilities/mi/

If you have any questions or concerns regarding the transportation benefit, please call McLaren Health Plan Customer Service at 888-327-0671 (TTY:711)

Appeals and Grievances

Member Complaint, Grievance and Appeal Procedure

We want to hear member comments so we can make our services better. We want our members to receive answers to questions they have about MHP. We will do our best to fairly resolve any problems members may have with us. Please contact us with any member comments or concerns. We are here to help.

We can help complete forms and take other steps. We also have TTY/TDD, interpreter services, auxiliary aids and services available. If required, foreign language services are available either in oral or written format.

Standard Grievances

Medicaid, Community, and Health Advantage Members

A grievance is a complaint about having a problem calling MHP or if a member is unhappy with the way a provider or an MHP employee treated them. The member or their representative can call Customer Service if they have questions or concerns. MHP's staff will try to resolve concerns during the first contact. If members are still unhappy with MHP's response, they may file a formal grievance. Members can file a grievance verbally with Customer Service or in writing by mail anytime. If a member chooses to submit a grievance via mail, they must send it to:

McLaren Health Plan
Attn: Member Appeals
G-3245 Beecher Road
Flint, MI 48532

Phone number: 888-327-0671 (TTY: 711)
Fax number: 810-600-7984
Email: MHPAppeals@mclaren.org

For Medicaid/HMP grievances related to dental services, dental providers, or Delta Dental customer services, members will contact Delta Dental at 866-558-0280.

Note that grievances do not include appeals. See the Appeals section for more information on appeals. Customer Service staff can help members submit their grievance over their phone and file it on their behalf. Customer Service will acknowledge the grievance verbally. If a member chooses to mail their grievance, MHP will acknowledge receipt of the grievance in writing within five days of receipt. MHP will complete the grievance process within 30 days with the exception of access to care and billing complaints/grievances. Access to care complaints will be resolved within 24-48 hours of receipt. Billing related complaints/grievances will be updated or resolved within two (2) weeks of receipt. Individuals who make decisions on the grievance will not have been involved in a previous level of review. They also will not be a subordinate of a person who made a decision. If required, we will use an appropriate clinical person.

MHP has a two-step process for reviewing grievances. We will complete Step 1 within 15 days of receipt of a grievance. MHP will provide a written decision. If members are not happy with our decision, they may move to Step 2 by appealing to MHP in writing or by phone. We will start Step 2 only if we receive an appeal within five days of our written decision. MHP will review the grievance appeal. We will provide the member with a final decision within 30 days from the initial date of the grievance. Our decision will be in writing.

Medicare

Medicare members can file a grievance verbally with Member Services at 833-358-2404 (TTY: 711) or in writing by mail anytime. If a member chooses to submit a grievance via mail, they must send it to:

Medicare medical-related grievances should be mailed to:

McLaren Medicare
Attn: Appeals & Grievances
PO Box 710
Flint, MI 48501-9900

Medicare pharmacy-related grievances should be mailed to:
MedImpact
Attn: Grievance Department
10181 Scripps Gateway Ct
San Diego CA 92131

Medicare grievances will generally be responded to in the same format as they were received, either in writing or orally. Standard Medicare grievances are processed as quickly as the member's health requires, but no later than 30 calendar days from receipt. Medicare grievances must be submitted within 60 calendar days of the event or incident to be processed.

Expedited (Fast) Grievances

Medicaid, Community, and Health Advantage Members

We will treat a member grievance as expedited if a physician substantiates the 30-day time frame would jeopardize their life or ability to regain maximum function. Call Customer Service to file an expedited grievance on behalf of a member. We will quickly make a decision. We will call the member and the physician and notify of our decision within 72 hours. We will send a written letter with our decision within two days after we call.

Members may, but are not required to, file an appeal of an expedited grievance with MHP.

Medicaid and Community Members

Members may file a request for an expedited external review at the same time they file a request for an expedited internal grievance. If the member files a request for an expedited external review, they may be considered to have exhausted MHP’s internal grievance process. If they file a request for an external expedited review, the internal expedited grievance will be pended until the Michigan Department of Insurance and Financial Services (DIFS) decides whether to accept the request. If DIFS accepts the expedited external request, the member will be considered to have exhausted MHP’s internal grievance process.

Medicare Members

Medicare members or their representatives may request an expedited grievance if McLaren Medicare extends the timeframe to make an organization or coverage determination, extends the timeframe to make a reconsideration or redetermination, denies the member's request for an expedited appeal or organization determination or if the decision on the grievance would seriously harm the member medically if processed under the standard timeframe. Expedited Medicare grievances will be responded to verbally within 24 hours of receipt.

Standard Internal Appeals

Medicaid Members

Members or their representative may file an appeal of an adverse benefit determination with MHP. Note that an untimely response by MHP to a request for coverage may become an adverse benefit determination. The member or their authorized representative has 60 days from the date of the adverse benefit determination letter to file an appeal.

Members can have someone else act as their authorized representative to file their appeal. However, for non-Medicare members they will need to complete MHP's authorized representative form. It is available at McLarenHealthPlan.org. Members or their representative can call Customer Service to be mailed a copy. Members can send the completed form via mail, email or fax to:

McLaren Health Plan
Attn: Member Appeals
G-3245 Beecher Road
Flint, MI 48532

Phone number: 888-327-0671 (TTY: 711)
Fax number: 810-600-7984
Email: MHPAppeals@mclaren.org

Members may appoint an authorized representative at any step of the appeals process. The member's estate representative may represent them if the member is deceased. We cannot start the appeals process until we receive a signed authorized representative form. Please ensure it is sent to us as soon as possible.

The member or their authorized representative can appeal in writing or verbally. If a member submits an appeal in writing, they can send the appeal request along with any added information to the following address, fax or email:

McLaren Health Plan
Attn: Member Appeals
G-3245 Beecher Road
Flint, MI 48532

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7984
Email: MHPAppeals@mclaren.org

McLaren Health Plan will acknowledge receipt of the appeal in writing within five days of receipt.

When MHP makes a decision subject to appeal, MHP will give a written adverse benefit determination notice to the member and the requesting provider, if applicable. Adverse benefit determination involving the suspension, reduction or termination of services, and the member would like to continue receiving those services, the appeal must be made at least 10 days prior to the change in services. MHP will continue member benefits if all the following conditions apply:

- The appeal is filed timely, meaning on or before the later of the following:
  - Within 10 days of MHP mailing the notice of action
  - The intended effective date of MHP proposed action
- The appeal involves the termination, suspension or reduction of previously authorized course of treatment
- The services were ordered by an authorized provider
- The authorization period has not expired
- The member requests an extension of benefits

If MHP continues or reinstates member benefits while the appeal is pending, the services will be continued until one of the following occurs:

- Withdrawal of the appeal
- The member does not request a State Fair Hearing and continuation of benefits within 10 days from the date MHP mails an adverse action notice
- A State Fair Hearing decision adverse to the member is made
- The authorization expires or authorization service limits are met

If we reverse the adverse action decision or if a State Fair Hearing reverses it, we will pay for services provided while the appeal is pending and authorize or provide the disputed services. MHP will do this as fast as the member's health needs require. This will be no more than 72 hours after we receive notice of a reversal.

If an adverse State Fair Hearing decision is made, they may be required to pay the cost of the services. However, MHP may only do this as allowed by state policy.

A member may request copies of information relevant to their appeal, free of charge, by contacting Customer Service. MHP will provide members with any new or added information considered, relied upon or generated by us related to the appeal. This is free of charge to the member. We will also provide the member with any new or added rationale for a denial of their claim or appeal. We will give the member a reasonable opportunity to respond.

Once we receive the appeal request, we will send a letter telling the member about the appeals process. It will also include the time and location of the appeal meeting, if applicable. The member or their authorized representative may speak before the committee in person or by phone. They can present evidence and testimony and make legal and factual arguments. The member or their

authorized representative must contact MHP if they want to take part in the appeal meeting. They can give documents and other information to us. We will consider this information during the appeal.

A person not involved in the initial decision will review the appeal. The person will not be a subordinate of anyone who previously made a decision on the appeal. If the appeal is based in whole or in part on medical judgment, the person who reviews the appeal will be of the same or similar specialty as would typically manage the case. For CSHCS enrollees, MHP will use an appropriate pediatric subspecialist provider to review the decision to deny, suspend, terminate or limit pediatric subspecialist provider services.

We will decide as fast as the member's health condition requires. For Non-CSHCS members MHP has 30 days to complete the internal appeal process. For CSHCS members MHP will complete the internal appeal process within 10 days. We may extend this time period at the member's request. We may also extend the time period for the shorter of 14 calendar days or 10 business days if we requested information from a health care provider but have not received it. The extension must be in the member's best interest. We will call the member if we need to request an extension. We will also send a letter telling the member of the delay. If they disagree with the extension, they may file an appeal.

The member will receive a written letter telling them of our final determination within three days after the decision is made. In addition, we may call the member and tell them of our decision.

Expedited Internal Appeals

If a physician tells us that he or she believes due to a member's medical status, a resolution of the appeal within MHP's normal time frames would seriously jeopardize their life or health or ability to regain maximum function, the expedited appeals process may be used.

A request for an expedited appeal should be made by calling MHP at 888-327-0671. A member can also make this request in writing. They must request an expedited appeal within 10 days of the adverse benefit determination. Expedited appeals are available only for pre-service adverse benefit determinations. This includes requests concerning admissions, continued stay or other health care services if they have received emergency services but have not been discharged from a facility. We may decide not to treat the appeal as expedited. If so, we will make reasonable efforts to call the member and tell them this. We will also mail a letter within two days of the request to tell them that their appeal is not expedited. The appeal will be treated as a standard appeal.

If we accept the appeal as expedited, we will tell the member and their physicians of our decision as fast as their medical condition requires. This will be no later than 72 hours after we receive their request for Non-Medicare Part B drug appeals. The expedited appeal for Medicare Part B drugs will be resolved within 24 hours. Generally, MHP will notify the member and their physician of MHP's

decision by phone. We will send the member and their physician a written letter of our decision within two days after we call.

A member may request an extension of an expedited appeal. But if they request an extension, we may deny their request for an expedited appeal. If so, we will move the appeal to the standard 30-day time frame.

The member's physician may confirm by phone or writing that he or she has a medical condition that the time frame for completing an expedited internal appeal would seriously jeopardize their life, health or ability to regain maximum function. If so, the member or their authorized representative, may file a request for an expedited external review. A member can do this at the same time they or their authorized representative files a request for an expedited appeal with MHP. See the Expedited External Appeals Section for more information on how to do this.

If a member chooses to file a request for an external expedited review, their internal appeal will be pended until DIFS decides whether to accept the request. If DIFS accepts the expedited external appeal, the member will be considered to have exhausted the internal appeal process.

External Review

If after the appeal we continue to deny payment, coverage or the service requested, or the member did not receive a timely decision, the member can ask for an external appeal with DIFS. They must do this within 127 days of receiving MHP's final adverse benefit determination. If the member is not required to exhaust MHP's appeals process, they must do this within 127 days from receiving MHP's adverse benefit determination. MHP will provide the form required to file an external appeal.

Requests should be mailed or faxed to:

DIFS – Office of General Counsel – Appeals Section
PO Box 30220
Lansing, MI 48909-7720

Delivery service:

DIFS – Office of General Counsel – Appeals Section
PO Box 30220
Lansing, MI 48909-7720
Toll-Free Telephone: 877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Submit online at difs.state.mi.us/complaints/externalreview.aspx

When appropriate, DIFS will request an opinion from an Independent Review Organization (IRO). The IRO is not contracted with or related to MHP. DIFS will issue a final order.

Expedited External Appeals

If after the expedited internal appeal we continue to deny coverage or the service requested, the member can ask for an expedited external appeal with DIFS. They must do this within 10 days of receiving our appeal decision. They may also file a request for an expedited external appeal at the same time they file a request for an expedited internal appeal with MHP. MHP will provide the form required to file an expedited external appeal.

These requests should be mailed or faxed to:

DIFS – Office of General Counsel – Appeals Section
PO Box 30220
Lansing, MI 48909-7720

Courier/Delivery Service:

DIFS – Office of General Counsel – Appeals Section
PO Box 30220
Lansing, MI 48909-7720
Toll-Free Telephone: 877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Submit online: difs.state.mi.us/complaints/externalreview.aspx

When appropriate, DIFS will request an opinion from an IRO. The IRO is not contracted with or related to MHP. DIFS will issue a final order.

Fair Hearing Process

If we uphold our decision after the member appeal, they may have additional appeal rights. The member can file a request with the Michigan Office of Administrative Hearing and Rules (MOAHR) with the DHHS. They must file the request with MOAHR within 120 days of our appeal decision. If we do not meet the notice and timing requirements required by law, the member is considered to have exhausted McLaren Health Plan's appeals process. Listed below are the steps for the State of Michigan's Medicaid Fair Hearing process:

Step 1: Call MOAHR at 800-648-3397 or send an email MOAHR at administrativetribunal@michigan.gov to have a hearing request (complaint) form sent to the member. They may also call to ask questions about the hearing process.

Step 2: The member fills out the request (complaint form) and return it to the address listed on the form.

Step 3: The member will be sent a letter telling them when and where their hearing will be held.

Step 4: The results will be mailed to them after the hearing is held. If the appeal is resolved before the hearing date, the member must call MAHS at 877-833-0870 to ask for a hearing request withdrawal form.

We can help complete forms and take other steps. We also have interpreter and TTY services available for members.

If an adverse State Fair Hearing decision is made, members may be required to pay the cost of the services. However, MHP may only do this as allowed by State policy.

Community Members

Members or their representative may file an appeal of an adverse benefit determination with MHP. Note that an untimely response by MHP to a request for coverage may become an adverse benefit determination. The member or their authorized representative have 180 days from the date of the adverse benefit determination letter to file an appeal.

Members can have someone else act as their authorized representative to file their appeal. However, the member will need to complete MHP's authorized representative form. It is available at McLarenHealthPlan.org. You may also call Customer Service to be mailed a copy.

Members can send the completed form via mail, email or fax to:

McLaren Health Plan
Attn: Member Appeals
G-3245 Beecher Road
Flint, MI 48532

Phone number: 888-327-0671 (TTY: 711)
Fax number: 810-600-7984
Email: MHPAppeals@mclaren.org

Members may appoint an authorized representative at any step of the appeals process. The member's estate representative may represent them if the member is deceased. We cannot start the appeals process until we receive a signed authorized representative form. Please ensure it is sent to us as soon as possible.

The member or their authorized representative can appeal in writing or verbally. If a member submits an appeal in writing, they can send the appeal request along with any added information to the following address, fax or email:

McLaren Health Plan
Attn: Member Appeals
G-3245 Beecher Road
Flint, MI 48532

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7984
Email: MHPAppeals@mclaren.org

McLaren Health Plan will acknowledge receipt of the appeal in writing within five days of receipt.

When MHP makes a decision subject to appeal, MHP will give a written adverse benefit determination notice to the member and the requesting provider, if applicable. Adverse benefit determination involving the suspension, reduction or termination of services, and the member would like to continue receiving those services, the appeal must be made at least 10 days prior to the change in services. MHP will continue member benefits if all the following conditions apply:

- The appeal is filed timely, meaning on or before the later of the following:
  - Within 10 days of MHP mailing the notice of action
  - The intended effective date of MHP proposed action
- The appeal involves the termination, suspension or reduction of previously authorized course of treatment
- The services were ordered by an authorized provider
- The authorization period has not expired
- The member requests an extension of benefits

If MHP continues or reinstates member benefits while the appeal is pending, the services will be continued until one of the following occurs:

- Withdrawal of the appeal
- The authorization expires or authorization service limits are met

If we reverse the adverse action decision, we will pay for services provided while the appeal is pending and authorize or provide the disputed services. MHP will do this as fast as the member's health needs require. This will be no more than 72 hours after we receive notice of a reversal.

If an adverse decision is made, they may be required to pay the cost of the services. However, MHP may only do this as allowed by state policy.

A member may request copies of information relevant to their appeal, free of charge, by contacting Customer Service. MHP will provide members with any new or added information considered, relied upon or generated by us related to the appeal. This is free of charge to the member. We will also provide the member with any new or added rationale for a denial of their claim or appeal. We will give the member a reasonable opportunity to respond.

Once we receive the appeal request, we will send a letter telling the member about the appeals process. It will also include the time and location of the appeal meeting, if applicable. The member or their authorized representative may speak before the committee in person or by phone. They can present evidence and testimony and make legal and factual arguments. The member or their

authorized representative must contact MHP if they want to take part in the appeal meeting. They can give documents and other information to us. We will consider this information during the appeal.

A person not involved in the initial decision will review the appeal. The person will not be a subordinate of anyone who previously made a decision on the appeal. If the appeal is based in whole or in part on medical judgment, the person who reviews the appeal will be of the same or similar specialty as would typically manage the case.

We will decide as fast as the member's health condition requires. MHP has 30 days to complete the internal appeal process for pre-service appeals and 60 days for post-service appeals. We may extend this time period at the member's request. We may also extend the time period for the shorter of 14 calendar days or 10 business days if we requested information from a health care provider but we have not received it. But, the extension must be in the member's best interest. We will call the member if we need to request an extension. We will also send a letter telling the member of the delay. If they disagree with the extension, they may file an appeal.

The member will receive a written letter telling them of our final determination within three days after the decision is made. In addition, we may call the member and tell them of our decision.

Expedited Internal Appeals

If a physician tells us that he or she believes that due to a member's medical status, a resolution of the appeal within MHP's normal time frames would seriously jeopardize their life or health or ability to regain maximum function, the expedited appeals process may be used.

A request for an expedited appeal should be made by calling MHP at 888-327-0671. A member can also make this request in writing. They must request an expedited appeal within 10 days of the adverse benefit determination. Expedited appeals are available only for pre-service adverse benefit determinations. This includes requests concerning admissions, continued stay or other health care services if they have received emergency services but have not been discharged from a facility. We may decide not to treat the appeal as expedited. If so, we will make reasonable efforts to call the member and tell them this. We will also mail a letter within two days of the request to tell them that their appeal is not expedited. The appeal will be treated as a standard appeal.

If we accept the appeal as expedited, we will tell the member and their physicians of our decision as fast as their medical condition requires. This will be no later than 72 hours after we receive their request.

Generally, MHP will notify the member and their physician of MHP's decision by phone. We will send the member and their physician a written letter of our decision within two days after we call.

A member may request an extension of an expedited appeal. But if they request an extension, we may deny their request for an expedited appeal. If so, we will move the appeal to the standard 30-day time frame.

The member's physician may confirm by phone or writing that he or she has a medical condition that the time frame for completing an expedited internal appeal would seriously jeopardize their life, health or ability to regain maximum function. If so, the member or their authorized representative, may file a request for an expedited external review. A member can do this at the same time they or their authorized representative files a request for an expedited appeal with MHP. See the Expedited External Appeals Section for more information on how to do this.

If a member chooses to file a request for an external expedited review, their internal appeal will be pended until DIFS decides whether to accept the request. If DIFS accepts the expedited external appeal, the member will be considered to have exhausted the internal appeal process.

External Review

If after the appeal we continue to deny payment, coverage or the service requested, or the member did not receive a timely decision, the member can ask for an external appeal with DIFS. They must do this within 127 days of receiving MHP's final adverse benefit determination. If the member is not required to exhaust MHP's appeals process, they must do this within 127 days from receiving MHP's adverse benefit determination. MHP will provide the form required to file an external appeal.

Requests should be mailed or faxed to:

DIFS – Office of General Counsel – Appeals Section
PO Box 30220
Lansing, MI 48909-7720

Delivery service:

DIFS – Office of General Counsel – Appeals Section
530 W. Allegan St., 7th Floor
Lansing, MI 48933-1521
Toll-Free Telephone: 877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Submit online: difs.state.mi.us/complaints/externalreview.aspx

When appropriate, DIFS will request an opinion from an Independent Review Organization (IRO). The IRO is not contracted with or related to MHP. DIFS will issue a final order.

Expedited External Review

If after the expedited internal appeal we continue to deny coverage or the service requested, the member can ask for an expedited external appeal with DIFS. They must do this within 10 days of receiving our appeal decision. They may also file a request for an expedited external appeal at the same time they file a request for an expedited internal appeal with MHP. MHP will provide the form required to file an expedited external appeal.

These requests should be mailed or faxed to:

DIFS – Office of General Counsel – Appeals Section
PO Box 30220
Lansing, MI 48909-7720

Courier/Delivery Service:

DIFS – Office of General Counsel – Appeals Section
530 W. Allegan St., 7th Floor
Lansing, MI 48933-1521Toll-Free Telephone: 877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Submit online: difs.state.mi.us/complaints/externalreview.aspx

When appropriate, DIFS will request an opinion from an IRO. The IRO is not contracted with or related to MHP final order.

Health Advantage Members

Members or their representative may file an appeal of an adverse benefit determination with MHP. Note that an untimely response by MHP to a request for coverage may become an adverse benefit determination. The member or their authorized representative have 180 days from the date of the adverse benefit determination letter to file an appeal.

Members can have someone else act as their authorized representative to file their appeal. However, the member will need to complete MHP's authorized representative form. It is available at McLarenHealthPlan.org. You may also call Customer Service to be mailed a copy.

Members can send the completed form via mail, email or fax to:

McLaren Health Plan
Attn: Member Appeals
G-3245 Beecher Road
Flint, MI 48532

Phone number: 888-327-0671 (TTY: 711)
Fax number: 810-600-7984
Email: MHPAppeals@mclaren.org

Members may appoint an authorized representative at any step of the appeals process. The member's estate representative may represent them if the member is deceased. We cannot start the appeals process until we receive a signed authorized representative form. Please ensure it is sent to us as soon as possible.

The member or their authorized representative can appeal in writing or verbally. If a member submits an appeal in writing, they can send the appeal request along with any added information to the following address, fax or email:

McLaren Health Plan
Attn: Member Appeals
G-3245 Beecher Road
Flint, MI 48532

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7984
Email: MHPAppeals@mclaren.org

MHP will acknowledge receipt of the appeal in writing within five days of receipt.

When MHP makes a decision subject to appeal, MHP will give a written adverse benefit determination notice to the member and the requesting provider, if applicable. Adverse benefit determination involving the suspension, reduction or termination of services, and the member would like to continue receiving those services, the appeal must be made at least 10 days prior to the change in services. MHP will continue member benefits if all the following conditions apply:

- The appeal is filed timely, meaning on or before the later of the following:
  - Within 10 days of MHP mailing the notice of action
  - The intended effective date of MHP proposed action
- The appeal involves the termination, suspension or reduction of previously authorized course of treatment
- The services were ordered by an authorized provider
- The authorization period has not expired
- The member requests an extension of benefits

If MHP continues or reinstates member benefits while the appeal is pending, the services will be continued until one of the following occurs:

- Withdrawal of the appeal
- The authorization expires or authorization service limits are met

If we reverse the adverse action decision, we will pay for services provided while the appeal is pending and authorize or provide the disputed services. MHP will do this as fast as the member's health needs require. This will be no more than 72 hours after we receive notice of a reversal.

If an adverse decision is made, they may be required to pay the cost of the services. However, MHP may only do this as allowed by state policy.

A member may request copies of information relevant to their appeal, free of charge, by contacting Customer Service. MHP will provide members with any new or added information considered, relied upon or generated by us related to the appeal. This is free of charge to the member. We will also provide the member with any new or added rationale for a denial of their claim or appeal. We will give the member a reasonable opportunity to respond.

Once we receive the appeal request, we will send a letter telling the member about the appeals process. It will also include the time and location of the appeal meeting, if applicable. The member or their authorized representative may speak before the committee in person or by phone. They can present evidence and testimony and make legal and factual arguments. The member or their authorized representative must contact MHP if they want to take part in the appeal meeting. They can give documents and other information to us. We will consider this information during the appeal.

A person not involved in the initial decision will review the appeal. The person will not be a subordinate of anyone who previously made a decision on the appeal. If the appeal is based in whole or in part on medical judgment, the person who reviews the appeal will be of the same or similar specialty as would typically manage the case.

We will decide as fast as the member's health condition requires. MHP has 30 days to complete the internal appeal process for pre-service appeals and 60 days for post-service appeals. We may extend this time period at the member's request. We may also extend the time period for the shorter of 14 calendar days or 10 business days if we requested information from a health care provider but we have not received it. But, the extension must be in the member's best interest. We will call the member if we need to request an extension. We will also send a letter telling the member of the delay. If they disagree with the extension, they may file an appeal.

The member will receive a written letter telling them of our final determination within three days after the decision is made. In addition, we may call the member and tell them of our decision.

Expedited Internal Review

If a physician tells us that he or she believes that due to a member's medical status, a resolution of the appeal within MHP's normal time frames would seriously jeopardize their life or health or ability to regain maximum function, the expedited appeals process may be used.

A request for an expedited appeal should be made by calling MHP at 888-327-0671. A member can also make this request in writing. They must request an expedited appeal within 10 days of the adverse benefit determination. Expedited appeals are available only for pre-service adverse benefit determinations. This includes requests concerning admissions, continued stay or other health care services if they have received emergency services but have not been discharged from a facility. We may decide not to treat the appeal as expedited. If so, we will make reasonable efforts to call the

member and tell them this. We will also mail a letter within two days of the request to tell them that their appeal is not expedited. The appeal will be treated as a standard appeal.

If we accept the appeal as expedited, we will tell the member and their physicians of our decision as fast as their medical condition requires. This will be no later than 72 hours after we receive their request.

Generally, MHP will notify the member and their physician of MHP's decision by phone. We will send the member and their physician a written letter of our decision within two days after we call.

A member may request an extension of an expedited appeal. But if they request an extension, we may deny their request for an expedited appeal. If so, we will move the appeal to the standard 30-day time frame.

The member's physician may confirm by phone or writing that he or she has a medical condition that the time frame for completing an expedited internal appeal would seriously jeopardize their life, health or ability to regain maximum function. If so, the member or their authorized representative, may file a request for an expedited external review. A member can do this at the same time they or their authorized representative files a request for an expedited appeal with MHP. See the Expedited External Appeals Section for more information on how to do this.

External Review

If after the appeal we continue to deny payment, coverage or the service requested, or the member did not receive a timely decision, the member can ask for an external review with an Independent Review Organization (IRO). They must do this within 120 days of receiving MHP's final adverse benefit determination.

Within five business days of receiving the external review request, MHP will complete a preliminary review of the request to determine eligibility of external review. To qualify for external review the adverse determination involves: (1) medical judgement or (2) a recissions of coverage or (3) whether we are complying with applicable surprise billing laws.

If the request qualifies for external review MHP will assign a review to one of our contracted IROs. The IRO will review. The IRO will provide written notice of the final decision within 45 days which is sent to the member and MHP. If the request does not qualify for external review the member will be notified in writing including the reasons for not meeting external review standards.

Expedited External Review

If after the expedited internal appeal we continue to deny coverage or the service requested, the member can ask for an expedited external review. They must do this within 10 days of receiving our appeal decision. They may also file a request for an expedited external appeal at the same time they

file a request for an expedited internal appeal with MHP. MHP will assign an IRO to the request. The IRO will provide notice of decision as expeditiously as the member's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for expedited external review.

Medicare Members

Members enrolled in McLaren Medicare plans are entitled to the CMS-required appeal process which includes requirements and time frames for standard and expedited appeals. Members or their representatives have the right to file an appeal of an adverse organization determination for payment or services that the member believes should have been covered benefits or services (including non-Medicare covered benefits). Note that an untimely response by McLaren Medicare to a request for coverage may become an adverse benefit determination. The member or their representative may file an appeal within 60 days of receipt of the denial.

Members may have someone else act as their appointed representative to file their appeal. However, they will need to complete the CMS Appointment of Representative form. It's available on our website at https://www.mclarenhealthplan.org/medicare/appeals-and-grievances-ma. They may also call Member Services and ask for a copy to be mailed to them. Members or their representatives may send the completed form via mail or email to:

McLaren Medicare
Attn: Appeals & Grievances
PO Box 710
Flint, MI 48501-9900
Email: MedicareAppeals@mclaren.org

Members may appoint an authorized representative at any step of the appeals process. The member's estate representative may represent them if the member is deceased. McLaren Medicare cannot start the appeals process until a signed authorized representative form is received. Please ensure it is sent to us as soon as possible.

The member or their authorized representative may appeal in writing or verbally. If a member submits an appeal in writing, they may send the appeal request along with any added information to the following address, fax or email:

Medicare medical-related appeals should be mailed to:

McLaren Medicare
Attn: Appeals & Grievances
PO Box 710

Flint, MI 48501-9900
Email: MedicareAppeals@mclaren.org

Medicare pharmacy-related appeals should be mailed to:

MedImpact
Attn: Grievance Department
10181 Scripps Gateway Ct.
San Diego CA 92131

As a contracted provider, you may be asked to submit an appeal on your patient's behalf or provide additional information regarding the member's appeal. Upon request, this information should be provided to McLaren Medicare as quickly as possible for us to make a timely and accurate determination.

A member may request copies of information relevant to their appeal, free of charge, by contacting Member Services. McLaren Medicare will provide members with any new or added information considered, relied upon or generated by us related to the appeal. This is free of charge to the member. We will also provide the member with any new or added rationale for a denial of their claim or appeal. We will give the member a reasonable opportunity to respond.

A person not involved in the initial decision will review the appeal. The person will not be a subordinate of anyone who previously made a decision on the appeal. If the appeal is based in whole or in part on medical necessity, the person who reviews the appeal will be completed by a physician with expertise in the field of medicine that is appropriate for the item or service in question.

We will decide as fast as the member's health condition requires. For Medicare appeals related to pre-service will be resolved within 30 days, post-service within 60 days and Part B drug appeals within seven (7) days. We may extend this time period at the member's request. We may also extend the time period for the shorter of 14 calendar days or 10 business days if we requested information from a health care provider but we have not received it. However, an extension is not permissible when the appeal is related to Medicare Part B drugs. The extension must be in the member's best interest. We will call the member if we need to request an extension. We will also send a letter telling the member of the delay. If they disagree with the extension, they may file an appeal.

The member will receive a written letter telling them of our final determination within three days after the decision is made. In addition, we may call the member and tell them of our decision.

Expedited Internal Appeals

If a physician tells us that he or she believes that due to a member's medical status, a resolution of the appeal within MHP's normal time frames would seriously jeopardize their life or health or ability to regain maximum function, the expedited appeals process may be used.

A request for an expedited appeal should be made by calling McLaren Medicare at 833-358-2404 (TTY:711). A member can also make this request in writing. They must request an expedited appeal within 10 days of the adverse benefit determination. Expedited appeals are available only for pre-service adverse benefit determinations. This includes requests concerning admissions, continued stay or other health care services if they have received emergency services but have not been discharged from a facility. We may decide not to treat the appeal as expedited. If so, we will make reasonable efforts to call the member and tell them this. We will also mail a letter within two days of the request to tell them that their appeal is not expedited. The appeal will be treated as a standard appeal.

If we accept the appeal as expedited, we will tell the member and their physicians of our decision as fast as their medical condition requires. This will be no later than 72 hours after we receive their request for Non-Medicare Part B drug. The expedited appeal for Medicare Part B drugs will be resolved within 24 hours. Generally, McLaren Medicare will notify the member and their physician of our decision by phone. We will send the member and their physician a written letter of our decision within two days after we call.

A member may request an extension of an expedited appeal. But if they request an extension, we may deny their request for an expedited appeal. If so, we will move the appeal to the standard 30-day time frame.

Office of Inspector General (OIG Audits and Appeals)

Adherence to the Medicaid Provider Manual. You must adhere to the Michigan Medicaid Provider Manual. Notwithstanding the foregoing, if there is a conflict between the Medicaid Provider Manual and the Agreement or Plan's policies and procedures, the applicable Plan document will control.

OIG Post-Payment Evaluations. Provider agrees that MDHHS-OIG has the authority to conduct post- payment evaluations of any claims paid by Plan.

OIG Appeals Process. Provider agrees to follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306 for post- payment evaluations conducted by MDHHS-OIG. If requested by Plan, Provider must appeal MDHHS-OIG's findings at all available levels of appeal and take all reasonable steps to appeal the findings, including submitting additional evidence or information.

Amounts Owed. Plan will promptly notify provider if MDHHS-OIG requests recovery of an overpayment from Plan related to provider, or if MDHHS-OIG actually recovers or otherwise receives the amount from Plan. Upon receipt of the notification from Plan, provider will immediately provide the entire overpayment amount to Plan. Notwithstanding the foregoing, Plan may, in its sole discretion, offset any amounts against claims submitted by provider to plan. If provider has not paid all amounts due to Plan, for any reason, Plan may refer collection of the unpaid amount to an attorney or

collections agency. If Provider's unpaid amounts are referred to an attorney or collections agency, Provider must pay all reasonable attorney's fees or collections agency fees.

Time Period for Recoveries. There is no time limit for recoveries arising out of or related to referrals from MDHHS-OIG, or for fraud, waste or abuse.

Medical Records. All medical records must be retained for at least 10 years, or longer if required by applicable law, regulation or a regulatory agency.

State Exclusion Checks. Provider and its employees must not be suspended, excluded, debarred or otherwise ineligible to participate in state government programs. Provider agrees to monitor and routinely conduct screenings to ensure that provider and its employees are properly licensed and not suspended, excluded, debarred or otherwise ineligible to participate in state government programs.

In-Office Laboratory Procedures

MHP contracts with Joint Venture Hospital Laboratories (JVHL) to provide all outpatient laboratory services. 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 for the Commercial and Health Advantage lines of business. MHP Medicaid reimburses in-office laboratory services in accordance with MDHHS policy.

In-Office Laboratory Billable Procedures	
CPT/HCPCS Code	**Procedure Description**
80047	BASIC METABOLIC PANEL
80047QW	BASIC METABOLIC PANEL
80048	BASIC METABOLIC PANEL
80051	ELECTROLYTE PANEL
80053	COMPREHENSIVE METABOLIC PANEL
80053QW	COMPREHENSIVE METABOLIC PANEL

In-Office Laboratory Billable Procedures	
CPT/HCPCS Code	**Procedure Description**
80305	DRUG TEST CAPABLE OF BEING READ BY DIRECT OPTICAL OBSERVATION
80306	DRUG TEST CAPABLE OF BEING READ BY INSTRUMENT ASSISSTED DIRECT OPTICAL OBSERVATION
80307	DRUG TEST CAPABLE OF BEING READ BY INSTRUMENT CHEMISTRY ANALYZERS
81000	URINALYSIS; NON-AUTOMATED, WITH MICROSCOPY
81001	URINALYSIS; AUTOMATED, WITH MICROSCOPY
81002	URINALYSIS; NON-AUTOMATED, WITHOUT MICROSCOPY
81003	URINALYSIS; AUTOMATED, WITHOUT MICROSCOPY
81007QW	URINALYSIS SCREEN FOR BACTERIA, EXCEPT BY CULTURE OR DIPSTICK
81015	URINANLYSIS; MICROSCOPIC ONLY
81025	URINE PREGNANCY TEST, BY VISUAL COLOR COMPARISON METHODS
82043	URINARY MICROALBUMIN, QUANTITATIVE
82044	URINARY MICROALBUMIN
82270	BLOOD, OCCULT; FECES SCREENING BY PEROXIDASE ACTIVITY, 1-3 SIMULTANEOUS DETERMINATIONS

In-Office Laboratory Billable Procedures	
CPT/HCPCS Code	**Procedure Description**
82271	BLOOD, OCCULT; FECES SCREENING BY OTHER SOURCES, 1-3 SIMULTANEOUS DETERMINATIONS
82272	BLOOD, OCCULT; FECES SCREENING BY PEROXIDASE ACTIVITY, SINGLE SPECIMEN (E.G., FROM DIGITAL RECTAL EXAM)
82274	BLOOD, OCCULT; FECAL HEMOGLOBIN SCREENING BY IMMUNOASSAY, 1-3 SIMULTANEOUS DETERMINATIONS
82274QW	BLOOD, OCCULT; FECAL HEMOGLOBIN SCREENING BY IMMUNOASSAY, 1-3 SIMULTANEOUS DETERMINATIONS
82310	CALCIUM; TOTAL
82374	CARBON DIOXIDE (BICARBONATE)
82435	CHLORIDE; BLOOD
82565	CREATININE; BLOOD
82570	ASSAY OF URINE CREATININE
82670	ESTRADIOL*
82947	GLUCOSE; QUANTITATIVE
82947QW	GLUCOSE; QUANTITATIVE
82948	GLUCOSE; BLOOD, REAGENT STRIP
82950	GLUCOSE TEST (Effective 1/01/2021)

In-Office Laboratory Billable Procedures	
CPT/HCPCS Code	**Procedure Description**
82962	GLUCOSE, BLOOD, BY GLUCOSE HOME USE DEVICE (Effective 1/01/2021)
83001	GONADOTROPIN; FOLLICLE STIMULATING HORMONE (FSH)
83001QW	GONADOTROPIN; FOLLICLE STIMULATING HORMONE (FSH) *
83002	GONADOTROPIN; LUTEINIZING HORMONE (LH) *
83036	HEMOGLOBIN, GLYCATED
83037	GLYCOSYLATED HEMOGLOBIN TEST
83655	LEAD
83861	TEAR ANALYSIS
84144	PROGESTERONE*
84146	PROLACTIN*
84295	SODIUM; SERUM, PLASMA OR WHOLE BLOOD
84520	UREA NITROGEN; QUANTITATIVE
84703QW	GONADOTROPIN, CHORIONIC (HCG); QUALITATIVE
85007	BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL DIFFERENTIAL WBC COUNT
85013	BLOOD COUNT; SPUN MICROHEMATOCRIT

In-Office Laboratory Billable Procedures	
CPT/HCPCS Code	**Procedure Description**
85014	BLOOD SMEAR; HEMATOCRIT (HCT)
85014QW	BLOOD SMEAR; HEMATOCRIT (HCT)
851018	BLOOD SMEAR; HEMOGLOBIN (HGB)
85018QW	BLOOD SMEAR; HEMOGLOBIN (HGB)
85025	COMPLETE BLOOD CT (CBC-HGB, HCT, RBC, WBC, AND PLT) AND DIFF, AUTOMATED
85027	BLOOD COUNT; COMPLETE (CBC) AUTOMATED (HGB, HCT, RBC, WBC, PLAT)
85048	BLOOD COUNT; LEUKOCYTE (WBC), AUTOMATED
85097	BONE MARROW; SMEAR INTERPRETATION ONLY, W/OR W/O DIFF. CELL CNT*
85610	PROTHROMBIN TIME
85651	SEDIMENTATION RATE, ERYTHROCYTE; NON-AUTOMATED
86308	HETEROPHILE ANTIBODIES; SCREENING
85007	BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL DIFFERENTIAL WBC COUNT
85013	BLOOD COUNT; SPUN MICROHEMATOCRIT
85014	BLOOD SMEAR; HEMATOCRIT (HCT)

In-Office Laboratory Billable Procedures	
CPT/HCPCS Code	**Procedure Description**
85014QW	BLOOD SMEAR; HEMATOCRIT (HCT)
85025	COMPLETE BLOOD CT (CBC-HGB, HCT, RBC, WBC, AND PLT) AND DIFF, AUTOMATED
85027	BLOOD COUNT; COMPLETE (CBC) AUTOMATED (HGB, HCT, RBC, WBC, PLAT)
85048	BLOOD COUNT; LEUKOCYTE (WBC), AUTOMATED
85097	BONE MARROW; SMEAR INTERPRETATION ONLY, W/OR W/O DIFF. CELL CNT*
85610	PROTHROMBIN TIME
85651	SEDIMENTATION RATE, ERYTHROCYTE; NON-AUTOMATED
86308	HETEROPHILE ANTIBODIES; SCREENING
86308QW	HETEROPHILE ANTIBODIES; SCREENING
86318	COVID
86328	COVID
86403	PARTICLE AGGLUTINATION (SCREENING EACH ANTIBODY) RAPID STREP TEST
86580	SKIN TEST; TUBERCULOSIS, INTRADERMAL
87081	CULTURE, BACTERIAL, SCREENING ONLY; FOR SINGLE ORGANISMS

In-Office Laboratory Billable Procedures	
CPT/HCPCS Code	**Procedure Description**
87210	SMEAR, PRIMARY SOURCE, W/INTERP; WET MOUNT SIMPLE STAIN
87220	TISSUE EXAMINATION BY KOH SLIDE FOR FUNGI*
87400	INFLUENZA, A OR B
87426	COVID
87428	COVID
87502	INFLUENZA VIRUS
87635	COVID
87636	COVID
87637	COVID
87650	STREPTOCOCCUS, GROUP A, DIRECT PROBE TECHNIQUE
87651	STREPTOCOCCUS, GROUP A, AMPLIFIED PROBE
87798	RSV
87804	INFLUENZA TEST (Effective 1/01/2021)
87807	RAPID RSV (Effective 1/01/2021)
87811	COVID
87880	STREP TEST (Effective 1/01/2021)

In-Office Laboratory Billable Procedures	
CPT/HCPCS Code	**Procedure Description**
87880QW	INFECTIOUS AGENT DETECTION IMMUNOASSAY OBS, STREPT GROUP A
89050	CELL COUNT, MISCELLANEOUS BODY FLUIDS, EXCEPT BLOOD
89190	NASAL SMEAR FOR EOSINOPHILS
89300/G0027	SEMEN ANALYSIS; PRESENCE AND/OR MOTILITY OF SPERM*
89310	SEMEN ANALYSIS; MOTILITY AND COUNT (NOT INC. HUHNER TEST) *
89320	SEMEN ANALYSIS; COMPLETE (VOLUME, COUNT, MOTILITY, DIFFERENTIAL) *
0241U	COVID
G0480	DRUG TEST, 1-7 DRUG CLASS(ES)
G0481	DRUG TEST, 8-14 DRUG CLASSES
G2023	COVID
U0002	COVID
U0003	COVID
U0004	COVID
U0005	COVID

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:

  McLaren Health Plan Attn: Appeals
  G-3245 Beecher Road Flint, MI 48532
  Fax: 810-600-7984
  Email: mhpappeals@mclaren.org

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

The 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
- 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
- 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 appeals request must accompany the PRA form. 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 either 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 the 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.

MHP staff who did not participate in the audit or are not subordinates of those who 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.

Billing & Claims

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.

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

Billing Reminders

- All claims must include member/subscriber ID to avoid receiving a rejected claim.
- 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 it is expected that all claims, including coordination of billing claims, are submitted 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. MHP will not accept any claim submissions via fax or email.

Paper claim submission must be done using the most current form version as designated by the CMS and the National Uniform Claim Committee (NUCC). If you are submitting paper claims, you need to contact your Provider Relations Representative for assistance with the submission of electronic claims.

Please note: You must submit your appropriate NPI on the claim form. If you have any questions, contact Provider Relations 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 Community – Commercial HMO/POS – 38338
- McLaren Health Advantage – 3833A
- McLaren Medicare (MA) - 3833R
- McLaren Medicare Supplemental – 3833S

Clearinghouse Information (Both Professional and Facility)

MHP receives EDI claims from our clearinghouse, Optum. Since you may choose to contract with a different clearinghouse, you must ensure your clearinghouse has a forwarding arrangement with Optum. 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 Optum - 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 to be processed.

- Subscriber Identification - We will not process a claim that contains an invalid or missing 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 Service 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 of Optum or have problems with claim rejections received by Optum, visit UHCprovider.com/ediconnect or contact Optum Support at 866-678-8646 and choose Option 2.

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

  - Access the McLaren Connect provider portal at McLarenHealthPlan.org
  - Contact Customer Service at 888-327-0671 (TTY: 711)

Clean Claims

MHP is required to process your clean claims within 45 days of MHP receiving the claim. Clean claims not processed in this time period are eligible for interest payments at 12 percent 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's 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.

Claims for Physician Administered Drugs with unlisted CPT/HCPCS codes or codes that do not have an established fee will be reimbursed in accordance with MHP's policy (a % of AWP), when authorized as applicable.

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 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.

COB claims should be submitted electronically. COB claims must be submitted to MHP within 12 months from the date of service or 90 days from the date of the primary payer's EOB. To ensure appropriate adjudication of secondary claims, the primary insurance payment must be reported at the line level, not at the claim level.

MHP has an active Coordination of Benefits Agreement (COBA) with CMS. COBA standardizes the way eligibility and Medicare claims payment information with a claims crossover is exchanged. When you are seeing a patient who has Medicare primary and MHP coverage secondary, you need to submit the claim to Medicare. Once Medicare adjudicates the claim, it will be forwarded, by CMS, to MHP. MHP will then process the claim for secondary benefits. You will not need to submit a secondary claim directly to MHP when a patient has Medicare primary.

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 the McLaren CONNECT provider portal. McLaren CONNECT is 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 register for access to McLaren CONNECT at McLarenHealthPlan.org and you will be given a password.

You can also status a claim by completing the Provider Claims Status Fax form and faxing it to Customer Service at 833-540-8648.

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 resubmitting 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, or who believe a service was denied inappropriately or that 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 833-540-8648 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:

- COB
- Subrogation
- Clinical inpatient review
- Fraud, waste or abuse
- 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 that 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

Overpayments

Providers are required to promptly report overpayments to McLaren Health Plan, but not later than 60 days of identification of the overpayment. Providers are required to notify McLaren Health Plan in writing of the reason for an overpayment and submit a Provider Refund Remittance Form with the overpayment. If McLaren Health Plan identifies an overpayment, we will work with Providers to ensure overpayments are returned/recovered, which may include offsetting future claims or the use of collections when McLaren Health Plan is unable to recover an overpayment by either offsetting future claims or through the Provider Refund Remittance Form from the provider. Notwithstanding McLaren Health Plan's ability to collect the overpayment, all encounters associated an overpayment related to

Medicaid lines of business must be adjusted within 45 days of identification. The following table outlines the time frames for MHP to request funds or do take-backs.

Type of Corrective Adjustment	Timeframe
COB	The longer of 12 months from the date of service or 90 days after MHP's receipt of information confirming the primary carrier
Subrogation	24 months from the initial date of reimbursement
Inpatient Clinical Review	24 months from the initial date of reimbursement
Gross Negligence, Billing Errors, Fraud by Provider	No time limit
Clerical Overpayments by MHP	No time limit
Termination of Member's Coverage	12 months from the date of service

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

MHP receives notice from an employer, including the State of Michigan for Medicaid/Healthy Michigan Plan members, if 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 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.

Sample Provider Payment Report

MHP Commercial – McLaren Health Advantage – McLaren Advantage

Return Address Name PO Box
999999 Anywhere, ZZ 12345

Forwarding Service Requested

Sample

Questions, call us at (888) 327-0671

Easy-to-locate customer service phone number

Group Name: ACME Sales, INC.
Group #: 12345
Division: 456
Provider TIN: 9999999999
Internal ID: 00123456
Check #: 006543
Check Date: 1/05/200 1

Voucher-level information grouped together

Claim information is easily located within the shaded area

COB information here

No.	Date(s) of Service	Proc Code	Description of Services	Billed Amount	Provider Discount	Ineligible Amount	Ineligible Code	Deductible	Copay Co-ins	Other Carrier	Benefits Paid
Claim #: 21417166-01 Patient Account #: ABC-123				Insured Name: John Doe Patient name: John Doe				Insured ID: 999-99-999			
1	08/01/8	36415	Office Visit	40.00	0.00	40.00	10	0.00	0.00	0.00	0.00
2	08/01/8	84015	Injection	35.00	4.42	0.00		0.00	0.00	0.00	20.58
	Totals			75.00	17.84	0.00		0.00	0.00	0.00	20.58

Reason descriptions are centralized in a separate section of the EOB

Other Credits or Adjustments	0.00
Total Net Payment	20.58

Reason Code Description
10 CHARGES PREVIOUSLY CONSIDERED

The statement total section summarizes all claims for the voucher

STATEMENT TOTALS

Total Charges	Provider Discount	Ineligible Amount	Deductible	Copay Co-ins	Other Carrier	Benefits
18.25	0.00	2.73	0.00	0.00	0.00	20.58
Other Credits or Adjustments						0.00
Total Net Payment						20.58

Understanding the Remittance Advice

The goal at MHP is to use a Provider Payment Report (PPR) format that makes our claims processing information understandable. If you have questions about your PPR, please contact Customer Service at 888-327-0671.

835 and EFT Options

The goal at MHP is to use a Provider Payment Report (PPR) format that makes our claims processing information understandable. If you have questions about your PPR, please contact Customer Service at 888-327-0671.

Anesthesia Services Billing

MHP 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 MHP'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, MHP 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:

Primary Modifier

Modifier	Description	MHP's Commercial Payment % of Allowable	MHP's Medicaid Payment % of Allowable
AA	Physician personally directs the entire case	100%	
AD	Physician supervising more than four concurrent cases	60%	
GC	Physician supervising up to two anesthesia residents	100%	

Modifier	Description	MHP's Commercial Payment % of Allowable	MHP's Medicaid Payment % of Allowable
QK	Physician directing two, three or four concurrent cases involving CRNAs or anesthesia assistants	60%	50%
QY	Physician is medically directing one CRNA	60%	50%
QX	CRNAs and anesthesia assistants, when medically directed by an anesthesiologist	40%	50%
QZ	Services performed by CRNAs without the medical direction of an anesthesiologist	100%	

Secondary Modifier

Modifier	Description
QS	Monitored anesthesia care
G8	Monitored anesthesia care for complex procedure
G9	Monitored anesthesia care for patient with history of cardiopulmonary condition
52	Reduced services
53	Discontinued procedure, started but discontinued
23	Unusual services

Hospital-Based Billing

MHP 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. Please refer to Payment Policies section of this Provider Manual for more details.

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.

OB Billing Requirements

When submitting professional claims to MHP using global prenatal, delivery and postpartum CPT codes, you are required to include on the claim the actual dates of the initial prenatal visit and the postpartum visit date using the following CPT category II codes:

- 0500F: Initial Prenatal Care, including the date of service
- 0503F: Postpartum Care, including the date of service

You will be reimbursed for the global payment appropriately; the documentation of the CPT category II codes is required to ensure that all dates for services rendered are captured and recorded for quality and HEDIS© reporting purposes.

Newborn Billing Requirement

MHP, 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 “4” (newborn). When billing with type of admission “4,” providers must report special point of origin code “5” (born inside this hospital) or “6” (born outside 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 weight is 2,764.5 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

Any claim received without this required information will be denied.

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.

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 preauthorization, 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 that are in the JVHL Provider network will continue to submit all laboratory claims through their JVHL agreement.

Urgent Care Billing Requirements

When submitting professional claims to MHP using the global urgent care billing code (99058), the following is also required:

- Report all services by individual CPT on the claim, including the corresponding E & M code (these codes will be included in the reimbursement for the global urgent care billing code)
- Report the rendering provider and NPI in Box 24J on the professional claim
- Claims not including the required information may be denied

You will be reimbursed for the global payment appropriately. The documentation of the additional CPT codes is required to ensure that all services rendered are captured and recorded for quality and HEDIS© reporting purposes.

Hospital Inpatient Clinical Claim Review & Payment Analytics

Health Management Systems, Inc. (HMS) conducts periodic reviews of inpatient hospital claims paid by McLaren Health Plan for health care services effective 11/1/24. HMS reviews ensure proper coding, integrity of paid claims, payment accuracy and compliance with regulations, policies, and contractual requirements. These reviews apply to the McLaren Health Plan Medicaid and McLaren Medicare Advantage lines of business.

Sending files to HMS electronically is secure, fast, convenient and preferred.

- Self-register for an HMS Provider Portal account at: hmsportal.hms.com
- To set up an SFTP connection, email HMS at: GoGreen@gainwelltechnologies.com
- Note: Appeal requests must be received within 90 calendar days from the date of notification letter

For questions about how to submit records to HMS electronically, contact HMS Provider Relations at: GoGreen@gainwelltechnologies.com or call HMS at: 833-879-7721.

Pharmaceutical Management – Medicare

McLaren Medicare Inspire, McLaren Medicare Inspire Plus, McLaren Medicare Inspire Flex, McLaren Medicare Inspire Duals.

Introduction

Part D drug formulary
Pharmaceutical Management promotes the use of the most clinically appropriate, safe and cost-effective medications. McLaren Medicare uses a customized formulary defined by the MedImpact Pharmacy and Therapeutics (P&T) Committee to develop Part D drug formularies that include drug categories and classes covering a variety of disease states. Each category must include at least two drugs, unless only one drug is available for a particular category or class. McLaren Medicare includes all or substantially all drugs in protected classes, as defined by The Centers for Medicare and Medicaid Services (CMS). The MedImpact Pharmacy and Therapeutics (P&T) Committee reviews all formularies for clinical appropriateness, including the utilization management edits placed on formulary products. McLaren Medicare submits all formulary changes to CMS according to the timelines designated by CMS.

Detailed information regarding Part D drugs, their utilization management requirements (prior authorization, step therapy, quantity limits), non-extended day supply limitations, and most recent plan formularies is available on our provider portal at McLarenHealthPlan.org or by calling Member Services at 833-358-2404.

Covered Benefits

A Part D drug is a drug that meets the following criteria:

- May be dispensed only by prescription
- Approved by the FDA
- Used and sold in the US
- Used for a medically accepted indication
    - Medically accepted indication is defined as both the uses approved by the FDA and off-label uses supported by the CMS recognized compendia, Micromedex and American Hospital Formulary Service Drug Information (AHFS-DI). On their own, uses described by clinical guidelines or peer-reviewed literature are insufficient to establish a medically accepted indication.
    - National Comprehensive Cancer Network (NCCN), Clinical Pharmacology, and Lexicomp, as well as peer-reviewed literature are also used to determine medically accepted indications for drugs or biologicals used off-label in an anti-cancer chemotherapeutic regimen.
    - Includes prescription drugs, biologic products, vaccines that are reasonable and necessary for the prevention of illness, insulin, and medical supplies associated with

insulin that are not covered under Parts A or B (syringes, needles, alcohol, swabs, gauze, and insulin delivery systems not otherwise covered under Medicare Part B).

Non-Covered Benefits

Drugs excluded under Part D include the following:

- Drugs for which payment as so prescribed or administered to an individual is available for that individual under Part A or Part B
- Drugs or classes of drugs, or their medical uses, which are excluded from coverage or otherwise restricted under Medicare (with the exception of smoking cessation products)
- Drugs for anorexia, weight loss or weight gain
- Drugs to promote fertility
- Drugs for cosmetic purposes and hair growth
- Drugs for symptomatic relief of coughs and colds
- Vitamins and minerals (except for prenatal vitamins and fluoride preparations)
- Non-prescription drugs
- Outpatient prescriptions for which manufacturers require the purchase of associated tests or monitoring services as a condition for getting the prescription (manufacturer tying arrangements)
- Agents used for treatment of sexual or erectile dysfunction (ED) (except when prescribed for other FDA-approved indications such as pulmonary hypertension)

Part D Utilization Management

McLaren Medicare formularies include utilization management requirements that include Prior Authorization, Step Therapy and Quantity Limits.

Prior Authorization (PA)

For a select group of drugs, McLaren Medicare requires the beneficiary or their physician to get approval for certain prescription drugs before the beneficiary is able to have the prescription covered at their pharmacy. A PA requirement is placed on certain drugs to gather necessary information to determine if the drug should be covered under the beneficiary's Medicare Part B or Part D benefit. Another common reason for a drug's PA requirement is to ensure the drug is being used for a medically accepted or Part D allowed indication as defined above. Finally, some drugs may have more detailed PA criteria that also require submission of medical information, such as lab results, and current and/or past medication history. Please contact MedImpact at 844-336-2678 for questions regarding the PA process or the status of a PA request.

Step Therapy (ST)

For a select group of drugs, McLaren Medicare requires the beneficiary to first try and fail certain drugs/ drug classes to treat their medical condition before covering another drug for that condition.

Quantity Limits (QL)

For a select group of drugs, McLaren Medicare limits the amount of the drug that will be covered without prior approval.

Note: If the member needs an emergency supply of a medication that requires prior authorization, please contact MedImpact at 844-336-2678 for assistance.

Guidelines and Requirements

Emergency and Urgent Care

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.

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 an MHP participating hospital emergency department or the nearest ED or call 911.

Members who present to an ED are instructed to identify themselves as an MHP member 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 appropriate and immediate follow-up care may be arranged. Please contact Medical Management at 888-327-0671 or 810-733-9522 for more details.

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 per day, seven days per week to coordinate an MHP member's access to care.

Referral Guidelines

Provider Referral and Preauthorization 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.
- 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 a resource for pharmacy management with quality and cost effectiveness as the primary goals. MHP Formularies, Commercial (Community HMO/POS and McLaren Health Advantage) and Medicaid/Healthy Michigan 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 MedImpact with specific questions regarding the formulary at 888-274-9689.
- To obtain an exception to the formulary, submit a Request for Prior Authorization to our Pharmacy Benefit Manager, MedImpact, by fax at 888-656-3604. 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 is available for all MHP lines of business.

Provider Demographic Updates

MHP audits all providers throughout the year to update and record valid provider information to maintain accuracy of our provider demographic information. MHP requires providers to update their demographic information at least 60 days prior to the change occurring. If a change does occur, providers are encouraged to complete the Provider Change Form at McLarenHealthPlan.org and send to MHP. The information listed below does not outline all required demographic information, only that required to be reported as a change.

Provider changes should be submitted using the Provider Change Form online, but may also be submitted with all of the provider information below via email to MHPProviderServices@mclaren.org or fax to 810-600-7979.

Provider Information Updates

MHP audits all providers throughout the year to update and record valid provider information to maintain accuracy of our provider demographic information.

Required Information	Previous	New
Name		
Specialty		
Tax ID		
Individual NPI		
Group NPI		
Language(s) Spoken		
CHAMPS Registered? Y or N		
Board Certification		
Medical Group Affiliation		
Hospital Affiliation		
Culturally and Linguistically Trained (CLAS)?		
Office Location		
Office Hours		

Pay to Information		

If you have any questions, contact Provider Relations at MHPProviderServices@mclaren.org or call 888-327-0671.

Emergency Department Facility E & M Coding Policy

McLaren Health Plan previously sent a communication to Hospitals in May 2024 regarding the Emergency Department Facility E & M Coding Policy. McLaren Health Plan is revising the information previously sent. The revised policy, effective 1/1/25 is as follows:

Scope

- LOB = Medicaid
- Claim Type = Institutional, Outpatient
- Service = ED visits

Policy

Beginning with claims submitted on 1/1/2025, McLaren Health Plan will implement Optum EDC Analyzer and deny facility ED claims where the level of service billed is not supported by the claim information submitted. Providers should rebill facility claims within 90 days with the appropriate level of service for payment.

McLaren Health Plan will use the following factors in considering appropriate levels of service:

- Presenting problems – as defined by the ICD-10 reason for visit diagnosis;
- Diagnostic services performed – based on the intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e. lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound); and,
- Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes.

Applicable codes to be evaluated include:

- 99282 G0381 ED Level 2
- 99283 G0382 ED Level 3
- 99284 G0383 ED Level 4
- 99285 G0384 ED Level 5

Claims for the following may be excluded from a denial:

1. Patients who were admitted from the ED or transferred to another health care setting (Skilled Nursing Facility, Long Term Care Hospital, etc.)
2. Critical care patients (99291, 99292)
3. Patients under 2 years of age
4. Certain diagnoses that when treated in the emergency department most often necessitate a greater than average usage, such as significant nursing time
5. Patients who have expired in the emergency department

Other

Internal denial code – C679: Information submitted does not support this ED level of service. Please rebill with the appropriate ED level of service.

- Remittance CARC code – 150: Payer deems the information submitted does not support this level of service.
- Remittance RARC code – M26: The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.

Payment Policies

Hospital Observation Payment Policy – Medicaid
Effective Date: 1/1/2025

This policy applies to observation services provided at a facility. If there is a conflict between this policy and applicable federal or state laws, regulations or regulatory requirements, the applicable laws or regulations will control. Further, if there is a conflict between this policy and a provider contract, the provider contract will govern. Note – coverage may be mandated by MDHHS or CMS.

Providers are required to submit accurate claims and documentation for all services performed.

Providers must submit claims using valid code combinations required by applicable law. Claims should be coded appropriately according to industry standard coding guidelines. All claims are subject to claims edits and may be subject to further reviews by McLaren or contracted third parties. Providers are expected to promptly work with McLaren and any third parties to provide any requested information related to a claim submission.

Observation Care - Definition

A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or if the patient is able to be discharged from the hospital. Observation services are commonly ordered for a patient who

presents to the Emergency Department (ED) and who then require a significant period of treatment or monitoring to make a decision concerning their admission or discharge. Observation services generally do not last more than 72 hours.

Policy

1. Authorization Requirements
   - Observation stays do not require authorization.
   - Hospital observation stays are those hospital services that are generally 48 hours or less in nature.
   - Observation Care must be medically necessary.
   - Observation services may be appropriate when the member does not meet an inpatient level of care and meets an observation level of care.
2. Authorization Required for Request for Inpatient Level of Care
   - A request for admission that meets inpatient criteria but could be treated in an observation setting will be considered an observation stay. Updated clinical information may be submitted by the facility at 48 hours.
   - All inpatient stays require prior authorization from McLaren Health Plan.
   - Obtaining authorization does not guarantee payment.
3. Authorization Review
   - All requests for inpatient authorizations will be reviewed against McLaren Health Plan's clinical criteria for inpatient level of care.
   - McLaren Health Plan uses nationally recognized criteria for its clinical criteria, including but not limited to, InterQual to determine the appropriate level of care. Guidelines are not a substitute for clinical judgment. McLaren's Chief Medical Officer or his/her designee may refer to guideline criteria in reaching the determination but are not required to adhere to any single published criteria.
   - Facilities must provide sufficient clinical information for McLaren Health Plan to make an appropriate medical necessity determination.
   - Facilities must supply documentation to support the claim submitted. This information includes but is not limited to complete medical charts, itemized bills and consent forms.
   - **Authorization approval does not guarantee payment (see below for the 48 hour rule)
   - McLaren Health Plan has the right to review, audit or otherwise deny claims based on benefit limitations and exclusions, eligibility, correct coding. billing practices and McLaren payment policies.
4. 48 Hour Rule
   - Less than 48 Hours
     - McLaren Health Plan will reimburse medically necessary observation services less than 48 hours without an authorization.

  - McLaren Health Plan will reimburse inpatient stays less than 48 hours for the exclusions listed below.
  - For purposes of calculating the 48 hours, the time starts at the time a patient is placed in a bed for the purpose of initiating observation care. Observation services should continue to be billed as an observation service.
  - Authorization is not a guarantee of payment.
  - Facilities may timely rebill at an observation level of care.
  - Inpatient stays billed and paid that are less than 48 hours are subject to retrospective reviews.
- 48 Hours or More
  - If the facility received an approved authorization, based on medically necessity review, for an inpatient stay, the claim will be approved at the inpatient level of care for payment purposes.
  - McLaren Health Plan reserves the right to review and/or deny the claim for other valid purposes (ineligible member, not medically necessary, etc.).
- Exclusions to the 48 Hour Rule
  - If an authorization request is submitted to McLaren at an inpatient level of care, for a stay less than 48 hours, but McLaren Health Plan determines that it meets the following exclusions and approves the authorization request, it will pay at the inpatient level:
  - Deliveries – APR DRGs 540-5404, 5411-5414, 5421-5424, 560-5604
  - Neonatal Services – APR DRGs 580-62641
  - Nursery/Newborns – APR DRGs 630-64041
  - ICU Revenue Codes: 0200-0209
  - Discharge Status of 20 (patient expired)
  - Diagnosis codes Z37-Z37.7, Z38-Z38.8 (births)
  - MSA Bulletin 15-32 Inpatient and Outpatient Hospital ICD-10 Short Stay Reimbursement, visit: michigan.gov
  - CMS Inpatient Only Code

Audit

McLaren Health Plan or a third party may audit or otherwise review all paid inpatient hospital claims to ensure the integrity of the paid claims. This includes, but is not limited to coding validation, payment accuracy, compliance with regulations, policies, and contractual requirements. These reviews include clinical claim reviews and payment analytics.

Forms

Health care fraud and abuse is both a state and federal offense.

Quick Links to Forms

- Provider Claims Adjustment Form
- Provider Claims Status Fax Form
- Provider Referral Form – Request for Preauthorization
- Provider Request for Appeal (PRA) Form
- Provider Refund Remittance Form

CMS 1500 Sample Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

1500 Health Insurance Claim Form File Guide

Providers billing electronic claims must refer to the ANSI 837 electronic claims file guide for proper field requirements. The information below is a summary of the CMS 1500 claim form.

Field Location CMS 1500	Field Name	Field Description	Required
1	MEDICARE MEDICAID	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.	Yes, if applicable
1a	Insured’s I.D. number	Enter insured’s ID number as shown on insured’s ID card for the payer to whom the claim is being submitted.	Yes
2	Patient’s name	Enter the patient’s last name, first name and middle initial as it appears on the ID card.	Yes
3	Patient’s birth date sex	Enter the patient’s eight-digit date of birth in (MM|DD|CCYY) format. Place an “X” in the appropriate box to indicate the patient’s sex. Mark only one box. If gender is unknown, leave blank.	Yes
4	Insured’s name	Enter insured’s last name, first name and middle initial.	Yes
5	Patient’s address	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.	Yes

Field Location CMS 1500	Field Name	Field Description	Required
6	Patient relationship to insured	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.	Yes
7	Insured’s address	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.	Yes, if known
8	Patient status	Place an “X” in the appropriate boxes. If the patient is a full-time student, complete field 11b if the information is available.	Yes, if applicable
9	Other insured’s name	When additional group health coverage exists, enter other insured’s last name, first name and middle initial.	Yes, if applicable
9b	Other insured’s date of birth sex	Enter the other insured’s eight-digit date of birth in (MM|DD|CCYY) format.	Yes, if applicable
9c	Employer’s name or school name	Enter the name of the other insured’s employer or school.	Yes, if applicable
9d	Insurance plan name or program name	Enter the other insured’s insurance plan or program name.	Yes, if applicable

Field Location CMS 1500	Field Name	Field Description	Required
10	Is patient's condition related to: a) Employment (current or previous) b) Auto accident c) Other accident	Only one box can be marked per submission. a) Place an "X" in the appropriate box. If "yes," complete field 14. b) Place an "X" in the appropriate box. If "yes," indicate state and also complete field 14. c) Place an "X" in the appropriate box. If "yes," complete field 14	Yes, if applicable
10d	Reserved for local use	Not used.	N/A
11	Insured's policy group or FECA number	Enter the insured's policy or group number as it appears on the ID card if present.	Yes, if applicable
11a	Insured's date of birth sex	If known, enter the insured's eight-digit date of birth in (MM|DD|CCYY) format. If insured's date of birth is unknown, leave blank. Place an "X" in the appropriate box to indicate the insured's sex. Mark only one box. If gender is unknown, leave blank.	Yes, if applicable
11b	Employer's name or school name	Complete if full-time student. Enter the name of the insured's employer or school.	Yes, if applicable
11c	Insurance plan name or program name	Enter the insurance plan or program name of the insured.	Yes, if applicable

Field Location CMS 1500	Field Name	Field Description	Required
11d	Is there another health benefit plan?	Place an “X” in the appropriate box. If “yes,” complete fields 9a through 9d.	Yes, if applicable
12	Patient’s or authorized person’s signature	Enter “Signature on File”	Yes, if applicable
13	Insured’s or authorized person’s signature	Enter “Signature on File”	Yes, if applicable
14	Date of current illness, injury or pregnancy	Enter the first date in six-digit (MM|DD|YY) or eight-digit (MM|DD|CCYY) format of the current illness, injury or pregnancy. For pregnancy, use the date of LMP as the first date. A date is required if injury or emergency.	Yes, if applicable
15	If patient has had same or similar illness, give first date	Enter the first date in six-digit (MM|DD|YY) or eight-digit (MM|DD|CCYY) format that the patient	Yes, if applicable
16	Dates patient unable to work in current occupation	Enter dates patient is unable to work in six-digit (MM|DD|YY) or eight-digit (MM|DD|CCYY) format. Leave blank if unknown.	Yes, if applicable
17	Name of referring physician or other source	Enter the name of the physician or other source that referred the patient to the billing provider or ordered the test(s) or item(s).	Yes, if applicable

Field Location CMS 1500	Field Name	Field Description	Required
17a SHADED	Other ID #	Enter the two-character qualifier and other ID.	No
17b UNSHADED	Referring provider NPI	Enter the 10-digit NPI.	Yes, if applicable
18	Hospitalization dates related to current services	Enter the inpatient hospital admission date followed by the discharge date (if discharge has occurred) using the six-digit (MM|DD|YY) or eight- digit (MM|DD|CCYY) format. If not discharged, leave discharge date blank.	Yes, if applicable
19	Reserved for local use	Not used.	N/A
20	Outside lab? $Charges	For lab services, enter an “X” in Yes if the reported service(s) was performed by an outside laboratory. If yes, enter the purchase price. Enter an “X” in No if outside lab service(s) is not included on the claim.	Yes, if applicable
21	Diagnosis or nature of illness or injury	List up to four ICD-9-CM diagnosis codes. Relate lines 1, 2, 3, 4 to lines of service in 24E by line number. Use the highest level of specificity.	Yes
22	Medicaid resubmission	For Medicaid resubmission claims only.	No

Field Location CMS 1500	Field Name	Field Description	Required
23	Prior authorization number	Enter the prior authorization as assigned by the payer for the current service.	Yes, if applicable
24A-24G SHADED	Narrative Description	Enter the supplemental information in the shaded section of 24A through 24G above the corresponding service line.	Yes, if applicable
24A UNSHADED	Date(s) of service	Enter the six-digit date(s) of service in (MM|DD|YY) format.	Yes
24B UNSHADED	Place of service	Enter the two-digit place of service code.	Yes
24C UNSHADED	EMG	Emergency indicator. Enter Y for “Yes” or leave blank for “No.”	Yes, if applicable
24D UNSHADED	Procedures, services or supplies	Enter CPT or HCPCS code and modifier(s).	Yes
24E UNSHADED	Diagnosis code	Enter diagnosis pointer(s) referenced in field 21 to indicate which diagnosis code(s) apply to the related CPT or HCPCS code. Do not enter ICS-9-CM codes or narrative descriptions in this field. Do not use slashed, dashes or commas between reference numbers.	Yes

Field Location CMS 1500	Field Name	Field Description	Required
24F UNSHADED	$ Charges	Enter the charge amount in (Dollars/Cents) format. If more than one date or unit is shown in field 24G, the dollar amount should reflect the TOTAL amount of the services. Do not indicate the balance due, patient liability, late charges/credits or a negative dollar line. Do not use decimals or dollar signs.	Yes
24G UNSHADED	Days or units	Enter number of days or units on each line of service. For anesthesia, enter total time in minutes. Do not include base units.	Yes
24H UNSHADED	EPSDT Family Planning	If related to EPSDT, enter Y for “Yes” with a valid referral code. If not related to EPSDT, enter N for “No.” If related to Family Planning, enter a Y for “Yes” or leave blank for “No.”	Yes, if applicable
24J	Rendering Provider NPI	Enter the 10-digit NPI.	Yes
25	Federal Tax ID number	Enter their Employer Identification Number (EIN) and place an “X” in the EIN box. If not available, enter their Social Security Number (SSN) and	Yes

Field Location CMS 1500	Field Name	Field Description	Required
		place an “X” in the SSN box. Only one box can be marked.	
26	Patient’s account number	Enter the patient’s account number.	Yes
27	Accept assignment?	Place an “X” in the appropriate box – for Medicaid, assignment should always be marked “YES.”	Yes
28	Total charge	Enter the sum of the charges in column 24F (lines 1-6). Enter the total charge amount in (Dollars/ Cents) format. Do not use negative numbers.	Yes
29	Amount paid	Enter payment amount from the patient or other payer. If other payer payment, an Explanation of Benefits is required.	Yes, if applicable
30	Balance due	Leave blank.	Leave blank
31	Signature of physician or supplier including degrees or credentials	Enter the signature of the physician, provider, supplier or representative with the degree, credentials or title and the date signed.	Yes

Field Location CMS 1500	Field Name	Field Description	Required
32	Service facility location information	Enter the name and actual address of the organization of facility where services were rendered if other than box 33 or patient's home. Enter this information in the following format: Line 1: name of physician or clinic Line 2: address Line 3: city, state, zip code	Yes
32a UNSHADED	Service Facility NPI	Enter the 10-digit NPI.	Yes
33a UNSHADED	Billing Provider NPI	Enter the 10-digit NPI.	Yes, if applicable

UB-04 Sample Form

UB-04 Data Field Requirements

Field Location UB-04	Description	Inpatient	Outpatient
1	Provider Name and Address	Required	Required
2	Pay-To Name and Address	Required	Required
3a	Patient Control Number	Required	Required
3b	Medical Record Number	Situational	Situational
4	Type of Bill	Required	Required
5	Federal Tax Number	Required	Required
6	Statement Covers Period	Required	Required
7	Future Use	N/A	N/A
8a	Patient ID	Required	Required
8b	Patient Name	Required	Required
9	Patient Address	Required	Required
10	Patient Birthdate	Required	Required
11	Patient Sex	Required	Required
12	Admission Date	Required	N/A
13	Admission Hour	Required	Required
14	Type of Admission/Visit	Required	N/A
15	Source of Admission	Required	Required

Field Location UB-04	Description	Inpatient	Outpatient
16	Discharge Hour	Required	N/A
17	Insurance plan name or program name	Enter the insurance plan or program name of the insured.	Yes, if applicable
18-28	Patient Discharge Status	Required	Required
29	Condition Codes	Required if applicable	Required if applicable
30	Accident State	Situational	Situational
31-34	Occurrence Code and Dates	Required if applicable	Required if applicable
35-36	Occurrence Span Codes and Dates	Required if applicable	Required if applicable
37	Future Use	N/A	N/A
38	Name of referring physician or other source	Enter the name of the physician or other source that referred the patient to the billing provider or ordered the test(s) or item(s).	Yes, if applicable
39-41	Value Codes and Amounts	Required if applicable	Required if applicable
42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
44	HCPCS/Rates	Required if applicable	Required if applicable

Field Location UB-04	Description	Inpatient	Outpatient
45	Service Date	N/A	Required
46	Units of Service	Required	Required
47	Total Charges (By Rev. Code)	Required	Required
48	Non-Covered Charges	Required if applicable	Required if applicable
49	Future Use	N/A	N/A
50	Payer Identification (Name)	Required	Required
51	Health Plan Identification Number	Optional	Optional
52	Release of Info Certification	Required	Required
53	Assignment of Benefit Certification	Required	Required
54	Prior Payments	Required if applicable	Required if applicable
55	Estimated Amount Due	Required	Required
56	NPI	Required	Required
57	Other Provider IDs	Optional	Optional
58	Insured's Name	Required	Required
59	Patient's Relation to the Insured	Required	Required
60	Insured's Unique ID	Required	Required

Field Location UB-04	Description	Inpatient	Outpatient
61	Insured Group Name	Situational	Situational
62	Insured Group Number	Situational	Situational
63	Treatment Authorization Codes as assigned by payer	Required if applicable	Required if applicable
64	Document Control Number	Situational	Situational
65	Employer Name	Situational	Situational
66	Diagnosis/Procedure Code Qualifier	Required	Required
67	Principal Diagnosis Code/Other Diagnosis Codes	Required	Required
68	Future Use	N/A	N/A
69	Admitting Diagnosis Code	Required	Required if applicable
70	Patient's Reason for Visit Code	Situational	Situational
71	PPS Code	Situational	Situational
72	External Cause of Injury Code	Situational	Situational
73	Future Use	N/A	N/A
74	Principal Procedure Code/Date	Required if applicable	Required if applicable
75	Future Use	N/A	N/A
76	Attending Name/ID-Qualifier 1 G	Required	Required
77	Operating ID	Situational	Situational

Field Location UB-04	Description	Inpatient	Outpatient
78-79	Other ID	Situational	Situational
80	Remarks	Situational	Situational
81	Code-Code-Field/Qualifiers *0-A0 *A1 -A4 *A5-B0 *B1 -B2 *B3	N/A Situational N/A Situational Required	N/A Situational N/A Situational Required

Most Commonly Used Eligible Codes

McLaren Health Advantage, McLaren Advantage (HMO)

Code	Explanation	Code	Explanation
001	Loss prior to effective date of coverage	PTP	PT covered only when billed by PT for continuous PT
002	Loss after termination date of coverage	RPC	Report CPT or CCPCS when billing this revenue code
01	Covered by other insurance (see COB)	TKB	Payment reduced due to previous payment
02	Service is not reimbursable	UER	Additional documentation required
05	Maximum benefit reached	WH	Withhold on provider
10	Duplicate charges previously considered	OPPS PAYMENT STATUS CODES	

Code	Explanation	Code	Explanation
11	Adjustment of previously processed claim	A	Services paid under fee schedule or other prospectively determined rate
34	Claim not submitted timely basis	AA	Ambulance fee schedule item
ADX	Invalid admitting diagnosis	AD	DMEPOS fee schedule item
ANT	Resubmit total anesthesia time units in minutes	AL	Clinical laboratory fee schedule item
ASC	Procedure typically performed as an outpatient	AM	National fee schedule item
AST	Assistant surgeons reimbursed at 16% MHP allowable	AR	Physician fee schedule item
ATH	Authorization required	AX	Other fee schedule item
BEN	Procedure/service is not a covered benefit	B	Service not allowed under OPPS on hospital outpatient claim
CAP	Services are capitated	C	Inpatient serve, not paid under OPPS
CLB	Lab services capitated through Joint Venture Hospital Laboratories (JVHL)	E	Non-covered service, not paid under OPPS
CPT	Procedure code does not exist or invalid	F	Corneal, CRNA and Hepatitis B
ICD	ICD-9 diagnostic code does not exist or invalid	G	Drug/biological pass-through
IDX	Incomplete diagnostic code 4th & 5th digit required		

Code	Explanation	Code	Explanation
IWH	IPHN withhold		
MDF	Correct modifier missing or invalid		
NCB	Procedure not a covered benefit		
NSR	Procedure not separately reimbursable		
PCT	Provider terminated from plan prior to/after date of service		
POS	Procedure not typically performed in the POS noted		
PPC	Payment reduced to previously processed claim		

EDI Claim File Instructions

MHP uses ENS Optum Insight as its preferred vendor for EDI claims submissions. To become a customer of ENS Optum Insight, or if you 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:

Relay Health (McKesson)	Gateway EDI
MedAvant	Payerpath / MISYS
ClaimLynx	PerSe
Claim Logic	SSI Group
CPSI	ZirMed

If they are using one of ENS Optum Insight's channel partners, your 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 Provider Relations 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)

- 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 MIDDLEINTITIAL
- Note: incorrect spelling of name can cause rejection

Member Identification #

- Utilize the Member ID # as presented on the Member's ID card; if the ID # does not match, your claim 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 your current clearinghouse. For claims status, visit the McLaren CONNECT Provider Portal.

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 10 years, or both. In addition to fines, probation or incarceration, fraudulent or abusive activities may result in a denial, suspension or termination of the provider's license under the Michigan Public Health Code or similar action from Medicaid under the Michigan Social Welfare Act.

MHP asks that providers and members partner with us to identify and eliminate fraud, waste and abuse. As part of that partnership, the provider while contracted with us, warrants that the provider and its employees: a) Have not been listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in federal or state health care programs or in administering health care and b) Have not been convicted of any crime related to defrauding any health care benefit program. The provider will also routinely screen its employees for the above-noted participation issues. The provider must notify MHP in writing immediately if provider or any employee are listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in federal or state health care programs or if Provider or any of its employees are convicted of any crime related to defrauding any health care benefit program.

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:

- 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:

McLaren Health Plan
Attn: Compliance Officer
G-3245 Beecher Road
Flint, MI 48532
Email: 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 michigan.gov/fraud. This can be done anonymously. Additionally, a fraud, waste and abuse claim can be made in writing to:

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

Or

Office of Inspector General
P.O. Box 30062
Lansing, MI 48909

Reporting Medicare Fraud, Waste and Abuse

To report Medicare fraud, waste and abuse via phone, contact the OIG Hotline:

Phone: 1-800-HHS-TIPS (1-800-447-8477) or
TTY: 1-800-377-4950
Fax: 1-800-223-8164
Online: https://oig.hhs.gov/fraud/report-fraud/index.asp

Mail:

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

McLaren Health Plan
G-3245 Beecher Rd
Flint, MI 48532
ATTN: Compliance Officer
Email: MHPcompliance@mclaren.org

A Road Map 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 oig.hhs.gov/compliance/physician-education/

False Claims Act

The Deficit Reduction Act of 2005 requires providing 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 they can contact MHP at:

Compliance Hotline – 866-866-2135

Compliance Officer – 888-327-0671

By mail:

McLaren Health Plan
Attn: Compliance Officer
G-3245 Beecher Road
Flint, Michigan 48532

Medicaid:

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

By mail:

Office of Inspector General
P.O. Box 30062
Lansing, Michigan 48909

Member Rights and Responsibilities

MHP providers have a responsibility to recognize the specific needs of the membership and treat members in a mutually respectful manner and ensure that members' rights and responsibilities are followed accordingly.

MHP Members Have:

- The right to receive information about health care services including beneficiary and plan information
- The right to be treated with respect and dignity with due consideration for their dignity and privacy.
- The right to receive culturally and linguistically appropriate services.
- Have personal and medical information kept private
- The right to participate in decision regarding health care, including the right to refuse treatment and express preferences about treatment options
- The right to be free from any form of restraint or seclusions used as a means of coercion, discipline, convenience or retaliation.
- The right to receive a copy of their medical record upon request, and request amendments or corrections.
- The right to receive covered benefits consistent with MHP’s contract with the state, and state and federal regulations.
- The right to be free to exercise their rights without adversely affecting the way MHP, providers or the state treats them.

- The right to file a grievance, to request a State Fair Hearing (Medicaid members only), or have an external review, under the Patient's Right to Independent Review Act. Including the right that the member or the provider cannot be penalized for filing a complaint or appeal in compliance with federal and state laws
- The right to be free from other discrimination prohibited by state and federal regulations.
- The right to receive information on treatment options and alternatives, presented in a manner appropriate to their condition and their ability to understand
- The right to request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided.
- The right to request information on the structure and operation of the Health Plan
- The right to make suggestions about our services and providers
- The right to make suggestions regarding MHP members' rights and responsibilities.
- The right to request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval
- The right to continue receiving services from a provider who has been terminated from the plan's network through episode of care as long as it remains medically necessary to continue treatment with this provider, including female members who are pregnant have the right to continue coverage from a terminated provider that extends to the postpartum evaluation of the member, up to six weeks after delivery
- The right to have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- The right to a current listing of network providers and access to a choice of specialists within the network who can treat chronic problems.
- The right to get covered routine and preventive OB-GYN and pediatric covered services without a referral, if the OB-GYN or pediatric specialist is a participating provider.

Medicaid Members:

- The right to receive Federally Qualified Health Clinic (FQHC) and Rural Health Clinic (RHC) services in-network or out-of-network with no prior authorization required.

Members of MHP Have the Following Responsibilities:

- To review the member handbook and MHP's Certificate of Coverage
- 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 treat doctors and their staff with respect
- To carry the MHP Member ID card at all times and protect against misuse.
- To contact MHP if they suspect fraud, waste, or abuse.
- Give MHP and their doctors as much info about their health as possible

- Learn about their health status
- Work with their doctor to set care plans and goals
- Follow the plans for care that they have agreed upon with their doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards their health by taking responsibility, including appropriate and inappropriate behavior.
- Apply for Medicare or other insurance when they are eligible.
- Allowing MHP to assist with health care and services to which they are entitled and notifying MHP of any problem related to health care, benefits, etc.
- Forwarding suggesting to MHP in writing or by contacting Customer Service.

Medicaid Members

- Report changes to their local MDHHS office if their contact info (like address or phone number) Changes
- Report changes that may affect their Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). Members can call their local MDHHS office or go to www.michigan.gov/mibridges.

McLaren Medicare members may have additional right and responsibilities as outlined in their Evidence of Coverage.

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 you for your assistance in providing requested information to us in a timely manner.

Non-Discrimination

Discrimination is against the law

McLaren Health Plan, McLaren Health Plan Community, McLaren Health Advantage and McLaren Medicare Supplement (collectively McLaren) complies with applicable federal civil rights laws and

does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. McLaren does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation. McLaren promotes a culture of inclusivity and diversity of lived experience.

McLaren:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact McLaren's Compliance Officer. If you believe that McLaren has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, gender identity or sexual orientation you can file a grievance with:

- McLaren's Compliance Officer
  - Write: G-3245 Beecher Rd., Flint, MI 48532
  - Call: 866-866-2135, TTY: 711
  - Fax: 810-733-5788
  - Email: mhpcompliance@mclaren.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, McLaren's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TTY)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-0671-327-888 (رقم هاتف الصم والبكم: 711).

Syriac/Assyrian:

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܡܗܡܙܡܢܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܫܟܚܬ ܕܩܒܠܬ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܕܝܠܘܟ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ

1-888-327-0671 (TTY: 711)

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-327-0671（TTY：711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số

1-888-327-0671 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-327-0671 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-327-0671 (TTY: 711)번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপদন বাাংলা, কথা বলতে পাতেন, োাহতল দনঃখেচায় ভাষা সহায়ো পদেতষবা উপলব্ধ আতে। ফ ান করুন ১- 888-327-0671 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-327-0671 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-327-0671 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-327-0671 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-327-0671

（TTY:711）まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-327-0671 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam

besplatno. Nazovite 1-888-327-0671 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-327-0671 (TTY: 711).

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