

# Provider Manual 2019

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# I - Introduction

McLaren Health Plan (MHP) offers a variety of products and benefits designed to meet the health care needs of each member. To this end, our mission is to partner with providers 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 Community Health Maintenance Organization (Commercial HMO)
- McLaren Community Point of Service (POS) Managed Care Plan
- McLaren Fully-insured Preferred Provider Organization (PPO) Plan
- McLaren Medicare Supplemental

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

McLaren Health Advantage (Self-Insured PPO Plan)

MHP combines the resources of independent physicians, multi-specialty groups, ambulatory care centers, ancillary providers, and hospitals to offer members access to a comprehensive array of high-quality health care providers. The member's ID card identifies which type of plan they have (see page 12-13 for examples). MHP will provide you with updated information through mailings and on our 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 POS, and McLaren HMO require members to select a Primary Care Provider (PCP) at the time of enrollment. Our PCPs will provide both primary care services and act as care coordinators, guiding members to the full range of health services. Staff at MHP will assist the health care providers in navigating the service delivery system.

# **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 and 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 provisions in this manual are intended to supplement the terms of the provider agreement ("Agreement") you entered into with McLaren. In the event of a direct conflict between a provision in this manual and the Agreement between you and McLaren, the provision in this manual will control unless it conflicts with a term required by law, regulation or a regulatory agency. Or, if your Agreement otherwise specifies that it controls.

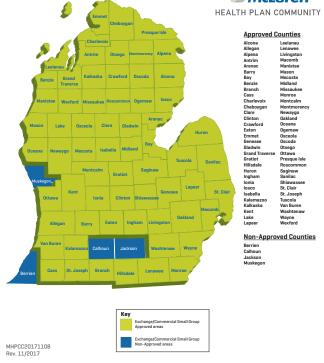
# McLaren Health Plan Service Area - Maps

# **Commercial Large Group** 2019 Approved Service Areas McLaren HEALTH PLAN COMMUNITY **Approved Counties Partially Approved Counties** Non-Approved Counties

Commercial Large Group Partially Approved areas

MHPCC20171109 Rev. 01/2018

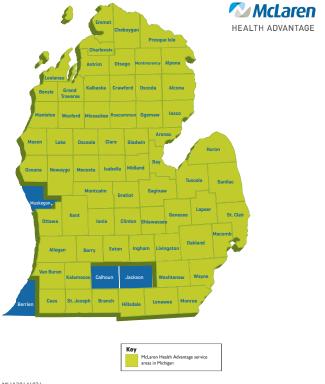
# Commercial/Exchange Small Group 2019 Approved Service Areas McLaren



# **McLaren Health Plan Service Area - Maps**



# McLaren Health Advantage 2019 Service Areas



# **II - 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 utilized most frequently by your practice.

MHP's 24-hour toll free number is (888) 327-0671 (TTY call 711). All departments can be accessed through this number. Normal business hours are 8:30 a.m. to 5:00 p.m., Monday – Friday.

# **Network Development**

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

- In-services or orientations for you or your staff to learn how best to work with MHP, including submitting claims, statusing member eligibility or claims via 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 are not certain of how to contact your assigned Network Development Coordinator, please call (888) 327-0671 to request the correct contact information.

# **Customer Service**

The Customer Service department is responsible for assisting providers and members with any questions they may have regarding MHP. Customer Service representatives are available from 8a.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
- Claims questions

Use the McLaren Connect provider portal to:

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

# **Medical Management**

Medical Management supports the needs of both the membership and the provider network. Medical Management offers support to coordinate our members' care and to facilitate access to appropriate services through the resources of our nurse case managers.

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

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

- Preauthorization requests: see Section X Referral and 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 Healthcare Services (CSHCS)

# **Utilization Management**

Medical Management, through its utilization management processes, is structured to deliver fair, impartial, and consistent decisions that affect the health care of our members. Medical Management coordinates 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 utilized in making the decision.

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

In addition, regarding incentives, utilization decision-making is based solely on appropriateness of care and service and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives for utilization decision-makers to encourage decisions which result in under-utilization.

# **Case Management Services**

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

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

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

# **Community Outreach**

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

Many community outreach programs are operational for members such as expectant mothers, breast

cancer patients, 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 Services- I

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

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

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

# **III - Contact Information**

Department	Telephone No.	Fax No.
Customer Service/Provider Inquiry Available to assist they claims, benefits, authorizations and coordination of benefit inquires. Hours: 8:00 a.m. – 6:00 p.m., Monday-Friday.	(888) 327-0671	Toll Free: (833) 540-8648
Network Development 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.mclaren.org/mhp/referral-request-form-mhp1.aspx	(888) 327-0671	Pre-Authorization 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 Rd. Flint, MI 48532		
Pharmacy Services	For formulary information or medication prior authorization request forms.  Please visit: McLarenHealthPlan.org/Community-Provider/Pharmacy-mhp.aspx. E-prescribing is available for all lines of business.		
Provider Demographic Changes	Contact Network Development at (888) 327-0671 8:30 a.m 5 p.m., Monday - Friday or submit changes online: https://www.mclarenhealthplan.org/mhp/provider-change-form-mhp.aspx.		
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 Supplemental – 3833S • 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/Healhty Michigan Plan, Commercial HMO/POS, and McLaren Health Advantage - Required lab vendor is Joint Venture Hospital Lab (JVHL) - (800) 445-4979.		

# IV - McLaren Health Plan - Plan Definitions

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

# **MHP Community HMO**

MHP Community HMO covers a comprehensive set of health care services obtained through a designated provider network. MHP Community HMO members have plans with varying levels of copayments, deductibles and out-of-pocket maximums that are chosen by the employer group. Each MHP Community HMO member selects a PCP who is responsible for coordinating the member's health care. The PCP provides the member with a medical home. McLaren Rewards: Members eligible to be included in the McLaren Rewards program are entitled to services provided by McLaren Rewards providers without the responsibility of member cost-sharing, such as co-pays, deductibles or coinsurance amounts. McLaren Rewards Providers are listed in the McLaren Rewards and Community provider directories.

## McLaren POS

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

# **MHP Medicaid**

MHP is contracted with the Michigan Department of Health and Human Services (MDHHS) to provide medical services to eligible Medicaid recipients. MHP provides administrative services and arranges for the provision of all MHP covered services, offering some additional benefits, including transportation. Each MHP Medicaid member selects a PCP, 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.

# McLaren Health Plan Healthy Michigan

MHP is contracted with the MDHHS to provide medical services to members eligible for Medicaid expansion. MHP administers the benefits for Healthy Michigan members and arranges for the provision of all eligible covered services. The benefit design of the Healthy Michigan Plan ensures member access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors. Healthy Michigan Plan members select a PCP who provides the member with a medical home. Healthy Michigan Plan members are required to complete, in collaboration with their PCP, an annual Health Risk Assessment with the ultimate goal of achieving their healthy behavior goals.

# **McLaren PPO**

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

# McLaren Health Advantage

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

# **McLaren Medicare Supplemental**

MHP offers a Medicare Supplemental program. This is available to any individual who is receiving benefits from Medicare Part A and Part B. A supplemental plan, also referred to as Medigap coverage, is health care coverage that is in addition to Original Medicare. A supplement plan helps to fill iln the "gaps" in coverage in Original Medicare.

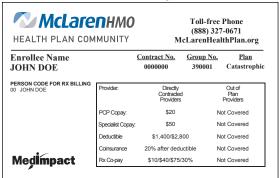
Possession of a MHP or MHA member ID card does not guarantee eligibility. Members eligibility should be verified through the McLaren CONNECT Provider Portal.

# **MHP Member Handbook**

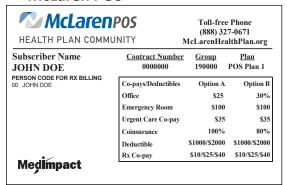
All enrolled members are given a member handbook as a guide for using the Plan. The member handbook contains information on emergency and urgent care procedures, out-of-area coverage, benefit limitations and exclusions, the enrollment process, PCP selection, member rights and responsibilities and the complaint and grievance procedures. 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.

# V - Sample Member Identification Cards

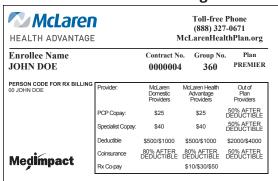
# **McLaren Community**



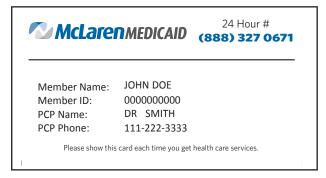
# **McLaren POS**



# McLaren Health Advantage



# **McLaren Medicaid**









# **Provider Information**

McLaren Health Plan Custom

**Eligibility and Benefits** 

Engiolity and benefits

For verification of eligibility and benefits, visit
our Provider Portal, McLaren CONNECT at
McLarenHealthPlan.org **Hospital Admission Authorization** 

Emergency Hospital admissions must be reported within 24 hours and require concurrent review. All other Hospital admissions require Authorization and oncurrent review Call (888) 327-0671 to seek authorization for hospital services.

Preferred Laboratory Network
JVHL is the preferred Laboratory VHL is the preferred laboratory network for McLaren Health Plan. To locate a participating JVHL lab, please call Customer Service at (888) 327-0671.

**Pharmacy Billing Information:** RxBIN: 017142

RxPCN: ASPROD1 RXPLN: ASPRODI Pharmacy Help Desk: (888) 274-9689 For verification of eligibility and benefits, visit our Provider Portal, McLaren CONNECT at McLarenHealthPlan.org

<u>Claims Submission</u> McLaren Health Plan utilizes ENS Optum Insight as our EDI Vendor. Payer ID for electronic claims is: Medicaid/Healthy Michigan – 3833C Secondary claims can also be submitted electronically.

This card is only valid if Member maintains McLaren Health Plan eligibility. Eligibility should be verified before rendering services Issue Date xx/xx/xxxx

# McLaren Healthy Michigan



24 Hour #

JOHN DOE Member Name: 000000000 Member ID: PCP Name: DR SMITH PCP Phone: 111-222-3333

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

#### **Provider Information**

McLaren Health Plan Custo er Service (888) 327-0671

#### **Eligibility and Benefits**

For verification of eligibility and benefits, visit our Provider Portal, McLaren CONNECT at McLarenHealthPlan.org

# **Hospital Admission Authorization**

Emergency Hospital admissions must be reported **within 24 hours** and require concurrent review. All other Hospital admissions require **Authorization** and concurrent review. Call **(888) 327-0671** to seek authorization for hospital services.

Preferred Laboratory Network

JVHL is the preferred laboratory network
for McLaren Health Plan. To locate a participating JVHL lab, please call Customer Service at (888) 327-0671.

# Pharmacy Billing Information: MedImpact

RxBIN: 017142 RxPCN: ASPROD1

RxGRP: ML329
Pharmacy Help Desk: (888) 274-9689
For verification of eligibility and benefits, visit our Provider Portal, McLaren CONNECT at McLarenHealthPlan.org

Claims Submission

McLaren Health Plan utilizes ENS
Optum Insight as our EDI Vendor.
Payer ID for electronic claims is:
Medicaid/Healthy Michigan – 3833C
Secondary claims can also be submitted
electronically. electronically

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

# **McLaren Medicare Supplemental**



SUPPLEMENT

Toll-free Phone (888) 327-0671

JOHN DOE

Member Number: 00000001 Medicare Supplement Plan X Member since xx/2018

McLarenHealthPlan.org/MedicareSupplement

#### MEMBER CONTACT INFORMATION

Customer Service (888) 327-0671 (TTY: 711) In case of an emergency, call 911 or go to the nearest emergency room

#### PROVIDER INFORMATION

### CLAIM SUBMISSION

Providers can submit claims to Medicare. Medicare will forward claims to McLaren for processing. Secondary claims can also be submitted electronically to McLaren via our EDI vendor, ENS Optum Insight by using our Payer Name: McLaren Medicare Supplement and Payer ID: 3833S; or

Secondary claims can be mailed to:

McLaren Health Plan P.O. Box 1511

Flint, MI 48501-1511

Eligibility and claims status information is available by calling Customer Service at (888) 327-0671

#### DISCLAIMER

Benefits under a Medicare Supplement plan are only payable in accordance with your Certificate of Coverage

# VI - Provider Network

# **National Provider Identifier (NPI)**

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

# **Participating (Contracted) Providers**

MHP has contracted with an extensive network of quality providers to deliver health care to its members. Unless the member's benefit allows, members must receive health care services from providers in the MHP network who are listed in the provider directory. The provider directories for McLaren Medicaid, Healthy Michigan Plan, McLaren HMO, McLaren PPO, McLaren POS, McLaren Rewards 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, a MHP network hospital must be used (in addition, inpatient hospital care requires preauthorization).

# **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 are requesting 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).

# **Non-Participating Providers**

# McLaren Community HMO, McLaren Medicaid and Healthy Michigan Plan

Preauthorization for services from a non-participating 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)

# McLaren PPO, McLaren Health Advantage, and McLaren Community POS

Members can seek services from in-network and out-of-network providers. Members seeking services from out of network providers may be responsible for higher coinsurance and/or deductibles. Please refer to Section X, Referral and Authorization Requirements for more detail.

# VII - Role of the PCP

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

MHP recognizes the following groups of providers as PCPs\*:

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

# \*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

<sup>\*</sup>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.

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 utilization 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 utilization 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 Network Development Coordinator at (888) 327-0671.

# **PCP Case Management Program**

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

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

Please involve Case Management with the care management of your patients. If you need further assistance, please contact 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 Network Development coordinator.

# **Gaps in Care Reports**

Gaps in Care reports are sent to MHP Primary Care Providers (PCP). These reports identify a PCP's assigned membership and services that have not been completed for the member based on current 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 your Gaps in Care reports and ensure that 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:

- Adult BMI
- 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.

# **Accessibility of Care**

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

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

The following are the MHP Commercial, Marketplace and Medicaid/Healthy Michigan Plan monitoring standards for high volume\* and high impact provider\* accessibility to members:

Type of Service	Standard
Initial Visit	Within 45-60 working days
Follow-up Care	Within 30-60 working days

<sup>\*</sup>High volume specialty providers are determined based on patient visit volume over a specified period of time. OB/GYN providers are always deemed high volume providers. High impact specialty providers typically treat conditions that have high mortality and morbidity rates, including provider types where treatment requires significant resources. Oncology providers are always deemed high impact specialists.

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

Type of Service	Standard
Non-life threatening emergency	Within 6 hours
Urgent	Within 48 hours
Initial visit for routine care	Within 10 working days
Routine	Within 30-45 working days

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

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

Results are reported to the Quality Improvement committee. MHP requires an 80 percent compliance rate for all access measures. Those 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**

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

Acceptable after-hours access methods include:

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

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

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

In the event the provider utilizes covering physician(s), we recommend the covering physician also be a participating MHP physician. It is the PCP's responsibility to ensure that his 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**

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

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

ATTN: <NAME OF NETWORK DEVELOPMENT COORDINATOR>
McLaren Health Plan
G-3245 Beecher Road
Flint, MI 48532

- 4. The request is reviewed and approved by the Network Development manager following verification of membership assigned to the PCP.
- 5. The Network Development manager will respond in writing to the provider's request within two weeks, indicating approval or denial.
- 6. If approved, the request for the acceptance status change is effective 30 days from the dateof approval and changes your acceptance status to "conversion only."

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

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

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

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

# **Opening a Practice**

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

# **Data Reporting**

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

MHP expects all providers to submit claims even when MHP is the secondary payer and no reimbursement is due from MHP.

Professional services should be reported on a standard CMS 1500 form to report all encounters and billable services provided.

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

# **Procedures for Dismissing Members for Disruptive Behavior or Fraud and Abuse**

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

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

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

- The provider office must notify the member of the dismissal by certified letter
- A copy of the letter must be sent to MHP at the following address:

McLaren Health Plan G-3245 Beecher Road Flint, MI 48532

ATT: Customer Service Manager

You can also fax the dismissal letter to: (833) 540-8648

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

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

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

# **VIII - Immunizations**

# Michigan Care Improvement Registry (MCIR)

The Michigan Public Health Code and Communicable Disease Rules require that immunization providers report vaccines administered to children born after 12/31/93. Registering with MCIR facilitates meeting this reporting requirement. MHP providers must register with MCIR by calling (888) 217-3900 or online at http://mcir.org. In addition, all 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 that all children in your practice, regardless of their insurance status, have access to appropriate immunizations as recommended by MHP's Pediatric Preventive Care Guidelines and the Alliance for Immunizations in Michigan (AIM).

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

# Michigan Vaccine Replacement Program (MI-VRP)

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

# **IX - Emergency and Urgent Care**

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

## **Definitions**

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

- Serious bleeding
- 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, which contribute to high utilization of the Emergency Department. Case managers ensure the member has established a relationship with their PCP and educate members on appropriate use of the Emergency Department.

Please contact Medical Management at (888) 327-0671 for more details.

# PCP's Role in Urgent and Emergency Care

Members must contact their PCP prior to an Emergency Department visit unless the member has what he or she believes to be a life-threatening emergency. If the PCP is contacted, an assessment of the situation for severity should determine the appropriate course of action (i.e., STAT office visit, urgent care visit, Emergency Department visit or regular office visit). If an urgent care or Emergency Department visit is required, authorization is not needed. However, when a member notifies his 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/7 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 does not have time to call the PCP, they are instructed to go to a MHP participating hospital Emergency Department, the nearest Emergency Department, or call 911.

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

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

# X - Referral and 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 that the PCP coordinates 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 may be attached. An electronic preauthorization request can be submitted. The electronic form can be accessed by selecting the Referral Form quick link via the provider tab drop down. The preauthorization request form also can be printed from the same webpage and submitted via fax to (810) 600-7959.

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 healthcare utilization management decision making:

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

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

As a reference guide, there is a complete 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 members care, including discharge planning, and that case management is initiated when appropriate.

Notify us of admissions by telephone or fax:

**Telephone:** (888) 327-0671 (toll free) | **Fax:** (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 non-payment of a hospital admission. The member's Case Management nurse will work with the hospital staff in managing the stay and assist with the planning and determining discharge needs.

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

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

- Admission date
- Delivery date
- Discharge date

- Type of delivery
- Status of the mother and baby

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

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

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

## **Outpatient/Observation Stay: Facility**

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

In addition to the evaluation of the emergency room treatment results, many other factors are also considered, such as patient's medical history, medical predictability of adverse outcomes with presenting signs and symptoms, and the expectation that the episode of care may be resolved in a short period.

Also, to help identify outpatient stays, system edits will identify an episode of care lasting less than 48 hours and members with a specific presenting diagnosis. Examples of diagnoses (not all inclusive) that may be reviewed for reimbursement as an outpatient include:

- Asthma
- Bronchitis/bronchiolitis
- Cellulitis
- Chest pain
- Closed-head injury without loss of consciousness

- Dehydration (gastroenteritis)
- Overdose/alcohol intoxication
- Pain: e.g., abdominal, head, back
- Pneumonia
- Pyelonephritis
- Syncope

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

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

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

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

### **Readmissions: Facility**

MHP reviews all inpatient readmissions when readmission occurs within 15 days after a member is discharged. We review cases to determine if the readmission is related to the first admission for reasons such as:

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

The outcome of the review may impact the hospital's reimbursement. When providing clinical review for members readmitted to the same hospital within 15 days, please provide a clinical review for the last two days of the first admission, and an admission review for the second, when calling in the second admission. If readmission involves a different facility, MHP will seek the clinical information from the first admission to determine if either hospital's reimbursement is impacted.

### **Emergency Care Requires Outpatient Surgery**

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

### XI - General Information

## **Physician Office Laboratory Services**

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

## **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 healthcare services. These guidelines may be found at http://mqic.org and www.McLarenHealthPlan.org/medicaid-provider/provider-guidelines-mhp.aspx. The MQIC guidelines are evidence-based and include both physical conditions such as asthma and diabetes, and behavioral health conditions such as depression and attention-deficit/hyperactivity disorder for children and adolescents. The guidelines are reviewed every two years for needed updates.

## Joint Venture Hospital Laboratories (JVHL)

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

- Service center locations
- JVHL provider directory

## **Reference Lab Billing Requirements**

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

## Diabetic Monitors and Supplies - MHP 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.

There 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

## 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. They include:

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

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

### **Medical Record Maintenance**

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

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

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

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

Provider must maintain medical records of all medical services received by members. Medical records include, but are not limited to the following: a) a record of outpatient and emergency care, b) specialist referrals, c) ancillary care, d) diagnostic test findings including all laboratory and radiology, e) prescriptions for medications, f) inpatient discharge summaries, g) histories and physicals, h) immunization records, and i) all other documentation sufficient to fully disclose the quantity, quality, appropriateness and timelines of services provided by provider. Medical records must be maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates a system for follow-up treatment.

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 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 on an annual basis chooses two medical record standards (e.g., patient identification, record content, and continuity and coordination of care) to be assessed through an on-site visit at 50 percent of our PCPs with >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 in 60 days.

The following documentation should be in each patient 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 timeframes 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 healthcare 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) EVIDENT OF DISCHARGE SUMMARIES OR PROGRESS NOTES FROM SKILLED NURSING FACILITIES/ HOME HEALTH PROVIDERS

## 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 allow employees who are authorized with a password have access to electronic information.

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

## **Quality Improvement Activities**

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

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

#### **Non-Discrimination**

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

## **Member Complaint, Grievance and Appeal Procedure**

We want to hear member comments so that we can make our services better. We want our members to receive answers to questions they have about McLaren. 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 interpreter and TTY services available.

#### STANDARD GRIEVANCES

A grievance is a complaint about having a problem calling McLaren or if a member is unhappy with the way a provider or a McLaren employee treated them. The member can call Customer Service if they have questions or concerns. McLaren staff will try to resolve concerns during the first contact. If members are still unhappy with McLaren's response, they may file a formal grievance. Please mail grievances to us at:

Atten: Member Appeals McLaren Health Plan G-3245 Beecher Rd Flint, MI 48532

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

Fax number: (810) 600-7984 Email: MHPAppeals@mclaren.org

Note that grievances do not include appeals. See the Appeals section for more information on appeals. Customer Service staff can help members document and file a grievance. McLaren will acknowledge receipt of the grievance in writing within five days of receipt. We will complete the grievance process within 30 days. Individuals who make decisions on the grievance will not be involved in a previous level of review. They will also not be a subordinate of a person who made a decision. If required, we will use an appropriate clinical person.

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

### **EXPEDITED (FAST) GRIEVANCES**

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. 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 McLaren.

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 McLaren'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 McLaren's internal grievance process.

STANDARD INTERNAL APPEALS

Members may file an appeal of an adverse benefit determination with McLaren. Note that an untimely response to a request may become an adverse benefit determination. The member or their authorized representative have 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, the member will need to complete McLaren's authorized representative form. It is available at McLarenHealthPlan.org You may also call Customer Service to mail a copy.

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 orally. However, oral appeals must be followed by a written, signed appeal. If the member does not timely send it to us in writing the appeal will be dismissed. Send appeal request along with any added information to:

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

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

Fax Number: (810) 600-7984

Email: MHPApeals@mclaren.org

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

When McLaren makes a decision subject to appeal, McLaren will give a written adverse benefit determination notice to the member and the requesting provider, if applicable. Adverse action notices for the suspension, reduction or termination of services must be made at least 10 days prior to the change in services. McLaren 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 McLaren mailing the notice of action
- The intended effective date of McLaren's 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 McLaren 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 fair hearing and continuation of benefits within 10 days from the date
   McLaren 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. McLaren will do this as fast as the members health needs. This will be no more than 72 hours after we receive notice of a reversal.

If an adverse State Fair Hearing decision is made, you may be required to pay the cost of your services. However, McLaren 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. McLaren will provider 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 within five days telling the member that we received their appeal. The letter will tell them about the appeals process. It will also include the time and location of the appeal meeting. The member or their authorized representative may speak before the committee in person or by phone. They can present evidence, testimony and make legal and factual arguments. The member or their authorized representative must contact McLaren 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 judgement, 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 needs. Normally we have 30 days to complete the internal appeal process. 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 McLaren'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 at (888) 327-0671. A member can also make this request in writing. They must request an expedited appeal within 10days of the adverse benefit determination. Expedited appeals are only available 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 discharge 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, McLaren will notify the member and their physician of McLaren'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 30day timeframe.

The member's physic an may confirm by phone or writing that he or she has a medical condition that the timeframe 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 the member or their authorized representative, files a request for an expedited appeal with McLaren. See the Expedited External Appeal 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 McLaren's final adverse benefit determination. If the member is not required to exhaust McLaren's appeals process, they must do this within 127 days from receiving McLaren's adverse benefit determination. McLaren will provide the form required to file an external appeal.

Requests should be mailed or faxed to:

Department of Insurance and Financial Services Health Plan Division PO Box 30220 Lansing, MI 48909-7720

**Delivery Service:** 

Department of Insurance and Financial Services Health Plan Division PO Box 30220 Lansing, MI 48909-7720

Toll Free Telephone: (877) 999-6442

Fax: (517) 284-8838

Submit online at: https://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 McLaren. 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 McLaren. McLaren will provide the form required to file an expedited external appeal.

These requests should be mailed or faxed to:
Department of Insurance and Financial Services
Health Plan Division
PO Box 30220
Lansing, MI 48909-7720

Courier/Delivery Service:

Department of Insurance and Financial Services Health Plan Division PO Box 30220 Lansing, MI 48909-7720

Toll Free Telephone: (877) 999-6442

Fax: (517) 284-8838

Submit online at: https://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

McLaren. 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 complaint with the Michigan Administrative Hearing System (MAHS) with the DHHS. They must file the complaint with MAHS 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's appeals process. Listed below are the steps for the Stat of Michigan's Medicaid fair hearing process:

**Step 1:** Call MAHS at (877) 833-0870 or send an email to administrative tribula@michigan.gove to have a hearing request (complaint) form sent to the member. They may also call to ask questions about the hearing process.

Step 2: Fill 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.

**Champs Enrollment** 

ALL providers rendering services to Medicaid beneficiaries, must be enrolled with the MDHHS CHAMPS System. If you are not enrolled your claims will deny as of Jan. 1, 2019. Register today by logging into the website: www.michigan.gov/mdhhs

- 1. Click on "Doing Business with MDHHS"
- 2. Click on "Health Care Providers"
- 3. Click on "Providers" (middle of page)
- Click on CHAMPS button
- 5. Click on "MI LOG In"
- 6. Click "Sign Up"

During registration, be sure to "associate" with McLaren Health Plan. This will ensure that MHP is notified of your registration, ensuring claims will process appropriately.

All new providers enrolling with CHAMPS will receive a Welcome Letter from MDHHS upon approval. MDHHS recommends all organizations keep a list of their user IDs.

CHAMPS training is available by emailing ProviderOutreach@michigan.gov.

In addition, when a prescription is submitted with a Type 2 (Group) NPI or any non-enrolled NPI as the prescribing provider, in the NCPDP filed: #411-DEB Prescriber ID, will deny. It is the prescribing physician's responsibility to ensure that they are actively enrolled within CHAMPS in order to prevent member access to care issues.

## Office of Inspector General (OIG Audits and Appeals)

Adherence to the Medicaid Provider Manual. You must adhere to the 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 Appeal's 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 but not limited to 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**

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

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

MHP In-Office Laboratory Billable Procedures		
CPT-4 Code	Procedure Description	
80048	BASIC METABOLIC PANEL	
80051	ELECTROLYTE PANEL	
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	
82044	URINARY MICROALBUMIN	
82270	BLOOD, OCCULT; FECES SCREENING BY PEROXIDASE ACTIVITY, 1-3 SIMULTANEOUS DETERMINATIONS	
82272	BLOOD, OCCULT; FECES SCREENING BY PEROXIDASE ACTIVITY, SINGLE SPECIMEN (E.G., FROM DIGITAL RECTAL EXAM)	
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	
82670	ESTRADIOL	
82947QW	GLUCOSE; QUANTITATIVE	
82948	GLUCOSE; BLOOD, REAGENT STRIP	
83001QW	GONADOTROPIN; FOLLICLE STIMULATING HORMONE (FSH)	
83002	GONADOTROPIN; LUTEINIZING HORMONE (LH)	
83036	HEMOGLOBIN, GLYCATED	
83037	GLYCOSYLATED HEMOGLOBIN TEST	
83655	LEAD	
84144	PROGESTERONE	
84146	PROLACTIN	
84295	SODIUM; SERUM, PLASMA OR WHOLE BLOOD	

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# **In-Office Laboratory Procedures**

MHP In-Office Laboratory Billable Procedures			
CPT-4 Code	Procedure Description		
84520	UREA NITROGEN; QUANTITATIVE		
84703QW	GONADOTROPIN, CHORIONIC (HCG); QUALITATIVE		
85007	BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL DIFFERENTIAL WBC COUNT		
85013	BLOOD COUNT; SPUN MICROHEMATOCRIT		
85014QW	BLOOD SMEAR; HEMATOCRIT (HCT)		
85018QW	BLOOD SMEAR; HEMOGLOBIN (HGB)		
85025	COMPLETE BLOOD CT (CBC-HGB, HCT, RBC, WBC, AND PLT) AND DIFF, AUTOMATED		
855027	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		
86308QW	HETEROPHILE ANTIBODIES; SCREENING		
86403	PARTICLE AGGLUTINATION (SCREENING EACH ANTIBODY) RAPID STREP TEST		
86580	SKIN TEST; TUBERCULOSIS, INTRADERMAL		
87081	CULTURE, BACTERIAL, SCREENING ONLY; FOR SINGLE ORGANISMS		
87210	SMEAR, PRIMARY SOURCE, W/INTERP; WET MOUNT SIMPLE STAIN		
87220	TISSUE EXAMINATION BY KOH SLIDE FOR FUNGI		
87650	STREPTOCOCCUS, GROUP A, DIRECT PROBE TECHNIQUE		
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)		

<sup>\*</sup>Only Specialists may perform these services.

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### **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. McLaren 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 the fifth surgical procedures. If more than five procedures are performed, an operative report must be provided with the claim.

### **Telemedicine**

In an effort to enhance our members' access to care, MHP has made available the use of telemedicine. 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 only covered 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 will be implementing a CES in 2019. The implementation of the CES will focus 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 will also detect coding errors, including but not limited to: errors relating to unbundling, incidental procedures, modifier appropriateness, diagnoses and duplicate claims.

# XII - Submitting a Claim

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

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

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**

- 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.

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 Network Development Coordinator 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 Network Development or access McLarenHealthPlan.org.

#### **Electronic Claims Submission**

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

Our Payer IDs for electronic claims are:

McLaren Medicaid / Healthy Michigan Plan – 3833C McLaren Community - Commercial HMO/POS – 38338 McLaren Health Advantage – 3833A McLaren Medicare Supplemental – 3833S

## **Clearinghouse Information (both Professional and Facility)**

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

### **Claims Data Validation**

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

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

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

## **Your Clearinghouse**

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

#### **Pre-Edit**

Your claim must contain the rendering and the billing NPI to be processed.

#### **Subscriber Identification**

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

## **Billing Provider Identification:**

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

#### **EDI Contacts**

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

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

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

#### **Clean Claims**

MHP is required to **process** your clean claims within forty-five (45) days of MHP receiving the claim. Clean claims not processed in this time period are eligible for interest payments at 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 name and their ID numbers
- Lists the date(s) and place of service
- The claim is a bill for covered services for an eligible member
- The claim is a bill for medically necessary and appropriate care
- The claim contains preauthorization or pre-certification information, if required
- The claim identifies the services rendered by using proper procedure and diagnosis codes
- The claim includes additional information when required by MHP

### **Non-Clean Claims**

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

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

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

## **Billing for Physician Administered Drugs and NDC Reporting**

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

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

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

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

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

## **Coordination of Benefits (COB)**

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

COB claims should be submitted electronically COB claims must be submitted to MHP within twelve (12) months from the date of service or 90 days from the date of the primary payers 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 that 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 re-submitting duplicate claims during this same time period. Also, your claim will not be statused within this time period.

Providers who wish to request a claims adjustment to correct a previously submitted claim, believe a service was denied inappropriately or a claim did not pay correctly, are encouraged to do one of the following:

- Complete the Provider Claim Adjustment Form, see Forms Section XVIII or
   McLarenHealthPlan.org, attaching a paper copy of the corrected claim or the claim in dispute,
   and supporting documentation for the adjustment, and fax it to Customer Service at
   (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 including, but not limited to:

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 MHP. Please contact MHP as soon as possible if you have identified an overpayment. Federal law requires that you notify MHP in writing of the reason for an overpayment. We will work with you to ensure the overpayment is promptly returned to MHP. In some cases, this may include offsetting future claims. However, please note that for overpayments related to MHP's Medicaid/Healthy Michigan Plan line of business, federal law requires that you return an overpayment within sixty (60) calendar days of identification of the overpayment. If MHP is unable to recover an overpayment by either offsetting future claims direct reimbursement from the provider; MHP will seek reimbursement through use of collections.

The following table outlines the timeframes for MHP to request funds or do take-backs.

Type of Corrective Adjustment	Timeframe
СОВ	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**

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

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

## **Understanding the Remittance Advice**

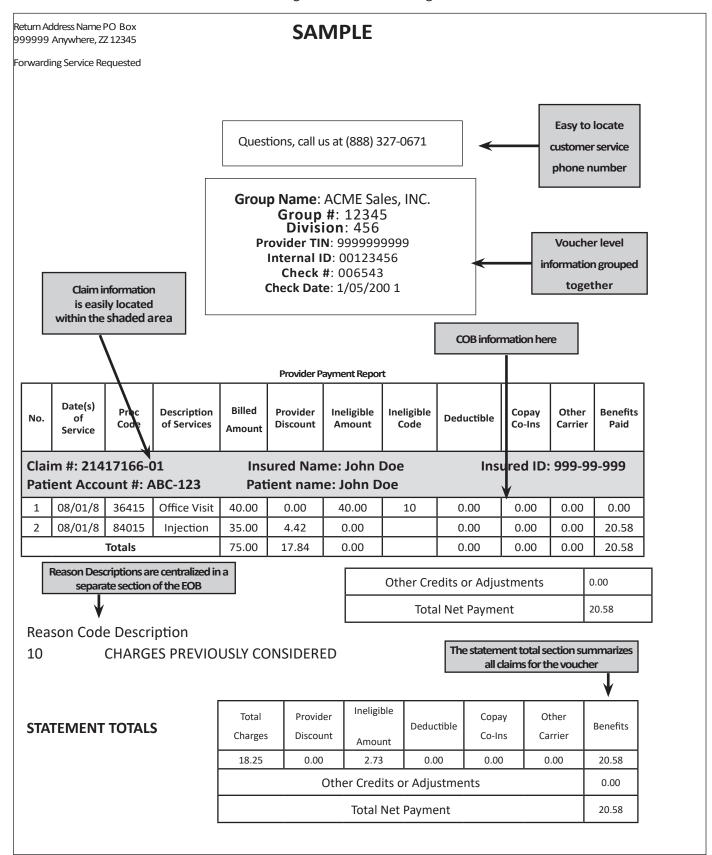
The goal at MHP is to use a Provider Payment Report (PPR) format that makes our claims processing information understandable. IF you have questions about your PPR, please contact Customer Service at (888) 327-0671.

## 835 and EFT Options

In an effort to add efficiency and speed to the payment of claims, MHP offers EFT/ACH and virtual card payment options. 835 remittance delivery options are also available. For more information on these payment and 835 remittance delivery options, please contact Customer Service at (888) 327-0671.

## **Sample Provider Payment Report**

MHP Commercial - McLaren Health Advantage - McLaren Advantage



# XIII - Pharmaceutical Management - Commercial and Medicaid

# Commercial (Community HMO/POS) and McLaren Health Advantage Pharmaceutical Management

### Introduction

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

- Standard commercial drug formulary: Used by large groups with 50 or more employees.
- On/Off the Marketplace Drug Formulary: Used by individuals and small groups with less than 50 employees.

Both MHP commercial drug formularies include one or more medications in each therapeutic class covered under a member's pharmacy benefit. The drug formularies can be found on our provider portal at McLarenHealthPlan.org.

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

## **Prescription Drug Rider**

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

#### **Covered Benefits**

- Federal legend drugs identified on an MHP commercial drug formulary.
- Select over-the-counter (OTC) items, identified on the drug formulary, prescribed by a prescribing provider.
- Diabetic supplies limited to needles, syringes, lancets and Abbott® manufactured test strips.
   Diabetic supplies for Marketplace members need to utilize the Bayer Contour meter and test strips.
- Flu shots covered at the pharmacy.

### **Non-Covered Benefits**

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

• Vaccines, except the flu shot.

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

### **Medication Copayment Tiers**

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

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

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

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

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

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

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

## **Step Therapy (ST) Edits**

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

# **Prior Authorization/Drug Exception Request**

MHP has placed a Prior Authorization (PA) restriction on certain medications within the drug formularies. PA means the medication requires special approval before it will be considered for coverage under MHP. A medication may require a prior authorization due to safety concerns or to ensure a more cost-effective

formulary alternative cannot be used.

If a prescribing provider feels a medication which requires prior authorization is medically necessary, then a prior authorization form, found in the forms section XVII, should be completed by the prescribing provider and faxed to the number indicated on the form. Please contact MedImpact at (888) 274-9689 for questions regarding the PA process or the status of a PA request.

Note: If the member needs an emergency supply of a medication that requires prior authorization, please contact MedImpact at (888) 274-9689 for assistance.

## **Compounded Medications**

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

## **Mail Order Pharmacy**

MHP has contracted mail order pharmacies. Our members can fill up to a 90-day supply of brand name medications through the mail order after a 30-day trial has been completed. Mail order brochures are available at McLarenHealthPlan.org or by calling MedImpact Direct at (855) 873-8739, TTY: 711

## **Specialty Pharmacy Medications**

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

### **Dose Optimization and Quantity Limits**

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

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

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

### **Drug Formulary Review and Modification**

A committee of health professionals (doctors, pharmacists and nurses) meets throughout the year and maintains the MHP commercial drug formularies. The following changes have an impact on the commercial drug formularies:

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

Prescribing providers may ask for a modification to any drug formulary by contacting our Pharmacy Administration department at (810) 244-1660 or by sending in a written request via e-mail to MHPPharmacy@mclaren.org. Requests for formulary modification will be reviewed by our Pharmacy Administration department and taken to the formulary committee for determination.

## Medicaid/Healthy Michigan Plan Pharmaceutical Management

### Introduction

Pharmaceutical Management promotes the use of the most clinically appropriate, safe and cost effective medications. MHP's Medicaid drug formulary is based upon the Michigan Medicaid Common Drug Formulary (Common Formulary). The use of the Common Formulary is a requirement of all Medicaid health plans in the state of Michigan. One or more medications are available in all required drug classes. The drug formulary can be found on our provider portal, McLaren Connect at McLarenHealthPlan.org.

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

### **Covered Benefits**

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

### **Non-Covered Benefits**

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

• Medical foods or agents that are not regulated by the Food and Drug Administration

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

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

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

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

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

## **Prior Authorization/Drug Exception Request**

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

If a prescribing provider feels a medication which requires PA is medically necessary than the Prior Authorization form (see Forms section XVII), should be completed by the prescribing provider and faxed to the number indicated on the form. Please contact MedImpact at (888) 274-9689 for questions regarding the PA process or the status of a PA request.

Note: If the member needs an emergency supply of a medication that requires PA, please contact MedImpact at (888) 274-9689 for assistance.

### **Step Therapy Edits**

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

### **Compounded Medications**

All compounded medications over \$200.00 require prior authorization. Upon approval the medication must be obtained through an in-network compounding pharmacy and billed to MHP electronically. Paper claims submitted by an out-of-network compounding pharmacy will not be accepted.

## **Specialty Pharmacy Medications**

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

### **Dose Optimization and Quantity Limits**

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

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

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

## **Drug Formulary Review and Modification**

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

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

Prescribing providers may ask for a modification to the drug formulary by contacting our Pharmacy Administration Department at (810) 244-1660 or by sending a written request via e-mail to MHPPHarmacy@mclaren.org. Requests for formulary modification will be reviewed by our Pharmacy Administration Department and then taken to the formulary committee for determination.

# **XIV - Provider Administrative Appeals**

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

## **Appeals Process: Investigation and Result**

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

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

McLaren Health Plan G-3245 Beecher Road Flint, MI 48532

Attn: Appeals

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

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

#### **Appeal Time Frames**

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

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

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

#### What Disputed Actions Can Be Appealed

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

Denial of inpatient days or other services;

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

### **Appeal Response Time Frame**

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

MHP's decision is final and binding for all products except Medicaid. The claims adjustment process is not available to a provider if the appeal process is used and the provider is not satisfied with the outcome.

## **Appeal Process Reminders**

The provider must have submitted a claim for the service in question, and/or received a denial or reduction in payment from MHP, before an appeal will be considered.

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

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

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

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

## **Appeals Process for Adverse Compliance Audit Findings**

As part of the MHP Compliance program, routine auditing and monitoring as well as data mining activities are performed. Providers are notified that they are part of one of these activities at the conclusion of the audit and if there are any findings that result in 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 30-day time frame and payment for amounts owed to MHP are due immediately upon expiration of the 30-day time period. Notwithstanding the foregoing, MHP may, in its sole discretion, offset against future claims.

McLaren staff who did not participate in the audit or are not subordinates of those that conducted the audit will review the documentation submitted by the provider. MHP will make a decision on the appeal

within 30 calendar days of its receipt of the appeal. MHP will provide a written decision to the provider. If MHP upholds the decision (in full or in part), the provider must remit payment of the amounts owed to MHP immediately, but in no case later than 30 calendar days of the date of the letter. In cases of fraud, waste or abuse, MHP may offset claims immediately. For all other cases, if payment is not received within 30 days of the date on the letter, MHP will offset against future claims.

# **Medicaid Appeals**

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

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

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

# XV - Fraud, Waste and Abuse

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

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

### Reporting Commercial Fraud, Waste and Abuse

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

McLaren Health Plan G-3245 Beecher Road Flint, MI 48532

ATT: Compliance Officer

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 http://michigan.gov/fraud. This can be done anonymously. Additionally, a fraud, waste and abuse claim can be made in writing to:

Or

Mail:

McLaren Health Plan G-3245 Beecher Road Flint, MI 48532

ATT: Compliance Officer

Phone: (866) 866-2135

Email: MHPcompliance@mclaren.org

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

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

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

### **False Claims Act**

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

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

Compliance Hotline – (866) 866-2135 Compliance Officer – (888) 327-0671

By mail: McLaren Health Plan G-3245 Beecher Rd. Flint, Michigan 48532

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Attn: Compliance Officer

# For Medicaid Only

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

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

# XVI - Member Rights and Responsibilities

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

### **MHP Members have:**

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

• The right to receive beneficiary information and information about the structure and operation of MHP, including the services, providers of care and member rights and responsibilities.

- The right to make suggestions regarding MHP member's rights and responsibilities.
- The right to have their medical record kept confidential by MHP and their provider.
- The right to be free from other discrimination prohibited by state and federal regulations.
- The right to be free exercise their rights without adversely affecting the way McLaren, providers or the state treats them.

# Members of MHP have the following responsibilities:

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

# **XVII - HIPAA Notice of Privacy Practices**

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

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

# FORMS SECTION XVIII

# CMS 1500 Claim Form

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 TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER	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
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
9a	Other insured's policy or group number	Enter the policy or group number of the other insured as indicated.	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.  Place an "X" in the appropriate box to indicate the other insured's sex.  Mark only one box. If gender is unknown, leave blank.	Yes, if applicable
9с	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
<b>11</b> a	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
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 had the same or similar illness. Previous pregnancies are not a similar illness. Leave blank if unknown.	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
17a SHADED	Other ID #	Enter the two-character qualifier and Other ID.	No
17b UNSHADED	Referring provider NPI	Enter the ten-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

- TOVIGET II	nunuun		Section Aviii
Field Location CMS 1500	Field Name	Field Description	Required
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
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.  If an unlisted or unclassified code is used, a narrative description must be present. Use this for NDC drug codes.	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 ICD-9-CM codes or narrative descriptions in this field. Do not use slashes, dashes, or commas between reference numbers.	Yes
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	Yes, if applicable
24J UNSHADED	Rendering Provider NPI	"No".  Enter the ten-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 place an "X" in the SSN box. Only one box can be marked.	Yes
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
		l .	1

Field Location CMS 1500	Field Name	Field Description	Required
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	<b>Enter payment amount from the patient or other payer.</b> 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
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
33a UNSHADED	Billing Provider NPI	Enter the ten-digit NPI.	Yes
32a UNSHADED	Service Facility NPI	Enter the ten-digit NPI.	Yes, if applicable

# 1500 Health Insurance Claim Form

1500			í
HEALTH INSURANCE CLAIM FORM			
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05			
	A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program.	PICA
MEDICARE   MEDICAID   TRICARE   CHAMPV   CHAMPUS   CHAMPUS   (Medicaid #)   (Sponsor's SSN)   (Memberii	HEALTH PLAN BLK LUNG	Ta. INSORED ST.D. NOMBER (For Program	in item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TC INSURED	7. INSURED'S ADDRESS (No., Street)	
	Self Spouse Child Other		
CITY STATE	8. PATIENT STATUS	CITY	STATE
ZIP CODE TELEPHONE (Include Area Code)	Single Married Other	ZIP CODE TELEPHONE (Include Area (	Code)
	Full-Time Part-Time Employed Student Student	( )	
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)	a. INSURED'S DATE OF BIRTH SEX	
a. OTHER INSURED'S POLICE OR GROUP NUMBER	YES NO	a. INSURED'S DATE OF BIRTH SEX	F□
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	F
M F	YES NO		
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO  10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
	104.11202.11207.01.2007.2002	YES NO // yes, return to and complete i	1
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the		<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I a payment of medical benefits to the undersigned physician or</li> </ol>	
to process this claim. I also request payment of government benefits either below.		services described below.	supplier for
SIGNED	DATE	SIGNED	
-	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCU	PATION
▼PREGNANCY(LMP)	GIVE FIRST DATE MM   DD   YY	FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178	.++	18. HCSPITALIZATION DATES RELATED TO CURRENT SEF	/ICES YY
19. RESERVED FOR LOCAL USE	. NPI	FROM TO	
TO THE SETTLES TO THE SOURCE SOL		YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2,	3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
1 3	<del>*</del>		
		23. PRIOR AUTHORIZATION NUMBER	
	DURES, SERVICES, OR SUPPLIES E.	F. G. H. I.	J.
Frcm	tin Unusual Circumstances) DIAGNOSIS CS   MODIFIER POINTER	OR Family ID.	DERING DER ID. #
		, , , , , , , , , , , , , , , , , , , ,	
		NPI NPI	J. DERING DER ID. #
		NPI	
		NPI	
		i NET	
		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S /	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TCTAL CHARGE 29. AMOUNT PAID 30. BAL	ANCE DUE
	(For govt. claims, see back YES NO	\$   \$   \$	
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )	
apply to this bill and are made a part therect.)			
elchied Date a.	b.	a.   b.	,
SIGNED DATE  NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM CMS-	1500 (08/05)

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

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

#### REFERS TO GOVERNMENT PROGRAMS ONLY

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

BLACK LUNG AND FECA CLAIMS

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

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

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

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

For CHAMPUS claims. I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

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

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

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

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411,24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

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

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

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," <u>Federal Register</u> Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law

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

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

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

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

#### MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

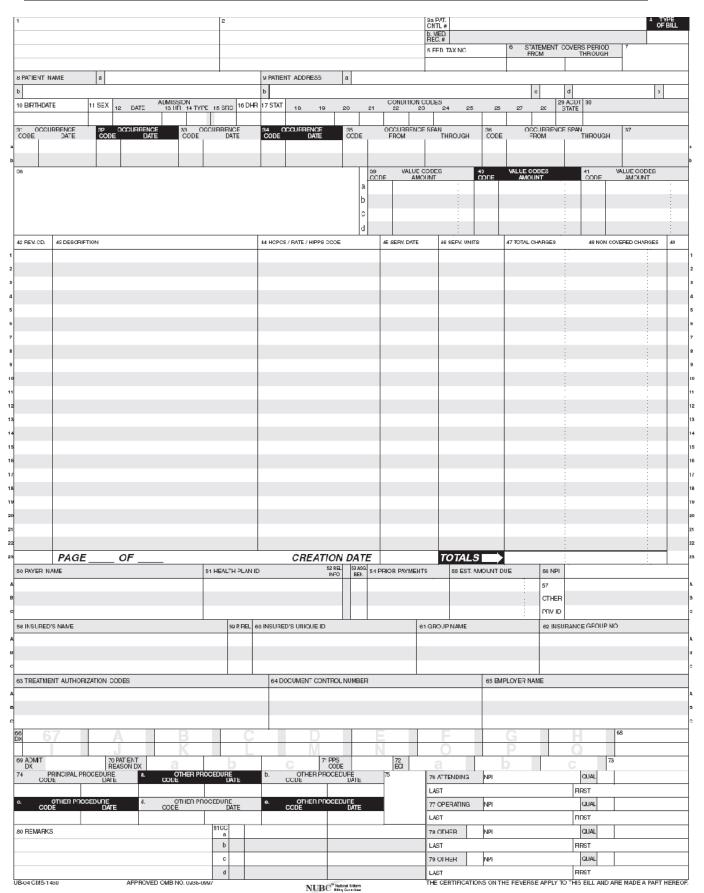
NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

# **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
16	Discharge Hour	Required	N/A
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required if Applicable	Required if Applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A
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	Subscriber Name and Address	Required	Required
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
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

Field Location	5		
UB-04	Description	Inpatient	Outpatient
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
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
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 Situationa Required I



UB-04 NOTICE:

THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

- If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file.
   Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
- If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
- Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
- For Religious Non-Medical facilities, verifications and if necessary recertifications of the patient's need for services are on file.
- Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
- The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
- 7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
- For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
- 9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

- (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
- (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
- (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits:
- (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
- (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
- (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
- (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

# **Most Commonly Used Eligible Codes**

MHP Commercial, 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)	ТКВ	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
11	Adjustment of previously processed claim	А	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	В	Service not allowed under OPPS on hospital outpatient claim
CAP	Services are capitated	С	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 4 <sup>th</sup> & 5 <sup>th</sup> digit required		
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 utilizes 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 Network Development at (888) 327-0671 to discuss options

**Companies/Groups** – Enter as much of full name as possible in **last name field** 

- Use format: GROUPNAME
- No punctuation (see example above)

### **Billing Provider Street Address (ALL Providers)**

- 999 S ANYWHERE ST(PO Box not accepted)
- No punctuation (such as periods or commas)
- No additional address information required or processed for street

#### Billing Provider City, State, Zip

- Full city name as space allows and standard USPS 2-digit state abbreviation
- IMPORTANT: use 9-digit Zip Code
- · Each in a separate field

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

**MEMBER – IL**: (same for QC dependent as applicable)

### Member Name: Enter each part of name in separate fields

- Use format: LASTNAME FIRSTNAME 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 REJECTEDAddress: 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 <a href="http://enshealth.com">http://enshealth.com</a> or your current clearinghouse. For claims status, visit the McLaren Connect Provider Portal.

# **Provider Referral Form - Request for Preauthorization**

McLaren

Electronic submission of authorization requests is available on our website at McLarenHealthPlan.org.

PROVIDER REFERRAL FORM REQUEST

HEALTH PLAN		FOR PRE-AUT	HORIZATION		
Member First			Date of Request:		<u>Member's Plan</u> Fax: (810)600-7959
Member Last Name: DOB:		DB:	Member ID:		Medicaid
Ordering Provider Informatio	n•				Healthy Michigan
Name:	ш,	15	Specialty:		Fax: (810)600-7966
Address:			City:		HMO Commercial/
Phone:	Fax:		Zip:		Community
Office Contact Name:			F .		POS Commercial/
Member is being referred to:					Community Health Advantage
Name:			Specialty:	-	
Address:			City/Zip:		
Phone:	Fax:		Billing NPI <i>(required)</i> : TIN:		
Office Contact Name:			1111		
*Check Requested Service (see Out-of-Network Consult	e back of form for compl	lete list by prod Specialty:		# of visits:	
Physician Name: Billing NPI(required):		Notes:		ICD-10:	
_Outpatient Ambulatory Pr	ocedure**	Facility Name	:	ICD-10:	
Performing Surgeon Name :		Date of Proceed	dure:	Procedure Codes:	
Billing NPI(required):					
Inpatient Procedure		Facility Name		ICD-10:	
Performing Surgeon Name:		Date of Proceed	lure:	Procedure Codes:	
Billing NPI(required): Therapy			Home Health Car		1
(4/1/18 Medicaid visit limit of	36 annual visits each of	f	ICD-10:	е	
PT/OT/ST)	oo amaaa visits caen o	•	Start of Care:		
ICD-10:			SN: # of visits:		
Start of Care:			PT: # of visits:		
PT: # of visits:			OT: # of visits:		
ST: # of visits:			ST: # of visits:		
OT: # of visits:			***		
DME (Attach Medical Nece. ICD-10:			Hospice ICD-10:		
DME Codes:	Rental: Purchase:		Certification Perio	od:	
Injectable/IV Therapy					
See Referral Category "Spec ICD-10:	cialty Medications/Inject	ions"			
J-Codes:					
Notes:					
1 10 1 0 1	anization anid for a detailed				

\*Please see the Preauthorization grid for a detailed listing of services requiring pre-authorization by product.

2. For Medicaid, McLaren HMO/POS, McLaren Advantage: If a specialist is completing this form, you must notify the PCP of services requested.

3. This authorization is for the services requested. The actual procedure codes billed may require additional documentation for reimbursement.

4. \*\*List of outpatient codes requiring pre-authorization may be found on MclarenHealthPlan.org

5. This pre-authorization is not guarantee of payment. Please contact McLaren Health Plan to verify eligibility and covered benefits.

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

3245 Beecher Road • Flint, Michigan • 48532 tel (888) 327 0671 • fax (810) 600 7959 McIarenHealthPlan.org

MHP41161014

This is not a complete listing of services that may require Preauthorization and all services rendered must be medically necessary.

The Certificate of Coverage or Plan Document includes more detailed information.

X= Requires Pre-Authorization NC= Not covered by this product NR= Auth not required	Medicaid	Healthy Michigan Medicaid	Commercial/ Community HMO/POS	Health Advantage (HA)
All Inpatient Services -obtained by admitting facility.	Wiculcalu	Wedicald	1110/103	Treatti Advantage (IIA)
Exception - Deliveries without sterilization requires only notification for all lines of				
business both contracted & non-contracted facilities.				
Community HMO/POS/HA - Non-contracted facilities are reimbursed at member's out-of-				
network benefit.	X	X	X	X
Inpatient Mental Health (MH)-obtained by admitting facility	NC	NC	Х	Х
All Out of Network Services (non-contracted providers)**				
Individual Plans on the Exchange should verify out of network benefits prior to receiving			s and a de	
services.	X	X**	X**	X**
Ambulance: Non-Urgent Transportation	X	X	X	X
Ambulance: Air, Emergent (Requires post-service review)	X	X	X	X
Applied Behavioral Analysis (ABA Therapy)	NC	NC	X	NC
Autism Services	NC	NC	X	Screening Only
Chiropractic				
(Medicaid up to 18 visits per calendar year. Additional visits require preauthorization)	NR	NR	NR	NR
Continuous Glucose Monitors/Supplies	X	X	X	X
Cosmetic Services	X	X	X	X
MEDICAID DME Purchase- (Durable Medical Equipment) - (allowable line by line as per	N.	Α	^	, A
Medicaid fee schedule)	>\$1500	>\$1500		
MEDICAID DME Rental-(allowable line by line as per Medicaid fee schedule)	>\$500/Mth	>\$500/Mth		
DME Purchase -(billable charges line by line)	,,,,,,	, , , , ,	>\$3000	>\$5000
DME Rentals (billable charges line by line)			>\$100/Mth	>\$500/Mth
Electroconvulsive Therapy (ECT)	NC**	NC**	X	X
Emergency Medical Response System	NC	NC	NC	NC
Genetic Testing, Counseling, Diagnosis and Treatment	X	X	X	X
Schede results, courseling, stagnosis and recutivent			HMO=NC	1
Hearing Aids (Commercial requires rider)	NR	x	POS=X	NC
Home Health Care	Х	Х	Х	NR
Hospice	Х	Х	Х	NR
Infertility Testing and Services	Х	Х	Х	Х
Injectables/IV Therapy (See J Code List)	Х	Х	Х	Х
In-Office Laboratory Procedure (Presumptive Drug Class Screening)	NC	NC	NC	NC
Insulin Pumps/Supplies	X	X	Х	X
Maternity Services-Out of Network	X	X	X**	NR**
Medication non-formulary drug requests (see formulary)***	X	X	Х	Х
Mental Health Outpatient Services:	NR	NR	NR	NR
In Network Consultations and Management	NR	NR	NR	NR
In Network Eating Disorders	NR	NR	NR	NR
In Network Substance Abuse	NC	NC NC	NR	NR
Oral procedures including TMJ and orthognathic	X	X	X	X
Podiatry Office Visits	NR	NR	NR	NR
Private Duty Nursing Services	NC	NC NC	NC	NC
Procedures to Treat Asthma (Bronchial Thermoplasty)	X	X	X	X
Prosthetics and Orthotics	>\$500	>\$500	>\$3000	>\$5000
	×3300	×3300	>33000 X	×33000
Proton Beam Therapy Rehabilitative Outpatient Facility Services	X	X	X	NR
			X**	X**
Routine Prenatal Care In and Out of Network  Skilled Nursing Home	NR v	NR v		
Skilled Nursing Home	X	X X	X X	NR NR
Sterilization-Voluntary				NR NB
Termination of Pregnancy	Х	X	Х	NR
ů i		1	1	
Therapies: Physical, Occupational and Speech				
Therapies: Physical, Occupational and Speech (10/1/18 The Medicaid visit limit of 36 visits each for PT/OT/ST will be calculated based	NR	NR	Х	NR
Therapies: Physical, Occupational and Speech	NR X	NR X	X X	NR X

This is not a complete listing of services that may require Pre-Authorization and all services must be medically necessary. The Certificate of Coverage, Plan Document or Policy includes more detailed information.

Medicaid/Healthy Michigan - Some Services covered under the Medicaid Mental Health Benefit

Medicaid sterilization requests require informed consent and a 30-day waiting period. Copies must be submitted with pre-authorization request.

<sup>\*\*</sup>Health Advantage/Community/Commercial: Not all Out of Network services require Pre-Authorization. Member will have higher out of pocket costs associated with Out of Network providers.

<sup>\*\*</sup>Individual Plans on the Exchange should verify out of network benefits prior to receiving services.

<sup>\*\*</sup>Medicaid/Healthy Michigan - This benefit is managed by the Prepaid Inpatient Health Plan (PIHP) or the Community Mental Health Center (CMH)

<sup>\*\*\*</sup>McLaren Health Plan does not pay for services, treatment or drugs, that are experimental, investigational or prescribed against FDA or manufacturer guidelines. Any service that may be classified as experimental or off-label should be prior authorized before the service is rendered\*\*\*

### **Provider Claims Status Fax Form**

Claims can be statused on the McLaren Connect Provider Portal or by submitting this form to Customer Service.







### **HEALTH PLAN COMMUNITY HEALTH PLAN**

Claims must first be statused via the McLaren CONNECT Provider Portal **Provider Claims Status Fax Form** Fax: (833) 540-8648

Email: MHPCustomerService@mclaren.org

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

Date:	From:	
Phone Number:	Fax Number:	Number of Pages Faxed:

- Please allow 15 days for MHP to process and/or respond to all claims status fax forms
- Claims will not be reviewed if status is requested less than 45 days from the date MHP received the original claim
- · Attach a copy of the original claim

Please complete the following information (required for each claim)			
Member Name:	Member ID #:		
MHP Claim Number:	Date of Service:		
Provider name:	Provider NPI#:		
Procedure Code:	Charges:		
Comments:			

MHP Status Response (for MHP use only)				
	Claim Processed	EOB Date:	Check #:	Amount:
	Claim Denied	Reason:		
	Corrected Claim Needed	Correction Needed:		
Cor	nments:			

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

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

# **Provider Claim Adjustment**







# McLaren Health Plan and McLaren Health Advantage **Provider Claim Adjustment Request Form** WHEN TO USE THIS FORM:

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

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

#### COMPLETE THE FOLLOWING REQUIRED INFORMATION:

Member Name:	ID #:	
MHP Claim #:	DOS:	
Provider Name:	Tax ID #:	
Office Contact:	NPI #:	
	Phone #:	
Date Provider Claim Adjustment Requ	est Form Submitted:	
Reason for Request (please check app	ropriate box):	
For a correction to a	For reconsideration:	
previously submitted claim:  ☐ Anesthesia Time	(supporting documentation required)	
☐ Date of Service	☐ Service denied for lack of authorization	
☐ Diagnosis Code ☐ Modifier	(attach copy of referral)	
	General denied as other insurance primary (COP)	
☐ MS DRG ☐ Service denied as other insurance primary (COB) ☐ Place of Service (attach copy of primary EOB)		
☐ Procedure Code	(account copy or primary 200)	
☐ Provider/Tax ID	☐ Service denied as a duplicate	
Other	(attach documentation)	

Send this completed Provider Claim Adjustment Request form along with the paper claim form (not EDI) and supporting documentation to:

> McLaren Health Plan Attention: Customer Service P.O. Box 1511 Flint, MI 48501-1511 Or Fax to: (833) 540-8648

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

# **Provider Request for Appeal (PRA) Form**







# **Provider Administrative Appeals**

It is the goal of McLaren Health Plan to resolve provider issues before reaching an appeal level. McLaren Health Plan 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 McLaren Health Plan, a written formal appeal may be filed.

Note: Providers who are appealing a professional clinical care review or a credentialing or re-credentialing action must pursue a different appeal process.

The following summarizes the McLaren Health Plan Administrative Appeals Process:

# What Administrative Disputed Actions Can Be Appealed

A provider may appeal an administrative action taken by McLaren Health Plan such as:

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

### **Appeal Process**

Within 90 calendar days of the disputed 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. These two items and any additional information can be mailed, faxed or emailed to:

> McLaren Health Plan G-3245 Beecher Road Flint, MI 48532 Attn: Appeals 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. Additional information may include charts and office notes, radiology or lab/pathology report(s), operative notes or surgery reports, etc.

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

# **Provider Appeal Time Frames**

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

- Explanation of payment (EOP)
- Original claim date of service
- Adjusted EOP
- Authorization Decision

The right to appeal is forfeited if 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.

# **Provider Request for Appeal (PRA) Form**







Appeal Process Investigation and Result	Appeal Response Time Frame
McLaren Health Plan 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, if appropriate.	from receipt of written appeal

#### **Process Clarification**

- Provider must have submitted a claim for the service in question and/or received a denial or reduction in payment before an appeal will be considered
- A written request, through the completion of a PRA form and the attachment of a paper claim, must be submitted to begin the Appeals Process
- A cover letter outlining the reason and rationale for the Appeal request must accompany the PRA
- Your written request should include any **new information**, such as:
  - o documentation from the medical record
  - o an explanation of payment
  - o other applicable documentation to support your position

### **Medicaid Appeals**

Non-contracted hospitals providing services to McLaren Health Plan members through the Michigan Department of Community Health Hospital Access Agreement are eligible to request a Rapid Dispute Resolution Process in compliance with the Medicaid Provider Manual, after hospital has first exhausted its efforts to achieve resolution through McLaren Health Plan'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 McLaren Health Plan Medicaid members are entitled to initiate a binding arbitration process, after the Provider has first exhausted their efforts to achieve resolution through McLaren Health Plan's Administrative Appeals Process as outlined above. To initiate binding arbitration, call McLaren Health Plan to obtain a list of arbitrators. Arbitrators are selected by the State of Michigan, Department of Community Health. The decision of the arbitrator is final. If the arbitrator does not reverse the decision, the provider is responsible for the arbitrator's charges.







# **Provider Request for Appeal (PRA) Form**

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

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

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

# Please complete the **REQUIRED** information below:

Member name:	ID #:	
DOS:	MHP Claim #:	
Provider name:	Tax ID #:	
Service being appealed:		
Reason for appeal:		
	REQUIRED ATTACHMENTS: rationale for the appeal request ion	
<ul> <li>Paper claim for the serv</li> <li>Name of person submitting appea</li> </ul>	ices being appealed	<b>Mail to:</b> McLaren Health Plan
Phone #:	Date submitted:	Attention: — Provider Appeals G-3245 Beecher Rd. — Flint, MI 48532
		Fax: (810) 600-7984 Email: MHPAppeals — @mclaren.org

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

The Provider Request for Appeal Form is available online at MclarenHealthPlan.org.

MHP42721081 Rev. 12/18

# QUICK REFERENCE SECTION

XIX

# **Emergency and Urgent Care Guidelines**

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

### **Emergency Care**

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

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

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

### **Urgent Care**

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

- Severe sore throat
- Sprains
- Severe headache
- Earache

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

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

## **Emergency Care Reminders**

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

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

### **Referral Guidelines**

### **Provider Referral 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 utilized as 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) 656-3604Detailed 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.

### Anesthesia

# **Billing for Anesthesia Services**

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

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

# **Payment Calculation**

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

# **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 4 concurrent cases	60%	
GC	Physician supervising up to two anesthesia residents	100%	
QK	Physician directing 2, 3, or 4 concurrent cases involving CRNA's or anesthesia assistants	60%	50%
QY	Physician is medically directing one CRNA	60%	50%
QX	CRNA's and anesthesia assistants, when medically directed by an anesthesiologist	40%	50%
QZ	Services performed by CRNA's without the medical direction of an anesthesiologist	100%	

# **Secondary Modifier**

Modifier	Description
QS	Monitored anesthesia care
G8	Monitored anesthesia care for complex complicated 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**

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

### **Revenue Code 510**

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

# **Newborn Billing Requirement**

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

- Reporting Newborn Priority (Type) of Admission or Visit Providers are required to report the appropriate priority (type) of admission or visit in accordance with NUBC guidelines. For instance, a newborn admission should be reported as type of admission of "4" (newborn). When billing with type of admission of "4", providers must report special point of origin code "5" (born inside this hospital) or "6" (born outside of this hospital)
- Reporting Newborn Birth Weight NUBC value code "54" (newborn birth weight in grams) is required on all claims with type of admission "4". Birth weight should be reported as a whole number. For example, if the birth weights is 2764.5 grams, then value code "54" amount should be reported as "2765"
- Reporting Cesarean Sections or Inductions Related to Gestational Age Providers are
  expected to report the following NUBC condition codes for cesarean sections or inductions
  related to gestational age, as appropriate:
  - **Condition Code "81"** C-Sections or inductions performed at less than 39 weeks gestation for medical necessity
  - **Condition Code "82"** C-Sections or inductions performed at less than 39 weeks gestation electively
  - Condition Code "83" C-Sections or inductions performed at 39 weeks gestation or greater

Any claim received without this required information will be denied.

# **Healthy Michigan Plan Beneficiary Notification of Copays**

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

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

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# **Information About Healthy Michigan Plan Co-Pays**

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

	Co-Pay	
Covered Services	Income less than or equal to 100% FPL	Income more than 100% FPL
Physician Office Visits (including Free-Standing Urgent Care Centers)	\$ 2	\$ 4
Outpatient Hospital Clinic Visit	\$ 1	\$ 4
Emergency Room Visit for Non-Emergency Services  Co-payment ONLY applies to non-emergency services  There is no co-payment for true emergency services	\$ 3	\$ 8
Inpatient Hospital Stay (with the exception of emergent admissions)	\$ 50	\$ 100
Pharmacy	\$ 1 preferred \$ 3 non-preferred	\$ 4 preferred \$ 8 non-preferred
Chiropractic Visits	\$ 1	\$ 3
Dental Visits	\$ 3	\$ 4
Hearing Aids	\$ 3 per aid	\$ 3 per aid
Podiatric Visits	\$ 2	\$ 4
Vision Visits	\$ 2	\$ 2

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

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

If you would like more information on copayment requirements,

visit <u>www.healthymichiganplan.org</u>, or call (800) 642-3195.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

# **Reference Lab Billing Requirements**

As laboratory testing continues to become increasingly specialized, hospital laboratories may find it

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

Definitions of reference and referring laboratories are as follows:

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

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

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

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

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

# **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 cdes is required to ensure that all services redenred are captured and recorded for quliaty and HEDIS © and reporting purposes.

# **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 th4 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 <sup>®</sup> reporting purposes.

# **Provider Demographic Updates**

In an effort to maintain accuracy of our Provider demographic information, MHP audits all providers throughout the year to update and record valid Provider information. MHP requires Providers to update their demographic information at least 60 days prior to the change occurring. If a change does occur, the Provider Information below must be completed and sent to MHP. The information listed below does not outline all required demographic information, only those that are required to be reported as a change.

The information may be submitted via email at MHPProviderServices@mclaren.org or via fax to (810) 600-7979.

# **Provider Information Updates**

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)? Y or N		
Office Location		
Office Hours		
Pay to Information		

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