McLaren HEALTH PLAN

Provider Network Update
SEPTEMBER 2019

COMING SOON: CLAIMS EDITING SYSTEM (CES) IMPLEMENTATION

Effective Jan. 1, 2020, all claims submitted to McLaren Health Plan (MHP) will be subject to Optum CES. CES 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. CES will also detect coding errors, including but not limited to: errors relating to unbundling, incidental procedures, modifier appropriateness, diagnoses and duplicate claims.

Sources used by Optum CES for edits, includes, but is not limited to, the following:

- National Correct Coding Initiative (NCCI) edits, including Medically Unlikely Edits (MUEs)
- Federal Register (the Daily Journal of the US Government that contains agency rules, proposed rules and public notices)
- Medicare publications
- Local and National Coverage Determinations (LCDs/NCDs)
- Outpatient Code Editor (OCE)
- Medicare Code Editor (MCE)

What do you need to do?
Since many other carriers with whom you work with already use Optum CES, we do not anticipate this implementation will disrupt how you work with MHP. CES will replace our legacy edits and automatically review and catch errors, omissions and questionable coding. The end result will be streamlined claims, reduced reimbursement errors and improved payment integrity. All edits are transparent, and you will be able to look up specific claims and see both the edits and the sourced citations.

Claims will be reviewed through CES and if a claim is denied, it will show on your payment file or EOP. CES denials will not be front-end edits.

REMINDER: HOSPITAL ACQUIRED CONDITIONS

What is a HAC? A hospital-acquired condition (HAC) is one of several medical conditions a patient can acquire during a hospital stay that was not present on admission (POA). CMS has used this designation since 2008. Indication of an HAC on an inpatient claim may result in adjustments to diagnosis-related group (DRG) reimbursement.

MHP reviews and analyzes submitted claims for HACs. Be sure claims are correctly submitted with the following information:

- Ensure a complete and accurate POA indicator is included for all diagnoses.
- Review all HAC designated ICD-10 CM codes to ensure claim is properly coded.

Additional information on HACs can be obtained on the CMS website:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

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McLarenHealthPlan.org

REMINDER: FRONT-END CLAIM EDITS

MHP has implemented front-end claims edits. These front-end edits will be recognized when you receive a ***"277" front-end edit.*** Reasons for front-end edits include, but are not limited to, the following:

- **Accurate member identification**: *ALL claims must contain accurate member information* (member name, member/subscriber ID and gender). Verification of assigned membership can be done on the McLaren CONNECT provider portal. Claims submitted with incorrect member identification will receive a front-end edit and not be accepted.

- **Correct billing provider information:** Claims must contain valid billing NPI and rendering provider NPI, as assigned by CMS. The tax ID number is not acceptable in 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. Claims submitted with incorrect billing provider information will receive a front-end edit and not be accepted.

- **Coordination of benefits:** Claims being considered for coordination of benefits must be submitted at the claim line level. Coordination of benefit claims submitted at the claim level will receive a front-end edit and not be accepted.

- **Invalid DRG:** Inpatient claims submitted with DRGs must be billed with the appropriate APR-DRG. Inpatient claims submitted with the MS-DRG will receive a front-edit edit and not be accepted.

Corrected, replacement or voided claims submitted to MHP electronically or by paper submission will reject for the following reasons:

- Missing a valid member ID or the billing provider tax ID that matches the original claim
- Missing a valid, original claim number to indicate that the claim is a corrected, replacement or voided claim

McLaren Health Plan does not accept handwritten notes as indicators of a corrected claim. **All resubmitted claims must contain a resubmission or frequency code to indicate that the claim is a corrected, replacement or voided claim.**

Claims that receive a "277" front-end edit will not be accepted. Claims must be resubmitted with the correct information. To avoid unnecessary claim edits or rejections, be sure to follow the Standard Billing Requirements listed on the following page and refer to the MHP Provider Manual at McLarenHealthPlan.org.

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REMINDER: STANDARD BILLING REQUIREMENTS

Ensure required billing requirements are followed to prevent claim denial.

McLaren Health Plan (MHP) encourages ***electronic claims submission***, including coordination of billing claims.

MHP Payer IDs for electronic claims are:

McLaren Health Plan Medicaid / Healthy Michigan Plan – 3833C
McLaren Health Plan Community - Commercial HMO/POS – 8338
McLaren Health Advantage – 3833A
McLaren Medicare Supplement – 3833S

If you must submit a paper claim, all paper claims are to 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 on the current form version as designated by the CMS and the National Uniform Claim Committee (NUCC). If you are submitting paper claims, please contact your Network Development Coordinator for assistance with transitioning to electronic claims submission.

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 exceeding 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.

Important Information:

- Industry standard HCPCS, CPT, Revenue and ICD codes must be used.
- Prenatal visits may be billed using the global code, but prenatal individual dates **MUST** be listed on the claim form.
- Inpatient claims require APR-DRGs; MS-DRGs will not be accepted.
- 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.

- 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.

For additional billing information, access the MHP Provider Manual at McLarenHealthPlan.org. If you have any questions, please contact Customer Service at 888-327-0671 (TTY: 711).

REMINDER: MCLAREN CONNECT- PROVIDER PORTAL

Do you have access to McLaren CONNECT?

The provider portal enables you to:

- Verify member eligibility
- View and print member eligibility rosters
- View member demographic information
- View member claims and print EOPs
- View and print member benefit information
- Directly contact the MHP provider team

Registering is easy! Go to McLarenHealthPlan.org/McLarenCONNECT, click Provider Portal and provide your provider contact information. If you have a question, please contact Customer Service at 888-327-0671 (TTY: 711).

REMINDER: MEMBER ROSTERS AVAILABLE ON MCLAREN CONNECT PORTAL

Member eligibility rosters are currently available for you to view and print through the McLaren CONNECT provider portal. As of Aug. 1, 2019, member rosters are ***no longer mailed*** to provider offices. Having the member rosters available online allows you access to the current member roster, while eliminating the delay of printing and sending mid-month.

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