McLaren HEALTH PLAN

mclarenhealthplan.org

Partners In Health

July 2025

CONTENTS

2. Customer Service

4. Provider Relations

6. Care Management

8. Advomas

9. Quality Quick Tips

13. Lead Testing Guidelines

14. Electronic Prior Authorization Notification Under MCL 500.2212

17. Member Language Needs and Resources

Introduction

Welcome to McLaren Health Plan's Partners in Health newsletter. This is a monthly communication that will be sent out via email and posted on our website at mclarenhealthplan.org/mclaren-health-plan/provider-communications.

If you would like to be added to our email distribution list to stay up-to-date on McLaren Health Plan's (MHP) processes and policies, learn about McLaren Health Plan community participation and sponsored events, Link directly to other online resources, and to receive this newsletter via email, please visit our website.

Customer Service

Phone: 888-327-0671 (TTY: 711)
Fax: 833-540-8648

Customer Service is responsible for assisting physicians, office staff, providers and members with questions. Representatives are available Monday through Friday from 9 a.m. to 6 p.m. Call if you have questions about:

- Transportation for MHP Medicaid and Healthy Michigan plan members
- Referrals
- Claims

MHP has FREE interpretation and translation services for members in any setting – ambulatory, outpatient, inpatient, office, etc. If MHP members need help understanding written materials or need interpretation services, call Customer Service.

McLaren Connect

If you have not yet registered for McLaren CONNECT, the provider portal, click here: https://www.mclarenhealthplan.org/mhp/mclaren-connect.aspx

McLaren CONNECT replaces the Health Edge portal and FACTSWeb. McLaren CONNECT is a secure web-based system for all MHP lines of business that allows you to:

- Verify member eligibility
- View member claims and EOPs
- View and print member eligibility rosters*
- View and print member benefit information
- View a member's demographic information
- Contact the MHP provider team

Your provider TIN and NPI are required for the login process. Logins require your username and password each time, for your security.

*Member eligibility rosters are no longer mailed to primary care offices. Using McLaren CONNECT provides access to an up-to-date roster while eliminating the delay of sending a printed roster mid-month.

McLarenHealthPlan.org

MHP's website contains information about the plan's policies, procedures and general operations. You'll find information about quality programs, preauthorization processes, health management programs, clinical and preventive practice guidelines, pharmaceutical management procedures, the pharmacy formulary, member rights and responsibilities, the provider appeal process and provider newsletters. Visit often for the most up-to-date news and information. If you would like a printed copy of anything on our website, please call Customer Service.

Interpretation and translation services are FREE to MHP members in any setting – ambulatory, outpatient, inpatient, etc. Oral interpretation services are available for people who are deaf, hard of hearing or have speech problems. If McLaren Health Plan members need help understanding MHP's written materials or need interpretation services, call 888-327-0671 (TTY: 711)

GetHelp.McLaren.org

Do you have patients who need help with food, education, housing, jobs or other 'quality of life' situations? McLaren Health Plan offers an online program to assist members who need community-based services. Simply put in a ZIP code and categories are listed with programs and services by location. There are thousands of resources to choose from, such as advocacy and legal aid; how to help pay for school; adoption and foster care services; tax preparation; mental health care; housing assistance; skills and training to enter or re-enter the workforce, among much more! Let your patients know about www.gethelp.mclaren.org.

Provider Relations

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

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

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

- Orientations for you and/or your office staff to learn about MHP – how to submit claims, obtaining member eligibility or claims via the MHP CONNECT provider portal
- Reviewing provider incentives, quality initiatives and program updates

If you have changes to your practice such as a new federal tax identification number, a payment address change or a name change, a new W-9 is required.

Current participating Primary Care Physicians who wish to open their practices to new MHP patients can do so at any time. Simply submit your request in writing, on office letterhead, to your Provider Relations representative, requesting to open your practice to new MHP members and your representative will make the change.

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

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

Medical Management

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7959

Medical Management supports the needs of both MHP providers and members. Medical Management coordinates members' care and facilitates access to appropriate services through the resources of our nurse care managers.

Through care management services, nurses promote the health management of MHP members by focusing on early assessment for chronic disease and special needs and by providing education regarding preventive services. Nurses also assist the physician and provider network with health care delivery to MHP members. Nurses are available 24 hours a day, seven days a week and work under the direction of MHP's Medical Director.

Call the Medical Management team for information and support with situations about:

- Preauthorization requests https://www.mclarenhealthplan.org/mhp/referral-request-form-mhp1
- Inpatient hospital care (elective, urgent and emergent)
- Medically necessary determinations of any care, including the criteria used in decision making
- Care management services
- Complex care management for members who qualify
- Disease management – diabetes, asthma, depression, Sickle Cell, hypertension, Hepatitis C, maternity care
- Preventive health education and community outreach support
- Children's Special Health Care Services (CSHCS)

Through its utilization management process, Medical Management is structured to deliver fair, impartial and consistent decisions that affect the health care of MHP members. Medical Management coordinates covered services and assists members, physicians and providers to ensure that appropriate care is received. Nationally recognized, evidence-based criteria are used when determining the necessity of medical or behavioral health services. The criteria are available to you upon request by calling the Medical Management team.

If there is a utilization denial, the member and physician will be provided with written notification – which will include the specific reason for the denial – as well as all appeal rights. MHP's Medical Director, or an appropriate practitioner, will be available by telephone to discuss utilization issues and the criteria used to make the decision.

Utilization decision making is based solely on appropriateness of care and service and existence of coverage. MHP does not specifically reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives for utilization decision-makers to

encourage decisions which would result in under-utilization.

Care Management

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7965

Care management is offered to all MHP members. A care management nurse is assigned to each primary care office to assist you with managing your MHP members. The MHP nurses help manage medical situations and are a resource for identified issues. This enables a circle of communication that promotes continuity of care, the member's understanding of their health care, support for the primary care physician and promotes the PCP office as the medical home.

MHP members are referred for care management services by physicians who identify at-risk patients. Complete a Referral to Care Management form. When MHP receives the form, a nurse begins an assessment of the member and identifies a proactive approach to managing the totality of the member's health care needs. The program focuses on preventive health management, disease management, general and complex care management and Children's Special Health Care Services (CSHCS) care management.

Program goals are:

Empower members to understand and manage their condition

Support your treatment plan

Encourage patient compliance

Preventive health management helps by:

- Informing members of preventive testing and good health practices
- Mailing reminders to members about immunizations, well-child visits and lead screenings
- Highlighting ways to stay healthy and fit in member newsletters
- Identifying members who are due for annual checkups and screenings and notifying PCPs of these patients
- Initiating call programs to assist members with scheduling annual checkups and screenings

If you do not know who your care management nurse is, please call Customer Service at 888-327-0671 (TTY: 711).

Complex Care Management

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7965

MHP has nurses trained in Complex Care Management (CCM). Members considered for CCM have complex care needs including, but not limited to:

- Those listed for a transplant
- Ones who have frequent hospitalizations or ER visits
- Members with multiple health care conditions
- Are part of Children's Special Health Care Services (CSHCS)

Virtual Care Management

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7965

The Medical Management team at McLaren Health Plan (MHP) has virtual care management services available for members. Using the 'ZOOM for Healthcare' platform, care managers can connect with members on a personal level with face-to-face conversations while maintaining social distancing and the need for privacy.

Conversations about health maintenance, missed services – or services which are due – and other important health discussions can take place during these visits. Members currently receiving care management services, or those who would like to, are eligible to participate.

Please call MHP at 888-327-0671 (TTY: 711) if you have an MHP patient you would like to refer for care management services.

Provider Data Attestation: Better Doctor

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

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

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

Failure to attest to your demographic information quarterly may result in being removed from the Provider Directory.

Advomas

McLaren Health Plan has entered a partnership with Advomas to assist members in applying for Medicare and Social Security.

Members will contact Advomas for help with the application process, including assistance with appealing a case should a denial be made. Advomas will conduct and interview, put the member with a Social Security Specialist if they fit the criteria for one.

Advomas is a Michigan-based company located in Troy. Please contact McLaren Health Plan with any questions or concerns. Please visit **advomas.com** for more information.

Benefits of Patient-Centered Medical Home Certification

McLaren Health Plan recognizes the critical importance of Patient Center Medical Home (PCHM) principles being incorporated into provider practices. PCMH certification enhances patient care, provider efficiency, and health outcomes by fostering a patient-centered approach seeking to improve care coordination and promote quality improvement. PCMH supports population health management using a variety of individual, organizational and cultural interventions to help improve the illness and injury burden and the health care use of defined populations.

PCMH increases effective communication, coordination and integration among primary care and specialty practices, including the appropriate flow of patient care information, and often provides clear definitions of roles and responsibilities.

Benefits to a provider practice becoming and maintaining PCMH designation also include:

- Lowering of overall cost of care
- Alignment with state/federal initiatives focusing on Value Based Care
- Improving access to care
- Increased chronic disease management.
- Reduction in the fragmentation of care
- Alignment with McLaren Health Plan’s quality of care initiatives

- Increased provider practice satisfaction
- Improved patient experience

McLaren Health Plan accepts NCQA PCMH certification and Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP) designation for PCMH. We capture provider PCMH designation information and share with our members in our provider directories to assist those looking for a PCMH practice, specifically. For more information on PCMH and the accreditation process, please contact your Provider Relations Representative or Provider Services at (888) 327-0761 (TTY: 711).

Quality Quick Tips

RESPIRATORY CONDITIONS

NCQA has developed many HEDIS standards around respiratory conditions including asthma, upper respiratory infections, COPD, pharyngitis, and bronchitis. Your testing and treatment of these illnesses is vital to meet these metrics. To assist your understanding of the HEDIS requirements surrounding respiratory conditions including Upper Respiratory Infection (URI), Pharyngitis (CWP), Bronchitis/Bronchiolitis (AAB) and Asthma (AMR) for your patients see the key respiratory related HEDIS measures with codes to identify below:

Asthma Medication Ratio (AMR)	***Appropriate Testing for Pharyngitis (CWP)***
Measure Description: Members aged 5-64 who have dx of asthma and had ratio or controller meds to total asthma meds of 0.50 or greater **Codes to Identify AMR:** E84.0, E84.11, E84.19, E84.8, E84.9, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.81, J44.89, J44.9, J68.4, J96.00, J96.01, J96.02, J96.20, J96.21, J96.22, J98.2, J98.3	**Measure Description**: Members 3 years and older with a diagnosis of Pharyngitis (only) who were dispensed an antibiotic and received a strep test for the episode of care **Codes to Identify CWP**: • Pharyngitis: J02.0, J02.8, J02.9, J03.00, J03.80, J03.81, J03.90, J03.91 • Group A Strep Test: 87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880

Appropriate Treatment for Upper Respiratory Infection (URI)	*Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB)*
Measure Description: Patients age 3 months and older with a diagnosis of URI (only) and are NOT dispensed an antibiotic **Codes to Identify URI**: • Acute Nasopharyngitis: J00 • URI: J06.0, J06.9	**Measure Description:** Members age 3 months and older with a diagnosis of acute bronchitis (only) and are NOT dispensed an antibiotic on or 3 days after the episode. **Codes to Identify AAB:** • Acute Bronchitis: J20.3-J20.9, J21.0, J21.1, J21.8, J21.9 **Note**: Prescribing antibiotics for acute bronchitis is not indicated unless there is a co-morbid diagnosis or bacterial infection.

Tips to Improve HEDIS Scores:

- Perform a strep test or throat culture to confirm diagnosis before prescribing antibiotics
- Educate patients on comfort measures for upper respiratory symptoms such as acetaminophen for fever, rest, and extra fluids. Also provide education that antibiotics are not necessary for a viral infection.
- Ensure co-morbid diagnosis codes are billed when appropriate.
- Discuss realistic expectations for recovery time
- Document competing diagnoses or co-morbid conditions (such as COPD) in addition to the bronchitis code
- Acute bronchitis/bronchiolitis almost always gets better on its own; therefore, individuals without the other health problems shouldn't be prescribed an antibiotic.
- Educate patients about the difference between controller and rescue medications for Asthma and importance of controller medications in their treatment plans
- Verify that patients' asthma diagnoses are coded correctly
- Assess asthma symptoms at every visit, evaluate patient's inhaler technique and compliance with medications.

This is a brief summary of the expectations for these measures. More details and other measures can be found in our McLaren Provider HEDIS Quality Toolkit which can be found at www.mclarenhealthplan.org. If you have questions or would like more information, please email us at MHPOutreach@mclaren.org.

Remember to also talk to your patients about tobacco cessation, MHP has a *free tobacco cessation program for MHP Community and Medicaid members*, call 800-784-8669 for more information.

Behavioral Health

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

It is important that children prescribed medication for ADHD be monitored appropriately. Members between the ages of 6-12, with a new prescription for an ADHD medication should have:

- At least **one** follow-up visit, with a practitioner with prescribing authority, during the **first 30 days after initial prescription:**
  2023 Rate: 48.04% 2024 Rate 48.36% Current Rate: 49.89%
- At least **two** follow-up visits **within 270 days after the end of the initial phase**. One of these visits may be a telephone call.
  2023 Rate: 55.43% 2024 Rate: 55.34% Current Rate: 58.94%

How to Improve HEDIS Scores

- When prescribing a new medication to your patient, schedule follow up visit within 30 days of initial prescription at the time of prescription to assess how the medication is working.
- Schedule two more visits within the next nine months after the first 30 days to monitor progress.
- Use a phone visit for one of the visits after the first 30 days. This may help you and your patients if getting to an office visit is difficult (codes: 98966-98968, 99441-99442).
- NEVER continue these controlled substances without at least two visits per year to evaluate a child's progress. If nothing else, you need to monitor the child's growth to make sure he or she is on the correct dosage.

On the Behavioral Health Radar:

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

This measure assesses the percentage of members 18-64 years of age with schizophrenia or schizoaffective disorder and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.

Diabetes Screening for People with Schizophrenia, Schizoaffective Disorder or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).

This measure assesses the percentage of members 18-64 years of age with serious mental illness who use antipsychotics who receive an annual diabetes screening at any time during the measurement year.

Why it Matters:

An estimated 33.4% of people with schizophrenia also have metabolic syndrome- a rate nearly two times higher than the general population! Among your patients with co-occurring schizophrenia and metabolic disorders, the nontreatment rate for diabetes is approximately 30%. In addition to general diabetes risk factors, diabetes is promoted in patients with schizophrenia by initial and current treatment with olanzapine and mid-potency first-generation antipsychotics (FGA), as well as by current treatment with low-potency FGAs and clozapine.

How to Improve HEDIS Scores

- Become knowledgeable about the measure and the clinical practice guidelines
- Encourage shared decision-making by educating members and caregivers about:
    - Increased risk of diabetes with antipsychotic medications
    - Importance of screening for diabetes
    - Symptoms of new-onset diabetes
- Order a diabetes screening test every year and build care gaps “alerts” in your electronic medical record
- Communicate and coordinate care between behavioral health and primary care physicians by requesting test results, communicating test results or scheduling appointments for testing
- Reach out to members who cancel appointments and assist them with rescheduling as soon as possible
- Behavioral Health Practitioners:
- Order diabetic screening tests for members who do not have regular contact with their PCP
- Coordinate care and communicate results with the member’s PCP

Children’s Health

Preventive screenings, anticipatory guidance and immunizations aid in the promotion of healthy lifestyles in children and adolescents. McLaren Health Plan encourages providers to continue to provide quality care and assist with the catching up of children past due for immunizations, well visits, and other preventive screenings. The following are key measures of care for children as well as best practices and tips on how to provide quality outcomes. **NOTE:** Michigan requires all children in foster care to receive a comprehensive medical exam, including behavioral/mental health screening, within 30 calendar days of entering foster care. This exam is known as EPSDT or Well-Child Exam.

Well Child Visits (Visit expectation by age)

- In the first 15 months of life – 6 visits
- 15 months to 18 months – 2 additional visits
- Children & Adolescents age 3-21 years – Annual well visits

Well Child Visits should include:

- Growth and Development Assessment
- Mental Developmental History
- Complete Physical Exam
- Anticipatory Guidance Documentation
- Vision Screening
- Oral Health Screening

Weight Assessment, Counseling for Nutrition, and Counseling for Physical Activity (for Children/Adolescents 3-17 years)

Expectation: Children/Adolescents who have had an outpatient visit with a PCP or OB/GYN during the measurement year with evidence of:

- BMI Percentile documentation
- Counseling for nutrition
- Counseling for Physical Activity

Tips & Best Practices

- Avoid missed opportunities by taking advantage of every office visit to provide a well child visit, immunizations, lead testing and BMI calculations
- A sports/day care physical becomes a well child visit by adding anticipatory guidance to the sports physical's medical history and physical exam.
- BMI percentiles should be calculated at every office visit. Also include nutrition counseling and physical activity discussions or guidance.
- Address vaccine hesitancy with parents. Ensure that all immunizations are logged through MCIR to ensure timely completion and closure of gaps.
- Encourage children to receive preventive dental care twice a year.
- Perform at least one capillary or venous lead test on all children by the age of two.
- McLaren Health Plan will reimburse you for one well child visit per calendar year for children 3 years old and older. You do not need to wait 12 months between visits.

Children's Health: Lead Testing Guidelines

Preventive screenings and anticipatory guidance all aid in the promotion of healthy lifestyles in children and adolescents. MDHHS and McLaren Health Plan encourages providers to recognize the new guidelines to test children twice for lead; at least once by their 1st birthday and again before age 2.

Are your patients at risk for lead poisoning?

Symptoms of lead poisoning can be silent and hard to recognize. Preventing lead poisoning before it happens is the best way to keep your patients safe. Asking parents the following questions can help determine if a child is at risk for lead poisoning:

- Does the child live in a home built before 1950 or have they lived in a home built before 1950 in the recent past?
- Does the child live in a home built before 1978 that was recently remodeled?
- Does the child have a brother or sister or playmate with lead poisoning?
- Does the child live with an adult whose job or hobby involves lead?
- Does the child's caregiver use home remedies that contain lead?
- Does the parent need advice about identifying and removing lead paint or remodeling their home? Refer to the Lead and Healthy Homes Section at 866-691-LEAD or www.michigan.gov/lead

Note: a lead risk assessment doesn't satisfy the blood lead test requirement for Medicaid patients and all Medicaid beneficiaries should be tested twice regardless of the risk score or household zip code.

All children should be tested for lead twice: Once at the age of 1 and again by age 2.

Tips & Best Practices

- Avoid missed opportunities by taking advantage of every office visit to provide lead testing
- Order lead testing at one year well visit or earlier and revisit at the 18-month visit
- Consider a standing order for in-office lead testing
- Educate parents about the dangers of lead poisoning and the importance of testing
- If patient is referred to a laboratory, implement a process for follow-up if order is outstanding after 30 days (sooner if the child's second birthday is approaching within 30 days)
- Date of service and result must be documented with the notation of the lead screening test
- **Lead test is considered late if performed after the child turns 2 years of age**

For more information and coding details on these and all HEDIS measures, please see the McLaren Health Plan HEDIS Quality Toolkit at: https://www.mclarenhealthplan.org/mclaren-health-plan/hedis-information

Your Patients May Qualify for Additional Benefits

Do you have patients that are disabled or potentially disabled?

If so, McLaren Health Plan partners with Centauri Health Solutions® to help them. Supplemental Security Income (SSI) is for adults with little or no work history and children. Social Security Disability Insurance (SSDI) is for people who have a work history but can no longer work. Your patients may qualify for SSI or SSDI even if they get other disability benefits. Centauri Health Solutions® helps people to apply for these benefits. If you have patients who want to apply for these benefits and need

help, advise them to contact McLaren Health Plan at 888-327-0671 (TTY: 711) and ask to speak with your nurse. The nurse will gather a few pieces of information from the patient and contact Centauri Health Solutions® on their behalf. Someone from Centauri Health Solutions® will contact the patient to help them. At any time, they may decline or "opt out" of Centauri Health Solutions® services and be removed from their call lists.

Source: "Centauri Health Solutions®" (n.d.). *Who is Centauri?* [Brochure]

Protecting babies from HIV and Syphilis

All pregnant women should be tested for HIV and Syphilis throughout their pregnancy. If a pregnant woman is found to be positive for either, it is important to protect the baby. HIV is a long-term disease that can damage the immune system. HIV cannot be cured, but it can be managed. Syphilis is a sexually transmitted infection that can cause serious health problems if not treated. Both infections can be passed to the baby during pregnancy and delivery. If you have pregnant patients, please recommend testing and discuss treatment options if the patient is positive. Pregnant women should be tested:

- At the first prenatal visit
- In the beginning of the third trimester (ideally at 28-32 weeks)
- At delivery, if appropriate (determined by the provider)

Source: Michigan Department of Health and Human Services. (n.d.). *It's Their Health Too HIV and Syphilis Testing During Pregnancy* [Brochure]

Authorization Changes

For the most recent and upcoming authorization information, visit McLaren Health Plan's website at mclarenhealthplan.org and select the Provider tab.

- All changes and announcements are posted online at least 60 days prior to becoming effective.
- Upcoming-Authorization-Changes.pdf
- As of 4/1/2025, the following items/services are being added and require authorization. Please see the list on the website for specific codes:
  - Medicaid – Incontinence supplies.
- As of 7/1/25, the following items/services are being added and require authorization. Please see the list on the website for specific codes:
  - Medicaid, Community, and Health Advantage – Additions to DME and Prosthetics & Orthotics.
- For all current prior authorization requirements, visit: Prior Authorization Codes List

- For all current Medicare prior authorization requirements, visit: Medicare Prior Authorization Information.

Please refer to the website for an updated authorization requirements list with effective dates of January 1, April 1, July 1, or October 1 of each year.

If you have any questions, please contact your Provider Relations Representative at 888-327-0761 (TTY: 711) for assistance.

Electronic Prior Authorization Notification Under MCL 500.2212

Under Public Act 60 of 2022 ("The Act"), Health Plans are required to provide a "standardized electronic prior authorization transaction process." McLaren Health Plan offers this service through our connection to JIVA. To reach JIVA, McLaren Health Plan has a single sign-on through our McLaren Connect portal.

All prior authorizations for McLaren Health Plan's marketplace membership must be submitted through this electronic prior authorization process. The Act says a "…health professional shall perform a prior authorization utilizing only a standard electronic prior authorization process."

The JIVA submission process meets the requirements of The Act by allowing providers to submit all necessary clinical criteria for a prior authorization under The Act.

McLaren Health Plan's Provider Relations representatives will work with providers to ensure all prior authorizations are submitted through JIVA. McLaren Health Plan will phase out prior authorizations not submitted through JIVA by Dec. 31, 2025. Should you have any questions about this process, please contact your Provider Relations representative.

This is intended to serve as notice for providers to use our electronic prior authorization portal. Our Provider Manual will be updated to reflect this change.

Clinical Practice Guidelines Available to Assist with Decision-Making

McLaren Health Plan uses Clinical Practice Guidelines to assist practitioners and members with decision-making about appropriate health care for specific clinical circumstances. New and revised guidelines are developed and updated through collaborative efforts of the Michigan Quality Improvement Consortium (MQIC) and other evidence-based resources.

Clinical Practice Guidelines are distributed to practitioners to improve health care quality and reduce

unnecessary variation in care. Documentation in your medical records should indicate you used the appropriate guideline in your practice decisions. The Clinical Practice Guidelines were reviewed, updated and approved in September 2024 by our Quality, Safety, and Satisfaction Improvement Committee.
Please review the guidelines found at https://www.mahp.org/michigan-quality-improvement-consortium/ or visit our website.

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

Member Language Needs and Resources

McLaren Health Plan uses census data to track and monitor the language needs of its enrolled members – as well as the language of the population in its geographical area – to ensure appropriate language assistance.

The top languages spoken by MHP members:

- English
- Spanish
- Arabic
- Swahili

MHP offers providers detailed reports on service area language needs and the language needs of assigned members. Language assistance resources are made available to providers and staff, along with training to identify needs and services available.

Please contact Customer Service at 888-327-0671 (TTY: 711) to obtain a list of language needs of assigned members in your practice or to request training about language services.

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 providers to partner with us to identify and eliminate fraud, waste and abuse.

What is Fraud, Waste and Abuse?

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

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

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

Examples of fraud, waste and abuse include:

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