Partners in Health

MARCH 2019

IN THIS ISSUE

McLaren HEALTH PLAN

McLaren HEALTH ADVANTAGE

McLaren HEALTH PLAN COMMUNITY

Welcome!

"Partners in Health" is the newsletter for McLaren Health Plan physicians, office staff and ancillary providers. It is published twice per year by McLaren Health Plan, Inc. who shall be referred to as "MHP" throughout this newsletter.

Contact Us – General Information About MHP's Departments and Services

Customer Service

(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 8 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.

Provider Portal

If you have not yet registered for McLaren CONNECT, the new provider portal, click here.

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 print 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 user name and password each time, for your security.

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)

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

The Network Development team is responsible for physician and provider-related issues and requests, including contracting. Network Development coordinators 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
- Delivering referral and preauthorization forms and pharmacy formularies to your office

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 Network Development coordinator, requesting to open your practice to new MHP members and your coordinator 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 Network Development coordinator.

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

OUTREACH TEAM **Phone: (888) 327-0671 (TTY: 711) Fax: (810) 600-7985**

The MHP Outreach team is available to assist your office with scheduling your MHP commercial and Medicaid patients for preventive care visits and ancillary tests.

Using *Gaps in Care* reports provided by MHP or by your office, the team can assist your staff by contacting and scheduling patients for these important visits.

By working together, we strive to achieve:

- Increased incentive payments
- Better patient outcomes when preventive services are provided
- Improved relationships among you, your patients and MHP

The MHP Outreach team is trained in several electronic scheduling systems and can assist with in-office or off-site scheduling. During patient contacts, the Outreach team can assist your patients by:

- Discussing the importance of preventive care services
- Determining barriers to care and assisting with barriers, such as transportation

Call us and ask to speak to an Outreach representative if you are interested in working with the Outreach team.

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 nurse case managers.

Through case 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 Chief Medical Officer.

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

- Preauthorization requests (See page 9, 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
- Preventive health education and community outreach support
- Children's Special Health Care Services (CSHCS)

You may get voice mail when you call the Medical Management team due to the volume of calls received. Voice mail is checked frequently throughout the day and all calls are returned within one business day.

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 is 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 Chief Medical Officer, 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.

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

Case management is offered to all MHP members. A case 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 his or her health care, support for the primary care physician and promotes the PCP office as the medical home.

MHP members are referred for case management services by physicians who identify at-risk patients. Complete a *Referral to Case 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 case management and Children's Special Health Care Services (CSHCS) case 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 case management nurse is, please call Customer Service at (888) 327-0671 (TTY: 711).

COMPLEX CASE MANAGEMENT **Phone: (888) 327-0671 (TTY: 711) Fax: (810) 600-7965**

MHP has nurses trained in Complex Case 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
- Are part of the Children's Special Health Care Services (CSHCS)

Have You Completed Your Training and Enrollment Requirements?

CLAS Training, CHAMPS Enrollment Required by NCQA, MDHHS

The National Committee for Quality Assurance (NCQA) *requires providers and office staff to complete the Culturally and Linguistically Appropriate Services (CLAS) training*. CLAS trains health professionals how to tailor services to an individual's culture and language preference to bring about positive health outcomes for diverse populations.

McLaren Health Plan offers CLAS training located here. The training includes an overview of CLAS standards, legal requirements, communication standards, continuous improvement recommendations and member diversity. Only one training per each provider location is required. After you complete the CLAS training online and sign the attestation included in the presentation (one attestation per office location), fax it to MHP at (810) 600-7979. If you've completed CLAS training through another health plan, we will accept a copy of that attestation.

If you see MHP Medicaid patients in your practice, you must *enroll in Community Health Automated Medicaid Processing System (CHAMPS)* – the state's online Medicaid enrollment and billing system.

For dates of service on or after Jan. 1, 2019, MDHHS prohibits contracted Medicaid Health Plans and Dental Health Plans from making payments to typical providers not actively enrolled in CHAMPS.

Typical providers are health care professionals who provider health care services to beneficiaries. They must meet education and state licensing requirements and have an assigned National Provider Identifier (NPI). Examples include, but are not limited to, physicians, physician assistants, certified nurse practitioners, dentists and chiropractors.

At this time, contracted Integrated Care Organizations (ICOs), Prepaid Inpatient Health Plans (PIHPs) and MI Choice Waiver agencies are exempt from this requirement. CHAMPS enrollment neither requires nor mandates providers in a managed care network to accept Fee-for-Service Medicaid beneficiaries. CHAMPS enrollment is used solely to screen providers participating in Medicaid.

For dates of service on or after July 1, 2019, MDHHS Fee-for-Service and Medicaid Health Plans will prohibit payment for prescription drug claims written by a prescriber who is not enrolled in CHAMPS. More details on prescriber enrollment will be forthcoming.

The federal Affordable Care Act and the 21st Century Cures Act require all providers who serve Medicaid beneficiaries to be screened and enrolled in the state Medicaid enrollment system. The purpose of this requirement is to protect beneficiaries by strengthening program integrity and care quality.

For information about the Provider Enrollment process and how to get started, visit www.michigan.gov/MedicaidProviders and click on Provider Enrollment.

Providers also can learn more details by viewing future Provider Bulletins from MDHHS. Providers who have questions about the enrollment process or require assistance may contact the MDHHS Provider Enrollment help desk at (800) 292-2550.

PCPs and Your Acceptance Status with MHP

MHP Community HMO, POS, Medicaid and Healthy Michigan members are assigned to a primary care provider upon enrollment. Every contracted PCP is listed as having an "open" acceptance status – accepting new patients – unless a request to close the practice has been made and approved.

Changing the accepting status of a practice requires 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:
   - The reason for the request to limit members
   - Attestation that your practice is being closed to all other health plans
   - Anticipated timeframe new enrollment is being limited
   - 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 by the Network Development manager following verification of assigned membership to the PCP.
5. The Network Development manager will respond in writing to the PCP'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 date of 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 accepance 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 accepance status will revert to "open" to accepting new MHP members.

Understanding the MHP Referral Process

Authorization or referral? Outpatient or inpatient? In-network or out-of-network? How do you know which CPT codes require an authorization from McLaren Health Plan, and when?

You can view a list of CPT codes that require an authorization when provided in the outpatient setting here. The list is reviewed quarterly and may be revised and updated as appropriate.

These codes also require an authorization when performed in the inpatient setting or an at out-of-network facility. All services and/or procedures billed to MHP must be both medically necessary and coded appropriately MHP reviews paid claims to ensure compliance and accuracy.

We have two versions of the MHP Request for Preauthorization form. The fillable PDF form is available for you to download, print and return to us by mail or fax and is located on our website here. If you'd like to scan it and email it to us, send it to MHPAuthandCharts@mclaren.org. There's also an option to complete the form and submit it directly from our website here. Print a copy of the completed request for your patient's records.

MHP is committed to the philosophy of the primary care provider as the patient's care coordinator and the medical home for its members. Ongoing coordination of care remains the responsibility of the PCP. As such, we continue to educate our members about the importance of discussing all health care needs with their PCPs.

Why It's Important to Refer to In-Network Providers

MHP Medicaid and MHP Community members must use providers who participate or are in-network with McLaren Health Plan for their health care needs. Click here to view the provider directory or call Customer Service at (888) 327-0671 (TTY: 711) if you need information about in-network providers when referring a member.

MHP members with Point-of-Service (POS) plans have an Option B benefit which allows self-referral and the use of non-participating/out-of-network providers. These members will have higher copays and/or deductibles and will be responsible for any balance bill from a non-participating/out-of-network provider. Some Option B benefits require plan preauthorization regardless of the network status of the provider. Call Customer Service if you have referral, authorization or benefit questions.

Genetic Testing Requires Pre-Authorization

All genetic testing, including prenatal genetic testing, requires preauthorization. It is the responsibility of the ***ordering practitioner*** *to provide the following information with the request for preauthorization of genetic testing:*

- Is this test appropriate for this patient?
- Is the technical and clinical performance of the genetic test supported by peer-reviewed published research?
- Does a definitive diagnosis remain uncertain despite a comprehensive workup that includes a detailed medical history, physical examination, pedigree analysis, genetic counseling and completion of conventional diagnostic studies?
- Will the test result impact or alter the medical management of the patient?
- What are the limitations of the test?
- Are there any major ethical, legal or safety issues of concern with the test?
- Has the genetic test been cleared or approved by the U.S. Food and Drug Administration or will it be performed in a Clinical Laboratory Improvement Amendment-certified laboratory?
- Is this a targeted test or a multi-gene panel?
- Has a pathogenic variant been identified in an affected family member?
- Is this the first time this test is being performed on this patient?
- Has the genetic test been ordered by a medical professional such as a medical geneticist, developmental-behavioral pediatrician, condition-specific subspecialist or neonatologist in the NICU, who has training in genetics and will ensure that face-to-face genetic counseling by appropriately trained professional(s) will accompany testing?

Care Coordination and the Importance of Communication with the PCP

The coordination of medical care is essential to a patient's overall state of health. MHP encourages physicians to communicate with each other when co-treating a patient, including behavioral health issues.

Communication among physicians and providers is one of the best ways to successfully treat a patient. The patient's primary care provider is the medical home for all health information regarding the patient's care.

It's critical to have medical information relayed to the PCP by:

- Prompting patients to return to their PCP after a consultation or hospital stay
- Having specialists send summaries of recommendations to PCPs
- Providing communication from pharmacy data identifying polypharmacy to PCPs
- Notifying members of PCP terminations
- Improving the process for members to authorize sharing of behavioral health information with their PCPs
- Promoting the sharing of information by the PCP to the behavioral health specialists when coexisting medical and behavioral health conditions exist
- Providing behavioral health services in the primary care home

Consider this question: What does the PCP need to know to treat this patient in the safest and most efficient manner?

"It is the responsibility of every treating provider to adequately inform the patient's PCP of all recommendations and medical treatment being proposed."

Credentialing with MHP

Here's how to avoid delays in the credentialing and recredentialing process with McLaren Health Plan:

- Update and/or re-attest to your CAQH application at least every 120 days.
- Update your Authorization for Release of Information at least every 12 months and upload to CAQH.
- Ensure the address and contact information is correct for all practice locations.
- Leave no gaps in your most recent five years of work history section. If gaps greater than six months exist, document the reason, including the month or years and reason, i.e., leaves of absence, maternity leave, moves, etc.
- Ensure a current copy of your liability license is attached to your CAQH. After uploading a new copy to CAQH, check after three days to make sure it wasn't rejected.
- Provide a credentialing contact in case outreach is needed.

IMPORTANT: Failure to respond to requests from the MHP credentialing team could result in termination from the network due to incomplete documentation.

New Pharmacy Benefit Manager for MHP as of Jan. 1

MedImpact became the new Pharmacy Benefit Manager for McLaren Health Plan as of Jan. 1, 2019. To date, the transition has been operating according to plan and the only change to physician office practices is where to send prior authorization (PA)

Pharmacy Prior Authorization

The appropriate pharmacy PA request form is located here. There are certain drugs that have their own PA form. All new PA requests will need to be submitted directly to MedImpact. Please use the following dedicated MHP PA information below when inquiring about and submitting PA requests:

MedImpact Prior Authorization Department

Electronic PA: https://surescripts.com/enhance-prescribing/prior-authorization
Phone: (888) 274-9689

Retail/Specialty/Mail Order Pharmacy Network

CVS and Target pharmacies are out-of-network. For a complete list of our in-network pharmacies, click here or call Customer Service at (888) 327-0671 (TTY: 711).

The MHP preferred specialty pharmacy vendor is AllianceRX Walgreens Prime. All specialty drugs will need to be obtained through this pharmacy.

AllianceRX Walgreens Prime

Phone: (888) 282-5166

The MHP preferred mail-order pharmacy is MedImpact Direct. Contact MedImpact Direct if a patient expresses interest in having medications mailed to them.

MedImpact Direct

Phone: (855) 873-8739

Questions about the transition can be directed to a MedImpact representative at (888) 274-9689.

E-Prescribe with Surescripts®

Prescribers can access McLaren formulary information and prescribe through Surescripts®. The Surescripts® Network Alliance includes virtually all EHRs, PBMs, pharmacies and clinicians, plus an increasing number of long-term and post-acute care organizations and specialty pharmacy organizations. Take advantage of the benefits of e-prescribing, such as:

- Increased patient safety and higher quality care
- Avoidance of drug-to-drug and drug allergy interactions
- Ability to view patient medication history
- Increased office efficiency due to fewer phone calls and faxes

For more information about Surescripts®, visit www.surescripts.com.

MCIR: A Helpful Tool for Your Office

The Michigan Care Improvement Registry, or MCIR, is an important tool that records and tracks immunization history and can help ensure that vaccines are not missed.
The secure website, www.MCIR.org, includes immediate patient immunization history, due dates, future dose dates, reminder and recall notices for due or overdue immunizations, printable official immunization records and batch reports. All MHP providers are required to submit vaccination information to MCIR.

Vaccine	Age
Human Papillomavirus Vaccine (HPV)	11-13 years old (3 doses) Or 2 doses at least 6 months apart
Meningococcal (MCV)	11-13 years old
Tetanus, Diphtheria, Pertussis (Tdap)	11-13 years old

MHP and MCIR sends reminder notices to your patients encouraging them to receive immunizations. Among the reminders being sent are ones for the 11, 12 and 13-year-olds in your practice who may be easy to overlook when it comes time to think about immunizations. The CDC recommends all preteens need HPV vaccination, so they can be protected from HPV infections that cause cancer. Encourage your patients to receive these important immunizations, and then submit the information to MCIR.

Source: www.cdc.gov

Turn a 'Sick Visit' into a 'Well-Child' Visit and Increase Your Reimbursement

Health screenings play an important part in a child's life. MHP encourages parents of young children to schedule well-child visits to make sure their kids are up-to-date on immunizations and are meeting milestones for growth and development.

Families get busy and many times, they see the doctor only for sick visits. But did you know you can easily turn a sick visit into a well-child visit? *When you have an MHP member in your office for a sick visit who also is due for a well-child visit, simply incorporate the elements of a well-child exam into the visit, bill MHP for both the sick and well-child services performed. You can do this by adding modifier -25 to the sick visit and you will be reimbursed for both services.*

Well-child visits must include physical, mental, developmental, hearing and vision components and other tests to detect potential problems.

Bill age-appropriate well-child codes as indicated below. When these services are provided to an MHP Medicaid member, MHP reimburses you at a higher rate than the Medicaid fee schedule. MHP will reimburse you for one well-child visit per patient each calendar year. You do not have to wait a full calendar year to perform a well-child visit.

Age	New Patient	Established Patient
Early Childhood (1-4 years)	99382	99392
Late Childhood (5-11 years)	99383	99393
Adolescent (12-17 years)	99384	99394

How to Get Free Lead Testing Supplies for Your Office

PCPs can earn an incentive when performing a Lead Test for MHP Medicaid Members

Lead screening and testing – it's not just for children who live in Flint and are victims of the water crisis. The percentage of children found in Michigan with elevated blood lead levels is higher than the national average. Michigan currently ranks as the sixth-highest state for estimated population of children with lead poisoning.

In a recent report from the Michigan Department of Health and Human Services (MDHHS), 16 percent of 2-year-old MHP children did not receive a blood lead test but had a documented well-child visit. PCPs can perform an in-office blood lead screening during a well-child visit and are eligible to receive FREE lead testing supplied from the State of Michigan. The kits are to be used for children receiving Medicaid benefits. MHP will assist you in obtaining the free kits.

You'll get:

- All the supplies and instructions needed to complete the lead screen test
- Prepaid envelopes to mail test samples

For MHP Medicaid members utilizing the lead screening kits from MDHHS to earn a $15 incentive, submit a claim to MHP with CPT code 36416 which indicates that the lead sample was obtained and sent for testing.
OR
If you have the capability to perform the actual lead test and receive immediate result, to earn a $25 incentive, submit claim to MHP with CPT code 83655 which indicates that the lead sample was obtained and tested.

Call your MHP Outreach Representative at (888) 327-0671 (TTY: 711) if you need information about obtaining the lead testing kits or if you would be interested in hosting a lead clinic.

Assuring Better Child Health and Development (ABCD)

Developmental screening should be included at every well-child visit and can be billed in addition to the well-child visit (see below.) It is recommended that standardized developmental screening tests be administered at the nine, 18-, 24- or 30-month visits.

CPT Code	ICD Code	Category	Notes	Incentive for Medicaid Members (age 0-3 yrs.)
96110	Z13.4	Developmental Screenings	Screening tool completed by parent or non-physician staff and reviewed by the physician	$20 (one per member per year)

The Michigan Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy requires developmental surveillance and screening and recommends providers use a tool, such as the PEDS; PEDS: DM or Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire Social-Emotional (ASQSE). You are encouraged to implement developmental surveillance and screening into your office to be compliant.

For our contracted MHP network practitioners, MHP purchased the rights to the ASQ screening tool. If you would like a copy of this material, please contact your Network Development Coordinator at (888) 327-0671 (TTY:711).

Suggestions for successful practice implementation include the following:

- Use a standardized screening tool, such as ASQ.
- Communicate with office staff, colleagues and parents about the importance of developmental surveillance and screening.
- Screen all children during well-child checks at the nine, 18- and 30-month (or 24-month) visits.
- Discuss any developmental concerns with the child's parents.
- Refer children to Michigan's Early On program if developmental delays* are found. You can make the referral online at www.1800earlyon.org or call the statewide line at (800) EARLY ON (327-5966.)

*Should the screening indicate developmental delays, additional objective development testing may be performed by the physician at an outpatient office visit using CPT code 96111.

Follow this Treatment for Children and Adolescents with Acute Pharyngitis

McLaren Health Plan follows the Michigan Quality Improvement Consortium (MQIC) guidelines that reference the recommended assessment, diagnosis and treatment of acute pharyngitis in children and adolescents.

First, conduct an assessment to identify high risk patients.

- Is there a history of rheumatic fever, especially carditis or valvular disease?
- Has there been household contact with a history of rheumatic fever?

High risk patients should start antibiotics immediately. If a throat culture is taken and is negative, stop antibiotics.

Assess the likelihood of strep pharyngitis using the following:

- Patient ages 5-15 years
- Sudden onset
- Sore throat
- Fever
- Patchy, discrete exudate
- Severe pain on swallowing
- Absence of cough
- Inflammation of pharynx and tonsils
- Tender, enlarged anterior cervical nodes
- Presentation in winter or early spring
- History of exposure

Children with a low probability of GABHS need no testing, require no antibiotics and need to be advised of symptomatic only treatment. Those at intermediate or high risk should have either a throat culture or rapid strep screen.

The preferred treatment for strep pharyngitis is:

- Penicillin V
- Amoxicillin

If a patient is allergic to penicillin, use Cephalexin or Azithromycin.

If the throat culture is positive, antibiotic treatment is indicated. If the throat culture is negative, avoid antibiotics and use only symptomatic treatment.

If the rapid strep screen is positive, antibiotic treatment is indicated. If the rapid strep screen is negative, perform a throat culture – then use antibiotics only if positive.

Medical and Oral Health Collaboration a Must for Optimal Pediatric Dental Outcomes

McLaren Health Plan covers both oral health screenings and fluoride varnish services provided by PCPs. Please be sure to discuss oral health with your patients and/or their parents to ascertain if they have a dental home and assist them with a referral if they do not. If there is no dental home, please perform an oral health screening and apply fluoride varnish, if applicable.

Bright Futures/American Academy of Pediatrics recommends the following:

- Assess whether a child has a dental home starting at 6 months. If no dental home is identified, perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and refer to a dental home.
- Once teeth are present, fluoride varnish may be applied to all children every three to six months in the primary care or dental office for children ages 6 months through 6 years of age. The American Academy of Pediatrics has online training modules and videos available to increase PCP oral health knowledge and improve your practice, patient care and care coordination. (http://pediatrics.aappublications.org/content/134/3/126)
- If primary water source is deficient in fluoride, consider oral fluoride supplements.
- Use CPT code 99188 when billing for the application of topical fluoride varnish.

HEDIS®

Measuring the Quality of Care

McLaren Health Plan supports care that keeps members at optimum levels of health while also controlling costs and meeting government and purchaser requirements. MHP is accredited by the National Committee for Quality Assurance (NCQA) Health Plan Accreditation, which builds upon more than 25 years of experience to provide a current, rigorous and comprehensive framework for essential quality improvement and measurement. It bases results on consumer experience and clinical performance, which is HEDIS® (Healthcare Effectiveness Data and Information Set), the most widely used set of performance measures in the managed care industry. HEDIS® measures performance in health care where improvements can make a meaningful difference in people's lives.

Key Impact Areas for 2019

MHP's team of dedicated professionals will work with you to educate members about resources available to them to improve key impact areas in the HEDIS® measures for 2019:

- Preventive screenings
- Medication management
- Use of services
- Behavioral health
- Respiratory conditions
- Cardiovascular
- Access and availability of care
- Diabetes
- Musculoskeletal

To become accredited, MHP submits claims and medical review data to NCQA. Many HEDIS® measures may only include a small number of your patients due to a continuous enrollment requirement of the specifications and a sampling of the eligible population.

Other measures can only be calculated by administrative results (claims data submitted by you, the practitioner) and some measures are calculated through a hybrid method of a combination of claim submissions and medical record review.

A summary table and the HEDIS® provider manual can be found here or call the MHP's Quality Management team at (888) 327-0671 (TTY: 711) for more information.

The following conditions serve as reminders for services that are HEDIS® measures for 2019.

MEASURE

LOW BACK PAIN

For adults between the ages of 18 and 50 years old with the primary diagnosis of low back pain, the expectation is no imaging studies (x-ray, MRI, CT scan) within 28 days of diagnosis. Exclusions include for cancer, recent trauma, IV drug use or neurological impairment.

MEASURE

UPPER RESPIRATORY TRACT INFECTIONS

McLaren Health Plan annually measures the rate at which our members are diagnosed with an upper respiratory infection (URI), diagnosis codes J00, J06.0 and J06.9, indicative of a viral URI and are not prescribed antibiotics. Coding or billing a viral URI diagnosis (code J00) or acute nasopharyngitis (common cold) diagnosis (code J06.9) where antibiotics are prescribed is inconsistent with evidence-based medicine or correct coding. Sneezing, running nose, nasal congestion and headache are the common symptoms of viral URIs. A viral URI (common cold) occurs with great frequency.

While there is no curative treatment for this type of URI, there are numerous over-the-counter cold remedies that provide symptomatic relief. A bacterial URI also can develop. Many factors, including duration and severity of symptoms, as well as underlying respiratory diseases, are considered when deciding whether to prescribe antibiotics in the treatment of URI. In contrast to viral URIs, prescription antibiotics do provide effective treatment for bacterial URIs.

When a patient presents with a bacterial URI that requires prescription antibiotics, please ensure you are documenting the appropriate diagnosis for the bacterial URI and your billing staff is submitting appropriate codes on claims to MHP.

MEASURE

ADULTS WITH ACUTE BRONCHITIS

Avoiding antibiotic treatment for adults with acute bronchitis looks at patients ages 18 to 64 who have had a diagnosis of acute bronchitis and were not dispensed an antibiotic prescription within three days of the date of the office visit.

Prescribing antibiotics for acute bronchitis (diagnosis codes J20.3-J20.9) is inconsistent with evidence-based medicine unless a co-morbid diagnosis or other bacterial infection exists.
Keep in mind:

- Less than 10 percent of acute cough/bronchitis are bacterial
- Use antibiotics wisely to prevent antibiotic resistance
- Encourage smoking cessation and avoidance of secondhand smoke
- If no relief, encourage a follow-up in three days
- Educate patients on self-help measures, such as drinking extra fluids, getting rest, using antitussive agents for cough and proper hand washing techniques

MEASURE

OBESITY AND BMI DOCUMENTATION

During the annual HEDIS® chart review, MHP will look to see if obesity issues were addressed; BMI was calculated and documented, and healthy lifestyle habits were encouraged. The measures are different for children and adults.
Children – For MHP members 3 to 17 years old who have had an office visit with a PCP or OB/GYN during the measurement year, the following should be documented:

BMI percentile: Simply recording the member's height and weight or BMI number will not meet the criteria. BMI percentiles must be used as BMI norms will vary with age and gender for children.

Counseling for nutrition:
Documentation with the date of the visit should include one of the following:
Discussion of eating habits
Counseling or referral regarding nutrition education
Providing anticipatory guidance for nutrition

Counseling for physical activity:
Documentation with the date of the visit should include one of the following:
Discussion of current physical activity behaviors
Counseling or referral regarding physical activity
Providing anticipatory guidance for physical activity

Adults – For MHP members 18 to 74 years old who had an office visit during the measurement year, the following should be documented:

BMI value: Must include the date and documentation of the BMI number, including weight for members 20 to 74 years old.
BMI percentile: Must include the date and documentation of the BMI percentile, including height and weight for 18 to 19 years old.

Resource material for children, including growth charts, training modules and a BMI calculator for children and teens, is available here. Materials for adults can be found here.

MEASURE

ACCESS TO CARE

The National Committee for Quality Assurance (NCQA) and the Michigan Department of Health and Human Services (MDHHS) monitor the access rates of health plans. This may consist of both well and/or sick visits. The measurement requires:

- Children and adolescents seen by the PCP at least once per year
- Adults age 20 and older have at least one outpatient ambulatory visit per year

McLaren Health Plan can help you identify your MHP members who have not received services and offer assistance in getting them scheduled for an appointment.

Our Outreach Team can assist you in contacting and scheduling patients for preventive care services. We also can contact patients (according to claims submission) who have not been seen by the PCP during the calendar year and encourage them to contact your office for an appointment. Call (888) 327-0671 (TTY: 711) if you are

interested in this service. MHP Customer Service can help you with address and telephone numbers of patients who have not yet established a relationship with your office. Call (888) 327-0671 (TTY:711) for assistance.

MEASURE

DIABETES CARE

The greatest number of people with diabetes are those patients in your practice between the ages of 40 to 59. Several tests are recommended annually that may reduce the risk of diabetes-related health problems:

- Hemoglobin A1c
- Dilated eye exam
- Urine microalbumin
- Physical examination, including a foot exam at least twice per year

The chart below lists diabetic testing supplies covered by MHP:

MEASURE

ADOLESCENT IMMUNIZATION

It's not only infants who need regular immunizations. You and your office staff can be an advocate to your patients and their parents about the safety and effectiveness of immunizations for adolescents. A fully-immunized 13-year-old patient will have received the following:

- One Meningococcal vaccine between ages 11 and 13
- One TD or Tdap on or between ages 10 and 13
- Two or three doses of the HPV vaccine by age 13
- For two doses, must be administered at least 146 days apart

Be sure to update MCIR after administering all patient immunizations.

MEASURE

WOMEN'S PREVENTIVE HEALTH

Breast and cervical cancer screenings continue to save lives when performed on time, in the right setting and for the right patient.

- Screen women patients age 21 to 64 years old for cervical cancer every year.
- Screen women patients age 50 to 74 years old for breast cancer every year.

MEASURE

CHLAMYDIA SCREENING

The ability to screen for Chlamydia using a urine sample has simplified the recommended preventive screening; however, less than 50 percent of women receive this important test.

- All sexually active women 16 to 24 years old ***and men*** 16 to 18 years old should be screened for Chlamydia every year.

Include Chlamydia screening as part of the adolescent well exam – and for women – as part of the annual Pap exam.

When your patients test positive for Chlamydia, have them inform previous and current sexual partners. Expedited Partner Therapy should be provided for the partners of patients with a clinical or laboratory diagnosis of Chlamydia. Information on Expedited Partner Therapy can be found at here.

PLAN	BAYER BRAND TEST STRIPS/ LANCETS	INSULIN PUMP SUPPLIES
MHP Community with Pharmacy Coverage	Pharmacy Benefit	DME Supplier
MHP Community without Pharmacy Coverage	DME Supplier	DME Supplier
MHP Medicaid HMO MHP Healthy Michigan	Pharmacy Benefit	DME Supplier
McLaren Health Advantage	Pharmacy Benefit	DME Supplier

PCPs: Review Your 'Gaps in Care' Reports

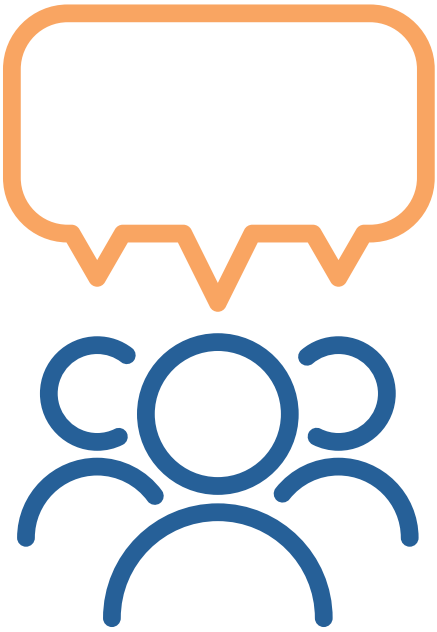
Gaps in Care reports are sent to MHP Primary Care Physicians (PCPs) to identify services that have not been completed for assigned membership based on current HEDIS® specifications. Reports are closed when a member receives the service and a claim has been billed to MHP. If you find you've billed a service, but your report shows it outstanding, please contact the MHP Quality Management team at (810) 733-9524 to confirm receipt of claims or to discuss why the claim(s) didn't meet the gap closure.

You can supplement claims data by faxing medical records for the following measures to MHP at (810) 733-9653:

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

If you have any questions, call Customer Service at (888) 327-0671, (TTY: 711) and ask for the Quality Management team.

How Well Do You Communicate with Your Patients?



Explaining things in a way that is easy for a patient to understand isn't always easy. It's imperative that patients understand what you and your staff are telling them.

The annual Consumer Assessment of Health Plans Survey (CAHPS®) measures a member's overall satisfaction with his or her treating physician. All health care providers should focus on making sure the "service encounter" is a positive experience for the patient.

Here are some tips to follow when communicating with your patients:

- Speak slowly
- Use plain language
- Make eye contact
- Use the patient's name during conversation
- Use pictures, if necessary
- Encourage your patients to ask questions
- Repeat the information back
- Always ask, "Do you understand?"
- Ask if the patient has been to an ER, urgent care or has seen a specialist since his or her last visit. Counsel if necessary.

Report Social Determinants of Health When Identified During Patient Visits

Social determinants of health (SDoH) are conditions in the places where people are born, live, learn, work worship and play that affect a wide range of health risks and health outcomes. [1]
There are ICD-10 codes that can be submitted with claims to help MHP identify members who have SDoH. These code categories include:

Z55 Problems related to education and literacy
Z56 Problems related to employment and unemployment
Z57 Occupational exposure to risk factors
Z59 Problems related to housing and economic circumstances
Z60 Problems related to social environment
Z62 Problems related to upbringing
Z63 Other problems related to primary support group, including family circumstances
Z64 Problems related to certain psychosocial circumstances
Z65 Problems related to other psychosocial circumstances

MHP is involved with targeted interventions intended to improve outcomes for members who are experiencing housing insecurity. You can help by including appropriate SDoH diagnosis codes with your claims. Housing insecurity does not always mean being homeless, but does include unsafe housing conditions and risk for homelessness such as:

- History of living outside or in a vehicle
- Staying with friends or family
- History of homelessness

- Having trouble paying rent or mortgage
- Recent inpatient treatment for drugs or alcohol
- Recent incarceration
- History of eviction

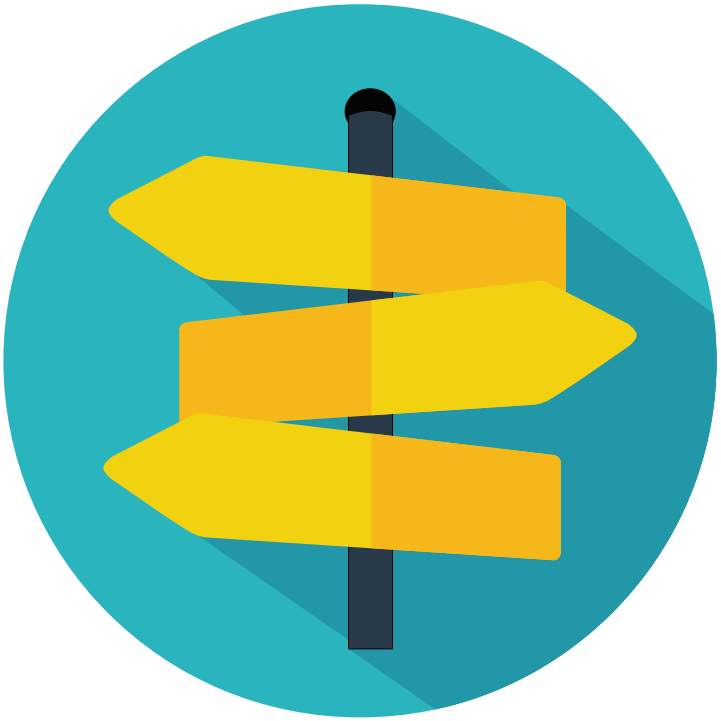
Here is a list of codes to bill specific to housing insecurity:

Z59 Problems related to housing and economic circumstances
Z59.0 Homelessness
Z59.1 Inadequate housing
Z59.2 Discord with neighbors, lodgers and landlord
Z59.3 Problems related to living in residential institution
Z59.4 Lack of adequate food and safe drinking water
Z59.5 Extreme poverty
Z59.6 Low income
Z59.7 Insufficient social insurance and welfare support
Z59.8 Other problems related to housing and economic circumstances
Z59.9 Problem related to housing and economic circumstances, unspecified

[1]Office of Disease Prevention and Health Promotion, October 11, 2018, Healthy People 2020 – Social Determinants of Health, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[2]ICD-10 Data, 2018, Factors Influencing Health Status and Contact with Health Services

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 2018 by our Quality Improvement committee.

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

MHP Aims to Improve Members' Health with Free Programs and Services

McLaren Health Plan has the following programs available in which you can enroll members by calling (888) 327-0671 (TTY: 711). Members may also self-refer and can exit the programs at any time. Upon enrollment, members receive educational mailings, ongoing nurse contacts and pharmacy management, where applicable.

Taking it Off — MHP nurses help both adults and children who want to lose weight. Members receive:

- Educational materials mailed to their home upon request
- Phone calls to offer support
- Coordination with their PCP

McLaren Moms – Upon enrollment, pregnant members receive a $10 gift card and are entered into a quarterly drawing for an iPad or a Pack-n-Play if they receive timely care after their baby is born. A nurse talks to members about pregnancy self-care; how to take care of the baby and the baby's growth and development. Other topics covered include:

- Take folic acid before and while pregnant to help prevent birth defects.
- A flu shot is the best protection from illness for mother and baby.
- Quit smoking and do not drink alcohol.
- Check with your doctor to make sure you can take your current medications while pregnant.
- Go to all your prenatal visits; these are very important to track the health of you and your baby.
- See your doctor within six weeks after having a baby.

Stop Smoking Quit Line – MHP members can call (800) 784-8669 for free counseling. You also can counsel and bill for stop smoking services as the PCP. There are several prescription medications available that are covered benefits for MHP members. Call (888) 327-0671 (TTY: 711) for details.

Diabetes and Asthma Management Programs – MHP has nurses who understand diabetes and asthma. They work with members to help them understand their diabetes or asthma and provide them with support. These nurses will keep you informed of your members who are enrolled in the programs. Members receive:

- Support from a nurse so they know the best ways to manage their condition and assess their health status
- Newsletters with the most up-to-date information about diabetes or asthma
- Materials that will help them understand and manage their medicine and plan visits to their doctor

Down with Hypertension Members are enrolled if their doctor diagnoses them with high blood pressure. All identified members will be mailed information about the program. MHP's pharmacists and nurses offer support by phone.

Quarterly iPad Drawing – Every quarter, MHP randomly chooses an entry form from all eligible participants age 50 or older who get a mammogram.

Case Management/Complex Case Management – Every MHP member has a case management nurse who helps coordinate the care and services necessary to stay healthy and improve health. This nurse helps with difficult health problems and connects members with community support services.

Provider Appeals and When to Submit a Request

Please allow McLaren Health Plan the opportunity to resolve issues before submitting an appeal. Contact Customer Service at (888) 327-0671 (TTY: 711) and ask for the Provider Team when a dispute occurs. If you continue to disagree with an action taken by MHP after informally attempting to resolve the dispute through a verbal contact or a provider claims adjustment, then a formal, written appeal may be submitted.

Supporting information (not previously submitted) regarding the reason and rationale for the appeal must be included with the appeal request. This could include:

- Additional medical records and or office notes
- Diagnostic reports
- Operative notes or surgery reports
- Other information as applicable to the appeal request

You 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. An appeal form 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; or
- authorization decision.

The right to appeal is forfeited if you do not submit a written request for an appeal within the 90-day timeframe and any changes in dispute must be written off.

To submit a provider appeal request or provide appeal-related information, send to MHPAppeals@mclaren.org

Details about the provider appeals process can be found here.

How to Help Your Patients Cope with Chronic Illness and Depression

For millions of people, chronic illnesses and depression are facts of life. A chronic illness is a condition that lasts for a very long time and usually cannot be completely cured. However, some illnesses can be controlled through diet, exercise and certain medications. Examples of chronic illnesses include diabetes, heart disease, arthritis, kidney disease, HIV/AIDS, lupus and multiple sclerosis.

Many people with chronic illness experience depression. In fact, depression is one of the most common complications of chronic illness. It is estimated that up to one-third of individuals with serious medical conditions experience symptoms of depression. It is not hard to identify the cause and effect relationship between chronic illness and depression.

Serious illness can cause tremendous changes in lifestyle and limit an individual's mobility and independence. Chronic illness may make it impossible to pursue the activities one enjoys and can undermine self-confidence and a sense of hope in the future. It is not surprising that people with chronic illness often experience a certain amount of despair and sadness. In some cases, the physical effects of the illness itself or side effects of medication may also lead to depression.

What Chronic Conditions Trigger Depression?

Although any illness can trigger depressed feelings, the risk of chronic illness and depression increases with the severity of the illness and the level of life disruption it causes. The risk of depression is generally 10 to 25 percent for women and five to 12 percent for men. However, those with chronic illness face a much higher risk – between 25 to 33 percent. Depression caused by chronic illness often aggravates the condition, especially if the illness causes pain and fatigue or limits a person's ability to interact with others. Depression can intensity pain as well as fatigue and sluggishness. The combination of chronic illness and depression also can cause people to isolate themselves, which is likely to exacerbate the depression.

What are the symptoms?

In people with chronic illness and depression, patients and their family members often overlook the symptoms of depression, assuming feeling sad is normal for someone struggling with disease. Symptoms of depression also are frequently masked by other medical problems, resulting in treatment for the symptoms but not the underlying depression. When both chronic illness and depression are present, it is extremely important to treat both at the same time.

Treatment Options

Treatment of depression in chronically ill patients is similar to treatment of depression in other people. Early diagnosis and treatment can reduce stress, as well as the risk of complications and suicide for those with chronic illness and depression. In many patients, depression treatment can produce an improvement in the patient's overall medical condition, a better quality of life and a greater likelihood of sticking to a long-term treatment plan.

If the depressive symptoms are related to the physical illness or the side effects of medication, treatment may need to be adjusted or changed. When the depression is a separate problem, it can be treated on its own. More than 80 percent of people with depression can be treated successfully with medicine, psychotherapy or both. Antidepressant drugs usually begin to have a positive effect within a matter of weeks. It is important for patients to work closely with their physician(s) or psychiatrist to find the most effective medication.

Source: www.webmd.com/depression/guide/chronic-illnesses-depression

Lab Service Info for MHP Providers and Members

MHP Providers: If you perform lab tests in your office, you must demonstrate that you have 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 here for a list of CPT codes that are billable when performed in an office setting.

MHP members: MHP uses Joint Venture Hospital Laboratories (JVHL) as our provider for laboratory services. JVHL has more than 400 phlebotomy locations, full-time courier service and 24/7 client support. For service center locations, the JVHL provider directory or other information, go to www.jvhl.org.

How to Help Your Patients Quit Tobacco Use

You can play a key role in the fight against smoking and tobacco use, the number one cause of preventable death and disease in the United States. Many smokers and tobacco users want to quit. Getting started often takes support and motivation from trusted sources, like you.

Communicate the hazards of smoking and tobacco use at each visit.

- Advise smokers and tobacco users to quit.
- Offer smoking cessation strategies.
- Offer cessation methods.

Smoking and tobacco-use counseling are covered benefits for MHP members. Document in the medical record and bill for tobacco cessation counseling services.

- 99406 – Smoking and tobacco-use cessation counseling, Intermediate > 3-10 minutes
- 99407 – Smoking and tobacco-use cessation counseling – Intensive > 10 minutes

MHP formulary medications available to assist members in their efforts to quit smoking are Chantix®, nicotine gum, nicotine lozenges, nicotine patches, Nicotrol® and Zyban®. The use of combination therapy for tobacco cessation is allowed and prior authorization is not required.

The Michigan Tobacco Quitline, in conjunction with the American Cancer Society, is available to MHP members free of charge. Eligible members who are ready to quit smoking receive help by calling (800) QUIT NOW or (800) 784-8669. The program offers an initial readiness assessment, self-help materials and enrollment in telephone counseling.

March is Colorectal Awareness Month

Online Preventive Screening Resources Available

How to Increase Colorectal Screening Rates in Practice: A Primary Care Clinician's Evidenced-Based Toolbox and Guide

Created by clinicians for clinicians, this toolbox can help improve colorectal cancer screening in actual practice. It provides state-of-the science information, advice to help make screening practices more efficient and tools for use in the practice. Also available in a web-based format here.

A shorter version of the toolbox above, this brief guide pulls together the most important material from the full action plan, including charts, templates and sample materials that clinicians can use. As the guide above, the tools are applicable to all types of clinical screening, click here.

How to Report Fraud, Waste and Abuse

MHP is committed to preventing health care fraud, waste and abuse, as well as complying with applicable state and federal laws governing fraud and abuse.

Examples of fraud and abuse by a member include:

- Altering or forging a prescription
- Altering medical records
- Changing or forging referral forms
- Allowing someone else to use his or her member ID card to obtain health care services

Examples of fraud and abuse by a provider include:

- Falsifying his or her credentials
- Billing for services not performed
- Billing more than once for same services
- Upcoding and unbundling procedure codes
- Over-utilization: performing inappropriate or unnecessary services
- Under-utilization: not ordering services that are medically necessary
- Collusion among providers

Examples of fraud and abuse by an MHP employee include:

- Altering provider contracts or forging signatures
- Collusion with providers or members
- Inappropriate incentive plans for providers
- Embezzlement or theft
- Intentionally denying services or benefits that are normally covered

Federal law prohibits an employer from discriminating against an employee in the terms and conditions of his or her employment because the employee reports or otherwise assists in a false claims action.
To report a possible violation, contact MHP's Compliance Officer:

- Mail: McLaren Health Plan, Attn: Compliance Officer, G-3245 Beecher Road, Flint, MI 48532
- Email: MHPCompliance@mclaren.org
- Phone: Compliance Hotline at (866) 866-2135

To report Medicaid fraud, waste and abuse, contact MHP as above or:

- Mail: Office of Inspector General, P.O. Box 30062, Lansing, MI 48909
- Online: www.michigan.gov/fraud
- Phone: Hotline at (855) MI-FRAUD (643-7283

To report Medicare fraud, waste and abuse, contact MHP as above or:

- Mail: U.S. Department of Health and Human Services, Attn: Hotline, P.O. Box 23489, Washington, D.C. 20026
- Online: www.oig.hhs.gov/fraud/report-fraud
- Phone: Hotline at (800) HHS-TIPS (447-8477)

Information provided will be kept confidential. You can remain anonymous by calling the hotline numbers or through the U.S. mail.