McLaren HEALTH PLAN

Hospital Update
NOVEMBER 2019

HEALTHY MICHIGAN PLAN WORK REQUIREMENTS

Effective Jan. 1, 2020, Michigan law requires Healthy Michigan Plan (HMP) Medicaid members to fulfill work requirements or qualify for an exemption, or health care coverage could be lost.

HMP beneficiaries ages 19-62 years old must report at least 80 hours of work or activities to MDHHS on a monthly basis or they must qualify for an exemption. If this requirement is not met, beneficiaries could lose their health care coverage.

To learn more about the work requirements and exemptions go to HealthyMichiganPlan.org.

MDHHS notified beneficiaries by mail in Sept/Oct of the work requirements and exemptions, if applicable. MDHHS is conducting educational forums throughout the State of Michigan, in an effort to preserve coverage for HMP beneficiaries.

McLaren Health Plan (MHP) is providing outreach to identified HMP members who may be affected by the new work requirement. Please encourage your HMP members to contact us to verify their current status.

If you have any questions, please contact Customer Service at 888-327-0671 (TTY: 711).

EFFECTIVE 1/01/20: RECONSIDERATION PROCESS FOR OBSERVATION STAYS

Do you have documentation not previously submitted to MHP that you believe supports an inpatient determination? Beginning Jan. 1, 2020, MHP will offer hospitals the opportunity to request a second clinical review of an observation decision. To start the reconsideration process, complete the Observation Reconsideration Request form found at mclarenhealthplan.org and follow the directions for submission. This reconsider process is only for cases where there is documentation to support the request and this documentation was not used to make the observation determination. The Observation Reconsideration Request form must be submitted:

a. **With new/additional documentation not submitted with the first clinical review.**
b. **Within 30 days** of the observation determination date. Requests submitted outside of this timeframe will not be accepted.
c. **Prior to claim submission.** If you have already filed a claim, you may NOT request reconsideration. See mclarenhealthplan.org for Appeals information.

Fax completed form along with the ***new/additional documentation*** to MHP at **810-600-7961** or mail to:

McLaren Health Plan
G-3245 Beecher Rd.
Flint, MI 48532
Attention: Medical Management Review

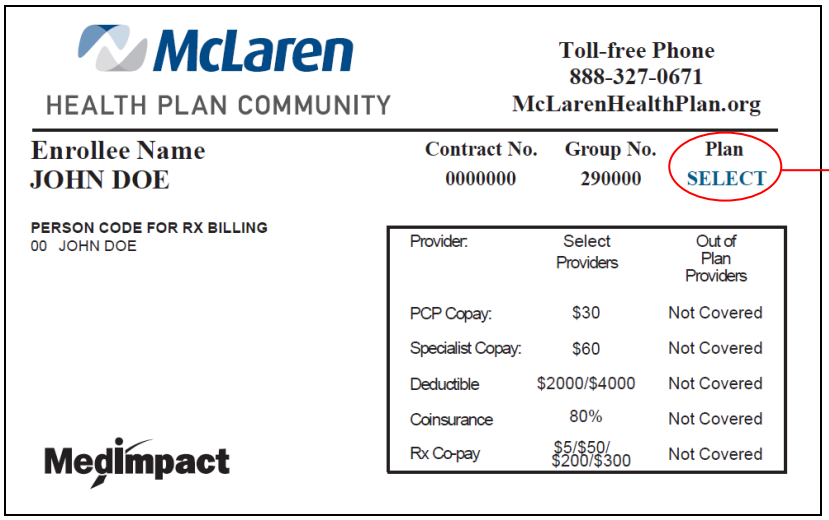
The Observation Reconsideration Request form is available on our website at McLarenHealthPlan.org/Provider Preauthorization.

NEW MCLAREN SELECT PLAN

Effective Jan. 1, 2020, McLaren Health Plan Community will be offering a new "SELECT" plan to Commercial members. Members who are enrolled in the "SELECT" plan will have "SELECT" listed as their plan on their ID card.

If you have a member with MHP Commercial insurance, please remember to verify eligibility and coverage prior to rendering services. This will ensure appropriate authorizations are obtained, if applicable.

Eligibility can be verified on the McLaren CONNECT provider portal or by calling Customer Service at 888-327-0671.



McLaren
HEALTH PLAN COMMUNITY

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

Enrollee Name	Contract No.	Group No.	Plan
JOHN DOE	0000000	290000	SELECT

PERSON CODE FOR RX BILLING
00 JOHN DOE

Provider:	Select Providers	Out of Plan Providers
PCP Copay:	$30	Not Covered
Specialist Copay:	$60	Not Covered
Deductible	$2000/$4000	Not Covered
Coinsurance	80%	Not Covered
Rx Co-pay	$5/$50/ $200/$300	Not Covered

MedImpact

TOP 5 FRONT END EDI CLAIM REJECTIONS

When submitting a claim, it is very important to ensure all information is submitted accurately. MHP regularly monitors the top reasons EDI claims are front-end rejected to allow for appropriate provider education when trends are identified.

The most recent top 5 front-end rejections were due to:

- Invalid phone number
- Invalid referring provider information
- Invalid ZIP code number
- Invalid attending provider information
- Invalid service location

It is important to ensure your team is receiving the front-end rejection report from your EDI vendor, researching the issues, correcting the claim and resubmitting, if applicable.

CLAIMS EDITING SYSTEM (CES) IMPLEMENTATION

Effective Jan. 1, 2020, MHP will implement the Optum Claims Editing System (CES). Optum CES is designed to automatically check each claim for errors, omissions and questionable coding relationships by testing the data against industry rules, regulations and policies governing health care claims. CES will also detect coding errors, including but not limited to: errors relating to unbundling, incidental procedures, modifier appropriateness, diagnoses and duplicate claims.

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

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

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

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

PRE/POST PAYMENT CLAIM REVIEW

MHP has partnered with Optum to conduct pre or post payment claim reviews on hospital admissions. All claims are subject to a review to ensure medical necessity.

Claims will continue to be adjudicated within the appropriate time frames and can be statused on our provider portal, McLarenHealthPlan.org/McLarenCONNECT

If you have any questions, please contact Customer Service at 888-327-0671 (TTY: 711).

G-3245 Beecher Road, Flint, MI 48532 • 888-327-0671 • 833-540-8648 Fax
McLarenHealthPlan.org

HOSPITAL ACQUIRED CONDITIONS

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

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

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

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

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DO YOU HAVE ACCESS TO MCLAREN CONNECT?

The McLaren Connect provider portal enables you to:

- Verify member eligibility
- View & print member eligibility rosters
- View member demographic information
- View member claims and print EOPs
- View & print member benefit information
- Directly contact the MHP Provider Team

Upcoming enhancements include: Viewing of authorizations and attestations

Registering is easy! Go to McLarenHealthPlan.org/McLarenCONNECT, click provider portal and provide your provider contact information.

If you have a question please, contact Customer Service at 888-327-0671 (TTY: 711).

NEW: HOME HEALTH AUTHORIZATION CHANGES FOR MEDICAID MEMBERS

Effective Jan. 1, 2020, Medicaid and Healthy Michigan Plan members will no longer require a pre-authorization for the first twenty-four (24) home health visits, per calendar year. Home health services needed beyond 24 visits will require an authorization.

Authorizations can be completed online at McLarenHealthPlan.org. If you have any questions, please contact Customer Service at 888-327-0671 (TTY: 711).

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