

IMPORTANT: 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.

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).

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).

NEW MCLAREN SELECT PLAN

Effective Jan. 1, 2020, McLaren Health Plan Community will offer a new “SELECT” plan to Commercial members. Members who are enrolled in the “SELECT” plan will be identified with “SELECT” 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.

		Toll-free Phone 888-327-0671																			
HEALTH PLAN COMMUNITY		McLarenHealthPlan.org																			
Enrollee Name JOHN DOE	Contract No. 0000000	Group No. 290000	Plan SELECT																		
PERSON CODE FOR RX BILLING 00 JOHN DOE	<table border="1"><thead><tr><th>Provider:</th><th>Select Providers</th><th>Out of Plan Providers</th></tr></thead><tbody><tr><td>PCP Copay:</td><td>\$30</td><td>Not Covered</td></tr><tr><td>Specialist Copay:</td><td>\$60</td><td>Not Covered</td></tr><tr><td>Deductible</td><td>\$2000/\$4000</td><td>Not Covered</td></tr><tr><td>Coinsurance</td><td>80%</td><td>Not Covered</td></tr><tr><td>Rx Co-pay</td><td>\$5/\$50/ \$200/\$300</td><td>Not Covered</td></tr></tbody></table>			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
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TOP 5 FRONT END EDI CLAIM REJECTIONS

When submitting a claim, it is 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

Eff. 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.

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

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).
