Partners In Health

2024 | Quarter 4

McLaren HEALTH PLAN

INDIVIDUAL
MEDICAID
MEDICARE

"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 is referred to as "MHP" throughout this newsletter.

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CONTACT US

General Information About MHP's Departments and Services

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 McLaren Health Plan Medicaid and Healthy Michigan plan members
- Referrals
- Claims

McLaren Health Plan (MHP) has **FREE** interpretation and translation services for members in any setting – ambulatory, outpatient, inpatient, office, etc. If your MHP patients need help understanding written materials or need interpretation services in their preferred language, call Customer Service at the number above.

Interpretation and translation services are FREE to McLaren 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 McLaren written materials or need interpretation services, call 888-327-0671 (TTY: 711)

McLaren CONNECT

If you have not yet registered for access to our McLaren CONNECT, 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 user 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.

McLaren Helps

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 McLaren Helps, our free online resource guide: 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 or your office staff to learn about MHP – how to submit claims, obtaining member eligibility or claims statuses through the McLaren 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.

Provider Relations Representative Territory POD Assignments

ORANGE POD
REP II Stephanie Anderson
Work Cell: 231-342-2012
Stephanie.Anderson2@mclaren.org

REP I Bev Hude (light orange)
Work Cell: 517-803-7509
Beverly.Hude@mclaren.org

REP I Kylie Weidenhammer (dark orange)
Work Cell: 810-845-4782
Kylie.Weidenhammer1@mclaren.org

PROVIDER RELATIONS

Phone: 888-327-0671
Fax: 810-600-7979

Visit the McLaren CONNECT provider portal at mclarenhealthplan.org to view your claim status and verify member eligibility.

BLUE POD
REP II Aimee Arseneault
Work Cell: 810-931-1948
Aimee.Arseneault@mclaren.org

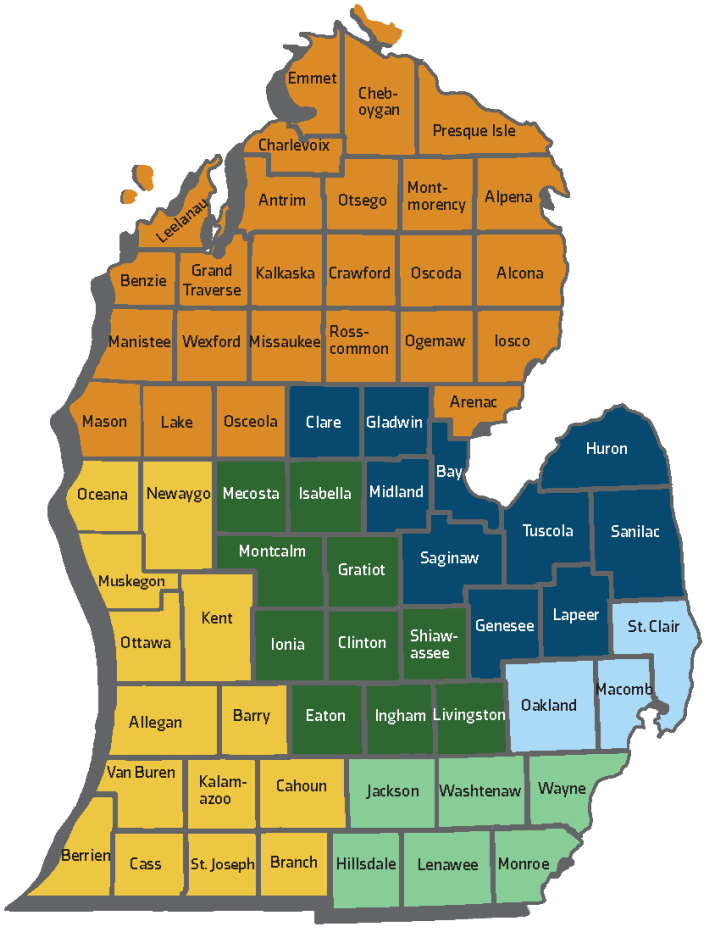
REP I Darrian Colborne (light blue)
Work Cell: 248-804-7871
Darrian.Colborne@mclaren.org

REP I Jessica Kline (dark blue)
Work Cell: 810-493-1044
Jessica.Kline@mclaren.org

GREEN POD
REP II Ken Axtell
Work Cell: 517-490-2626
Ken.Axtell@mclaren.org

REP I Dawn Dunn (light green)
Work Cell: 810-701-2182
Dawn.Dunn@mclaren.org

Manager, Kelly Short (dark green - Interim)
Work Cell: 810-733-9664
Kelly.Short@mclaren.org



Medical Management

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

Medical Management supports the needs of both 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
- 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, and others
- 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 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** found here. 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.

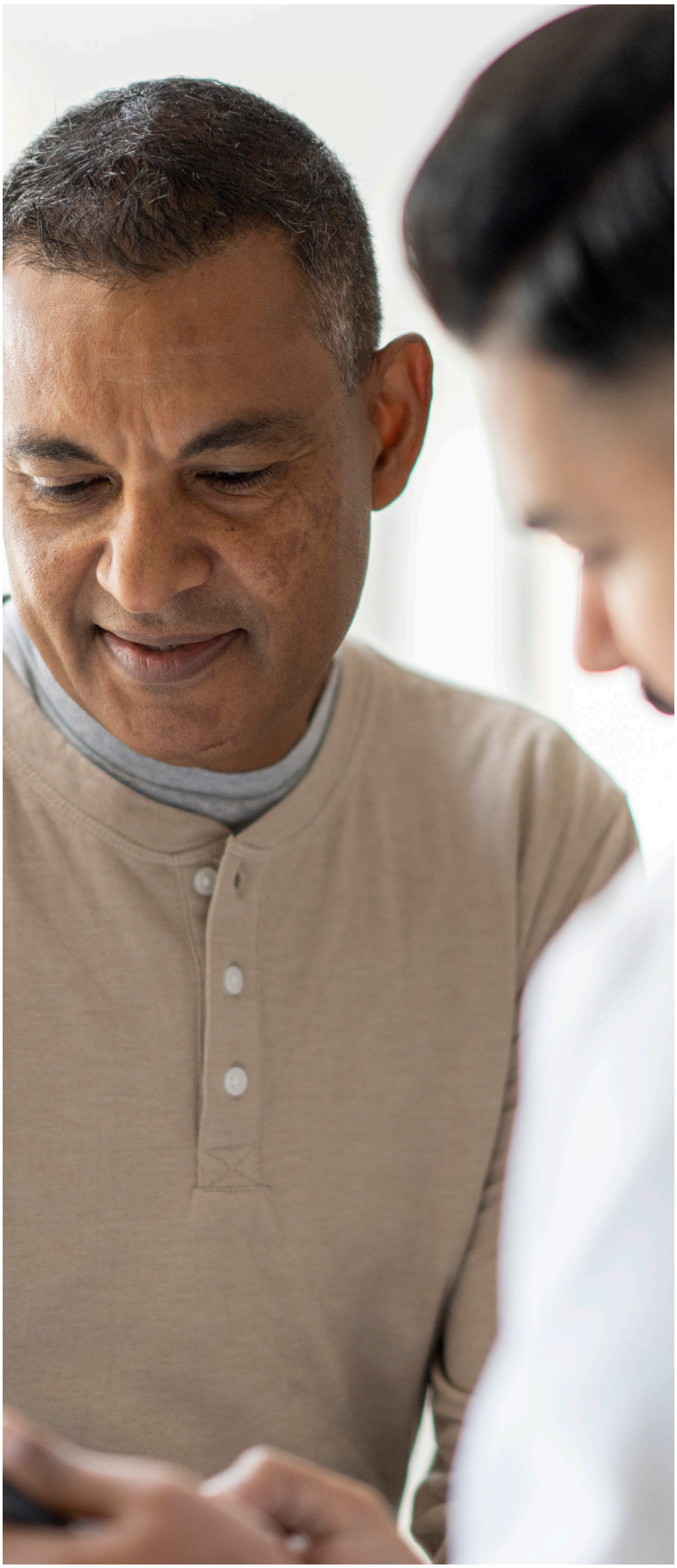
Program goals are:

- **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
- Members with multiple health care conditions
- Are part of the Children's Special Health Care Services (CSHCS)

Virtual Case Management

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

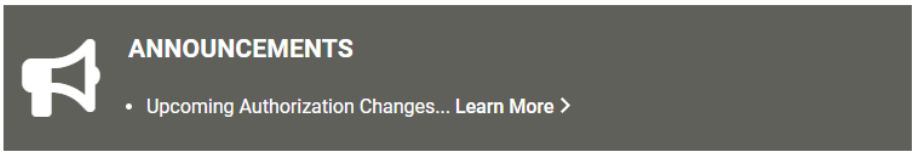
The Medical Management team at McLaren Health Plan (MCL) has virtual case management services available for members. Using the 'ZOOM for Healthcare' platform, case managers can connect with members on a personal level with face-to-face conversations while maintaining social distancing and the need for 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 case management services, or those who would like to, are eligible to participate.

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

Authorization Updates

- 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 10/1/2024, the following codes are being added and require prior authorization for Commercial/ Health Advantage/Medicaid/Medicare:
  - G0482 – Laboratory; Definitive drug tests that identify 15–21 drug classes
  - G0483 – Laboratory; Definitive drug tests that identify 20+ drug classes
  - CPT 81513 RNA marker testing for bacterial vaginosis – Prior Authorization requirements removed for Medicaid, Community, and HA - retroactive to 1/1/24. (Note: claims will be automatically reprocessed)
  - CPT A9278 non-durable medical equipment Continuous Glucose Monitors (receiver/monitor) – no longer be covered effective 1/1/25 per MDHHS bulletin Numbered Letter L 24-79-DMEPOS-Final.pdf
- For all current prior authorization requirements, visit: Prior Authorization Codes List
- For all current Medicare prior authorization requirements, visit: Medicare Prior Authorization Information

Quality Quick Tips

McLaren Health Plan's monthly education for Primary Care Providers called "Quality Quick Tips" are below. Quality Quick Tips are education on various HEDIS and CAHPS measures, performance, incentives, and improvement opportunities to provide McLaren Health Plan members with the best possible care.

July - The ADHD Measure Set

August - Child & Adolescent Immunizations

September – Respiratory Conditions

October – Women's Health & CAHPS

November - Diabetes

December - Oral Health

MC3

MC3 offers no-cost psychiatry support to prescribing health care providers who treat behavioral/mental health in youth and perinatal people in Michigan through same-day phone consultations to offer guidance on diagnostic questions, safe medications, and appropriate psychotherapy.

View MC3 resources and trainings here.

Measurement Year 2023 HEDIS® Results and Trends - Measuring the Quality of Care

	COMMERCIAL		MEDICAID	
MEASURE	**RATE**	**TREND**	**RATE**	**TREND**
Living with illness				
Diabetes Care, HbA1c Testing <8.0	64%	▲	49%	▲
Kidney Health, Evaluating for Patients with Diabetes	42%	▲	36%	▲
Diabetes Care, Eye Exam	55%	▲	57%	▲
Controlling High Blood Pressure	63%	▲	53%	▲
Taking Care of Women				
Breast Cancer Screening	78%	=	55%	=
Cervical Cancer Screening	81%	▲	57%	▲
Chlamydia Screening	44%	▼	58%	=
Timeliness of Prenatal Care	80%	▲	78%	▲
Postpartum Care	90%	▲	78%	▲
Keeping Kids Healthy				
Childhood Immunization, Combo 3	86%	▲	59%	▲
Childhood Immunization, Combo 10	40%	▼	22%	▼
Well-Child Visits in First 15 months, 6+ Visits	84%	▼	66%	▲
Well-Child Visits 15-30 months, 2 visits	85%	▲	66%	▲
Child & Adolescent Well-Care Visit	55%	=	50%	▲
Blood Lead Level (on or before age 2)	N/A		52%	▲
Access to Care				
Adult Access (ages 20-44)	94%	=	71%	▲
Adult Access (ages 45-64)	96%	=	81%	=

Hospital Inpatient Clinical Claim Review & Payment Analytics

Effective 11/1/2024, McLaren Health Plan has retained Health Management Systems, Inc. (HMS) to conduct periodic reviews of inpatient hospital claims paid by McLaren Health Plan for health care services to ensure the integrity of the paid claims, including coding validation, payment accuracy, compliance with regulations, policies, and contractual requirements.

These reviews apply to the McLaren Health Plan Medicaid and McLaren Medicare lines of business. More information on working with HMS is included with the Powerpoint attached to this communication.

National Prevention Information Network

The National Prevention Information Network (NPIN) is the CDC's reference and referral service for information on HIV/AIDS, viral hepatitis, sexually transmitted diseases (STDs) and tuberculosis (TB).

NPIN is an information and resource platform connecting public health partners through collaborative communication and innovative technology solutions for HIV, viral hepatitis, STDs, TB, and adolescent and school health.

For more NPIN information, visit: npin.cdc.gov

NPIN Registration link: npin.cdc.gov/organization/submit

Vaccines for Children Program (VFC)

The Vaccines for Children (VFC) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Michigan providers have participated in VFC since 1995.

The success of this program is built upon the cooperation and collaboration of many agencies. Your participation is vital to increasing Michigan's immunization rates and ensuring all children are protected against vaccine-preventable diseases.

- Being a VFC provider is a sound investment in your practice and your patients. It reduces up-front costs by providing vaccines for VFC-eligible children. Your patients benefit by not having to go elsewhere for vaccines, and there's no charge to the provider.
- VFC providers work with their Local Health Department for support to ensure VFC requirements are followed per CDC and MDHHS guidelines.
- The LHD is a provider's main contact for VFC-related questions and can also offer additional support to improve vaccination rates and practices.

Do your providers participate in VFC? Let us know!
surveymonkey.com/r/mhp_vfc

McLaren Health Plan is capturing this information to include in our Provider Directory to assist members seeking vaccination treatment options for their children.

For more information, visit Michigan.gov to access

MDHHS' VFC Resource Guide

MI VFC Provider Manual

MI VFC Frequently Asked Questions

VFC program: Vaccines for Uninsured Children, visit: cdc.gov

Provider availability and member access to care requirements

McLaren Health Plan maintains standards and processes to ensure member access to care by contracted primary care physicians and participating specialists. Accessibility of services from providers is assessed during initial credentialing and each year thereafter for high-volume PCPs, high-volume and high-impact specialists, including but not limited to: OB-GYNs and oncology specialists, and high-volume mental health specialists through quality improvement site visit audits and surveys. The availability of physician access after-hours is also measured.

Providers are required to follow MHP's Access to Care appointment standards listed below to ensure health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, days a week to members.

The established monitoring standards are set as minimum guidelines of measurement. The following are the MHP standards for provider accessibility to members:

Primary Care Provider Access and Availability Standards			
Type of Service	**Line of Business**		
	Medicaid/HMP	**Medicare**	**Commercial/Marketplace**
Emergency Care	Immediately 24 hours per day, 7 days per week	Immediately	Immediately 24 hours per day, 7 days per week
Urgent Care	Within 48 hours	Immediately; or within 7 business days (if non-emergent)	Within 48 hours
Routine/Regular Care including preventive services (physicals)	Within 30 business days of request	Within 30 business days	Within 15 business days
Non-Urgent Symptomatic Care	Within 7 business days of request	Within 7 business days of request	Within 7 business days of request
In Office Wait Time	Patient seen within 30 minutes of their appointment	Patient seen within 30 minutes of their appointment	Patient seen within 30 minutes of their appointment
After-Hours Coverage (Information/advice is given to patients when medical care is needed after regular office hours)	100%	100%	100%

Specialty Provider Access and Availability Standards			
Type of Service	**Line of Business**		
	Medicaid/HMP	**Medicare**	**Commercial/Marketplace**
Routine/Regular Care including preventive services (physicals)	Within 6 weeks of request	Within 6 weeks of request	Within 30 business days
Acute Specialty Care	Within 5 business days of request	Within 5 business days of request	Within 5 business days of request
Non-Urgent Symptomatic Care	Within 7 business days of request	Within 7 business days of request	Within 7 business days of request
In Office Wait Time	Patient seen within 30 minutes of their appointment	Patient seen within 30 minutes of their appointment	Patient seen within 30 minutes of their appointment
After-Hours Coverage (Information/advice is given to patients when medical care is needed after regular office hours)	100%	100%	100%

Provider availability and member access to care requirements (cont.)

Mental Health Provider Access and Availability Standards			
Type of Service	**Line of Business**		
	Medicaid/HMP	**Medicare**	**Commercial/Marketplace**
MH Emergency	Immediately or within 6 hours of request	Immediately or within 6 hours of request	Immediately or within 6 hours of request
MH Urgent	Within 48 hours of request	Immediately or within 48 hours of request	Within 5 business days of request
MH Non-Urgent Symptomatic Care	Within 7 business days	Within 7 business days	Within 7 business days of request
MH Initial Visit for Routine Care	Within 10 business days of request	Within 30 business days of request	Within 10 business days of request
MH Follow-up for Routine Care	Within 45 business days of request	Within 30 business days of request	Within 10 business days of request

The following are the McLaren Health Plan Commercial, Marketplace, and Medicaid monitoring standards for prenatal care provider accessibility to pregnant members:

Visit Type	Timeframe
Initial prenatal appointment (Obstetrician, OB-GYN, PCP, certified nurse midwife, or other advanced practice registered nurse with experience, training and demonstrated competence in prenatal care)	If member is in first or second trimester: Within 7 business days of member being identified as pregnant.
	If member is in third trimester: Within 3 business days of member being identified as pregnant.
	If there is any indication of the pregnancy being high-risk (regardless of trimester): Within 3 business days.

Monitoring appointment access and timeliness

The information about monitoring appointment access applies to primary care, obstetrician-gynecologist, specialty and mental health practitioners. McLaren Health Plan conducts appointment access reviews annually. Reviews are conducted more frequently for practitioners who do not meet access standards.

McLaren Health Plan contacts the practitioner's office to determine access and records the next available appointment for each of the designated appointment types. Physician-specific member complaints related to access are also analyzed.

An annual evaluation and analysis is conducted by Provider Relations staff on the following:

- Primary care appointment availability for regular, routine and urgent care appointments
- Primary care after-hours availability
- Mental Health care appointment availability (a separate analysis is performed for Mental Health care providers who prescribe medication and those who do not prescribe medication)

As a reminder, providers must offer hours of operation that are no less than the hours of operation offered to commercial members, or hours of operation must be comparable to Medicaid fee-for-service office hours if the provider serves only Medicaid enrollees. McLaren Health Plan monitors for complaints to ensure providers offer and maintain hours of operations that are compliant with these expectations. Results are reported to the Quality Improvement committee.

Providers who fail to meet the access standards will be notified and asked to submit a corrective action plan to MHP within 30 days. Failure to comply with corrective action plan may result in departicipation.

If you have any questions, contact McLaren Health Plan Customer Service at 888-327-0761 (TTY: 711) for assistance or visit mclarenhealthplan.org.

Hospital Observation

McLaren Health Plan is implementing a Hospital Observation Payment Policy, effective 1/1/2025. The policy outlines observation level of care reimbursement and authorization requirements. The policy is included with this update for your review and can be found in our Provider Manual at https://www.mclarenhealthplan.org/mclaren-health-plan/provider-communications.

Emergency Department Facility E & M Coding Policy

McLaren Health Plan previously sent a communication to Hospitals in May 2024 regarding the Emergency Department Facility E & M Coding Policy. McLaren Health Plan is revising the information previously sent. The revised policy, effective 1/1/25 is as follows:

SCOPE

LOB = Medicaid Claim Type = Institutional, Outpatient Service = ED visits

POLICY

Beginning with claims submitted on 1/1/2025, McLaren Health Plan will implement Optum EDC Analyzer and deny facility ED claims where the level of service billed is not supported by the claim information submitted. Providers should rebill facility claims within 90 days with the appropriate level of service for payment.

McLaren Health Plan will use the following factors in considering appropriate levels of service:

1. Presenting problems – as defined by the ICD-10 reason for visit diagnosis;
2. Diagnostic services performed – based on the intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e. lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound); and,
3. Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes

Applicable codes to be evaluated include:

99282 G0381 ED Level 2 | 99283 G0382 ED Level 3 | 99284 G0383 ED Level 4 | 99285 G0384 ED Level 5

Claims for the following may be excluded from a denial:

1. Patients who were admitted from the ED or transferred to another health care setting (Skilled Nursing Facility, Long Term Care Hospital, etc.)
2. Critical care patients (99291, 99292)
3. Patients under 2 years of age
4. Certain diagnoses that when treated in the ED most often necessitate a greater than average usage, such as significant nursing time
5. Patients who have expired in the ED

OTHER

Internal denial code – C679: Information submitted does not support this ED level of service. Please rebill with the appropriate ED level of service.

Remittance CARC code – 150: Payer deems the information submitted does not support this level of service.

Remittance RARC code – M26: The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.

Hospital Observation Payment Policy

Line of Business: McLaren Health Plan Medicaid Effective Date: 1/1/2025

This policy applies to observation services provided at a facility. If there is a conflict between this policy and applicable federal or state laws, regulations or regulatory requirements, the applicable laws or regulations will control. Further, if there is a conflict between this policy and a provider contract, the provider contract will govern. Note – coverage may be mandated by MDHHS or CMS.

Providers are required to submit accurate claims and documentation for all services performed.

Providers must submit claims using valid code combinations required by applicable law. Claims should be coded appropriately according to industry standard coding guidelines. All claims are subject to claims edits and may be subject to further reviews by McLaren or contracted third parties. Providers are expected to promptly work with McLaren and any third parties to provide any requested information related to a claim submission.

Definition

Observation Care: a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or if the patient is able to be discharged from the hospital. Observation services are commonly ordered for a patient who presents to the Emergency Department (ED) and who then require a significant period of treatment or monitoring to make a decision concerning their admission or discharge. Observation services generally do not last more than 72 hours.

Policy

1. Authorization Requirements

- Observation stays do not require authorization.
- Hospital observation stays are those hospital services that are generally 48 hours or less in nature.
- Observation Care must be medically necessary.
- Observation services may be appropriate when the member does not meet an inpatient level of care and meets an observation level of care.

2. Authorization Required for Request for Inpatient Level of Care

- A request for admission that meets inpatient criteria but could be treated in an observation setting will be considered an observation stay. Updated clinical information may be submitted by the facility at 48 hours.
- All inpatient stays require prior authorization from McLaren.
- Obtaining authorization does not guarantee payment.

3. Authorization Review

- All requests for inpatient authorizations will be reviewed against McLaren's clinical criteria for inpatient level of care.
- McLaren uses nationally recognized criteria for its clinical criteria, including but not limited to, InterQual to determine the appropriate level of care. Guidelines are not a substitute for clinical judgment. McLaren's Chief Medical Officer or his/her designee may refer to guideline criteria in reaching the determination but are not required to adhere to any single published criteria.
- Facilities must provide sufficient clinical information for McLaren to make an appropriate medical necessity determination.
- Facilities must supply documentation to support the claim submitted. This information includes but is not limited to complete medical charts, itemized bills and consent forms.
- **Authorization approval does not guarantee payment (see below for the 48 hour rule)
- McLaren has the right to review, audit or otherwise deny claims based on benefit limitations and exclusions, eligibility, correct coding. billing practices and McLaren payment policies.

4. 48 Hour Rule

Less than 48 Hours

- McLaren will reimburse medically necessary observation services less than 48 hours without an authorization.
- McLaren will reimburse inpatient stays less than 48 hours for the exclusions listed below.
- For purposes of calculating the 48 hours, the time starts at the time a patient is placed in a bed for the purpose of initiating observation care. Observation services should continue to be billed as an observation service.
- Authorization is not a guarantee of payment.
- Facilities may timely rebill at an observation level of care.
- Inpatient stays billed and paid that are less than 48 hours are subject to retrospective reviews.

48 Hours or More

- If the facility received an approved authorization, based on medically necessity review, for an inpatient stay, the claim will be approved at the inpatient level of care for payment purposes.
- McLaren reserves the right to review and/or deny the claim for other valid purposes (ineligible member, not medically necessary, etc.).

Exclusions to the 48 Hour Rule

- If an authorization request is submitted to McLaren at an inpatient level of care, for a stay less than 48 hours, but McLaren determines that it meets the following exclusions and approves the authorization request, it will pay at the inpatient level:
  - Deliveries – APR DRGs 540-5404, 5411-5414, 5421-5424, 560-5604
  - Neonatal Services – APR DRGs 580-62641
  - Nursery/Newborns – APR DRGs 630-64041
  - ICU Revenue Codes: 0200-0209
  - Discharge Status of 20 (patient expired)
  - Diagnosis codes Z37-Z37.7, Z38-Z38.8 (births)
  - MSA Bulletin 15-32 Inpatient and Outpatient Hospital ICD-10 Short Stay Reimbursement.
  - CMS Inpatient Only Code

Audit

McLaren or a third party may audit or otherwise review all paid inpatient hospital claims to ensure the integrity of the paid claims. This includes, but is not limited to coding validation, payment accuracy, compliance with regulations, policies, and contractual requirements. These reviews include clinical claim reviews and payment analytics.

HELP PREVENT FRAUD, WASTE AND ABUSE

McLaren Health Plan works hard to prevent fraud, waste and abuse. We follow state and federal laws about fraud, waste and abuse. Examples of fraud, waste and abuse by a member include:

- Changing a prescription form
- Changing medical records
- Changing referral forms
- Letting someone else use his or her MHP ID card to get health care benefits
- Resale of prescriptions

Examples of fraud, waste and abuse by a doctor include:

- Falsifying his or her credentials
- Billing for care not given
- Billing more than once for the same service
- Performing services that are not needed
- Not ordering services that are medically necessary
- Prescribing medicine that is not needed

Call MHP's Fraud and Abuse line at 866-866-2135 if you think a doctor, other health care provider or member might be committing fraud, waste or abuse.

You can email MHP's Compliance department at MHPcompliance@McLaren.org.

You also can write to MHP at:

McLaren Health Plan, Inc.
Attn: Compliance
P.O. Box 1511
Flint, MI 48501-1511

Contact the State of Michigan if you think a member has committed fraud, waste or abuse. Here's how:

- Fill out a fraud referral form at https://mdhhs.michigan.gov/Fraud OR
- Call the MDHHS office in the county where you think the fraud, waste or abuse took place OR
- Call the MDHHS office in the county where the member lives

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 2022 by our Quality, Safety, and Satisfaction Improvement Committee.

Please review the guidelines found at MQIC | Michigan Association of Health Plans | Michigan Association of Health Plans There is also a link on 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.

Eligibility & Claim Inquiries

- Prior to rendering services, always verify eligibility and coverage using the McLaren Connect Provider Portal. Eligibility can be verified on the McLaren Connect Provider Portal with just the Member ID.
- For questions regarding the status of a claim, login to the McLaren Connect Provider Portal, to view the status of a claim, if you have additional questions, please initiate a request on the McLaren Connect Provider Portal.
- Maintain your tracking number from your portal request in the event you need to reach to Customer Service for further information.
- Direct all claims inquiries to MHP Customer Service to investigate any issues by calling MHP Customer Service at 888-327-0671 or initiating a request on the McLaren Connect Provider Portal.
- To dispute a claim denial, providers must submit an Appeal within 90 calendar days of the action and include supporting documentation.
  - Submit corrected claims within 90 days.
  - Visit the MHP Appeals information page online and the Provider Administrative Appeal Form.
- Provider Relations Representatives can assist with claims issues after a provider has already contacted MHP Customer Service and is unable to achieve resolution though established channels. Provider Relations intervention is limited to exclusive situations when denials occur due to complex configuration, contracting or enrollment issues following Customer Service involvement.

Member Rights and Responsibilities

McLaren Health Plan Members have the right to:

- Confidentiality
- Be treated with respect and recognition of their dignity and the right to privacy, including to be free from restraint and seclusion
- Have access to a primary care provider or provider designee 24 hours a day, 365 days a year for urgent care
- Receive culturally and linguistically appropriate services
- The right to receive covered benefits consistent with your contract and State and Federal regulations
- Obtain a current provider directory of participating providers and access to a choice of specialists within the network who are experienced in treatment of chronic disabilities, with a referral
- Obtain OB-GYN and pediatric services from network providers without a referral request
- Continue receiving services from a provider who has been terminated from the Plan's network, through the episode of care, as long as it remains medically necessary to continue treatment with this provider, including female members who are pregnant have the right to continue coverage from a terminated provider that extends to the postpartum evaluation of the member, up to 6 weeks after delivery
- Have no "gag rules" from the Plan. Doctors are free to discuss all medical treatment options, even if they are not covered services
- Participate in decision-making regarding his/her health care, including the right to refuse treatment, to obtain a second opinion, and express preferences about treatment options
- Receive a copy of their medical record upon request, and request those to be amended or corrected
- Know how the Plan pays its doctors, allowing Members to know if there are financial incentives or disincentives tied to medical decisions; and the right to be provided with a telephone number and address to obtain additional information about compensation methods, if desired
- Voice complaints or appeals about McLaren Health Plan, the care provided or a decision to deny or limit coverage, including that a member or provider cannot be penalized for filing a complaint or appeal in compliance with federal and state laws
- Receive information about McLaren Health Plan, including the services provided, the practitioners and providers, and the members' rights and responsibilities
- Make recommendations regarding McLaren Health Plan's member's rights and responsibilities
- Be free from other discrimination prohibited by State and Federal regulations
- Having the member's medical record be kept confidential by McLaren Health Plan and the PCP

McLaren Health Plan Members have the responsibility to:

- Schedule appointments in advance and be on time; and cancel an appointment with the doctor's office as soon as possible
- Use the hospital emergency room only for acute or emergency care, not for routine care - this means following the protocol and using the emergency room only when medically necessary, and contacting the PCP prior to a visit to the emergency room
- Become a partner with the PCP in planning individual health care and completing treatments, including supplying the information (to the extent possible), to practitioners, providers, and the health plan that is needed to deliver the services needed
- Follow plans and instructions for care that the member has agreed on with all their treating health care providers and practitioners
- Understanding their health problems and participate in developing treatment goals to the degree possible
- Notify McLaren Health Plan's Customer Service immediately for any change in address or telephone number
- Allow McLaren Health Plan to assist with health care and services to which a member is entitled and of notifying the Plan of any problem related to health care, benefits, etc.
- Forward suggestions to McLaren Health Plan in writing or contacting Customer Service for assistance
- Carry the McLaren Health Plan Member ID card at all times