



 **McLaren**  
HEALTH PLAN

# Provider Manual



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## Section I

# Introduction

McLaren Health Plan (MHP) offers a variety of products and benefits designed to meet the health care needs of each member. To this end, our mission is to partner with providers who offer high-quality, accessible and cost-effective health services throughout our service area.

MHP products include:

- » McLaren Medicaid (Medicaid Managed Care Plan)
- » McLaren Health Plan Healthy Michigan
- » McLaren Community – Health Maintenance Organization (Commercial HMO)
- » McLaren Community – Point of Service (POS) Managed Care Plan
- » McLaren Fully Insured Preferred Provider Organization (PPO) Plan
- » McLaren Medicare Supplemental

MHP also has a subsidiary that functions as third-party administrator (TPA) for self-insured products that include:

- » McLaren Health Advantage (Self-Insured PPO Plan)

MHP combines the resources of independent physicians, multispecialty groups, ambulatory care centers, ancillary providers and hospitals to offer members access to a comprehensive array of high-quality health care providers. The member's ID card identifies which type of plan they have (see pages 12-13 for examples). MHP will provide you with updated information through mailings and on our website, at [McLarenHealthPlan.org](http://McLarenHealthPlan.org).

### About Managed Care

The objective of managed care is to form effective links between patients and providers, thereby improving access to appropriate health services while containing costs. However, the specific strategies for accomplishing this goal vary widely from one managed care company to another. MHP's philosophy is to assign as few "rules" as possible so that health care providers can do what they do best – practice medicine. Our managed care products, McLaren Medicaid/Healthy Michigan Plan, McLaren POS and McLaren HMO, require members to select a Primary Care Provider (PCP) at the time of enrollment. Our PCPs will both provide primary care services and act as care coordinators, guiding members to the full range of health services. Staff at MHP will assist the health care providers in navigating the service delivery system.

### Quick Reference Guides

This Provider Manual contains detailed information regarding MHP's operations and business practices

that are important for you and your staff to be aware of. We have also summarized this information on Quick Reference Guides (Section XVIII) to provide you with easy references.

## Website

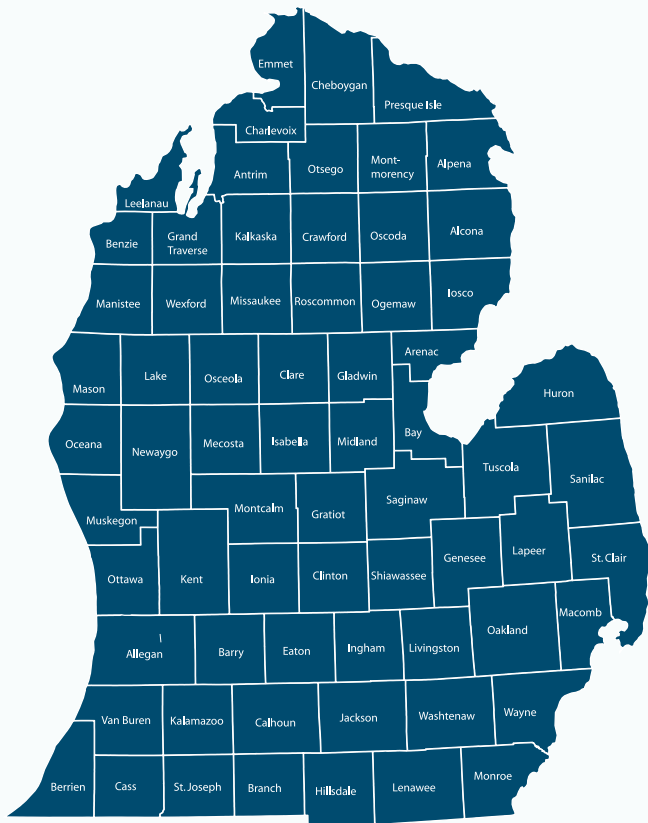
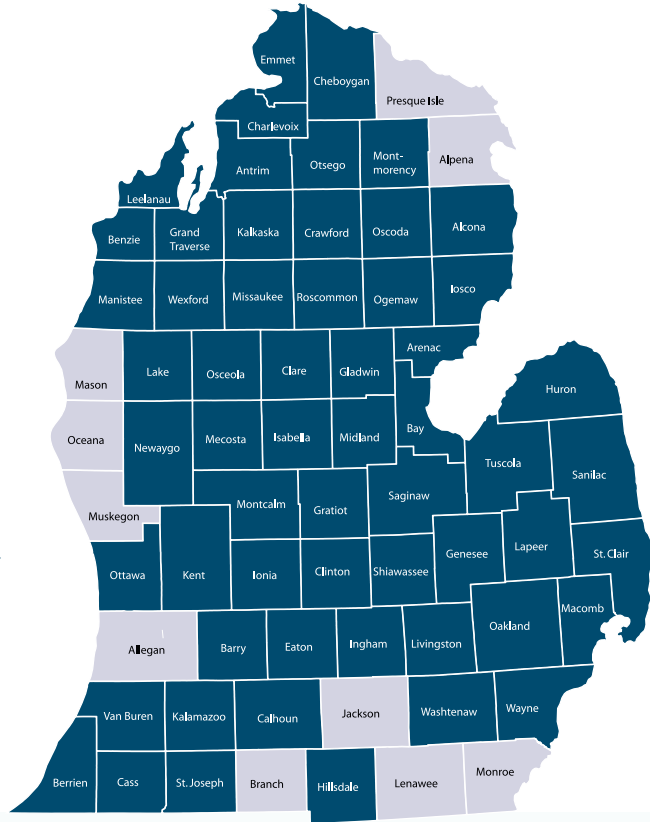
MHP maintains a website that provides an array of information regarding the health plan's policies, procedures and general operations. Such information includes the quality programs, preauthorization processes, health management programs, clinical and preventive practice guidelines, pharmaceutical management procedures, the formulary, member rights and responsibilities, the provider appeal process and provider newsletters. Providers also can verify member eligibility and benefit coverage, as well as status claims that are submitted for payment, through the McLaren Connect provider portal. Please visit [McLarenHealthPlan.org](http://McLarenHealthPlan.org) frequently for the latest updates and new information. A printed hard copy of any information on the website can be obtained by calling Customer Service at (888) 327-0671.

## Using This Manual

This Provider Manual ("manual") is a guidebook for providers that includes general information and instructions on operational and administrative procedures, which may be revised from time to time. The dates of review and/or revisions are on the last page of the Provider Manual. The provisions in this manual are intended to supplement the terms of the provider agreement ("Agreement") you entered into with McLaren. In the event of a direct conflict between a provision in this manual and the Agreement between you and McLaren, the provision in this manual will control unless it conflicts with a term required by law, regulation or a regulatory agency. Or, if your Agreement otherwise specifies that it controls.

# McLaren Health Medicare Advantage

- Full County Approval
- Not Approved



# McLaren Health Plan — Medicaid

- Full County Approval





## Section II

# Department Services

MHP has several departments that are available to assist providers and provider staff with their MHP membership. The following information provides a brief description of the departments that will be utilized most frequently by your practice.

MHP's 24-hour toll-free number is (888) 327-0671 (TTY call 711). All departments can be accessed through this number. Normal business hours are 8:30 a.m. to 5 p.m., Monday–Friday.

### Provider Relations

The Provider Relations department is responsible for all provider-related issues and requests, including Provider enrollment and contracting. The Provider Relations Representatives are assigned to provider practices based on the county location of the practice. Coordinators act as a liaison between the provider and MHP. They are available to assist with any of the following:

- » In-services or orientations for you or your staff to learn how best to work with MHP, including submitting claims, statusing member eligibility or claims via the McLaren CONNECT provider portal, or to discuss any issues you or your office staff may have.
- » Providing office materials:
  - » Referral and preauthorization forms
  - » Pharmacy formularies
- » Reporting changes in your practice such as:
  - » Hospital staff privileges
  - » Office hours
  - » Office address or phone number
  - » Office services
  - » Call coverage
- » A new W-9 form is required to notify us of a change to your:
  - » Federal Tax Identification number
  - » Payment address
  - » Name
- » To discuss any questions regarding your participation in MHP.

If you have questions about how to become a McLaren Health Plan Provider or other questions, contact a Provider Relations Representative by calling (888) 327-0671.

## Customer Service

The Customer Service department is responsible for assisting providers and members with any questions they may have regarding MHP. Customer Service Representatives are available from 8 a.m. to 6 p.m., Monday–Friday. Providers and members are encouraged to call (888) 327-0671 (TTY call 711) for assistance with any of the following:

- » Arrange for member transportation (Medicaid and Healthy Michigan Plan only)
- » Inquire about referrals
- » Ask claims questions

Use the McLaren Connect provider portal to:

- » Verify member eligibility
- » Review status of claims
- » View/print provider explanation of payments (EOP)

## Medical Management

Medical Management supports the needs of both the membership and the provider network. Medical Management offers support to coordinate our members' care and to facilitate access to appropriate services through the resources of our nurse case managers.

Through our case management services, the nurses promote health management of our members by focusing on early assessment for chronic disease and special needs, and by providing education regarding preventive services. In addition to this member focus, the nurses are available to assist our provider network with health care delivery to our members. The nurses are available for members 24 hours per day, seven days a week and work under the direction of MHP's Chief Medical Officer.

The Medical Management department can be reached by calling (888) 327-0671 and following the prompts. Medical Management's business hours are from 8:30 a.m. to 5 p.m. Monday–Friday. Please be aware, you may get voicemail when you call direct numbers due to the large volume of incoming calls. Voice messages are checked frequently throughout the day and all calls are returned within one business day. Call Medical Management for information and support with situations such as:

- » Preauthorization requests: see Section X, 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 and others

## Section II: Department Services

- » Preventive health education and community outreach support
- » Children's Special Health Care Services (CSHCS)

### Utilization Management

Medical Management, through its utilization management processes, is structured to deliver fair, impartial and consistent decisions that affect the health care of our members. Medical Management coordinates covered services and assists members and providers in ensuring that appropriate care is received. There are nationally recognized, evidence-based criteria used when determining the necessity of medical or behavioral health services. The criteria are available to you upon request by calling Medical Management at (888) 327-0671.

If there is a utilization denial, you will be provided with written notification and the specific reason for the denial, as well as your appeal rights. In addition, MHP's Chief Medical Officer, or an appropriate practitioner, will be available by phone to discuss any utilization issues and the criteria utilized in making the decision.

Please call Medical Management at (888) 327-0671 for more information, or to schedule a time to speak with the Chief Medical Officer about a utilization denial or any utilization issue.

In addition, regarding incentives, utilization decision-making is based solely on appropriateness of care and service and existence of coverage. We do 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 that result in under-utilization.

### Case Management Services

MHP offers case management to all members. A case management nurse is assigned to each PCP's office to assist the physician and staff in managing their MHP patients. Nurses are available to all members, PCPs and specialty care physicians for management of complex problems or as a resource for any identified issues. Call Case Management toll free at (888) 327-0671.

Complex Case Management (CCM) nurses are specially trained nurses who are available to MHP members who have complex care needs. Members considered for CCM include:

- » Members listed for a transplant
- » Frequent hospitalizations
- » Frequent ER visits
- » Children's Special Health Care Services (CSHCS)

## Community Outreach

MHP provides community outreach with a focus on support services, such as food programs, housing and utilities, special family services, clothing needs and more. Customer Service and Medical Management work in tandem to provide outreach, education and ongoing support to our membership.

Many community outreach programs are operational for members such as expectant mothers, breast cancer patients, members with asthma and diabetes, members needing preventive screening reminders and much more. For more information about the literature and services that are available, call our toll-free number at (888) 327-0671, or for correspondence in writing, send a request to:

McLaren Health Plan  
Attn: Customer Service  
P.O. Box 1511  
Flint, MI 48501-1511

## Interpretation and Translation Services

Interpretation and translation services are FREE to MHP Medicaid and Healthy Michigan Plan members in any setting (ambulatory, outpatient, inpatient, etc.). If these members need help understanding MHP's written material or need interpretation services, they can call Customer Service at (888) 327-0671.

If a member is deaf or hard of hearing or has speech problems, oral interpretation services are available to MHP Medicaid and Healthy Michigan Plan members who require this service. Please call Customer Service at (888) 327-0671 for assistance. If the member can access a TTY line, the number is 711. The Michigan Relay line is available 24 hours a day.

Member materials are available in other languages, if needed. Please call Customer Service at (888) 327-0671 to request copies.

## Pregnancy Resources

McLaren Miracles: a program for pregnant McLaren Health Plan members with special nurses who will send information on what to expect throughout pregnancy. Participants receive all kinds of information on healthy habits and the nurse can help members with any questions or problems. McLaren Miracles also covers Breast Pumps (with a prescription).

Members identified as currently pregnant are automatically enrolled in the McLaren Miracles program. Members can become ineligible if they are incorrectly identified as being pregnant, are no longer an MHP member (termed/expired) or if the member chooses to opt out of the program. For questions or to opt out of this program, contact Customer Service toll free at 1-888-327-0671 (TTY: 711).

Maternal mortality prevention: Healthcare professionals play a critical role in eliminating preventable maternal mortality. Listening goes a long way when engaging patients in their care. Really hear your patient's concerns during and after pregnancy to facilitate open conversation and ensure any issues are

addressed. Help your patients recognize urgent warning signs and when to seek medical attention right away. Take steps to make pregnant patients feel understood and valued during their visit. The following resources may make a difference:

- HEAR HER Michigan MDHHS' Hear Her Michigan Campaign aims to empower women and their support networks to recognize urgent maternal warning signs and speak up when they have concerns. The campaign is also dedicated to encouraging everyone, including providers, caregivers, friends, and family to listen and act.
- McLaren Health Plan pregnancy information: [www.mclarenhealthplan.org/mclaren-health-plan/pregnancy-health-information](http://www.mclarenhealthplan.org/mclaren-health-plan/pregnancy-health-information)
- Centers for Disease Control HEAR HER Campaign resources for healthcare providers - [www.cdc.gov/hearher/healthcare-providers/index.html](http://www.cdc.gov/hearher/healthcare-providers/index.html)

### Section III

## Contact Information

Department	Telephone No.	Fax No.
<b>Customer Service/Provider Inquiry</b> Available to assist with claims, benefits, authorizations and coordination of benefit inquiries. Hours: 8 a.m. - 6 p.m., Monday-Friday.	(888) 327-0671	Toll Free: (833) 540-8648
<b>Provider Relations</b> Available to assist with contracting, provider education and incentive opportunities.	(888) 327-0671	Flint: (810) 600-7979
<b>Medical Management</b> Referral requests can be submitted electronically via the following link: <a href="http://www.mclarenhealthplan.org/mclaren-health-plan/provider-preauthorization-form">www.mclarenhealthplan.org/mclaren-health-plan/provider-preauthorization-form</a>	(888) 327-0671	Preauthorization Requests – (810) 600-7959  Inpatient Authorization Requests – (810) 600-7960
<b>Quality Management/Member Outreach</b> Available to assist with Gaps in Care reports, HEDIS reports, quality incentives, member outreach	(888) 327-0671	Flint: (810) 600-7985
<b>Sales Department</b>	(888) 327-0671	Flint: (810) 600-7931

Other Information	
Administrative	McLaren Health Plan G-3245 Beecher Road Flint, MI 48532
Pharmacy Services	For formulary information or medication prior authorization request forms, please visit: <a href="https://McLarenHealthPlan.org/mclaren-health-plan/pharmacy-mhp-providers">McLarenHealthPlan.org/mclaren-health-plan/pharmacy-mhp-providers</a> . E-prescribing is available for all lines of business.
Provider Demographic Changes	Submit changes online at: <a href="https://mclarenhealthplan.org/mclaren-health-plan/documents-and-links/provider-change-form-8051">mclarenhealthplan.org/mclaren-health-plan/documents-and-links/provider-change-form-8051</a> , via email at <a href="mailto:MHPPProviderServices@mclaren.org">MHPPProviderServices@mclaren.org</a> or via McLaren CONNECT provider portal ( <a href="https://mclarenhealthplan.org/mclaren-health-plan/mclaren-connect">mclarenhealthplan.org/mclaren-health-plan/mclaren-connect</a> ).
Other Information	
Provider Portal	The <b>McLaren CONNECT</b> provider portal is available to all contracted MHP providers. On McLaren CONNECT, you can check the status of claims, check member eligibility and view/print EOPs. If you are not currently registered, contact Customer Service today at (888) 327-0671.
Claims	MHP receives EDI claims from our clearinghouse, ENS Optum Insight. Our Payer IDs for electronic claims are: <ul style="list-style-type: none"> <li>» MHP Medicaid/Healthy Michigan Plan – 3883C</li> <li>» MHP Community (Commercial HMO) – 38338</li> <li>» McLaren Health Advantage (PPO) – 3833A</li> <li>» McLaren Medicare Supplemental – 3833S</li> <li>» <b>You are expected to submit your MHP claims electronically.</b></li> <li>» Secondary claims are also able to be submitted electronically.</li> <li>» Medicare secondary claims are received by MHP from the CMS Coordination of Benefits System. If you are billing Medicare primary, CMS will forward the claims to MHP for secondary adjudication.</li> </ul>
Laboratory	For Medicaid/Healthy Michigan Plan, Commercial HMO/POS and McLaren Health Advantage, required lab vendor is Joint Venture Hospital Lab (JVHL) – (800) 445-4979.

## Section IV

# McLaren Health Plan – Plan Definitions

MHP offers a variety of plans designed specifically to meet the needs of our members and their communities. Our diverse plans offer employer groups and members varying levels of flexibility in benefit coverage and provider access. An overview of each plan is presented below. For additional information, contact Provider Relations at (888) 327-0671, Monday-Friday, 8:30 a.m.–5 p.m.

### MHP Community HMO

MHP Community HMO covers a comprehensive set of health care services obtained through a designated provider network. MHP Community HMO members have plans with varying levels of copayments, deductibles and out-of-pocket maximums that are chosen by the employer group. Each MHP Community HMO member selects a PCP who is responsible for coordinating the member's health care. The PCP provides the member with a medical home.

McLaren Rewards: Members eligible to be included in the McLaren Rewards program are entitled to services provided by McLaren Rewards providers without the responsibility of member cost-sharing, such as copays, deductibles or coinsurance amounts. McLaren Rewards Providers are listed in the McLaren Rewards and Community provider directories.

### McLaren POS

McLaren POS offers the member the most flexibility in obtaining care. Although the member must still select a PCP, for each episode of medical care, the member determines his or her level of coverage based on the "point" from which the member receives the "service." Medical care is PCP-coordinated (HMO-like) care within the network, or self-referred care within or outside the network with greater out-of-pocket expenses.

### MHP Medicaid

MHP is contracted with the Michigan Department of Health and Human Services (MDHHS) to provide medical services to eligible Medicaid recipients.

Medicaid Eligibility: The Medical Services Administration administers the Medicaid program in Michigan. Eligibility is determined by the state with the sole authority to determine whether individuals or families meet eligibility requirements as specified for enrollment in the Comprehensive Health Care Program (CHCP) and other state assistance programs.

Children's Special Health Care Services (CSHCS) Eligibility: Eligibility for CSHCS (authorized by Title V of the Social Security Act) is determined by the state with the sole authority to determine whether individuals meet eligibility requirements. Individuals eligible for both CSHCS and Medicaid are a mandatorily enrolled Medicaid-Eligible Group (see II-C (1)(c)).



## Medicaid-Eligible Groups

Within the Medicaid-eligible population, there are groups enrolled in the CHCP mandatorily, groups who may voluntarily enroll, and groups excluded from enrollment. Those groups are as follows:

### 1. Medicaid-Eligible Groups Mandatorily Enrolled in the CHCP:

- a. Children in foster care
- b. Families with children receiving assistance under the Financial Independence Program (FIP)
- c. Persons enrolled in Children's Special Health Care Services (CSHCS)
- d. Persons under age 21 who are receiving Medicaid
- e. Persons enrolled in the MIChild Program
- f. Persons receiving Medicaid for the aged
- g. Persons receiving Medicaid for the blind or disabled
- h. Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
- i. Pregnant women
- j. Medicaid-eligible persons enrolled under the Healthy Michigan Plan (HMP)
- k. Supplemental Security Income (SSI) beneficiaries who do not receive Medicare

### 2. Medicaid-Eligible Groups Who May Voluntarily Enroll in the CHCP:

- a. Migrants
- b. American Indian/Alaska Native
- c. Persons with both Medicare and Medicaid eligibility

### 3. Medicaid-Eligible Groups Excluded from Enrollment in the CHCP:

- a. Children in child care institutions
- b. Deductible clients (also known as Spenddown)
- c. Persons without full Medicaid coverage
- d. Persons with Medicaid who reside in Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID) or a state psychiatric hospital
- e. Persons receiving long-term care (custodial care) in a nursing facility
- f. Persons authorized to receive private-duty nursing services
- g. Persons being served under the Home & Community Based Elderly Waiver

#### Section IV: McLaren Health Plan

- h. Persons with commercial HMO/PPO coverage
- i. Persons in PACE (Program for All-inclusive Care for the Elderly)
- j. Persons in the Refugee Assistance Program
- k. Persons in the Repatriate Assistance Program
- l. Persons in the Traumatic Brain Injury Program
- m. Persons diagnosed with inherited disease of metabolism who are authorized to receive metabolic formula
- n. Persons disenrolled due to Special Disenrollment or Medical Exception for the time period covered by the Disenrollment or Medical Exception
- o. Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the contractor's plan
- p. Persons incarcerated in a city, county, state or federal correctional facility.
- q. Persons participating in the MI Health Link Demonstration

MHP provides administrative services and arranges for the provision of all MHP covered services, offering some additional benefits, including transportation. Each MHP Medicaid member selects a PCP, who provides the member with a medical home. Medicaid recipients are entitled to a second opinion from in- or out-of-network qualified health care professionals. Special requirements apply for out-of-network second opinions. Please contact Medical Management for assistance.

#### Medicaid Service Area – Regions/Counties:

McLaren Health Plan is contracted to service members in Regions 2-10 below.

- » Region 2. Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford
- » Region 3. Alcona, Alpena, Cheboygan, Crawford, Iosco, Ogemaw, Oscoda, Otsego, Presque Isle, Montmorency, Roscommon
- » Region 4. Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm, Newaygo, Oceana, Osceola, Ottawa
- » Region 5. Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw
- » Region 6. Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola
- » Region 7. Clinton, Eaton, Ingham
- » Region 8. Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
- » Region 9. Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw

- » Region 10. Macomb, Oakland, Wayne

### McLaren Health Plan Healthy Michigan

MHP is contracted with the MDHHS to provide medical services to members eligible for Medicaid expansion. MHP administers the benefits for Healthy Michigan members and arranges for the provision of all eligible covered services. The benefit design of the Healthy Michigan Plan ensures member access to quality health care, encourages utilization of high-value services and promotes adoption of healthy behaviors. Healthy Michigan Plan members select a PCP who provides the member with a medical home. Healthy Michigan Plan members are required to complete, in collaboration with their PCP, an annual Health Risk Assessment with the ultimate goal of achieving their healthy behavior goals.

### McLaren PPO

McLaren PPO is a fully insured product. Members do not have to select a PCP or obtain specialty care referrals. This is not a managed care product. This product is targeted toward employer groups with 50 or more employees. The majority of employees must be based in Michigan, but coverage is available for employees throughout the United States. Reimbursement is fee-for-service (FFS) with rates that are competitive with other local payers.

### McLaren Health Advantage

McLaren Health Advantage (MHA) is a self-funded PPO. This is utilized by McLaren Health Care Corporation for employee health care benefits. Reimbursement is FFS with rates that are competitive with other local payers.

### McLaren Medicare Advantage

Effective 1/01/2022, McLaren offers Medicare Advantage Plans:

- » McLaren Medicare Inspire (\$0 premium HMO)
- » McLaren Medicare Inspire Plus (HMO)
- » McLaren Medicare Inspire Flex (HMO-POS)
- » McLaren Medicare Inspire Duals (DSNP)

Reimbursement for Medicare is based on the original Medicare fee schedule. Covered services and exclusions for McLaren Medicare members are listed in the Evidence of Coverage (EOC) available at [McLarenhealthplan.org/medicare/medicare-home](https://www.McLarenhealthplan.org/medicare/medicare-home).

### McLaren Medicare Supplemental

MHP offers a Medicare Supplemental program. This is available to any individual who is receiving benefits from Medicare Part A and Part B. A supplemental plan, also referred to as Medigap coverage,

#### Section IV: McLaren Health Plan

is health care coverage that is in addition to Original Medicare. A supplement plan helps to fill in the “gaps” in coverage in Original Medicare.

**Possession of an MHP or MHA member ID card does not guarantee eligibility.  
Member eligibility should be verified through the McLaren CONNECT provider portal.**



#### MHP Member Handbook



All enrolled members are given a member handbook as a guide for using the Plan. The member handbook contains information on emergency and urgent care procedures, out-of-area coverage, benefit limitations and exclusions, the enrollment process, PCP selection, member rights and responsibilities and complaint and grievance procedures. MHP handbooks are also available at [McLarenHealthPlan.org](http://McLarenHealthPlan.org). If you or your MHP members have any questions, please contact Customer Service at (888) 327-0671.



# Section V



## Sample Member Identification Cards



### Community ID Card Examples



		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Enrollee Name</b> FIRST LAST	<b>Contract No.</b> 9999999	<b>Group No.</b> 000000	<b>Plan</b> Gold Select
<b>PERSON CODE FOR RX BILLING</b> 00 FIRST LAST	<b>Provider:</b>	<b>Select Providers</b>	<b>Out of Plan</b>
	PCP Copay:	\$25	Not Covered
	Specialist Copay:	\$50	Not Covered
	Deductible:	\$2,000/\$4,000	Not Covered
	Coinsurance:	20%	Not Covered
	Rx Co-pay:	\$30/\$65/\$150/\$350	Not Covered
	Out of Pocket Maximum:	\$6500/\$13000	Not Covered
			



		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Enrollee Name</b> FIRST LAST	<b>Contract Number</b> 9999998	<b>Group</b> 000000	<b>Plan</b> Gold Rewards
<b>PERSON CODE FOR RX BILLING</b> 00 FIRST LAST	<b>Provider:</b>	<b>Directly Contracted Providers</b>	<b>Rewards Providers</b>
	PCP Copay:	\$40	\$0 Not Covered
	Specialist Copay:	\$60	\$0 Not Covered
	Deductible:	\$3,000/\$6,000	\$0 Not Covered
	Coinsurance:	25%	\$0 Not Covered
	Rx Deductible:	\$0	N/A Not Covered
	Rx Co-pay:	\$30/\$65/ \$150/\$350	\$30/\$65/ \$150/\$350 Not Covered
	Out of Pocket Maximum:	\$8150/\$16300	N/A Not Covered
			



		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Enrollee Name</b> FIRST LAST	<b>Contract Number</b> 9999999	<b>Group</b> 000000	<b>Plan</b> Gold Rewards
<b>PERSON CODE FOR RX BILLING</b> 00 FIRST LAST	<b>Provider:</b>	<b>Directly Contracted Providers</b>	<b>Rewards Providers</b>
	PCP Copay:	\$40	\$0 Not Covered
	Specialist Copay:	\$60	\$0 Not Covered
	Deductible:	\$3,000/\$6,000	\$0 Not Covered
	Coinsurance:	25%	\$0 Not Covered
	Rx Deductible:	\$0	N/A Not Covered
	Rx Co-pay:	\$30/\$65/ \$150/\$350	\$30/\$65/ \$150/\$350 Not Covered
	Out of Pocket Maximum:	\$8150/\$16300	N/A Not Covered
			



		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Enrollee Name</b> FIRST LAST	<b>Contract No.</b> 9999998	<b>Group No.</b> 000000	<b>Plan</b> Platinum
<b>PERSON CODE FOR RX BILLING</b> 00 FIRST LAST	<b>Provider:</b>	<b>Directly Contracted Providers</b>	<b>Out of Plan Providers</b>
	PCP Copay:	\$20	Not Covered
	Specialist Copay:	\$40	Not Covered
	Deductible:	\$750/\$1,500	Not Covered
	Coinsurance:	20%	Not Covered
	Rx Deductible:	\$0	Not Covered
	Rx Co-pay:	\$25/\$55/\$100/\$300	Not Covered
	Out of Pocket Maximum:	\$2500/\$5000	Not Covered
			



		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Enrollee Name</b> FIRST LAST	<b>Contract No.</b> 9999999	<b>Group No.</b> 000000	<b>Plan</b> Platinum
<b>PERSON CODE FOR RX BILLING</b> 00 FIRST LAST	<b>Provider:</b>	<b>Directly Contracted Providers</b>	<b>Out of Plan Providers</b>
	PCP Copay:	\$20	Not Covered
	Specialist Copay:	\$40	Not Covered
	Deductible:	\$750/\$1,500	Not Covered
	Coinsurance:	20%	Not Covered
	Rx Deductible:	\$0	Not Covered
	Rx Co-pay:	\$25/\$55/\$100/\$300	Not Covered
	Out of Pocket Maximum:	\$2500/\$5000	Not Covered
			

		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Subscriber Name</b> FIRST LAST	<b>Contract Number</b> 9999999	<b>Group</b> 000000	<b>Plan</b> POS Plan 1
<b>PERSON CODE FOR RX BILLING</b> 00 FIRST LAST	<b>Co-pays/Deductibles</b>	<b>Option A</b>	<b>Option B</b>
	Office:	\$50	30%
	Emergency Room:	\$300	\$300
	Urgent Care Co-pay:	\$75	\$75
	Coinsurance:	30%	50%
	Deductible:	\$5,000/\$10,000	\$10,000/\$20,000
	Rx Deductible:	\$0	N/A
	Rx Co-pay:	\$20/\$40/\$200	Not Covered
	Out of Pocket Maximum:	\$8150/\$16300	Unlimited
			

		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Enrollee Name</b> FIRST LAST	<b>Contract No.</b> 9999999	<b>Group No.</b> 390001	<b>Plan</b> Bronze
<b>PERSON CODE FOR RX BILLING</b> 00 FIRST LAST	<b>Provider:</b>	<b>Directly Contracted Providers</b>	<b>Out of Plan Providers</b>
	PCP Copay:	50% After Deductible	Not Covered
	Specialist Copay:	50% After Deductible	Not Covered
	Deductible:	\$6,500/\$13,000	Not Covered
	Coinsurance:	50% After Deductible	Not Covered
	Rx Deductible:	\$0	Not Covered
	Rx Co-pay:	\$25/\$75/50%/50%	Not Covered
	Out of Pocket Maximum:	\$8700/\$17400	Not Covered
			

		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Enrollee Name</b> FIRST LAST	<b>Contract No.</b> 9999998	<b>Group No.</b> 690001	<b>Plan</b> Bronze
<b>PERSON CODE FOR RX BILLING</b> 00 FIRST LAST	<b>Provider:</b>	<b>Directly Contracted Providers</b>	<b>Out of Plan Providers</b>
	PCP Copay:	50% After Deductible	Not Covered
	Specialist Copay:	50% After Deductible	Not Covered
	Deductible:	\$6,500/\$13,000	Not Covered
	Coinsurance:	50% After Deductible	Not Covered
	Rx Deductible:	\$0	Not Covered
	Rx Co-pay:	\$25/\$75/50%/50%	Not Covered
	Out of Pocket Maximum:	\$8700/\$17400	Not Covered
			

		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Subscriber Name</b> FIRST LAST	<b>Contract Number</b> 9999999	<b>Group</b> 190128	<b>Plan</b> HDHP Plan 1
<b>PERSON CODE FOR RX BILLING</b> 00 FIRST LAST	<b>Co-pays/Deductibles</b>		
	Deductible \$1,400/\$2,800		
	Rx Deductible \$0		
	Rx Co-pay After Deductible \$10/\$25/\$40		
	100% After Deductible is Met		
	Out of Pocket Maximum \$2,800/\$5,600		
			

		Toll-free Phone (888) 327-0671 McLarenHealthPlan.org	
HEALTH PLAN COMMUNITY			
<b>Subscriber Name</b> First Last	<b>Contract Number</b> 9999999	<b>Group</b> 190128	<b>Plan</b> HDHP Plan 1
<b>PERSON CODE FOR RX BILLING</b> 00 First Last	<b>Co-pays/Deductibles</b>		
	Deductible \$1,400/\$2,800		
	Rx Deductible \$0		
	Rx Co-pay After Deductible \$10/\$25/\$40		
	100% After Deductible is Met		
	Out of Pocket Maximum \$2,800/\$5,600		
			

Section V: Sample Identification Cards

Advantage ID Card Examples

**McLaren** HEALTH ADVANTAGE  
Toll-free Phone (888) 327-0671  
McLarenHealthPlan.org

Enrollee Name: FIRST LAST  
Contract No.: 9999999  
Group No.: 485  
Plan: Marwood

Provider:	McLaren Domestic Providers	McLaren Health Advantage Providers	Out of Plan Providers
PCP Copay:	\$15	\$25	50% AFTER DEDUCTIBLE
Specialist Copay:	\$30	\$30	50% AFTER DEDUCTIBLE
Deductible:	\$200/\$400	\$750/\$1500	\$2000/\$4000
Coinsurance:	20% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	50% AFTER DEDUCTIBLE
Rx Deductible:	\$0	\$0	\$0
Rx Copay:	\$0	\$10/\$30/\$50	\$0
Out of Pocket Maximum:	\$8700/\$17400	\$8700/\$17400	\$11000/\$22000

MediImpact

**McLaren** HEALTH ADVANTAGE  
Toll-free Phone (888) 327-0671  
McLarenHealthPlan.org

Enrollee Name: FIRST LAST  
Contract No.: 9999999  
Group No.: 100  
Plan: PREMIER

Provider:	McLaren Domestic Providers	McLaren Health Advantage Providers	Out of Plan Providers
PCP Copay:	\$25	\$40	50% AFTER DEDUCTIBLE
Specialist Copay:	\$40	\$40	50% AFTER DEDUCTIBLE
Deductible:	\$500/\$1000	\$500/\$1000	\$2000/\$4000
Coinsurance:	80% AFTER DEDUCTIBLE	80% AFTER DEDUCTIBLE	50% AFTER DEDUCTIBLE
Rx Deductible:	\$0	\$0	\$0
Rx Copay:	\$0	\$10/\$30/\$50	\$0
Out of Pocket Maximum:	\$8700/\$17400	\$8700/\$17400	\$15000/\$30000

MediImpact

**McLaren** HEALTH ADVANTAGE  
Toll-free Phone (888) 327-0671  
McLarenHealthPlan.org

Enrollee Name: FIRST LAST  
Contract No.: 9999999  
Group No.: 100  
Plan: Supplemental Flirt

MediImpact

Medicaid & Medicare ID Card Examples

**McLaren MEDICAID** 24 Hour # (888) 327 0671  
www.McLarenHealthPlan.org/Medicare

Member Name: FIRST LAST  
Member ID: 9999999999  
PCP Name: PCPFirst PCPLast  
PCP Phone: 999-999-9999

Please show this card each time you get health care services.

**McLaren** MEDICARE  
Toll-free 833-358-2404  
www.McLarenHealthPlan.org/Medicare

Member Name: FIRST LAST  
Member ID: 9999999999  
Issuer: (80840)  
Plan Name: Inspire Plus

Rx BIN: 015574  
Rx PCN: ASPROD1  
Rx GRP: ML500

CMS Contract #: H6322-002

Medicare Rx Prescription Drug Coverage

**McLaren** MEDICARE  
Toll-free 833-358-2404  
www.McLarenHealthPlan.org/Medicare

Member Name: FIRST LAST  
Member ID: 9999999999  
Issuer: (80840)  
Plan Name: Inspire Flex

Rx BIN: 015574  
Rx PCN: ASPROD1  
Rx GRP: ML500

CMS Contract #: H6322-003

Medicare Rx Prescription Drug Coverage

**McLaren** MEDICARE  
Toll-free 833-358-2404  
www.McLarenHealthPlan.org/Medicare

Member Name: FIRST LAST  
Member ID: 9999999999  
Issuer: (80840)  
Plan Name: Inspire Duals

Rx BIN: 015574  
Rx PCN: ASPROD1  
Rx GRP: ML501

CMS Contract #: H6322-004

Medicare Rx Prescription Drug Coverage

**McLaren** MEDICARE  
Toll-free 833-358-2404  
www.McLarenHealthPlan.org/Medicare

Member Name: FIRST LAST  
Member ID: 9999999999  
Issuer: (80840)  
Plan Name: Inspire

Rx BIN: 015574  
Rx PCN: ASPROD1  
Rx GRP: ML500

CMS Contract #: H6322-001

Medicare Rx Prescription Drug Coverage

**McLaren MEDICARE SUPPLEMENT**  
Toll-free Phone (888) 327-0671

FIRST LAST  
Member Number: 9999999  
Medicare Supplement Plan A  
Member since 11/1/2022

McLarenHealthPlan.org/MedicareSupplement

**McLaren HMP** 24 Hour # (888) 327 0671

Member Name: FIRST LAST  
Member ID: 9999999999  
PCP Name: PCPFirst PCPLast  
PCP Phone: 999-999-9999

Please show this card each time you get health care services.

## Section VI

# Provider Network

### National Provider Identifier (NPI)

All providers must bill MHP using their unique rendering and billing (if applicable) NPI for claims to be accepted for processing. Providers can apply for their NPI at the CMS website, [nppes.cms.hhs.gov](https://nppes.cms.hhs.gov).

### Participating (Contracted) Providers

MHP has contracted with an extensive network of quality providers to deliver health care to its members. Unless the member's benefit allows, members must receive health care services from providers in the MHP network who are listed in the provider directory. The provider directories for McLaren Medicaid, Healthy Michigan Plan, McLaren HMO, McLaren PPO, McLaren POS, McLaren Rewards, McLaren Medicare Advantage and McLaren Health Advantage can be found at [McLarenHealthPlan.org](https://McLarenHealthPlan.org). For example, if an MHP member needs to be hospitalized for an elective inpatient procedure, an MHP network hospital must be used (in addition, inpatient hospital care requires preauthorization).

### Background Checks

Upon request, McLaren Health Plan must perform background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the state and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The state, in its sole discretion, may also perform background checks.

### Culturally and Linguistically Appropriate Services (CLAS) Training Requirement

CLAS is a way to improve the quality of services provided to all individuals. By tailoring services to an individual's culture and language preference, health professionals can bring about positive health outcomes for diverse populations.

CLAS training is an NCQA requirement for all providers and staff. McLaren Health Plan is pleased to offer CLAS training online at [www.mclarenhealthplan.org](http://www.mclarenhealthplan.org). The training provides an overview of CLAS standards, legal requirements, communication standards, continuous improvement recommendations and member diversity.

We are requesting that each provider location complete the CLAS training online and sign the attestation included in the presentation (one per office location). **Fax your completed attestation to (810) 733- 9651.**

(If you have completed CLAS training with another health plan, we will accept their signed attestation.)

## Nonparticipating Providers

### McLaren Community HMO, McLaren Medicaid and Healthy Michigan Plan

Preauthorization for services from a nonparticipating provider must be obtained from Medical Management prior to services being rendered. Preauthorization will be considered in the following situations:

- » When a covered service is needed but not available within the network
- » When the member needs emergent care while outside the MHP service area and travel back to the service area is not feasible
- » When a member has begun an episode of care prior to becoming an MHP member (continuity of care)

### McLaren PPO, McLaren Health Advantage and McLaren Community POS

Members can seek services from in-network and out-of-network providers. Members seeking services from out-of-network providers may be responsible for higher coinsurance and/or deductibles. Please refer to Section X, Referral and Authorization Requirements for more detail.



## Section VII

# Role of the PCP

McLaren Community HMO, McLaren Community POS, McLaren Medicaid and Healthy Michigan Plan members must select a PCP at the time of enrollment. If a member does not choose a PCP, MHP will assign a PCP to that member. A PCP is an MHP participating physician who has contracted to provide primary care services and to coordinate and manage the member's access to all health services. Each family member must select a PCP and members have the right to change PCPs.

MHP recognizes the following groups of providers as PCPs\*:

- » Family Practice Physicians
- » General Practice Physicians
- » Internal Medicine Physicians
- » Pediatricians
- » Nurse Practitioners\*
- » Physician Assistants\*

\*Under certain circumstances, a member can request primary care services be provided by a participating specialty care physician. For further information, contact Customer Service at (888) 327-0671.

### **\*Physician Assistants (PAs) and Nurse Practitioners (NPs)**

Except in an emergency situation, PAs and NPs shall provide medical care services only under the supervision of a physician or properly designated alternative physician, and only if those medical care services are within the scope of practice of the supervising physician and are delegated by the supervising physician.

PAs and NPs shall conform to the minimal standards of acceptable and prevailing practice for the supervising physician.

The supervising physician must be a contracted in-network provider of MHP and credentialed by MHP.

PAs and NPs shall only prescribe drugs as a delegate of a supervising physician in accordance with applicable laws, regulations and rules.

PAs and NPs must comply with all other applicable laws, regulations and rules. Primary care services should be provided to a member by his/her designated PCP or physician designated to cover for that PCP. Examples of primary care services are:

- » Annual physical exams

## Section VII: Role of the PCP

- » EPSDT visits (Medicaid only)
- » Preventive care and screenings
- » Sudden onset of illness
- » Management of chronic conditions
- » Laboratory and diagnostic tests performed routinely in an ambulatory care setting

Eligibility can be verified on the McLaren CONNECT provider portal. Contact Customer Service at (888) 327-0671 for information on accessing and using McLaren CONNECT.

### PCP as the Care Coordinator

When required, the PCP is the member's care coordinator. As such, the PCP is expected to coordinate and manage the member's utilization of specialty care, ancillary services and inpatient services. When a member needs non-emergent inpatient care, MHP recommends that the PCP coordinates the entire episode of care (i.e., initiate the admission or collaborate with the admitting specialist/hospitalist) to ensure timely initiation and appropriate utilization of health services. Case Management nursing staff can assist in this process and can be reached at (888) 327-0671.

### Children's Special Health Care Services (CSHCS) PCP

MHP, through its contract with the MDHHS, is responsible for working with our provider network to coordinate care for all CSHCS-eligible members. To ensure that MHP has PCPs available to handle the complex needs of CSHCS enrollees, MHP PCPs are eligible to receive a care management fee for all MHP CSHCS members assigned to their panel. To become a CSHCS PCP, you must complete a CSHCS readiness survey. This brief survey is required by the MDHHS to ensure that primary care requirements necessary for CSHCS members can be met. If you would like to become a CSHCS PCP, please contact your Provider Relations Representative at (888) 327-0671.

### PCP Case Management Program

Case management is a collaborative process that assists the member in accessing care. MHP's Case Management Program includes the PCP. MHP proactively assigns a nurse case manager to each PCP to assist the PCP and/or office staff with any member issues (e.g., arranging community services, assisting patients in keeping their appointments, etc.).

The goal of this program is for MHP to be the physician's advocate. The program has proved successful in many ways, as the PCP has additional resources that can support the management of his or her caseload and at the same time helps to resolve the individual member's concerns.

Please involve Case Management with the care management of your patients. If you need further assistance, please contact Medical Management at (888) 327-0671. If you have a member who would benefit from a contact by a nurse case manager, please complete a Referral to Case Management form.

Forms are available at McLarenHealthPlan.org and can also be obtained by contacting your Provider Relations Representative.

### Gaps in Care Reports

Gaps in Care reports are sent to MHP Primary Care Providers (PCPs). These reports identify a PCP's assigned membership and services that have not been completed for the member based on current HEDIS specifications. Reports are closed when a member receives the service and a claim has been billed to MHP. It is necessary for all MHP PCPs to review their Gaps in Care reports and ensure that all services provided have been submitted to MHP. If you find that you have billed a service but your report still shows it as outstanding, please contact MHP's Quality Management department at (810) 733-9524 to confirm receipt of the claim or to discuss why the claim did not meet the gap closure.

You can supplement your claim data by faxing medical records to MHP at (810) 733-9653. Supplemental medical records can be sent to MHP for the following measures:

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

If you have questions, please contact MHP Customer Service at (888) 327-0671 and ask for the Quality department.

### Accessibility of Care

The established monitoring standards are set as minimum guidelines of measurement. The following are the MHP Commercial, Marketplace and Medicaid/Healthy Michigan Plan standards for PCP accessibility to members:

Type of Service	Standard
Emergency Services	Immediately 24 hours per day / 7 days per week
Urgent Care	Within 48 hours
Routine/Regular Care including preventive services (physicals)	Within 30 business days of request

Section VII: Role of the PCP

Type of Service	Standard
Non-Urgent Symptomatic Care	Within 7 business days of request
In Office Wait Time	Patient seen within 30 minutes of time of their appointment
After-Hours Coverage (Information/advice is given to patients when medical care is needed after regular office hours)	100%
Customer Service Line - Speed to Answer	80% of calls are answered within 30 seconds
Customer Service Line - Abandonment Rate	5% or less

The following are the McLaren Health Plan Commercial, Marketplace, and Medicaid monitoring standards for high-volume and high impact provider accessibility to members:

Type of Service	Standard
Routine Specialty Care (non-urgent)	Within 30 business days of request
Acute Specialty Care	Within 5 business days of request

The following are the McLaren Health Plan Commercial, Marketplace, and Medicaid monitoring standards for behavioral health (BH) provider accessibility to members:

Visit Type	Timeframe
BH Non-Life-Threatening Emergency	Within 6 hours of request
BH Urgent	Within 48 hours of request
BH Initial Visit for Routine Care	Within 10 business days of request
BH Follow-up for Routine Care	Within 45 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's any indication of the pregnancy being high-risk (regardless of trimester): Within 3 business days.

The following are the McLaren Health Plan Medicaid monitoring standards for dental provider accessibility to members, as monitored and managed by Delta Dental:

Visit Type	Timeframe
Emergency Dental Services	Immediately 24 hours per day, 7 days per week
Urgent Dental Care	Within 48 hours
Routine Dental Care	Within 21 business days of request
Preventive Dental Services	Within 6 weeks of request
Initial Appointment	Within 8 weeks of request

An annual evaluation and analysis is conducted by Quality Improvement staff on the following:

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

Results are reported to the Quality Improvement committee. MHP requires an 80 percent compliance rate for all access measures. Those providers who do not meet the 80 percent requirement will be notified and requested to submit a corrective action plan to MHP within 30 days. Failure to comply with this requirement may result in deparicipation.

## Section VII: Role of the PCP

### Coverage Responsibilities

The hours of operation that practitioners offer to Medicaid members must be no less than those offered to commercial members. All services are available 24 hours a day, 7 days a week when medically necessary.

Acceptable after-hours access methods include:

- » An answering service
- » On-call paging system
- » Call forwarded to physician's cell phone or other contact phone
- » Recorded message with instructions directing the member to another provider

There must be a method to talk to a physician 24/7 regarding after-hours care for urgent or non-life-threatening conditions. There must also be instructions to call 911 or go to the emergency department for life-threatening situations. Members with non-life-threatening behavioral health emergencies should be directed to the nearest emergency room or behavioral health crisis units.

The message should not direct members to seek after-hours care at the nearest emergency department for non-life-threatening situations.

In the event the provider utilizes covering physician(s), we recommend the covering physician also be a participating MHP physician. It is the PCP's responsibility to ensure that his or her members have access to a covering physician when the PCP is not available. If the PCP is paid on a per-member, per-month basis (capitation), financial reimbursement for services rendered by the covering physician is also the responsibility of the PCP.

MHP expects the PCP to maintain ultimate responsibility for managing the member's care, even when a covering physician provides a portion of the care.

Non-contracted physicians who are covering a contracted physician must receive preauthorization before services can be rendered to a member.

### Accepting Status of Primary Care Practices

The MHP Community HMO, POS and Medicaid/Healthy Michigan Plan products assign members to a PCP upon enrollment. Each contracted PCP is designated to have an open practice, unless a request to close a practice has been made and approved.

### Changing the Accepting Status of a Practice

Changing the acceptance status of a practice requires the following 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:
  - a. The reason for the request to limit members
  - b. Attestation that your practice is being closed to all other health plans
  - c. Anticipated time frame new enrollment is to be limited
  - d. Signature of physician making the request
3. Mail the letter to your MHP Provider Relations Representative:

McLaren Health Plan  
Attn: <Name of Provider Relations Representative>  
G-3245 Beecher Road  
Flint, MI 48532

4. The request is reviewed and approved by the Provider Relations Manager following verification of membership assigned to the PCP.
5. The Provider Relations Representative will respond in writing to the provider'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 with office space
- » Leave of absence
- » Provider agreement language

**If a request for acceptance 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 acceptance status will revert to "open" to accepting new MHP members.**

### Opening a Practice

A participating PCP may open a practice at any time by submitting a letter, on office letterhead, to their Provider Relations Representative or by calling (888) 327-0671, requesting that the practice be open to new MHP members.

## Section VII: Role of the PCP

### Data Reporting

All providers must submit claims to MHP for every encounter or consultation provided to a member. MHP encourages providers to submit claims within 60 days of the date of service in order to document service utilization. MHP needs encounter data to document the amount of work health care providers perform on a member's behalf. This data is used to track utilization (the content, type and timing of services) to monitor over-utilization and under-utilization of services and for required documentation to state regulators, the Healthcare Effectiveness Data and Information Set (HEDIS) and accrediting bodies. If MHP does not receive encounter data, it will be assumed that no visit or consultation has taken place, which could have a negative impact on your future reimbursement rates.

MHP expects all providers to submit claims even when MHP is the secondary payer and no reimbursement is due from MHP.

Professional services should be reported on a standard CMS 1500 form to report all encounters and billable services provided.

Please refer to Submitting a Claim in Section XII of this Provider Manual for further details on the data elements required for billing.

### Procedures for Dismissing Members for Disruptive Behavior or Fraud and Abuse

Participating health care providers can request that an MHP member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include noncompliance with medication schedules, no-show office policies or failure to modify behavior as requested. Anytime a member misses three or more consecutive appointments, providers are expected to notify Customer Service for assistance.

Providers shall not discriminate against members when terminating from their practice. Involuntary dismissal policies must be designed and implemented in a neutral, nondiscriminatory manner.

We strongly recommend that your office make at least three attempts to educate the member about noncompliant behavior and document them in the patient's record. Please remember that MHP can assist you in educating the member. After three attempts, providers may initiate the dismissal by following the guidelines below:

- » The provider office must notify the member of the dismissal by certified letter
- » A copy of the letter must be sent to MHP at the following address:

McLaren Health Plan  
Attn: Customer Service Manager  
G-3245 Beecher Road  
Flint, MI 48532

You can also fax the dismissal letter to: (833) 540-8648.



**For PCPs only**, the letter must contain specific language stating that:

- » The member must contact MHP to choose another PCP
- » The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal

When a member changes to a new PCP, the provider must forward the member's medical records or copies of medical records to the new PCP at no cost within ten (10) working days from receipt of a written request.

### Membership Moves

As an open and accepting status Primary Care Provider, it's essential for you to make outreach attempts to those members assigned to your practice. The goal is to establish care and create a patient/practitioner relationship. McLaren expects Primary Care Offices to make multiple and varied outreach efforts, including phone calls, letters, postcards, text messaging or email. We understand there are sometimes circumstances where a member would still need to be removed from your member listing. The instances to which McLaren will move members include:

- » Formal member discharge from practice due to relationship breakdown, violence or inappropriate behavior to the office staff, other patients or the provider. Providers must offer coverage of health services for 30 days following a formal discharge to allow appropriate time to find a new provider.
- » Member does not live in the same county or area as your practice. McLaren will assist with outreach to move a member to a more appropriate Primary Care Provider.
- » Retirement, death or moving of a Primary Care Provider from an office location. This information must be provided to McLaren in order to move any assigned membership.

McLaren outreach staff are available to assist offices with outreach efforts if an office finds that after multiple, varied attempts they are unsuccessful at contacting a member and establishing care. However, McLaren is unable to move members without their consent or failed outreach attempts by the office.

## Section VIII

# Immunizations

### Michigan Care Improvement Registry (MCIR)

The Michigan Public Health Code and Communicable Disease Rules require that immunization providers report vaccines administered to children born after 12/31/93. Registering with MCIR facilitates meeting this reporting requirement. MHP providers must register with MCIR at (888) 217-3900 or [mcir.org](http://mcir.org). In addition, all vaccines administered to all MHP members must be reported to MCIR.

### Vaccines Available Through Local Health Department

Michigan physicians may obtain many childhood vaccines, and some vaccines for adults, through the public health system for patients meeting specific eligibility requirements. Health care professionals should check with their local health department regarding the availability of these vaccines for both children and adults.

### Vaccines for Children (VFC) Programs

Protecting children from diseases that can be prevented by vaccination is a primary goal of MHP and the MDHHS. The federally funded Vaccines for Children Basic (VFC-Basic) and Vaccines for Children Expanded (VFC-Expanded) Programs are cooperatively run by local and state public health departments. These programs provide free vaccines for children who are enrolled in Medicaid, have no insurance, are American Indian or Alaskan Native or are underinsured.

Vaccines are covered for all MHP Medicaid members through the VFC Program. MHP reimburses practitioners for vaccine administration. However, you may want to consider participating in this program to ensure that all children in your practice, regardless of their insurance status, have access to appropriate immunizations as recommended by MHP's Pediatric Preventive Care Guidelines and the Alliance for Immunizations in Michigan (AIM).

If you are not already a VFC provider and you want to learn more about VFC, contact the immunization program at your local health department or the MDHHS Communicable Diseases and Immunization service at (517) 335-8159.

### Michigan Vaccine Replacement Program (MI-VRP)

The MI-VRP program provides certain vaccines for qualifying adults 19 years of age or older at the local health department and, under certain circumstances, at private providers' offices.

## Section IX

# Emergency and Urgent Care

Patients often find it difficult to distinguish between an urgent health care need and a medical emergency. Therefore, MHP members are instructed to contact their PCP if a medical problem or question arises that the member believes should be taken care of right away.

### Definitions

Emergency care is defined as a sudden and/or unexpected sickness or injury that could result in a serious problem or death if not treated right away. Examples of emergency conditions include:

- » Serious bleeding
- » Loss of consciousness
- » Convulsions or seizures
- » Severe breathing problems
- » Fracture
- » Chest pain
- » Sudden high fever in a child

Urgent health problems are not life threatening, but they may require immediate attention. Members are encouraged to contact their PCP if they experience a health problem they believe requires immediate attention. Examples of common urgent health problems include:

- » Severe sore throat
- » Minor cuts and bruises associated with trauma
- » Sprains
- » Rashes
- » Severe headache
- » High fevers
- » Earache

A PCP or covering physician must be available 24 hours a day, seven days a week to provide or arrange for coverage of services.

### Emergency Care Program

MHP has developed an Emergency Room program that identifies high utilizers and provides member education and support. The relationship between PCPs and their patients is an important one. The PCP

## Section IX: Emergency and Urgent Care

is contracted to coordinate the care of MHP members 24 hours a day, seven days a week. At MHP, we realize this is not always easy or convenient, but caring for a patient's urgent medical problems instead of automatically referring a member to the emergency department fosters your relationship with your patient, reduces member anxiety and provides continuity of care.

Members who have multiple visits to the emergency department within a six-month period are contacted by their MHP case manager. They work collaboratively with the member and the PCP to identify needs the member may have that contribute to high utilization of the emergency department. Case managers ensure the member has established a relationship with their PCP and educate members on appropriate use of the emergency department.

Please contact Medical Management at (888) 327-0671 for more details.

### PCP's Role in Urgent and Emergency Care

Members must contact their PCP prior to an emergency department visit unless the member has what he or she believes to be a life-threatening emergency. If the PCP is contacted, an assessment of the situation for severity should determine the appropriate course of action (e.g., STAT office visit, urgent care visit, emergency department visit or regular office visit). If an urgent care or emergency department visit is required, authorization is not needed. However, when a member notifies his or her PCP of an intended emergency department visit, the PCP should call the emergency department to alert them on the member's behalf. The PCP should notify MHP no later than the next day of the emergency department visit.

If the member self-refers for emergent care, the emergency department staff will evaluate the member's condition. The member will be treated, stabilized and the PCP contacted. If the condition is non-life threatening, the PCP is contacted by the emergency department staff allowing him or her the option of caring for their patient at this point or authorizing emergency department treatment. The PCP must arrange for all follow-up care.

The PCP or covering physician is responsible for coordination of urgent problems 24 hours a day, seven days a week.

### Out-of-Area Emergent Care

When an MHP member presents to an out-of-area facility for emergency care, the institution providing this emergency care (or emergency admission) must notify MHP no later than the next business day.

### Out-of-Area Non-Emergent Care

MHP's members may be eligible to receive non-emergent or routine covered services while outside the MHP service area (with prior approval from the Plan) under the following circumstances:

- » When travel back to the service area is not possible or is impractical
- » When preauthorization is obtained from MHP

## Member Responsibility

If the member feels they have an emergent medical condition and doesn't have time to call the PCP, they're instructed to go to an MHP participating hospital emergency department or the nearest emergency department or call 911.

Members who go to an urgent care or emergency department are instructed to identify themselves as MHP members and present their MHP member identification card.

Members are encouraged to notify their PCP within 24 hours or the next business day, of an urgent care or emergency department visit to ensure that appropriate and immediate follow-up care may be arranged.

## Section X

# Referral and Preauthorization Requirements

MHP promotes the traditional primary care relationship between physicians and their patients. PCPs are generally responsible to issue referrals for care outside of the PCP office setting. MHP recommends that the PCP coordinates the entire episode of care to ensure the timely initiation and appropriate utilization of health services. We do recognize there are certain situations and circumstances in which the specialist provider would be more appropriate to request services. Therefore, referrals and request for preauthorization are also accepted from the specialist provider.

The Provider Referral and Preauthorization form is used by MHP to obtain preauthorization when certain services outside of the PCP office setting are requested. The Provider Referral and Preauthorization form is available electronically for completion and submission to MHP at [McLarenHealthPlan.org](http://McLarenHealthPlan.org). Electronic clinical notes should be attached. An electronic **preauthorization request** can be submitted. The electronic form can be accessed at [McLarenHealthPlan.org](http://McLarenHealthPlan.org) > Providers > Medical Management and Authorization > Provider Preauthorization Form. The form also can be printed from the same webpage and submitted via fax to (810) 600-7959.

Use of the electronic form is secure and is the preferred method of submitting requests for preauthorization of services to MHP. Urgent requests for preauthorization may be made by contacting Medical Management at (888) 327-0671. MHP Medical Management strives to respond to provider requests for preauthorization of services in an efficient and prompt manner. MHP uses the following time frames for timeliness of non-behavioral health care utilization management decision-making:

- » For non-urgent pre-service decisions, MHP makes decisions within 14 calendar days of receipt of the request
- » For urgent, pre-service decisions, MHP makes decisions within 72 hours of receipt of the request
- » For urgent concurrent review, MHP makes decisions within 24 hours of the request
- » For post-service decisions, MHP makes decisions within 30 calendar days of receipt of the request

Providers will be notified by fax of the utilization management decision.

As a reference guide, there is a complete list of service codes requiring preauthorization for each line of business. There also is a complete list, by CPT code, of procedures that do and do not require preauthorization on the website in the same location as the Provider Referral form.

MHP does not require any preauthorization for in-network (contracted) specialty consultations, or for care provided in the specialist office. However, preauthorization is required regardless of the contracted status of the physician for:

- » Certain injections given in a specialist office

In summary, a completed Provider Referral and Preauthorization form and preauthorization are required for:

- » Any care that is referred to an out-of-network (non-contracted) physician
- » Any service listed on the back of the Provider Referral form
- » Certain injections (please call Medical Management for clarification)

In addition, any health care provider who is not a participating provider with MHP must obtain preauthorization for all non-emergency services provided.

Please note that preauthorization requirements are subject to change. Please refer to [McLarenHealthPlan.org](http://McLarenHealthPlan.org) for the most current information on services that require preauthorization and the preauthorization process. MHP's list of service codes requiring preauthorization is available on our website. Updates, changes and clarifications to authorization requirements will be completed on a quarterly basis. Any updates, changes or clarifications will be effective January, April, July and October of each year.

Preauthorization requests are subject to a medical review by MHP and may require additional information and/or documentation before a service can be approved.

When completing the **Provider Referral and Preauthorization form**:

- » There is an option of requesting an office consult with or without follow-up visits
- » Provider must contact MHP to add any testing, outpatient procedures or additional consults to other specialists to the original office consult referral
- » An in-network specialist can complete the Provider Referral form to request authorization for services in the non-office setting, such as:
  - » Outpatient surgery
  - » MRI
  - » Physical therapy

The following fields are required on the **Provider Referral and Preauthorization form**:

- » Request date
- » Member's plan
- » Patient information
- » Requestor information
- » Referred to information including NPI

## Section X: Referral and Preauthorization Requirements

- » Diagnosis/procedure code
- » Facility information
- » Requested service

If these fields are not appropriately completed, the referral will be returned to the requesting office and will not be processed by MHP.

Referrals are valid for the duration of the episode of care, not to exceed one year. The provider may request follow-up or subsequent visits on the same referral form. If the episode of care exceeds one year, a new referral will need to be generated.

MHP will return the form to the requesting provider authorized, redirected, pending or not authorized. If the referral is authorized, MHP will complete the Authorization Request Response form with the authorization number and fax the referral back to the requestor. The authorization number is automatically activated upon receipt and remains subject to member eligibility on the date of service.

### Inpatient Hospital Services: Provider

All patient hospital admissions require preauthorization (except in emergency situations). For inpatient elective or urgent admissions, the provider must contact Medical Management by calling (888) 327-0671 toll free or by calling your Case Management nurse. For **elective admissions**, notify MHP at least seven (7) business days in advance, and for **urgent admissions**, notify MHP prior to admission or within 24 hours (or next business day). Include the clinical information that supports the need for inpatient care.

All elective and urgent hospitalizations must be made to an MHP network hospital unless **prior** approval from Medical Management has been obtained.

### Inpatient Hospital Services: Facility

Contracted facilities must notify MHP of all admissions and provide clinical information within one business day of the admission. Timely facility notification allows us to ensure our members are receiving care in the most appropriate setting, that our Medical Management nurses are involved in the member's care, including discharge planning, and that case management is initiated when appropriate.

Notify us of admissions by telephone or fax:

**Telephone:** (888) 327-0671 (toll free) | **Fax:** (810) 600-7960 | (810) 733-9645 (direct)

If the clinical information meets MHP's criteria for admission, an authorization will be given. If additional information is needed to verify the level of care for any admission, an Authorization Process is faxed to the hospital. After medical review, the form is returned with the final authorization number for reimbursement purposes. In addition, for all inpatient admissions, Medical Management will conduct concurrent reviews. Concurrent review of inpatient admissions requires frequent and comprehensive



updates to verify need for continued stay and to aid in discharge planning. If adequate and timely information is not received during concurrent review, the status of the authorization may be adversely affected. Also, notification of the inpatient admission is required prior to a member's discharge. This includes a required notification to MHP of a member's date of discharge. Failure to supply the information necessary may result in nonpayment of a hospital admission. The member's Case Management nurse will work with the hospital staff in managing the stay and assist with the planning and determining discharge needs.

When an admission occurs through the emergency room, we ask the hospital to contact the PCP prior to admission to discuss the member's medical condition and to coordinate care prior to admitting.

For inpatient obstetrical admissions, MHP requires hospitals to provide both admission and discharge information for all deliveries. The following information must be provided within 48 hours of delivery:

- » Admission date
- » Delivery date
- » Discharge date
- » Type of delivery
- » Status of the mother and baby

Newborns discharged home with their mothers from the newborn nursery do not require a separate authorization from their mother. However, we do require a separate authorization within 24 hours when the newborn requires extended services. Examples include when a newborn:

- » Is admitted directly into the NICU or special care nursery from the delivery room
- » Is transferred to an NICU or special care nursery from the newborn nursery
- » Remains in the nursery after the mother is discharged

If questions arise regarding the appropriateness of any inpatient admission or the course of treatment, a concurrent review nurse or MHP's Chief Medical Officer will contact the hospital utilization review staff and/or the admitting physician to discuss the case. Please contact Medical Management at (888) 327-0671 for further details.

### Outpatient/Observation Stay: Facility

Sometimes a facility may request inpatient authorization for an episode of care when an outpatient authorization is more appropriate. MHP considers an episode of care to be more appropriately authorized as outpatient when medical documentation reveals that a patient's presenting symptoms have been stabilized or resolved with emergency room treatment but additional time is needed for continued short-term treatment and/or observation.

## Section X: Referral and Preauthorization Requirements

In addition to the evaluation of the emergency room treatment results, many other factors are also considered, such as the patient's medical history, medical predictability of adverse outcomes with presenting signs and symptoms, and the expectation that the episode of care may be resolved in a short period.

Also, to help identify outpatient stays, system edits will identify an episode of care lasting less than 48 hours and members with a specific presenting diagnosis. Examples of diagnoses that may be reviewed for reimbursement as an outpatient include:

- » Asthma
- » Bronchitis/bronchiolitis
- » Cellulitis
- » Chest pain
- » Closed-head injury without loss of consciousness
- » Dehydration (gastroenteritis)
- » Overdose/alcohol intoxication
- » Pain: e.g., abdominal, head, back
- » Pneumonia
- » Pyelonephritis
- » Syncope

If the clinical information suggests that the admission requires outpatient authorization and the hospital is pursuing an inpatient authorization, additional clinical information will be required. The Authorization Process Form will be faxed to the hospital to aid in the determination of the final authorization for reimbursement. After medical review, the form is returned with the final authorization number for reimbursement purposes.

MHP will respond to a non-contracted facility's request for approval of post-stabilization services within one (1) hour. If MHP does not respond within one (1) hour, the post-stabilization services (hospitalization or other health care services) will be prior authorized for payment. Payment and authorization for an inpatient hospitalization in this instance will be for inpatient DRG, not as observation payment.

Additionally, outpatient reimbursement for observation care is **not payable** in the following situations:

- » After outpatient surgery – Reimbursement for recovery room care is included in the outpatient surgical fees

- » For monitoring of pregnancy-related conditions such as preterm labor, hyperemesis gravidarum, and gestational diabetes. These services are billable in the outpatient setting using the labor room/delivery room revenue code only.

### Readmissions: Facility

MHP reviews all inpatient readmissions when readmission occurs within 15 days after a member is discharged. We review cases to determine if the readmission is related to the first admission for reasons such as:

- » Premature discharge or a continuity-of-care issue
- » Lack of, or inadequate, discharge planning
- » A planned readmission
- » Complications from surgery performed on first admission

The outcome of the review may impact the hospital's reimbursement. When providing clinical review for members readmitted to the same hospital within 15 days, please provide a clinical review for the last two days of the first admission and an admission review when calling in the second admission. If readmission involves a different facility, MHP will seek the clinical information from the first admission to determine if either hospital's reimbursement is impacted.

### Emergency Care Requires Outpatient Surgery

When a member is transferred from the emergency room for any outpatient surgical procedures, the hospital must call Medical Management at (888) 327-0671 to obtain authorization for the services.

## Section XI

# General Information

### Physician Office Laboratory Services

MHP providers who perform laboratory tests in their office must demonstrate that they have either 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 providers and specialist. Please see the MHP In-Office Laboratory Billable Procedures form for a complete list of CPT codes that are billable when performed in an office setting.

### Clinical Practice Guidelines (MQIC)

MHP has adopted the Michigan Quality Consortium's (MQIC) Clinical Practice Guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances and behavioral health care services. These guidelines may be found at <http://mqic.org> and [www.McLarenHealthPlan.org/medicaid-provider/provider-guidelines-mhp.aspx](http://www.McLarenHealthPlan.org/medicaid-provider/provider-guidelines-mhp.aspx). The MQIC guidelines are evidence-based and include both physical conditions such as asthma and diabetes, and behavioral health conditions such as depression and attention-deficit/hyperactivity disorder for children and adolescents. The guidelines are reviewed every two years for needed updates.

### Joint Venture Hospital Laboratories (JVHL)

MHP uses JVHL as our provider for laboratory services. JVHL will provide you and your patients with responsive, convenient, high-quality services. JVHL specializes in outreach laboratory services with more than 400 phlebotomy locations, full-time courier services and 24/7 client service support. You may contact JVHL at (800) 445-4979 or visit [www.jvhl.org](http://www.jvhl.org) for additional information, including:

- » Service center locations
- » JVHL provider directory

### Reference Lab Billing Requirements

As laboratory testing continues to become increasingly specialized, hospital laboratories may find it necessary to refer specimens to reference laboratories for testing if they lack the capability to process the specimens in-house. This information pertains to covered laboratory procedures performed by reference laboratories that are under contractual arrangements with MHP contracted hospitals. This would include any laboratory procedure covered by CPT codes 80000–89999, or any applicable HCPCS codes. See Reference Guide “H” for more information on Reference Lab Billing Requirements.

### Diabetic Monitors and Supplies – MHP Community and Health Advantage

MHP uses Abbott as our sole supplier for diabetic monitors and diabetic monitor supplies for MHP Community and Health Advantage members. To request a monitor for a member, give your patient a prescription for one of the following diabetic meters or test strips:

- » FreeStyle Lite meter
- » FreeStyle Freedom Lite meter
- » Precision Xtra meter
- » FreeStyle Lite test strips
- » Precision Xtra test strips
- » Precision Xtra Beta Ketone test strips

The member can take the prescription to their local pharmacy to receive the meter and test strips. The exception to the requirement to use Abbott for monitors and supplies is:

- » Children 18 years and younger coming to one of our health plans already trained on another meter

### Diabetic Monitors and Supplies – MHP Medicaid/Healthy Michigan Plan and Marketplace

MHP uses Bayer as our sole supplier for diabetic monitors and diabetic monitor supplies for MHP Medicaid/Healthy Michigan Plan and Marketplace members. To request a monitor for a member, give your patient a prescription for the Bayer Contour meter and test strips.

The member can take the prescription to their local pharmacy to receive the meter and test strips. There are a few exceptions to the requirement to use Bayer for monitors and supplies:

- » Children 18 years and younger coming to one of our health plans already trained on another meter
- » Blind or serious vision impairments requiring the use of a talking meter
- » Insulin pump users coming to the health plan with a meter that speaks to their pump

If you have any questions, please call Customer Service at (888) 327-0671.

### Medical Record Maintenance

State regulations require MHP's participating practitioners and other providers to maintain accurate patient medical records regarding treatment and diagnostic procedures provided to MHP members for at least ten (10) years. CMS requires that records related to McLaren Advantage (HMO) or Medicare Advantage members be maintained for ten (10) years.

Each provider contracting with MHP is required to maintain a medical record for each member served while enrolled in MHP. These records are to be made available to authorized representatives of MHP, regulatory agencies, accrediting bodies and appropriate state and federal agencies.

Medical records of members shall be sufficiently complete and legible to permit subsequent peer review or medical audit.

## Section XI: General Information

MHP requires participating providers to release medical records, as may be directed by the member, or by authorized representatives of appropriate state and federal agencies.

Provider must maintain medical records of all medical services received by members. Medical records include the following: a) a record of outpatient and emergency care, b) specialist referrals, c) ancillary care, d) diagnostic test findings including all laboratory and radiology, e) prescriptions for medications, f) inpatient discharge summaries, g) histories and physicals, h) immunization records, and i) all other documentation sufficient to fully disclose the quantity, quality, appropriateness and timelines of services provided by provider. Medical records must be maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates a system for follow-up treatment.

Providers must maintain in English and in a legible manner written or electronic records necessary to fully disclose and document the extent of services provided to members. Failure to maintain legible and complete records will result in a denial of payment.

Medical records must be legible, signed and dated. All medical records must be kept in the time periods required by applicable regulatory agencies. Medical records will be made promptly available, at no cost to MHP, MDHHS or CMS, upon request.

When a member changes a PCP, the former PCP must forward copies of the member's medical records to the new PCP within ten (10) working days from receipt of a written request from the new PCP or the member. Medical records must be stored in a manner that ensures compliance with federal and state privacy and security requirements and must be stored securely so that only authorized personnel have access to the records. If provider is a hospital, provider must comply with all medical record requirements contained within 42 CFR 456.101-145.

Provider will comply with any additional medical record standards established in MHP's policies, which are available upon request.

### Medical Record Review Standards

MHP requires provider's medical records to be maintained in a manner that is current, detailed and organized and which permits effective and confidential patient care and quality review.

MHP Medical Record Review Standards apply to:

- » All services provided directly by a practitioner who provides primary care services
- » All ancillary services and diagnostic tests ordered by a practitioner
- » All diagnostic and therapeutic services for which a member was referred by a practitioner

MHP on an annual basis chooses two medical record standards (e.g., patient identification, record

content, and continuity and coordination of care) to be assessed through an on-site visit at 50 percent of our PCPs with >50 members.

The medical record shall pass at a minimum of 80 percent for passing for the entire review and for each section. If any section is below 80 percent, a corrective action plan (CAP) is required to be submitted within 30 days. If the medical record score is below 80 percent, a CAP is required within 30 days as well as re-visit in 60 days.

The following documentation should be in each patient's medical record:

**A. PATIENT IDENTIFICATION**

Identification sheet or demographic data documented and current.

**1. AN IDENTIFICATION SHEET, WHICH INCLUDES ALL OF THE FOLLOWING INFORMATION PERTAINING TO THE PATIENT/ENROLLEE:**

- a. Name
- b. Address
- c. Date of birth or age
- d. Gender (except obstetrics and gynecology)
- e. Emergency contact person
- f. Home and work telephone numbers
- g. Employer
- h. Marital status

**B. RECORD CONTENT**

The following documentation should be in each patient's medical record:

**1. ALLERGIES AND ADVERSE REACTIONS TO MEDICATIONS PROMINENTLY DISPLAYED**

May be on front cover, inside cover, medication sheet, patient information sheet.

**2. ALL ENTRIES IN MEDICAL RECORD CONTAIN THE WRITER'S ID (INCLUDING FLOW SHEETS)**

All writers in the patient record (including flow sheet) must be identified. If initials or signature stamp is used, a signature list is available. A written policy and procedure is needed for use of the signature stamp and the stamp must be locked or kept with the practitioner at all times.

**3. ALL PAGES CONTAIN PATIENT ID**

If pages are not secured in the record, each page must have an ID# (e.g., DOB, MR#, etc.) in addition to the name.

**4. RECORD LEGIBLE**

Can be read by at least two people other than the writer.

## Section XI: General Information

### 5. ALL ENTRIES DATED

### 6. UPDATED PROBLEM LIST

Pediatric records should include any acute or recurrent problems.

### 7. UPDATED MEDICATION LIST

Must be separate from progress notes.

### 8. IMMUNIZATION RECORD PRESENT

Is there a centralized form in record for recording all immunizations?

### 9. ADVANCE DIRECTIVES

The Michigan Legislature authorized the use of Durable Power of Attorney for Health Care in our state. The member can appoint another individual to make decisions concerning his/her care, custody and medical treatment when member is unable to participate in medical treatment decisions. Need to have evidence of inquiry of Advance Directives prominently located. (Adults age 18 and older.)

### 10. APPROPRIATE MEASURES TAKEN TO ENSURE CONFIDENTIALITY OF PATIENT MEDICAL RECORDS

Includes storage, accessibility of records (must not be accessible to patients), release of information, a written policy and procedure, and a signed confidentiality statement.

### 11. MEDICAL/TREATMENT RECORD ORGANIZED IN A CONSISTENT MANNER

All labs, X-ray reports, consults, etc., organized in the record in a consistent manner.

## C. HEALTH HISTORY

Comprehensive health assessment completed or offered. If patient refuses to complete the form, documentation should be present. Checklists are acceptable as long as they include the following:

#### 1. MEDICAL HISTORY DOCUMENTED (UPDATED WITH A PHYSICAL)

Patient can complete, but practitioner must review, date and sign. Include delivery data for children.

#### 2. FAMILY HISTORY DOCUMENTED (UPDATED WITH A PHYSICAL)

As above. For children, if in foster care or adopted, it must be documented.

#### 3. SOCIAL HISTORY DOCUMENTED

Marital status, number of children, sexual activity and contraceptive usage.

#### 4. SUBSTANCE USE DOCUMENTED

Includes documentation of smoking habits and history of patient alcohol use, according to Plan's preventive guidelines.

#### 5. SAFETY EDUCATION

Evidence of inquiry regarding use of seat belts, helmets, smoke detectors, etc.

#### 6. COMPLETE PHYSICAL EXAMINATION

A completed physical exam should be documented or offered, in time frames according to Plan's preventive guidelines.



**7. ABUSE INQUIRY**

Evidence of inquiry regarding present or previous mental, physical, sexual abuse.

**D. PROGRESS NOTES**

**1. REASON FOR VISIT**

The reason patient came to see the practitioner.

**2. OBJECTIVE PHYSICAL FINDINGS**

What physical findings are found according to patient presenting complaints.

**3. DIAGNOSIS/PHYSICAL FINDINGS**

**4. TREATMENT RENDERED**

What was done for the patient relative to the patient's presenting complaints.

**5. FOLLOW-UP PLANS**

Next visit, return as needed, etc.

**6. PREVIOUS UNRESOLVED PROBLEMS ADDRESSED**

**E. REFERRALS/CONSULTANTS**

**1. REPORT DATED UPON REVIEW BY PHYSICIAN**

**2. SIGNED OR INITIALED UPON REVIEW BY PHYSICIAN**

**3. CONSULTANT/REFERRAL REPORTS IN RECORD**

**4. REFERRALS ISSUED APPROPRIATELY**

**F. LAB/X-RAY REPORTS**

**1. DATED UPON REVIEW BY PHYSICIAN (CAP required if not passed)**

**2. SIGNED OR INITIALED UPON REVIEW BY PHYSICIAN (CAP required if not passed)**

**3. FOLLOW-UP TO ABNORMAL FINDINGS**

Need documentation of patient notification of abnormal findings and plan to address findings (CAP required if not passed).

**G. PREVENTIVE SERVICES**

Preventive health care services should be offered and documented accordingly.

**1. IMMUNIZATIONS APPROPRIATE FOR AGE**

Evidence of immunizations, according to the Plan's preventive guidelines.

**2. BREAST CANCER SCREENING**

**3. CERVICAL CANCER SCREENING**

**4. PSA**

Performed in accordance with the Plan's preventive guidelines.

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### 5. COLORECTAL CANCER SCREENING

### 6. PATIENT EDUCATION

Based on diagnosis and Plan's preventive guidelines.

### 7. SMOKING INQUIRY ON EACH VISIT

Recommended to be done on each visit; may be noted on vital signs sheet.

### 8. SMOKING COUNSELING ON EACH VISIT (if required)

## H. CONTINUITY AND COORDINATION OF CARE

### 1. IS THERE EVIDENCE OF CONTINUITY AND COORDINATION OF CARE BETWEEN PRIMARY AND SPECIALTY PHYSICIANS?

Exchange information in an effective, timely and confidential manner, including patient-approved communications between medical practitioners, behavioral health practitioners and other specialist providers.

### 2. EVIDENCE OF DISCHARGE SUMMARIES FROM HOSPITALS

### 3. EVIDENCE OF DISCHARGE SUMMARIES OR PROGRESS NOTES FROM SKILLED NURSING FACILITIES/HOME HEALTH PROVIDERS

## Confidentiality

MHP guarantees its members the right to privacy of information through the policies and procedures. A privacy notice is available to all members. In addition, every MHP employee signs a statement when they are hired that states they are required to keep member information private. Employees are trained every year on keeping information private and only employees who are authorized with a password have access to electronic information.

Providers must ensure that all information relating to or identifying specific patients shall be kept strictly confidential. Each MHP participating provider is responsible for maintaining the confidentiality of medical, social and economic information contained in the member's medical record. Storage of medical and confidential files shall be subject to physical security measures during non-working hours.

## Quality Improvement Activities

MHP's contracted provider network is obligated to comply with all MHP quality improvement activities. These activities include utilization review, quality management, care coordination, peer review and other such programs as established by MHP to promote the provision of quality health care and cost containment.

Performance data collected by MHP's provider network is utilized in quality improvement activities. This data is collected through claims history, HEDIS chart review and other means. This data is utilized in a variety of ways. Individual provider performance is reported as well as compiled into the Plan's performance overall. From this data, work plans, opportunities for action and provider incentives are developed to help increase quality outcomes and member satisfaction.

## Gag Clause Prohibition

The Consolidated Appropriations Act (CAA) prohibits group health plans and health insurance issuers from entering into an agreement with a providers that include certain gag clauses related to costs and quality. As required by the CAA, your Agreement with MHP and its subsidiaries does not directly or indirectly restrict MHP or a group health plan from:

1. Providing provider-specific cost or quality of care information or date to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individual eligible to become participants, beneficiaries, or enrollees of the plan or coverage.
2. Electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee.
3. Sharing such information, consistent with applicable privacy regulations.

## Non-Discrimination

In connection with the performance of services under the contract between MHP and the provider, the provider agrees to comply with the Americans with Disability Act, 42 USLA 12112 (ADA) and Section 1557. Additionally, the provider agrees with the Civil Rights Act of 1964 (78 stat. 252).

## Discussing Treatment Options

MHP providers may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations. Providers shall not be prohibited from advocating on behalf of a member in any grievance or utilization review process or individual authorization process to obtain necessary health care services.

## Member Complaint, Grievance and Appeal Procedure

We want to hear member comments so that we can make our services better. We want our members to receive answers to questions they have about McLaren Health Plan. We will do our best to fairly resolve any problems members may have with us. Please contact us with any member comments or concerns. We are here to help.

We can help complete forms and take other steps. We also have interpreter and TTY services available.

## Standard Grievances

A grievance is a complaint about having a problem calling McLaren Health Plan or if a member is unhappy with the way a provider or a McLaren employee treated them. The member can call Customer Service if they have questions or concerns. McLaren Health Plan staff will try to resolve concerns during the first contact. If members are still unhappy with McLaren Health Plan's response, they may file a formal grievance. Members can file a grievance verbally with Customer Service or in writing by mail. If a member chooses to submit via mail, they must send it to:

McLaren Health Plan  
Attn: Member Appeals  
G-3245 Beecher Road  
Flint, MI 48532

Phone number: (888) 327-0671 (TTY: 711)  
Fax number: (810) 600-7984  
Email: [MHPAppeals@mcclaren.org](mailto:MHPAppeals@mcclaren.org)

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Note that grievances do not include appeals. See the Appeals Section for more information on appeals. Customer Service staff can help members submit their grievance over their phone and file it on their behalf. Customer Service will acknowledge the grievance verbally. If a member chooses to mail their grievance, McLaren Health Plan will acknowledge receipt of the grievance in writing within five days of receipt. We will complete the grievance process within 30 days. Individuals who make decisions on the grievance will not have been involved in a previous level of review. They will also not be a subordinate of a person who made a decision. If required, we will use an appropriate clinical person.

McLaren Health Plan has a two-step process for reviewing grievances. We will complete Step 1 within 15 days of receipt of a grievance. McLaren Health Plan will provide a written decision. If members are not happy with our decision, they may move to Step 2 by appealing to McLaren Health Plan in writing or by phone. We will start Step 2 only if we receive an appeal within five days of our written decision. McLaren Health Plan will review the grievance appeal. We will provide the member with a final decision within 30 days from the initial date of the grievance. Our decision will be in writing.

### Expedited (Fast) Grievances

We will treat a member grievance as expedited if a physician substantiates the 30-day time frame would jeopardize their life or ability to regain maximum function. Call Customer Service to file an expedited grievance. We will quickly make a decision. We will call the member and the physician and notify of our decision within 72 hours. We will send a written letter with our decision within two days after we call.

Members may, but are not required to, file an appeal of an expedited grievance with McLaren Health Plan.

Members may file a request for an expedited external review at the same time they file a request for an expedited internal grievance. If the member files a request for an expedited external review, they may be considered to have exhausted McLaren Health Plan's internal grievance process. If they file a request for an external expedited review, the internal expedited grievance will be pended until the Michigan Department of Insurance and Financial Services (DIFS) decides whether to accept the request. If DIFS accepts the expedited external request, the member will be considered to have exhausted McLaren Health Plan's internal grievance process.

### Standard Internal Appeals

Members may file an appeal of an adverse benefit determination with McLaren Health Plan. Note that an untimely response to a request may become an adverse benefit determination. The member or their authorized representative has 60 days from the date of the adverse benefit determination letter to file an appeal.

Members can have someone else act as their authorized representative to file their appeal. However, the member will need to complete McLaren Health Plan's **authorized representative form**. It is available at **McLarenHealthPlan.org**. You may also call Customer Service to be mailed a copy.

Members may appoint an authorized representative at any step of the appeals process. The member's estate representative may represent them if the member is deceased. We cannot start the appeals process until we receive a signed authorized representative form. Please ensure it is sent to us as soon as possible.

The member or their authorized representative can appeal in writing or verbally. If a member submits an appeal in writing, they can send the appeal request along with any added information to the following address, fax or email:

McLaren Health Plan  
Attn: Member Appeals                      Phone: (888) 327-0671 (TTY: 711)  
G-3245 Beecher Road                      Fax: (810) 600-7984  
Flint, MI 48532                              Email: [MHPAppeals@mclaren.org](mailto:MHPAppeals@mclaren.org)

McLaren Health Plan will acknowledge receipt of the appeal in writing within five days of receipt.

When McLaren Health Plan makes a decision subject to appeal, McLaren Health Plan will give a written adverse benefit determination notice to the member and the requesting provider, if applicable. Adverse action notices for the suspension, reduction or termination of services must be made at least 10 days prior to the change in services. McLaren Health Plan will continue member benefits if all the following conditions apply:

- » The appeal is filed timely, meaning on or before the later of the following:
  - » Within 10 days of McLaren Health Plan mailing the notice of action
  - » The intended effective date of McLaren Health Plan's proposed action
- » The appeal involves the termination, suspension or reduction of previously authorized course of treatment
- » The services were ordered by an authorized provider
- » The authorization period has not expired
- » The member requests an extension of benefits

If McLaren Health Plan continues or reinstates member benefits while the appeal is pending, the services will be continued until one of the following occurs:

- » Withdrawal of the appeal
- » The member does not request a State Fair Hearing and continuation of benefits within 10 days from the date McLaren Health Plan mails an adverse action notice
- » A State Fair Hearing decision adverse to the member is made
- » The authorization expires or authorization service limits are met

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If we reverse the adverse action decision or if a State Fair Hearing reverses it, we will pay for services provided while the appeal is pending and authorize or provide the disputed services. McLaren Health Plan will do this as fast as the member's health needs require. This will be no more than 72 hours after we receive notice of a reversal.

If an adverse State Fair Hearing decision is made, you may be required to pay the cost of your services. However, McLaren Health Plan may only do this as allowed by state policy.

A member may request copies of information relevant to their appeal, free of charge, by contacting Customer Service. McLaren Health Plan will provide members with any new or added information considered, relied upon or generated by us related to the appeal. This is free of charge to the member. We will also provide the member with any new or added rationale for a denial of their claim or appeal. We will give the member a reasonable opportunity to respond.

Once we receive the appeal request, we will send a letter within five days telling the member that we received their appeal. The letter will tell them about the appeals process. It will also include the time and location of the appeal meeting. The member or their authorized representative may speak before the committee in person or by phone. They can present evidence and testimony and make legal and factual arguments. The member or their authorized representative must contact McLaren Health Plan if they want to take part in the appeal meeting. They can give documents and other information to us. We will consider this information during the appeal.

A person not involved in the initial decision will review the appeal. The person will not be a subordinate of anyone who previously made a decision on the appeal. If the appeal is based in whole or in part on medical judgment, the person who reviews the appeal will be of the same or similar specialty as would typically manage the case.

We will decide as fast as the member's health condition requires. Normally we have 30 days to complete the internal appeal process. We may extend this time period at the member's request. We may also extend the time period for the shorter of 14 calendar days or 10 business days if we requested information from a health care provider but we have not received it. But, the extension must be in the member's best interest. We will call the member if we need to request an extension. We will also send a letter telling the member of the delay. If they disagree with the extension, they may file an appeal.

The member will receive a written letter telling them of our final determination within three days after the decision is made. In addition, we may call the member and tell them of our decision.

### Expedited Internal Appeals

If a physician tells us that he or she believes that due to a member's medical status, a resolution of the appeal within McLaren Health Plan's normal time frames would seriously jeopardize their life or health or ability to regain maximum function, the expedited appeals process may be used.

A request for an expedited appeal should be made by calling McLaren Health Plan (MHP) at (888) 327-0671. A member can also make this request in writing. They must request an expedited appeal within 10 days of the adverse benefit determination. Expedited appeals are available only for pre-service adverse benefit determinations. This includes requests concerning admissions, continued stay or other health care services if they have received emergency services but have not been discharged from a facility. We may decide not to treat the appeal as expedited. If so, we will make reasonable efforts to call the member and tell them this. We will also mail a letter within two days of the request to tell them that their appeal is not expedited. The appeal will be treated as a standard appeal.

If we accept the appeal as expedited, we will tell the member and their physicians of our decision as fast as their medical condition requires. This will be no later than 72 hours after we receive their request. Generally, MHP will notify the member and their physician of MHP's decision by phone. We will send the member and their physician a written letter of our decision within two days after we call.

A member may request an extension of an expedited appeal. But if they request an extension, we may deny their request for an expedited appeal. If so, we will move the appeal to the standard 30-day time frame.

The member's physician may confirm by phone or writing that he or she has a medical condition that the time frame for completing an expedited internal appeal would seriously jeopardize their life, health or ability to regain maximum function. If so, the member or their authorized representative, may file a request for an expedited external review. A member can do this at the same time they or their authorized representative files a request for an expedited appeal with MHP. See the Expedited External Appeals Section for more information on how to do this.

If a member chooses to file a request for an external expedited review, their internal appeal will be pended until DIFS decides whether to accept the request. If DIFS accepts the expedited external appeal, the member will be considered to have exhausted the internal appeal process.

### External Review

If after the appeal we continue to deny payment, coverage or the service requested, or the member did not receive a timely decision, the member can ask for an external appeal with DIFS. They must do this within 127 days of receiving MHP's final adverse benefit determination. If the member is not required to exhaust MHP's appeals process, they must do this within 127 days from receiving MHP's adverse benefit determination. MHP will provide the form required to file an external appeal.

Requests should be mailed or faxed to:  
Department of Insurance and Financial Services  
Health Plan Division  
PO Box 30220  
Lansing, MI 48909-7720

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Delivery service:

Department of Insurance and Financial Services

Health Plan Division

PO Box 30220

Lansing, MI 48909-7720

Toll-Free Telephone: (877) 999-6442

Fax: (517) 284-8838

Submit online at [difs.state.mi.us/complaints/externalreview.aspx](https://difs.state.mi.us/complaints/externalreview.aspx).

When appropriate, DIFS will request an opinion from an Independent Review Organization (IRO). The IRO is not contracted with or related to MHP. DIFS will issue a final order.

### Expedited External Appeals

If after the expedited internal appeal we continue to deny coverage or the service requested, the member can ask for an expedited external appeal with DIFS. They must do this within 10 days of receiving our appeal decision. They may also file a request for an expedited external appeal at the same time they file a request for an expedited internal appeal with MHP. MHP will provide the form required to file an expedited external appeal.

These requests should be mailed or faxed to:

Department of Insurance and Financial Services Health Plan Division

PO Box 30220

Lansing, MI 48909-7720

Courier/Delivery Service:

Department of Insurance and Financial Services

Health Plan Division

PO Box 30220

Lansing, MI 48909-7720

Toll-Free Telephone: (877) 999-6442

Fax: (517) 284-8838

Submit online at [difs.state.mi.us/complaints/externalreview.aspx](https://difs.state.mi.us/complaints/externalreview.aspx).

When appropriate, DIFS will request an opinion from an IRO. The IRO is not contracted with or related to MHP. DIFS will issue a final order.

### Fair Hearing Process

If we uphold our decision after the member appeal, they may have additional appeal rights. The member can file a request with the Michigan Office of Administrative Hearing and Rules (MOAHR) with the DHHS. They must file the request with MOAHR within 120 days of our appeal decision. If we do not meet the notice and timing requirements required by law, the member is considered to have exhausted MHP's appeals process. Listed below are the steps for the State of Michigan's Medicaid Fair Hearing process:



**Step 1:** Call MOAHR at (877) 833-0870 or send an email to [administrativetribunal@michigan.gov](mailto:administrativetribunal@michigan.gov) to have a hearing request (complaint) form sent to the member. They may also call to ask questions about the hearing process.

**Step 2:** Fill out the request (complaint form) and return it to the address listed on the form.

**Step 3:** The member will be sent a letter telling them when and where their hearing will be held.

**Step 4:** The results will be mailed to them after the hearing is held. If the appeal is resolved before the hearing date, the member must call MAHS at (877) 833-0870 to ask for a hearing request withdrawal form.

We can help complete forms and take other steps. We also have interpreter and TTY services available for members.

If an adverse State Fair Hearing decision is made, members may be required to pay the cost of the services. However, MHP may only do this as allowed by State policy.

## CHAMPS Enrollment

ALL providers rendering services to Medicaid beneficiaries, must be enrolled with the MDHHS Community Health Automated Medicaid Processing System (CHAMPS). If you are not enrolled, your claims will be denied. Register today by logging in to [www.michigan.gov/mdhhs](http://www.michigan.gov/mdhhs).

1. Click on "Doing Business with MDHHS"
2. Click on "Health Care Providers"
3. Click on "Go to Health Care Providers" (top of page)
4. Click on "Information for Medicaid Providers"
5. Click on "Providers"
6. Click on CHAMPS button
7. Click on "Register for MiLogin Account for Access to CHAMPS "
8. Click "MiLogin Instructions"

During registration, be sure to "associate" with McLaren Health Plan. This will ensure that MHP is notified of your registration, ensuring claims will process appropriately.

All new providers enrolling with CHAMPS will receive a welcome letter from MDHHS upon approval. MDHHS recommends all organizations keep a list of their user IDs.

CHAMPS training is available by emailing [providersupport@michigan.gov](mailto:providersupport@michigan.gov).

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In addition, when a prescription is submitted with a Type 2 (Group) NPI or any non-enrolled NPI as the prescribing provider, in the NCPDP filed #411-DEB Prescriber ID, it will be denied. It is the prescribing physician's responsibility to ensure that they are actively enrolled within CHAMPS in order to prevent member access-to-care issues.

### Office of Inspector General (OIG Audits and Appeals)

**Adherence to the Medicaid Provider Manual.** You must adhere to the [Michigan Medicaid Provider Manual](#). Notwithstanding the foregoing, if there is a conflict between the Medicaid Provider Manual and the Agreement or Plan's policies and procedures, the applicable Plan document will control.

**OIG Post-Payment Evaluations.** Provider agrees that MDHHS-OIG has the authority to conduct post-payment evaluations of any claims paid by Plan.

**OIG Appeals Process.** Provider agrees to follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306 for post-payment evaluations conducted by MDHHS-OIG. If requested by Plan, Provider must appeal MDHHS-OIG's findings at all available levels of appeal and take all reasonable steps to appeal the findings, including submitting additional evidence or information.

**Amounts Owed.** Plan will promptly notify provider if MDHHS-OIG requests recovery of an overpayment from Plan related to provider, or if MDHHS-OIG actually recovers or otherwise receives the amount from Plan. Upon receipt of the notification from Plan, provider will immediately provide the entire overpayment amount to Plan. Notwithstanding the foregoing, Plan may, in its sole discretion, offset any amounts against claims submitted by provider to plan. If provider has not paid all amounts due to Plan, for any reason, Plan may refer collection of the unpaid amount to an attorney or collections agency. If Provider's unpaid amounts are referred to an attorney or collections agency, Provider must pay all reasonable attorney's fees or collections agency fees.

**Time Period for Recoveries.** There is no time limit for recoveries arising out of or related to referrals from MDHHS-OIG, or for fraud, waste or abuse.

**Medical Records.** All medical records must be retained for at least 10 years, or longer if required by applicable law, regulation or a regulatory agency.

**State Exclusion Checks.** Provider and its employees must not be suspended, excluded, debarred or otherwise ineligible to participate in state government programs. Provider agrees to monitor and routinely conduct screenings to ensure that provider and its employees are properly licensed and not suspended, excluded, debarred or otherwise ineligible to participate in state government programs.



## In-Office Laboratory Procedures

McLaren Health Plan (MHP) contracts with Joint Venture Hospital Laboratories (JVHL) to provide all outpatient laboratory services. To better serve our members, MHP allows physicians to perform and submit claims for specific laboratory services performed in their offices.

The **in-office** laboratory procedures listed below are billable by primary care physicians and specialists for Medicaid, Commercial and Health Advantage lines of business.

\*Only specialists may perform these services.

MHP In-Office Laboratory Billable Procedures	
CPT-4/HCPCS Code	Procedure Description
80047/80047QW/80048	BASIC METABOLIC PANEL
80051	ELECTROLYTE PANEL
80053/80053QW	COMPREHENSIVE METABOLIC PANEL
80305	DRUG TEST CAPABLE OF BEING READ BY DIRECT OPTICAL OBSERVATION
80306	DRUG TEST CAPABLE OF BEING READ BY INSTRUMENT ASSISTED DIRECT OPTICAL OBSERVATION
80307	DRUG TEST CAPABLE OF BEING READ BY INSTRUMENT CHEMISTRY ANALYZERS
81000	URINALYSIS; NON-AUTOMATED, WITH MICROSCOPY
81001	URINALYSIS; AUTOMATED, WITH MICROSCOPY
81002	URINALYSIS; NON-AUTOMATED, WITHOUT MICROSCOPY
81003	URINALYSIS; AUTOMATED, WITHOUT MICROSCOPY
81007QW	URINALYSIS SCREEN FOR BACTERIA, EXCEPT BY CULTURE OR DIPSTICK
81015	URINALYSIS; MICROSCOPIC ONLY
81025	URINE PREGNANCY TEST, BY VISUAL COLOR COMPARISON METHODS
82043	URINARY MICROALBUMIN, QUANTITATIVE
82044	URINARY MICROALBUMIN
82270	BLOOD, OCCULT; FECES SCREENING BY PEROXIDASE ACTIVITY, 1-3 SIMULTANEOUS DETERMINATIONS

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CPT-4/HCPCS Code	Procedure Description
82271	BLOOD, OCCULT; FECES SCREENING BY OTHER SOURCES, 1-3 SIMULTANEOUS DETERMINATIONS
82272	BLOOD, OCCULT; FECES SCREENING BY PEROXIDASE ACTIVITY, SINGLE SPECIMEN (E.G., FROM DIGITAL RECTAL EXAM)
82274/82274QW	BLOOD, OCCULT; FECAL HEMOGLOBIN SCREENING BY IMMUNOASSAY, 1-3 SIMULTANEOUS DETERMINATIONS
82310	CALCIUM; TOTAL
82374	CARBON DIOXIDE (BICARBONATE)
82435	CHLORIDE; BLOOD
82565	CREATININE; BLOOD
82570	ASSAY OF URINE CREATININE
82670	ESTRADIOL*
82947/82947QW	GLUCOSE; QUANTITATIVE
82948	GLUCOSE; BLOOD, REAGENT STRIP
82950	GLUCOSE TEST (Effective 1/01/2021)
82962	GLUCOSE, BLOOD, BY GLUCOSE HOME USE DEVICE (Effective 1/01/2021)
83001	GONADOTROPIN; FOLLICLE STIMULATING HORMONE (FSH)
83001QW	GONADOTROPIN; FOLLICLE STIMULATING HORMONE (FSH)*
83002	GONADOTROPIN; LUTEINIZING HORMONE (LH)*
83036	HEMOGLOBIN, GLYCATED
83037	GLYCOSYLATED HEMOGLOBIN TEST
83655	LEAD
83861	TEAR ANALYSIS
84144	PROGESTERONE*
84146	PROLACTIN*
84295	SODIUM; SERUM, PLASMA OR WHOLE BLOOD
84520	UREA NITROGEN; QUANTITATIVE

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CPT-4/HCPCS Code	Procedure Description
84703QW	GONADOTROPIN, CHORIONIC (HCG); QUALITATIVE
85007	BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL DIFFERENTIAL WBC COUNT
85013	BLOOD COUNT; SPUN MICROHEMATOCRIT
85014/85014QW	BLOOD SMEAR; HEMATOCRIT (HCT)
85018QW	BLOOD SMEAR; HEMOGLOBIN (HGB)
85025	COMPLETE BLOOD CT (CBC-HGB, HCT, RBC, WBC, AND PLT) AND DIFF, AUTOMATED
85027	BLOOD COUNT; COMPLETE (CBC) AUTOMATED (HGB, HCT, RBC, WBC, PLAT)
85048	BLOOD COUNT; LEUKOCYTE (WBC), AUTOMATED
85097	BONE MARROW; SMEAR INTERPRETATION ONLY, W/OR W/O DIFF. CELL CNT*
85610	PROTHROMBIN TIME
85651	SEDIMENTATION RATE, ERYTHROCYTE; NON-AUTOMATED
86308/86308QW	HETEROPHILE ANTIBODIES; SCREENING
86318/86328	COVID
86403	PARTICLE AGGLUTINATION (SCREENING EACH ANTIBODY) RAPID STREP TEST
86580	SKIN TEST; TUBERCULOSIS, INTRADERMAL
87081	CULTURE, BACTERIAL, SCREENING ONLY; FOR SINGLE ORGANISMS
87210	SMEAR, PRIMARY SOURCE, W/INTERP; WET MOUNT SIMPLE STAIN
87220	TISSUE EXAMINATION BY KOH SLIDE FOR FUNGI*
87400	INFLUENZA, A OR B
87426/87428	COVID
87502	INFLUENZA VIRUS
87635/87636/87637	COVID
87650	STREPTOCOCCUS, GROUP A, DIRECT PROBE TECHNIQUE
87651	STREPTOCOCCUS, GROUP A, AMPLIFIED PROBE
87798	RSV

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CPT-4/HCPCS Code	Procedure Description
87804	INFLUENZA TEST (Effective 1/01/2021)
87807	RAPID RSV (Effective 1/01/2021)
87811	COVID
87880	STREP TEST (Effective 1/01/2021)
87880QW	INFECTIOUS AGENT DETECTION IMMUNOASSAY OBS, STREPT GROUP A
89050	CELL COUNT, MISCELLANEOUS BODY FLUIDS, EXCEPT BLOOD
89190	NASAL SMEAR FOR EOSINOPHILS
89300/G0027	SEMEN ANALYSIS; PRESENCE AND/OR MOTILITY OF SPERM*
89310	SEMEN ANALYSIS; MOTILITY AND COUNT (NOT INC. HUHNER TEST)*
89320	SEMEN ANALYSIS; COMPLETE (VOLUME, COUNT, MOTILITY, DIFFERENTIAL)*
024IU/ G2023/ U0002/U0003/ U0004/U0005	COVID
G0480	DRUG TEST, 1-7 DRUG CLASS(ES)
G0481	DRUG TEST, 8-14 DRUG CLASSES

### Allowable Amount

MHP reimburses all providers of care, for all lines of business, at applicable facility and professional fee schedule rates and methodologies. Reimbursement is provided as payment in full at the lesser of billed charges or 100 percent of the allowed amount less any deductible, copayments or coinsurance amounts that are the responsibility of the member.

### Mid-Level Providers

MHP reimburses mid-level providers according to industry standard methodology. Mid-level providers are reimbursed at 85 percent of the standard professional fee schedule, applicable to each line of business, less any deductibles, copayments or coinsurance amounts that are the responsibility of the member. Mid-level providers are classified as:

- Physician Assistant (PA)
- Certified Nurse Midwife (CNM)
- Nurse Practitioner (NP)
- Certified Nurse Specialist (CNS)

### Multiple Surgical Procedures

When submitting claims for multiple surgical procedures performed during the same surgical session, for both professional and facility charges, report the primary surgery on the first service line with no modifier. Report the subsequent procedures performed during the same surgical session with modifier 51.

The multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician or physicians of the same specialty in the same group practice. McLaren reimburses up to 100 percent of the fee screen for the most complex surgical procedure, and up to 50 percent of the fee screens for the second through fifth surgical procedures. If more than five procedures are performed, an operative report must be provided with the claim.

## Telemedicine

In an effort to enhance our members' access to care, MHP has made available the use of telemedicine. Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location. It allows real-time interaction at both the originating and distant sites between the patient and health care professional via the telecommunication system. Telemedicine should be used primarily when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services. Telemedicine is most often limited to specialty consults with an ED physician or visits that are of low complexity and when it is not anticipated that a follow-up encounter will be required. It is never to be used for physician convenience.

Providers must ensure the privacy of the member and the security of any information shared via telemedicine. The technology used must comply with current regulations and industry standards for audio and visual equipment and software.

There are no preauthorization requirements when in-network providers provide telemedicine services to MHP members.

All allowable telemedicine services must be submitted with the appropriate telemedicine modifier, GT. For services that can be billed only via telemedicine, the GT modifier must always be used. Failure to include the GT modifier for these services will result in denial of the service.

## DME, Prosthetics and Orthotics Benefits

As a reminder, MHP members in any line of business have benefits for DME, prosthetics and orthotics.\* Certain authorization requirements apply and are different for specific lines of business. (Please see the authorization requirements listed by service code at [McLarenHealthPlan.org](http://McLarenHealthPlan.org).) In addition to authorization requirements, there are quantity limits, age parameters and rental caps that MHP applies when considering reimbursement of medically necessary, covered services. If you have any questions, please contact Customer Service at (888) 327-0671.

\*Orthotics are covered only by providers who have facility accreditation through the American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., to furnish and bill for custom-fabricated P&O appliances. Providers must maintain their ABC accreditation and be able to provide accreditation proof upon request. Coverage for orthotics is not available when received from a podiatrist.

## Clinical Editing System (CES) Implementation

MHP implemented a CES in 2019. The implementation of the CES focused on professional claims and is designed to automatically check each claim, on a pre-payment basis, for errors, omissions and questionable coding relationships by testing the data against industry rules, regulations and policies governing health care claims. The CES also detects coding errors, including errors relating to unbundling, incidental procedures, modifier appropriateness, diagnoses and duplicate claims.

## Section XII

# Submitting a Claim

In general, MHP follows the claims reimbursement policies and procedures set forth by the MDHHS and CMS. Reimbursement for Medicaid and Medicare is based on the prevailing state of Michigan Medicaid or Medicare fee schedule.

MHP accepts both paper (CMS 1500 and UB-04 claim forms) and electronic claims. All claims must be submitted and received by MHP no later than one (1) year from the date of service to be eligible for reimbursement. Claims received that exceed this filing limit may be denied.

Use a CMS 1500 form for:	Use a UB-04 form for:
Professional services provided by physicians, behavioral health providers, DME providers, laboratories, ambulances, etc.	Services provided by hospitals (inpatient/outpatient), ambulatory surgery centers, hospices, home health care companies, skilled nursing facilities and dialysis facilities.

### Billing Reminders

- » All claims must include member/subscriber ID to avoid receiving a rejected claim.
- » Prenatal visits may be billed using the global code, but prenatal individual dates **MUST** be listed on the claim form.
- » DME claims must have appropriate modifiers listed (refer to HCPC's reference book).
- » Anesthesia is to be billed listing the total number of minutes. **DO NOT** include base units. Example: Total anesthesia time is two (2) hours, units would equal 120 (minutes). Total time in minutes should be provided in box 24G, in the unshaded area. The procedure base units will be added to the total number of units by MHP. See Reference Guide "D" for more information on anesthesia billing.
- » Industry standard HCPCS, CPT, Revenue and ICD codes must be used.
- » DO NOT include the MHP Provider Identification Number (PIN) on claims.
- » Hospital-based clinics/providers will be reimbursed for professional services. See Reference Guide "E" for more information on hospital-based billing.

### Paper Claims

Although it is expected that all claims, including coordination of billing claims, are submitted electronically, if you do submit them on paper, all paper claims should be mailed to:

McLaren Health Plan  
P.O. Box 1511  
Flint, MI 48501-1511



**Handwritten claims will not be accepted.** Paper claims must be typed and mailed to the address provided above. McLaren Health Plan will not accept any claim submissions via fax or email.

Paper claim submission must be done using the most current form version as designated by the CMS and the National Uniform Claim Committee (NUCC). If you are submitting paper claims, you need to contact your Provider Relations Representative for assistance with the submission of electronic claims.

**Please note:** You must submit your appropriate NPI on the claim form. If you have any questions, contact Provider Relations or access [McLarenHealthPlan.org](https://www.McLarenHealthPlan.org).

### Electronic Claims Submission

For claims filed electronically through MHP's Electronic Data Interchange (EDI) vendors, the claims payment process does not differ from paper claim submissions. However, electronic claims may require providers to put the information in different "fields" or "loops." Refer to the Clearinghouse Information section for detailed instructions for submitting electronic claims.

Our Payer IDs for electronic claims are:

McLaren Medicaid/Healthy Michigan Plan – 3833C

McLaren Community – Commercial HMO/POS – 38338

McLaren Health Advantage – 3833A

McLaren Medicare Advantage (MA) 3833R

McLaren Medicare Supplemental – 3833S

### Clearinghouse Information (Both Professional and Facility)

MHP receives EDI claims from our clearinghouse, ENS Optum Insight. Since you may choose to contract with a different clearinghouse, you must ensure your clearinghouse has a forwarding arrangement with ENS Optum Insight. A forwarding arrangement allows your clearinghouse to pass your claims on to ours so that we will receive them. Please visit [McLarenHealthPlan.org](https://www.McLarenHealthPlan.org) for an updated listing of ENS Optum Insight-affiliated clearinghouses.

### Claims Data Validation

EDI claims that you submit to us will be validated at several points before they are loaded into our claims payment system for review by a claims analyst.

- » Your clearinghouse validates your data
- » Our clearinghouse validates your data
- » Pre-Edit: Our system validates the subscriber and billing provider

The following suggestions will improve your ability to submit a claim for processing:

## Section XII: Submitting a Claim

### Your Clearinghouse

You should be provided with rejection reports by your clearinghouse for claims that we do not receive. We do not receive a copy of your rejection reports. Please understand that we have no control over or knowledge of the validation that your clearinghouse performs.

### Pre-Edit

Your claim must contain the rendering and the billing NPI to be processed.

### Subscriber Identification

We will not process a claim that contains an invalid or missing subscriber/member ID. The correct subscriber ID can be found on the MHP member ID card. If you are unsure of the number, call Customer Service at (888) 327-0671.

### Billing Provider Identification

We will not process a claim that contains an invalid billing NPI. Be sure to also submit the rendering provider's NPI as assigned by CMS. The tax ID number is not acceptable in lieu of this field. This must be included as the "Billing Provider Secondary Identifier." The billing address cannot contain a P.O. box or department number for electronic claims, as specified by 5010 billing requirements.

### EDI Contacts

If you have questions about becoming a customer at ENS Optum Insight or have problems with claim rejections that were received by ENS Optum Insight, contact <http://enshealth.com> or (866) 367-9778.

If you have questions about the instructions in this document or would like the status of a claim you have submitted to us:

- » Access the McLaren Connect provider portal at McLarenHealthPlan.org
- » Contact Customer Service at (888) 327-0671 (TTY call 711)

### Clean Claims

MHP is required to **process** your clean claims within forty-five (45) days of MHP receiving the claim. Clean claims not processed in this time period are eligible for interest payments at 12 percent per annum in compliance with Michigan's prompt payment legislation (Public Act 28 of 2004).

Public Act 28 defines a clean claim when the following information is present on the claim:

- » Identifies the provider of service, including any provider identification number and Federal Tax Identification number
- » Lists the patient's name and their ID numbers
- » Lists the date(s) and place of service

- » The claim is a bill for covered services for an eligible member
- » The claim is a bill for medically necessary and appropriate care
- » The claim contains preauthorization or pre-certification information, if required
- » The claim identifies the services rendered by using proper procedure and diagnosis codes
- » The claim includes additional information when required by MHP

### Non-Clean Claims

When MHP is unable to process a submitted claim, notification will be provided identifying the reason for rejection. Common reasons include:

- » Valid NPI is missing or incorrect
- » Unable to identify the provider (using your NPI)
- » Unable to identify the member (copy the name and member number from the MHP ID card)
- » Provider did not complete form correctly

MHP's Ineligible (Reason) Codes and their definitions are listed in the Forms Section XVII.

### Billing for Physician-Administered Drugs and NDC Reporting

Providers are required to report the National Drug Code (NDC) supplemental information in addition to the procedure code (CPT or HCPCS) when billing for a physician-administered drug on the electronic and paper claim formats. This requirement is mandated to ensure the MDHHS's compliance with the Patient Protection and Affordable Care Act (PPACA). The PPACA requires Medicaid to collect rebates for certain drugs.

When billing MHP for physician-administered drugs, in addition to the appropriate CPT or HCPCS codes, the following must be reported on the claim:

- » 11-digit NDC number
- » Unit price (EDI only)
- » 2-digit unit of measure code, e.g., GM (gram), ML (milliliter), UN (unit)
- » Quantity dispensed
- » The prescription number

Due to the implementation of the HIPAA X12 version 5010, only one LIN segment is used to report the supplemental NDC information along with the HCPCS Code. For electronic and DDE claims, the prescription number must be reported to link multiple service lines together for the same procedure code.

## Section XII: Submitting a Claim

If billing multiple lines for the same injectable medication due to different NDC numbers, a 59 modifier is required.

### Coordination of Benefits (COB)

MHP does not pay a claim when it is unclear as to whether MHP is the primary or secondary payer. We recommend that you always ask patients when they register if they have coverage from more than one insurance carrier or if their injury is the result of an accident.

COB claims should be submitted electronically. COB claims must be submitted to MHP within twelve (12) months from the date of service or 90 days from the date of the primary payer's EOB. To ensure appropriate adjudication of secondary claims, the primary insurance payment must be reported at the line level, not at the claim level.

MHP has an active Coordination of Benefits Agreement (COBA) with CMS. COBA standardizes the way that eligibility and Medicare claims payment information with a claims crossover is exchanged. When you are seeing a patient who has Medicare primary and MHP coverage secondary, you need to submit the claim to Medicare. Once Medicare adjudicates the claim, it will be forwarded, by CMS, to MHP. MHP will then process the claim for secondary benefits. You will not need to submit a secondary claim directly to MHP when a patient has Medicare primary.

### COB Provider Payment Reports (PPR)

When a claim is submitted to MHP for coordination of benefits, the primary payer may have been paid more than the plan's allowable amount. When this happens, the provider will see a provider discount amount on the PPR, but no ineligible code. This is explained by subtracting the discounted amount from the charged amount, giving you the plan's allowed amount. The primary payer's amount will be listed in the "Other Carrier" column of the PPR. This amount will be more than the Plan's allowed amount.

### Checking the Status of Your Claims or Requesting a Claims Adjustment

All claim inquiries and adjustments must be submitted to MHP within 90 calendar days of the administrative action, excluding COB/subrogation claims. Inquiries and requests for adjustments after 90 calendar days will not be given consideration.

You can status your claim in our system by accessing the McLaren CONNECT provider portal. McLaren Connect is HIPAA compliant and will allow you, or anyone you designate, to status claims submitted by you, and also to verify member eligibility and coverage. You will need to register for access to McLaren CONNECT at [McLarenHealthPlan.org](https://McLarenHealthPlan.org) and you will be given a password.

You can also status a claim by completing the Provider Claims Status Fax form and faxing it to Customer Service at (833) 540-8648.

For a Provider [Claims Status Fax form](#), see Forms Section XVII or visit [McLarenHealthPlan.org](https://McLarenHealthPlan.org).

Please remember, just as MHP must pay simple interest on clean claims not processed within 45 days, providers can be fined for resubmitting duplicate claims during this same time period. Also, your claim will not be statused within this time period.

Providers who wish to request a claims adjustment to correct a previously submitted claim, or who believe a service was denied inappropriately or that a claim did not pay correctly, are encouraged to do one of the following:

- » Complete the **Provider Claim Adjustment Form** (see Forms Section XVIII or **McLarenHealthPlan.org**), attaching a **paper** copy of the corrected claim or the claim in dispute, and supporting documentation for the adjustment, and fax it to Customer Service at (833) 540-8648 for processing.
- » Contact Customer Service at (888) 327-0671 to request a claim adjustment.

Requests for claim adjustments cannot be submitted electronically. The completed **Provider Claim Adjustment form** must accompany a **paper claim** to avoid it from being automatically denied as a duplicate claim.

## Submitting a Claim

In general, MHP follows the claim reimbursement policies and procedures set forth by the MDHHS for Medicaid and the CMS for Medicare, its Commercial business and Health Advantage. Provider shall comply with MHP's payment policies. Please contact MHP for details.

## Claims Recovery

MHP identifies opportunities to recover payments made to providers.

The claims recovery process will include adjustments on the following types of previously paid claims:

- » COB
- » Subrogation
- » Clinical inpatient review
- » Fraud, waste or abuse
- » Overpayments due to billing, clerical error and termination of a member's coverage

COB includes the following:

- » MHP paid primary and then found out at a later date that MHP should have paid secondary or tertiary
- » MHP paid primary/secondary and then found out at a later date that MHP should not have paid at all

## Section XII: Submitting a Claim

### Overpayments

Providers are required to promptly report overpayments to MHP. Please contact MHP as soon as possible if you have identified an overpayment. Federal law requires that you notify MHP in writing of the reason for an overpayment. We will work with you to ensure the overpayment is promptly returned to MHP. In some cases, this may include offsetting future claims. However, please note that for overpayments related to MHP's Medicaid/Healthy Michigan Plan line of business, federal law requires that you return an overpayment within 60 calendar days of identification of the overpayment. If MHP is unable to recover an overpayment by either offsetting future claims or direct reimbursement from the provider: MHP will seek reimbursement through use of collections.

The following table outlines the time frames for MHP to request funds or do take-backs.

Type of Corrective Adjustment	Timeframe
COB	The longer of 12 months from the date of service or 90 days after MHP's receipt of information confirming the primary carrier
Subrogation	24 months from the initial date of reimbursement
Inpatient Clinical Review	24 months from the initial date of reimbursement
Gross Negligence, Billing Errors, Fraud by Provider	No time limit
Clerical Overpayments by MHP	No time limit
Termination of Member's Coverage	12 months from the date of service

### Corrective Adjustments

MHP (or a contracted representative) will notify the provider of the corrective adjustment. The provider has 30 days from the date of the notice to reimburse MHP or object to the proposed corrective adjustment. Any disagreements to the proposed corrective adjustment shall be communicated to MHP and be supported in writing. If the provider does not object in writing within the required time period, MHP will offset the amounts against future claims. Appeals, if any, will be handled in accordance with the appeals section (see Provider Administrative Appeals, Section XIV).

### Termination of a Member's Coverage

At times, MHP receives notice from an employer, including the State of Michigan for Medicaid/Healthy Michigan Plan members, that they are retroactively terminating their benefits through MHP. For any services provided and payments made during this period, MHP shall recover those payments.

Payments will be recovered up to twelve (12) months from the date of service. Providers may bill the terminated member or another insurance carrier as appropriate for services provided during the retroactive period.

### Understanding the Remittance Advice

The goal at MHP is to use a Provider Payment Report (PPR) format that makes our claims processing information understandable. If you have questions about your PPR, please contact Customer Service at (888) 327-0671.

### 835 and EFT Options

In an effort to add efficiency and speed to the payment of claims, MHP offers EFT/ACH and virtual card payment options. 835 Remittance delivery options are also available. For more information on these payments and 835 remittance delivery options, contact Customer Service at (888) 327-0671.

Section XII: Submitting a Claim

Sample Provider Payment Report

MHP Commercial – McLaren Health Advantage – McLaren Advantage

**Sample**

Return Address Name PO Box  
999999 Anywhere, ZZ 12345

Forwarding Service Requested

Questions, call us at (888) 327-0671

**Group Name:** ACME Sales, INC.  
**Group #:** 12345  
**Division:** 456  
**Provider TIN:** 9999999999  
**Internal ID:** 00123456  
**Check #:** 006543  
**Check Date:** 1/05/2001

Claim information is easily located within the shaded area

Easy-to-locate customer service phone number

Voucher-level information grouped together

COB information here

No.	Date(s) of Service	Proc Code	Description of Services	Billed Amount	Provider Discount	Ineligible Amount	Ineligible Code	Deductible	Copay Co-ins	Other Carrier	Benefits Paid
Claim #: 21417166-01 Patient Account #: ABC-123				Insured Name: John Doe Patient name: John Doe			Insured ID: 999-99-999				
1	08/01/8	36415	Office Visit	40.00	0.00	40.00	10	0.00	0.00	0.00	0.00
2	08/01/8	84015	Injection	35.00	4.42	0.00		0.00	0.00	0.00	20.58
<b>Totals</b>				75.00	17.84	0.00		0.00	0.00	0.00	20.58

Reason descriptions are centralized in a separate section of the EOB

Other Credits or Adjustments	0.00
Total Net Payment	20.58

Reason Code Description  
10 CHARGES PREVIOUSLY CONSIDERED

The statement total section summarizes all claims for the voucher

**STATEMENT TOTALS**

Total Charges	Provider Discount	Ineligible Amount	Deductible	Copay Co-ins	Other Carrier	Benefits
18.25	0.00	2.73	0.00	0.00	0.00	20.58
Other Credits or Adjustments						0.00
Total Net Payment						20.58



## Section XIII

# Pharmaceutical Management – Medicare

McLaren Medicare Inspire, McLaren Medicare Inspire Plus, McLaren Medicare Inspire Flex, McLaren Medicare Inspire Duals, McLaren Medicare EGWP

### Introduction

#### Part D drug formulary

Pharmaceutical Management promotes the use of the most clinically appropriate, safe and cost-effective medications. McLaren Medicare utilizes a customized formulary defined by the MedImpact Pharmacy and Therapeutics (P&T) Committee to develop Part D drug formularies that include drug categories and classes covering a variety of disease states. Each category must include at least two drugs, unless only one drug is available for a particular category or class. McLaren Medicare includes all or substantially all drugs in protected classes, as defined by The Centers for Medicare and Medicaid Services (CMS). The MedImpact Pharmacy and Therapeutics (P&T) Committee reviews all formularies for clinical appropriateness, including the utilization management edits placed on formulary products. McLaren Medicare submits all formulary changes to CMS according to the timelines designated by CMS.

Detailed information regarding Part D drugs, their utilization management requirements (prior authorization, step therapy, quantity limits), non-extended day supply limitations, and most recent plan formularies is available on our provider portal at [McLarenHealthPlan.org](https://www.mclarenhealthplan.org) or by calling Customer Service at (888) 327-0671.

### Covered Benefits

A Part D drug is a drug that meets the following criteria:

- » May be dispensed only by prescription
- » Approved by the FDA
- » Used and sold in the US
- » Used for a medically accepted indication
  - » Medically accepted indication is defined as both the uses approved by the FDA and off-label uses supported by the CMS recognized compendia, Micromedex and American Hospital Formulary Service Drug Information (AHFS-DI). On their own, uses described by clinical guidelines or peer-reviewed literature are insufficient to establish a medically accepted indication.
  - » National Comprehensive Cancer Network (NCCN), Clinical Pharmacology, and Lexicomp, as well as peer-reviewed literature are also used to determine medically accepted indications for drugs or biologicals used off-label in an anti-cancer chemotherapeutic regimen.

### Section XIII: Pharmaceutical Management – Medicare

- » Includes prescription drugs, biologic products, vaccines that are reasonable and necessary for the prevention of illness, insulin, and medical supplies associated with insulin that are not covered under Parts A or B (syringes, needles, alcohol, swabs, gauze, and insulin delivery systems not otherwise covered under Medicare Part B).

### Non-Covered Benefits

Drugs excluded under Part D include the following:

- » Drugs for which payment as so prescribed or administered to an individual is available for that individual under Part A or Part B
- » Drugs or classes of drugs, or their medical uses, which are excluded from coverage or otherwise restricted under Medicare (with the exception of smoking cessation products)
- » Drugs for anorexia, weight loss or weight gain
- » Drugs to promote fertility
- » Drugs for cosmetic purposes and hair growth
- » Drugs for symptomatic relief of coughs and colds
- » Vitamins and minerals (except for prenatal vitamins and fluoride preparations)
- » Non-prescription drugs
- » Outpatient prescriptions for which manufacturers require the purchase of associated tests or monitoring services as a condition for getting the prescription (manufacturer tying arrangements)
- » Agents used for treatment of sexual or erectile dysfunction (ED) (except when prescribed for other FDA-approved indications such as pulmonary hypertension)

### Part D Utilization Management

McLaren Medicare formularies include utilization management requirements that include Prior Authorization, Step Therapy and Quantity Limits.

### Prior Authorization (PA)

For a select group of drugs, McLaren Medicare requires the beneficiary or their physician to get approval for certain prescription drugs before the beneficiary is able to have the prescription covered at their pharmacy. A PA requirement is placed on certain drugs to gather necessary information to determine if the drug should be covered under the beneficiary's Medicare Part B or Part D benefit. Another common reason for a drug's PA requirement is to ensure that a drug is being used for a medically accepted or Part D allowed indication as defined above. Finally, some drugs may have more detailed PA criteria that also require submission of medical information, such as lab results, and current and/or past medication history. Please contact MedImpact at (844) 336-2678 for questions regarding the PA process or the status of a PA request.

### Step Therapy (ST)

For a select group of drugs, McLaren Medicare requires the beneficiary to first try and fail certain drugs/ drug classes to treat their medical condition before covering another drug for that condition.

### Quantity Limits (QL)

For a select group of drugs, McLaren Medicare limits the amount of the drug that will be covered without prior approval.

Note: If the member needs an emergency supply of a medication that requires prior authorization, please contact MedImpact at (844) 336-2678 for assistance.

## Section XIV

# Provider Administrative Appeals

It is the goal of MHP to resolve provider issues before reaching an appeal level. MHP encourages providers to first contact Customer Service when a dispute occurs. If, after informally attempting to resolve the dispute through a verbal contact or a Provider Claims Adjustment, a provider continues to disagree with an administrative action taken by MHP, a written formal appeal may be filed.

### Appeals Process: Investigation and Result

A provider may appeal an administrative action by MHP by submitting the following:

- » Within 90 calendar days of the administrative action by MHP, the provider must complete and submit a **Provider Request for Appeal** (PRA) form and attach a copy of the claim in paper form. For a PRA form, see Forms Section XVIII or visit our website at [McLarenHealthPlan.org](http://McLarenHealthPlan.org). These two items and any additional information should be sent to:

McLaren Health Plan  
Attn: Appeals  
G-3245 Beecher Road  
Flint, MI 48532  
Fax: 810-600-7984  
Email: [mhpappeals@mclaren.org](mailto:mhpappeals@mclaren.org)

- » Supporting documentation must be included with the PRA form. This would include information not previously submitted regarding the reason and rationale for the appeal.
- » The paper claim must be attached to the PRA form (cannot submit EDI).

MHP staff will research the necessary contractual, benefit, claims, medical record information and other pertinent clinical documentation to reassess the appropriateness of the initial decision and make a new determination.

### Appeal Time Frames

The PRA form must be received within 90 calendar days of the disputed action. Disputed actions 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 the provider does not submit a written request for an appeal within this 90-calendar-day time frame, and any charges in dispute must be written off.

## What Disputed Actions Can Be Appealed

Providers may appeal such administrative actions taken by MHP related to:

- » Denial of inpatient days or other services;
- » Denial of authorization;
- » Place of service authorization (inpatient versus outpatient);
- » Payment issues;
- » Clinical claim edits; or
- » Denial of a claim.

## Appeal Response Time Frame

The provider will receive a decision in writing, which may be either a letter or a new EOP. The response should come within 60 (calendar) days of MHP's receipt of the written appeal request.

MHP's decision is final and binding for all products except Medicaid. The claims adjustment process is not available to a provider if the appeal process is used and the provider is not satisfied with the outcome.

## Appeal Process Reminders

The provider 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.

A written request to MHP's appeals department through completion of the **PRA form** and the attachment of a paper claim must be submitted to begin the appeal process.

A cover letter outlining the reason and rationale for the appeals request must accompany the PRA form.

The written request should include any new information, such as:

- » Documentation from the medical record.
- » An explanation of payment.
- » Other applicable documentation supporting the request for appeal.

## Appeals Process for Adverse Compliance Audit Findings

As part of the MHP Compliance program, routine auditing and monitoring as well as data mining activities are performed. Providers are notified that they are part of one of these activities at the

#### Section XIV: Provider Administrative Appeals

conclusion of the audit and if there are any findings that result in either billing education, corrective action or recoupment of claims payments.

Within 30 calendar days of the date written on the audit results notice, the provider must complete and submit an appeal with supporting documentation. The provider must attach a copy of the audit results notice letter.

The right to appeal is forfeited if the provider does not submit a written request for an appeal within the 30-day time frame and payment for amounts owed to MHP are due immediately upon expiration of the 30-day time period. Notwithstanding the foregoing, MHP may, in its sole discretion, offset against future claims.

McLaren staff who did not participate in the audit or are not subordinates of those who conducted the audit will review the documentation submitted by the provider. MHP will make a decision on the appeal within 30 calendar days of its receipt of the appeal. MHP will provide a written decision to the provider. If MHP upholds the decision (in full or in part), the provider must remit payment of the amounts owed to MHP immediately, but in no case later than 30 calendar days of the date of the letter. In cases of fraud, waste or abuse, MHP may offset claims immediately. For all other cases, if payment is not received within 30 days of the date on the letter, MHP will offset against future claims.

#### Medicaid Appeals

Non-contracted hospitals providing services to MHP members through the MDHHS Hospital Access Agreement are eligible to request a Rapid Dispute Resolution Process in compliance with the Medicaid Provider Manual, after the hospital has first exhausted its efforts to achieve a resolution through MHP's Administrative Appeals Process.

Non-contracted hospitals that have not signed a Hospital Access Agreement, or non-contracted, non-hospital providers, do not have access to the Rapid Dispute Resolution Process. These providers serving MHP Medicaid members are entitled to initiate a binding arbitration process, after the provider has first exhausted their efforts to achieve a resolution through MHP's Administrative Appeals Process. To initiate binding arbitration, call MHP to obtain a list of arbitrators. Arbitrators are selected by the MDHHS. The decision of the arbitrator is final. If the arbitrator does not reverse the decision, the provider is responsible for the arbitrator's charges.

Providers who are appealing a professional clinical care review or a Credentialing or Recredentialing action taken by MHP's Quality Improvement Committee must pursue a different type of appeal, which is governed by separate policies. Call Customer Service for more information at (888) 327-0671. Providers can access the PRA form in Section XVIII in this manual or go to [McLarenHealthPlan.org](https://www.mclarenhealthplan.org).

## Section XV

# Fraud, Waste and Abuse

Health care fraud and abuse is both a state and federal offense. The HIPAA Act of 1996 indicates a dishonest provider or member is subject to fines or imprisonment of not more than 10 years, or both. In addition to fines, probation or incarceration, fraudulent or abusive activities may result in a denial, suspension or termination of the provider's license under the Michigan Public Health Code or similar action from Medicaid under the Michigan Social Welfare Act.

MHP asks that providers and members partner with us to identify and eliminate fraud, waste and abuse. As part of that partnership, the provider while contracted with us, warrants that the provider and its employees: a) Have not been listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in federal or state health care programs or in administering health care and b) Have not been convicted of any crime related to defrauding any health care benefit program. The provider will also routinely screen its employees for the above-noted participation issues. The provider must notify MHP in writing immediately if provider or any employee are listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in federal or state health care programs or if Provider or any of its employees are convicted of any crime related to defrauding any health care benefit program.

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

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

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

Examples of fraud, waste and abuse include:

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

## Section XV: Fraud, Waste and Abuse

### Reporting Commercial Fraud, Waste and Abuse

To report fraud, waste and abuse, please contact MHP at (866) 866-2135. This can be done anonymously. Additionally, a fraud, waste and abuse claim can be made in writing to:

McLaren Health Plan  
Attn: Compliance Officer  
G-3245 Beecher Road  
Flint, MI 48532  
Email: [MHPcompliance@mclaren.org](mailto:MHPcompliance@mclaren.org)

### Reporting Medicaid Fraud, Waste and Abuse

**To report fraud, waste and abuse via phone, please contact the Medicaid Fraud Hotline at (855) MI-FRAUD (643-7283) or MHP at (866) 866-2135.** Reports can be made online at [michigan.gov/fraud](http://michigan.gov/fraud). This can be done anonymously. Additionally, a fraud, waste and abuse claim can be made in writing to:

McLaren Health Plan  
Attn: Compliance Officer  
G-3245 Beecher Road  
Flint, MI 48532

Phone: (866) 866-2135  
Email: [MHPcompliance@mclaren.org](mailto:MHPcompliance@mclaren.org)

Or

Office of Inspector General  
P.O. Box 30062  
Lansing, MI 48909

### A Road Map to Avoid Medicare and Medicaid Fraud, Waste and Abuse

The Office of Inspector General (OIG) has created free materials for providers to assist them in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse. This brochure can be found on the Office of Inspector General's website at [oig.hhs.gov/compliance/physician-education/](http://oig.hhs.gov/compliance/physician-education/).

### False Claims Act

The Deficit Reduction Act of 2005 requires providing information about both the federal False Claims Act and other laws, including state laws dealing with fraud, waste and abuse and whistleblower protection for reporting those issues.

Federal law prohibits an employer from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. To report a possible violation, please inform your employees they can contact MHP at:

Compliance Hotline - (866) 866-2135  
Compliance Officer - (888) 327-0671



By mail:  
McLaren Health Plan  
Attn: Compliance Officer  
G-3245 Beecher Road  
Flint, Michigan 48532

**For Medicaid Only**

Office of Inspector General - (855) MI-FRAUD (643-7283)

By mail:  
Office of Inspector General  
P.O. Box 30062  
Lansing, Michigan 48909

## Section XVI

# Member Rights and Responsibilities

MHP providers have a responsibility to recognize the specific needs of the membership and treat members in a mutually respectful manner and ensure that members' rights and responsibilities are followed accordingly.

### MHP Members Have:

- » The right to confidentiality.
- » The right to be treated with respect and dignity, including to be free from restraint and seclusion.
- » The right to a Primary Care Provider at all times.
- » The right to receive culturally and linguistically appropriate services.
- » The right to receive covered benefits consistent with McLaren's contract with the state, and state and federal regulations.
- » The right to a current listing of network providers and access to a choice of specialists within the network who can treat chronic problems.
- » The right to get covered routine and preventive OB-GYN and pediatric covered services without a referral, if the OB-GYN or pediatric specialist is a participating provider.
- » The right to receive Federally Qualified Health Clinic (FQHC) and Rural Health Clinic (RHC) services.
- » The right to be free from any form of restraint or seclusions used as a means of coercion, discipline, convenience or retaliation.
- » The right to continue receiving services from a specialty provider who is no longer in the MHP network, if it is medically necessary.
- » The right for female members who are pregnant to continue coverage with a provider who is no longer in the MHP network (that includes up to six weeks after they have their baby).
- » The right to no "gag rules" from MHP. Doctors are free to discuss all medical treatment even if they are not covered services.
- » The right to participate in decision-making regarding their health care.
- » The right to refuse treatment, to get a second opinion and express preferences about treatment options.
- » The right to receive a copy of their medical record upon request, and request amendments or corrections.
- » The right to know how MHP pays its providers, including incentive arrangements or financial risk.

- » The right to be provided with a telephone number and address to obtain additional information about payment methods, if desired.
- » The right to tell MHP if they have a complaint, the care provided and the right to appeal a decision to deny or limit coverage.
- » The right to know that they or a provider cannot be penalized for filing a complaint or appeal about care.
- » The right to receive beneficiary information and information about the structure and operation of MHP, including the services, providers of care and member rights and responsibilities.
- » The right to make suggestions regarding MHP members' rights and responsibilities.
- » The right to have their medical record kept confidential by MHP and their provider.
- » The right to be free from other discrimination prohibited by state and federal regulations.
- » The right to be free to exercise their rights without adversely affecting the way McLaren, providers or the state treats them.

#### Members of MHP Have the Following Responsibilities:

- » To schedule appointments in advance and be on time. If a member needs to cancel an appointment with any doctor's office, call as soon as possible.
- » To use the hospital emergency room only for emergency care. If possible, a member should call his/her doctor before going to the emergency room.
- » To give all the information that the member can to his or her providers and MHP so they can be cared for in the best way.
- » To ask questions if the member does not understand the care he or she is getting.
- » To talk about their care and help their doctors plan what they will be receiving.
- » To complete the treatments that the member has agreed to and follow all plans of care.
- » To tell the MDHHS and Customer Service right away with any change in address or telephone number.
- » To help MHP assist with the member's health care by telling us of any problems he/she has with services.
- » To tell MHP suggestions in writing or by contacting Customer Service for assistance.
- » To carry the MHP Member ID card at all times.

## Section XVII

# HIPAA Notice of Privacy Practices

Members are notified of privacy practices as required by HIPAA. This notice includes a description of how and when medical information about members is used or disclosed and how members can access it. We take measures across our organization internally to protect oral, written and electronic personal health information of members.

Please remember that disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the regulation 45 CFR 164. For example, health care providers may disclose patient information to us for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others. Thank you for your assistance in providing requested information to us in a timely manner.

## Section XVIII Forms

### CMS 1500 Claim Form

Providers billing electronic claims must refer to the ANSI 837 electronic claims file guide for proper field requirements. The information below is a summary of the CMS 1500 claim form.

Field Location CMS 1500	Field Name	Field Description	Required
1	MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER	Place an "X" in the appropriate box for the type of health insurance applicable to this claim. If the "other" box contains an "X," complete field 1a with the primary coverage identification number. If secondary coverage, refer to field 9. Mark only one box.	Yes, if applicable
1a	Insured's I.D. number	Enter insured's ID number as shown on insured's ID card for the payer to whom the claim is being submitted.	Yes
2	Patient's name	Enter the patient's last name, first name and middle initial as it appears on the ID card.	Yes
3	Patient's birth date sex	Enter the patient's eight-digit date of birth in (MM)DD(CCYY) format. Place an "X" in the appropriate box to indicate the patient's sex. Mark only one box. If gender is unknown, leave blank.	Yes
4	Insured's name	Enter insured's last name, first name and middle initial.	Yes
5	Patient's address	Enter the patient's address, city, state, ZIP code and phone number. If the patient's phone number is unknown, leave blank. Do not use punctuation. Use two-digit state code and, if available, nine-digit ZIP code.	Yes
6	Patient relationship to insured	Place an "X" in the box for "self" if the patient is the insured, "spouse" if the patient is the insured's husband or wife. If none of the above applies, place an "X" to indicate "child" or "other" as applicable. Mark only one box.	Yes

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Field Location CMS 1500	Field Name	Field Description	Required
7	Insured's address	Enter the insured's address, city, state, ZIP code and phone number. Do not use punctuation. If insured's address or telephone number is unknown, leave blank. Use two-digit state code and, if available, nine-digit zip code.	Yes, if known
8	Patient status	Place an "X" in the appropriate boxes. If the patient is a full-time student, complete field 11b if the information is available.	Yes, if applicable
9	Other insured's name	When additional group health coverage exists, enter other insured's last name, first name and middle initial.	Yes, if applicable
9b	Other insured's date of birth sex	Enter the other insured's eight-digit date of birth in (MM DD CCYY) format. Place an "X" in the appropriate box to indicate the other insured's sex. Mark only one box. If gender is unknown, leave blank.	Yes, if applicable
9c	Employer's name or school name	Enter the name of the other insured's employer or school.	Yes, if applicable
9d	Insurance plan name or program name	Enter the other insured's insurance plan or program name.	Yes, if applicable
10	Is patient's condition related to: a. Employment (current or previous) b. Auto accident c. Other accident	Only one box can be marked per submission. a. Place an "X" in the appropriate box. If "yes," complete field 14. b. Place an "X" in the appropriate box. If "yes," indicate state and also complete field 14. c. Place an "X" in the appropriate box. If "yes," complete field 14	Yes, if applicable
10d	Reserved for local use	Not used.	N/A
11	Insured's policy group or FECA number	Enter the insured's policy or group number as it appears on the ID card if present.	Yes, if applicable
11a	Insured's date of birth sex	If known, enter the insured's eight-digit date of birth in (MM DD CCYY) format. If insured's date of birth is unknown, leave blank. Place an "X" in the appropriate box to indicate the insured's sex. Mark only one box. If gender is unknown, leave blank.	Yes, if applicable

Field Location CMS 1500	Field Name	Field Description	Required
11b	Employer's name or school name	Complete if full-time student. Enter the name of the insured's employer or school.	Yes, if applicable
11c	Insurance plan name or program name	Enter the insurance plan or program name of the insured.	Yes, if applicable
11d	Is there another health benefit plan?	Place an "X" in the appropriate box. If "yes," complete fields 9a through 9d.	Yes, if applicable
12	Patient's or authorized person's signature	Enter "Signature on File"	Yes, if applicable
13	Insured's or authorized person's signature	Enter "Signature on File"	Yes, if applicable
14	Date of current illness, injury or pregnancy	Enter the first date in six-digit (MM DD YY) or eight-digit (MM DD CCYY) format of the current illness, injury or pregnancy. For pregnancy, use the date of LMP as the first date. A date is required if injury or emergency.	Yes, if applicable
15	If patient has had same or similar illness, give first date	Enter the first date in six-digit (MM DD YY) or eight-digit (MM DD CCYY) format that the patient had the same or similar illness. Previous pregnancies are not a similar illness. Leave blank if unknown.	Yes, if applicable
16	Dates patient unable to work in current occupation	Enter dates patient is unable to work in six-digit (MM DD YY) or eight-digit (MM DD CCYY) format. Leave blank if unknown.	Yes, if applicable
17	Name of referring physician or other source	Enter the name of the physician or other source that referred the patient to the billing provider or ordered the test(s) or item(s).	Yes, if applicable
17a SHADED	Other ID #	Enter the two-character qualifier and other ID.	No
17b UNSHADED	Referring provider NPI	Enter the 10-digit NPI.	Yes, if applicable
18	Hospitalization dates related to current services	Enter the inpatient hospital admission date followed by the discharge date (if discharge has occurred) using the six-digit (MM DD YY) or eight-digit (MM DD CCYY) format. If not discharged, leave discharge date blank.	Yes, if applicable

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Field Location CMS 1500	Field Name	Field Description	Required
19	Reserved for local use	Not used.	N/A
20	Outside lab? \$Charges	For lab services, enter an "X" in Yes if the reported service(s) was performed by an outside laboratory. If yes, enter the purchase price. Enter an "X" in No if outside lab service(s) is not included on the claim.	Yes, if applicable
21	Diagnosis or nature of illness or injury	List up to four ICD-9-CM diagnosis codes. Relate lines 1, 2, 3, 4 to lines of service in 24E by line number. Use the highest level of specificity.	Yes
22	Medicaid resubmission	For Medicaid resubmission claims only.	No
23	Prior authorization number	Enter the prior authorization as assigned by the payer for the current service.	Yes, if applicable
24A-24G SHADED	Narrative Description	Enter the supplemental information in the shaded section of 24A through 24G above the corresponding service line. If an unlisted or unclassified code is used, a narrative description must be present. Use this for NDC drug codes.	Yes, if applicable
24A UNSHADED	Date(s) of service	Enter the six-digit date(s) of service in (MM DD YY) format.	Yes
24B UNSHADED	Place of service	Enter the two-digit place of service code.	Yes
24C UNSHADED	EMG	Emergency indicator. Enter Y for "Yes" or leave blank for "No."	Yes, if applicable
24D UNSHADED	Procedures, services or supplies	Enter CPT or HCPCS code and modifier(s).	Yes
24E UNSHADED	Diagnosis code	Enter diagnosis pointer(s) referenced in field 21 to indicate which diagnosis code(s) apply to the related CPT or HCPCS code. Do not enter ICD-9-CM codes or narrative descriptions in this field. Do not use slashes, dashes or commas between reference numbers.	Yes



Field Location CMS 1500	Field Name	Field Description	Required
24F UNSHADED	\$ Charges	Enter the charge amount in (Dollars/Cents) format. If more than one date or unit is shown in field 24G, the dollar amount should reflect the TOTAL amount of the services. Do not indicate the balance due, patient liability, late charges/credits or a negative dollar line. Do not use decimals or dollar signs.	Yes
24G UNSHADED	Days or units	Enter number of days or units on each line of service. For anesthesia, enter total time in minutes. Do not include base units.	Yes
24H UNSHADED	EPSDT Family Planning	If related to EPSDT, enter Y for "Yes" with a valid referral code. If not related to EPSDT, enter N for "No." If related to Family Planning, enter a Y for "Yes" or leave blank for "No."	Yes, if applicable
24J UNSHADED	Rendering Provider NPI	Enter the 10-digit NPI.	Yes
25	Federal Tax ID number	Enter their Employer Identification Number (EIN) and place an "X" in the EIN box. If not available, enter their Social Security Number (SSN) and place an "X" in the SSN box. Only one box can be marked.	Yes
26	Patient's account number	Enter the patient's account number.	Yes
27	Accept assignment?	Place an "X" in the appropriate box – for Medicaid, assignment should always be marked "YES."	Yes
28	Total charge	Enter the sum of the charges in column 24F (lines 1-6). Enter the total charge amount in (Dollars/ Cents) format. Do not use negative numbers.	Yes
29	Amount paid	Enter payment amount from the patient or other payer. If other payer payment, an Explanation of Benefits is required.	Yes, if applicable
30	Balance due	Leave blank.	Leave blank.
31	Signature of physician or supplier including degrees or credentials	Enter the signature of the physician, provider, supplier or representative with the degree, credentials or title and the date signed.	Yes

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Field Location CMS 1500	Field Name	Field Description	Required
32	Service facility location information	Enter the name and actual address of the organization of facility where services were rendered if other than box 33 or patient's home. Enter this information in the following format: Line 1: name of physician or clinic Line 2: address Line 3: city, state, zip code	Yes
32a UNSHADED	Service Facility NPI	Enter the 10-digit NPI.	Yes
33a UNSHADED	Billing Provider NPI	Enter the 10-digit NPI.	Yes, if applicable

1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																																																									
1. MEDICARE <input type="checkbox"/> (Medicare#)					MEDICAID <input type="checkbox"/> (Medicaid#)					TRICARE <input type="checkbox"/> (ID#/DoD#)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (ID#)					FECA BLK LUNG <input type="checkbox"/> (ID#)					OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																										
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																																																															
CITY					STATE					8. RESERVED FOR NUCC USE					CITY					STATE					8. RESERVED FOR NUCC USE																																																																										
ZIP CODE					TELEPHONE (Include Area Code)					ZIP CODE					TELEPHONE (Include Area Code)					8. RESERVED FOR NUCC USE																																																																															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					10d. CLAIM CODES (Designated by NUCC)																																																																
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE																																																																															
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)										15. OTHER DATE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION																																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI										17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																																																																					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY										22. RESUBMISSION CODE																																																																															
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. EP/SOT Family Plan										I. ID. QUAL.										J. RENDERING PROVIDER ID. #									
25. FEDERAL TAX I.D. NUMBER										SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT?										28. TOTAL CHARGE										29. AMOUNT PAID										30. Rsvd for NUCC Use																																							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #																																																																															
SIGNED										DATE										a. NPI										b. NPI																																																																					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

## Section XVIII: Forms

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

### REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

### BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

### SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.**

### NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

### MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

## UB-04 Data Field Requirements

Field Location UB-04	Description	Inpatient	Outpatient
1	Provider Name and Address	Required	Required
2	Pay-To Name and Address	Required	Required
3a	Patient Control Number	Required	Required
3b	Medical Record Number	Situational	Situational
4	Type of Bill	Required	Required
5	Federal Tax Number	Required	Required
6	Statement Covers Period	Required	Required
7	Future Use	N/A	N/A
8a	Patient ID	Required	Required
8b	Patient Name	Required	Required
9	Patient Address	Required	Required
10	Patient Birthdate	Required	Required
11	Patient Sex	Required	Required
12	Admission Date	Required	N/A
13	Admission Hour	Required	Required
14	Type of Admission/Visit	Required	N/A
15	Source of Admission	Required	Required
16	Discharge Hour	Required	N/A
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required if applicable	Required if applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A

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Field Location UB-04	Description	Inpatient	Outpatient
31-34	Occurrence Code and Dates	Required if applicable	Required if applicable
35-36	Occurrence Span Codes and Dates	Required if applicable	Required if applicable
37	Future Use	N/A	N/A
38	Subscriber Name and Address	Required	Required
39-41	Value Codes and Amounts	Required if applicable	Required if applicable
42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
44	HCPCS/Rates	Required if applicable	Required if applicable
45	Service Date	N/A	Required
46	Units of Service	Required	Required
47	Total Charges (By Rev. Code)	Required	Required
48	Non-Covered Charges	Required if applicable	Required if applicable
49	Future Use	N/A	N/A
50	Payer Identification (Name)	Required	Required
51	Health Plan Identification Number	Optional	Optional
52	Release of Info Certification	Required	Required
53	Assignment of Benefit Certification	Required	Required
54	Prior Payments	Required if applicable	Required if applicable
55	Estimated Amount Due	Required	Required
56	NPI	Required	Required
57	Other Provider IDs	Optional	Optional
58	Insured's Name	Required	Required
59	Patient's Relation to the Insured	Required	Required
60	Insured's Unique ID	Required	Required

Field Location UB-04	Description	Inpatient	Outpatient
61	Insured Group Name	Situational	Situational
62	Insured Group Number	Situational	Situational
63	Treatment Authorization Codes as assigned by payer	Required if applicable	Required if applicable
64	Document Control Number	Situational	Situational
65	Employer Name	Situational	Situational
66	Diagnosis/Procedure Code Qualifier	Required	Required
67	Principal Diagnosis Code/Other Diagnosis Codes	Required	Required
68	Future Use	N/A	N/A
69	Admitting Diagnosis Code	Required	Required if applicable
70	Patient's Reason for Visit Code	Situational	Situational
71	PPS Code	Situational	Situational
72	External Cause of Injury Code	Situational	Situational
73	Future Use	N/A	N/A
74	Principal Procedure Code/Date	Required if applicable	Required if applicable
75	Future Use	N/A	N/A
76	Attending Name/ID-Qualifier 1 G	Required	Required
77	Operating ID	Situational	Situational
78-79	Other ID	Situational	Situational
80	Remarks	Situational	Situational
81	Code-Code-Field/Qualifiers *O-A0 *A1 -A4 *A5-B0 *B1 -B2 *B3	N/A Situational N/A Situational Required	N/A Situational N/A Situational Required

Section XVIII: Forms

1		2		3a PAT. CNTRL # b. MED. REC. #		4 TYPE OF BILL	
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		a		9 PATIENT ADDRESS		a	
b		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR	
17 STAT		18		19		20	
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29 ACCT STATE		30		31		32	
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**UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE <http://www.nubc.org/> FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Section XVIII: Forms

## Most Commonly Used Eligible Codes

MHP Commercial, McLaren Health Advantage, McLaren Advantage (HMO)

Code	Explanation	Code	Explanation
001	Loss prior to effective date of coverage	PTP	PT covered only when billed by PT for continuous PT
002	Loss after termination date of coverage	RPC	Report CPT or CCPCS when billing this revenue code
01	Covered by other insurance (see COB)	TKB	Payment reduced due to previous payment
02	Service is not reimbursable	UER	Additional documentation required
05	Maximum benefit reached	WH	Withhold on provider
10	Duplicate charges previously considered	OPPS PAYMENT STATUS CODES	
11	Adjustment of previously processed claim	A	Services paid under fee schedule or other prospectively determined rate
34	Claim not submitted timely basis	AA	Ambulance fee schedule item
ADX	Invalid admitting diagnosis	AD	DMEPOS fee schedule item
ANT	Resubmit total anesthesia time units in minutes	AL	Clinical laboratory fee schedule item
ASC	Procedure typically performed as an outpatient	AM	National fee schedule item
AST	Assistant surgeons reimbursed at 16% MHP allowable	AR	Physician fee schedule item
ATH	Authorization required	AX	Other fee schedule item
BEN	Procedure/service is not a covered benefit	B	Service not allowed under OPPTS on hospital outpatient claim
CAP	Services are capitated	C	Inpatient serve, not paid under OPPTS
CLB	Lab services capitated through Joint Venture Hospital Laboratories (JVHL)	E	Non-covered service, not paid under OPPTS
CPT	Procedure code does not exist or invalid	F	Corneal, CRNA and Hepatitis B

Code	Explanation	Code	Explanation
ICD	ICD-9 diagnostic code does not exist or invalid	G	Drug/biological pass-through
IDX	Incomplete diagnostic code 4th & 5th digit required		
IWH	IPHN withhold		
MDF	Correct modifier missing or invalid		
NCB	Procedure not a covered benefit		
NSR	Procedure not separately reimbursable		
PCT	Provider terminated from plan prior to/after date of service		
POS	Procedure not typically performed in the POS noted		
PPC	Payment reduced to previously processed claim		

## EDI Claim File Instructions

MHP utilizes ENS Optum Insight as its preferred vendor for EDI claims submissions. To become a customer of ENS Optum Insight, or if you are already a customer and are having difficulty submitting claims electronically, please contact the ENS Optum Insight's Payer Services team at [inform@optum.com](mailto:inform@optum.com). ENS Optum Insight has affiliations with various clearinghouses and uses them as "channel partners" to submit claims. Some of those clearinghouses include:

Relay Health (McKesson)	Gateway EDI
MedAvant	Payerpath / MISYS
ClaimLynx	PerSe
Claim Logic	SSI Group
CPSI	ZirMed

If they are using one of ENS Optum Insight's channel partners, your claims will be received by MHP.

MHP accepts the standard ANSI 837 professional and institutional file formats for claims billed electronically. In addition to the ANSI 837 data requirements, below are some key points to consider when submitting claims electronically to ensure the quickest and most accurate results:

## Section XVIII: Forms

### Individual Providers

- » Enter each part of name in **separate fields**
- » Use format: LASTNAME FIRSTNAME MIDDLE INITIAL (not required) TITLE (not recommended)
- » No punctuation (example: EDI with NPI: NM1\*85\*1\* SMITH\*JOHN\*A\*\*\*XX\*12345)
- » If their software does not allow name separation, contact Provider Relations at (888) 327-0671 to discuss options

**Companies/Groups** – Enter as much of full name as possible in last name field

- » Use format: GROUPNAME
- » No punctuation (see example above)

### Billing Provider Street Address (ALL Providers)

- » Full city name as space allows and standard USPS 2-digit state abbreviation
- » **IMPORTANT: use 9-digit ZIP Code**
- » Each in a separate field

**Member Group Number:** Must be filled in. Can be a default of 999999

**MEMBER – IL:** (same for QC dependent as applicable)

**Member Name:** Enter each part of name in **separate fields**

- » Use format: LASTNAME FIRSTNAME MIDDLEINITIAL
- » Note: incorrect spelling of name can cause rejection

### Member Identification #

- » Utilize the Member ID # as presented on the Member's ID card; if the ID # does not match, your claim will be REJECTED Address: Member Street, City, State, ZIP (same format as billing provider)

**Member Date of Birth:** (and any other date)

- » CCYYMMDD – no punctuation (example: 20030114)

### Claims Detail

- » Units value cannot be 0

### Alternate Providers Info

- » Individual Providers – enter each part of name in **separate fields**
- » Format: LASTNAME FIRSTNAME MIDDLEINITIAL (not required) TITLE (not recommended)
- » No punctuation
- » Alternate Provider Street Address – where applicable

For assistance in submitting an electronic claim file, please contact ENS Optum Insight at <http://enshealth.com> or your current clearinghouse. For claims status, visit the McLaren Connect Provider Portal.

## Provider Referral Form – Request for Preauthorization

Electronic submission of authorization requests is available on our website at [McLarenHealthPlan.org](http://McLarenHealthPlan.org).



### Provider Referral Form Request For Pre-Authorization

Member First Name:		Date of Request:	<b>Member's Plan</b> <b>Fax: (810) 600-7959</b> Medicaid _____ Healthy Michigan _____  <b>Fax: (810)600-7966</b> HMO Commercial/ Community _____ POS Commercial/ Community _____ Health Advantage _____
Member Last Name:		Member ID:	
DOB:			
<b>Ordering Provider Information:</b>			
Name:		Specialty:	
Address:		City/Zip:	
Phone:	Fax:		
Office Contact Name:			
<b>Member is being referred to:</b>			
Name:		Specialty:	
Address:		City/Zip:	
Phone:	Fax:		
Office Contact Name:			

**\*Check Requested Service (see back of form for complete list by product):**

<b>__Out-of-Network Consult</b>		Specialty:	# of visits:
Physician Name:		Notes:	ICD-10:
Billing NPI (required):			
<b>__Outpatient Ambulatory Procedure**</b>		Facility Name:	ICD-10:
Performing Surgeon Name :		Date of Procedure:	Procedure Codes:
Billing NPI (required):			
<b>__Inpatient Procedure</b>		Facility Name:	ICD-10:
Performing Surgeon Name :		Date of Procedure:	Procedure Codes:
Billing NPI (required):			
<b>__Therapy</b> (4/1/18 Medicaid visit limit of 36 annual visits each of PT/OT/ST)		<b>__Home Health Care</b> (4/1/18 Medicaid visit limit of 36 annual visits each of PT/OT/ST)	
ICD-10:		ICD-10:	
Start of Care:		Start of Care:	
PT: # of visits: _____		SN: # of visits: _____	
ST: # of visits: _____		PT: # of visits: _____	
OT: # of visits: _____		OT: # of visits: _____	
		ST: # of visits: _____	
<b>__DME (Attach Medical Necessity)</b>		<b>__Hospice</b>	
ICD-10:		ICD-10:	
Rental: _____		Certification Period:	
DME Codes:			
Purchase: _____			
<b>__Injectable/IV Therapy</b>			
See Referral Category "Specialty Medications/Injections"			
ICD-10:			
J-Codes:			
Notes:			

1. Please see the Preauthorization grid for a detailed listing of services requiring pre-authorization by product.
  2. For Medicaid, McLaren HMO/POS, McLaren Advantage: If a specialist is completing this form, you must notify the PCP of services requested.
  3. This authorization is for the services requested. The actual procedure codes billed may require additional documentation for reimbursement.
  4. \*\*List of outpatient codes requiring pre-authorization may be found on [McLarenHealthPlan.org](http://McLarenHealthPlan.org)
  5. This pre-authorization is not guarantee of payment. Please contact McLaren Health Plan to verify eligibility and covered benefits.
- All information, including any attachments are confidential and intended solely for the use of the intended recipient(s). All information is privileged or otherwise protected from disclosure by applicable law. Any unauthorized disclosure, dissemination, use or reproduction is strictly prohibited. If you receive in error, please notify the sender immediately and destroy the information.
- 3245 Beecher Road • Flint, Michigan • 48532 • tel (888) 327 0671 • fax (810) 600 7959 • [McLarenHealthPlan.org](http://McLarenHealthPlan.org)

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Section XVIII: Forms

This is not a complete listing of services that may require Preauthorization and all services rendered must be medically necessary. The Certificate of Coverage or Plan Document includes more detailed information.				
X= Requires Pre-Authorization NC= Not covered by this product NR= Auth not required	Medicaid	Healthy Michigan Medicaid	Commercial/Community HMO/POS	Health Advantage (HA)
All Inpatient Services - obtained by admitting facility. Exception - Deliveries without sterilization requires only notification for all lines of business both contracted & non-contracted facilities. Community HMO/POS/HA - Non-contracted facilities are reimbursed at member's out-of-network benefit.	X	X	X	X
Inpatient Mental Health (MH) - obtained by admitting facility	NC	NC	X	X
All Out of Network Services (non-contracted providers)** <b>Individual Plans on the Exchange should verify out of network benefits prior to receiving services.</b>	X	X	X	X
Ambulance: Non-Urgent Transportation	X	X	X	X
Ambulance: Air, Emergent (Requires post-service review)	X	X	X	X
Applied Behavioral Analysis (ABA Therapy)	NC	NC	X	NC
Autism Services	NC	NC	X	Screening Only
Chiropractic (Medicaid up to 18 visits per calendar year. Additional visits require preauthorization)	NR	NR	NR	NR
Continuous Glucose Monitors/Supplies	X	X	X	X
Cosmetic Services	X	X	X	X
<b>MEDICAID</b> DME Purchase - (Durable Medical Equipment) - (allowable line by line as per Medicaid fee schedule)	>\$1500	>\$1500		
<b>MEDICAID</b> DME Rental - (allowable line by line as per Medicaid fee schedule)	>\$500/Mth	>\$500/Mth		
DME Purchase - (billable charges line by line)			>\$3000	>\$3000
DME Rentals (billable charges line by line)			>\$500/Mth	>\$500/Mth
Electroconvulsive Therapy (ECT)	NC**	NC**	X	X
Emergency Medical Response System	X	X	X	X
Genetic Testing, Counseling, Diagnosis and Treatment	X	X	X	X
Hearing Aids (Commercial requires rider)	NR	X	HMO=NC POS=X	NC
Home Health Care	X	X	X	NR
Hospice	X	X	X	NR
Infertility Testing and Services	X	X	X	X
Injectables/IV Therapy (See J Code List)	X	X	X	X
In-Office Laboratory Procedure (Presumptive Drug Class Screening)	NC	NC	NC	NC
Insulin Pumps/Supplies	X	X	X	X
Maternity Services-Out of Network	X	X	X**	NR**
Medication non-formulary drug requests (see formulary)***	X	X	X	X
Mental Health Outpatient Services:	NR	NR	NR	NR
In Network Consultations and Management	NR	NR	NR	NR
In Network Eating Disorders	NR	NR	NR	NR
In Network Substance Abuse	NC	NC	NR	NR
Oral procedures including TMJ and orthognathic	X	X	X	X
Podiatry Office Visits	NR	NR	NR	NR
Private Duty Nursing Services	NC	NC	NC	NC
Procedures to Treat Asthma (Bronchial Thermoplasty)	X	X	X	X
Prosthetics and Orthotics	>\$500	>\$500	>\$3000	>\$5000
Proton Beam Therapy	X	X	X	X
Rehabilitative Outpatient Facility Services	X	X	X	NR
Routine Prenatal Care In and Out of Network	NR	NR	X**	X**
Skilled Nursing Home	X	X	X	NR
Sterilization-Voluntary	X	X	X	NR
Termination of Pregnancy	X	X	X	NR
Therapies: Physical, Occupational and Speech <b>(10/1/18 The Medicaid visit limit of 36 visits each for PT/OT/ST will be calculated based on calendar year)</b>	NR	NR	X	NR
Transplant Services (Organ and Tissue)	X	X	X	X
Transportation	X	X	NC	Transplant related only
This is not a complete listing of services that may require Pre-Authorization and all services must be medically necessary. The Certificate of Coverage, Plan Document or Policy includes more detailed information.				
**Health Advantage/Community/Commercial: Not all Out of Network services require Pre-Authorization. Member will have higher out of pocket costs associated with Out of Network providers. **Individual Plans on the Exchange should verify out of network benefits prior to receiving services.				
**Medicaid/Healthy Michigan - This benefit is managed by the Prepaid Inpatient Health Plan (PIHP) or the Community Mental Health Center (CMH) Medicaid/Healthy Michigan - Some Services covered under the Medicaid Mental Health Benefit Medicaid sterilization requests require informed consent and a 30-day waiting period. Copies must be submitted with pre-authorization request				
***McLaren Health Plan does not pay for services, treatment or drugs, that are experimental, investigational or prescribed against FDA or manufacturer guidelines. Any service that may be classified as experimental or off-label should be prior authorized before the service is rendered***				

If you have any questions, please call (888) 327-0671 or visit our website for clarification - McLarenHealthPlan.org

## Provider Claims Status Fax Form

Claims can be statused on the McLaren Connect Provider Portal or by submitting this form to Customer Service.



Claims must first be statused via the McLaren CONNECT Provider Portal  
 Provider Claims Status Fax Form Fax: (833) 540-8648  
 Email: [MHPCustomerService@mcclaren.org](mailto:MHPCustomerService@mcclaren.org)

Please complete form and fax to McLaren Health Plan (MHP) and we will fax back a status response.

Date:	From:	
Phone Number:	Fax Number:	Number of Pages Faxed:

- » Please allow 15 days for MHP to process and/or respond to all claims status fax forms
- » Claims will not be reviewed if status is requested **less** than 45 days from the date MHP received the original claim
- » Attach a copy of the original claim

Please complete the following information (required for each claim)	
Member Name:	Member ID #:
MHP Claim Number:	Date of Service:
Provider Name:	Provider NPI#:
Procedure Code:	Charges:
Comments	

MHP Status Response (for MHP use only)				
	Claim Processed	EOB Date:	Check #:	Amount:
	Claim Denied	Reason:		
	Corrected Claim Needed	Correction Needed:		
Comments:				

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

**Important:** This message, including any attachments, is confidential and intended solely for the use of the intended recipient(s). This message may contain information that is privileged or otherwise protected from disclosure by applicable law. Any unauthorized disclosure, dissemination, use, or reproduction is strictly prohibited. If you have received this message in error, please destroy it and notify the sender immediately.

Provider Claims Adjustment



McLaren Health Plan and McLaren Health Advantage  
 Provider Claim Adjustment Request Form  
 WHEN TO USE THIS FORM:

A **Claim Adjustment** - is a request for payment reconsideration for a paid or denied claim. Any claim for which an Explanation of Payment (EOP) was issued that was paid inappropriately, or was denied, must be resubmitted on a paper claim (not EDI) with supporting documentation as an adjustment.

**Claim Adjustment Request Time Frame** - All claim adjustment inquiries and requests must be made to McLaren Health Plan (MHP) **within 90 calendar days** of the most current MHP/MHA EOP. Any inquiry or request made **after 90 calendar days** will not be given consideration. The acknowledgement of receipt date will only be considered when a completed request form and supporting documentation is received by MHP/MHA.

Complete the following required information:

Member Name:	ID #:
MHP Claim #:	DOS::
Provider Name:	Tax ID #:
Office Contact:	NPI #:
	Phone #:
Date Provider Claim Adjustment Request Form Submitted:	

Reason for Request (please check appropriate box):

<p>For a correction to a previously submitted claim:</p> <p><input type="checkbox"/> Anesthesia Time</p> <p><input type="checkbox"/> Date of Service</p> <p><input type="checkbox"/> Diagnosis Code</p> <p><input type="checkbox"/> Modifier</p> <p><input type="checkbox"/> MS DRG</p> <p><input type="checkbox"/> Place of Service</p> <p><input type="checkbox"/> Procedure Code</p> <p><input type="checkbox"/> Provider/Tax ID</p> <p><input type="checkbox"/> Other _____</p>	<p>For reconsideration: (supporting documentation required)</p> <p><input type="checkbox"/> Service denied for lack of authorization</p> <p><input type="checkbox"/> (attach copy of referral)</p> <p><input type="checkbox"/> Service denied as other insurance primary (COB)</p> <p><input type="checkbox"/> (attach copy of primary EOB)</p> <p><input type="checkbox"/> Service denied as a duplicate</p> <p><input type="checkbox"/> (attach documentation)</p>
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Send this completed Provider Claim Adjustment Request form along with the paper claim form (not EDI) and supporting documentation to:

McLaren Health Plan  
 Attention: Customer Service  
 P.O. Box 1511 Flint, MI 48501-1511  
 Or Fax to: (833) 540-8648

For questions regarding the Provider Claims Adjustment Process, call Customer Service at (888) 327-0671.



## Provider Request for Appeal (PRA) Form



### Provider Administrative Appeals

It is the goal of McLaren Health Plan to resolve provider issues before reaching an appeal level. McLaren Health Plan encourages providers to first contact Customer Service when a dispute occurs. If, after informally attempting to resolve the dispute through a verbal contact or a Provider Claims Adjustment, a provider continues to disagree with an administrative action taken by McLaren Health Plan, a written formal appeal may be filed.

Note: Providers who are appealing a professional clinical care review or a credentialing or re-credentialing action must pursue a different appeal process.

The following summarizes the McLaren Health Plan Administrative Appeals Process:

What Administrative Disputed Actions Can Be Appealed	
<p>A provider may appeal an administrative action taken by McLaren Health Plan such as:</p> <ul style="list-style-type: none"> <li>» Denial of inpatient days or other services</li> <li>» Place of service authorization (inpatient verses outpatient)</li> <li>» Denial of authorization</li> <li>» Payment issues</li> <li>» Clinical claim edits</li> <li>» Denial of a claim</li> </ul>	
Appeal Process	Provider Appeal Time Frames
<p><b>Within 90 calendar days of the disputed action by MHP</b>, the provider must complete and submit a Provider Request for Appeal (PRA) form and attach a copy of the claim in paper form. These two items and any additional information can be mailed, faxed or emailed to:</p> <p>McLaren Health Plan                      G-3245 Beecher Road                      Flint, MI 48532                      Attn: Appeals                      Fax: 810-600-7984                      Email: <a href="mailto:mhpappeals@mcclaren.org">mhpappeals@mcclaren.org</a></p> <p>Supporting documentation must be included with the PRA form. This would include information not previously submitted regarding the reason and rationale for the appeal. Additional information may include charts and office notes, radiology or lab/pathology report(s), operative notes or surgery reports, etc.</p> <p>The paper claim must be attached to the PRA form (cannot submit EDI).</p>	<p>PRA must be received <b>within 90 calendar days of the disputed action</b>. Disputed action dates are from the latter of the:</p> <ul style="list-style-type: none"> <li>» Explanation of payment (EOP)</li> <li>» Original claim date of service</li> <li>» Adjusted EOP</li> <li>» Authorization Decision</li> </ul> <p>The right to appeal is forfeited if the provider does not submit a written request for an appeal within this 90 calendar day time frame, and any charges in dispute must be written off.</p>

Section XVIII: Forms

Provider Request for Appeal (PRA) Form



Appeal Process Investigation and Result	Appeal Response Time Frame
<p>McLaren Health Plan staff will research the necessary contractual, benefit, claims, medical record information, and other pertinent clinical documentation to reassess the appropriateness of the initial decision and make a new determination, if appropriate.</p>	<p>Provider will be notified in writing within 60 calendar days from receipt of written appeal request.</p>
<p><b>Process Clarification</b></p> <ul style="list-style-type: none"> <li>» Provider must have submitted a claim for the service in question and/or received a denial or reduction in payment before an appeal will be considered</li> <li>» A <b>written request</b>, through the completion of a PRA form and the attachment of a paper claim, must be submitted to begin the Appeals Process</li> <li>» A <b>cover letter</b> outlining the reason and rationale for the Appeal request must accompany the PRA</li> <li>» Your written request should include any <b>new information</b>, such as:             <ul style="list-style-type: none"> <li>» documentation from the medical record</li> <li>» an explanation of payment</li> <li>» other applicable documentation to support your position</li> </ul> </li> </ul>	

**Medicaid Appeals**

Non-contracted hospitals providing services to McLaren Health Plan members through the Michigan Department of Community Health Hospital Access Agreement are eligible to request a Rapid Dispute Resolution Process in compliance with the Medicaid Provider Manual, after hospital has first exhausted its efforts to achieve resolution through McLaren Health Plan’s Administrative Appeals Process.

Non-contracted hospitals that have not signed a Hospital Access Agreement, or non- contracted non-hospital providers do not have access to the Rapid Dispute Resolution Process. These providers serving McLaren Health Plan Medicaid members are entitled to initiate a binding arbitration process, after the Provider has first exhausted their efforts to achieve resolution through McLaren Health Plan’s Administrative Appeals Process as outlined above. To initiate binding arbitration, call McLaren Health Plan to obtain a list of arbitrators. Arbitrators are selected by the State of Michigan, Department of Community Health. The decision of the arbitrator is final. If the arbitrator does not reverse the decision, the provider is responsible for the arbitrator’s charges.



**Provider Request for Appeal (PRA) Form**

A formal **Provider Appeal** process is made available to any provider who challenges administrative action taken by McLaren Health Plan (MHP).

Appeal Time Frame - A PRA must be submitted to MHP or within **90 calendar days** of the administrative action. The PRA form must be complete **and** supporting documentation must be included.

The right to appeal is forfeited if the provider does not submit a completed PRA form with supporting documentation (within the 90 calendar day time frame), and any charges in dispute must be written off.

Please complete the REQUIRED information below:	
Member Name:	Member ID #:
Date of Service:	MHP Claim #:
Provider Name:	Tax ID #:
Service Being Appealed:	
Reason For Appeal:	

**Required Attachments**

- » Letter documenting the rationale for the appeal request
- » Supporting documentation
- » Paper claim for the services being appealed

Name of Person Submitting Appeal:	
Phone #:	Date Submitted:
Address to Send Response:	

**Mail to:** McLaren Health Plan Attention: Provider Appeals  
G-3245 Beecher Rd. Flint, MI 48532  
Fax: (810) 600-7984  
Email: MHPAppeals@mcclaren.org

For questions regarding the Provider Request for Appeal Process, call Customer Service at (888) 327-0671

The Provider Request for Appeal Form is available online at McLarenHealthPlan.org.

MHP42721081 Rev. 12/18

## Section XIX

# Emergency and Urgent Care Guidelines

Members must contact their PCP prior to an urgent care or emergency department (ED) visit unless the member has what he or she believes to be a life-threatening emergency.

### Emergency Care

Emergency care is defined as a sudden and/or unexpected sickness or injury that could result in a serious problem or death, if not treated right away. Examples of emergency conditions include:

- » Serious bleeding
- » Loss of consciousness
- » Convulsions or seizures
- » Severe breathing problems

If an ED visit is required, authorization is not needed, but the PCP should alert the hospital of the member's pending arrival. Whenever possible, the PCP should serve as the admitting physician or consult with the ED physician to promote the quality and continuity of care delivered to the member.

### Urgent Care

Urgent health problems are not life threatening, but they may require immediate attention. Members are encouraged to contact their PCP if they experience a health problem they believe requires immediate attention. Examples of common urgent health problems include:

- » Severe sore throat
- » Sprains
- » Severe headache
- » Earache

If an urgent care visit is needed, authorization is not needed.

A PCP or covering physician must be available 24 hours per day, 7 days per week to coordinate an MHP member's access to care.

### Emergency Care Reminders

If the member feels he or she has an emergent medical condition and does not have time to call the PCP, he or she is instructed to go to an MHP participating hospital emergency department or the nearest ED or call 911.

Members who present to an ED are instructed to identify themselves as an MHP member and present their MHP member identification card. Members are encouraged to notify their PCP within 24 hours or the next business day of an ED visit to ensure appropriate and immediate follow-up care may be arranged. Please contact Medical Management at (888) 327-0671 or (810) 733-9522 for more details.

## Referral Guidelines

### Provider Referral and Preauthorization Form

When a member needs care that the PCP cannot provide, a Provider Referral form needs to be completed.

A completed **Provider Referral form** and **preauthorization** are required for:

- » Any care that is referred to an out-of-network (non-contracted) physician.
- » Any service listed on the back of the Provider Referral form (see Section XVIII Forms Section).
- » Certain injections (please call Medical Management for clarification).

Preauthorization requests are subject to a medical review by MHP and may require additional information and/or documentation before a service can be approved.

### When Completing the Provider Referral Form:

- » PCP has the option of requesting an office consult with or without follow-up visits.
- » PCP must contact MHP to add any testing, outpatient procedures or additional consults to other specialists to the original office consult referral.
- » Referrals are valid for the duration of the episode of care, not to exceed one year.
- » A new referral form will be required if the episode of care exceeds one year.
- » The Provider Referral form must be completed appropriately or it will be returned to the requesting office and will not be processed by MHP.

### Authorization Number

- » The authorization number is located in the body of the Authorization Request Response form.
- » For preauthorization: After medical review occurs, the referral decision will be returned as either authorized, redirected, pended or not authorized.

### Referral Time and Scope

- » Referrals are valid for the episode of care, but not to exceed one year.
- » A contact must be made to MHP by the specialist or PCP to add services to the original referral.

## Section XIX: Emergency and Urgent Care Guidelines

- » Any addition to an original referral that is to an out-of-network provider requires preauthorization, without exception.
- » Whenever possible, the treatment plan should be delivered by the PCP in conjunction with the specialist.
- » Each referral is for the testing and the treatment of the current diagnosis and said diagnosis.
- » The referral is invalid if the member is not eligible.

The Provider Referral form Request for Preauthorization may be completed and submitted electronically, including any clinical attachments, by using the form available on the MHP website, [McLarenHealthPlan.org](https://www.mclarenhealthplan.org), under the Provider tab.

Please call Medical Management at (888) 327-0671 with questions about our referral process.

## Pharmaceutical Management

The MHP Formulary is utilized as a resource for pharmacy management with quality and cost effectiveness as the primary goals. MHP Formularies, Commercial (Community HMO/POS and McLaren Health Advantage) and Medicaid/Healthy Michigan consist of:

- » Introduction
- » Prescribing Protocols
- » Full Positive Listings and Quick Formulary Reference Guide
- » Request for Prior Authorization Procedure and Form

To facilitate the member's access to needed medications, consult our Quick Formulary Reference Guide per product. This useful tool directs the prescribing practitioner to high-quality, cost-effective medications. The first line of medication is listed by therapeutic class. The second line of medication is provided, if available. In addition, some of the non-formulary medications are also listed by therapeutic class.

Any specific prescribing restriction is listed by code per the medication. At the bottom of each page, the codes are described for your convenience. In addition, the complete Positive Drug List is available on the website at [McLarenHealthPlan.org](https://www.mclarenhealthplan.org), or you can request a hard copy by calling Customer Service at (888) 327-0671.

When prescribing a medication:

- » Consult the Quick Formulary Reference or the complete Positive Drug List.
- » Review by therapeutic class for the preferred or generic medications that are available.

- » Note any prescribing restriction codes listed by the medication.
- » If the medication needed is listed as Preferred or Generic, the member can proceed to the pharmacy with their prescription.
- » If, per the Quick Reference or the Positive Drug List, the medication is not a Preferred or Generic Medication, please review the formulary for a suitable alternative. If one cannot be found, you may request an exception to the formulary by completing a Request for Prior Authorization.
- » If, per the Quick Reference or the Positive Drug List, the medication has a prescribing restriction of Prior Authorization Required, please complete a Request for Prior Authorization.
- » If, per the Quick Reference or the Positive Drug List, the medication has any other prescribing restriction, and you wish to seek an override, please complete a Request for Prior Authorization and follow the directions for this request.

### Reminders:

- » Contact MedImpact with specific questions regarding the formulary at (888) 274-9689.
- » To obtain an exception to the formulary, submit a Request for Prior Authorization to our Pharmacy Benefit Manager, MedImpact, by fax at (888) 656-3604. Detailed instructions are on the form, which is included in the Forms Section XVIII of this manual.
- » Do not send the request to MHP.
- » MHP formularies are product specific.
- » E-prescribing is available for all MHP lines of business.

## Anesthesia

### Billing for Anesthesia Services

McLaren Health Plan requires providers to bill anesthesia services with the total number of minutes provided. The number of minutes is to be recorded in the units field. Do not add the base number of units for the procedure, as that is automatically added by McLaren Health Plan's claim system.

Modifiers are required in order to administer payment appropriately. Failure to provide the modifier will result in the claim being denied. Secondary modifiers should also be billed, as applicable.

### Payment Calculation

For payment purposes, McLaren Health Plan calculates the units by dividing the actual minutes by 15 and rounding to the nearest full unit. Anesthesia services are based on the following calculation:

## Primary Modifier

Modifier	Description	MHP's Commercial Payment % of Allowable	MHP's Medicaid Payment % of Allowable
AA	Physician personally directs the entire case	100%	
AD	Physician supervising more than four concurrent cases	60%	
GC	Physician supervising up to two anesthesia residents	100%	
QK	Physician directing two, three or four concurrent cases involving CRNAs or anesthesia assistants	60%	50%
QY	Physician is medically directing one CRNA	60%	50%
QX	CRNAs and anesthesia assistants, when medically directed by an anesthesiologist	40%	50%
QZ	Services performed by CRNAs without the medical direction of an anesthesiologist	100%	

## Secondary Modifier

Modifier	Description
QS	Monitored anesthesia care
G8	Monitored anesthesia care for complex procedure
G9	Monitored anesthesia care for patient with history of cardiopulmonary condition
52	Reduced services
53	Discontinued procedure, started but discontinued
23	Unusual services

## Hospital-Based Billing

McLaren Health Plan reimburses professional services rendered in a hospital-based or facility setting when performed by a contracted provider. Facility charges associated with evaluation and management (E&M) services in these settings are not reimbursed.

## Revenue Code 510

All charges for professional services must be billed on a CMS-1500. Revenue Code 510 is billed on a UB-04 and is used to report the technical charge associated with a physician/practitioner service. Facility charges billed in addition to professional charges with Revenue Code 510 will be denied.



as charges included in professional fee. The member is not liable for these charges. Providers are contracted based on the professional fee schedule and E&M services reimburse at a global rate that includes facility and professional services.

### OB Billing Requirements

When submitting professional claims to MHP using global prenatal, delivery and postpartum CPT codes, you are required to include on the claim the actual dates of the initial prenatal visit and the postpartum visit date using the following CPT category II codes:

- » 0500F: Initial Prenatal Care, including the date of service
- » 0503F: Postpartum Care, including the date of service

You will be reimbursed for the global payment appropriately; the documentation of the CPT category II codes is required to ensure that all dates for services rendered are captured and recorded for quality and HEDIS® reporting purposes.

### Newborn Billing Requirement

McLaren Health Plan, in accordance with the Michigan Department of Community Health Provider Bulletin MSA 14-34, is instituting the following hospital claim requirements for newborns:

- » **Reporting Newborn Priority (Type) of Admission or Visit** – Providers are required to report the appropriate priority (type) of admission or visit in accordance with NUBC guidelines. For instance, a newborn admission should be reported as type of admission “4” (newborn). When billing with type of admission “4,” providers must report special point of origin code “5” (born inside this hospital) or “6” (born outside this hospital).
- » **Reporting Newborn Birth Weight** – NUBC value code “54” (newborn birth weight in grams) is required on all claims with type of admission “4.” Birth weight should be reported as a whole number. For example, if the birth weight is 2,764.5 grams, then value code “54” amount should be reported as “2765.”
- » **Reporting Cesarean Sections or Inductions Related to Gestational Age** – Providers are expected to report the following NUBC condition codes for cesarean sections or inductions related to gestational age, as appropriate:
  - » **Condition Code “81”** – C-sections or inductions performed at less than 39 weeks' gestation for medical necessity
  - » **Condition Code “82”** – C-sections or inductions performed at less than 39 weeks' gestation electively
  - » **Condition Code “83”** – C-sections or inductions performed at 39 weeks' gestation or greater

Any claim received without this required information will be denied.

## Section XIX: Emergency and Urgent Care Guidelines

### Healthy Michigan Plan Beneficiary Notification of Copays

In accordance with the Michigan Department of Community Health L-Letter (L 14-52, date October 28, 2014), McLaren Health Plan is reminding you of the requirement to notify all Healthy Michigan Plan beneficiaries of their potential copay information when they receive services. The document below, titled "Information About Healthy Michigan Plan Copays," is to be given to each Healthy Michigan Plan beneficiary when they receive health care services. You may copy the information below. It is also available online at [www.michigan.gov/healthymichiganplan](http://www.michigan.gov/healthymichiganplan).

As a reminder, McLaren Health Plan Healthy Michigan Plan beneficiaries are not responsible for the payment of copays at the point of service as long as the service is covered by McLaren Health Plan.

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### Information About Healthy Michigan Plan Copays

Healthy Michigan Plan members enrolled in a health plan pay most copays through their MI Health Account at a later time. Below is a table that shows how much members could be expected to pay for health care services.

Covered Services	Copay	
	Income less than or equal to 100% FPL	Income more than 100% FPL
Physician Office Visits (including Freestanding Urgent Care Centers)	\$2	\$4
Outpatient Hospital Clinic Visit	\$1	\$4
Emergency Room Visit for Non-Emergency Services » Copayment applies ONLY to non-emergency services » There is no copayment for true emergency services	\$3	\$8
Inpatient Hospital Stay (with the exception of emergent admissions)	\$50	\$100
Pharmacy	\$1 preferred \$3 non-preferred	\$4 preferred \$8 non-preferred
Chiropractic Visits	\$1	\$3
Dental Visits	\$3	\$4
Hearing Aids	\$3 per aid	\$3 per aid
Podiatric Visits	\$2	\$4
Vision Visits	\$2	\$2

Not all services have copays and not all people are required to pay copays. For example, services that help members get or stay healthy, like preventive services or certain services or medications that help you manage a chronic condition, may have no copays. Also, some people don't have to pay co-pays at all, like those who are under 21.

The amount a member owes could be different than what is shown in the table. These amounts are for informational purposes only. The members' MI Health Account Statement will advise members what they're expected to pay and how the amounts were calculated.

For more information on copayment requirements, visit [www.healthymichiganplan.org](http://www.healthymichiganplan.org), or call (800) 642-3195.

### Reference Lab Billing Requirements

As laboratory testing continues to become increasingly specialized, hospital laboratories may find it necessary to refer specimens to reference laboratories for testing if they lack the capability to process the specimens in-house. This information pertains to covered laboratory procedures performed by reference laboratories that are under contractual arrangements with McLaren Health Plan contracted hospitals. This would include any laboratory procedure covered by CPT codes 80000–89999, or any applicable HCPCS codes.

Definitions of reference and referring laboratories are as follows:

- » Reference laboratory – A laboratory that receives a specimen from another, referring laboratory for testing and that actually performs the test.
- » Referring laboratory – A laboratory that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.

Following Medicare and Medicaid guidelines and applicable state and federal laws, in situations where a contracted hospital laboratory must refer a specimen to a reference laboratory, the contracted laboratory will be allowed to bill MHP for the services provided by the reference laboratory under the following conditions:

- » The reference laboratory holds the required Clinical Laboratory Improvement Amendments (CLIA) certification and state licensure, if required, to perform the test;
- » The contracted hospital laboratory and the reference laboratory have a contractual agreement to provide such services with the hospital laboratory responsible for reimbursing the reference laboratory for the services; and
- » If the service requires preauthorization, the contracted hospital laboratory must request and receive preauthorization from MHP for the services to be performed by the reference laboratory. The preauthorization number must be included on the claim.

For a list of laboratory services that require preauthorization, please visit [McLarenHealthPlan.org](http://McLarenHealthPlan.org). Follow the links to Providers/Referrals and Requests for Preauthorization/Preauthorization Program Guidelines.

MHP contracted hospitals that are in the JVHL Provider network will continue to submit all laboratory claims through their JVHL agreement.

## Section XIX: Emergency and Urgent Care Guidelines

### Urgent Care Billing Requirements

When submitting professional claims to MHP using the global urgent care billing code (99058), the following is also required:

- » Report all services by individual CPT on the claim, including the corresponding E & M code (these codes will be included in the reimbursement for the global urgent care billing code)
- » Report the rendering provider and NPI in Box 24J on the professional claim
- » Claims not including the required information may be denied

You will be reimbursed for the global payment appropriately. The documentation of the additional CPT codes is required to ensure that all services rendered are captured and recorded for quality and HEDIS® reporting purposes.

### Provider Demographic Updates

In an effort to maintain accuracy of our provider demographic information, MHP audits all providers throughout the year to update and record valid provider information. MHP requires providers to update their demographic information at least 60 days prior to the change occurring. If a change does occur, providers are encouraged to complete the Provider Change Form at [McLarenHealthPlan.org](http://McLarenHealthPlan.org) and send to MHP. The information listed below does not outline all required demographic information, only that required to be reported as a change.

Provider changes should be submitted using the **Provider Change Form** online, but may also be submitted with all of the provider information below via email to [MHPPProviderServices@mcclaren.org](mailto:MHPPProviderServices@mcclaren.org) or fax to (810) 600-7979.

### Provider Information Updates

Required Information	Previous	New
Name		
Specialty		
Tax ID		
Individual NPI		
Group NPI		
Language(s) Spoken		
CHAMPS Registered? Y or N		

Section XIX: Emergency and Urgent Care Guidelines

Required Information	Previous	New
Board Certification		
Medical Group Affiliation		
Hospital Affiliation		
Culturally and Linguistically Trained (CLAS)? Y or N		
Office Location		
Office Hours		
Pay to Information		

If you have any questions, contact Provider Relations at [MHPPProviderServices@mclaren.org](mailto:MHPPProviderServices@mclaren.org) or call (888) 327-0671.

Revised 12/2023



### Discrimination is against the law

McLaren Health Plan, McLaren Health Plan Community, McLaren Health Advantage and McLaren Medicare Supplement (collectively McLaren) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. McLaren does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation. McLaren promotes a culture of inclusivity and diversity of lived experience.

McLaren:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact McLaren's Compliance Officer. If you believe that McLaren has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, gender identity or sexual orientation you can file a grievance with:

- McLaren's Compliance Officer
  - Write: G-3245 Beecher Rd., Flint, MI 48532
  - Call: (866) 866-2135, TTY: 711
  - Fax: (810) 733-5788
  - Email: [mhpcompliance@mcclaren.org](mailto:mhpcompliance@mcclaren.org)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, McLaren's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue  
SW Room 509F, HHH Building  
Washington, D.C. 20201  
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

G-3245 Beecher Road • Flint, Michigan • 48532  
tel (888) 327-0671 • fax (877) 502-1567  
[McLarenHealthPlan.org](http://McLarenHealthPlan.org)



