McLaren HEALTH PLAN

mclarenhealthplan.org

Partners In Health

March 2025

CONTENTS

Introduction

Welcome to McLaren Health Plan's Partners in Health newsletter. This is a monthly communication that will be sent out via email and posted on our website at mclarenhealthplan.org/mclaren-health-plan/provider-communications.

If you would like to be added to our email distribution list to stay up-to-date on McLaren Health Plan's (MHP) processes and policies, learn about McLaren Health Plan community participation and sponsored events, Link directly to other online resources, and to receive this newsletter via email, please visit our website.

Customer Service

Phone: 888-327-0671 (TTY: 711)
Fax: 833-540-8648

Customer Service is responsible for assisting physicians, office staff, providers and members with questions. Representatives are available Monday through Friday from 9 a.m. to 6 p.m. Call if you have questions about:

- Transportation for MHP Medicaid and Healthy Michigan plan members
- Referrals
- Claims

MHP has FREE interpretation and translation services for members in any setting – ambulatory, outpatient, inpatient, office, etc. If MHP members need help understanding written materials or need interpretation services, call Customer Service.

McLaren Connect

If you have not yet registered for McLaren CONNECT, the provider portal, click here: https://www.mclarenhealthplan.org/mhp/mclaren-connect.aspx

McLaren CONNECT replaces the Health Edge portal and FACTSWeb. McLaren CONNECT is a secure web-based system for all MHP lines of business that allows you to:

- Verify member eligibility
- View member claims and EOPs
- View and print member eligibility rosters*
- View and print member benefit information
- View a member's demographic information
- Contact the MHP provider team

Your provider TIN and NPI are required for the login process. Logins require your username and password each time, for your security.

*Member eligibility rosters are no longer mailed to primary care offices. Using McLaren CONNECT provides access to an up-to-date roster while eliminating the delay of sending a printed roster mid-month.

McLarenHealthPlan.org

MHP's website contains information about the plan's policies, procedures and general operations. You'll find information about quality programs, preauthorization processes, health management programs, clinical and preventive practice guidelines, pharmaceutical management procedures, the pharmacy formulary, member rights and responsibilities, the provider appeal process and provider newsletters. Visit often for the most up-to-date news and information. If you would like a printed copy of anything on our website, please call Customer Service.

Interpretation and translation services are FREE to MHP members in any setting – ambulatory, outpatient, inpatient, etc. Oral interpretation services are available for people who are deaf, hard of hearing or have speech problems. If McLaren Health Plan members need help understanding MHP's written materials or need interpretation services, call 888-327-0671 (TTY: 711)

GetHelp.McLaren.org

Do you have patients who need help with food, education, housing, jobs or other 'quality of life' situations? McLaren Health Plan offers an online program to assist members who need community-based services. Simply put in a ZIP code and categories are listed with programs and services by location. There are thousands of resources to choose from, such as advocacy and legal aid; how to help pay for school; adoption and foster care services; tax preparation; mental health care; housing assistance; skills and training to enter or re-enter the workforce, among much more! Let your patients know about www.gethelp.mclaren.org.

Provider Relations

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

The Provider Relations team is responsible for physician and provider-related issues and requests, including contracting.

Provider relations representatives are assigned to physician or provider practices by county. Their services include:

- Orientations for you and/or your office staff to learn about MHP – how to submit claims, obtaining member eligibility or claims via the MHP CONNECT provider portal
- Reviewing provider incentives, quality initiatives and program updates

If you have changes to your practice such as a new federal tax identification number, a payment address change or a name change, a new W-9 is required.

Current participating Primary Care Physicians who wish to open their practices to new MHP patients can do so at any time. Simply submit your request in writing, on office letterhead, to your Provider Relations representative, requesting to open your practice to new MHP members and your representative will make the change.

Other changes, such as hospital staff privileges, office hours or services, address or phone number or on-call coverage, please contact your Provider Relations representative Notification at least 30 days prior to any change is requested to allow time to make system changes.

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

McLaren HEALTH PLAN

Provider Relations Representative Territory POD Assignments

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

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

REP I Kylie Weidenhammer (dark orange)
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Kylie.Weidenhammer@mclaren.org

PROVIDER RELATIONS

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

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

BLUE POD
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McLaren HEALTH PLAN

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Medical Management

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

Medical Management supports the needs of both MHP providers and members. Medical Management coordinates members' care and facilitates access to appropriate services through the resources of our nurse care managers.

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

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

- Preauthorization requests https://www.mclarenhealthplan.org/mhp/referral-request-form-mhp1
- Inpatient hospital care (elective, urgent and emergent)
- Medically necessary determinations of any care, including the criteria used in decision making
- Care management services
- Complex care management for members who qualify
- Disease management – diabetes, asthma, depression, Sickle Cell, hypertension, Hepatitis C, maternity care
- Preventive health education and community outreach support
- Children's Special Health Care Services (CSHCS)

Through its utilization management process, Medical Management is structured to deliver fair, impartial and consistent decisions that affect the health care of MHP members. Medical Management coordinates covered services and assists members, physicians and providers to ensure that appropriate care is received. Nationally recognized, evidence-based criteria are used when determining the necessity of medical or behavioral health services. The criteria are available to you upon request by calling the Medical Management team.

If there is a utilization denial, the member and physician will be provided with written notification – which will include the specific reason for the denial – as well as all appeal rights. MHP's Chief Medical Officer, or an appropriate practitioner, will be available by telephone to discuss utilization issues and the criteria used to make the decision.

Utilization decision making is based solely on appropriateness of care and service and existence of coverage. MHP does not specifically reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives for utilization decision-makers to

encourage decisions which would result in under-utilization.

Care Management

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

Care management is offered to all MHP members. A care management nurse is assigned to each primary care office to assist you with managing your MHP members. The MHP nurses help manage medical situations and are a resource for identified issues. This enables a circle of communication that promotes continuity of care, the member's understanding of their health care, support for the primary care physician and promotes the PCP office as the medical home.

MHP members are referred for care management services by physicians who identify at-risk patients. Complete a Referral to Care Management form found here. When MHP receives the form, a nurse begins an assessment of the member and identifies a proactive approach to managing the totality of the member's health care needs. The program focuses on preventive health management, disease management, general and complex care management and Children's Special Health Care Services (CSHCS) care management.

Program goals are:

Empower members to understand and manage their condition

Support your treatment plan

Encourage patient compliance

Preventive health management helps by:

- Informing members of preventive testing and good health practices
- Mailing reminders to members about immunizations, well-child visits and lead screenings
- Highlighting ways to stay healthy and fit in member newsletters
- Identifying members who are due for annual checkups and screenings and notifying PCPs of these patients
- Initiating call programs to assist members with scheduling annual checkups and screenings

If you do not know who your care management nurse is, please call Customer Service at 888-327-0671 (TTY: 711).

Complex Care Management

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

MHP has nurses trained in Complex Care Management (CCM). Members considered for CCM have complex care needs including, but not limited to:

- Those listed for a transplant
- Ones who have frequent hospitalizations or ER visits
- Members with multiple health care conditions
- Are part of the Children's Special Health Care Services (CSHCS)

Virtual Care Management

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

The Medical Management team at McLaren Health Plan (MHP) has virtual care management services available for members. Using the 'ZOOM for Healthcare' platform, care managers can connect with members on a personal level with face-to-face conversations while maintaining social distancing and the need for privacy.

Conversations about health maintenance, missed services – or services which are due – and other important health discussions can take place during these visits. Members currently receiving care management services, or those who would like to, are eligible to participate.

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

Living with HIV-Viral Load

In 2022, an estimated 1.2 million people in the United States had HIV.[1] Although there is no cure for HIV, prevention, early diagnosis and detection, and treatment are essential to treat HIV infection and to stop the spread. The HIV Viral Load Suppression Measure is an important indicator of the effectiveness of treatment in people with HIV. This measure demonstrates the "percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year."[2]
In addition, people with HIV that have a suppressed but detectable viral load and are adhering to their prescribed medication regime have almost zero risk of transmitting HIV to their sexual partners.[3]
Having low HIV viral load test results are especially important to individual health, sexual transmission risk, and maternal and infant health. People living with HIV who have a nondetectable viral load and

are adhering to their prescribed medications have zero risk of transmitting HIV to their sexual partners. Viral load suppression and medication adherence is also important in reducing or eliminating the risk of transmission from mom to baby during pregnancy and breastfeeding.

[1] CDC. *Fast Facts: HIV in the United States*. Retrieved from https://www.cdc.gov/hiv/data-research/facts-stats/index.html
[2] HRSA Ryan White HIV/AIDS Program. *Core Measures, HIV Viral Load Suppression*, Retrieved from https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio/core-measures/hiv-viral-load-suppression. (note this was accessed January 2025, the link currently states access denied)
[3] World Health Organization (WHO). (2023) *The Role of HIV Suppression in Improving Individual Health and Reducing Transmission*, Retrieved from https://iris.who.int/bitstream/handle/10665/360860/9789240055179-eng.pdf?sequence=1

Provider Data Attestation: Better Doctor

McLaren Health Plan has partnered with Better Doctor (Quest Analytics) to gather data attestations quarterly as required by MDHHS, CMS, NCQA and other governing bodies. This process also helps ensure our directory information is accurate. Providers and offices will receive a communication every 90 days from Better Doctor asking to have a representative visit verify.betterdoctor.com and use the access code provided to confirm the demographic information MHP currently has in our systems for each practice. The process is simple and required for continuing participation with MHP.

The easiest way to attest is by sharing your provider roster each quarter with McLaren Health Plan at mhpproviderservices@mclaren.org and Better Doctor at rosters@questanalytics.com.

When providing a roster to your Provider Relations Representative, please copy Better Doctor in your email message and add rosters@questanalytics.com to your distribution list. Attesting or sharing your roster each quarter allows MHP to keep your information most up-to-date in our records, systems and provider directories while also properly documenting information for compliance and reporting purposes.

Failure to attest to your demographic information quarterly may result in being removed from the Provider Directory.

Updating and Certifying Provider Data in NPPES

Reminder: To ensure accuracy, Medicare providers are legally required to keep their information up-to-date, including National Provider Identifiers (NPI) and corresponding data in the National Plan & Provider Enumeration System (NPPES).

The Centers for Medicare & Medicaid Services (CMS) encourages Medicare Advantage Organizations such as MHP to use NPPES as a resource for online provider directories.

Using NPPES and keeping it current provides more reliable information to Medicare beneficiaries. When reviewing your provider data in NPPES, update any inaccurate information in modifiable fields, including: provider name, mailing address, telephone and fax numbers and specialty.

- Be sure to include all addresses where you practice and actively see patients. This is the same location where a member may call and schedule an appointment.
- Do not include addresses where you could see a patient, but don't actively practice.
- Remove any practice locations no longer in use.

Once you update your information, confirm accuracy by certifying it in NPPES. Remember, NPPES has no bearing on billing Medicare.

If you have any questions pertaining to NPPES, reference NPPES help here. Direct general questions about this notice to your MHP Provider Relations Representative.

Laboratory Information - JVHL

McLaren Health Plan uses Joint Venture Hospital Laboratories (JVHL) as our exclusive vendor 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 client service support 24 hours a day, 7 days a week. Outpatient laboratory services should be received at a JVHL location when available to prevent additional out-of-pocket costs for members. For a listing of service centers and a provider directory, please contact JVHL at 800-445-4979 or visit www.jvhl.org.

- Reference Lab Billing Requirements
- In-Office Laboratory Billable Procedures

MDHHS Doula Initiative

Michigan Medicaid began reimbursing for doula services provided to individuals covered by or eligible for Medicaid effective January 1, 2023 (MMP 22-47).

Doula providers seeking reimbursement for their professional services to Medicaid beneficiaries are required to be on the MDHHS Doula Registry and enrolled in CHAMPS.

- Doulas are non-clinical providers who typically offer physical, emotional, and educational support services to pregnant individuals during the prenatal, labor and delivery, and postpartum periods.

- Evidence indicates doula services are associated with improved birth outcomes.
- Doula services have been shown to positively impact social determinants of health, support birth equity, and decrease existing health and racial disparities.
- Medicaid covers different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas.

Doula services must be recommended by a licensed healthcare provider, including but not limited to: licensed practical nurse, registered nurse, social worker, midwife, nurse practitioner, physician assistant, certified nurse midwife or physician.

Licensed healthcare providers recommending doula services are not required to be part of the beneficiary's healthcare team, but collaboration is highly encouraged.

- Beginner Guide for Doula Providers
- Doula 101
- Doula-Billing-Guidance
- Doula Fee Schedule

Doulas must submit claims to McLaren Health Plan for services rendered to MHP members with Medicaid.

- Claims and Encounters (michigan.gov)
- CHAMPS claim status instructions

Inpatient Hospital Claims – Working with HMS

On behalf of McLaren Health Plan, Health Management Systems, Inc. (HMS) conducts periodic reviews of inpatient hospital claims paid by MHP for health care services effective 11/1/24.

This review process helps to ensure the integrity of paid claims, payment accuracy, compliance with regulations, policies, and contractual requirements. These reviews apply to Medicaid and Medicare Advantage lines of business.

For more information about the process and how HMS works, visit our website: https://www.mclarenhealthplan.org/mclaren-health-plan/billing-claims-mhp

Quality Quick Tips

March is Kidney Health Awareness Month

Diabetes and hypertension (HTN) are the leading causes of Chronic Kidney Disease (CKD). Approximately 1 in 5 adults (20%) in the US with hypertension may have CKD. HTN is common in CKD, and it may aggravate CKD progression.

- Because CKD is often asymptomatic, many patients are unaware they have the disease until it has progressed to later stages.
- Early identification of CKD in your at-risk patients creates the opportunity to slow or prevent the progression of this disease and can result in decreased hospitalizations and costs.
- Understanding who has CKD allows you to provide education, develop treatment plans and goals or refer outside your practice as needed to help facilitate better outcomes for these patients.

The American Diabetes Association and the National Kidney Foundation recommend annual screening for patients with diabetes using both the eGFR and uACR lab tests. (Patients with diabetes can have changes in either their eGFR, uACR or both, so it is important to track both tests). Together the two tests, also known as the Kidney Profile, provide key information about kidney health, including determining CKD stage and risk of progression.

eGFR-Estimated Glomerular Filtration rate measures kidney function through filtration rate and is determined via a blood test.

- Creatinine Blood- CPT Code 82565 **or**
- Any of the Blood Panels which contain this test: 80047, 80048, 80050, 80053, 80069

uACR-Urine Albumin Creatinine Ratio measures kidney damage through albuminuria levels found in the urine, however, there is not one CPT code for this measurement it is a combination of 2 separate tests:

- Quantitative Urine Albumin Test – CPT Code 82043 **and**
- Urine Creatinine Test – CPT Code 82570

Resources for Patients and Providers: Are You the 33% Campaign is a strategic digital campaign from NKF focused on reaching, educating, and empowering those most at risk for CKD to take control of their kidney health -it is available at www.nkm.org/areyouthe33

Thank you for the quality care you deliver!

Authorization Changes

For the most recent and upcoming authorization information, visit McLaren Health Plan's website at mclarenhealthplan.org and select the Provider tab.

- All changes and announcements are posted online at least 60 days prior to becoming effective.
- Upcoming-Authorization-Changes.pdf

- As of 4/1/2025, the following items/services are being added and require authorization. Please see the list on the website list for specific codes:
- Community and Medicaid – Spine procedures
- Community and Medicaid – Site of service requirements for GI Procedures and Eye Procedures
    - Community, Health Advantage, and Medicaid – Certain specialty dressings and supplies
    - For all current prior authorization requirements, visit: Prior Authorization Codes List
    - For all current Medicare prior authorization requirements, visit: Medicare Prior Authorization Information

Please refer to the website for an updated authorization requirements list with effective dates of January 1, April 1, July 1, or October 1 of each year.

If you have any questions, please contact your Provider Relations Representative at 888-327-0761 (TTY: 711) for assistance.

Screen Your Patients for:

Hepatitis C

The Michigan Department of Health and Human Services (MDHHS) recommends screening for hepatitis C at least once in a lifetime for people ages 18-79. McLaren Health Plan covers the drugs used to treat Hep C. Please make sure your eligible patients are screened for this contagious infection.

Chronic Kidney Disease (CKD)

Chronic Kidney Disease (CKD) is permanent kidney damage or decreased level of kidney function for three months or more. Left untreated, CKD can lead to kidney failure. The National Kidney Foundation of Michigan (NKFM) reports 33% of adults or 1 in 3 people in the United States are at risk for kidney disease. Learn more about the NKF's "Are You The 33% campaign here: : https://nkfm.org/morris-hood-iii-ckd-and-covid-complications-prevention-initiative/kidney-risk-quiz-campaign-toolkit-2/ According to the Michigan Department of Health and Human Services, more than 1 million adults over age 20 in Michigan are living with CKD.

MDHHS has collaborated with the NKFM to raise awareness about the prevalence of kidney disease. McLaren Health Plan is also collaborating with the NKFM on multiple outreach initiatives to educate members about chronic kidney disease. Visit www.mclarenhealthplan.org for details.

The latest MDHHS/NKFM plan focuses on kidney disease prevention, early detection, management and control efforts across Michigan. Review the MDHHS/NKFM Michigan CKD Prevention Strategy at

Michigan.gov.

Sickle Cell

McLaren Health Plan's Sickle Cell management program is a comprehensive program that begins with early identification of members with Sickle Cell Disease, and through patient education and monitoring, promotes improved outcomes. The emphasis of the program is on self-management and coordination with the primary care physician (PCP) and hematologist and assisting with getting needed testing and treatment.

Program goals include emphasis on self-management, follow-up with health care providers, adherence to prescribed medications, and getting recommended testing to prevent Sickle Cell Disease complications. Ongoing individualized contacts with the member are conducted on an as needed basis to ensure understanding of treatment plans, promotion of the preventive measures and prevention of disease complications.

Psychiatry Support for Providers

The majority of children and women who have depression or anxiety do not receive treatment. That is where MC3 comes in.

ABOUTMC3

MC3 offers no-cost psychiatry support to pediatric and perinatal providers in Michigan through same-day phone consultations to offer guidance on diagnostic questions, safe medications, and appropriate psychotherapy.

CONSULTATION PROCESS

- Consult requests can be initiated by anyone in your practice with knowledge about the patient.
- Requests can be submitted either by phone using regional phone numbers or online via a secure form.
- A psychiatrist will call the prescribing provider with recommendations.
- An MC3 Behavioral Health Consultant (BHC) can provide consultations on local resources.
- Consult summary will be sent to provider.

ADDITIONAL SERVICES

In addition to provider consultations, MC3 also offers:

- Telepsychiatry patient evaluations
- Trainings

- Workflow analysis to better integrate screening, care coordination, and MC3 services
- Local and regional behavioral health resource and referral navigation
- Group case consultations with MC3 psychiatrist
- Perinatal patient care in select counties

LEARN MORE

Request a Clinic Presentation

If you'd like to learn more about MC3 services, please contact us to set up a time for a group presentation for your clinic. MC3-admin@med.umich.edu

To sign up for MC3, visit the sign up page on our website: MC3Michigan.org

Clinical Practice Guidelines Available to Assist with Decision-Making

McLaren Health Plan uses Clinical Practice Guidelines to assist practitioners and members with decision-making about appropriate health care for specific clinical circumstances. New and revised guidelines are developed and updated through collaborative efforts of the Michigan Quality Improvement Consortium (MQIC) and other evidence-based resources.

Clinical Practice Guidelines are distributed to practitioners to improve health care quality and reduce unnecessary variation in care. Documentation in your medical records should indicate you used the appropriate guideline in your practice decisions.
The Clinical Practice Guidelines were reviewed, updated and approved in September 2024 by our Quality, Safety, and Satisfaction Improvement Committee.
Please review the guidelines found at https://www.mahp.org/michigan-quality-improvement-consortium/ or visit our website.

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

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 providers to partner with us to identify and eliminate fraud, waste and abuse.

What is Fraud, Waste and Abuse?

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 consists of 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