McLaren HEALTH PLAN

McLaren HEALTH PLAN COMMUNITY

McLaren HEALTH ADVANTAGE

Provider Newsletter

Partners in Health

March 2018

In this Issue

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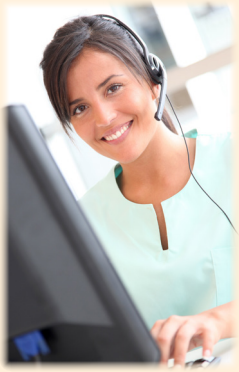
This newsletter is for providers who participate in our McLaren Health Plan, Inc. (MHP) Medicaid products, our McLaren Health Plan Community (MHP Community) commercial and Medicare Supplement products and our McLaren Health Advantage (MHP) self-funded products. Throughout this newsletter, when the article applies to all three companies, we will refer to them as "McLaren."

2018 Pay for Performance (P4P) Program



The **P4P** program provides our Primary Care Providers (PCPs) incentives that optimize quality by recognizing the outstanding efforts of physicians. Positive outcomes of the program include:

- A strong partnership between MHP and MHP Community and our contracted PCPs
- Improved health care services for members
- Physician awards of up to $2 per member per month (pmpm)

In order for a PCP to be included in the P4P program, all general terms of the P4P must be met. The following measures for the 2018 P4P are as follows:

- **Open access**: Open physician panels, to new MHP and MHP Community members, open for 12 months of measurement year
- **Health Information Exchange (HIE) / Health Information Technology (HIT) participation**
- **Well-child visit:** 70 percent of members 3-4 years of age
- **Mammograms**: 71 percent of members 50-70 years of age
- **E-prescriber and E-portal:** 90 percent annual generic prescribing rate and evidence of e-prescribing and e-portal availability for members
- **Achieved Primary Care Medical Home (PCMH)** recognition through one of the following: (must provide evidence of PCMH recognition)
  - Physician Group Incentive Program (PGIP)
  - National Committee for Quality Assurance (NCQA); or
  - Industry standard activity defined as extended hours and a patient disease registry

Any PCP with 50 or more members in January 2018 will automatically be entered in the 2018 P4P program. If you do not have enough assigned members, you must call your Network Development Coordinator, prior to June 30, to enroll.

Medical and Oral Health Collaboration/Pediatric Oral Health Screenings and Fluoride Varnish Services

MHP covers both oral health screenings and fluoride varnish services provided by PCPs. Please be sure to discuss oral health with your patients and/or their parents to ascertain if they have a dental home and assist them with a referral if they do not. If there is no dental home, please perform an oral health screening and apply fluoride varnish, if applicable.

Bright Futures/American Academy of Pediatrics recommends the following:

- Assess whether a child has a dental home starting at six months. If no dental home is identified, perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and refer to a dental home.
- Once teeth are present, fluoride varnish may be applied to all children every three to six months in the primary care or dental office for children ages 6 months through 6 years of age. The American Academy of Pediatrics has online training modules and videos available to increase PCP oral health knowledge and improve your practice, patient care and care coordination. (http://pediatrics.aappublications.org/content/134/3/626)
- If primary water source is deficient in fluoride, consider oral fluoride supplements.

Use CPT Code 99188 when applying topical fluoride varnish.

Care Coordination

Keep Talking!

The coordination of medical care is essential to a member's overall state of health. McLaren encourages providers to communicate with one another when co-treating a patient, including behavioral health issues.

Communication between providers is one of the best ways to successfully treat a patient.

Key Contact Numbers

Customer Service
Phone: (888) 327-0671 (TTY: 711)
Fax: (877) 502-1567

Medical Management
Phone: (888) 327-0671 (TTY: 711)
Fax: (810) 733-9647

Network Development
Phone: (888) 327-0671 (TTY: 711)
Fax: (810) 733-9651

Utilization Management
Phone: (888) 327-0671 (TTY: 711)
Fax: (810) 733-9647

The patient's PCP is the medical home of all health information regarding the patient's care. It is important that all medical information be related back to the PCP by:

- Prompting patients to return to their PCP after a consultation or hospital stay
- Reminding specialists to send summaries of recommendations to the PCP
- Providing communication from pharmacy data identifying polypharmacy
- Notifying members of PCP terminations
- Improving the process for members to authorize sharing of behavioral health information with their PCP
- Promoting the sharing of information by the PCP to Behavioral Health specialists when coexisting medical and behavioral health conditions exist
- Providing Behavioral Health services in the primary care home

Remember to consider this question: What does the PCP need to know to treat the member in the safest and most efficient manner?

It is the responsibility of each treating provider to adequately inform the patient's PCP of all recommendations and medical treatment being proposed.

E-Prescribing

You can access all of McLaren formulary information and prescribe through Sure Scripts®.

Take advantage of the benefits offered by e-prescribing, such as:

- Increased patient safety and higher quality care
- Avoiding drug-to-drug and drug allergy interactions
- Viewing patient medication history
- Increasing office efficiency due to fewer phone calls and faxes

E-Prescribing is part of the McLaren 2018 P4P program.

surescripts®

McLaren HEALTH PLAN

MHP Outreach Team

MHP is committed to assisting you to achieve:

- Higher P4P payment
- Increased incentive payments to both you and your patients
- Better patient outcomes when preventive services are provided
- Increased positive relationships between the plan, your office and your patients

MHP's Outreach Team of professionals is available to assist your office in scheduling your MHP assigned Commercial and Medicaid patients for preventive care visits and ancillary tests.

Using gaps in care reports provided by the health plan or by your office, the team can assist your staff in contacting and scheduling your patients for these important visits.

The Outreach Team can assist with in-office or off-site scheduling and they are trained in several electronic scheduling systems. During these patient contacts, MHP can assist your patients by:

- discussing the importance of preventive care services
- determining barriers to care and assisting with such barriers as transportation
- offering member incentives

The Outreach Team can also assist you in submitting secondary claims and monitoring to ensure that you are billing and being paid for these essential services.

If you are interested in working with the Outreach Team, please contact MHP at (888) 327-0671 (TTY:711) and ask to speak to an outreach representative.

We thank you for the quality care you deliver!

2018 PROVIDER INCENTIVE PROGRAM

LINE OF BUSINESS	INITIATIVE	INCENTIVE	HOW
Medicaid	**Adult BMI**	$5 for each member, annually	Based on billed claim; paid at time of submission
Community / Medicaid	**Chlamydia screening**	$25 per eligible member screened	Based on data of billed claim; annual payout
Medicaid	**Club 101**	$101 reimbursement for well visits, age 1–11	Based on billed claim; paid at time of submission
Medicaid	**Developmental screening**	$20 per annual screening for eligible population	Based on claim billed with appropriate codes; paid at time of submission
Community / Medicaid	**Expanded access award**	99050 / 99051 reimbursed $17.38	Based on billed claim; paid at time of submission
Community / Medicaid	**Healthy child incentive**	$15 total incentive ($5 for each annual component): - Weight assessment; - Counseling for nutrition; and - Physical activity for child/adolescents	Based on billed claim with appropriate codes; paid at time of submission
Healthy Michigan Plan	**Healthy Michigan HRA**	$50 per completed HRA for Healthy Michigan Plan members	Based on billed claim and HRA received within 150 days of enrollment
Medicaid	**Lead screening**	36416 reimburses $15 83655 reimburses $25	Based on billed claim; paid at time of submission
Community / Medicaid	**Mammogram**	$50 per eligible member screened	Based on billed claim; annual payout
Community / Medicaid	**Postpartum visit for OB-GYN providers**	$100 per eligible member	Based on billed claim and self-reported data; quarterly payout
Community / Medicaid	**Pay-for-Performance program**	PCMH recognition and up to $2 pmpm for eligible PCP assigned membership **Measures:** - Open access - Well child 3-4 yrs. - Mammogram screening - E-prescribing, EHR and E-Portal - HIE qualified organization participation - Achieved PCMH recognition	Annual payout based on prior year's performance measures

The above incentive programs are current as of the date of publication of this document. If we change a program, we will provide timely notice of any change. We reserve the right to modify our programs at any time without notice.

Referral Process

Certain outpatient services and/or procedures will be reimbursed without an authorization when performed in the outpatient setting at an in-network facility.

You can view a list of all CPT codes* that require an authorization from McLaren when provided in the outpatient setting on our website, McLarenHealthPlan.org. This list is reviewed quarterly and may be revised and updated as appropriate.

The provider referral form (Request for Preauthorization) is available on our website in two formats. There is a standard fillable PDF form that you can download, print and return by fax or mail. You can also the scan the completed form and email it to MHPAuthandCharts@mclaren.org. You now have the option of completing and submitting the provider referral form directly from our website. Go to McLarenHealthPlan.org, select **Provider**. From the dropdown menu, you can choose the referral form from the Quick Links. You may print a copy of the completed online referral request for your patients' records.

McLaren continually reviews our referral requirements in an effort to streamline processes for our participating practitioners and members. McLaren remains committed to the PCP as the care coordinator and the medical home for our members. Ongoing coordination of care remains the PCP's responsibility. McLaren will continue to educate our members on the importance of discussing all health care needs with their PCP.

Please contact McLaren at (888) 327-0671 (TTY:711) with any questions.

* Any of these procedures, when performed in the inpatient setting or at an out-of-network facility, still require an authorization. All services and/or procedures billed to McLaren must be both medically necessary and coded appropriately. McLaren reviews paid claims to ensure compliance and accuracy.

Adolescent Immunizations

The Michigan Care Improvement Registry (MCIR) is an important tool that records and tracks a child's immunization history. The tool, located at **www.MCIR.org**, can save time and money, and ensures that vaccines are not missed.

The secure website includes immediate patient immunization history and what's due, future dose dates, reminder and recall notices for due or overdue immunizations, printable official immunization records and batch reports. All McLaren providers are required to submit vaccination information to MCIR.

Both McLaren and MCIR send reminders to your patients encouraging them to receive these important immunizations.

VACCINE	AGE
Human Papillomavirus Vaccine (HPV)	**11-13 years old (3 doses) or 2 doses - at lease six months apart**
Menigococcal (MCV)	**11-13 years old**
Tetanus, Diphtheria, Pertussis (TDap)	**11-13 years old**

Well-Child Visits — Increased Reimbursement!

McLaren Health Plan (MHP) is committed to appropriate health screenings that aid in the promotion of healthy lifestyles. MHP frequently contacts our members' parents through newsletters, outreach telephone calls and mailings to remind them of the importance of such screenings.

Did you know that you can easily turn a sick visit into a well-child visit? When you have an MHP member in your office for a sick visit who is also due for a well-child visit, simply incorporate the elements of a well-child exam into the visit, and bill MHP for both the sick and well-child services performed. You can do this by adding modifier -25 to the sick visit and you will be reimbursed for both services.

Well-child visits must include physical, mental, developmental, hearing and vision components, and other tests to detect potential problems.

Please bill age-appropriate well-child codes as indicated below. When these services are provided to an MHP Medicaid member, MHP reimburses you at a higher rate than the Medicaid fee schedule. These well-child visit codes are now reimbursed at **$101** per visit.

Age	New Patient	Established Patient
Early childhood (1-4 Years)	99382	99392
Late childhood (5-11 Years)	99383	99393
Adolescent (12-17 years)	99384	99394

As another way of ensuring that our members receive this important well-child exam, MHP will reimburse you for one well-child visit each calendar year. **You don't have to wait a full calendar year to perform a well-child visit.**

Helping Your Patients Cope With Chronic Illness and Depression

For millions of people, chronic illnesses and depression are facts of life. A chronic illness is a condition that lasts for a very long time and usually cannot be completely cured. However, some illnesses can be controlled through diet, exercise and certain medications. Examples of chronic illnesses include diabetes, heart disease, arthritis, kidney disease, HIV/AIDS, lupus and multiple sclerosis.

Many people with chronic illness experience depression. In fact, depression is one of the most common complications of chronic illness. It is estimated that up to one-third of individuals with a serious medical condition experience symptoms of depression. It is not hard to identify the cause and effect relationship between chronic illness and depression.

Serious illness can cause tremendous changes in lifestyle and limit an individual's mobility and independence. Chronic illness may make it impossible to pursue the activities one enjoys, and can undermine self-confidence and a sense of hope in the future. It is not surprising that people with chronic illness often experience a certain amount of despair and sadness. In some cases, the physical effects of the illness itself or side effects of medication may also lead to depression.

What Chronic Conditions Trigger Depression?

Although any illness can trigger depressed feelings, the risk of chronic illness and depression increases with the severity of the illness and the level of life disruption it causes. The risk of depression is generally 10-25 percent for women and 5-12 percent for men. However, those with chronic illness face a much higher risk — between 25-33 percent. Depression caused by chronic illness often aggravates the condition, especially if the illness causes pain and fatigue, or limits a person's ability to interact with others. Depression can intensify pain as well as fatigue and sluggishness. The combination of chronic illness and depression also can cause people to isolate themselves, which is likely to exacerbate the depression.

What Are the Symptoms?

In people with chronic illness and depression, patients and their family members often overlook the symptoms of depression, assuming that feeling sad is normal for someone struggling with disease. Symptoms of depression are also frequently masked by other medical problems, resulting in treatment for the symptoms but not the underlying depression. When both chronic illness and depression are present, it is extremely important to treat both at the same time.

Treatment Options

Treatment of depression in chronically ill patients is similar to treatment of depression in other people. Early diagnosis and treatment can reduce stress as well as the risk of complications and suicide for those with chronic illness and depression. In many patients, depression treatment can produce an improvement in the patient's overall medical condition, a better quality of life, and a greater likelihood of sticking to a long-term treatment plan.

If the depressive symptoms are related to the physical illness or the side effects of medication, treatment may need to be adjusted or changed. When the depression is a separate problem, it can be treated on its own. More than 80 percent of people with depression can be treated successfully with medicine, psychotherapy or both. Antidepressant drugs usually begin to have a positive effect within a matter of weeks. It is important for patients to work closely with their physician or psychiatrist to find the most effective medication.

Source: www.webmd.com/depression/guide/chronic-illnesses-depression

Chlamydia Screening

The Most Often Missed Preventive Screening

The ability to screen for chlamydia using a urine sample has simplified the recommended preventive screening. However, less than 50 percent of women receive this important screening. How does your practice assure all sexually active women between 16-24 years of age and sexually active men ages 16-18 years of age are screened for chlamydia?

- Is it assessed during an adolescent well exam?
- Is it included as a component of the annual Pap smear for women?

Answering "no" to one of the above questions may indicate potential gaps within your practice as well as opportunities to provide this important preventive screen.

When your patients test positive for chlamydia, they should inform their previous sexual partners. Expedited Partner Therapy should be provided for the partners of patients with a clinical or laboratory diagnosis of chlamydia. Additional information can be found at the following MDHHS website: www.michigan.gov/documents/mdch/EPT_for_Chlamydia_and_Gonorrhea_Guidance_for_Health_Care_Providers_494241_7.pdf.

Chlamydia Screening Incentive

The chlamydia screening program is an easily achievable, simple incentive plan designed to reward and recognize MHP and MHP Community PCPs who meet the requirement of performing and ordering an annual chlamydia screening for female members age 16-24 years and male members age 16-18 years.

For each of your assigned MHP Medicaid and MHP Community members who receive a chlamydia screening as identified by the procedure codes listed below, MHP will reimburse you as follows:

PROCEDURE CODE	INCENTIVE
87491–In-office urine test 87110, 87270, 87320, 87810, 87490-87492	$25

For more information regarding this incentive, contact your Provider Network Development Coordinator at (888) 327-0671 (TTY:711).

HEDIS® — Measuring the Quality of Care

The Healthcare Effectiveness Data and Information Set (HEDIS) measures are developed and defined by the National Committee for Quality Assurance (NCQA), which evaluates heath plans for accreditation. HEDIS measures address a wide span of services and facilitate improved outcomes for members. McLaren realizes that your focus is to provide high-quality, appropriate health care and sometimes the HEDIS specifications can be confusing. We hope the brief reference of HEDIS measures we have listed will help. If you would like in-depth information regarding administrative specifications, eligible populations, exclusions from measure or other details, please contact Medical Management at (888) 327-0671 (TTY:711) or visit McLarenHealthPlan.org, select "Are you a Provider?" / Quality & Medical Management/HEDIS information.

Low Back Pain

Use of Imaging Studies for Uncomplicated Low Back Pain (18–50 years) Expectation: Adults between the ages of 18 and 50 with the primary diagnosis of low back pain are not to have any imaging studies (X-ray, MRI, CT scan) within 28 days of the diagnosis. Exclusions include: cancer, recent trauma, IV drug use or neurological impairment.

Upper Respiratory Tract Infections (URI)

McLaren annually measures the rate at which our members are diagnosed with a URI (diagnosis codes J00, J06.0, J06.9) indicative of a viral URI and are not prescribed antibiotics. Coding or billing a viral URI diagnosis (code J00) or acute nasopharyngitis (common cold) diagnosis (code J069) where antibiotics are prescribed is inconsistent with evidence-based medicine or correct coding. Sneezing, runny nose, nasal congestion and headache are the common symptoms of viral URIs. A viral URI (common cold) occurs with great frequency.

When a patient presents with a bacterial URI that requires prescription antibiotics, please ensure that you are documenting the appropriate diagnosis for the bacterial URI and your billing staff is submitting appropriate codes on claims to McLaren.

While there is no curative treatment for this type of URI, there are numerous over-the-counter (OTC) cold remedies that provide symptomatic relief. A bacterial URI can also develop. Many factors, including duration and severity of symptoms as well as underlying respiratory diseases, are considered when deciding whether to prescribe antibiotics in the treatment of URI. In contrast to viral URIs, prescription antibiotics do provide effective treatment for bacterial URIs.

Avoiding Antibiotic Treatment for Adults with Acute Bronchitis

Avoidance of antibiotic treatment in adults with acute bronchitis looks at patients 18 - 64 years of age who had a diagnosis of acute bronchitis and were not dispensed an antibiotic prescription within three days of the visit date.

What You Need to Know:

- less than 10 percent of acute cough/bronchitis are bacterial
- use antibiotics wisely to prevent antibiotic resistance
- encourage smoking cessation and avoidance of secondhand smoke
- if no relief, encourage a follow-up in three days
- educate patients on self-help measures, such as drinking extra fluids, getting rest, using antitussive agents for cough, and proper hand washing techniques

Prescribing antibiotics for acute bronchitis (diagnosis codes J20.3-J20.9) is inconsistent with evidence-based medicine unless a co-morbid diagnosis or other bacterial infection exists.

HEDIS® — Measuring the Quality of Care

Obesity and BMI Documentation

McLaren reviews obesity issues and BMI documentation during the annual HEDIS review. A review of chart documentation will be done annually to see if obesity was addressed, BMI was calculated and healthy lifestyle habits were encouraged. The obesity measures are different for children and adults.

Children

For members 3-17 years of age who have had an office visit with a PCP or OB/GYN during the measurement year, MHP looks for the following documentation:

- **BMI percentile:** Simply recording the member's height and weight or BMI number will not meet the criteria. BMI percentiles must be used, as BMI norms will vary with age and gender for children.
- **Counseling for nutrition:** Documentation with the date of the visit should include one of the following:
  - Discussion of eating habits
  - Counseling or referral regarding nutrition education
  - Providing anticipatory guidance for nutrition
- **Counseling for physical activity:** Documentation with the date of the visit should include one of the following:
  - Discussion of current physical activity behaviors
  - Counseling or referral regarding physical activity
  - Providing anticipatory guidance for physical activity

Healthy Child Incentive

This Healthy Child screening program is an easily achievable, simple incentive plan designed to reward and recognize MHP and MHP Community PCPs. As an incentive for your cooperation in this screeing endeavor, we will reimburse you annually for each asisgned MHP Community and Medicaid member, ages 3-17 as described below:

Annual Screening Tests	CPT Code	HCPCS Code	Dx Code	Incentive
Documented BMI/ BMI Percentile		G8420; or G8418; or G8417	Z68.51 – Z68.54	$5
Documented Counseling for Nutrition	97802 97803 97804	G0270, G0271 G0447, S9452 S9449, S9470	Z71.3	$5
Documented Counseling for Physical Activity		G0447 S9451	Z71.82 Z02.5	$5

In order to receive your incentive payment for each of your assigned members ages 3-17, simply follow these steps:

- Calculate and document BMI/BMI percentile
- Document and counsel for nutrition and physical activity annually
- Submit a claim to MHP/MHP Community using the identified HCPCS codes and corresponding diagnosis codes

As a contracted PCP, you are eligible to bill for and receive one annual $15 incentive per child.

HEDIS® — Measuring the Quality of Care

Adult BMI

For members ages 18-74 who had an office visit during the measurement year, McLaren looks for the following documentation:

- BMI value: Must include the date and documentation of the BMI number including weight for members 20-74 years of age.
- BMI percentile: Must include the date and documentation of the BMI percentile including height and weight for 18-19 years of age.

Resource materials for **children** are available at www.cdc.gov/growthcharts (contains growth charts, training modules, and a BMI calculator for children and teens). Resource materials for **adults** are available at www.cdc.gov/nccdphp/dnpa/healthyweight/ assessing/index.htm.

Healthy Adult Incentive-Adult BMI, for Medicaid Members, age 18-74

This healthy screening is an easily achievable, simple incentive plan designed to reward and recognize MHP's PCPs. As an incentive for your cooperation in this screening effort, MHP will reimburse you annually for each assigned MHP member as described below:

Annual Screening Test CPT Code	DX Code	MHP Reimbursement
G8417 - G8420	Z68.1, Z68.20 - Z68.39, Z68.41 - Z68.45, Z68.51 - Z68.54	$5

For each of your assigned MHP Medicaid members who present to your office, annually calculate and document their BMI. In order to receive your incentive payment, submit a claim to MHP using the identified HCPCS code and corresponding diagnosis code. As an MHP contracted PCP, you are eligible to receive one annual $5 incentive per adult.

Access to Care for All Members

McLaren is committed to appropriate health screenings that aid in the promotion of healthy lifestyles. In an effort to promote annual exams and preventive services, we want to help you identify McLaren members who have NOT received services in 2017.

- We have an Outreach Team that can assist you in contacting and scheduling your patients for preventive care services. Please contact us at (888) 327-0671 (TTY:711) if you are interested in participating with this service.
- We also will contact members (according to claims submission) who have not been seen by a PCP during 2017 and encourage them to contact your office for an appointment.
- You can contact Customer Service at (888) 327-0671 (TTY:711) for assistance with the address and telephone numbers of members who have not yet established a relationship with your office.

Both the National Committee for Quality Assurance (NCQA) and the Michigan Department of Health and Human Services (MDHHS) monitor the access rates (may consist of both well and/or sick visits) of health plans.

The measurement requires:

- children and adolescents be seen at least once per year by a PCP
- adults age 20 and older have at least one outpatient ambulatory visit per year

You can improve your HEDIS scores by:

- Submitting diagnosis codes for co-morbid conditions, such as disorders of the immune system or other diseases of the respiratory system.
- Submitting diagnosis codes for bacterial infections, if identified, such as sinusitis (J01.90), otitis media (H66.90), acute lymphadenitis (L04.9), etc.
- Coding and billing for all diagnoses based on your patient evaluation
- Submitting claims for McLaren members including secondary (COB) claims

Treatment of Children and Adolescents with Acute Pharyngitis

McLaren follows the Michigan Quality Improvement Consortium (MQIC) guidelines in reference to the recommended assessment, diagnosis and treatment of acute pharyngitis in children and adolescents.

Assessment to identify **high risk patients**:

- a past history of rheumatic fever (especially carditis or valvular disease)
- household contact with a history of rheumatic fever

A **high risk** patient should start antibiotics immediately. If a throat culture is obtained and is negative, stop antibiotics.

Assess the likelihood of strep pharyngitis using the following:

- sudden onset
- sore throat
- fever
- patchy discrete exudate
- severe pain on swallowing
- absence of cough
- inflammation of pharynx and tonsils
- tender, enlarged anterior cervical nodes
- patient ages 5-15 years
- presentation in winter or early spring
- history of exposure

Children with a low probability of GABHS need no testing, require no antibiotics and need to be advised of symptomatic treatment only. Those at intermediate or high risk should have either a throat culture or rapid step screen.

Preferred Treatment for Strep Pharyngitis:

- Penicillin V
- Amoxicillin
- If allergic to Penicillin, use Cephalexin or Azithroymycin.

If the throat culture is **positive**, antibiotic treatment is **indicated**; negative throat culture indicates symptomatic treatment only, avoid antibiotics. If the rapid strep screen is **positive**, antibiotic treatment is **indicated**; if the rapid strep screen is **negative**, culture and use antibiotics only if the throat culture is positive.

Diabetes

Diabetes and diabetes-related illnesses are the fastest growing health concerns in the United States. Per the International Diabetes Federation, as of 2015 an estimated 415 million people had diabetes worldwide; this will rise to 642 million. The greatest number of people with diabetes are between 40-59 years of age.

Several tests are recommended that may reduce the risk of diabetes-related health problems. The following tests are recommended on an annual basis:

- hemoglobin A1c
- dilated eye exam
- urine microalbumin
- physical examination including a foot exam at least twice a year

Please help our diabetic members get these important annual tests by contacting the member and scheduling an office visit.

Coverage for Diabetic Testing Supplies

Plan	Bayer Brand Test Strips/Lancets	Insulin Pump Supplies
MHP Community **with** Pharmacy Coverage	Pharmacy Benefit	DME Supplier
MHP Community **without** Pharmacy Coverage	DME Supplier	DME Supplier
MHP Medicaid HMO MHP Healthy Michigan	Pharmacy Benefit	DME Supplier
McLaren Health Advantage	Pharmacy Benefit	DME Supplier

Helping your Patients Quit Smoking

McLaren is committed to help our members obtain appropriate health screenings that aid in the promotion of healthy lifestyles. It is important that you communicate to your patients the hazards of smoking at each visit.

Please be sure you:

- advise smokers and tobacco users to quit
- offer smoking cessation strategies
- offer cessation medications

The following smoking and tobacco-use counseling codes are reimbursable CPT codes and covered benefits for McLaren members. Please document in your medical records and bill for tobacco cessation counseling services.

- 99406 - Smoking and tobacco-use cessation counseling — Intermediate > 3 - 10 minutes
- 99407 - Smoking and tobacco-use cessation counseling— Intensive > 10 minutes

McLaren's 2017 Consumer Assessment Survey (which is a random sample of McLaren adult members) indicates that of the members surveyed only:

- 77 percent indicated that a medical professional had advised them to quit smoking
- 48 percent were offered smoking cessation strategies
- 55 percent were offered cessation medications

> *Formulary medications that are available to assist members in their efforts to stop smoking are Chantix,® Nicotine gum, Nicotine lozenges, Nicotine patches, Nicotrol® and Zyban.® The use of combination therapy for tobacco cessation is allowed and prior authorization is not required.*

McLaren is pleased to offer the Michigan Tobacco Quitline, in conjunction with the American Cancer Society. Eligible McLaren members who are ready to quit smoking receive help by calling the Quitline. McLaren members can access the Quitline FREE of charge by calling (800) QUIT-NOW or (800) 784-8669. The program offers an initial readiness assessment, self-help materials and enrollment in telephonic counseling.

March is Colorectal Awareness Month

Online Preventive Screening Resources Available

How to Increase Colorectal Screening Rates in Practice: A Primary Care Clinician's Evidenced-Based Toolbox and Guide

Created by clinicians for clinicians, this toolbox can help improve colorectal cancer screening in actual practice. It provides state-of-the-science information, advice to help make screening practices more efficient, and tools for use in the practice. Also available in a web-based format. This is available at http://nccrt.org/about/provider-education.

How to Increase Colorectal Screening Rates in Practice: An Action Plan

A shorter version of the toolbox above, this brief guide pulls together the most important material from the full action plan, including charts, templates and sample materials that clinicians can put to use. As the guide above, the tools are applicable to all types of clinical screening. This is available at https://cancer.org/healthy/informationforhealth-care-professionals.

Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers

This is a more up-to-date toolkit for increasing screening rates. While it focuses on colorectal cancer screening and was designed for Community Health Centers, the principles apply to all primary care practices. It provides field-tested tools, templates and resources. This is available at http://nccrt.org/about/provider-education/manual-for-community-health-centers-2/.

Communication

How Well Do You Communicate with your Patients?

Explaining things in a way that is easy for a patient to understand can be difficult. It is imperative that patients understand what you are telling them.

The Annual Consumers Assessment of Health Plans Survey (CAHPS®) measures the member's overall satisfaction with their treating physician. All health care providers should focus on ensuring the "service encounter" is a positive experience for their patients.

Here are some tips to follow when communicating with your patient:

- speak slowly
- use plain language
- make eye contact
- use the patient's name during conversation
- use pictures if necessary
- encourage your patient to ask questions
- repeat the information back
- always ask, "do you understand?"
- ask if patient has been to an ER, urgent care or seen a specialist since his/her last visit (counsel if necessary).

How Medical Management Helps You

McLaren has a *Referral to Case Management* form to use when you need help with your high-risk members. This form can be found on our website, McLarenHealthPlan.org. In the Provider's section, select any line of business, then choose Provider Materials. You can use the search function or scroll down to the "Referral Guidelines" heading where you will find the form.

When a member is referred to our case management department, a nurse begins an assessment of the member and a proactive approach to managing the member's health care needs. To promote the well-being of each member, we have programs that focus on preventive health management, disease management, general and complex case management and CSHCS case management.

McLaren Preventive Health Management helps by:

- informing our members of preventive testing and good health practices;
- mailing reminders about immunizations, well-child visits and lead screenings;
- highlighting ways to stay healthy and fit in our member newsletters;
- targeting preventive care measures just for females in our member newsletters;
- initiating call programs to assist members with scheduling annual checkups and screenings, and
- keeping track of members who are due for annual checkups and screenings, then sending that list to the PCP's office.

The McLaren Medical Management department has nurses to help support all members with access to high quality, cost-effective care. Each PCP's office and its assigned members have their own McLaren nurse case manager. This enables a circle of communication that promotes continuity of care, members' understanding of their health care, support for the PCP and promotes our PCP offices as the medical home. If you do not know who your nurse is, call Customer Service at (888) 327-0671 (TTY:711).

Our program goals are:

Empower members to understand and manage their condition
Support your treatment plan
Encourage patient compliance

Appeals Department – NEW Email Address

If a practitioner's office would like to submit a new appeal or provide appeal related information via email to McLaren, please use the following email address: MHPAppeals@mclaren.org.

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

Disease Management

McLaren has programs for **asthma, diabetes, depression, hypertension, obesity, CSHCS case management and complex case management.** Members receive educational mailings, ongoing nurse contacts and pharmacy management. **McLaren Moms**, our maternity management program, works to ensure members receive timely prenatal and postpartum care.

If you have a member you would like in our case management or disease management programs, please call us at (888) 327-0671 (TTY:711).

Clinical Practice Guidelines

McLaren uses Clinical Practice Guidelines to assist practitioners and members in making decisions 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 in an effort to improve health care quality and reduce unnecessary variation in care. Documentation in your medical record should indicate you used the appropriate Clinical Practice Guideline in your practice decisions.

The Clinical Practice Guidelines were reviewed, updated and approved in September 2017 by our Quality Improvement Committee.

Please review a list of these guidelines at McLarenHealthPlan.org or go to www.MQIC.org to view the most recent guidelines. If you have any questions, please contact Medical Management at (888) 327-0671 (TTY:711). If you would like to have these guidelines mailed to you, please contact us at (888) 327-0671 (TTY:711).

Weight Management Program

McLaren has a weight management program called "**Taking It Off.**" There are two types of Taking it Off programs- one specifically designed for adults and one for children. Each member enrolled in the program will be offered:

- personal phone contacts from his or her own nurse
- educational materials
- assistance and support
- discounts on healthy foods at meijer

McLaren members can refer themselves to the program by calling Customer Service at (888) 327-0671 (TTY:711).

Lead Screening

The percentage of children found in Michigan with elevated blood lead levels is higher than the national average. Michigan currently ranks as the sixth highest state for estimated population of children with lead poisoning.

In a recent report from the Michigan Department of Health and Human Services (MDHHS), 16 percent of our two-year-old MHP children did not receive a blood lead test but had a documented well-child visit.

In an effort to assure that children being seen in your office for any reason have easy access to lead screening, MHP will assist you in obtaining **FREE** lead testing supplies from the State of Michigan. These kits are to be used for Medicaid-eligible children receiving an in-office blood lead screening. Your office will be provided with:

- ALL OF THE SUPPLIES AND INSTRUCTIONS NEEDED TO COMPLETE THE LEAD SCREEN TEST
- PREPAID ENVELOPES TO MAIL TEST SAMPLES

As an incentive for your cooperation in this lead screening endeavor, MHP will reimburse you $15 for procedure code 36416 and $25 for procedure code 83655 when you provide a lead test to an MHP Medicaid member.

If you need information on how to obtain the lead testing kits, or if you would be interested in hosting a lead clinic, please call your Outreach Representative at (888) 327-0671 (TTY:711).

Assuring Better Child Health and Development (ABCD)

Developmental screening should be included at every well-child visit and can be billed in addition to the well-child visit (see below). It is recommended that standardized developmental screening tests be administered at the nine, 18, 24 or 30 month visits.

CPT Code	ICD Code	Category	Notes	Incentive for Medicaid Members (age 0-3 yrs)
96110	Z13.4	Developmental Screenings	Screening tool completed by parent or non-physician staff and reviewed by the physician	$20 (one per member, per year)

The Michigan Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy requires developmental surveillance and screening, and recommends providers use a tool, such as the PEDS, PEDS: DM or Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire Social-Emotional (ASQSE). You are encouraged to implement developmental surveillance and screening in your office to be in compliance.

For our contracted MHP network practitioners, MHP has purchased the rights to the ASQ screening tool. If you would like a copy of this material, please contact your Network Development Coordinator at (888) 327-0671 (TTY:711).

Suggestions for successful practice implementation include the following:

- Use a standardized screening tool such as ASQ (which MHP will provide).
- Communicate with office staff, colleagues and parents about the importance of developmental surveillance and screening.
- Screen all children during well-child checks at the nine, 18 and 30 months (or 24 month) visits.
- Discuss any developmental concerns with the child's parents.
- Refer children to Michigan's Early On program if developmental delays* are found. You may make the referral online at **www.1800earlyon.org** or call the statewide line at (800) EARLY-ON (327-5966).

*Should the screening indicate developmental delays, additional objective developmental testing may be performed by the physician at an outpatient office visit using CPT code 96111.

Credentialing Hot Spot

Please be sure to complete the following to avoid delays in the credentialing and recredentialing processes:

- Update and/or re-attest to your CAQH application at least every 120 days.
- Update your Authorization for Release of Information at least every 12 months and upload to CAQH.
- Ensure all practice location(s) address and contact information is accurate.
- Leave no gaps in your most recent five years of work history section. If gaps (greater than six months) exist, please document the reason including the month/years (i.e. leaves of absence, maternity leave, moves, etc.).
- Ensure that a current copy of your liability insurance is attached to your CAQH. After uploading a new copy to CAQH, check CAQH in about three days to ensure it wasn't rejected.
- Provide an accurate credentialing contact in case we need to do outreach.
- **IMPORTANT** - Failure to respond to requests from our credentialing team could result in termination from the McLaren network due to incomplete documentation.

Not Using CAQH?

If you are not a practitioner who uses a CAQH application, we highly encourage you to consider moving to CAQH. Most health plans accept CAQH applications. By using this centralized application, you and/or your staff can avoid completion of multiple plan-specific applications and ease the burden of data collection, maintenance and distribution.

For more information, visit http://www.caqh.org/solutions/caqlgproview

Utilization decision-making is based only on appropriateness of care and service and existence of coverage. We do not reward practitioners or other individuals for issuing denials of coverage, service or care. Nor are there financial incentives for utilization decision makers to encourage decisions that result in under utilization.

The Importance of Referring to In-Network Providers

MHP and MHP Community HMO members must use providers who participate/are in-network with us for their health care needs. Please visit our website or contact customer service for a complete list of in-network providers when referring a member. Members with Point of Service (POS) plans do have an Option B that allows self-referral and the use of non-participating/out-of-network providers. They will have higher copayments and/or deductibles and will be responsible for any balance bill from the provider. Some Option B benefits require plan preauthorization.

HEDIS® - 2018 Measures

The requirements in the 2018 HEDIS measures include the following:

- human papillomavirus vaccine - adolescents who turn 13 during the measurement year
- breast cancer screening - women age 50-74 years
- cervical cancer screening - women age 21-64 years

A complete list of the 2018 HEDIS measures can be found under the "Quality and Medical Management" section of the Provider tab on our website.

Provider Appeals and When to Submit a Request

It is McLaren's goal to resolve provider issues before reaching an appeal level. McLaren encourages providers to first contact McLaren Health Plan Customer Service (Provider Team) when a dispute occurs. A formal written appeal may be submitted if a provider continues to be in disagreement with an action taken by McLaren after informally attempting to resolve the dispute through a verbal contact or a provider claims adjustment.

If a provider has contacted the Customer Service (Provider Team) and the issue was not resolved to the provider's satisfaction, a written request for appeal is required.

Supporting information, not previously submitted, regarding the reason and rationale for the appeal must be included with the appeal request. Such documentation may include the following:

- additional medical record and/or office notes
- diagnostic report(s)
- operative notes or surgery reports, etc.
- other information, as applicable to the appeal request

A provider must have submitted a claim for the service(s) in question, and/or received a denial or reduction in payment from McLaren before an appeal will be considered. Provider Appeals process information can be found on our website at:

- http://www.mclaren.org/Uploads/Public/Documents/HealthAdvantage/documents/HA%20Documents/Provider%20Appeal%20Process%20with%20Form.pdf

To submit a provider appeal request or provide appeal-related information via email, please send to: MHPAppeals@mclaren.org

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

Genetic Testing Pre-Authorization Requirements

McLaren requires pre-authorization for all genetic testing, including prenatal genetic testing.

It is the responsibility of the **ordering practitioner** to provide the following information with any request for pre-authorization of genetic testing:

1. Is this test appropriate for this patient?
2. Is the technical and clinical performance of the genetic test supported by peer-reviewed published research?
3. Does a definitive diagnosis remain uncertain despite a comprehensive workup that includes a detailed medical history, physical examination, pedigree analysis, genetic counseling and completion of conventional diagnostic studies?
4. Will the test result impact or alter the medical management of the patient?
5. What are the limitations of the test?
6. Are there any major ethical, legal or safety issues of concern with the test?
7. Has the genetic test been cleared or approved by the U.S. Food and Drug Administration or will it be performed in a Clinical Laboratory Improvement Amendment-certified laboratory?
8. Is this a targeted test or a multi-gene panel?
9. Has a pathogenic variant been identified in an affected family member?
10. Is this the first time this test is being performed on this patient?
11. Has the genetic test been ordered by a medical professional such as a medical geneticist, developmental-behavioral pediatrician, condition-specific subspecialist, or neonatologist in the NICU, who has training in genetics and will ensure that face-to-face genetic counseling by appropriately trained professional(s) will accompany testing?

Patient Registries

A patient registry is an electronic or manual system that compiles and manages information on a practice's patient population by disease state (e.g., diabetes).

By using a patient registry, a physician can, for example, monitor the course of chronic diseases and observe the condition of patients before and after medical interventions.

Ideally a patient registry can:

- track patients' appointments
- classify patients according to the severity of their disease
- generate reminders for patients and/or physicians and office staff to perform certain tasks
- identify opportunities for possible quality improvement

Source: www.ama-assn.org/ama/pub/physician-resources/practice-management-center/health-insurer-payer-relations/clinical-integrity/care-coordination/patient-registries.page

Interpretation and Translation Services

Interpretation and translation services are FREE to members in any setting (ambulatory, outpatient, inpatient, etc.). If McLaren members need help understanding McLaren's written materials or need interpretation services, they can call Customer Service at (888) 327-0671, TTY:711.

If a McLaren member is deaf, hard of hearing or has speech problems, oral interpretation services are available. Please call Customer Service at (888) 327-0671, TTY:711.

Report Fraud, Waste and Abuse

McLaren is committed to preventing health care fraud, waste and abuse, as well as complying with applicable state and federal laws governing fraud and abuse.

Examples of fraud and abuse by a member include:

- Altering or forging a prescription
- Altering medical records
- Changing or forging referral forms
- Allowing someone else to use his or her member ID card to obtain health care services

Examples of fraud and abuse by a provider include:

- Falsifying his or her credentials
- Billing for services not performed
- Billing more than once for same services
- Upcoding and unbundling procedure codes
- Over-utilization: performing inappropriate or unnecessary services
- Under-utilization: not ordering services that are medically necessary
- Collusion among providers

Examples of fraud and abuse by a McLaren employee include:

- Altering provider contracts or forging signatures
- Collusion with providers or members
- Inappropriate incentive plans for providers
- Embezzlement or theft
- Intentionally denying services or benefits that are normally covered

Federal law prohibits an employer from discriminating against an employee in the terms and conditions of his or her employment because the employee reports or otherwise assists in a false claims action.

To report a possible violation, contact McLaren's Compliance Officer by:

- Mail: McLaren Health Plan, Attn: Compliance Officer, G-3245 Beecher Rd, Flint, MI 48532
- Email: MHPCompliance@mclaren.org
- Phone: Compliance Hotline at (866) 866-2135

Report Medicaid Fraud, Waste and Abuse by contacting McLaren as above, or:

- Mail: Office of Inspector General, P.O. Box 30062, Lansing, MI 48909
- On-line: www.michigan.gov/fraud
- Phone: Hotline at (855) MI-FRAUD (643-7283)

Report Medicare Fraud, Waste and Abuse by contacting McLaren as above, or:

- Mail: U.S. Department of Health and Human Services,
  Attn: Hotline, P.O. Box 23489, Washington, DC 20026
- On-line: www.oig.hhs.gov/fraud/report-fraud
- Phone: Hotline at (800) HHS-TIPS (447-8477)

Information provided will be kept confidential, but you can remain anonymous by calling the hotline numbers or through the U.S. Mail.