Provider Welcome Packet

2016

McLaren

HEALTH PLAN

(888) 327-0671 • MclarenHealthPlan.org

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Welcome

Welcome to McLaren Health Plan! We are dedicated to partnering with providers such as you who will offer high quality, accessible, and cost effective health care throughout our service area.

Our mission is to enhance our members' health status in the communities we serve by promoting:

- Preventive care and well-being
- Access to quality health services
- Strong relationships with our members, providers and employers

Our vision is to be a premier health plan committed to providing:

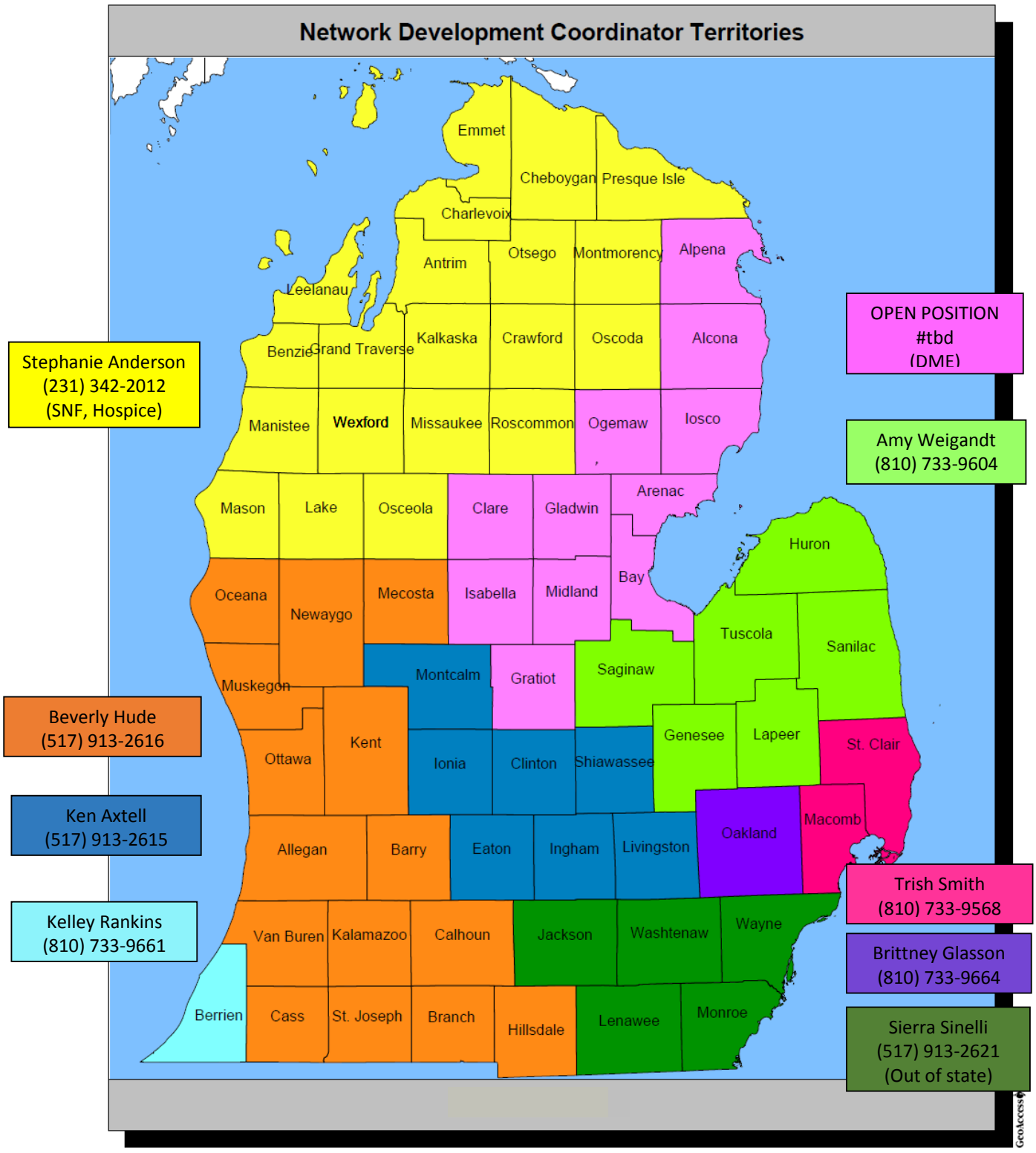
- The best value for the members we serve
- The utmost respect and personal attention to our members, providers and employees
- The highest standard of quality, service and care

Contact Information

Department	Telephone No.	Fax No.
Customer Service/Provider Inquiry Available to assist you with claim, benefit, eligibility, authorizations and coordination of benefit inquires **Hours: 7:30-5:30, Monday-Friday**	(888) 327-0671	Toll Free (877) 502-1567
Network Development Please visit the MHP website to view the most up-to-date Network Development Service Area Map and Provider Manual	(888) 327-0671	Flint: (810) 733-9651 Lansing: (517) 913-2659
Medical Management Referral requests can be submitted electronically via the MHP website at www.MclarenHealthPlan.org/Medicaid -Provider/Referral-guidelines-mhp.aspx	(888) 327-0671	Referrals and Medical Documentation: (810) 733-9647 All Other: (810) 733-9645
Quality Management/Member Outreach Available to assist you with Gaps in Care reports, HEDIS reports, quality incentives, member outreach	(888) 327-0671	Flint: (810) 733-9653
Sales Department	(888) 327-0671	Flint: (810) 733-9596

Other Information	
Pharmacy Services	For formulary information or medication prior authorization request forms. please visit our website at www.MclarenHealthPlan.org/Community-Provider/Pharmacy-mhp.aspx E-prescribing is available for all lines of business through SureScripts®
Provider Demographic Changes	Contact Network Development at (888) 327-0671 or visit our website at www.mclaren.org/uploads/public/documents/healthplan/documents/Provider%20Forms/PCPchangerequestform.pdf
Provider Portal	The MHP Provider Portal is available to all contracted MHP providers. On the MHP Provider Portal, you can status claims, check member eligibility, and get your monthly member roster. If you are not currently registered, call Network Development today.
Claims	MHP receives EDI claims from our clearinghouse, ENS Optum Insight. Our Payer IDs for electronic claims are: • McLaren Medicaid/Healthy Michigan - 3883C • McLaren Health Plan Community (Commercial HMO) - 38338 • McLaren Health Advantage (PPO) - 3833A • McLaren Advantage (Mediicare HMO) - 3833R • **You are expected to submit your McLaren Health Plan claims electronically; if you are able.**
Laboratory	For Medicaid and Commercial HMO - Required lab vendor is Joint Venture Hospital Lab (JVHL); (800) 445-4979

Network Development Coordinator Service Area
May 2016



About McLaren Health Plan

Background

- Michigan HMO operating in all counties throughout lower Michigan
- Product Portfolio:
  - » McLaren Health Plan Community: Commercial HMO and Point of Service
  - » McLaren Health Plan: Medicaid HMO
  - » McLaren Health Advantage: Self-Funded PPO
  - » McLaren Advantage: HMO (Medicare Advantage Product)
  - » McLaren MIChild
  - » Healthy Michigan Plan
- Combined membership exceeds 237,000
- Current network of over 41,000 providers and over 113 hospitals throughout lower Michigan
- Operates at the lowest administrative cost among all Michigan HMOs

Physician Reimbursement

- Commercial Products: PCP and Specialist reimbursement paid FFS at MHP's commercial fee schedule, no risk, no withhold
- Medicaid Product: PCP and Specialist reimbursement paid at the Michigan Medicaid FFS rates and methodology, no withhold
- PCP Pay-for-Performance program that is simple and achievable, up to $2 per member per month

McLaren Health Plan's Philosophy

- Providers want to care for patients, not be insurance companies
- Insurance companies should hold the risk of insuring health benefits
- Providers strive to "do the right thing for the right reasons"
- Local care should be provided in the local community, whenever clinically appropriate
- Premium dollars should be spent on health care services, not administrative overhead

Other Unique Points of Interest

- E-Prescribing available through Sure Scripts®
- Every PCP office is assigned an MHP nurse to provide personalized support
- RN may attend employer open enrollment meetings to answer employees' clinical questions and facilitate their transition to MHP
- New members receive a welcome call within first month of enrolling with MHP to assess their health status
- MHP Health Care Coaches available for every member
- Early Pregnancy Program connects our nurse with every pregnant mother from prenatal to post-natal care (Commercial and Medicaid)
- Complex Case Management program for higher risk members
- Online verification for member eligibility or to view status of a claim
- Outreach team available to assist providers to increase quality ratings
- Every provider office is assigned a Network Development Coordinator to provide personalized support
- Offer electronic fund transfer and electronic remit options

Service Area

Medicaid 2016

Sample Member ID Card

McLaren MEDICAID

24 Hour #
(888) 327 0671
McLarenHealthPlan.org

MEMBER NAME: JOHN DOE
Member ID: 0123456789
PCP NAME: JOHN DEER MD
PCP Phone: 517-111-2222

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

Sample Healthy Michigan Member ID Card

McLaren HMP

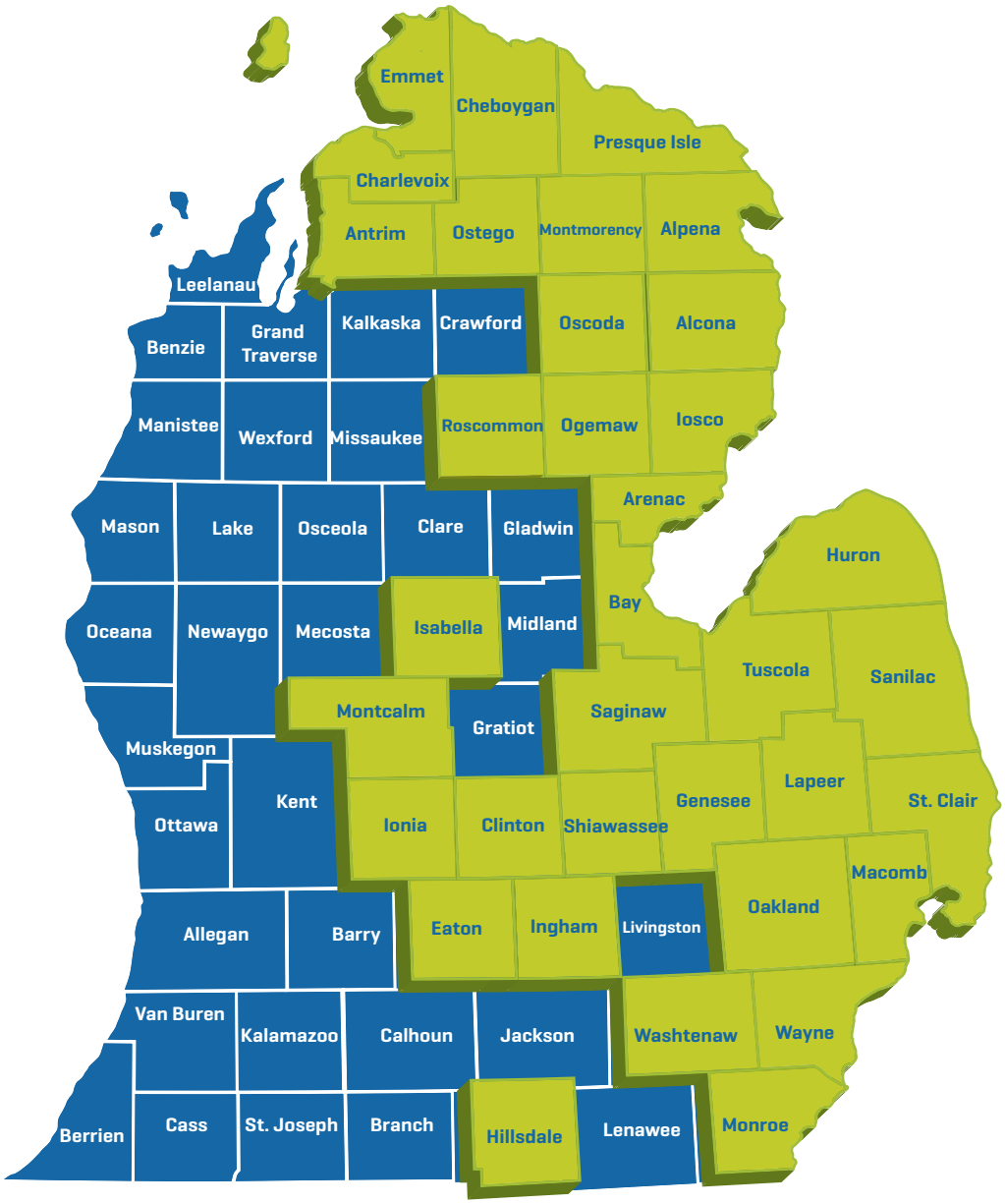
24 Hour #
(888) 327 0671
McLarenHealthPlan.org

MEMBER NAME: JANE DOE
Member ID: 0123456789
PCP NAME: JANE DEER MD
PCP Phone: 517-111-2222

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

Service Area *(Continued)*

Community (Commercial) 2016



Sample Member ID Card- POS

McLarenPOS
HEALTH PLAN COMMUNITY

Toll-free Phone
(888) 327-0671
McLarenHealthPlan.org

Enrollee Name	Contract No.	Group No.	Plan
JOHN DOE	1234567	123456	1234

PERSON CODE FOR RX BILLING
00 JOHN DOE

Co-pays/Deductibles	In Plan	Out of Plan
Office	$30	30%
Specialist	$50	30%
Coinsurance	90%	70%
Deductible	$250/$500	$1000/$2000
Rx Co-pay	$5/$30/$60	Not Covered

4D Pharmacy Management Systems Inc.

McLaren Health Plan Inc.

Sample Member ID Card- HMO

McLarenHMO
HEALTH PLAN COMMUNITY

Toll-free Phone
(888) 327-0671
McLarenHealthPlan.org

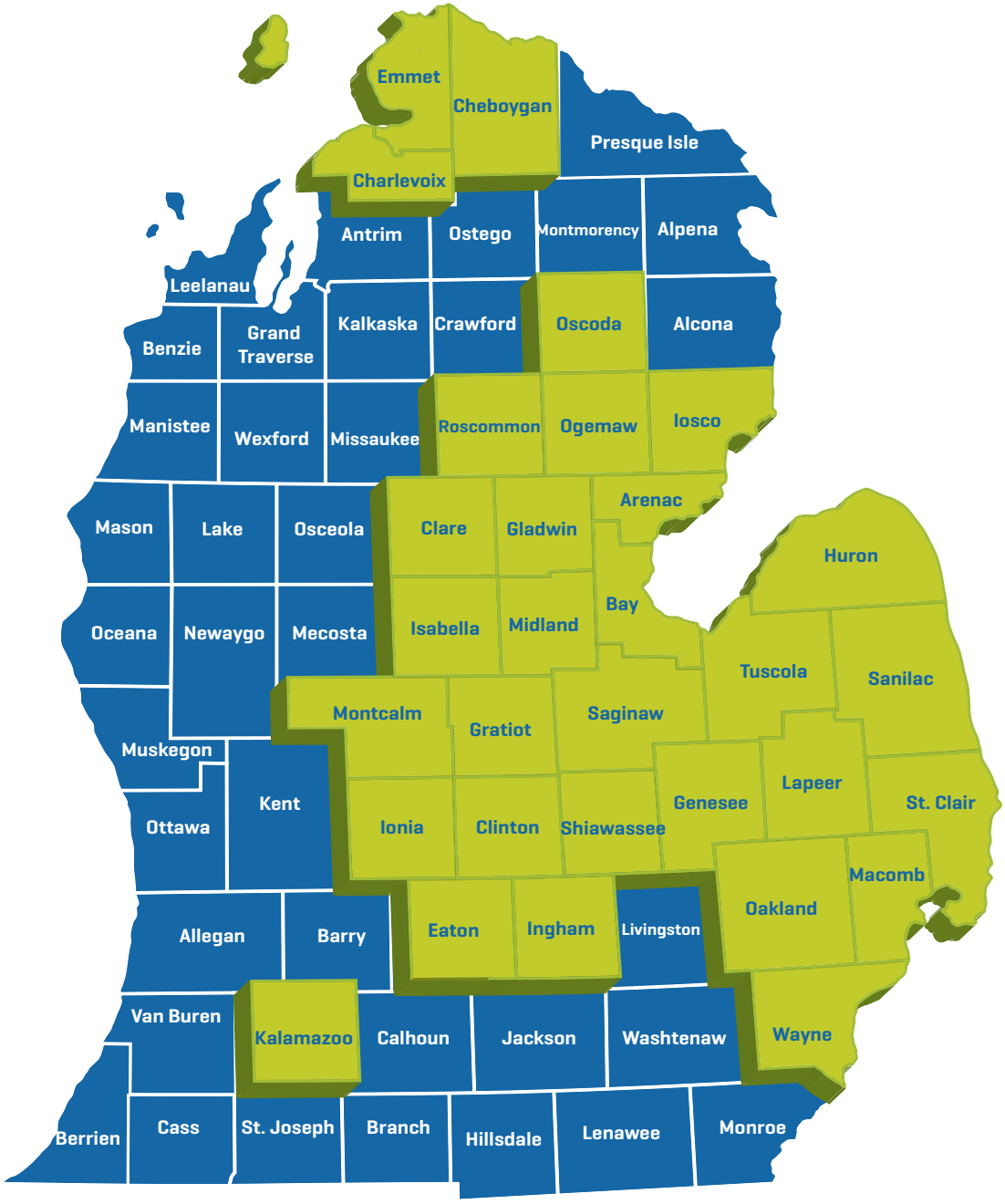
Enrollee Name	Contract No.	Group No.	Plan
JANE DOE	1126265	123456	1234

PERSON CODE FOR RX BILLING
00 JOHN DOE

Provider:	Directly Contracted Providers	Rewards Providers	Out of Plan Providers
PCP Copay	$30	$0	Not Covered
Specialist Copay:	$45	$0	Not Covered
Deductible	$250/$500	$0	Not Covered
Coinsurance	90%	0%	Not Covered
Rx Co-pay	$10/$40/$80	$10/$40/$80	Not Covered

4D Pharmacy Management Systems Inc.

Service Area *(Continued)*



Sample Member ID Card

McLaren HEALTH ADVANTAGE

Toll-free Phone
(888) 327-0671
McLarenHealthPlan.org

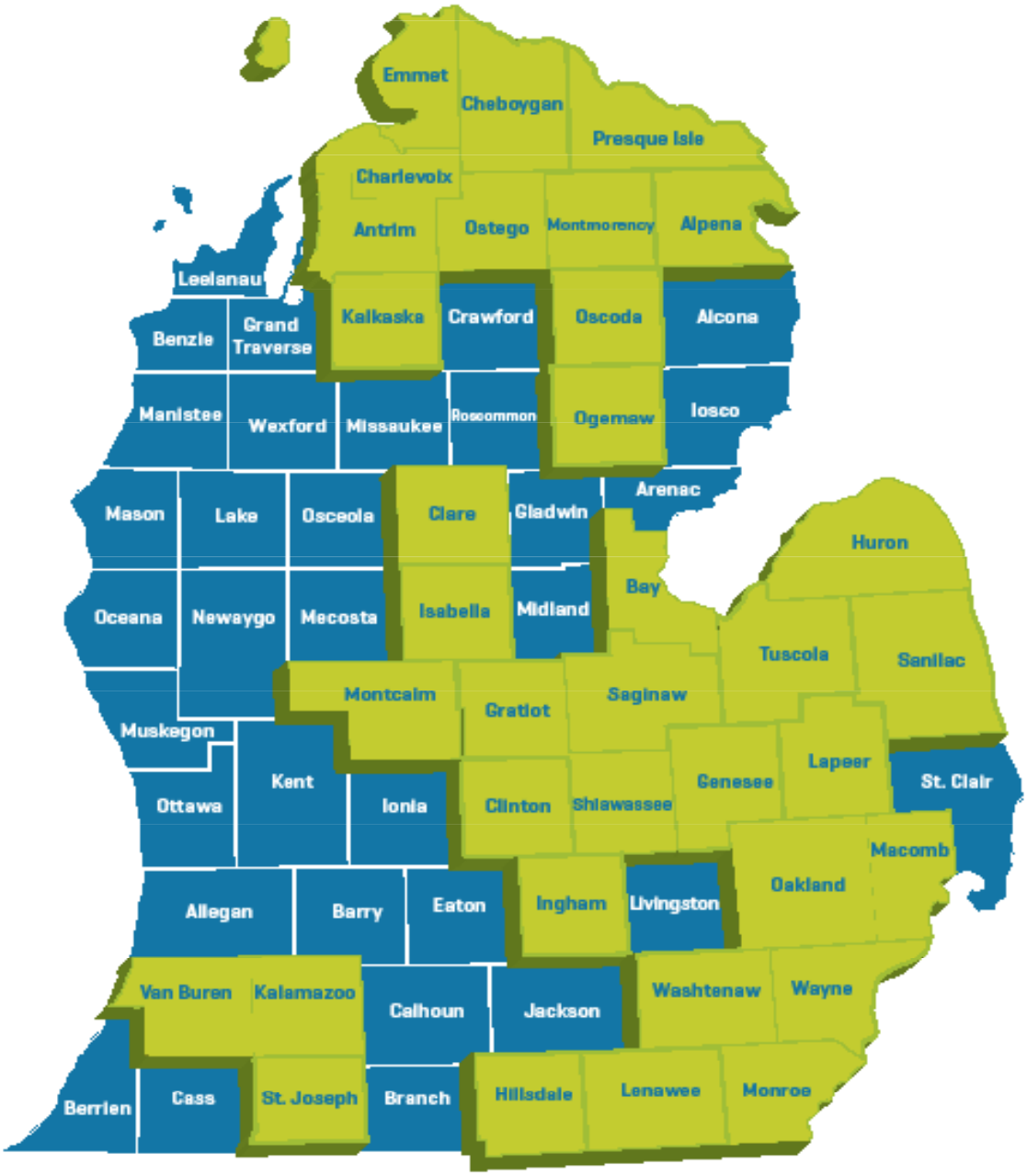
Enrollee Name	Contract No.	Group No.	Plan
JOHN DOE	1234567	400	Premier Plus

PERSON CODE FOR RX BILLING
00 JOHN DOE

Provider:	McLaren Domestic Providers	McLaren Health Advantage Providers	Out of Plan Providers
PCP Copay:	$15	$15	60% after Deductible
Specialist Copay:	$30	$30	60% after Deductible
Deductible	$100/$200	$100/$200	$1000/$2000
Coinsurance	90% after Deductible	90% after Deductible	60% after Deductible
Rx Co-pay	$10/$30/$50	$10/$30/$50	$10/$30/$50 PLUS 25%

4D Pharmacy Management Systems Inc.

Service Area *(Continued)*



Sample Member ID Card- Diamond

McLaren ADVANTAGE
DIAMOND (HMO)

Toll-free Phone
(888) 327-0671
MclarenAdvantage.org

Member Name: JOHN DOE
Member ID: 000000001
Policy #: 001
Plan Type: Managed Care

Rx BIN: 012353
Rx PCN: 06706701
Pharmacy Help Desk: (888) 863-9281

Primary Care Physician/Clinic: DEERE, JOHN MD
Physician/Clinic Phone: 123-456-7890

CMS Contract # H0141-004
Issuer (80840)

MedicareRx
Prescription Drug Coverage

Sample Member ID Card- Sapphire

McLaren ADVANTAGE
SAPPHIRE (HMO)

Toll-free Phone
(888) 327-0671
MclarenAdvantage.org

Member Name: JOHN DOE
Member ID: 000000001
Policy #: 001
Plan Type: Managed Care

Rx BIN: 012353
Rx PCN: 06706702
Pharmacy Help Desk: (888) 863-9281

Primary Care Physician/Clinic: DEERE, JOHN MD
Physician/Clinic Phone: 123-456-7890

CMS Contract # H0141-005
Issuer (80840)

MedicareRx
Prescription Drug Coverage

Products Overview

McLaren Medicaid

MHP is contracted with the State of Michigan to provide medical services to eligible Medicaid recipients. MHP provides administrative services and arranges for the provision of all Medicaid services, along with some additional benefits, including transportation. The PCP provides the member with a medical home.

McLaren Healthy Michigan Plan

The Healthy Michigan Plan covers people with incomes up to 133 percent of the Federal Poverty Level who are:

- Ages 19-64
- Not currently eligible for other Medicaid programs
- Not in or qualified for Medicare
- Not pregnant when applying for the Healthy Michigan Plan
- Residents of the State of Michigan

McLaren Community - HMO

MHP's commercial HMO covers a comprehensive set of health care services obtained through a designated provider network. Each MHP HMO member selects a Primary Care Physician (PCP), who is responsible for coordinating the member's health care. The PCP provides the member with a medical home.

McLaren Communit- POS

MHP's Point of Service (POS) product 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/her level of coverage based on the "point" at which the member receives the "service" – PCP coordinated (HMO-like) care within the network, or self-referred care within or outside the network.

McLaren Rewards Program

We offer serval HMO plans on the Michigan Health Insurance Marketplace (sometimes referred to as the "Exchange") Some individuals plans and all small group products. With Rewards, members can choose from a high-quality network of providers and hospitals with copayments and deductibles as a part of the standard plan design. Copayment, deductibles and coinsurance are waived when a member chooses to seek care from a designated "Rewards" provider. The program greatly reduces member out-of-pocket costs, while providing tremendous benefits and access to quality care. If you want more information about becoming a Rewards Provider, call your Network Development Coordinator.

McLaren Health Advantage

A self-funded PPO that is utilized by McLaren Health Care Corporation for employee coverage. Reimbursement is fee-for-service with rates that are competitive with other local payers.

McLaren Advantage HMO

McLaren Advantage HMO is a Medicare Advantage HMO. Members must select a PCP. Reimbursement is based on the rates established and published by the Centers for Medicare and Medicaid Services. Covered services and exclusions for Medicare Advantage members are listed in the Evidence of Coverage (EOC). The EOC is located on our website at MclarenAdvantage.org.

Provider Manual

The Provider Manual can be found under the Provider Tab/Provider Information/McLaren Health Plan/ Provider Manual at *McLarenHealthPlan.org*. The Provider Manual contains a great deal of information to assist in navigating the requirements of MHP, including:

- McLaren Health Plan Facts and Information
- Departmental Contacts
- Member ID Cards
- Plan Definitions
- Provider Requirements
- Coverage Responsibilities
- Immunizations
- Referral and Authorization Requirements
- General Information
- Claim Information
- Provider Appeals
- Fraud, Waste and Abuse
- Forms

Eligibility

All McLaren Health Plan members are issued a member identification card. The member identification number is located on the identification card. Member eligibility can be verified by accessing the online eligibility system, FACTSWeb or the Provider Portal. An application to obtain a login and password to these systems has been included in the welcome packet of information and can also be obtained on our website. Eligibility can also be verified by contacting Customer Service at (888) 327-0671.

Participating Contracted Providers

McLaren Health Plan has contracted with an extensive network of quality providers to deliver health care to its members. Unless the member's benefit otherwise allows, members **must** receive health care services from providers in the McLaren Health Plan network who are listed in the Provider Directory located on our website.

Medical Management

Medical Management supports the needs of both the member and the provider network. Medical Management offers support to coordinate our member's care and to facilitate access to appropriate services through the resources of case management, complex case management and utilization management.

Case Management

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 McLaren Health Plan's Chief Medical Officer.

A Case Management Nurse is assigned to each PCP's office to assist the physician and staff in managing their McLaren Health Plan patients. In addition, all McLaren Advantage (HMO SNP) members are enrolled in case management and a health assessment is completed within 90 days of their effective date with McLaren Advantage.

Complex Case Management

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 but are not limited to:

- Members listed for a transplant
- Members with frequent hospitalizations
- Members with frequent ER visits
- Children's Special Healthcare Services (CSHCS) Members

Disease Management

McLaren Health Plan has several Disease Management programs. These programs include Asthma, Diabetes, Depression, Hypertension and Obesity. Members receive educational mailings, ongoing nurse contacts, and pharmacy management. McLaren Moms, MHP's maternity management program, works to ensure members receive timely prenatal and postpartum care. (If you have a member you would like in the Case Management or Disease Management programs, please call (888) 327-0671.)

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. There is nationally recognized evidence based criteria that is used when determining the necessity of medical or behavioral health services. The criteria are available to you upon request.

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, McLaren Health Plan'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. 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 which result in under-utilization.

You can reach Medical Management by calling (888) 327-0671 and following the prompts. Medical Management's business hours are 8:30 am to 5:00 pm, Monday through Friday.

Quality Management

McLaren Health Plan submits claims and medical review data to the National Committee for Quality Assurance (NCQA). This NCQA reporting requirement, defined as the Healthcare Effectiveness Data and Information Set (HEDIS®), is one of the measurements utilized to assess how well MHP is delivering health care. NCQA is an independent, not-for-profit organization dedicated to measuring the quality of health care.

Many HEDIS measures may only include a small number of a practitioner's patients. This is due to a continuous enrollment requirement in the specifications and sampling of the eligible population.

Some of the HEDIS measures can only be calculated by administrative results (which is claims data submitted by a practitioner) and some measures can be calculated through the hybrid method (which is a combination of claim submissions and medical record review).

To help physicians better understand the HEDIS measures, we have included a summary table with the Quality Indicator that is being measured. We hope this information is useful.

In addition, we have several incentive programs for Primary Care Physicians related to the HEDIS measures described in the summary table. If you have any questions regarding HEDIS specifications or would like more information on specifications or incentive programs that are available please contact your Network Development Coordinator.

Incentive Summary

The following are the current Primary Care Physician Incentives offered by McLaren Health Plan

Line of Business	Effective Date	Initiative	Incentive	How
Commercial/ Medicaid	Jan. 2016 Ongoing	Pay for Performance Program	PCMH Recognition and up to $2.00 pmpm for eligible PCP assigned membership Measures: - Open Access - Adult Access -Well Child 3-4yrs -Mammogram Screening - E-Prescribing and Generic Prescribing Rates	Annual payout based on prior year's performance measures
Medicaid	Oct. 2011 Ongoing	Club 101	Reimburse $101.00 for well visits age 1-11	Based on billed claim
Commercial/ Medicaid	Jan. 2012 Ongoing	Expanded Access Award	99050 & 99051 reimburse $17.38	Based on billed claim
Medicaid	Aug. 2012 Ongoing	Lead Screening	36416 reimburses $15.00 83655 reimburses $ 25.00	Based on billed claim
Medicaid	Jan. 2013 Ongoing	Chlamydia Screening	$25.00 per eligible member screened	Based on billed claim
Commercial/ Medicaid	Jan 2013 Ongoing	Mammogram	$50.00 per eligible member screened	Based on billed claim
Commercial/ Medicaid	Oct. 2013 Ongoing	Diabetic Screenings 5 for $5.00	$5.00 per Diabetic core measure performed	Based on billed claim and report received
Healthy Michigan Plan	Apr. 2014 Ongoing	Healthy Michigan HRA	$50.00 per completed HRA for Healthy Michigan plan members	Based on billed claim and HRA received within 150 days of enrollment
Medicaid	Nov. 2014 Ongoing	Healthy Michigan 4 x 4	$5.00 for each test completed (BMI, BP reading, LDL and Glucose Level)	Based on billed claim and report received
Commercial/ Medicaid	Sept. 2015 Ongoing	Healthy Child Incentive	$15.00 Total Incentive ($5.00 for each annual component) Weight Assessment, Counseling for Nutrition and Physical Activity for Child/Adolescents	Based on billed claims, with appropriate codes
Medicaid	Jan. 2016 Ongoing	Adult BMI	$5.00 for each member	Based on billed claims
Medicaid	Jan. 2016 Ongoing	Developmental Screening	$20.00 per annual screening	Based on billed claims, with appropriate codes

McLaren HEALTH PLAN

2016 HEDIS® Measures

PREVENTIVE SCREENING	
2016 Measure	**Quality Indicator**
Childhood Immunization • Children who turn 2 during the measurement year	Percent of fully immunized 2 year olds • 4 DTaP • 3 IVP • 1 MMR • 3 HIB • 1 Hep A • 3 Hep B • 2 Influenza • 4 Pneumococcal Conjugate • 2 or 3 Rotavirus • 1 VZV
Adolescent Immunization • Adolescents who turn 13 during the measurement year	Percent of fully immunized 13 year olds • 1 Meningococcal Vaccine between the 11th and 13th birthday • 1 TD or Tdap on or between the 10th and 13th birthday
Human Papillomavirus Vaccine for Female Adolescents • Female adolescents who turn 13 during the measurement year	Percent who have had 3 doses of the HPV vaccine by their 13th birthday
Lead Screening • Children who turn 2 during the measurement year	Percent with at least one capillary or venous blood test for lead poisoning
Breast Cancer Screening • Women age 50-74 years	Percent who have had a mammogram during the measurement year, or 15 months prior to the measurement year
Cervical Cancer Screening • Women age 21-64 years	Percent who have had a PAP during the measurement year, or the two years prior to the measurement year, or women 30-64 who had a PAP and HPV test with service dates 4 or less days apart during the measurement year or the 4 years prior to the measurement year
Colorectal screening • Adults age 50-75 years	Percent who have had one of three screenings for colorectal cancer such as: • Fecal occult blood test in the measurement year • Flexible sigmoidoscopy in the last five years • Colonoscopy in the last ten years
Chlamydia screening • Women age 16-24 years	Percent of sexually active members who have had one test for chlamydia during the measurement year
Adult BMI • Adults age 18-74 years	Percent who have had an outpatient visit and had their body mass index documented during the measurement year, or the year prior to the measurement year
Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents • Children and Adolescents age 3-17 years	Percent who have had an outpatient visit with a PCP or OB/GYN during the measurement year with evidence of: • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity

McLaren HEALTH PLAN

2016 HEDIS® Measures

PREVENTIVE SCREENING, CONTINUED	
2016 Measure	**Quality Indicator**
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) • Adolescent females 16-20 years of age	Adolescent females 16-20 years of age who were screened unnecessarily for cervical cancer
Non-Recommended PSA-Based Screening in Older Men • Men 70 years and older during the measurement year	Percent of Medicare men 70 years and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA) based screening.

MEDICATION MANAGEMENT	
2016 Measure	**Quality Indicator**
Annual Monitoring for Patients on Persistent Medications • Members age 18 and older	Percent of members age 18 or older who received at least 180 treatment days of ambulatory medical therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the agent in the measurement year • ACE Inhibitors • Digoxin • Diuretics
Potentially Harmful Drug-Disease Interactions in the Elderly • Members age 65 and older	Percent of **Medicare** members who have evidence of an underlying disease, condition, or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis
Use of High-Risk Medications in the Elderly • Members age 66 and older	Percent of **Medicare** members who received at least one high-risk medication

USE OF SERVICES	
2016 Measure	**Quality Indicator**
Well Child Visits • First 15 Months of Life	Percent of members who turn 15 months during the measurement year, and their corresponding dates of well child visits since birth
Well Child Visits • 3rd, 4th, 5th and 6th Years of Life	Percent of members who have had at least one well visit with a PCP during the measurement year
Adolescent Well Child Visits • Adolescents age 12-21 years	Percent of members who have had at least one well visit with a PCP or OB/GYN practitioner during the measurement year

McLaren HEALTH PLAN

2016 HEDIS® Measures

BEHAVIORAL HEALTH	
2016 Measure	**Quality Indicator**
Antidepressant Medication Management • Adults age >18 years	Percent of members who: • In the initial three months of treatment had no gap in medications • In the initial six months of treatment had no gap in medications
Follow Up Care for Children Prescribed ADHD Medication • Children age 6-12 years	Percent of members who: • In the initiation phase, had a follow up visit within 30 days after the start of a medication • Had a follow up visit and 2 visits during 31-300 days after the start of a medication
Follow Up After Hospitalization for Mental Illness • Members > 6 years	Percent of discharges for members who were hospitalized for treatment of selected mental health disorders that within 7 days of discharge, and within 30 days of discharge, had: • An outpatient visit • An intensive outpatient encounter, or • A partial hospitalization with a mental health practitioner
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment • Adolescent and Adult Members Age 13 years and older	Percent of members who initiate treatment within 14 days of the diagnosis through: • An inpatient admission • An outpatient visit • An intensive outpatient encounter, or • A partial hospitalization And who had two or more additional services with a diagnosis of AOD within 30 days of the initial visit
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics • Children and Adolescents 1-17 years of age	Percent of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment

MUSCULOSKELETAL	
2016 Measure	**Quality Indicator**
Disease Modifying Anti-Rheumatic Drug Therapy • Adults age >18 years	Percent of members who have had two face-to-face physician encounters, who were dispensed at least one prescription for a disease modifying anti-rheumatic (DMARD)
Use of Imaging Studies for Low Back Pain • Adults age 18-50 years	Percent of members with a diagnosis of low back pain, who have had no imaging in the 28 days following the initial diagnosis
Osteoporosis Management in Women Who had a Fracture • Female members 67-85 years	Percent of **Medicare** female members ages 67-85 years who suffered a fracture and who had either a bone mineral density test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture

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2016 HEDIS® Measures

RESPIRATORY CONDITIONS	
2016 Measure	**Quality Indicator**
Appropriate Testing for Children with Pharyngitis • Children and Adolescents age 2-18 years	Percent of children with a diagnosis of Pharyngitis who were dispensed an antibiotic, and received a strep test for the episode of care
Appropriate Treatment for Children with URI • Children and Adolescents age 3 months-18 years	Percent of children with a diagnosis of URI who were not dispensed an antibiotic
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis • Adults age 18-64 years	Percent of members with a diagnosis of acute bronchitis who were not dispensed an antibiotic
Use of Spirometry Testing in the Assessment and Diagnosis of COPD • Adults over 40 years	Percent of members with a new diagnosis of COPD who received a spirometry to confirm diagnosis
Medication Management for Children and Adults with Asthma • Medicaid: Age 5-64 years • Commercial: Age 5-85 years	Percent of members with persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.
Pharmacotherapy Management of COPD Exacerbation • Adults over 39 years	The percent of COPD exacerbations for members who had an acute inpatient discharge or ED visit on or between January 1—November 30 of the measurement year, who were dispensed appropriate medications. Two rates are reported: • Dispensed a systemic corticosteroid (or evidence of an active prescription) within 14 days of the event • Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

CARDIOVASCULAR	
2016 Measure	**Quality Indicator**
Controlling High Blood Pressure • Adults age 18-85 years	Percent of members: • With a diagnosis of hypertension, have a blood pressure of < 140/90 • With a diagnosis of diabetes, have a blood pressure of < 150/90
Persistence of a Beta-Blocker After a Heart Attack • Adults age >18 years	Percent of members who were hospitalized with an acute myocardial infarction who received a beta blocker for six months after discharge
Statin Therapy • Males 21-75 years of age • Females 40-75 years of age	Percent of members who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one high or moderate-intensity statin medication during the measurement year and percent who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

2016 HEDIS® Measures

ACCESS AND AVAILABILITY OF CARE	
2016 Measure	**Quality Indicator**
Adult Access to Preventive/Ambulatory Health Services • Adults age 20 years and older	Percent of Medicaid or Medicare members who have had one or more ambulatory or preventive visit during the measurement year Percent of Commercial members who have had one or more ambulatory or preventive visit during the measurement year, or the two years prior to the measurement year.
Children and Adolescents' Access to Primary Care Practitioners • Children and Adolescents age 12 months -19 years	• 12 months to 6 years: Percent of members who have had one or more PCP visit during the measurement year • 7 to 11 years: Percent of members who have had one or more PCP visit during the measurement year, or the year prior to the measurement year
Prenatal and Postpartum Care	Percent of members who: • Received care within their first trimester, or within 42 days of enrollment • Had a postpartum visit between 21 and 56 days after delivery
Frequency of Prenatal Care	Percent of deliveries between November 6th of the year prior to the measurement year, and November 5th of the measurement year that had the expected number of prenatal visits.

DIABETES Comprehensive Diabetes Care (18-75 years)	
2016 Measure	**Quality Indicator**
HbA1c Testing	Percent of members with one HbAlc test during year
HbA1c Poor Control • >9%	Percent of members with HbA1c result of higher than 9.0
HbA1c Good Control • < 7%	Percent of members with HbA1c result of lower than 7.0
Eye Exam • Retinal	Percent of members who have had an annual retinal exam in the measurement year, or have had a negative exam in the year prior
Medical Attention for Nephropathy	Percent of members who have had attention to the presence of nephropathy
Blood Pressure Control • <140/90 mm Hg	Percent of members with acceptable BP <140/90 mm Hg
Statin Therapy for Patients with Diabetes • 40-75 years of age	Percent with diabetes who were identified as not having clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one statin medication of any intensity during the measurement year and percent who remained on statin medication of any intensity for at least 80% of the treatment period

Laboratory Services

McLaren Health Plan utilizes JVHL (Joint Venture Hospital Laboratories) as our provider for laboratory services for our Commercial and Medicaid members. 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 hour / 7 day client service support. You may contact JVHL at (800) 445-4979 or visit the JVHL website at *jvhl.org* for additional information, including:

- Service Center Locations
- The JVHL Provider Directory

In-Office Laboratory Services

McLaren Health Plan (MHP) contracts with Joint Venture Hospital Laboratories (JVHL) to provide all outpatient laboratory services. In order 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.

MHP In-Office Laboratory Billable Procedures		
CPT-4 Code		**Procedure Description**
80048		BASIC METABOLIC PANEL
80051		ELECTROLYTE PANEL
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		URINANLYSIS; MICROSCOPIC ONLY
81025		URINE PREGNANCY TEST, BY VISUAL COLOR COMPARISON METHODS
82044		URINARY MICROALBUMIN
82270		BLOOD, OCCULT; FECES SCREENING BY PEROXIDASE ACTIVITY, 1-3 SIMULTANEOUS DETERMINATIONS
82272		BLOOD, OCCULT; FECES SCREENING BY PEROXIDASE ACTIVITY, SINGLE SPECIMEN (EG, FROM DIGITAL RECTAL EXAM)
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
82670	*	ESTRADIOL
82947QW		GLUCOSE; QUANTITATIVE
82948		GLUCOSE; BLOOD, REAGENT STRIP
83001QW	*	GONADOTROPIN; FOLLICLE STIMULATING HORMONE (FSH)
83002	*	GONADOTROPIN; LUTEINIZING HORMONE (LH)
83036		HEMOGLOBIN, GLYCATED
83037		GLYCOSYLATED HEMOGLOBIN TEST
83655		LEAD

In-Office Laboratory Services *(Continued)*

CPT-4 Code		Procedure Description
84144	*	PROGESTERONE
84146	*	PROLACTIN
84295		SODIUM; SERUM, PLASMA OR WHOLE BLOOD
84520		UREA NITROGEN; QUANITITATIVE
84703QW		GONADOTROPIN, CHORIONIC (HCG); QUALITATIVE
85007		BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL DIFFERENTIAL WBC COUNT
85013		BLOOD COUNT; SPUN MICROHEMATOCRIT
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
86308QW		HETEROPHILE ANTIBODIES; SCREENING
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
87650		STEPTOCOCCUS, GROUP A, DIRECT PROBE TECHNIQUE
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)
* Only Specialists may perform these services		

Diabetic Monitors and Supplies

McLaren Health Plan utilizes Bayer HealthCare as our sole supplier for diabetic monitors and diabetic monitor supplies for all lines of business. To request a monitor for a member please contact Customer Service at (888) 327-0671. There are a few exceptions to the requirement to utilize Bayer for monitors and supplies. They include:

- 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.

Pharmaceutical Management

Pharmaceutical Management promotes the use of the most clinically appropriate, safe and cost effective medications. The McLaren Health Plan Formulary is utilized as the fundamental resource for our pharmacy management for all products. McLaren Health Plan's formulary has been developed by physicians representing various specialties, and approved by our Quality Improvement Committee. The McLaren Health Plan Formulary is utilized as a resource for pharmacy management with quality and cost effectiveness as primary goals. Formularies are product specific.
All Formularies consists of:

- Prescribing Protocols
- Full Positive Listing and a Quick Formulary Reference Guide
- Request for Prior-Authorization Procedure and Form

Formularies for each product are available on our website or you can request a hard copy by calling Customer Service at (888) 327-0671.

Referral/Authorization 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 coordinate the entire episode of care to ensure the timely initiation and appropriate utilization of health services. We do recognize that there are certain situations and circumstances in which the specialist provider would be more appropriate to request services. Therefore, referrals and requests for Pre-Authorization are also accepted from the specialist provider.

The Provider Referral Form is utilized by MHP to obtain Pre-Authorization when certain services outside of the PCP office setting are requested. The Provider Referral Form is available electronically for completion and submission to MHP. The document can be found under the Provider Tab, Referrals/ Request for Pre-Authorization on our website. The form can be completed and submitted online or printed from the website and submitted via fax to (877) 502-1567. Use of the electronic form is secure and is the preferred method of submitting requests for Pre-Authorization of services to MHP. Urgent requests for Pre-Authorization may be made by contacting Medical Management at (888) 327-0671. MHP Medical Management strives to respond to provider requests for Pre-Authorization of services in an efficient and prompt manner. MHP utilizes the following time frames for timeliness of non-behavioral healthcare 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.

A detailed list of services requiring Pre-Authorization per product line is listed on the back of the MHP Referral Form. In addition, MHP has a list by CPT Code of outpatient services requiring Pre-Authorization. Both of these can be found on our website at *McLarenHealthPlan.org* under the Provider tab; Referrals/ Requests for Pre-Authorization.

Remember:

- All Inpatient services require Pre-Authorization
- All Out-of-Network services require Pre-Authorization
- All "not otherwise classified" (NOC), "unlisted", or "unspecified" codes require clinical review
- All services/procedures billed to MHP must be both medically necessary and coded appropriately. MHP reviews paid claims to ensure compliance and accuracy

Claims Payment

In general, McLaren Health Plan follows the claims reimbursement policies and procedures set forth by the Michigan Department of Community Health (MDCH) and Centers for Medicare and Medicaid Services (CMS). Reimbursement for Medicaid and Medicare is based on the prevailing state of Michigan Medicaid or Medicare fee schedule. If you have the ability to submit claims electronically, you are expected to submit your McLaren Health Plan claims electronically.

McLaren Health Plan accepts both paper (CMS 1500 and UB-04 claim forms) and electronic claims. All claims must be submitted and received by McLaren Health Plan no later than one 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

Although we prefer receiving claims 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.

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare and Medicaid Services (CMS) and the National Uniform Claim Committee (NUCC).

McLaren Health Plan receives EDI claims from our clearinghouse, ENS Optum Insight. For claims filed electronically through McLaren Health Plan'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 /MIChild – 3833C
McLaren Commercial HMO – 38338
McLaren Health Advantage – 3833A
McLaren Advantage – 3833R

Since you may choose to contract with a different clearinghouse, you must ask whether 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 our website at *MclarenHealthPlan.org* for an updated listing of ENS Optum Insight affiliated clearinghouses.

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 *enshealth.com* or (866) 367-9778.

What's on the Web?

McLaren Health Plan is in the process of updating our website. MHP utilizes our website as a means to inform, educate and engage our providers, members, and employers. Once the updated website is complete, notification will be sent out to all Providers. As a member of our provider network, we appreciate that you provide high quality, accessible, and cost effective health services to our membership.

"What's On the Web?"

Information is presented on subjects such as:

- Case Management Support
- Credentialing Process
- Electronic Billing
- How to Contact Us
- Provider Directory
- FACTSWeb

In addition, visit our website frequently for the most up to date information regarding:

- Pharmaceutical Management Information
  - » Drug Formulary
  - » Request for Prior Authorization Form
- Many Clinical Practice Guidelines, including:
  - » ADHD
  - » Asthma
  - » Depression
  - » Diabetes
  - » Prenatal
  - » Preventive Services
- Developmental Surveillance and Screening
- Disease Management Programs
  - » How to access programs and what your enrolled member receives
- Quality Performance Improvement Plan
- Utilization Management
  - » Criteria Availability
  - » Denial Process
  - » Incentive Statement
  - » Referral Process
- Member Rights and Responsibilities
- Fraud, Waste & Abuse
- Provider Complaint and Appeals Process

If you would like a printed copy of any information, please contact Medical Management at (810) 733-9711 or toll free at (888) 327-0671

HEALTH PLAN

Provider Welcome Packet