McLaren HEALTH PLAN

Provider Network Update

June 2015

Change to authorization requirements for McLaren Health Plan's Medicaid/Healthy Michigan/MIChild Physical/Occupational/Speech Therapy Services – Effective July 1, 2015

Evaluations for Physical/Occupational/Speech Therapy will not require an authorization, but **all visits** for treatment will require an authorization. **Effective July 1, 2015**, the following procedure codes **do not require an authorization**, when received from an **In-Network Physical Therapy Provider:**

Physical Therapy Evaluation – 97001

Occupational Therapy Evaluation – 97003

Speech Therapy Evaluation – 92521, 92522, 92523

All other therapy treatment codes will require pre-authorization from McLaren Health Plan.

McLaren Health Plan thanks you for your patience as we continue to streamline our processes and continue to work towards easing the administrative burden for our providers and their office staff.

Inpatient and Outpatient Short Hospital Stay Reimbursement

McLaren Health Plan, in accordance with the Michigan Department of Health and Human Services (MDHHS) Provider Bulletin MSA 15-17, is instituting a new Short Hospital Stay rate of reimbursement for certain outpatient and inpatient hospital stays effective for outpatient dates of service or inpatient discharges on and after July 1, 2015. This rate will be the same for inpatient and outpatient services and will apply to all services billed on the claim. If a claim does not qualify for the Short Hospital Stay rate based on the criteria described below, it will be reimbursed using the normally applicable inpatient or outpatient reimbursement logic. The Short Hospital Stay logic will apply to both emergent and elective claims. For purposes of this reimbursement structure, Short Hospital Stays will be defined using the following criteria:

Outpatient Hospital Claims Qualification – An outpatient hospital claim will qualify for the Short Hospital Stay reimbursement if all of the following criteria are met:

- The primary diagnosis code billed on the outpatient claim is listed in the diagnosis table below
- The claim does not include a surgical revenue code (36x) billed on any line of the outpatient claim
- The claim does not include cardiac catheterization lab revenue code 481
- The claim includes an observation-related revenue code (762)
- The claim must include discharge status codes 01, 06, 09, 21, 30, 50, or 51

Inpatient Hospital Claims Qualification – An inpatient hospital claim will qualify for the Short Hospital stay reimbursement if all of the following criteria are met:

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- The primary diagnosis code billed on the inpatient claim is listed in the diagnosis table below
- The claim does not include a surgical revenue code (36x) billed on any line of the inpatient claim
- The claim has a date of discharge equal to or one day greater than the date of admission
- The claim does not include cardiac catheterization lab revenue code 481
- The claim must include discharge status codes 01, 06, 09, 21, 30, 50, or 51

Exclusions – The Short Hospital Stay logic will not apply to inpatient or outpatient claims with the following conditions:

- Claims where MHP is the secondary payer. MHP will follow the rules of the primary payer and MHP will be responsible for payment of co-insurance and/or deductible
- Transfers out of a Hospital
- Claims for patients who leave the Hospital Against Medical Advice (AMA)
- Claims for deceased patients
- Claims that include primary diagnoses that are not on the table listed below, for example, claims for births and deliveries

Diagnoses

As indicated, in order to qualify for a Short Hospital Stay rate, a claim must include one of the primary diagnosis codes listed in the table below. This table will be maintained and updated on the MDHHS website at Michigan.gov/MedicaidProviders/Billing and Reimbursement/Provider Specific Information. The list of eligible codes will be evaluated by MDHHS annually and updated as necessary. Additional information regarding ICD-10 will be forthcoming.

ICD-9 Code	Description
038.9	Unspecified septicemia
250.10	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled
250.11	Diabetes with ketoacidosis, type I (juvenile type), not stated as uncontrolled
250.12	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled
250.80	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
250.81	Diabetes with other specified manifestations, type I (juvenile type), not stated as uncontrolled
250.82	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled
250.83	Diabetes with other specified manifestations, type I (juvenile type), uncontrolled
276.50	Volume depletion, unspecified
276.51	Dehydration
276.52	Hypovolemia
345.90	Epilepsy, unspecified, without mention of intractable epilepsy
401.9	Unspecified essential hypertension
414.00	Coronary atherosclerosis of unspecified type of vessel, native or graft
414.01	Coronary atherosclerosis of native coronary artery
466.11	Acute bronchiolitis due to Respiratory Syncytial Virus (RSV)

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466.19	Acute bronchiolitis due to other infectious organisms
486	Pneumonia, organism unspecified
ICD-9 Code	**Description**
491.21	Obstructive chronic bronchitis with (acute) exacerbation
491.22	Obstructive chronic bronchitis with acute bronchitis
493.22	Chronic obstructive asthma with (acute) exacerbation
493.91	Asthma, unspecified type, with status asthmaticus
493.92	Asthma, unspecified type, with (acute) exacerbation
558.9	Other and unspecified noninfectious gastroenteritis and colitis
577.0	Acute pancreatitis
682.1	Cellulitis and abscess of neck
682.2	Cellulitis and abscess of trunk
682.3	Cellulitis and abscess of upper arm and forearm
682.4	Cellulitis and abscess of hand, except fingers and thumb
682.5	Cellulitis and abscess of buttock
682.6	Cellulitis and abscess of leg, except foot
682.7	Cellulitis and abscess of foot, except toes
682.8	Cellulitis and abscess of other specified sites
682.9	Cellulitis and abscess of unspecified sites
780.2	Syncope and collapse
780.39	Other convulsions
786.50	Chest pain, unspecified
786.59	Other chest pain

Short Hospital Stay Rate and Methodology

A single Short Hospital Stay rate has been developed by MDHHS for certain outpatient and inpatient hospital stays. This rate will encompass funding for both operating and capital costs, will be identical for inpatient and outpatient services, and will encompass all services billed on the claim.

The Short Hospital Stay rate will be $1,314. MDHHS will monitor the diagnosis code sets and reimbursement to ensure budget neutrality is maintained or to maintain consistency with future reimbursement changes. As a result, future changes to the reimbursement process are possible.

Countdown to ICD-10: The Clock is Running!

The October 1, 2015 ICD-10 implementation date is just around the corner. ICD-10, which will replace ICD-9 code sets and update ICD-9 terminology, consists of two parts: (1) ICD-10 CM for diagnosis coding for all claims, and (2) ICD-10 PCS for procedure coding on inpatient hospital claims. **Here are ICD-10 Tips & Tools published by MDHHS**:

1. Check CMS Timelines and Checklists for your Organization to ensure readiness at www.cms.gov/icd10
    a. ICD-10 training of staff and Physicians in clinical documentation exercises and medical terminology should be well underway:

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i. Ensure that your clinical documentation can support the new ICD-10 codes
ii. Conduct dual coding:
    1. Take a patient's chart and code it in ICD-10 and note the time that it takes to turn it into a claim
    2. Evaluate all the systems and personnel that are impacted by the claim
    3. Make necessary adjustments accordingly based on finding of ICD-10 impact assessment for that claim (training, system upgrades, forms, etc.)
    4. Dual coding can assist in measure the impact of ICD-10 productivity while helping apply a standard measure of coding application

b. ICD-10 testing should be well underway:
    i. B2B Testing: Check with your Billing Vendor to assess their readiness if you do not conduct your own billing within your organization
    ii. Scenario Based Testing: ICD-10 assessment of staff knowledge

2. Review the ICD-10 CM and ICD-10 PCS Official Coding Guidelines and 2015 ICD-10 Coding Gems at www.cms.gov/icd10
3. Review CMS's ICD-10 Resource: "Road to ICD-10" @ www.roadto10.org

Inpatient All Patient Refined Diagnosis-Related Group (APR-DRG) Reimbursement Update

On December 1, 2014, the State issued Policy Bulletin MSA 14-59 and expressed its intent to modify the Michigan Medicaid inpatient reimbursement system effective October 1, 2015. This reform will include development of a statewide inpatient rate with adjustors and conversion to an APR-DRG system. Below are the conceptual highlights that the Michigan Department of Health and Human Services (MDHHS) would like to share at this time. MDHHS anticipates:

- Establishing a statewide rate and evaluating additional peer group options
- Calculating hospital-specific cost-to-charge rations that will be used to develop the statewide rate(s) and relative weights, and reimburse outliers and transplants. The rations will be comprised of managed care and fee-for-service data, and will be updated annually on October 1
- Maintaining cost outliers and low day payments, but eliminating high day payments
- Incorporating a revised area wage adjustor to reflect geographic variances in labor costs
- Establishing Michigan-specific relative weights to reflect resource utilization for the Michigan Medicaid population. In addition, the State is evaluating alternate weights for hospitals with neonatal intensive care units

MHP will keep you updated on additional information as it is made available from MDHHS.

If you have any questions, please contact your Network Development Coordinator at (888) 327-0671.

McLaren Health Plan thanks you for the quality care you deliver!

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