McLaren HEALTH PLAN

Provider Network Update

January 2017

Common Medicaid Managed Care Formulary

In order to streamline drug coverage policies for Medicaid and Healthy Michigan Plan members and providers, the Michigan Department of Health and Human Services (MDHHS) has created a formulary that is common across all Medicaid Health Plans. The development of the Common Formulary is required under Section 1806 of Public Act 84 of 2015.

The Common Formulary also includes certain drug utilization management tools, such as prior authorization criteria and step therapies. Health plans may be less restrictive, but not more restrictive, than the coverage parameters of the Common Formulary.

The list of drugs that are currently covered under the Fee-for-Service benefit and the Medicaid Carve-Out process will remain unchanged.

To promote safe medication transitions and minimize the burden on prescribers and patients, all contracted health plans will be required to follow one set of policies and procedures on transition of care and grandfathering of drug therapy.

The Common Formulary includes drugs that are covered as a pharmacy benefit. The following are examples of products that are not identified on the Common Formulary because a Medicaid Health Plan may cover it as a medical benefit: Physician-administered injectable drugs, vaccines and intrauterine devices.

As a reminder, with the exception of products that are carved out, Medicaid Health Plans must have a process to approve provider requests for any prescribed medically appropriate product identified on the Medicaid Pharmaceutical Product List (MPPL). Products that are listed on the MPPL but are not listed on the Medicaid Common Formulary are available for coverage consideration through a non-formulary prior authorization process.

A mandatory generic drug policy encourages the generic version to be dispensed rather than a brand name product. In most instances, a brand name drug for which a generic product becomes available will become non-formulary, with the generic product covered in its place, upon release of the generic product onto the market.

McLaren Health Advantage New Exclusive Laboratory Vender

McLaren Health Plan is pleased to announce Joint Venture Hospital Laboratory (JVHL) as the preferred laboratory, for McLaren Health Advantage Members, effective January 1, 2017.

In addition to the MHP Community and MHP Medicaid Members continuing to utilize JVHL services, McLaren Health Advantage members will soon be utilizing JVHL services.

Many of you currently use a JVHL Network Laboratory for your patients, however; if you are using a different laboratory provider, it will be necessary to coordinate transitioning your laboratory services to JBHL as soon as possible. You may contact JVHL at (800) 445-4979 or visit the JVHL website at www.jvhl.org.

If the patient chooses to go to a non-JVHL laboratory for outpatient laboratory services, such as Quest, LabCorp or another independent laboratory, they will incur higher out-of-pocket costs.

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

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Joint Venture Hospital Laboratories (JVHL) now offers BRCA Testing

McLaren Health Plan and Joint Venture Hospital Laboratory (JVHL) are pleased to announce that JVHL provider, MLab™ Michigan Medical Genetics Laboratories (MMGL) Molecular Genetics Laboratory now offers a full complement of BRCA testing. The following test options are available:

Test	Order Code	CPT Code
BRCA1 Gene Sequencing	BRCA1	81214
BRCA2 Gene Sequencing	BRCA2	81216
BRCA1 Deletion/Duplication Analysis	BRC1D	81213
BRCA2 Deletion/Duplication Analysis	BRC2D	81213
BRCA1 & BRCA2 Gene Sequencing (Tier 1)	BRC1	81211
BRCA1 & BRCA2 Deletion/Duplication Analysis (Tier 2)	BRC2	81213
BRCA1 Targeted Sequencing Familial	BR1F	81215
BRCA2 Targeted Sequencing Familial	BR2F	81217
BRCA Ashkenazi Jewish Founder Mutations	BRAJ	81212
BRCP Panel (includes Tier 1 & Tier 2)	BRCP1	

To better understand the scope of BRCA analyses provided by MMGL, and to review additional information please reference the websites below. To request a collection kit, please call the MLabs, Client Services Center at (800) 862-7284.

- Test descriptions, specimen collection and handling guidelines (http://mlabs.umich.edu)
- Instructions for specimen transport (800) 862-7284 or (http://mlabs.umich.edu/customer-service/submit-specimens/)
- Sample test requisition form (http://mlabs.umich.edu/customer-service/formsreqssuppplies/test-requisitions/)
- Sample informed consent form (http://mlabs.umich.edu/files/pdfs/PCI-MMGL_InformedConsent.pdf)

NOTE: BRCA Testing must be authorized prior to testing for your McLaren Health Plan Patients.

Please submit a *Provider Referral Form* for BRCA testing to McLaren Health Plan to begin the test preauthorization process. The form can be completed on-line at www.mclarenhealthplan.org or completed and faxed to (877) 502-1567. Patient demographics, including McLaren Health Plan coverage information and family history should be provided along with the referral form.

The addition of BRCA1 and BRCA2 Gene Analyses by MLabs™, Michigan Medical Genetics Laboratories furthers the JVHL commitment to provide testing locally and to continue to bring you the best in laboratory medicine.

If you have any question, please contact McLaren Health Plan Customer Service at (888) 327-0671.

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Health Rules Claims System – Update

Since our Medicaid implementation of Health Rules on July 1, 2014, MHP has realized many successes and improved processes, such as quicker payment turnaround time for our provider network and enhancements to our provider portal. **The next line of business to transition to the Health Rules platform for claims processing is McLaren Health Advantage, our self-funded PPO. We anticipate this transition will occur in January of 2017.**

With the McLaren Health Advantage transition, you will continue to experience many of the improvements that you have with the Medicaid line of business. Only 2017 dates of service and after will be transitioned to the Health Rules platform; claims for 2016 dates of service will continue to be processed on our legacy claims processing system. Some important reminders:

- **Billing Requirement:** All claims submitted to MHP, for all lines of business, must be submitted with both a Billing NPI (Box 33A) and Rendering NPI (Box 24J). Claims submitted to MHP without a valid Billing NPI and Rendering NPI will be denied.
- **New Explanation of Payment (EOP) Layout:** With the McLaren Health Advantage transition to Health Edge, the EOP for that line of business will be the same as you have been receiving for the MHP Medicaid line of business. This EOP layout will give clear, concise information on claims adjudication.
- **Payer ID:** information to be utilized when submitting electronic claims to McLaren Health Plan:
  - MHP Medicaid – 3833C
  - MHP Community – 38338
  - McLaren Health Advantage – 3833A
  - McLaren Advantage (HMO) – 3833R
- **NPI and Taxonomy:** It is extremely important that you bill with the correct billing and rendering NPI and taxonomy (if available) for the Provider and group rendering the service as claims are matched based on these values.

MHP Medicaid Providers – CHAMPS Enrollment Requirement

MHP Medicaid-contracted Providers must enroll and attest to their information within the CHAMPS system.
Enrolling in CHAMPS does not require you to be a Medicaid FFS Provider.
To enroll in CHAMPS:

1. Go to www.michigan.gov/mdhhs
2. Click on “Doing Business with MDHHS” Icon (top of page)
3. Click on “Health Care Providers” Icon (right side of page)
4. Click on “Providers” (middle of page)
5. Click on CHAMPS button
6. Click on “MILogin” Icon
7. Click “Create New Account” Button (under “MILogin”)

If you are not registered, enroll today and complete this requirement as soon as possible. If you have any questions, please contact Customer Service at (888) 327-0671.

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Billing Reminders!

Hospice Providers Medicaid Billing Guidelines

As a reminder, in accordance with the Michigan Department of Health and Human Services (MDHHS) Bulletin MSA 15-60, effective 1/1/16 hospice routine home care is on a two-tiered rate of reimbursement:

- A higher rate will be paid for the first 60 days of hospice care
- A decreased rate will be paid for hospice days 61 and beyond

A day of hospice is counted when any level of hospice care is provided (i.e. Routine Home Care, Continuous Home Care, General Inpatient Care, and Inpatient Respite Care)

APR-DRG Medicaid Billing Guidelines

At this time, MHP does not require that an APR-DRG be submitted on inpatient facility claims. We utilize Optum's EasyGroup software and methodology to calculate the DRG and reimbursement based on the claim data provided. However, our system does use the submitted DRG (MS-DRG or APR-DRG) to determine if the billed service requires preauthorization or not. Inpatient services such as Deliveries or Routine Nursery do not require preauthorization, but may deny for lack of preauthorization if the submitted DRG is blank.

Emergency Department Professional Billing Guidelines

As a reminder, when billing professional claims for emergency department visits, make sure that you are including the appropriate modifier to the E & M code:

- UA – when ED patient is admitted to the hospital
- UD – when ED patient is discharged

The correct coding for claims submission is required for quality, reporting and reimbursement purposes.

Urgent Care Billing Guidelines

If you are an Urgent Care Center that is contracted with MHP under a global reimbursement methodology, it is crucial for you to submit claims that include both the global billing code and the corresponding E & M code along with any ancillary services provided. You will be reimbursed for the global billing code and all other reported CPT/HCPCS will be denied as not separately reimbursable. It is critical for you to submit all CPT/HCPCS to accurately reflect the services performed for quality, HEDIS and reporting purposes.

Skilled Nursing Facility Billing Guidelines

Skilled Nursing Facilities must use the appropriate revenue codes and HCPCS codes for services performed. Other important reminders:

- Each ancillary service must be billed on a separate claim line; series billing is not allowed
- Each claim line requires a date of service, revenue code and a HCPCS code (except room and board)
- Dual therapy codes may be billed by a physical therapist and an occupational therapist on the same date of service; the codes are identified with the following required modifiers:
    - Occupational therapy modifier: GO
    - Physical therapy modifier: GP

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