Physicians Health Plan

Provider Connection

Q2 2024

In this issue...

WE HAVE MOVED!

OUR NEW LOCATION

Physicians Health Plan
1301 N Hagadorn Rd., Ste 1E
East Lansing, MI 48823

All P.O. Boxes and phone numbers will remain the same:

Mailing Address

Physicians Health Plan
PO Box 30377
Lansing, MI 48909-7877

Customer Service

Employer/Group Coverage
517.364.8500
800.832.9186 (toll free)

Individual Coverage
517.364.8567
866.539.3342 (toll free)

Mon-Fri, 8:30 a.m. to 5:30 p.m., ET
excluding major holidays

Website

PHPMichigan.com

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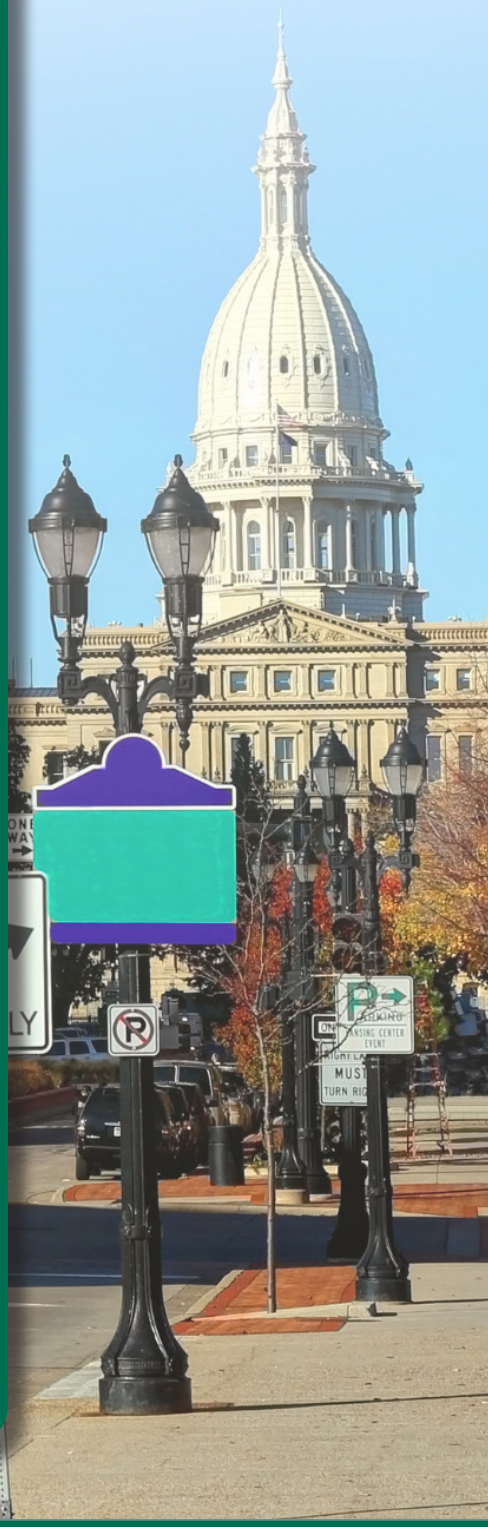


THANK YOU!

The HEDIS 2023 audit process will be ending as you receive this publication. The HEDIS Nurse Reviewer team would like to extend a sincere *thank you* to you and your office staff for your assistance in the process. We appreciate your timely response to our requests for records and your courtesy in allowing us into your office to review and gather records.

The performance scores will provide comparative data used to focus on quality improvement activities in the next year. Thank you again for assisting in this important goal to improve the health of individuals, families, and communities.

Thank you for all you do for our members.

If you have questions, please feel free to contact the PHP Quality Department at **PHPQualityDepartment@phpmm.org**.

A Heartfelt Thank You to Our Provider Network

We want to take a moment to express our deepest gratitude to each of you. Since the introduction of our new provider portal in October 2023, your unwavering support, understanding, and invaluable feedback have been instrumental in our journey.

The implementation of our new system aimed to deliver more efficient, user-friendly, and responsive solutions. Your support has enabled us to make remarkable progress and enhancements.

Thanks to your constructive feedback, we've been able to identify opportunities for improvement and refine the system to better align with the high standards we all strive to uphold.

We remain fully committed to providing you with the support and resources necessary to maximize the benefits of our new provider portal.

What's New

PHP Medicare has partnered with Lumeris to bring their suite of technology to our PHP Medicare provider partners to help achieve success in value-based care. PHP Medicare has migrated our network from the **Maestro™** platform to the **Lumeris Technology Suite™**.

Please look for training sessions on the PHP Medicare portal at **MyPHPProvider.HealthTrioConnect.com**.

The Lumeris Technology Suite™ consists of the following components:

LumerisRealize™ enables users to track clinical and financial performance for their organizations by viewing metrics at various levels of the provider hierarchy. LumerisRealize reports also capture populations' demographic and health profiles using industry standards and Lumeris proprietary risk models. LumerisRealize replaces Maestro HealtheAnalytics.

LumerisEngage™ is used to view and manage industry-specific patient cohorts organized by attributes such as gaps in care, cost, care management, risk adjustment, and admissions. This solution also provides access to patient-level information for viewing patient demographic information from various data sources across the continuum of care. The LumerisEngage platform can execute automated patient outreach pathways, eliminating repetitive office workflows so care teams can focus on patient care. LumerisEngage replaces Maestro HealtheInsights.

PHP Medicare Provider Pay Disputes

If PHP Medicare has made a payment on a claim or claim line(s), but the in-network provider disagrees with the amount paid, the payment may be disputed within the timeframe outlined in the provider's contract. In no case may contracted providers seek additional compensation from members other than copays, coinsurance, and payment for non-covered services.

Provider pay disputes should be submitted in writing. The request should outline the dispute's basis and include documents supporting your position. PHP Medicare will communicate the decision verbally or in writing if we feel the correct amount was previously paid. If we correct the payment, it will appear on remittance advice to the requesting provider. The review by PHP Medicare and its determination is final.

Send written claims dispute requests with all supporting documentation to PHP Medicare Correspondence. Disputes other than those related to claims or authorizations should also be submitted in writing to PHP Medicare Correspondence:

PHP Provider Dispute
P.O. Box 7119
Troy, MI 48007

PHP Correspondence or Claims
P.O. Box 7119
Troy, MI 48007

PHP Medicare Appeals

A claim appeal can be filed by either a member, a member's representative, or a **non-contracted provider**. Appeals must be filed within 60 days from the date of the initial organizational determination (for example, an EOB is issued or provider remit, whichever is applicable). Appeals must be submitted in writing and do not apply to contracted providers unless it involves a pre-service request. Any non-contracted provider appeal must include a CMS waiver of liability (WOL) statement found in the PHP Medicare provider portal. The CMS WOL statement states that the provider will not bill the member regardless of the outcome of the appeal.

PHP Medicare
844.529.3757

Fax
844.527.9400

Mail
P.O. Box 7119
Troy, MI 48007

Email
Appeals@PHPMedicare.com

How to Obtain Claims Status in the MyPHP Provider Portal

The MyPHP Provider Portal can be used to review claim status and download the Explanation of Payment (EOP). To begin your claims search, select "Claims" from the Office Managment dropdown menu. The Date of Service (DOS) range will default to three months before the current date. You must change the DOS from date to view older claims. Claims that were processed more than two years will not appear in the portal.

You can search by:

Claim Number – enter a full or partial PHP claim ID number

OR

Patient – enter a full or partial last name, or member ID, or the full Patient Account No. that was submitted on the claim

OR

Provider – Select a provider from the dropdown list, or enter a full or partial provider last name, or full Provider Tax ID or Provider NPI in the search field*

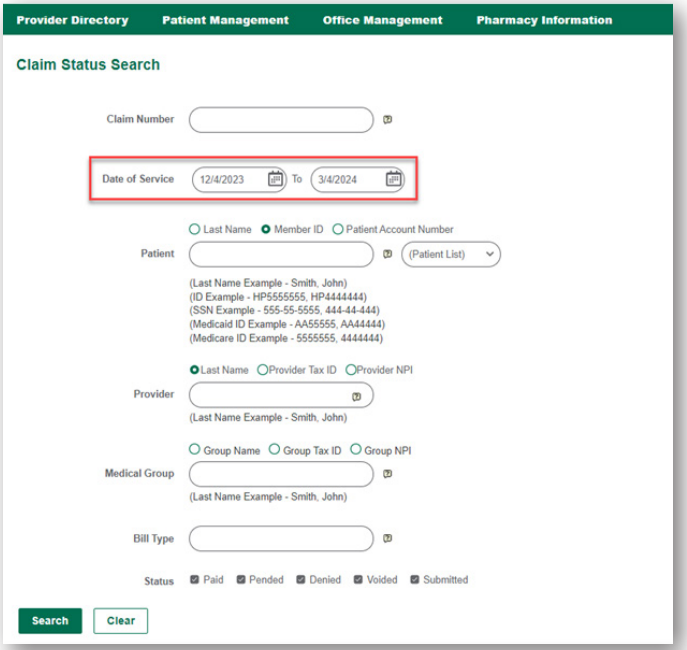
OR

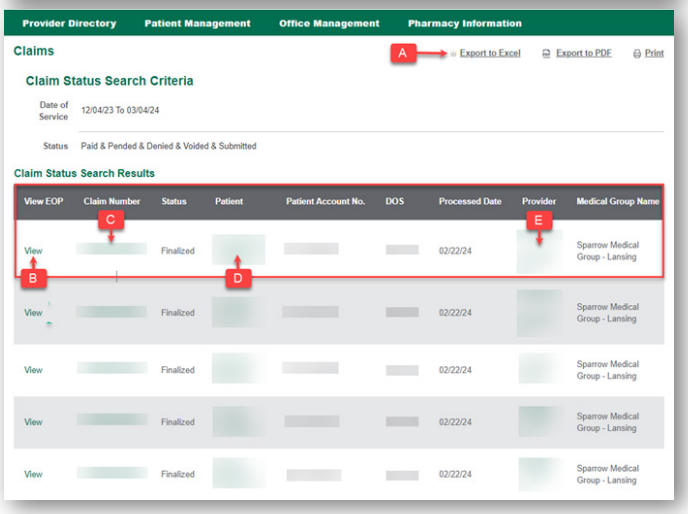
Medical Group – Select a medical group from the dropdown list, or enter a full group name, Group Tax ID, or Group NPI in the search field*

**The presence of the dropdown list or search field depends on the size of your practice. Portal users registered under smaller practice groups or organizations will see a dropdown list, while larger practice groups or organizations will see search fields.*

Tips and Tricks:

- If your search results return the message "Too Many Records Returned," try reducing the DOS range, or entering a full patient last name or ID, or full provider last name instead of partial information.
- When searching for a medical group, you must enter the full medical group name exactly as it appears in PHP's system. You can reference your provider's medical group name by searching for them in the online provider directory within the MyPHP Provider Portal.
- Only PCPs can select a patient from the patient list dropdown. Only patients that you have previously selected in Patient Management will populate on this list.





A. Claim search results can be exported to Excel, PDF, or printed.

B. The EOP can be viewed by clicking "View" in the View EOP column.

C. Individual claim details can be viewed by clicking on the claim number.

D. Clicking on the Patient Name will take you to the member's Requesting Provider selection for an Eligibility Request.

E. Clicking the Provider Name will take you to their Provider Detail information.

Tips and Tricks:

- You can click each column header to sort the results by the information in that column.
- Payor Remarks are currently only available on the EOP.

Real-Time Prescription Benefit Tool for CVS

Physicians can take action to help their patients with the click of a button.

PHP has an exciting tool that will save your team time and extra work when ePrescribing medications – it's called the **Real-Time Prescription Benefit** tool.

STEP 1:

Your Electronic Medical Record (EMR) vendor may have access to the Real-Time Prescription Benefit Tool provided by CVS Caremark for Physicians Health Plan Members. Surescripts is the vendor that connects your EMR to CVS Caremark. You can review the list to see if your EMR vendor can connect to the Real Time Benefits Tool.

Surescripts.com/Network-Connections/Real-Time-Prescription-Benefit-Technology-Vendors

STEP 2:

Contact your EMR vendor and request access to the CVS Caremark Real-Time Prescription Benefit Tool. Once connected, you'll be able to:

- Confirm if the patient is active with PHP.
- View the cost of a medication based on the member's benefit.
- Compare prices between medications.
- Find out if a drug requires authorization, step therapy, or has quantity limits, and obtain alternatives for these medication(s).

Please contact PHP Provider Relations if you have any questions by emailing PHPProviderRelations@phpmm.org.

PHP Medicare Provider Portal

Providers participating with PHP Medicare plans can access Commerical and PHP Medicare information with a single sign-on. Log into your MyPHP Provider Portal account, select the dropdown 'Office Management' and choose PHP Medicare Portal. The first-time logging into the portal, you must accept the End User License Agreement and verify your provider information. Once you have completed the sign-up process, you will receive an email from Lumeris, our contracted Medicare Advantage vendor, within 48 hours.

Any provider may be granted access to claims, eligibility, referral/prior authorization Inquiry, and the ability to submit a request for a prior authorization of services. Only PCPs (not specialists) may be granted access to generate online referrals. Roles and access are determined by how a user registers for the MyPHP Provider Portal. Medicare customer support cannot change a user's access type or access to specific providers. Below is a list of available User Roles that can be added during account creation:

- **PCP Office Staff** – May register for Lumeris Technology Suite; May enter referral to for Non-Par Specialist, Prior Authorizations.
- **PCP** – May register for Lumeris Technology Suite; May enter referral to for Non-Par Specialist, Prior Authorizations.
- **Specialist Office Staff** – Unable to access Lumeris Technology Suite; May enter prior authorization.
- **Specialist** – Unable to access Lumeris Technology Suite; May enter prior authorization.
- **Billing Specialist** – Unable to access Lumeris Technology Suite or enter prior authorizations.

Portal Resources

In our continuous effort to ensure a seamless experience for our network, we understand that navigating online portals can sometimes present challenges. To help you address any difficulties efficiently, we've detailed direct contact resources for our commercial and Medicare portals below. Whether you're encountering login problems, need password assistance, username inquiries, or facing errors, here's how to get the support you need:

Commercial Portal Tech Support

If you're experiencing issues with the commercial portal, the HealthTrio Help Desk is your first point of contact. They provide dedicated support for login issues, password recovery, usernames, errors, and more.

- **Phone:** 877.814.9909
- **Support Hours:** Monday – Friday, 8:00 a.m.- 8:00 p.m., ET

Medicare Portal Tech Support

For issues with the Medicare portal, please reach out to Lumeris Customer Support directly.

- **Phone:** 866.397.2812
- **Email:** CustomerSupport@Lumeris.com
- **Support Hours:** Monday – Friday, 8:00 a.m.– 7:00 p.m. ET

Additional Support

Should your issue remain unresolved, please contact **PHP Customer Service at 517.364.8500**. PHP Provider Relations is also available to offer additional assistance or address inquiries, such as registration assistance and portal navigation, at **PHPProviderRelations@phpmm.org**.

Training Opportunities

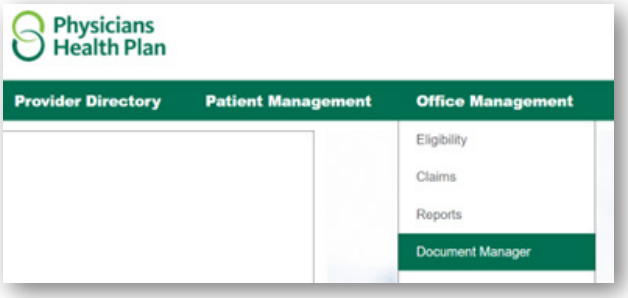
If you are interested in a training session for you or your office, please email PHP Provider Relations at **PHPProviderRelations@phpmm.org**.

Accessing PCP Incentive Reports, Technical Guides, and Member Rosters on MyPHP Provider Portal

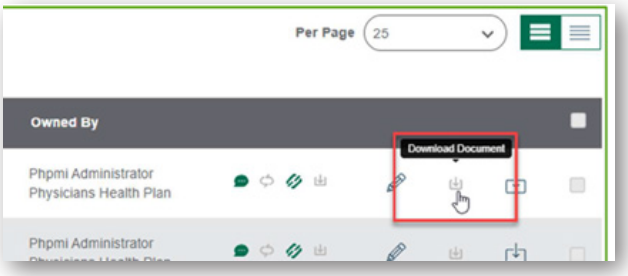
For PHP commercial primary care providers (PCPs), accessing your PCP Incentive Reports, Technical Guides, and PCP Member Rosters is easy on the MyPHP Provider Portal. Follow these steps to view your reports and rosters:

To View Your Primary Care Incentive Management Report:

1. Log in to your MyPHP Provider Portal account at **PHPMichigan.com/MyPHP**.
2. Navigate to the Office Management dropdown menu and select **Document Manager**.



3. Scroll down and select PCP Incentive Reports listed.
4. To download a report, click the Download Document icon next to the report you wish to access.



To View Your PCP Member Roster:

1. From the MyPHP Provider Portal, go to the Office Management dropdown menu and choose **Reports**.
2. Select **Member Roster by PCP – No SSN** from the options.
3. Use Select **Provider** to search for the PCP by Name, NPI, or PHP Provider ID. Alternatively, choose your provider from the Select Provider dropdown menu.
4. Click **Continue** to display the PCP Roster.

Note: If you encounter any difficulties finding the specific PCP you need, please reach out for assistance by sending an email to **PHPProviderRelations@phpmm.org**. Include the following information in your email:

- The provider's name and NPI
- The provider's group name, address, and NPI

The 2024 Primary Care Management Incentive Program Overview and **Technical Guide** are in Quick Access under "Provider Incentive Program."

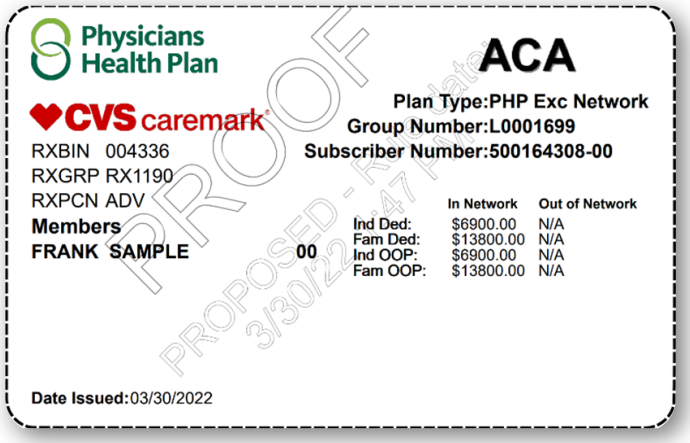
Identifying ACA Plans in the MyPHP Provider Portal

PHP offers individual/family ACA-compliant plans that can be purchased on-exchange at **HealthCare.gov** or off-exchange at **ChoosePHPMI.com**. Members who are enrolled in an ACA-compliant plan can be identified by their PHP member ID card or by checking eligibility in the MyPHP Provider Portal.

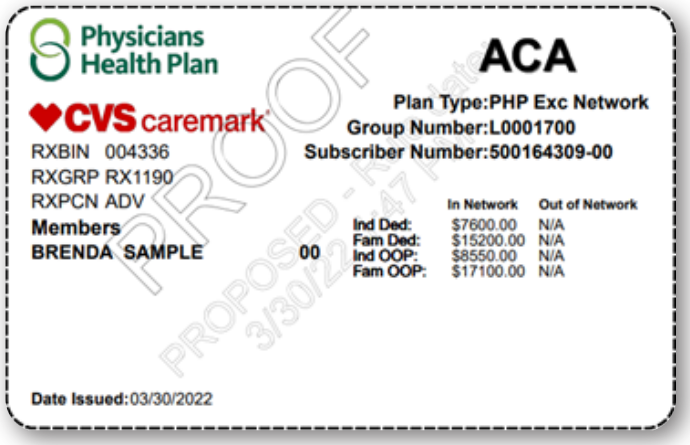
Member eligibility should be verified at the time of service. Members should present their ID cards at every visit. If a member cannot provide their PHP ID card at the time of service, you may verify eligibility by contacting PHP Customer Service at 517.364.8500 or 800.832.9186. PHP also encourages offices to utilize the MyPHP Provider Portal to verify member eligibility and view benefit information. For detailed instructions on how to check eligibility and benefits in the MyPHP Provider Portal, please refer to the article "Eligibility, Benefits, and Accumulators in the MyPHP Provider Portal," on page 10 of this newsletter.

Member ID Card Examples:

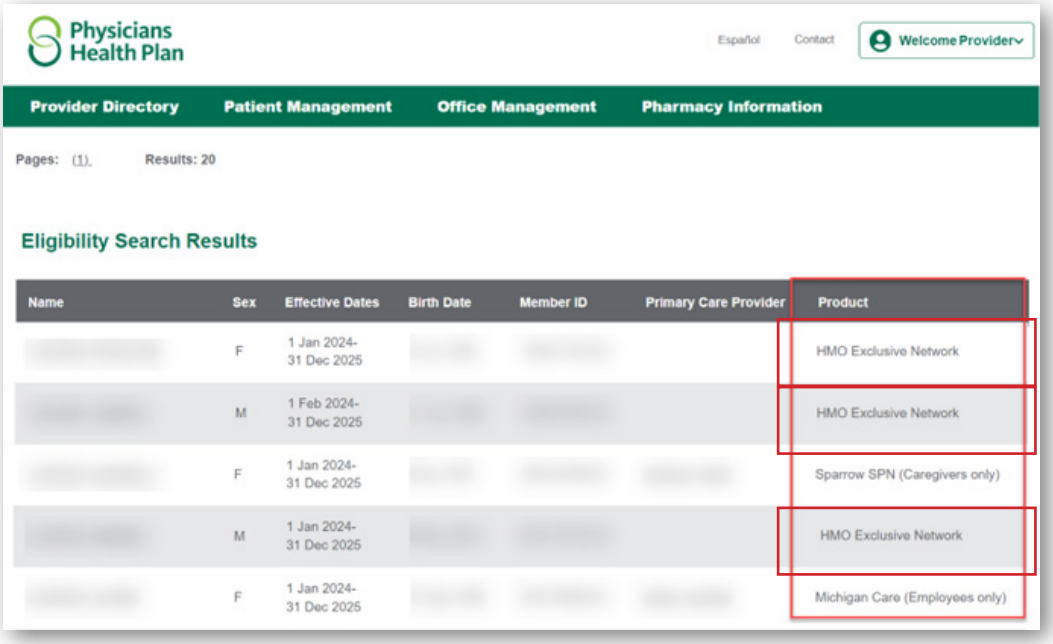
On-Exchange



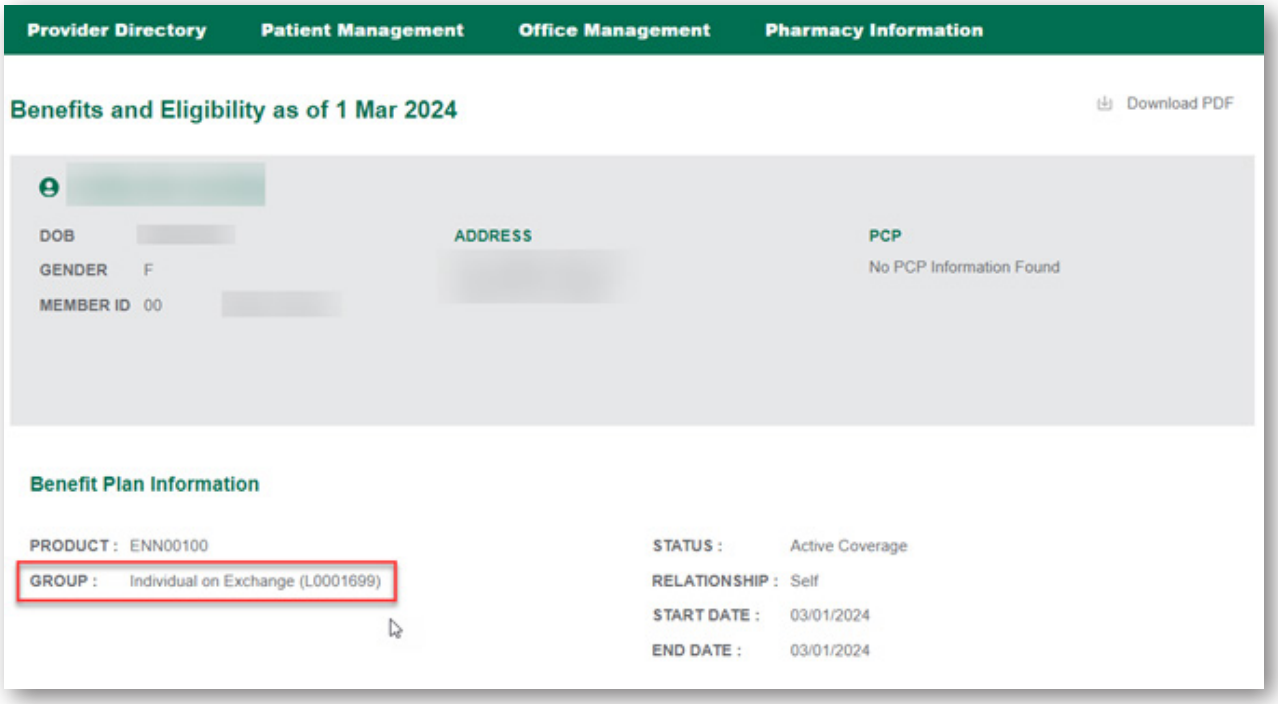
Off-Exchange



When reviewing eligibility search results in the MyPHP Provider Portal, ACA plans will have "HMO Exclusive Network" listed as the product:



While viewing a member's benefits and eligibility, ACA plans will have the group name "Individual On Exchange," "Individual Off Exchange," or the employer group name.



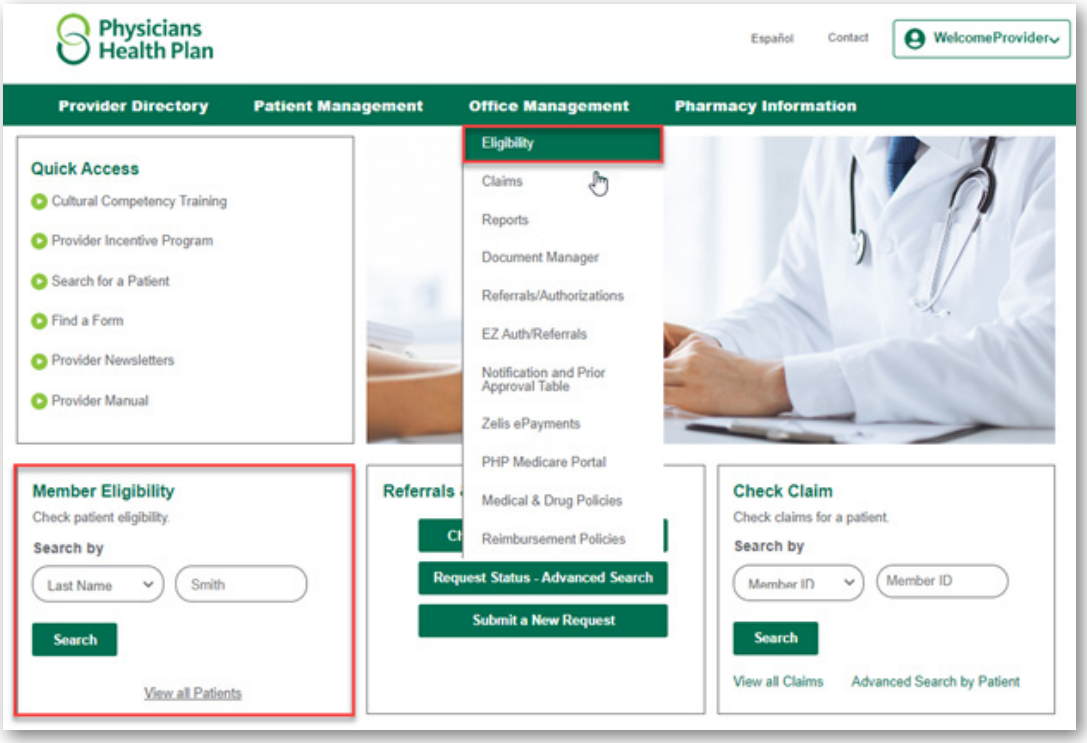
PCPs can also identify ACA plans on their PCP member rosters. ACA plans will have the line of business name "HMO Exclusive Network," and the network name "HMO Exclusive Network." The employer group name will reflect either the name of the employer for Small Group HMO Exclusive Benefit Plans or "Individual On Exchange" or "Individual Off Exchange" for Individual HMO Exclusive plans.

Line of Business	Network	Employer Group Name	Employer Group Number	Division Number	Benefit Plan
Sparrow SPN (Caregivers only)	Sparrow SPN (Caregivers only)	Sparrow Health System SPN	L0001269	1001	SPARROW HEALTH PPO NGF
HMO Exclusive Network	HMO Exclusive Network	Bailey & Terranova	L0001853	1000	SMALL GROUP HMO EXCLUSIVE
HMO Exclusive Network	HMO Exclusive Network	Individual OFF Exchange	L0001700	XVE3	INDIVIDUAL HMO OFF EXCHANGE EXCLUSIVE
Sparrow SPN (Caregivers only)	Sparrow SPN (Caregivers only)	Sparrow Health System SPN	L0001269	1030	SPARROW HEALTH PPO BASE NGF
HMO Exclusive Network	HMO Exclusive Network	Individual on Exchange	L0001699	EXP5	INDIVIDUAL HMO ON EXCHANGE EXCLUSIVE

For instructions on how to obtain PCP Rosters, refer to the article "Accessing PCP Incentive Reports, Technical Guides, and Member Rosters on MyPHP Provider Portal" that appears on page 7 of this newsletter.

Eligibility, Benefits, and Accumulators in the MyPHP Provider Portal

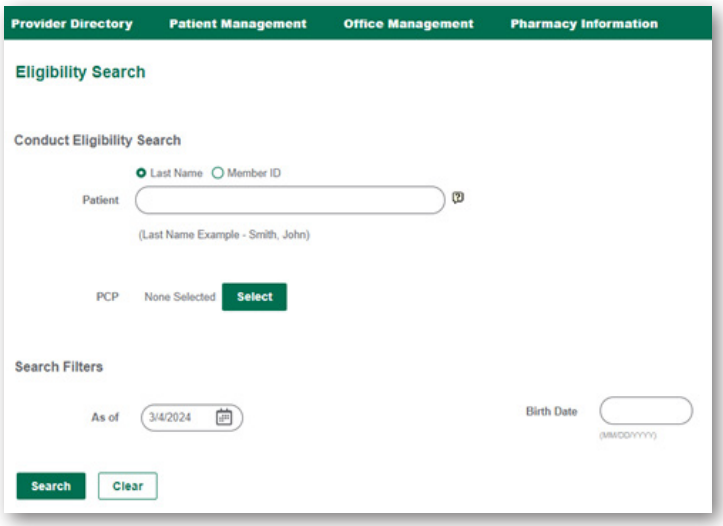
Member eligibility, benefits, and accumulator amounts can be viewed in the MyPHP Provider Portal. To begin a basic eligibility search, enter a full or partial last name or member ID in the Member Eligibility Card on the bottom-left of your MyPHP Provider Portal homepage or by hovering over “Office Management” and selecting “Eligibility”.



If you are in a PCP office, you can search for eligibility by selecting a PCP from the PCP dropdown list or by clicking “Select” and searching for the PCP. * If you are not in a PCP office, you must use the Member Eligibility search options.

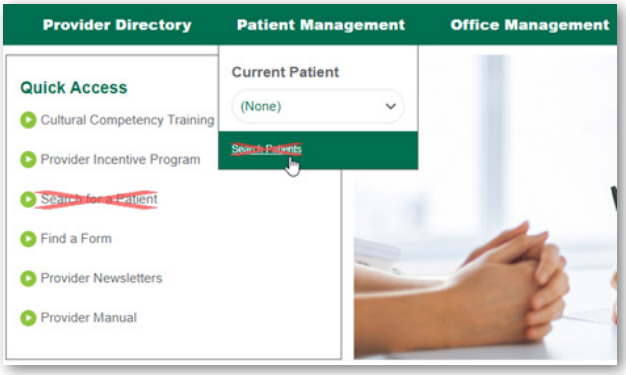
Change the “as of” date to view a member’s eligibility on a previous date or enter a member’s birth date to narrow down search results, if desired.

**The presence of the dropdown list or search field depends on the size of your practice. Portal users registered under smaller practice groups or organizations will see a dropdown list, while larger practice groups or organizations will see search fields.*



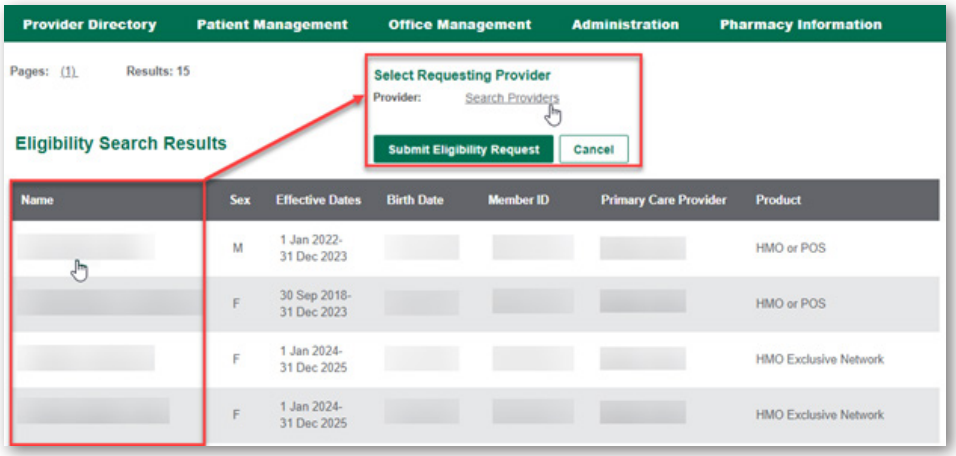
Tips and Tricks:

» Do **NOT** select search for a patient from the Quick Access menu or Search Patients from the Patient Management menu. These options are for PCPs to search for patients on their rosters and will return "No Records Found" if your account is not associated with the PCP's office.

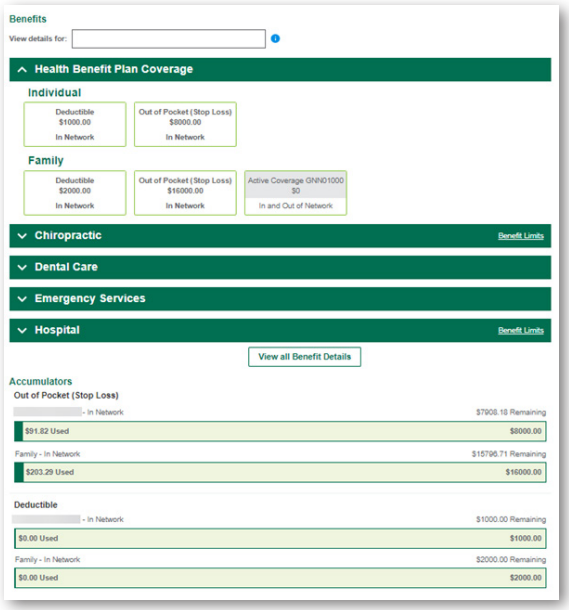


Eligibility Search Results

Click the member's name to Select a Requesting Provider and then click Submit Eligibility Request.



Benefits and Eligibility will display for the current date, or the "as of" date selected in your search filters. Scroll down to view the member's demographic information, benefit plan information, dependents, other insurance (if any has been reported to PHP), benefit details by category, and accumulators.



Tips and Tricks:

» Click the arrow on each Benefit Category to expand or collapse benefit details.

» Accumulators are live as of the date you are viewing the information, however, PHP recommends billing member deductibles only after you have received your Electronic Remittance Advice (ERA) or Explanation of Payment (EOP).

» You may need to reach out to **PHP Customer Service at 517.364.8400** to confirm certain benefit details, for example, the number of visits remaining for physical therapy.

Modifier Q6

A Fee-for-Time Compensation Arrangement (also called Locum Tenens) is the established practice for a provider to retain a substitute provider to cover their practice during a short-term absence. Short-term absence reasons include illness, pregnancy, vacation, and continuing medical education. As of Jan. 1, 2023, PHP does not require a Locum Tenens provider to be credentialed if covering for a provider for less than 60 days, but services must be submitted with the modifier Q6.

Keep in mind the following when submitting claims for Fee-for-Time Compensation/Locum Tenens:

- Apply the absent providers NPI in Box 24 of the CMS-1500 form.
- Apply modifier Q6 in box 24D of the CMS-1500 form for each line-item service on the claim to indicate that this service was performed by a substitute provider.
- Q6 does not apply to non-physician providers (e.g., nurse practitioners and physician assistants).
- 60 days is the maximum no matter how many substitute providers are used (exception: a temp filling in for a physician who is a member of the armed forces called to active duty).
- A substitute provider cannot be used to cover expansion or growth in a practice.
- Claim payment is made under the name and billing number of the provider that hired the substitute provider. If the provider has left the practice, every claim still must have a rendering provider, so the practice would still use their name and NPI with modifier Q6.
- The practice must keep on file a record of each service furnished by a substitute provider, with their NPI.
- Do not bill for services provided by a temp while waiting for a provider to be credentialed.
- If postoperative services are furnished by the substitute provider, the services cannot be billed with modifier Q6 since the regular provider is paid a global fee.

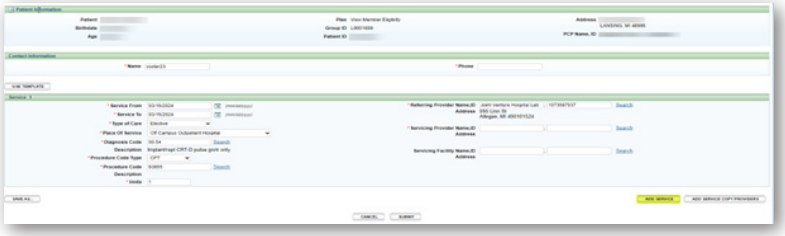
It is imperative to keep detailed records of all services provided by a substitute provider. This includes keeping practice confirmation letters on file to ensure that the service dates align with the assignment dates should there be an audit.

Requesting Prior Authorization for Procedures with a Surgical Assistant

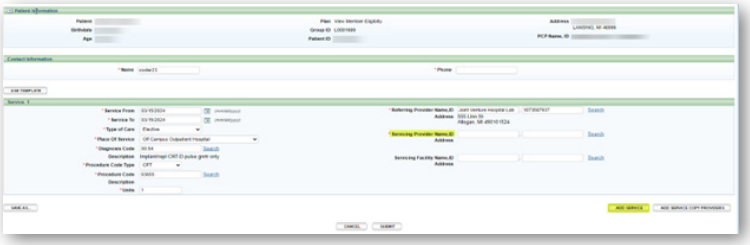
When submitting prior authorization requests for surgical procedures, please be sure to include both the surgeon and the surgical assistant on the request. For claims to pay the surgical assistant, the request must include both.

To add both surgeon and surgical assistant to the PA request, you will need to list all applicable codes and units twice. One set of codes for the primary surgeon and one set of codes for the surgical assistant.

Example of how to submit a request in EZ Auth/Referrals:
First, you will enter your primary surgeon's name in the "Servicing Provider Name" field. Once all required fields are input, you will need to click "Add Service."



You will then enter all the same information in the required fields, except for the Servicing Provider. Here you will enter the surgical assistant's name and NPI. Once completed, click "Submit."



Keeping PHP informed: Provider Information Update Form

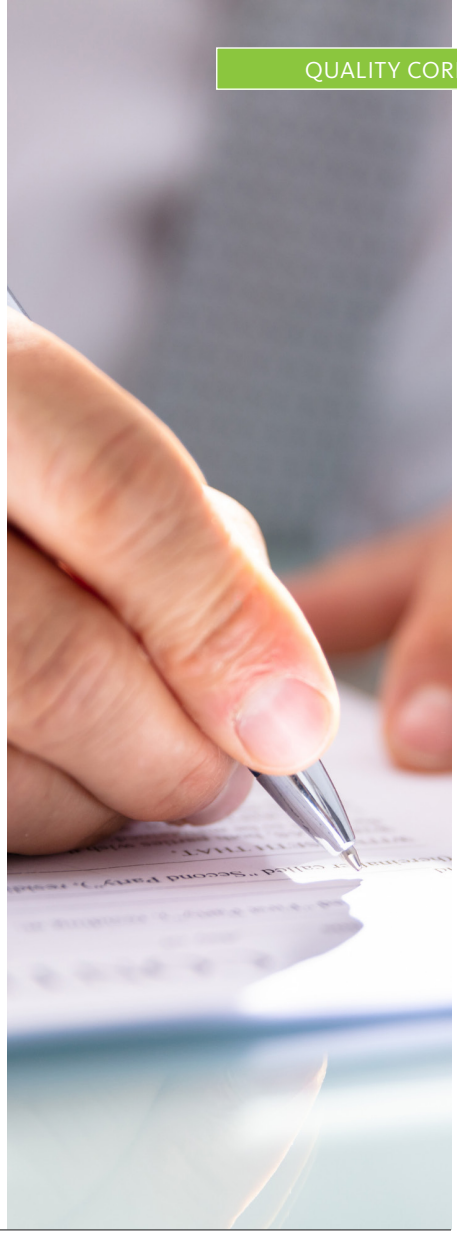
Please inform PHP of any updates by filling out the Provider Information Update Form found at PHPMichigan.com/Providers/General-Forms-and-Information. Some of these changes could include, but are not limited to:

- No Longer Accepting New Patients
- Providers Leaving the Practice/Location
- Provider Name Change
- Location Closing
- Changing Office Hours
- Update Facility/Group Services

Once the form is filled out it can be returned to us in one of the following ways:

- **Mail:**
  Physicians Health Plan (PHP)
  Attn: Network Services
  PO Box. 30377
  Lansing, MI 48909
- **Fax:**
  517.364.8412
- **Email:**
  PHPProviderUpdates@phpmm.org

Failure to notify PHP could cause delays in claim processing. Please refer to your participation agreement and the Provider Manual for specific notification requirements.



When to Submit a Claim Adjustment Request Form

You might consider submitting a Claim Adjustment Request Form if you've previously filed a claim with PHP and later discovered inaccuracies in the submitted claims data. Submitting this form allows you to correct such errors. Here are some key scenarios when you might need to use the Claim Adjustment Request Form:

- **Coordination of Benefits:** When PHP is not the primary carrier, you must include the primary carrier's EOP (Explanation of Payment).
- **Incorrect Provider or Member Information:** If you identify an error on your original claim submission for a provider or member. Make sure a new claim with the correct information is attached to the claim adjustment request form.
- **Corrected code(s):** Attach the corrected claim and provide a written description of the correction. Is it important that even if you are only correcting one line or code, you include all lines you wish to get paid for on the corrected claim, not just the incorrect line/code.
  (Example: If you have submitted CPT 99204, billing an appointment as a new patient exam, but it needs to be billed as an established patient exam, which is CPT 99214)

Provider Appeals– Prepay Claim Reviews

PHP completes claims audit/medical record reviews on both a pre-payment and post-payment basis. Pre-payment audits are completed prior to claim adjudication and payment. The findings may result in a denied service and may be appealed by following the PHP Provider Appeal process. Before submitting a letter of appeal regarding a prepayment service denial, review the claim denial detail to identify the reason the service was denied ensuring the appeal is addressing the reason for the denial.

Things to remember when submitting an appeal request:

- Fill out the Provider Appeal Form completely and accurately.
  - Do not use the PHP Claim Adjustment Form or Medical Record Submission Form to submit an appeal.
- Submit the appeal request within 180 calendar days of the adverse benefit decision letter or the date of the initial claim denial.
- Include a clear narrative of rationale for the appeal.
- Include all pertinent clinical information and/or coding source rationale relevant to the appeal. This documentation may include medical records such as office notes, surgical notes, radiology, or lab reports, coding source rationale, or any other pertinent information. All information must be accurate and supported in the records.
- Highlight or call out a section of the record used to determine code application as applicable.
- Include a contact person and direct phone number/email.

If a denial is due to no response to the request for records, the claim does not meet the requirements of a clean claim. In these instances, records must be submitted using the Medical Record Submission Form within the provider's appeal time limits.

Appeal requests submitted after the 180-day time limit will be denied, and a letter will be mailed with an explanation. The Provider Appeal Form is accessible on the PHP Website at **PHPMichigan.com/Providers/General-Forms-and-Information**.

Pharmacy Communication

To access information regarding our pharmaceutical authorization criteria and policies, visit **PHPMichigan.com/MedicalandDrugPolicies**.

To access information regarding preferred medications, changes to the prescription drug list (PDL), pharmaceutical management procedures, medication limits, authorization forms, generic substitution, therapeutic interchange, step therapy, specialty medications, preventive medications, drug recalls, and electronic prescribing information, visit **PHPMichigan.com/Providers/General-Forms-and-Information/Pharmacy_Services**.

Unlisted Codes

We are committed to ensuring that our network of healthcare providers is well-informed about the correct procedures for claim submissions, particularly concerning unlisted CPT/HCPCS codes. As part of our ongoing efforts to streamline the reimbursement process, please be reminded of our **Payment Reimbursement Policy, titled PRP-03 Unlisted CPT-HCPCS Codes.**

This policy is designed to guide you through the correct coding requirements, especially when services performed do not have a direct corresponding CPT/HCPCS code and are thus considered unlisted. It's crucial to remember that using unlisted codes requires comprehensive documentation to support the medical necessity and specifics of the service provided. This ensures that your claims are processed efficiently and accurately.

Prior Authorization

Prior authorization may be necessary for procedures reported with unlisted codes if they are considered unproven, experimental, investigational, or cosmetic. Similarly, prior authorization might be required for services/items reported under unspecified codes, such as accidental dental services. Submission of prior authorization requests must be done using the designated form and include a comprehensive description of the planned procedure or supply item. For surgical procedure requests, it's essential to provide details regarding devices, biomedical grafting, technique/approach, and any additional documentation supporting medical necessity.

Required Documentation

- A complete description of the procedure or item (e.g., operative report, lab report, order, etc.)
- Surgical services should indicate if the procedure was performed independently from other services and if it was performed at the same site or through the same surgical opening
- Documentation of techniques, surgical approach, and/or method of surgery
- Physician Order and Invoice for unlisted DME/Supply Codes
- Patient's diagnosis and associated risks
- Surgical findings
- A reasonably comparable code and rationale for the selection of an unlisted code

Before submitting a claim with an unlisted code, please consider the following:

- Is there a more suitable code available that accurately represents the documented service?
- Is the chosen unlisted code the most appropriate option for the category of service?
- Does the documentation meet the necessary requirements for reporting the unlisted code?
- Have authorization requirements been met, if applicable?
- Do the modifiers reported alongside the unlisted code(s) align with the documentation and are they acceptable with the unlisted code? (e.g., assistant surgeon, co-surgeon, bilateral, etc.)
- Is the required documentation included with the claim?

Claims submitted without supporting documentation will be subject to denial.

If you have any questions regarding claim submissions, contact **PHP Customer Service at 517.364.8500**.
This policy, along with further details and resources, can be found on our website.

PHPMichigan.com/Providers/Claims-and-Provider-Reimbursements/Payment-Reimbursement-Policies-prp.

Lunch and Learn

PHP Provider Relations will continue to offer Lunch and Learn sessions throughout 2024.

The PHP Provider Relations team offers quarterly Lunch and Learn sessions. During these sessions, you will learn helpful information about specific PHP programs and processes. We also welcome requests for topics that you would like to know more about. The topic for each session will be announced closer to the training date, and a flyer will be posted to provide additional information.

If you would like to submit suggestions for topics to be covered, please email **PHPProviderRelations@phpmm.org**.

Register today by visiting **PHPMichigan.com/Providers** and selecting "Training Opportunities."

Please join us on the remaining 2024 Training Dates:

Tuesday, July 16, 2024
Noon–1:00 p.m.

Thursday, October 24, 2024
Noon–1:00 p.m.

Physicians Health Plan General Training 101

PHP Provider Relations offers training sessions throughout the year to help you and your office staff work successfully with PHP.

The information presented includes an overview of PHP Commercial and PHP Medicare plan requirements, a review of PHP's online resources, and how to navigate the MyPHP Provider Portal including checking eligibility and benefits, claim status, prior authorization requests, and much more. All office administration and staff are encouraged to attend.

Register today by visiting **PHPMichigan.com/Providers** and selecting "Training Opportunities."

Questions? Contact PHP Provider Relations at **PHPProviderRelations@phpmm.org**

2024 Training Dates:

Tuesday, August 15, 2024
8:30 a.m. – 10:00 a.m.

Thursday, November 12, 2024
Noon–1:30 p.m.

Pharmacy Updates

Medication	Formulary Action	Justification	Effective Date
Elrexfio (elranatamab)	Medical Benefit, Requires PA	New to Market Medication	12/13/23
Talvey (talquetamab)	Medical Benefit, Requires PA	New to Market Medication	12/13/23
Sohonos (palovarotene)	Non-Preferred Specialty Tier, PA	New to Market Medication	12/13/23
Jesduvroq (daprodustat)	Non-Preferred Specialty Tier, PA	New to Market Medication	12/13/23
Aphexda (motixafortide)	Medical Benefit, Requires PA	New to Market Medication	12/13/23
Pombiliti (cipaglucosidase)	Medical Benefit, Requires PA	New to Market Medication	12/13/23
Opfolda (miglustat)	Preferred Specialty Tier, PA	New to Market Medication	12/13/23
Xphozah (tenapanor)	Tier 3, Step Edit, Quantity Limit	New to Market Medication	2/28/24
Fruzaqla (fuquintinib)	Non-Preferred Specialty Tier, PA	New to Market Medication	2/28/24
Truqap (capivasertib)	Non-Preferred Specialty Tier, PA	New to Market Medication	2/28/24
Loqtorzi (toripalimab-tpzi)	Preferred Specialty Tier, PA	New to Market Medication	2/28/24
Ogsiveo (nirogacestat)	Preferred Specialty Tier, PA	New to Market Medication	2/28/24
Augtyro (repotrectinib)	Non-Preferred Specialty Tier, PA	New to Market Medication	2/28/24
Fabhalta (iptacopan)	Non-Preferred Specialty Tier, PA	New to Market Medication	2/28/24

Medication	Formulary Action	Justification	Effective Date
Hyrimoz (adalimumab-adaz)	Adding to Preferred Specialty Tier, PA	Adding Humira Biosimilars to Formulary	1/1/24
Hadlima (adalimumab-bwwd)	Adding to Preferred Specialty Tier, PA	Adding Humira Biosimilars to Formulary	1/1/24
Adalimumab-adaz	Adding to Preferred Specialty Tier, PA	Adding Humira Biosimilars to Formulary	1/1/24

For up-to-date information on drug recalls, please visit **PHPMichigan.com/Providers** and select "Pharmacy Services" from the menu on the left side of the screen.

Pharmacy Updates (continued)

Important Things to Remember When Submitting a Prior Authorization Request Form

- The Medication Authorization Form can be found at **PHPMichigan.com/Providers**. Select "Pharmacy Services" from the left side menu.
- Fill out the form completely and legibly.
- If requesting an infusion drug, please include the name of the office and/or facility and NPI number of where the drug will be administered.
- Provide accurate provider contact information:
  - Contact person's name
  - Phone number
  - Fax number
- Include the patient's most current chart notes documenting their status and clinical documentation of previous medication trials related to the request.
- Submissions from Cover My Meds are routinely transmitted with incomplete information which delays care for the patient. Sending requests directly to PHP will reduce the time it will take to process the request.
  If you have issues sending authorization requests for PHP members through Cover My Meds, please reach out directly to **PHP Customer Service** at **800.562.6197** or **517.364.8400**.

Prior Authorization Turnaround Times

As a reminder, turnaround times for prior authorization will change beginning June 1, 2024.

- **Non-Urgent Pre-Services 7 days** – A request for coverage of medical services that the organization must approve in advance, in whole or in part.
- **Urgent Concurrent 3 days** – A request for coverage of medical care or services made while a member is receiving the requested medical care or services, even if PHP did not approve the earlier care.
- **Retrospective 30 days** – A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.
- **Urgent 24 hours** – A request for coverage of medical care or services where application of the time frame for making routine or non-life-threatening care determinations: could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.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Physicians Health Plan

MAILING ADDRESS INFO
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Contact Us.

PHPMichigan.com

Department	Contact information
Customer Service » Verify a covered person's eligibility, benefits, or to check claim status to report suspected member fraud and abuse » Obtain claims mailing address » Claims and EDI questions » Request a copy of our Preferred Drug List	517.364.8500 800.832.9186 (toll-free) 517.364.8411 (fax)
Medical Resource Management » Notification of procedures and services outlined in the Notification/Authorization Table » Request benefit determinations and clinical information » Obtain clinical decision-making criteria » Behavioral Health/Substance Abuse Services, for information on Behavioral Health and/or Substance Abuse Services including Prior Authorizations, Case Management, Discharge Planning and referral assistance	517.364.8560 866.203.0618 (toll-free) 517.364.8409 (fax)
Network Services » Credentialing » Provider data: Report changes in practice demographic information » Provider/Practitioner education » Report suspected Provider/Practitioner Fraud and Abuse » Initiate electronic claims submission	517.364.8312 800.562.6197 (toll-free) 517.364.8412 (fax) Report suspected fraud and abuse: 866.PHPCOMP (866.747.2667) Credentialing: PHP.Credentialing@phpmm.org Data: PHPProviderUpdates@phpmm.org Provider Relations team: PHPProviderRelations@phpmm.org
Quality Management Quality Improvement Programs, HEDIS, NCQA, CAHPS	517.364.8408 (fax) PHPQualityDepartment@phpmm.org
Pharmacy Services » Request drug coverage » Fax medication prior authorization forms » Medication Therapy Management Program	517.364.8545 877.205.2300 (toll-free) 517.364.8413 (fax) Pharmacy@phpmm.org

Commercial plans

Where to send claims:

In-network
Physicians Health Plan
PO Box 313
Glen Burnie, MD 21060-0313

Non-network
Physicians Health Plan
PO Box 247
Alpharetta, GA 30009-0247

Electronic
In-network: Payor ID 37330
Non-network: Payor ID 07689

Where to send refunds:
Physicians Health Plan, Attn: Provider Refund
PO Box 3377, Lansing, MI 48909-7877

Medicare plans

Where to send claims and refunds:
Physicians Health Plan
PO Box 7119
Troy, MI 48007