Provider Connection

FIRST QUARTER 2022

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Physicians Health Plan

Lunch and Learn Series

We are excited to be offering Lunch and Learns in 2022!

These quarterly, one-hour events are targeted at a variety of PHP providers and their staff. Our goal is to cover some of our frequently asked questions and new updates that affect the provider network. We will also leave time for a question-and-answer session at the end of each session. Invitations will be sent by email. Reservations are required so that we may send you a link to participate in the event. You may also email the PHP Provider Relations Team at **PHPProviderRelations@phpmm.org** for more information.

Dates for Lunch and Learns 2022:

- Tuesday, Apr. 12, 2022 12 to 1 p.m.
- Tuesday, July 19, 2022 12 to 1 p.m.
- Thursday, Oct. 20, 2022 12 to 1 p.m.

We look forward to working with you and welcome your suggestions of topics you'd like to see covered. Please email any suggestions to **PHPProviderRelations@phpmm.org**.

To register go to **PHPMichigan.com/Providers** and click on "Training Opportunities."

PHP Primary Care Incentive Program (PIP)

Primary Care Physicians (PCP) of Physicians Health Network (PHN) may be eligible for an incentive payment in accordance with Physicians Health Plan (PHP) PCP Incentive Program. Eligibility for the incentive payment is based on quality and health management factors and not referral services. This PCP Incentive Program applies to PHP HMO members in the commercial HMO plans only.

The PHP Primary Care Incentive measures for 2022 will remain the same as they were in 2021. The program will continue to be divided into Pediatric and Adults Measures. PCPs can review the full 2022 Program Description on the MyPHP Provider Portal, located at **PHPMichigan.com/MyPHP**.

If you have questions regarding the PCP Incentive Program or would like additional training to maximize your incentive reimbursement, please contact the Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Physicians Health Plan General Training Dates for 2022

The Provider Relations Team will be offering training sessions again in 2022 to help assist you and your office staff work more efficiently with PHP.

Training opportunities will include both PHP Commercial and PHP Medicare requirements, a review of the Provider Manual, how to check patient eligibility and benefits, status claims, submit authorizations and approvals, and much more. Provider office management and all office staff are welcome to attend.

2022 trainings will take place virtually at this time.

Register today! Go to **PHPMichigan.com/Providers** and select "Training Opportunities" to view 2022 training opportunities and to register.

If you have questions, please contact PHP Provider Relations at **PHPProviderRelations@phpmm.org**.

Happy National Doctors' Day!

Doctors' Day: Thank You

Every day, not just on National Doctors' Day, PHP values and respects the physicians who partner with us to deliver care to our members.

Amidst the fear and anxiety unearthed by one of the worst ongoing pandemics our nation has ever endured (and endure we will), the gratitude could not be more deserved.

Thank you for your bravery, perseverance, and professionalism during these trying times. Thank you for your unwavering commitment to patients and delivering care. Thank you for being the truly special humans and doctors that you are.

Thank you for making a difference every day, providing guidance in uncertain times, and saving lives everywhere.

Medical Record Review

PHP strives to improve the health of individuals, families, and communities. But, we can't do it without you. The Quality Department collects and evaluates member health information to identify opportunities to assist you in helping our members reach and maintain their optimum health. One of the data sources we utilize is the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® is a standardized set of performance measurement criteria used by the managed care industry to compare health plan performance across plans and against national benchmarks. The National Committee for Quality Assurance (NCQA) develops and coordinates the HEDIS process and scoring. Performance scores provide comparative data that is used to focus on quality improvement efforts.

The HEDIS audit process will begin soon.

What does this mean for you?

The majority of the record review will be conducted from Feb. through May 2022. Your office or facility will be contacted directly by a PHP HEDIS Nurse Reviewer. If we require less than five records, this contact and request will come in the form of a fax. If more than five records are needed, the Nurse will call to make arrangements with you for the review, which can be in person at your office or in another format of your choice. The Nurse will need to obtain a copy of the actual medical record information being audited, which may include vital signs, problem lists, diagnoses, medication lists, office visit notes, lab results, education, growth charts, etc. This can be accomplished by printing, copying, faxing, or downloading to an encrypted flash drive or disc. We will bring the paper for copying and an encrypted flash drive if you request one.

Frequently ask questions:

Q: Does the Health Information Portability and Accountability Act (HIPAA) permit me to release records to a PHP representative?

A: Yes. Under HIPAA requirements, HEDIS data collection is a quality assessment and improvement activity and is therefore included in the definition of healthcare operations and may be provided to PHP without member consent.

Q: Is my participation in HEDIS mandatory?

A: Yes. Contracted providers are required to participate in PHP's Quality Improvement activities. This includes participation in office reviews and chart access and audits.

Q: We submit claims; why does PHP need medical records?

A: Not all services rendered are captured through claims and encounter data. Therefore, in order to accurately capture the quality of care being provided to our members, NCQA allows us the opportunity to collect medical record data that was not billed or coded for the service rendered. While record review cannot be eliminated completely, it can be reduced through correct and complete billing and coding.

We look forward to working with you in this process. The Quality Department can be reached at **PHPQualityDepartment@phpmm.org**.

Vaccines: Member Benefits

Members that have a pharmacy benefit with PHP may receive vaccines at an In-Network participating Retail Pharmacy for $0.00 copay*

- INFLUENZA
- CORONAVIRUS (COVID-19)
- PREVNAR 13/PNEUMOVAX 23 (Pneumococcal)
- HEPATITIS A
- HEPATITIS B
- POLIO
- GARDASIL 9 (HPV- Human Papillomavirus Virus)
- ROTAVIRUS
- ZOSTER Shingrix (Shingles)
- VARICELLA (Chicken Pox)
- MMR (Measles, Mumps, Rubella)
- HiB (Haemophilus B)
- MENINGOCOCCAL (Meningitis)
- TD (Tetanus, diptheria)
- DTaP (Diptheria, Tetanus, Pertussis)
- Tdap (Tetanus, Diptheria, Pertussis)

Any member can utilize an In-network physician office, Fast Care or other medical provider that administers vaccines including Ingham County Health Department.

*Coverage is based on the member's benefit document.
**Age restrictions follow ACIP recommendations.

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Physicians Health Plan

PHPMichigan.com

1400 E. Michigan Ave
Lansing, MI 48912
517.364.8400

Procedural & Diagnostic Coding: Medical Necessity

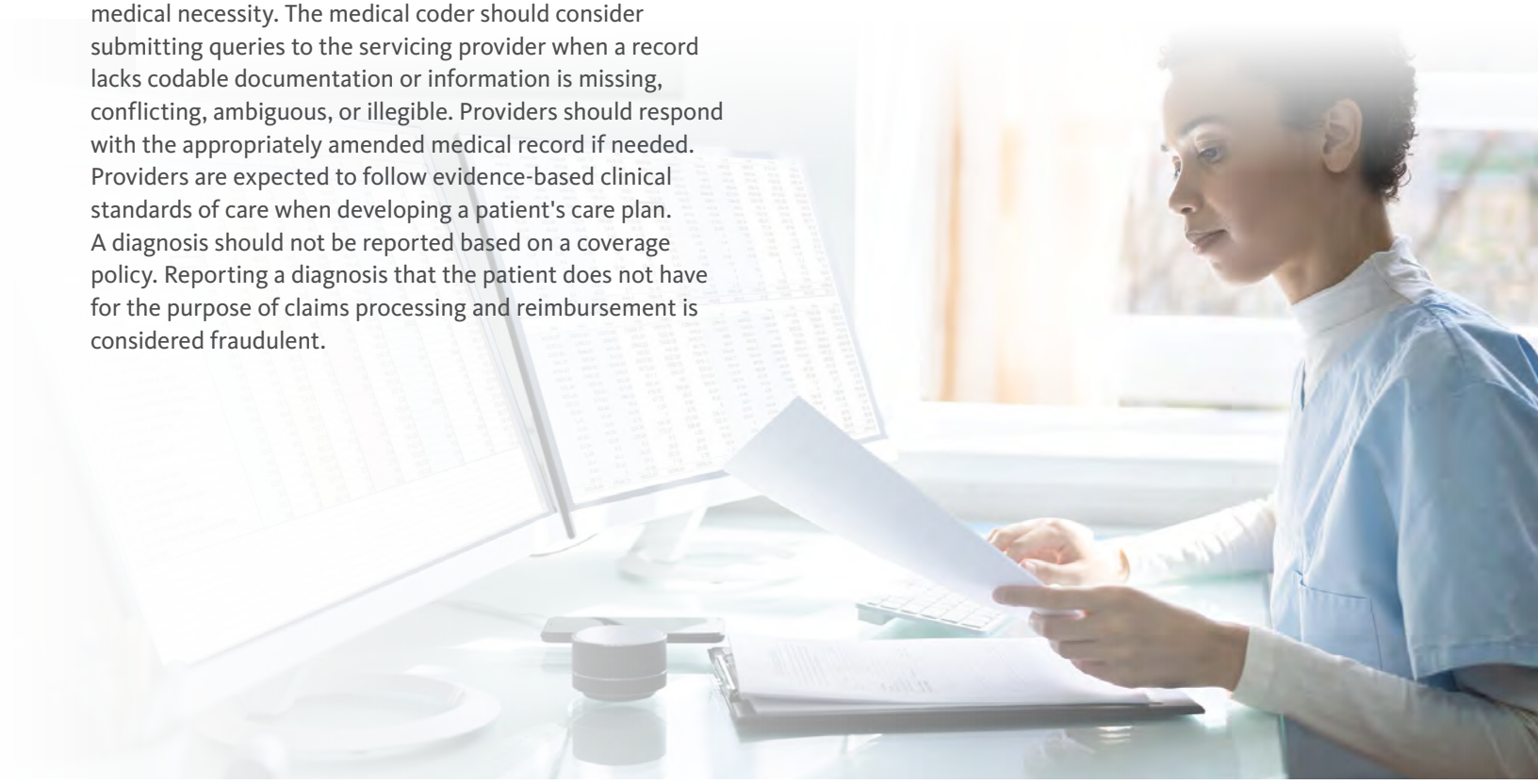
Correct coding begins with complete and accurate documentation. A service is considered medically necessary when reasonable and necessary to diagnose or treat a patient's medical condition. The Plan also considers coverage of health care services and supplies that are determined to be medically appropriate per Health Plan medical policy and nationally recognized guidelines, and are:

- Not experimental or investigational;
- Necessary to meet the basic health needs of the Covered Person;
- Delivered in the most cost-efficient manner and type of setting that is appropriate;
- Consistent in type, amount, frequency, level, setting, and duration of treatment with scientifically based guidelines that are accepted by the Health Plan;
- Consistent with the diagnosis of the condition;
- Not done for reasons of convenience; and
- Demonstrated through current peer-reviewed medical literature to be safe and effective.

Determination to provide a treatment or service is not a guarantee of coverage. Medical records are the source of truth in support of coding, and incomplete documentation can result in claim denials. An accurately reported diagnosis may be the determining factor in support of medical necessity. The medical coder should consider submitting queries to the servicing provider when a record lacks codable documentation or information is missing, conflicting, ambiguous, or illegible. Providers should respond with the appropriately amended medical record if needed. Providers are expected to follow evidence-based clinical standards of care when developing a patient's care plan. A diagnosis should not be reported based on a coverage policy. Reporting a diagnosis that the patient does not have for the purpose of claims processing and reimbursement is considered fraudulent.

Consider the following principles of record keeping and reporting when documenting services to support medical necessity and prevent claim denials

- Identify chief complaints and reason(s) for the encounter
- Avoid abbreviations and symbols
- Code to the highest level of specificity
- Document the outcomes of, but do not code, diagnoses that are considered "rule-out," “consider,” or “suspected” but not confirmed diagnoses.
- Record clear, detailed narratives of key medical record components such as services, symptoms, testing results, patient history, and operative reports
- Identify chronic conditions or secondary diagnoses related to the current treatment or impact the overall management of the patient's care plan
- Be accurate and comprehensive; your documentation should “tell” the patient’s clinical story of their conditions, treatments, and outcomes.
- Answer all queries for clarification promptly and fully. Be sure to document the clarification or additional information in the medical record.



CVS Health

Real-Time Prescription Benefits

Providers have the ability to view member-specific plan and drug cost information provided across multiple points of care

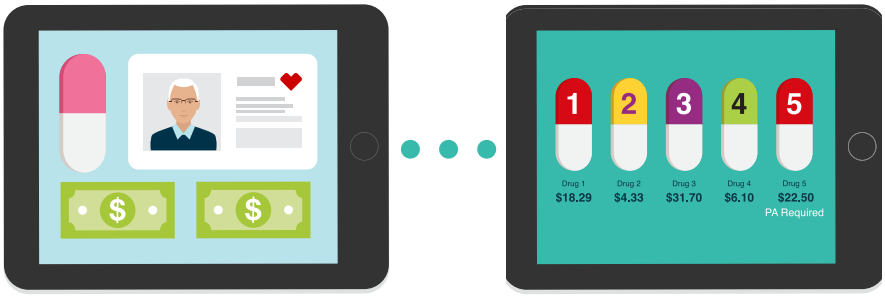
The cost of health care is a major source of worry for consumers across the nation, especially for those enrolled in high deductible health plans who may pay thousands of dollars out of pocket (OOP) each year.

Consumers must navigate their health and prescription benefit plans to make the most cost-effective choices. As a result, they are demanding greater cost transparency and easier access to the information they need to make these health care decisions.

CVS Health is committed to helping plan members find the most affordable options to keep them healthy.

We continue to help lower member OOP costs through formulary and plan design strategies. The majority of members — 85 percent — spent less than $300 on their medications last year.

We also offer real-time prescription benefits to provide greater visibility to member OOP costs and available lower-cost options to help members and their providers make more informed treatment decisions.



By utilizing member-specific benefit information, including formulary, plan design, deductible status, and other accumulators, our solution lets providers and members:

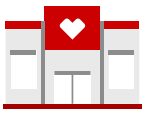
- **Know if a drug is covered** and the member's OOP cost
- **See up to five** clinically appropriate lower-cost brand and generic alternatives

Physicians Health Plan

continued >>

Information Provided Across All Member Touchpoints

At the doctor's office
Information is integrated into the e-prescribing workflow, so physicians can take action to help patients save right at the point of prescribing. Market projections estimate we will be connected with nearly 400,000 physicians by the end of 2020.



At the pharmacy
CVS pharmacists use our proprietary search tool, Rx Savings Finder, to quickly identify available opportunities for members to save money on their medications.

Directly to members
Our online tool lets members check what their OOP costs are and find possible lower-cost alternatives to talk about with their doctor.

Calling in to Customer Care
Customer Care representatives have access to the same real-time benefit and cost information, and can tell members exactly what they will pay OOP based on their plan design, formulary, and where they are in their deductible.

CVS Health

Source: CVS Health Enterprise Analytics, 2019. Market projections provided by Surescripts P1002380719.
CVS Health uses and shares data as allowed by applicable law, and by our agreements and our information firewall.

Physicians Health Plan

Preventive Pharmacy Benefits

Physicians Health Plan (PHP) provides in-network pharmacy benefits with no cost sharing ($0 copay) for prescription and over-the-counter (OTC) medications for use in preventive screening procedures and prevention of certain diseases. For this coverage to apply, a prescription for the medication or product must be attained from a provider and filled at an in-network pharmacy. These services meet and, in some cases, exceed the Affordable Care Act (ACA) requirements and recommendations.

Adult Preventive Health Screenings and Treatments

Cardiovascular Health

» Aspirin, 81 mg (OTC, generic) for adults ages 50–59 years

» Statins, for adults ages 40–70 years:

Atorvastatin 10 mg, 20 mg	Fluvastatin ER 80 mg	Pravastatin 10 mg, 20 mg, 40 mg, 80 mg	Simvastatin 5 mg
Fluvastatin 20 mg, 40mg	Lovastatin 10 mg, 20 mg, 40 mg	Rosuvastatin 5 mg, 10 mg, 20 mg, 40 mg	

Colorectal Cancer Prevention

» OTC bowel prep products (prescription, generic), for adults ages 45–75 years:

Bisacodyl 5 mg oral tablet	Polyethylene glycol (PEG) 3350 oral powder	Generics to GaviLyte-N or Nulytely (PEG 3350, KCI, sodium bicarbonate, NaCl)
Generics to Golytely (PEG 3350, KCI, sodium bicarbonate, NaCl, sodium sulfate)	Magnesium citrate Polyethlene glycol (PEG) 3350 oral packet	Generics to GaviLyte-C (PEG 3350, KCI, sodium bicarbonate, NaCl, Sodium sulfate)

HIV Prevention

» Emtricitabine/tenofovir disoproxil fumarate (generic for Truvada), one tablet daily, for pre-exposure prophylaxis for HIV-negative persons who are at high risk of HIV acquisition by sex or injectable drug usage

Tobacco Cessation

» Chantix®, bupropion, and generic nicotine replacement products (e.g. patches, gum) are covered for up to a 180-day supply in 365 days for adults ages 18 years and older who use tobacco; *additional quantities require prior authorization*

Women's Health: Pregnancy and Family Planning

Primary Prevention of Invasive Breast Cancer Care

» Criteria must be met for tamoxifen or raloxifene to be covered without cost share

Pre-eclampsia

» Aspirin, 81 mg (OTC, generic), after 12 weeks of gestation for women ages 12–59 years at high risk for pre-eclampsia

Women's Health: Pregnancy and Family Planning – Continued

Vitamins/Supplements

» Folic Acid, 0.4–0.8 mg supplement, for all women planning or capable of pregnancy

Contraceptives, Prescriptions, OTC Medications, and Devices

» For this coverage to apply, a prescription for the medication or product, including OTC items, must be attained from a provider and filled at an in-network pharmacy

» For all women planning or capable of pregnancy

Prescription Oral Contraceptives	Prescription Devices	Over-the-Counter
Apri	Mirena (IUD)	Today Sponge (vaginal sponge)
Camila	Liletta (IUD)	VCF Vaginal Foam 12.5%
Enpresse-28	Paragard (Copper IUD)	VCF Vaginal Gel 4%
Introvale	Skyla (IUD)	FC – Female Condom
Junel FE 1.5/30	Kyleena (IUD)	FC2 – Female Condom
Junel FE 1/20	Nexplanon (implant)	Cervical Cups
Junel FE 24		Conceptrol Vaginal Gel 4%
Kariva		Diaphrams
Low-Ogestrel		Ella (emergency oral contraceptive)
Lo Loestrin FE		Levonorgestrel 1.5 mg (emergency oral contraceptive)
Natazia		
Sprintec 28		
Tri-Sprintec		
Velivet		
EluRyng (vaginal ring)		
Medroxyprogesterone (injectable)		
Xulane (patch)		

Vaccines — Adult and Children

Advisory Committee on Immunization Practices (ACIP) recommendations are followed for coverage ages

Coronavirus (COVID–19)	Human Papillomavirus (HPV)*	Pertussis (Whooping Cough)	Rubella (German Measles)
Diptheria	Influenza	Pneumococcal	Tetanus
Hepatitis A	Measles	Polio	Varicella (Chicken Pox)
Hepatits B	Meningococcal	Rotavirus	Zoster (Shingles)**
Hib	Mumps		

**Covered for ages 9-45 years* ***Covered for adults ages 50 years and older*

Children's Oral Health

Generic prescription providing up to 0.5 mg per day of fluoride for children with low fluoride exposure ages birth–5 years

The ACA requires that non-grandfathered* health plans cover preventive care services with no cost sharing.

*Non-Grandfathered – a plan effective after the Affordable Care Act (ACA) was signed on March 23, 2010, or a plan that existed before the ACA, but lost its grandfathered status at renewal.

Questions? Call PHP Customer Service at **517.364.8500**

Physicians Health Plan

Preventive Care Services Reminder

Keeping up with preventive health care services helps PHP members stay healthy and save money. PHP covers preventive care services rendered by network practitioners for most members with a $0 member cost share, even before the member's deductible has been met. Preventive health services include screenings, tests, and services performed for symptom-free or disease-free individuals. They may also include immunizations and screening services for symptom-free or disease-free individuals and those who are at increased risk for a particular disease.

Under the Affordable Care Act (ACA), certain services recommended by the U.S. Preventive Services Task Force (USPSTF) must be covered under non-grandfathered plans. The preventive services requiring no-cost coverage for plan members may be updated periodically. For example, early in 2021, the USPSTF changed the starting age for its general colorectal cancer screening recommendation, lowering it from age 50 to 45. The current U.S. Preventive Services Task Force A and B Recommendations are available at **USPreventiveServicesTaskForce.org/uspstf/Recommendation-Topics/USPSTF-And-B-Recommendations**

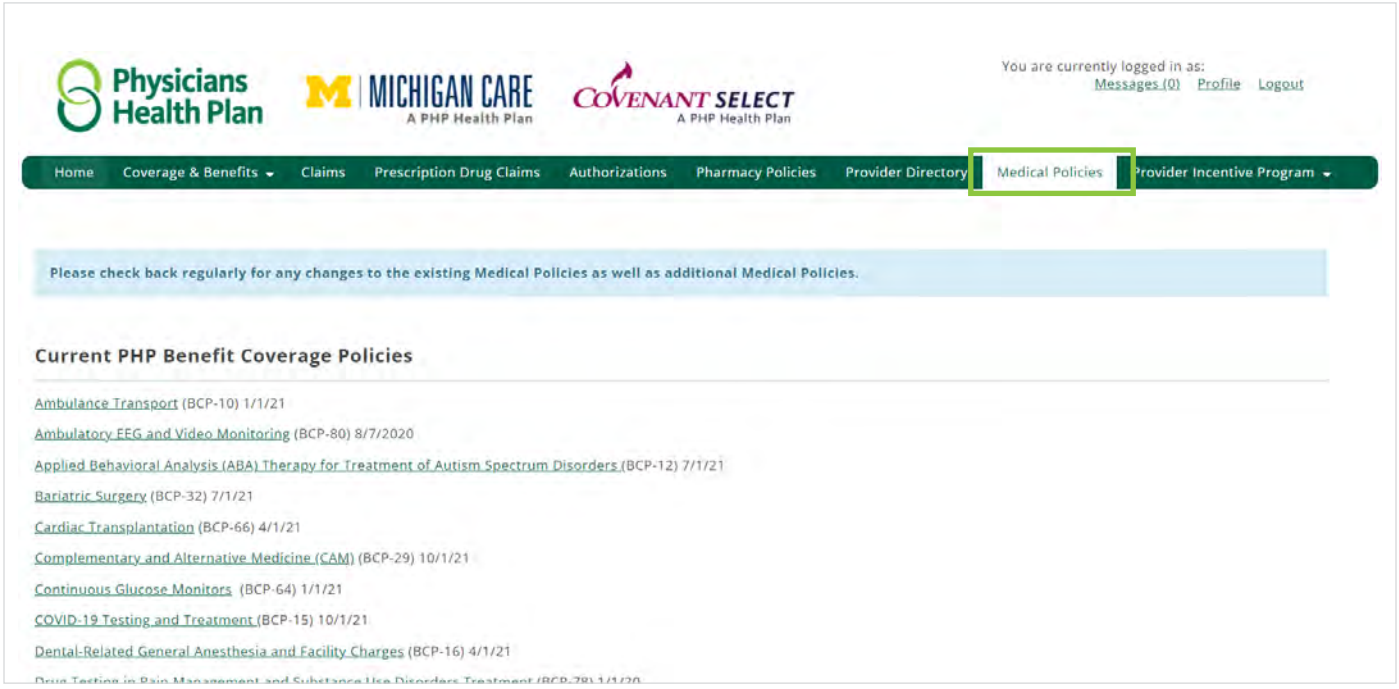
Certain preventive health services require prior approval for coverage. Coverage for preventive health services other than those mandated by the ACA is dependent on benefit plan language. Network practitioners can verify member eligibility, coverage, and benefits in the MyPHP Provider Portal or by calling PHP Customer Service at **517.364.8500**.

Preventive health claims require modifier 33 to be considered payable as a preventive service. However, the presence of modifier 33 does not automatically make the service preventive. Preventive health services depend upon claim submission using preventive diagnosis (when applicable) and procedure codes to be identified and covered as preventive health services.

Age, gender, or frequency limits are utilized for certain designated services (i.e., wellness exams, vision, and hearing screening, administration of Human Papillomavirus [HPV] vaccines, nutritional and genetic counseling). Preventive health services submitted with diagnosis codes representing the treatment of illness or injury are paid as applicable under the member's normal medical benefits rather than preventive care coverage.

For more detailed information on PHP's benefits and coverage for preventive health services, including a list of covered codes, please refer to the current Benefit Coverage Policy Preventive Health Services (BCP-45). This and all current PHP Policies can be found by logging in to your MyPHP Provider Portal account and navigating to "Medical Policies" in the toolbar.

If you need assistance registering for the portal, please reach out to PHP Provider Relations Team at **PHPProviderRelations@phpmm.org.**



Claim Rejected or Denied as Same-Day Duplicates

Have you had claims rejected as a Same-Day Duplicate? Please carefully review your claims submission history and/or Explanation of Payment (EOP) remarks to ensure claims and/or requested documentation were submitted according to PHP's requirements.

Below are some examples of why your claim may have been rejected:

- **Is there is a duplicate service date or CPT/HCPC code billed in the patient's billing history?**
  PHP's claims editing will identify the entire claim or individual claim line as a potential duplicate of a previously submitted claim or service.
- **Was an Adjusted or Corrected claim submitted electronically?**
  PHP requires all adjusted and corrected claims to be submitted in paper with the Claim Adjustment Request Form. The Claim Adjustment Request Form is available online at **PHPMichigan.com/Providers/General-Forms-and-Information**.
- **Were requested medical records submitted to the correct requestor?**
  Please review your EOP Remarks and the Medical Records Submission Form to ensure that requested records were submitted to the correct location (PHP or Change Healthcare). EOPs are available in the MyPHP Provider Portal, and the Medical Records Submission Form is available online at **PHPMichigan.com/Providers/General-Forms-and-Information**.

If you need additional assistance with front-end claims rejections, please reach out to your claims clearinghouse. For assistance with claims denials from PHP, please contact PHP Customer Service. To register for the MyPHP Provider Portal and obtain EOPs, or questions related to your EOP remark codes, please reach out to the PHP Provider Relations team at **PHPProviderRelations@phpmm.org**.

Telehealth: 2022 Changes

PHP aligns its coverage of telehealth services with the current list of Medicare-covered telehealth services.

Effective Jan. 1, 2022, the place of service (POS) code 02 has been revised. POS 02 will now be used for telehealth provided other than in the patient's home. The location where services are provided or received through telecommunication technology. The patient is not located in their home when receiving health services or health-related services through telecommunication technology.

A new POS has been created to clarify the location of the patient when providing telehealth services. POS 10 must be reported when providing telehealth services to patients in their own homes. This does not apply to patients located in a hospital or other facility where the patient receives care in a private residence such as a nursing home or assisted living facility. POS 02 would still be reportable for those scenarios.

Interactive Complexity

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure.

Interactive complexity is reported with CPT® add-on code 90785. This add-on code is intended for the increased intensity, not increased time, and must be reported with an appropriate primary service code. According to the American Academy of Child & Adolescent Psychiatry, "interactive complexity refers to 4 specific communication factors during a visit that complicates the delivery of the primary psychiatric procedure." These factors are typically present among patients who have other individuals legally responsible for their care, those who request others to be involved in their care during the visit, or those who require the involvement of other third parties.

Interactive complexity may be reported with psychiatric procedures when at least one of the following communication difficulties is present:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate the delivery of care.
2. Caregiver emotions/behavior that interferes with the implementation of the treatment plan.
3. Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with the patient and other visit participants.
4. Use of play equipment, physical devices, interpreter, or translator to overcome significant language barriers.

If a third party is present during the encounter, documentation must indicate who the third party is. Documentation must also indicate the communication difficulty with detail adaptations utilized in the session, the rationale for employing these interactive techniques, and treatment recommendations. Interactive complexity code is not reportable in conjunction with Psychotherapy for crisis codes, or in conjunction with E/M services when no psychotherapy service is also reported.

90785 is not reportable for

- The sole purpose of translation or interpretation services
- Multiple participants in the visit with straightforward communication
- Individual patient visit with no sentinel event or language barriers
- Visits where the treatment plan was explained and understood without significant communication difficulties
- "Difficult" patients
- Therapies already inclusive of reported services

Physicians Health Plan

PHP MEDICARE

COVID-19 Benefits Update
COVID Vaccine Member Cost Share Waived Until Further Notice
$0 Member Cost Share for Coronavirus-Related Benefits Sunset Dec. 31, 2021.

Through the nearly two-year-long COVID-19 pandemic, **Physicians Health Plan (PHP)** has taken action to support our members, providers, and communities. We continue to monitor COVID-19 and respond with operational and clinical processes to ensure access to needed medical care, pharmacy, and other resources for our members. As our communities continue to live with COVID-19, PHP is taking the following steps with our members' health, safety, and peace of mind at the top of ours.

PHP Commercial Members*

COVID-19 Vaccine

Member Cost Share Waived Until Further Notice

- PHP will reimburse providers for the administrative fee for providing the immunization.
- Includes in- and out-of-out-network providers.

On Dec. 31, 2021, $0 member cost share expires for COVID-19 testing, treatment, telemedicine, as well as for COVID-related pharmacy services.

COVID-19 Testing

- After Dec. 31, 2021, member cost share at plan defined level will apply. COVID-19 testing must be considered medically necessary, which is determined by and appropriately coded by the ordering medical provider.
- The cost of COVID-19 testing is not covered as a condition of employment or returning to work, as outlined in the member's Certificate of Coverage.
- COVID-19 testing performed by an out-of-network provider is covered as outlined by the member's healthcare coverage and member cost share will apply. **Note:** Not all plans cover out-of-network benefits, and members are encouraged to understand their plan benefits.

Treatment

- After Dec. 31, 2021, member cost share (copays, coinsurance, and deductibles) at their plan-defined level will apply. For COVID-19 treatment to be covered, members must be receiving approved evidence-based care for treatment to be covered.
- COVID-19 treatment performed by out-of-network providers is covered as outlined by the member's healthcare coverage, and member cost share will apply. Note: Not all plans cover out-of-network benefits. Members are encouraged to understand their plan benefits before obtaining care at an out-of-network provider.

Telemedicine Visits

- Telemedicine coverage will end after Dec. 31, 2021, for
  - Applied Behavioral Analysis Therapy for the Treatment of Autism Spectrum Disorder
  - Physical Therapy, Occupational Therapy, Speech Therapy
  - Prenatal Care
- Approved telemedicine services are covered when rendered by an in-network PHP provider, including telemedicine visits rendered telephonically. Member cost share will apply. For a list of eligible telemedicine codes, please review PHP's Telemedicine Services Policy on the MyPHP Provider Portal under Medical Policies. Prior authorization rules and guidelines will still apply, if applicable.

Amwell Telemedicine

- PHP member cost share will apply (copays, coinsurance, and deductibles) for the Amwell telemedicine Medical, Behavioral Health Therapy Visits and Psychiatry.

Early Prescription Refill Limits and Existing Prescription Prior Authorizations

- The PHP waiver for early prescription refill lockouts and pharmacy prior authorization extension will end Dec. 31, 2021.
- For specific questions about prescription prior authorization, the member may contact PHP Customer Service using the number on the back of their ID card.

*(*Note: Applicable for all fully insured PHP members. Please*

be sure to check eligibility for all PHP members to ensure the appropriate member cost share is applied.)

PHP Medicare Members*

Sequestration

- Suspension of sequestration will expire Dec. 31, 2021.

Public Health Emergency (PHE) Flexibilities

The Department of Health and Human Services Public Health Emergency (PHE) has an expiration date of Jan. 16, 2022. With the PHE in place, PHP Medicare will continue to extend COVID-related benefits to our Medicare members during this time, which includes:

Pharmacy

- Waive refill-too-soon-edits for prescription drugs.
- Allow pharmacists to authorize emergency refills when prescribers are not available for provider renewal prescriptions.
- Allow initiation of prescription drug coverage reviews submitted by representatives without the necessary documentation as authorized representatives.
- Provide access to 90-day supplies of most drugs; however, safety and opioid edits still apply.
- Relaxed home and mail delivery policies for retail pharmacies. Large pharmacy retailers such as Rite-Aid, CVS, and Walgreens provide home delivery services to our members.
- Waived signature requirements for prescription drug deliveries.

Telemedicine

- Telehealth visits for specialist allowed during the PHE. Member cost share is the same as in-person visit.

Telemedicine - effective Jan. 1, 2022

- $5 member cost share for PCP telemedicine visits.
- $30 member cost share for mental health visits.

$0 Member Cost Share COVID-19 Testing and Treatment

Transitional Care Management

In the 2021 Q4 Newsletter, the code for face-to-face visits completed within 7 days of discharge was incorrectly stated as 99495. The correct code is 99496.

Transitional Care Management (TCM) services represent the coordination of care between the discharge from a qualifying facility care setting and the community setting. TCM oversees the management and coordination of services needed for all medical conditions, psychosocial needs, and activities of daily living support for the full 30-day post-discharge period as the patient transitions back into the community setting with the goal of preventing facility readmission. A qualifying facility care setting may be an inpatient acute care hospital, inpatient psychiatric hospital, long-term care hospital, skilled nursing facility, inpatient rehabilitation facility, hospital outpatient observation, or partial hospitalization, including partial hospitalization at a community mental health center. The patient must be discharged to one of the following community settings: the patient's home, a domiciliary center, a rest home, a nursing home, or an assisted living facility. Skilled nursing facilities are not eligible as discharge locations.

Who Can Provide TCM?

- Physicians including MDs, DOs, and Mid-Level Practitioners including Nurse Practitioners, Physician Assistants, Certified Nurse Specialists, and Certified Nurse-Midwives

CPT® Codes

- 99495 TCM with moderate medical decision complexity with a face-to-face visit within 14 calendar days of discharge
- 99496 TCM with high medical decision complexity with a face-to-face visit within 7 calendar days of discharge

Required Elements for reporting

1. Interactive Contact: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge (not same day) that must include:
    - Obtaining and reviewing all discharge information given to the patient
    - Reviewing the need for any follow-up diagnostic tests or treatment
    - Interaction with other healthcare professionals involved in the patient's aftercare
    - Education provided to the patient, family members, or caregivers
    - Establishment of referrals/arrangement of community resources related to regaining activities of daily living
    - Assistance with scheduling the follow-up visit to the physician
2. **Face to Face Visit**
    - 99496 Face to face visit must be completed within 7 days of discharge
    - 99495 Face to face visit must be completed within 14 days of discharge
    - The date of the face-to-face visit is the reportable date of service for TCM billing
3. **Medical Decision Making**
    - 99495 Moderate complexity
    - 99496 High complexity

TCM is not billable if these elements are not met or the patient passes away within 30-days post-discharge . In these instances, an appropriate E/M service code may be billed for any face-to-face visits provided.

Frequency

TCM is reportable once by only one provider during the 30-days post-discharge and used only when this provider assumes responsibility for a patient's post-discharge care. Additional practitioners may report other services, including E/M services during the 30-days according to CPT® guidelines and PHP policies.

Documentation

PHP has implemented TCM Code Editing to ensure proper reporting of TCM services. When submitting appeals, medical records must clearly identify and support the date of discharge, the date that interactive contact was made with the patient and/or their caregiver, the date of the face-to-face visit, and the documented complexity of medical decision making.

Advance Directive Standard

Advance directives allow patients to make their own decisions regarding the care they would prefer to receive if they develop a terminal illness or a life-threatening injury.

Physicians Health Plan (PHP) requires documentation that advance directives have been discussed with adult patients. Documentation should include either that the member has declined an offer to receive additional information or if an advance directive has been executed, a copy must be maintained in the patient's medical record.

How to Accomplish Compliance with this Standard: A question concerning advance directives could be included on the Patient registration form or health history form. Having a question that asks if the patient has an Advance Directive with a box to check yes or no, along with a statement that they may obtain more information regarding the subject from you, would meet PHP's standard.

Begin the Conversation: Talk to your patient about the end of life medical care. The Michigan Dignified Death Act (Michigan law) and the Patient Self-Determination Act (federal law) recognize the rights of patients to make choices concerning their medical care, including the right to accept, refuse or withdraw medical and surgical treatment, and to write advance directives for medical care in the event they are unable to express their wishes.

Advance Care Directives Can Reduce:

- Personal worry
- Futile, costly, specialized interventions
- Overall health care costs

For Questions call:
PHP Compliance Department: **800.562.6197**

Or visit:
MDHHS Patient Advocate Form DCH-3916:
Michigan.gov/MDHHS

Types of Advance Directives

1. A durable power of attorney for health care allows the patient to name a "patient advocate" to act for the patient and carry out their wishes.
2. A living will allows the patient to state their wishes in writing but not name a patient advocate.
3. A do-not-resuscitate (DNR) declaration allows a patient to express their wishes in writing that if their breathing and heartbeat cease, they do not want anyone to resuscitate them.

Laws
Michigan Dignified Death Act

Patients have the right to be informed by their physician about their treatment options.

- This includes the treatment you recommend and the reason for this recommendation.
- You must tell your patient about other forms of treatment. These must be treatments that are recognized for their illness. They must be within the standard practice of medicine.
- You must tell your patient about the advantages and disadvantages of any treatments, including any risks.
- You must tell your patient about the right to limit treatment to comfort care, including hospice.
- You should encourage your patient to ask any questions about their illness.

Patient
Federal Patient Self-Determination Act

- Patients have the right to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
- Doctors must maintain written policies and procedures with respect to advance directives and inform patients of the guidelines.
- You must document in the patient's medical record whether or not they have executed an advance directive.
- You must ensure compliance with the requirements of Michigan laws respecting advance directives.
- Provide education for staff and the community on issues concerning advance directives.
- The Act also requires providers not to condition the provision of care of individual based on whether or not the individual has executed an advance directive.

Member Complaint and Grievance Procedure & Process

Member Complaints

PHP is committed to the satisfaction of our members. As such, members can voice complaints without fear of punishment or retaliation and/or without fear of loss of coverage. If a member reaches out to your practice for help with their PHP coverage, please direct them to reach out to PHP for assistance.

PHP members, should contact PHP's Customer Service Department at **800.832.9186**, with questions or to discuss a concern. We will answer their question and solve any problem right away.

If necessary, members may also file a formal grievance or complaint related to one of the following areas as defined by PHP:

- **Administrative Complaint** - issue related to health plan policy and procedure, or service received from health plan staff.
- **Quality of Care Compliant** - issue relating to alleged misdiagnosis, inappropriate management including delay or refusal in providing or arranging for care, continuity of care issues, alleged incompetence and unfavorable/unexpected outcomes of care.
- **Quality of Service Complaint** - issue related to non-medical matters in which the provider has not met the expectations of the member, including, but not limited to, access/availability, facility environment, provider attitude, or administrative non-compliance.
- **Sentinel Event** - a type of Possible Adverse Clinical Event (PACE) that is an unexpected occurrence involving death or serious physical or psychological injury or risk thereof. Serious injury includes loss of limb or function not related to the natural course of the illness or underlying condition or permanent loss of sensory, motor, physiologic or intellectual impairment not present on admission to a hospital, facility, or practitioner's office visit.

Grievances

A grievance must be in writing. Members can either write a letter or fill out a grievance form, located within the Member Reference Desk. Customer Service can send the member a grievance form, if needed.

The member will be notified within five days of receipt of their grievance. The case and grievance will be thoroughly reviewed. If it is related to a PHP decision, and we change our decision, PHP will let the member know in writing. If we do not change our decision, the member will have the opportunity to ask for a grievance hearing. If a hearing is needed, we will notify the member at least one week before the hearing date.

A special committee will be appointed to hear the member's grievance. If the member would like someone to attend the hearing on their behalf, they must let us know in writing prior to their hearing date so we can complete the needed paperwork to allow that person to represent them.

The member and their authorized representative have the right to present additional information at the hearing. The member or their representative may attend in person or by telephone or may choose to not attend.

If the member cannot attend on the date scheduled, they may reschedule by sending their request in writing. We must receive their written request before the originally scheduled hearing date. If we do not receive this written request, we will make a final decision using all information available at that time.

The PHP grievance process will be completed within a total of 30 days. We will mail the member a letter with a final decision. In addition, PHP may mail a letter to the network provider when applicable.

If the member's situation meets the definition of urgent under the law, the review will be conducted within 72 hours. An Appeal/Grievance where the timeframe for the normal Appeal/Grievance procedure would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function. Expedited/ Urgent Care Appeals/Grievances may also be substantiated by a practitioner with knowledge of the member's medical condition.

If the member believes their situation is urgent, they may request an expedited appeal by faxing or emailing us their request. Please note that any appeal that is processed as urgent does not qualify for a hearing if it is denied. Members may also request an external review at the same time through the Department of Insurance and Financial Services. The address and telephone number are below:

By mail:
DIFS - Office of General Counsel - Appeals Section
PO Box 30220
Lansing, MI 48909-7720

By courier or delivery:
DIFS - Office of General Counsel - Appeals Section
530 W Allegan St, 7th Floor
Lansing, MI 48933

Telephone: 877.999.6442
Fax: 517.284.8838
Michigan.gov/DIFS

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

If you have any questions about this notice, please contact our Customer Service Department at **800.832.9156**.

Physicians Health Plan (PHP) provides health benefits to you as described in your Certificate of Coverage. PHP receives and maintains your medical information in the course of providing these benefits to you. When doing so, PHP is required by law to maintain your health information's privacy and provide you with this notice of our legal duties and privacy practices concerning your health information. PHP (we) will follow the terms of this notice.

The effective date of this notice is Sept. 23, 2013. We must follow the terms of this notice until it is replaced. We reserve the right to change the terms of this notice at any time. If we make substantive changes to this notice, we will revise it and send a new notice to all subscribers covered by us at that time. We reserve the right to make the new changes apply to all your medical information maintained by us before and after the effective date of the new notice.

You have the right to get a paper copy of this notice from us, even if you have agreed to accept this notice electronically. Please contact our Customer Service Department to receive a paper copy.

Generally, federal privacy laws regulate how we may use and disclose your health information. However, in some circumstances, we may be required to follow Michigan state law. In either event, we will comply with the appropriate law to protect your health information (for example, in accordance with the Genetic Information Nondiscrimination Act (GINA), we will not use genetic information for underwriting purposes) and to grant your rights concerning your health information in oral, written, or electronic form.

Your Protected Health Information

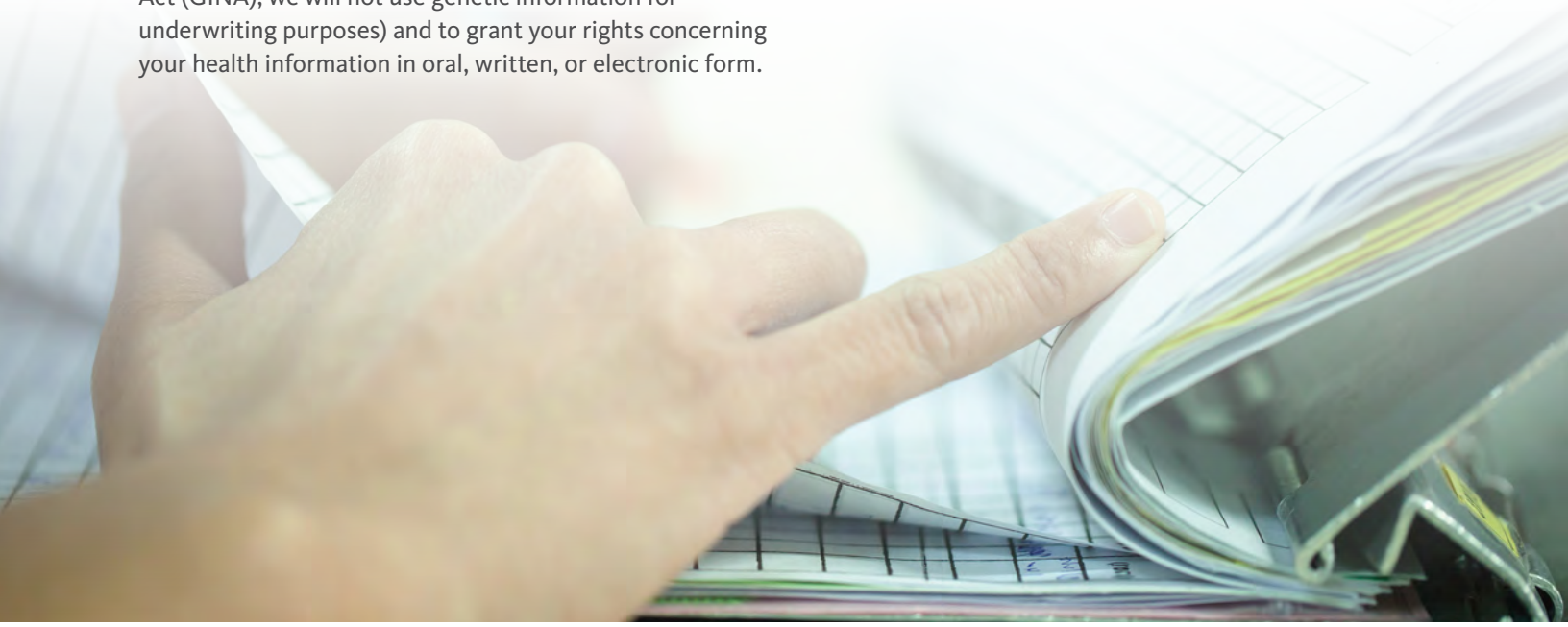
Ways We May Use or Disclose Your Health Information Without Your Permission: We must have your written authorization to use and disclose your health information, except for the following uses and disclosures.

To You or Your Personal Representative: We may release your health information to you or your personal representative (someone who has the legal right to act for you).

For Treatment: We may use or disclose health information about you for the purpose of helping you get the services you need. For example, we may disclose your health information to healthcare providers in connection with disease and case management programs.

For Payment: We may use or disclose your health information for our payment-related activities and those of healthcare providers and other health plans, including, for example:

- Obtaining premiums and determining eligibility for benefits
- Paying claims for healthcare services that are covered by your health plan
- Responding to inquiries, appeals, and grievances
- Deciding whether a particular treatment is medically necessary and what payment should be made
- Coordinating benefits with other insurance you may have



For Healthcare Operations: We may use and disclose your health information in order to support our business activities. For example, we may use or disclose your health information:

- To conduct quality assessment and improvement activities, including peer review, credentialing of providers, and accreditation
- To perform outcome assessments and health claims analyses
- To prevent, detect and investigate fraud and abuse
- For underwriting, rating, and reinsurance activities
- To coordinate case and disease management services
- To communicate with you about treatment alternatives or other health-related benefits and services
- To perform business management and other general administrative activities, including system management and customer service

We may use or disclose parts of your health information to offer you information that may be of interest to you. For example, we may use your name and address to send you newsletters or other information about our activities.

We may also disclose your health information to other providers and health plans that have a relationship with you for certain aspects of their healthcare operations. For example, we may disclose your health information for quality assessment and improvement activities or healthcare fraud and abuse detection.

To Others Involved in Your Care. We may, under certain circumstances, disclose to a member of your family, a relative, a close friend, or any other person you identify the health information directly relevant to that person's involvement in your healthcare or payment for healthcare. For example, we may discuss a claim determination with you in the presence of a friend or relative unless you object.

As Required by Law. We will use and disclose your health information if required to do so by law. For example, we will use and disclose your health information to respond to court and administrative orders and subpoenas and comply with 'workers' compensation or other similar laws. We will disclose your health information when required by the Secretary of the S.U.S. Department of Health and Human Services.

For Health Oversight Activities. We may use and disclose your health information for health oversight activities such as governmental audits and fraud and abuse investigations.

For Matters in the Public Interest. We may use and disclose your health information without your written permission for matters in the public interest, including, for example:

- Public health and safety activities, including disease and vital statistic reporting and Food and Drug Administration oversight
- To report victims of abuse, neglect, or domestic violence to government authorities, including a social service or protective service agency
- To avoid a serious threat to health or safety by, for example, disclosing information to public health agencies
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and the protective services for the president and others
- To provide information regarding decedents. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties
- For organ procurement purposes. We may disclose information for procurement, banking, or transplantation of organs, eyes, or tissues to organ procurement and tissue donation organizations

For Research. We may use your health information to perform select research activities (such as research related to the prevention of disease or disability), provided that certain established measures to protect the privacy of your health information are in place.

To Business Associates. We may release your health information to business associates we hire to assist us. Each business associate must agree in writing to ensure the continuing confidentiality and security of your medical information.

To Group Health Plans and Plan Sponsor (Enrolling Group). If you participate in one of our group health plans, we may release summary information to the employers or other entities that sponsor these plans, such as general claims history. This summary information does not contain your name or other distinguishing characteristics. We may also release to a plan sponsor that you are enrolled or disenrolled from a plan. Otherwise, we may share health information with plan sponsors only when they have agreed to follow applicable laws governing the use of health information in order to administer a plan.

Uses and Disclosures of Health Information Based Upon Your Written Authorization. If none of the above reasons apply, we must get your written authorization to use or disclose your health information. For example, your written authorization is required for most uses and disclosures of psychotherapy notes and disclosures of your health information for remuneration and most marketing

purposes. Once you authorize us to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, unless we have already acted based on your authorization. Also, you may not revoke your authorization if it was obtained as a condition for obtaining insurance coverage. Other law provides an insurer with the right to contest a claim under the insurance policy. We may condition your enrollment or eligibility for benefits on your signing an authorization, but only if the authorization is limited to disclosing information reasonable for underwriting or risk rating determinations needed for us to obtain insurance coverage. To revoke an authorization or obtain an authorization form, call the Customer Service Department at the number on your identification card.

Your Rights

You have the following rights. You must make a written request on one of our standard forms to exercise them. To obtain a form, please call the Customer Service Department.

You Have the Right to Inspect and Copy Your Health Information. This means you may inspect and obtain a paper or electronic copy of the health information that we keep in our records for as long as we maintain those records. You must make this request in writing. Under certain circumstances, we may deny you access to your health information – for instance, if part of particular psychotherapy notes or collected for use in court or at hearings. In such cases, you may have the right to have our decision reviewed. Please contact our Customer Service Department if you have questions about seeing or copying your health information.

You Have the Right to Request an Amendment of Your Health Information. If you feel that the health information we have about you is incorrect or incomplete, you can make a written request to us to amend that information. We can deny your request for certain limited reasons, but we must give you a written explanation for our denial.

You Have the Right to Accounting of Disclosures We Have Made of Your Health Information. Upon written request to us, you have the right to receive a list of our disclosures of your health information, except when you have authorized those disclosures or if the releases are made for treatment, payment, or healthcare operations. This right is limited to six years of information, starting from the date you make the request.

You Have the Right to Request Confidential Communications of Your Health Information. You have the right to request that we communicate with you about health information in a certain way or specific location. Your request must be in writing. For example, you can ask that we only contact you at home or at a specific address or by mail.

You Have the Right to Request Restrictions on How We Use or Disclosure of Your Health Information. You may request that we restrict how we use or disclose your health information. We do not have to agree to your request except for requests for a restriction on disclosures to another health plan if the disclosure is for payment or health care operations, is not required by law, and pertains only to a healthcare item or service for which you or someone on your behalf (other than a health plan) has paid for the item or service in full.

You Have the Right to Receive Notice of a Breach. If your unencrypted information is impermissibly disclosed, you have a right to receive notice of that breach unless, based on an adequate risk assessment, it is determined that the probability is low that your health information has been compromised.

How to Use Your Rights Under this Notice. If you want to use your rights under this notice, you may call us or write to us. In some cases, we may charge you a nominal, cost-based fee to carry out your request.

Complaints

You may complain to PHP or the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our Customer Service Department in writing of your complaint. We will not retaliate against you for filing a complaint.

To Complain to the Federal Government, Write to:

Region V, Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

Or Call:

Voice mail: **312.886.2359**
Fax: **312.886.1807**
TDD: **312.353.1807**

There will be no negative consequences to you for filing a complaint to the federal government.

You May Write to Our Customer Service Department at:

Physicians Health Plan
Attn: Customer Service
PO Box 30377
Lansing, MI 48909-7877

You may also call our Customer Service Department at **800.832.9186**.

Website Privacy Practices

PHP works hard to protect your privacy. Listed below are ways that PHP protects your privacy while you are on our website:

Using Email: If you send PHP an email using any of the email links on our site, it may be shared with a Customer Service Representative or agent in order to address your inquiry.

Once we have responded to your email, it may be discarded or archived, depending on the nature of the inquiry. The email function on our website provides a completely secure and confidential means of communication. All emails are sent under 128-bit encryption on a secure server.

Obtain a Quote: Some employers request quotes online for PHP health coverage. If your employer does this, it may enter the following information into the PHP website: employee name and date of birth, employee gender, ' 'spouse's date of birth, and whether you have Medicare.

This information is used only to prepare an accurate quote for your employer. PHP does not use this information for any other reason.

Website Visitor Data: At no time are internet "cookies" placed on the computer hard drives of visitors to the PHP website.

Disease Management Programs: You may enroll in one of our disease management programs online. If you do, you may have to enter the following information into the PHP website: name, member number, address and telephone number.

This information is used only for your enrollment into the program of your choice and is not used by PHP for any other purpose.

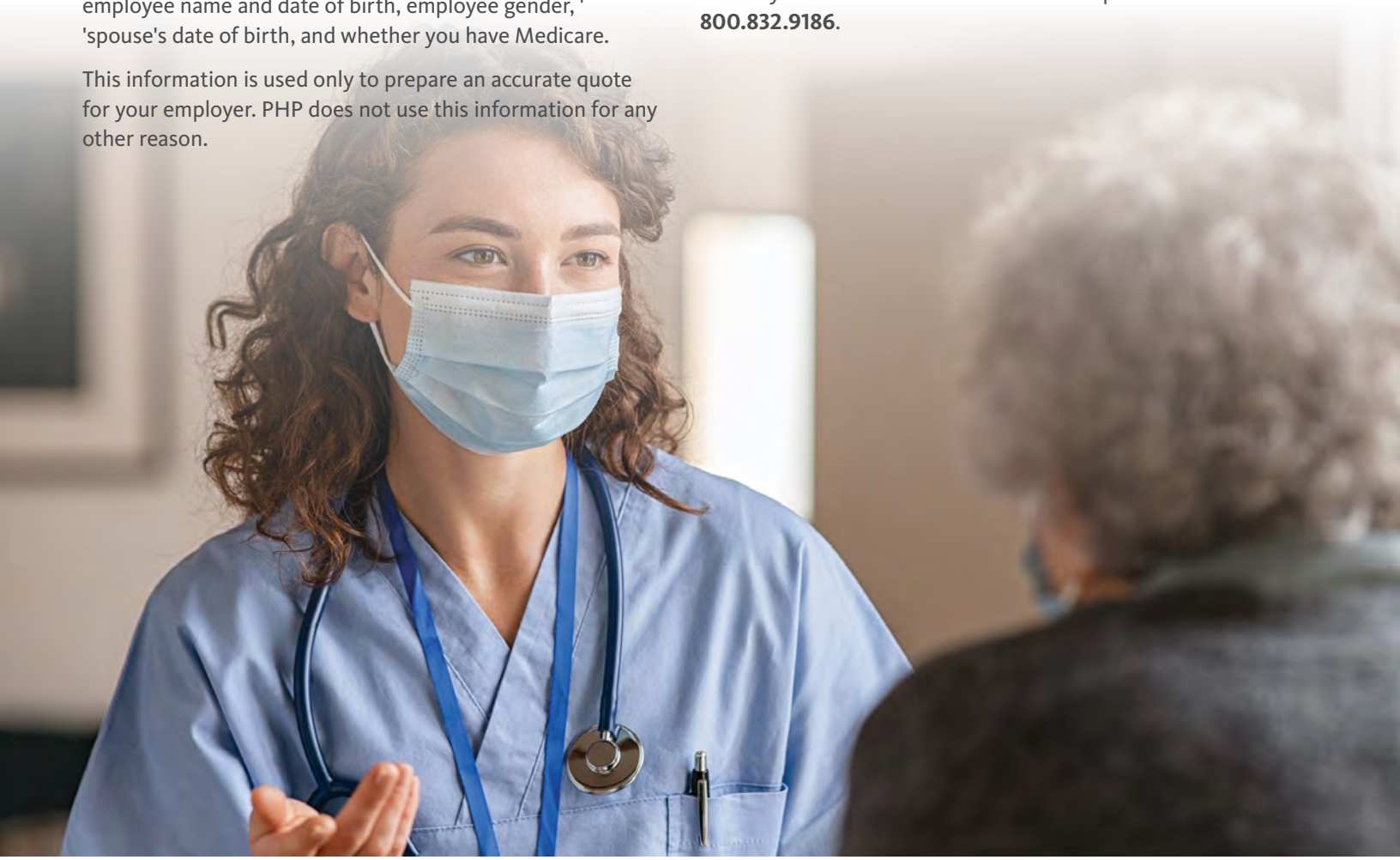
Links to Other Sites: The PHP website contains links to other websites. PHP is not responsible for the privacy and security practices used by other website owners or the content of those sites.

Contact Us

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact our Customer Service Department at

PO Box 30377,
Lansing, MI 48909-7877.

You may also call our Customer Service Department at **800.832.9186**.



Provider Manual Updates

The PHP Provider Manual is updated frequently. You can find the most current version online by visiting **PHPMichigan.com/Providers** and selecting "Provider Manual" from the left sidebar. Some of the most recent changes include:

- Requirements and Rights of Participation Credentialing and Re-Credentialing
  - Added Physician Assistants to list of provider types that are credentialed
- Telehealth Services
- Submitting a Claim
- Laboratory Tests Lists
  - Refer to your provider agreement

If you have any questions regarding the Provider Manual, please feel free to reach out to the Provider Relations Team at **PHPProviderRelations@phpmm.org**. Providers should use the Provider Manual to obtain information including, but not limited to:

- Referral/Notification/Authorizations Process
- Credentialing and Re-Credentialing
- Standard of Care Guidelines
- General Guidelines (Admission Services, Emergency Care, etc.)
- Reimbursement for Health Care Services
- How to submit a claim
- Copay, Coinsurance, Deductibles, and Non-Covered Services

Coming Soon!

New Electronic Funds Transfer Vendor

This is a notice that PHP is transitioning our Provider payment process, Electronic Funds (EFT) from PNC to a new vendor effective June 1, 2022. At this time, no action is needed by you, this is only a notice. More information will be shared with the PHP Network in the coming days. Please watch for updates on the PHP Website; **PHPMichigan.com/Providers**.

PHP New Mailing Address

Physicians Health Plan (PHP) is transitioning to a new mailing address. All Providers can begin using the new mailing address right away.

New Mailing Address

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

Old Mailing Address

Physicians Health Plan
PO Box 853936
Richardson TX 75085-3936

All mail sent to the Old Mailing Address will be forwarded on your behalf to the New Mailing Address thru Sept. 30, 2022. Please update your records and transition to the New Mailing Address before Sept. 30, 2022.

PHP appreciates your partnership!

Physicians Health Plan

1400 E. Michigan Avenue
PO Box 30377
Lansing, MI 48909-7877

Contact Us

PO Box 30377 Lansing, MI 48909-7877 517.364.8400 PHPMichigan.com

Department	Contact Purpose	Contact Number	Email Address
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	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 » Claims and EDI questions » 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 » URAC » HEDIS » CAHPS	517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org
Pharmacy Services	» Request a copy of our Preferred Drug List » 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** Pharmacy@phpmm.org
Change Healthcare (CHC)	» When medical records are requested	**Mail To:** Change Healthcare Attn: Pre-Pay 1849 West Drake Drive STE 101 Tempe, AZ 85283 952.224.8650 949.234.7603 (fax)	MedicalRecords@changehealthcare.com

	Physicians Health Plan	PHP Service Company	PHP Insurance Company
Where to Send Claims	Physicians Health Plan (PHP) In-Network: PO Box 313 Glen Burnie, MD 21060-0313 Non-Network: PO Box 247 Alpharetta, GA 30009-0247 Electronic Claims In Network: Payer ID: 37330 Non-Network: Payer ID: 07689	PHP Service Company In-Network: PO Box 313 Glen Burnie, MD 21060-0313 Non-Network: PO Box 247 Alpharetta, GA 30009-0247 Electronic Claims In Network: Payer ID: 37330 Non-Network: Payer ID: 07689 Includes SPN and MCN	PHP Insurance Company In-Network: PO Box 313 Glen Burnie, MD 21060-0313 Non-Network: PO Box 247 Alpharetta, GA 30009-0247 Electronic Claims In Network: Payer ID: 37330 Non-Network: Payer ID: 07689
Where to Send Refunds	Physicians Health Plan Attn: Provider Refund PO Box 30377 Lansing MI 48909-7877	Physicians Health Plan Attn: Provider Refund PO Box 30377 Lansing MI 48909-7877	Physicians Health Plan Attn: Provider Refund PO Box 30377 Lansing MI 48909-7877