Provider Connection

THIRD QUARTER 2022

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WORKING WITH PHP

QUALITY CORNER

UPDATES

Physicians Health Plan

Balance Billing

PHP is experiencing an increase in the number of member complaints regarding bills for services that are covered under their medical policy and should not be billed as member responsibility. The member should not be billed for services provided unless it is indicated as a member responsibility on the Explanation of Payment. Members are responsible for charges including copayments, co-insurances, deductibles and non-covered services if applicable. Amounts may be different among benefit plans and services. Member Benefits can be verified by contacting PHP's Customer Service Department at **517.364.8500** or **800.832.9186 (toll free)**.

PHP accepts paper and electronic claims. All claims for health services need to be submitted to PHP in industry standard formats. PHP does not reimburse any charges that may be required for the submission of claims. All claims, including adjusted claims, must be received within 6 months from the date that services are rendered or the date of discharge, or as required by law. When PHP is not the Primary Carrier, claims need to be submitted within 6 months from the date on the Primary Carriers' Explanation of Payment (EOP). If claims are not submitted within that timeframe, a financial penalty may be applied, including non-payment of the claim.

Patient Identification and Document Submission

In addition to identifying each page of a medical record as required, PHP also recommends that you include a patient identifier on each page when submitting documents such as invoice, itemization, or other non-clinical supporting documentation. This can help reduce processing time for documents that must be reviewed as part of the claims payment process. Identifiers can include the patient name and DOB, member ID, or date of service the document pertains to. All records submitted to PHP should be accompanied by the appropriate form, available on the PHP website by visiting **PHPMichigan.com/Providers** and selecting "Forms."

Please reach out to PHP Provider Relations at **PHPProviderRelations@phpmm.org** if you have any questions about the correct form to use or what you should include with your submission.

PHP 2021 Network Adequacy Assessment and Follow Up

Each year, PHP assesses the access and availability of Primary Care Providers (PCPs), Behavioral Health Providers, Essential Community Providers (ECPs), and high-volume key specialties in our network. We also examine provider turnover rates, PCP change rates, and drive times to ensure that the PHP network has enough providers available to meet the needs and preferences of our members.

We celebrate the following achievements from our 2021 Network Adequacy assessment:

- Our network grew tremendously with 1,362 new providers added, and only 329 existing providers departing.
- We also had a very low PCP change rate of only 1.80%, compared to a plan standard of less than 5.00%.
- The drive times for all medical specialties and facilities were within PHP's established performance goals, shown in the tables accompanying this article.
- All PHP Commercial plans met goals for member-to-provider ratios, geographical access, and volume requirements.
- All specialties and facilities met the requirements for PHP's Qualified Health Plan (QHP) members.
- Our network also met or exceeded performance standards for PCP after-hours access and meets the cultural and linguistic needs of our members.

PHP extends our gratitude to our participating providers for contributing to a strong network capable of supporting the health needs of our members. Thank you!

There were also areas for opportunity identified from our 2021 Network Adequacy Assessment:

- We are monitoring appointment access for new patient physicals, routine care, non- urgent care, urgent care, and emergency care in the office to help us meet our performance goal of 90% adherence with defined standards for waiting times, also shown in the tables accompanying this article.
- PHP experienced longer than normal credentialing turn-around times in 2021 due to the large expansion of our provider network.

In response to these challenges, we have partnered with Symplr to assist with the large volume of providers we continue to credential to support our network. PHP will continue to add PCP, Specialists, and Behavioral Health Providers to the network as available. We will also continue to regularly validate our provider directory through outreach from the Provider Relations team and targeted audits to improve accuracy.

Our Network Adequacy reporting relies on the information reported to us by you, our provider network. Please help ensure that our reporting accurately reflects the strengths and opportunities in our network by keeping all your information up to date. PHP recommends that all practitioners periodically review their information in our directory for accuracy and completeness.

Our Provider and Facility Directory is available at **PHPMichigan.com/Providers**. If you have changes to report, please complete the required sections of the Provider Information Update Form, also available on our provider website. If you need to notify PHP of a change in your New Patient Acceptance Status, please complete either Section IV: Practice Move/Address Change or Section V: Adding an Additional Address and the attestation page. Keeping this information current can also help members who reach out to PHP Medical Resource Management for assistance with locating practitioners and other service providers to meet their needs and can help direct new patients to your practice. PCP offices are encouraged to regularly check their provider rosters by logging into the MyPHP Provider Portal at **PHPMichigan.com/MyPHP**, and report any changes to PHP Customer Service by phone at **517.364.8500** or **800.832.9186 (toll free)**.

Thank you again for your continued commitment to the health and wellness of our members as a valued participating provider in the PHP Network!

Standards for Accessibility for Primary Care

PHP supports that members shall have access to health care on a timely basis as follows:

Types of Appointment	Waiting Time
Initial appointment with primary care practitioner	Within 8 weeks
Routine non-symptomatic	Within 4 weeks
Non-urgent symptomatic	Within 5 days
Urgent Care	Within 24 hours
Emergency Crisis Care	Immediately seen in office or referral to Emergency Room as appropriate

24 Hour Access to Medical Care:

Participating Licensed Independent Practitioners (LIP) shall have appropriate methods for directing members to seek medical care when the LIP is not available. The LIP shall provide or arrange for the provision of advice and assistance to members in emergency situations 24 hours per day, 7 days per week.

The LIP office shall provide information/communication to members how they may seek medical care when the LIP is not available (e.g., during normal business hours - vacation/lunch - or after hours).

The Primary Care Practitioner (PCP) shall arrange for access to medical care through (1) one phone number which is answered during office hours by LIP staff and at other times automatically transfers to another location to be answered, (2) an answering service, or (3) a recording directing members how to reach the PCP or another medical LIP whom the PCP has designated to treat PHP members.

After-Hours Telephone Access:

A LIP shall return a patient's telephone call within one hour of receiving the patients call after regular office hours.

In-Office Waiting Time

Waiting time is measured from the beginning scheduled appointment time until the LIP sees the patient. Ideally, the waiting time should be less than 15 minutes, but not more than 30 minutes. Should unforeseen circumstances arise that make it impossible to see the patient within this time period (e.g., OB delivery, emergency) office/clinic staff should offer the following options:

- See another LIP within the group (if a group practice).
- Reschedule the appointment
- Wait until LIP is available

Standards for Accessibility of Behavioral Health

Types of Appointment	Waiting Time
Routine Office Visit (established or new patient)	Within 10 days
Urgent Care	Within 48 hours
Non-Life Threatening Emergency Care	Within 6 hours
Emergency Crisis Care	Immediately seen in office or referral to Emergency Room as appropriate
Post Hospital Discharge for Mental Illness	Within 7 days

After Hours Telephone Access

A telephone call is returned by a behavioral health Licensed Independent Practitioner (LIP) with one hour of receiving the patient's call.

In-Office Waiting Time

Waiting time is measure from the beginning scheduled appointment time until the LIP sees the patient. Ideally, the waiting time should be less than 15 minutes, but not more than 30 minutes. If it is impossible for the LIP to see the patient during this time period, clinic staff should offer the patient the opportunity to be seen by another LIP within the group, (if a group practice) reschedule the appointment, or wait until the LIP is available.

Newborn Claims

All newborns must be enrolled within the first 31 days after birth. It is important to remember that if claims are submitted to Physicians Health Plan before the newborn is added to the policy, the claim could be denied. To avoid newborn claim denials, follow best practice standard billing by waiting 31 days to bill the claim and checking eligibility on the provider portal prior to billing the service.

Newborns enrolled within 31 days from the date of birth will be effective as of the date of their birth. Newborns not enrolled within 31 days of date of birth will not be eligible for coverage until the next open enrollment period for their benefit plan.

PHP members are responsible for facilitating the appropriate paperwork to enroll their newborns in their benefit plan for coverage of any services.

If you have questions, please contact PHP Customer Service at **517.364.8500**.

Non-Face-to-Face Evaluation and Management Services

Evaluation and Management (E/M) services are non-procedural services where a physician or other qualified healthcare professional (QHP) diagnoses and treats illness or injury upon obtaining a patient's history, examination, and any pertinent diagnostic test findings. Most medical care, including E/M services, is performed with the provider and patient in immediate proximity. This method of care is considered face-to-face care. However, the COVID-19 pandemic has prompted healthcare providers to reevaluate their delivery of care options to maintain adequate access to care. Providers may deliver non-face-to-face evaluation and management services through asynchronous and synchronous options. As more providers incorporate non-face-to-face care options and continue to offer these services beyond the COVID-19 pandemic, it is critical that documentation of these services fully support the Common Procedural Terminology (CPT) code(s) reported.

Non-Face-to-Face E/M service code descriptions and parentheticals outline the required elements to support reporting of each code. The record must reflect the method of evaluation (i.e., telephone, online digital evaluation, or video conference). Indication as "telehealth" or "telemed" visit alone does not provide enough supporting detail for the delivery method when the code description explicitly indicates a delivery method.

A brief phone call with test results may not warrant reporting a non-face-to-face E/M. To prevent claim denials or delays in reimbursement, review code descriptions in full, verify documentation supports code selection before claims submission,
and submit any requested documentation promptly.

Documentation must support any code description elements such as:

- Total time spent in medical discussion
- Verbal and written reports
- Indication of patient consent to telephone, online, or e-visit E/M

Out-of-Network Laboratory Services

Providers requiring laboratory testing for a member that can only be completed by an out-of-network laboratory are required to submit a prior authorization before laboratory services are rendered. This can be done by completing the Medical Prior Approval or Out of Network Request Form found on the **PHPMichigan.org/Providers** on PHP's website, on PHP's Provider Portal through the EZ Authorization and Referral Quick Link or by contacting PHP's Medical Resource Management department at **866.203.0618**. Obtaining a prior authorization prior to service will ensure that the member does not incur unexpected out-of-pocket expenses and ensures the provider is complying with contractual agreements.

Failure to comply with the protocols established by your participation agreement may result in a referral to the Network Education and Integrity Program (NEIP) for monitoring purposes.

If you have any questions regarding the authorization process or would like to obtain a copy of the **Network Education and Integrity Program** policy (NSP-02 Network Education and Integrity Program), please contact PHP Provider Relations by email at **PHPProviderRelations@phpmm.org**.

Submitting Prior Authorization Requests

To help ensure safe, high quality and affordable care for members, Physicians Health Plan (PHP) requires prior authorization for certain medical and pharmacy services. We understand that the prior authorization process requires additional time and effort of providers and staff. That is why we want to help your practice streamline the authorization process and avoid unnecessary delays in patient care or claim denials for lack of prior authorization.

The first step to success is understanding what services and medications require prior authorization:

- Members with a PHP pharmacy benefit can have their prescriptions sent electronically by ePrescribing with the Real-Time Benefits tool within your EHR. The tool will provide immediate feedback indicating if a medication is covered or needs authorization. The medication may have a step therapy or limit in place. Utilizing the tool will provide an alternative medication or any limits that are in place, as well as the out-of-pocket cost for the member before the member tries to fill the medication at the pharmacy.
- PHP Commercial Plans, including all HMO, PPO, TPA, and Exclusive (Marketplace) plans, should refer to the Notification Table and Prescription Drug Lists (PDLs) available on our website at **PHPMichigan.com/Providers**.
- The notification and prior authorization table contain all services and medications that may require prior authorization for all PHP commercial plans.
- The table is updated frequently, so please make sure you reference the most current version on the **PHPMichigan.com/Providers**.
- Network providers must only refer members to other PHP participating providers unless health services are not available through a participating provider and the out-of-network services have been authorized by PHP. Referrals to physicians, practitioners, or other healthcare providers not in the PHP network also require prior notification and approval from PHP.

The member's specific benefit plan will define which services or medications require prior authorization. Please note that certain services may be excluded from coverage under the member's specific plan. For questions about a member's benefit and coverage, please contact PHP Customer Service at **800.832.9186**, or you can ePrescribe for PHP members with a pharmacy benefit to receive immediate feedback from the Real Time Benefit tool.

Next, gather the required information and submit your request on the correct form:

- Authorization forms for PHP commercial plans are conveniently available on our website.
- Visit **PHPMichigan.com/Providers**, select "Forms," then scroll to the bottom of the page to see our Prior Authorization Forms.

NEW! All PHP Commercial providers may now use the EZ Authorization/Referrals portal, available inside the MyPHP Provider Portal:

- The EZ Authorization/Referral tool is now available for use by all providers.
- If you need access to the portal or training for EZ Authorization/Referrals tool, please contact PHP Provider Relations at **PHPProviderRelations@phpmm.org**.

Alternately, submit your request on the correct form:

- Authorization forms for PHP commercial plans are conveniently available on our website.
- Visit **PHPMichigan.com/Providers**, select the link for "Forms" on the left side of the page, then scroll to the bottom of the page to see our Prior Authorization Forms.

Once received, your request will be assigned a 9-digit authorization ID number that begins with a 2 or 3 (e.g., 2XXXXXXXX, 3000XXXXX). Next, the PHP Medical Resource Management will review and make a determination. You will be notified of the determination in writing, and the member will also receive a decision letter.

You can check the status of your request by logging in to the MyPHP Provider Portal and searching for the authorization ID or member information under the "Authorizations" tab or in the EZ Authorization/Referrals portal.

FAQ

Q: What if my request is denied?

A: You may submit an appeal for the benefit denial within 90 calendar days of the adverse benefit decision letter. Please complete and submit the provider appeal form available in the Forms section on our website.

Q: What if I do not provide the Medical Resource Management Department notification for a service that requires prior authorization?

A: Payment for those services may be denied. Please consult the claim Explanation of Payment (EOP) to determine which services are provider responsibility, and which services may be billable to the member, in accordance with their member benefit plan.

Q: Is prior authorization required when PHP Commercial or PHP Medicare Advantage is not the primary payor?

A: Services requiring prior authorization must be reviewed before the service, even when PHP is a secondary payor.

Q: Is prior authorization criteria available?

A: Yes. PHP utilizes InterQual criteria for medical services. Please reach out to PHP Medical Resource Management **517.364.8560** or **866.203.0618 (toll free)** to obtain clinical decision-making criteria. Pharmacy criteria can be found in the Drug Determination Policies on our website at **PHPMichigan.com/MedicalAndDrugPolicies**. If you have questions, please contact PHP Pharmacy at **517.364.8545** or **877.205.2300 (toll free).**

Q: I do not see the specific CPT or HCPC for the service; how do I confirm if prior authorization is required?

A: For PHP commercial plan members, please refer to the related Benefit Coverage, Drug Determination, or Payment and Reimbursement Policy. These policies are available on our website, PHPMichigan.com/Providers, under Claims and Provider Reimbursements, and Medical and Drug Policies. You can also contact PHP Customer Service at **800.832.9186** with the code and member information.

Q: What happens if PHP has questions about my request or needs to follow up with me?

A: Please make sure to include your contact information when you submit a request. Include your name, department or title, and a phone number where we can reach you. This information should be placed on your request form or in the Case Communication screen in the EZ Authorization/ Referrals tool.

Q: What is the required timeframe to submit a prior authorization request?

A: For most services, authorization must be requested at least 14 days before the service is provided. Certain acute services, such as urgent or emergent admissions, require notification within one business day. When an authorization request is not received, services may not be eligible for coverage, and a financial penalty may apply.

IMPORTANT: PHP Medicare Advantage (MA) uses separate forms for prior authorization requests. The forms must be submitted to PHP MA or as otherwise directed by the plan. Please make sure you use the appropriate PHP MA forms when requesting authorization for PHP MA members to avoid delays and denials. Forms and additional information for PHP MA prior authorization requests can be found inside the PHP Medicare Provider Portal.

PHP MA prior authorization requirements can be located in the PHP MA Provider Quick Reference Guide and the PHP Medicare Provider Administrative Manual for the current plan year. Both resources are available inside the PHP Medicare Provider Portal, which can be accessed by signing in to the MyPHP Provider Portal at **PHPMichigan.com/MyPHP**. Please contact PHP Provider Relations if you need assistance with the provider portal. For other questions related to PHP MA, please call PHP Medicare **844.529.3757**

Prior Authorization Approval is Not a Guarantee of Reimbursement

The authorization process begins when the treating or referring provider submits a request for a prior authorization review of a specific procedure and/or service to PHP. Upon receiving the request, a complete review of the member's benefit plan, in coordination with any applicable medical benefit policies, will be reviewed to determine prior authorization approval. A letter with notification of approval or denial will then be sent to the requesting provider and member. If there is any question regarding which services require prior authorization, don't hesitate to contact **PHProviderRelations@phpmm.org** or PHP Customer Service at **800.832.9186**.

Prior authorization approval is a critical component of claims processing, and failure to obtain authorization when required can impact reimbursement. However, this is not the only determining factor in claims processing and final reimbursement of a service. All claim submissions must be coded correctly based on the services provided and supported in the medical record. At the time of prior authorization review, the prior approval is based on anticipated coding provided with the provider's request, existing medical records to support medical necessity, and any required elements to support coverage. The final medical record for the authorized service is not established until the point of service. PHP performs pre-and post-payment reviews of claims. You may receive a letter from our approved vendor, Change Healthcare, when a claim has been selected for review. This letter will indicate what documentation is needed based on the services under review. Documentation must be submitted to Change Healthcare within 30 days to prevent claim denials for no records received. Upon receiving the requested records, a thorough review is completed, and findings are returned to PHP. PHP ultimately confirms findings, determines what edits are applicable, and processes the audit findings.

The audit findings applied following the medical record review are separate from the prior authorization review. Prior authorizations are confirmation of benefit coverage of service and, in some instances, benefit level coverage (in- or out-of-network). An incorrectly coded service or service deemed unsupported by the submitted medical record will not be reimbursed even if a prior authorization is in place. If a denial is received for a previously prior authorized service following submission of requested records, please have your coding team review the denial explanation, medical records, and coding.

Depending on the internal review outcome, it may be necessary to submit a corrected claim or file an appeal with PHP.

- If submitting a corrected claim, attach the PHP claim adjustment form with the corrected claim.
- If submitting an appeal, include a statement addressing the rationale for code selection and any supporting documentation.

Please do not hesitate to contact PHP Provider Relations regarding any questions about denial reasons and next steps at **PHPProviderRelations@phpmm.org.**

Medicare Annual Enrollment Tips from PHP Medicare

Medicare Annual Enrollment Basics

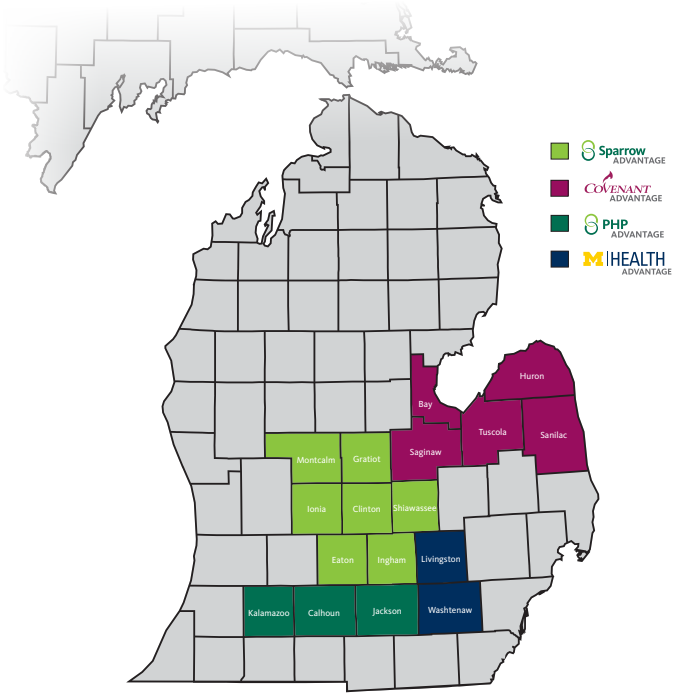
The Annual Enrollment Period (AEP) for Medicare can be a confusing time for your patients who are Medicare-eligible at 65-years old or older. Often, they will seek advice from trusted sources including their primary care provider. PHP Medicare is here to ensure you feel equipped to handle those questions and provide the best information for your patients.

- AEP begins Oct. 15, 2022 and ends Dec. 7, 2022
- All Medicare beneficiaries can adjust their Medicare coverage during this time
- There is no cost to seniors to utilize a licensed Medicare agent to help navigate options

PHP Medicare is Local, Personal, and Trusted

PHP Medicare Advantage plans are now available in 17 Michigan counties*

*Our 17-county service area includes: Clinton, Eaton, Gratiot, Ingham, Ionia, Montcalm, Shiawassee, Bay, Saginaw, Tuscola, Huron, Sanilac, Calhoun, Kalamazoo, Jackson, Livingston, and Washtenaw Counties.



As a reminder, all PHP Medicare products (Sparrow Advantage, Covenant Advantage, PHP Advantage, and University of Michigan Health Advantage) include the same great benefits and access to our single substantial network of providers.

Trust is essential in healthcare, and we take that trust seriously. Our accomplishments in 2022 demonstrate our deep commitment to serving our members, and others are noticing as well.

- We offer high-quality care that's close to home
- Vision and dental coverage through EyeMed® and Delta Dental®
- Worldwide coverage – emergency and urgent care
- 92% of people who enroll in our plans stay with PHP Medicare[1]
- In 2022, 1 in 4 Medicare enrollees chose a PHP Medicare (HMO-POS) plan over every other plan in our 15-county service area[2]

[1]CMS 2021 disenrollment data, August 2022. [2] Based on net growth for HMO/HMO-POS and PPO plans for Bay, Calhoun, Clinton, Eaton, Gratiot, Ingham, Ionia, Jackson, Kalamazoo, Livingston, Montcalm, Saginaw, Shiawassee, Tuscola, and Washtenaw counties from CMS enrollment data published January 2022 compared to December 2021 enrollment data (CMS.gov). Data set excludes employer group (EGWP) and special needs (SN) plan enrollments.

Our Focus on the Community – Medicare Resource Centers

PHP Medicare offers seniors the opportunity to learn more about their Medicare options through our Medicare Resource Centers during AEP. These centers serve as our commitment to improving the health and well-being of members in our communities. At a Medicare Resource Center, patients can:

- Attend a seminar
- Schedule an appointment with a licensed Medicare expert to answer questions
- Self-enroll in a plan
- Learn about money-saving extra benefits such as dental, vision, and fitness memberships
- And much more!

Specific dates, times, and locations for the resource centers can be found online at **PHPMedicare.com** or by the phone at **844.908.0051 (TTY: 711)**.

Any questions regarding original Medicare or PHP Medicare Advantage plans can be handled by our licensed and certified PHP Medicare Staff. Email or call Tonya Sundermann, our PHP Medicare Sales Manager, at **Tonya.Sundermann@phpmm.org** or **517.364.8403** for assistance.

Community Medicare Resource Centers

Open Oct. 17 - Dec 7.

Sparrow Region:

AgroLiquid
3055 M-22, St. Johns, MI 48879

Physicians Health Plan
1400 E Michigan Ave, Lansing, MI 48912

Hannah Community Center
819 Abbot Rd, East Lansing, MI 48823

Covenant Region:

Sleeper Public Library
226 E Main St, Ubly, MI 48475

Zauel Memorial Library
3100 N Center Rd, Saginaw, MI 48603

Bay County Community Center
800 John F Kennedy Dr, Bay City, MI 48706

UM Region:

Weber's Boutique Hotel
3050 Jackson Ave, Ann Arbor, MI 48103

Oceola Community Center
1661 N Latson Rd, Howell, MI 48843

Jackson Region:

American 1 Credit Union Event Center
128 W Ganson St, Jackson, MI 49201

Tonya Sundermann
PHP Medicare Sales Manager

Tonya.Sundermann@phpmm.org
517.364.8403

Reduced and Discontinued Services

PHP strives to ensure accurate claims processing and reimbursement of services. In an effort to help providers prevent claim denials and appeals, the following guidelines should be considered before the submission of claims with these modifiers. If you receive a denial for a service reported with one of these modifiers, please thoroughly review the explanation code and detail on the remit. Additional documentation may be submitted for further review and claim reprocessing, such as the operative report and detailed appeal letter.

Modifier 52 Reduced Services

- In consideration of an unexpected circumstance and at the provider's discretion, a portion of the procedure is reduced or modified.
- Not reportable with E/M services, unlisted procedure codes, or time-based codes.
- The allowable amount for the service will be reduced if reported with this modifier or if audit findings determine the modifier should have been reported and was not.
- If there is another Procedural Code or Modifier (i.e., modifier 26) that represents the reduced or modified service, the more appropriate coding should be reported.
- If requested, documentation should include a statement addressing the nature of the reduced service.

Modifier 53 Discontinued Procedure

- A physician or other qualified health care professional elects to terminate a surgical or medical diagnostic procedure for extenuating circumstances when the patient's well-being is at risk. The surgical or medical diagnostic procedure is discontinued, not modified.
- If additional procedures are not performed as planned as a result of the discontinued procedure, those procedures are not separately reportable on the claim.
- This modifier is not applicable when service is electively canceled before anesthesia induction and/or surgical preparation in the surgical suite.
- This modifier does not apply to laparoscopic or endoscopic procedures converted to an open or more extensive procedure. The procedure code for the open or more extensive procedure should be reported on the claim.

Modifiers 73 & 74 Discontinued Procedure

- Applicable to reporting of services reported by Ambulatory Surgical Centers (ASC).
- Modifier 73 may be applied when a procedure is discontinued due to extenuating circumstances or the case where the patient's well-being is at risk. The decision was made subsequent to the surgical preparation in the surgical suite but prior to anesthesia induction.
- Modifier 74 may be applied when a procedure is discontinued due to extenuating circumstances or the case where the patient's well-being is at risk. The decision was made after the surgical preparation in the surgical suite and anesthesia induction.
- Discontinued radiology procedures that do not require anesthesia may not be reported using modifiers 73 and 74.

Specialty Drug Site-of-Care Policy

PHP encourages a strong relationship between our Members and Providers while providing cost-effective care. The following medication list requires administration in a non-facility setting, such as in your office or by a home infusion provider.

Medication Brand Names	Generic Name	HCPCS Codes
Synagis**	Palivizumab	90378
Orencia**	Abatacept	J0129
Benlysta	Belimumab	J0490
Fasenra**	Benralizumab	J0517
Xgeva, Prolia	Denosumab	J0897
Privigen, Asceniv, Cuvitru, Bivigam, Gammaplex, Xembify, Hizentra, Gamunex-C/Gammaked, Carimune NF, Octagam, Gammagard, Flebogamma, Hyqvia, Pangyza, Cutaquig	Immune Globulin	J1459, J1554,J1555, J1556, J1557,J1558, J1559, J1561,J1566, J1568, J1569,J1572, J1575, J1599, J3590
Simponi Aria	Golimumab	J1602
Remicade, Inflectra, Renflexis	Infliximab	J1745, Q5103, Q5104
Nucala**	Mepolizumab	J2182
Ocrevus	Ocrelizumab	J2350
Xolair	Omalizumab	J2357
Cinqair**	Reslizumab	J2786
Vyepti**	Eptinezumab-jjmr	J3032
Actemra**	Toclizumab	J3262
Stelara	Ustekinumab	J3357
Entyvio	Vedolizumab	J3380
Evkeeza**	Evinacumab-dgnb	J3490

** Medications added effective 10/1/2022

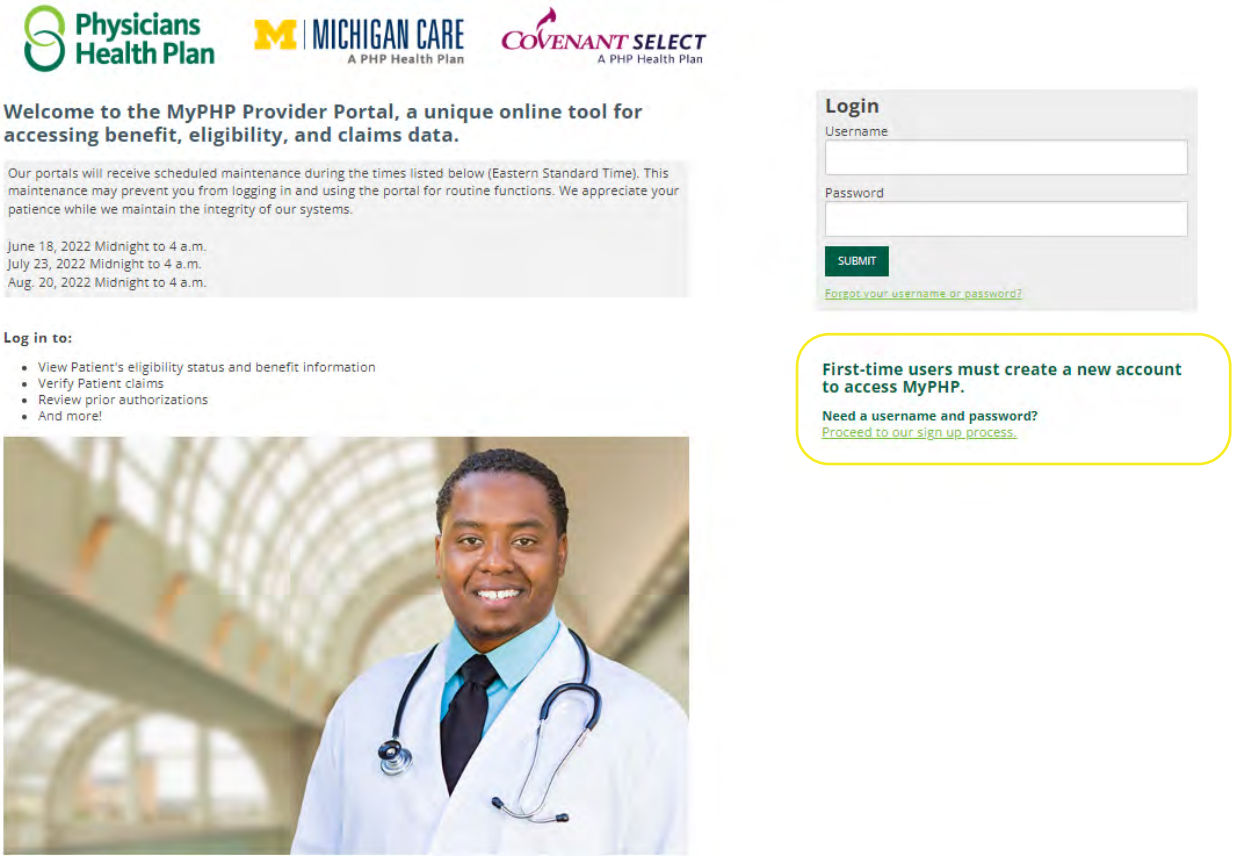
Place of service exceptions may be made when submitting a prior approval request. **Prior approval of the medication is required before outpatient administration, regardless of the site of service**. This program does not include oncology medications. This program does not apply to the self-funded SHS products (groups L0001269 or L0000264) or Michigan Medicine products (L0002184).

If you have questions regarding the PHP site-of-care policy, please visit our website at **PHPMichigan.com/Providers** or contact PHP Customer Service at **800.832.9186**.

Using the Provider Portal

PHP encourages all providers and office staff to use the MyPHP Provider Portal. Each user will need to self-register for an individual account. Sharing account information is not recommended.

To register for the provider portal, visit **PHPMichigan.com/MyPHP** and select the MyPHP Provider Portal. You'll need your Tax ID, individual NPI, and individual PHP Provider ID (e.g., 2000000XXXX). The PHP Provider ID number can be found on the "Welcome Letter" received when joining PHP or on an EOP (Explanation of Payment). If you do not know your PHP Provider ID, you can request this information by emailing the PHP Provider Relations team. **PHPProviderRelations@phpmm.org**. Please include your Tax ID and applicable NPI. You may also email PHP Provider Relations team to request account reactivation, password resets, or additional training with the portal. Please note that your account will deactivate after ninety (90) days of inactivity. The PHP Medicare Advantage portal can also be located within the PHP Commercial provider portal, by clicking on "For all Medicare Advantage access, please Click Here".



Making portal updates.

It may be appropriate for you to update your portal account from time to time. To review and make updates to your account, go to "Profile" in the upper right-hand corner of the landing page. Examples of updates may include changing your password, updating your security questions, adding/deleting an NPI or PHP ID.

Member Rights and Responsibilities

Member Rights

Enrollment with PHP entitles members to:

1. Receive information about rights and responsibilities as a member
2. Have access to cultural and linguistic interpretation services
3. Be treated at all times with respect and recognition of dignity and the right to privacy
4. Choose and change a Primary Care Physician (PCP) from a list of network physicians or practitioners
5. Information on all treatment options in terms members can understand and give informed consent before treatment begins
6. Participate in health care decisions, such as having treatment or not and what may happen
7. Voice complaints or file appeals without fear of punishment or retaliation and/or without fear of loss of coverage
8. Be given information about PHP, its services, and the providers in its network, including their qualifications
9. Make suggestions regarding PHP's member rights and responsibilities policies

Member Responsibilities

As a covered person, members are expected to:

1. Select or be assigned a Primary Care Physician from PHP's list of network providers and notify PHP when they have made a change
2. Be aware that PHP must approve all hospitalizations in advance, except in emergencies or for urgently needed health services
3. Use Emergency Department services only for the treatment of a serious or life-threatening medical condition
4. Always present their PHP ID card to providers each time they receive services, never let another person use it, report its loss or theft to PHP, and destroy any old cards
5. Notify PHP of any changes in address, eligible family members, and marital status, or if they acquire other health insurance coverage
6. Provide complete and accurate information (to the extent possible) that PHP and providers need in order to provide care
7. Understand their health problems and develop treatment goals they agree on with their PHP Provider
8. Follow the plans and instructions for care that they agree on with their provider
9. Understand what services have cost shares and pay them directly to the network provider who provided the care
10. Read PHP member materials and become familiar with and follow health plan benefits, policies and procedures
11. Report health care fraud or wrongdoing to PHP

National Correct Coding Initiative

CMS established the CMS National Correct Coding Initiative (NCCI) to promote national correct coding methodologies that help prevent incorrect coding and improper payments. NCCI coding policies are based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. PHP utilizes the National Correct Coding Initiative Policy Manual for Medicare and the NCCI procedure to procedure files as a source for clinical editing rationale, auditing, and appeal reviews.

Integral Services

Many procedures are comprised of multiple components of work. Some components of work are considered more comprehensive than others. The comprehensive procedure may inherently include duplicate work effort, or the subsequent service requires minimal additional provider resources. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during hysterectomy surgery. In other instances, two procedures are routinely performed in conjunction with each other. The additional procedure is clinically integral to the positive outcome of the primary procedure. Therefore, an incidental procedure is not reimbursed separately.

Mutually Exclusive Service

These services that cannot reasonably be provided to the same patient on the same day based on anatomic consideration or the nature of the service. These code pairs are identified on the CMS procedure to procedure edit file.

Associated Modifiers

There may be times when it's clinically justified to provide these services to the same patient on the same day. The NCCI manual provides additional detail regarding the appropriateness of identifying distinct services. Due to the limited nature of appropriate instances an edit may be applied to initiate a documentation review even when a modifier has been applied. Modifier 59 indicates a "distinct procedural service." PHP also accepts subcategory modifiers instead of modifier 59 because they provide additional detail regarding how the services are distinct. Specific subcategory modifiers accepted in place of modifier 59 are:

- XE (separate encounter)
- XS (separate organ/structure)
- XP (separate practitioner)
- XU (unusual, non-overlapping service)

Modifiers should only be used when clinically justified and supported in the documentation. Do not append a modifier to a code pair solely to bypass a NCCI edit if the clinical circumstances don't justify its use. Chapter 1 of the National Correct Coding Initiative Policy Manual for Medicare provides additional guidance on the use of modifiers with NCCI edits.

Medically Unlikely Edits

The CCI system also includes a set of edits called Medically Unlikely Edits (MUEs) for Medicare Part B and Medicaid claims. An MUE is the maximum number of times that the code can be billed for the same patient on the same day. The unit may represent time or frequency as defined in the description of each code. MUEs apply to both provider and hospital-based services, as well as durable medical equipment (DME). If CMS has does not have an established MUE for a covered service, PHP will assign an MUE to the code. In some instances, it may be appropriate to file an appeal with supporting documentation to support medical necessity of additional units.

Provider Satisfaction Survey Coming Soon

We thank you for your participation in the Physicians Health Plan (PHP) network. The PHP provider satisfaction survey will be mailed soon, followed up by an email. The survey will be sent to all primary care providers, behavioral health providers, and specialist participating in our PHP commercial products. PHP is committed to quality improvement and want to understand how our services impact your staff and practice daily. Results from the provider satisfaction survey have made an impact on what happens here at PHP. Our goal is to improve member outcomes and the Provider experience which is achieved by ensuring our providers have the tools and resources they need.

Upon receipt, we kindly ask that you please take a few minutes to complete the survey.

Pharmacy Updates

Drug	Formulary Placement
Livtencity (Maribavir)	Prior Authorization, Tier 3
Tavenos (Avacopan)	Prior Authorization, Non-Preferred Specialty Tier
Voxzogo (Vosoritide)	Prior Authorization, Medical Benefit
Besremi (Ropeginterferon Alfa-2B-NJFT)	Prior Authorization, Non-Preferred Specialty Tier
Ryplazim (Plasminogen, Human)	Prior Authorization, Medical Benefit
Vyvgart (Efgartigimod Alfa)	Prior Authorization, Medical Benefit
Fyarro (Sirolimus Protein-Bound Particles)	Prior Authorization, Medical Benefit
Scemblix (Asciminib)	Prior Authorization, Non-Preferred Specialty Tier
Leqvio (Inclisiran)	Prior Authorization, Non-Preferred Specialty Tier
Apretude (cabotegravir)	Step Therapy, Preferred Specialty Tier
Vabysmo (faricimab)	Prior Authorization, Medical Benefit
Kimmtrak (tebentafusp)	Covered, Medical Benefit

For up to date information on drug recalls please visit **PHPMichigan.com/Providers**. A link to the FDA's drug recall website is available under the Pharmacy Services tab.

Important Things to Remember When Submitting a Prior Authorization Request Form

- The Medication Authorization Form is located on the Provider Pharmacy Services page on the website **PHPMichigan.com**.
- Fill out 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 as well as 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.

To access information from PHP regarding preferred medications, changes to the prescription drug list (PDL), pharmaceutical management procedures, medication limits and criteria, authorization forms, generic substitution, therapeutic interchange, step therapy, specialty medications, preventive medications, drug recalls and electronic prescribing information is available on the PHP Provider Pharmacy Services page.

https://www.PHPMichigan.com/Providers/General-Forms-and-Information/Pharmacy_Services

Attention Medicare Providers: Getting Enrolled in an EFT/ERA

To begin enrollment, log in to the MyPHP Provider Portal at **PHPMichigan.com/MyPHP**. The link to get to all Medicare Advantage information can be found at the bottom of the landing page.

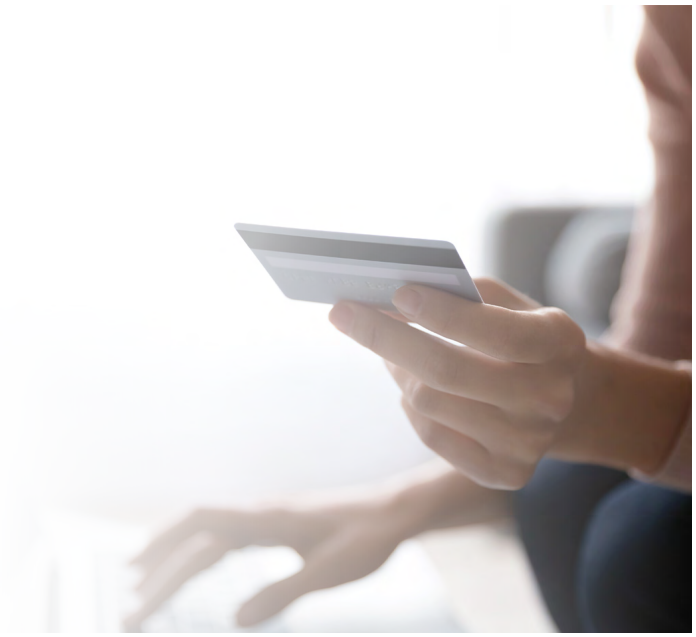
PHP Medicare has the ability to send an Electronic Funds Transfer (EFT) or a Virtual Credit Card for electronic payment of services, as well as a standard 837 Electronic Remittance Advice (ERA).

When scrolling to the bottom of the page, you will come to this section of the website:

This will allow you to view two options:

- Electronic Payment and Remittance
  - Billing guidelines (including Provider Administrative Manual)
  - Electronic Claims Submission and Electronic Remittance Advice
  - Electronic Payment and Remittance (EFT Payments/ERA Enrollment)
- *Provider VPay FAQ*

All forms will be available on this section of the site to get enrolled in an EFT/ERA. If you should need assistance or have any questions, please reach out by emailing **CustomerSupport@Lumeris.com** or by calling **866.397.2812**, 8 a.m. to 7 p.m., Monday - Friday (EST).



Physicians Health Plan General Training 101

The Provider Relations team offers training sessions throughout the year to help you and your office staff work more efficiently with PHP.

Training opportunities include PHP Commercial and PHP Medicare requirements, a review of the Provider Manual, checking eligibility and benefits, claim status, authorizations/approvals, and much more. Practice management and all office staff are encouraged and welcome to attend.

2022 Training Dates

Thurs., Nov. 10, 8:30 a.m.

Register today!

Visit **PHPMichigan.com/Providers** and select "Training Opportunities."

Prior to the training date, all registered attendees will receive login information to the email used to register.

Questions? Contact **PHPProviderRelations@phpmm.org.**

Provider Information Update Form

To remain compliant with CMS, State, and Federal guidelines, PHP requires prompt notification of the following types of changes:

- Physicians joining or leaving the practice or taking a leave of absence
- Change in the status of Accepting new patients
- Changes in Telephone number
- Address information
- Changes in Tax ID number
- Changes in privileges
- Changes in licensure
- Changes in your prescribing
- Sanctions or debarment status
- Malpractice cases, filed or closed
- Renewal of Professional Liability coverage
- After-hours availability for PCP offices

You can find the applicable form by visiting the Forms section on the PHP website at **PHPMichigan.com/Providers/General-Forms-and-Information** and selecting "Provider Information Update Form." Please return the completed form to:

Physicians Health Plan
Attn: Network Services
PO Box 30377 Lansing, MI 48909

Fax: **517.364.8412** or
Email: **PHPProviderUpdates@phpmm.org**

Please refer to your participation agreement and the provider manual for the specific notification requirements.

Zelis ePayment Center

Zelis ePayment Physicians Health Plan (PHP) recently introduced a new electronic payment (ePayment) platform to accelerate and add efficiency to our claims payment process, ePayment Center. PHP partnered with Zelis® Payments on July 27, 2022, to offer you secure ePayment options.

You are invited to enroll in a no-fee ACH delivery of claim payments with access to remittance files by download in the ePayment Center. Delivery of 835 files to clearinghouses is available directly through the ePayment Center enrollment portal. Providers already enrolled with Zelis may complete a new registration to include the PHP no-fee ACH option to maintain your existing relationship with Zelis. The current electronic platform through PNC Bank Remittance Advantage will continue to support your payment setup through July 25, 2022.

How do I register for Zelis ePayment Center?

1. Visit PhysiciansHealthPlan.ePayment.Center
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a Zelis customer service representative, and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and set up your account
5. Log in to the Zelis ePayment Center portal
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click "Submit"

Upon completion of the registration process, your bank account will undergo a pre-notification process to validate the account prior to commencing the EFT delivery. This process may take up to six business days to complete.

What do I need to register for the ePayment Center?

- 9-digit Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
- Practice's corporate name and principal information
- Bank account routing transit number (RTN) or ABA Routing Number

Where can I find more information/assistance on the registration process?

Additional enrollment instructions and a detailed question and answer guide are available for download at **PhysiciansHealthPlan.ePayment.Center**. Need additional help? Call **855.774.4392** or email **Help@ePayment.Center**.

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

	All Physicians Health Plan (PHP) Plans
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
Where to Send Refunds	Physicians Health Plan Attn: Provider Refund PO Box 30377 Lansing MI 48909-7877