Physicians Health Plan

Provider Connection

Q2 2023

In this issue...

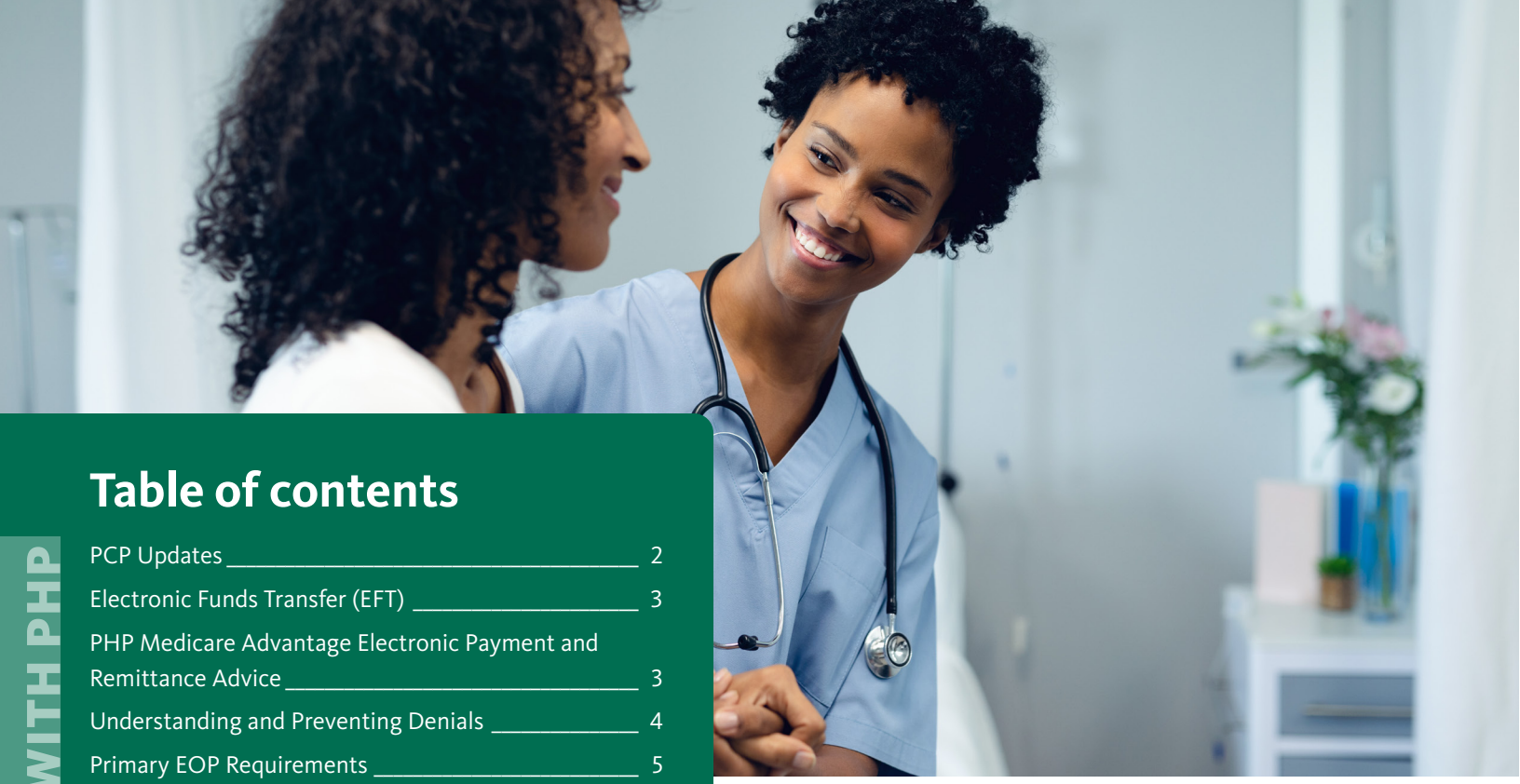


Table of contents

WORKING WITH PHP

QUALITY

UPDATES

PCP Updates

You are required to inform PHP if you are no longer accepting new patients.

Providing the most updated information to our members is important. If you had a change in the status of accepting new patients, we need to know. To remain compliant with CMS, state, and federal guidelines, we require prompt notification when a PHP provider is no longer accepting new patients. You are required to complete the Provider Information Update Form and return it to PHP.

The Provider Information Update Form can be found on the PHP website, PHPMichigan.com/Providers/General-Forms-and-Information, and can be submitted by mail, fax, or email.

Mail: Physicians Health Plan (PHP)
Attn. Network Services
PO Box 30377
Lansing MI 48909

Fax: 517.364.8412

Email: PHPProviderUpdates@phpmm.org

Thank you for your adherence to this policy.

Electronic Funds Transfer (EFT)

Physicians Health Plan (PHP) has partnered with Zelis® Payments. Are you currently receiving payment by paper checks and would prefer electronic payment via ACH? Are you a new provider? If so, please enroll with Zelis ePayment Center. If you are already enrolled with Zelis, you may register for the no fee ACH option for PHP and maintain your existing relationship with Zelis.

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

Additional enrollment instructions and a detailed question and answer guide are available for download at PhysiciansHealthPlan.ePayment.Center.

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 setup your account
5. Log into 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.

Need additional help?
Call 855.774.4392 or email Help@epayment.center

PHP Medicare Advantage Electronic Payment and Remittance Advice

For added convenience, PHP Medicare network providers can receive electronic funds transfer (EFT) for payment of services, and electronic remittance advice (ERA) for explanation of payment (EOP) information.

Several claims payment options are available through VPay®. PHP Medicare offers EFT, virtual credit card transactions through MasterCard financial services, or paper checks. All PHP Medicare Advantage network providers must register for their preference by contacting VPay® customer service at 844.224.7568 to elect the EFT or paper check options. If you do not register with VPay®, you will receive payments through the MasterCard financial services network.

If you have never received a payment from VPay through PHP Medicare, or any other third-party administrator (TPA), then you cannot register for EFT. You must receive your first payment via VCard, then you can contact VPay to request EFT or check.

For enrollment to receive an ERA, please contact Change Healthcare customer service at 866.924.4634 Option 4, Option 1 or on their website, Support.ChangeHealthcare.com/Customer-Resources/Enrollment-Services. If you receive the ERA, you will not receive an additional paper copy. If you have not signed up for the ERA, paper remits are generated and mailed weekly. Paper copies of the PHP Medicare Advantage ERA and EOPs are not available in the Provider Portal.

Understanding and Preventing Denials

Denials in any form can be frustrating and time-consuming for medical offices. While not all denials are avoidable, many are preventable. The volume of denials your organization receives can substantially impact office resources. The first step in reducing denials is understanding the types of denials received and why.

Before scheduling services or prescribing medication, some important questions to ask are:

- Is prior authorization required?
- Does the patient meet PHP criteria for coverage?
- Is this service being provided in a manner or setting other than the industry standard?
- Is the provider contracted to provide these services?
- Could this service be considered experimental/unproven?

The notification/authorization process begins with the communication initiated by the provider treating or scheduling specific procedures and/or services. Notifications allow PHP to facilitate access to needed care and support a positive outcome for members. Understanding the terms of your provider contract and quality documentation is key. Failure to adequately document a patient's condition, previous treatments, length of trial treatments, and medication outcomes may prevent a patient from meeting the necessary criteria resulting in a prior authorization denial. Providing and billing for services outside the terms of your contract may also result in denials.

Before billing for services, some important questions to ask are:

- Does the documentation support the services billed?
- Have all the necessary modifiers been applied?
- Are there any PHP Payment Reimbursement Policies regarding these services?

When entering claim details, review all data elements for accuracy. Claims submitted with typos regarding patient demographics, missing modifiers, or incorrect coding will result in denials, incorrect payments, or incorrect member cost share. PHP strives for timely and accurate claims processing. If records are requested for prepayment reviews, complete records supporting coding assignments must be provided promptly.

Please refer to the Providers section of the PHP website at PHPMichigan.com for the following resources to help prevent unnecessary denials.

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

Medical and Drug Policies: PHPMichigan.com/MedicalandDrugPolicies

Notification and Prior Approval table: PHPMichigan.com/Providers/Notification-and-Prior-Approval-Table

Provider Manual: PHPMichigan.com/Providers/Provider-Manual

Primary EOP Requirements

Prior to submitting a claim, it is important to determine if any other payer has primary responsibility for payment of a claim. The identification of the primary payer prior to claim submission will improve the efficiency and accuracy of the claim payment process. The "Primary Plan" is the plan whose benefits for a member's healthcare coverage must be determined without taking the existence of any other plan into consideration.

If another payer is primary, that payer should be billed prior to billing PHP. After receipt of payment, submit a paper claim to PHP with the following information:

1. A completed paper CMS-1500 or UB-04 form
2. A copy of the primary plan's Explanation of Benefits (EOB) or Explanation of Payment (EOP) statement, which includes:
    - The subscriber's name
    - The claim date(s) of service
    - The original billed charges
    - The claims processing results from the primary payer (amount received from primary plan, denial codes, etc.)
    - The date the claim was processed or the check date

When PHP is not the primary payer, secondary PHP claims must be submitted as paper claims. PHP cannot accept secondary claims electronically.

More information about Medical Coordination of Benefits for PHP Commercial plans can be found inside the PHP Provider Manual, available online at PHPMichigan.com/Providers/Provider-Manual.

Online Support Tools

The MyPHP provider portal offers secure, convenient, web-based access to information and support anytime. This includes healthcare information like claims, eligibility, and benefits. We encourage you to register for the portal today!

How to register to access MyPHP:

1. Visit PHPMichigan.com/MyPHP
2. Select Provider Portal
3. Review the instructions
4. Create your username and password
5. Answer the security questions

You will need the provider tax identification number (TIN), national provider identifier (NPI), and PHP Provider ID number to register. Your PHP Provider ID number can be found on an EOP or obtained by contacting PHP Provider Relations. Once you are registered, you will have immediate access to the portal. If you would like more information or need assistance with an existing account, please send an email with your practice information, including the practice TIN and all individual provider NPIs to PHPProviderRelations@phpmm.org for assistance.

The portal account will become disabled if you have not logged in within 90 days. If your account becomes disabled, you can email the PHP Provider Relations Team at PHPProviderRelations@phpmm.org with your username and TIN. Once we verify your account, we'll reactivate your account and reset your password if necessary.

Providers participating with PHP Medicare Advantage plans can access information for both with a single sign-on. Log in to your MyPHP portal account and find the words, '*For all Medicare Advantage access, please Click Here*,' and the PHP Medicare logo.

The first time logging in to the portal, you must accept the End User License Agreement and verify your provider information. Once you've completed the sign-up process, you will receive an email from Lumeris, our contracted Medicare Advantage vendor, within 48 hours.

Provider portal features:

- Eligibility and coverage: Search Patients to verify eligibility and coverage information (effective dates, Primary Care Physician, and member profile information)
- Benefits: View and download a member's benefits
- Prior Authorizations: View the status of authorization and obtain the prior authorization number
- Claims: Search and view claims (status, amount paid, paid dates, and claim history)
- Explanation of Payment (EOP): Search, view, and print EOPs
- Accumulators: View, a member's out-of-pocket or deductible balances
- View and print Primary Care Physician Patient Rosters
- Access to PHP's Medical and Pharmacy Policies
- Single-sign-on access to the PHP Medicare Portal
- Medicare portal

Some of the helpful guides and resources available include the following:

- Referral Guide
- Prior Authorization Guide
- Inpatient Admission Guide
- Prior Authorization Quick Reference Guide
- Billing Guidelines
- Electronic Payment and Remittance

All information related to the 2023 plan year is available in PDF format.

2023 Lunch & Learn Sessions

PHP is excited to continue our lunch and learn sessions in 2023! 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 latest updates that affect the provider network. We will also leave time for a question-and-answer period at the end of each session. Cameras are not required to be on so please bring your lunch.

If you have an idea for lunch and learn topics, please email them to PHPProviderRelations@phpmm.org.

Register today!

Go to PHPMichigan.com/Providers and select "Training Opportunities."

General Training 101

PHP Provider Relations presents virtual training sessions to help you and your office staff be more efficient with PHP. Topics include:

- PHP Commercial and PHP Medicare requirements
- Checking Member Eligibility and Benefits
- Overview of the Provider Manual and Provider Portal
- Claim Status, Authorizations, and much more

Attendees should include management and office staff.

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

Utilization Management News and Updates

A comprehensive list of procedures and services requiring prior approval is available on the PHP website at PHPMichigan.com/Providers. Select "Notification and Prior Approval Table" to access the list. This information is also available in the MyPHP provider portal.

If you have any questions about the prior approval process, please call PHP Customer Service at 517.364.8500 or 800.832.9168, Monday through Friday, 8:30 a.m. to 5:30 p.m. EST, excluding holidays.

Reminder: Prior approval requests may be faxed to Utilization Management at 517.364.8409, Monday through Friday, 8 a.m. to 5 p.m.

New Policies

- N/A

Policy Updates

- BCP-06 Outpatient Rehabilition/Habilitation Services: PT/OT — removal of prior authorization for Group L0001631; effective 01/01/2023
- BCP-12 Applied Behavioral Analysis (ABA) Therapy for Treatment of Autism Spectrum Disorders: Removal of age requirement, per federal mandate, for all HMO/PPO groups and the following ASO groups: L0002193, L0001269 (non-union products only) effective 1/1/2023
- BCP-22 Hospice Care Services: Enhanced hospice room and board benefit for group L0002184, with prior authorization; effective 1/1/2023

Changes to Coverage for Services

Code(s)	Procedure or service	Action	Effective date
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft	Change from "Covered" to "Prior Authorization" to align with InterQual criteria	4/1/2023
21685	Hyoid myotomy and suspension	Change from "Covered" to "Prior Authorization" to align with InterQual criteria	4/1/2023
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (i.e., balloon dilation); unilateral	Change from "Prior Authorization" to "Covered"	12/31/2021

Any provider or member that was directly impacted by these changes received a direct mailing explaining the changes.

Physicians Health Plan Commercial Provider Manual and Medicare Advantage Provider Administrative Manual

The PHP Commercial Provider Manual is a valuable resource that can help your office when providing care for PHP members. The Provider Manual is updated often and can be accessed online at PHPMichigan.com/Providers/Provider-Manual Information in the Provider Manual can answer many of your most frequently asked questions, and includes:

- Plan Definitions
- Credentialing and Re-Credentialing
- Submitting a Claim
- Timely Filing Limits
- Medical Coordination of Benefits
- Non-Covered Services Not Billable to Members
- Clinical Editing
- Claims Audit/Medical Record Review Process
- How to Contact Us
- Member ID card examples, and more!

If you have any questions about the PHP Commercial Provider Manual, please email PHP's Provider Relations Team at PHPProviderRelations@phpmm.org.

If you need information about PHP Medicare Advantage policies and guidelines, please refer to the PHP Medicare Advantage Provider Administrative Manual. The Provider Administrative Manual contains general information, and resources including:

- Operational Policies and Procedures
- PCP Specific Information
- Utilization Management Information
- Member ID Card Examples
- Billing Guidelines
- Quality Improvement Services

The PHP Medicare Advantage Provider Administrative Manual is available in the "Forms & Resources" tab on the Medicare Advantage side in the MyPHP Provider Portal. You can login to your account, or self-register for a new account at PHPMichigan.com/ProviderPortal. Please email the PHP Provider Relations Team if you need assistance with registering for the provider portal. For questions regarding the content of the PHP Medicare Advantage Provider Administrative Manual, please call PHP Medicare at 844.529.3757.

Please note that language in your contract or provider agreement takes precedence over information in either the PHP Commercial Provider Manual or PHP Medicare Advantage Provider Administrative Manual.

PHP Medicare Advantage: Continuous Glucose Monitors

PHP Medicare Advantage plans require prior authorization for Continuous Glucose Monitors (CGM). The health plan reviews CGM authorization requests for medical necessity using Centers for Medicare & Medicaid Services (CMS) criteria, specifically Local Coverage Determination (LCD) L33822.

To be eligible for coverage of a CGM and related supplies, the beneficiary must meet all of the following coverage criteria:

1. The beneficiary has diabetes mellitus (Refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses); and,
2. The beneficiary is insulin-treated with multiple (three or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump; and,
3. The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of Blood Glucose Monitors (BGM) or CGM testing results; and,
4. Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the beneficiary to evaluate their diabetes control and determined that criteria (1-3) above are met; and,
5. Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the beneficiary to assess adherence to their CGM regimen and diabetes treatment plan.

To request coverage of a CGM and supplies for your patients, please send supporting clinical documentation to the health plan for review. CGMs and supplies are covered under a member's Part B benefit and require prior authorization by the health plan. They should not be submitted to the Pharmacy Benefit Manager (PBM). Requests and clinical documentation can be submitted via fax to 855-229-2187, or on the PHP Medicare Advantage side of the MyPHP Provider Portal.

Did You Know?

PHP has many plans offered under the names of our system partners and employer partners. Despite their names, many of our plans include the same rich benefits and coverage options.

PHP contact information is included on all member ID cards.

Commercial plans

Physicians Health Plan

MICHIGAN CARE
A PHP Health Plan
Self-funded plan for University of Michigan employees only

Sparrow
Self-funded plan for Sparrow employees only

COVENANT SELECT
A PHP Health Plan
Self-funded plan for Covenant HealthCare employees only

Medicare plans

PHP MEDICARE

M | HEALTH ADVANTAGE

PHP ADVANTAGE

COVENANT ADVANTAGE

Sparrow ADVANTAGE
A PHP Medicare Plan

COVENANT RETIREES ADVANTAGE
A PHP Medicare Plan

HEDIS MY 2022: Thank you!

The HEDIS 2022 audit process will be coming to a close as you receive this publication. The HEDIS Nurse Reviewer team would like to extend a sincere "thank you" to you and your office staff for your assistance in the process. We appreciate your timely response to our requests for records and your courtesy in allowing us into your office to review and gather records.

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

Please feel free to contact the PHP Quality Team if you have questions: PHPQualityDepartment@phpmm.org

Critical Care Coding

In 2022 the Centers for Medicare & Medicaid Services (CMS) clarified its stance on the reporting of critical care. The clarifications included how critical care is defined, who can provide these services in various settings, what is included in the services, and what is not separately payable.

CPT® and CMS define critical care as, the direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of the patient's condition. It involves high complexity decision-making to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

PHP follows CMS guidelines regarding the reporting of critical services. To ensure the proper processing of claims, keep the following guidelines in mind when reporting these services:

Full attention of rendering provider:

- Services require the full attention of the physician or QHP rendering the service.
- The physician cannot provide services to any other patient for any given time period spent providing critical care services.

Critical care is a time-based service:

- Time may be continuous, or an aggregate of intermittent time spent by members of the same group and same specialty.
- Progress notes must document the total time that critical care services were provided for each date and encounter entry. When multiple physicians are involved, the documentation must support the medical necessity of the critical care services rendered by each physician.
- Only one physician/QHP must meet the time requirement of the initial critical care service.

Single physician/QHP:

- When a single physician/QHP furnishes 30 -74 minutes of critical care services to a patient on a given date, the physician/QHP will report CPT code 99291.
- CPT code 99291 will be used only once per date, even if the time spent by the practitioner is not continuous on that date. Thereafter, the physician/QHP will report CPT code 99292 for additional 30-minute time increments provided to the same patient.
- For continuous services that extend beyond midnight, the physician/QHP will report the total units of time provided continuously. Any disruption in the service, however, creates a new initial service.

Multiple physicians/QHP different specialties:

- More than one physician, regardless of group affiliation, can provide critical care concurrently if the service meets the definition of critical care, is medically necessary, and is not duplicative care. Examples: an internist and a surgeon; an allergist and a cardiologist
- Physicians of a different specialty may each report CPT code 99291 if they are providing care that is unique to his/her individual medical specialty and managing at least one of the patient's critical illnesses or critical injuries

Multiple physicians/QHP same specialty and same group:

- Physicians/QHP of the same specialty within the same group practice who bill and are paid as though they were a single physician.
- CPT code 99291 should be used once per calendar date per patient by the same physician or physician group of the same specialty.
- CPT code 99292 can only be reported by a practitioner in the same specialty and group when an additional 30 minutes of critical care services have been furnished to the same patient on the same date (e.g., 74 minutes + 30 minutes = 104 total minutes).

Split (Shared) critical care visits:

- Split (or shared) visits occur when the total critical care service time furnished by a physician/QHP in the same group on a given calendar date to a patient is summed, and the practitioner who furnishes the substantive portion of the cumulative critical care time reports the critical care service(s)
  - The billing practitioner bills the initial service (CPT 99291) and any add-on codes(s) for additional time (CPT 99292)
  - Modifier -FS (split or shared E/M visit) must be appended to the claim's critical care CPT code(s).
  - **Bundled services:**
    When provided during the time period of critical care for a given patient, interpretation of cardiac output measurements, chest X-rays, pulse oximetry, blood gases and collection and interpretation of physiologic data (for example, ECGs, blood pressures, hematologic data), gastric intubation, temporary transcutaneous pacing, ventilator management, and vascular access procedures are inclusive of critical care services and therefore not separately payable.

Reference

CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Clinical Edit Denial Appeals

Clinical editing analyzes professional and facility claims for reimbursement, ensuring clinical data accuracy and completeness. This includes potential coding errors and rule infractions based on codes submitted on the same or different claims. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. PHP may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but are covered by the Plan to support covered benefits available through one of the Plan's products. Clinical editing rules are effective based on the date of service, and services will be denied payment when the edit is applied.

When responding to denials related to clinical edits, please follow the PHP appeal process outlined in the PHP Provider Manual, including these key steps.

- Fill out the Provider Appeal Form completely and accurately. The form is available online at PHPMichigan.com/Providers/General-Forms-and-Information.
- Submit the appeal request within 180 calendar days of the adverse benefit decision letter or the date of the initial claim denial.
- Include all pertinent clinical information and/or coding source rationale relevant to the appeal.
- Include a contact person and direct phone number/email so PHP can contact you if there are any questions.

In addition to the key steps outlined above, the claim should be reviewed in full. What was the reason for the claim or line-item denial? The explanation detail on the explanation of payment should be referenced. This explanation detail will provide information as to why a denial or reduction in allowable occurred. If it is unclear, please reach out to PHP customer service for additional clarification. Many denials are related to incorrect coding, missing or unsupported modifiers, incomplete documentation, and unbundled services. The appeal should include a thorough explanation regarding the code selection and rationale for the appeal. Do not submit the appeal form with generic statements like, services were medically necessary, please re-review, or reprocess the claim. Be as specific as possible and provide all documentation that was used to support code selection. Appeal requests submitted after the 180-day time limit will be denied, and a letter will be mailed with an explanation.

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

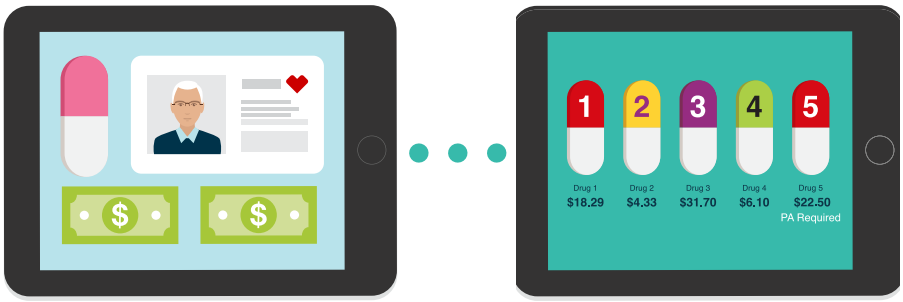
The cost of health care is a major source of worry for consumers across the nation, especially for those enrolled in high deductible health plans who may pay thousands of dollars out of pocket (OOP) each year.

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

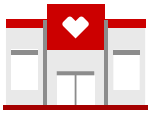
Physicians Health Plan

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.

Pharmacy Updates

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

To access information regarding preferred medications, changes to the Prescription Drug List (PDL), pharmaceutical management procedures, medication limits, authorization forms, generic substitution, therapeutic interchange, step therapy, specialty medications, preventive medications, drug recalls and electronic prescribing information, use the following link to access our PHP Provider Pharmacy Services page: PHPMichigan.com/Providers/Pharmacy-Services

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.

New-to-market drug	Formulary placement
Gemtesa (vibegron)	Step Therapy, Tier 3
Qulipta (atogepant)	Step Therapy, Quantity Limit, Tier 2
Xenpozyme (olipudase alfa)	PA, Medical Benefit
Spevigo (spesolimab)	PA, Medical Benefit
Adbry (tralokinumab)	PA, Preferred Specialty Tier
Relyvrio (sodium PB-T)	PA, Non-Preferred Specialty Tier
Imjudo (tremelimumab)	PA, Medical Benefit
Lytgobi (futibatinib)	PA, Non-Preferred Specialty Tier
Tecvayli (teclistamab)	PA, Non-Preferred Specialty Tier
Elahere (mirvetuximab soravtansine)	PA, Medical Benefit

Therapeutic category	Medication	Formulary action	Formulary alternative
Insulins	NovoLog Flexpen ReliOn	Exclude	NovoLog Flexpen
Creams and ointments	Analpram products	Exclude	Over-the-counter products

Important things to remember when submitting a prior authorization request form:

- The Medication Authorization Form can be found in the dropdown menu on the Pharmacy Services Page located at PHPMichigan.com/Providers/pharmacy-services
- 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. If you have issues sending authorization requests for PHP members through Cover My Meds, please reach out directly to PHP Customer Service at 800.562.6197 or 517.364.8400, 8:30 a.m. – 5:30 p.m. EST, Monday – Friday, excluding holidays.

Office/Urgent Care Laboratory Test List: Codes Added

87502 and **87634** have been added to PHP's laboratory test list for office and urgent care. The Provider Manual, available online at PHPMichigan.com/Providers/Provider-Manual, has been updated to reflect these changes.

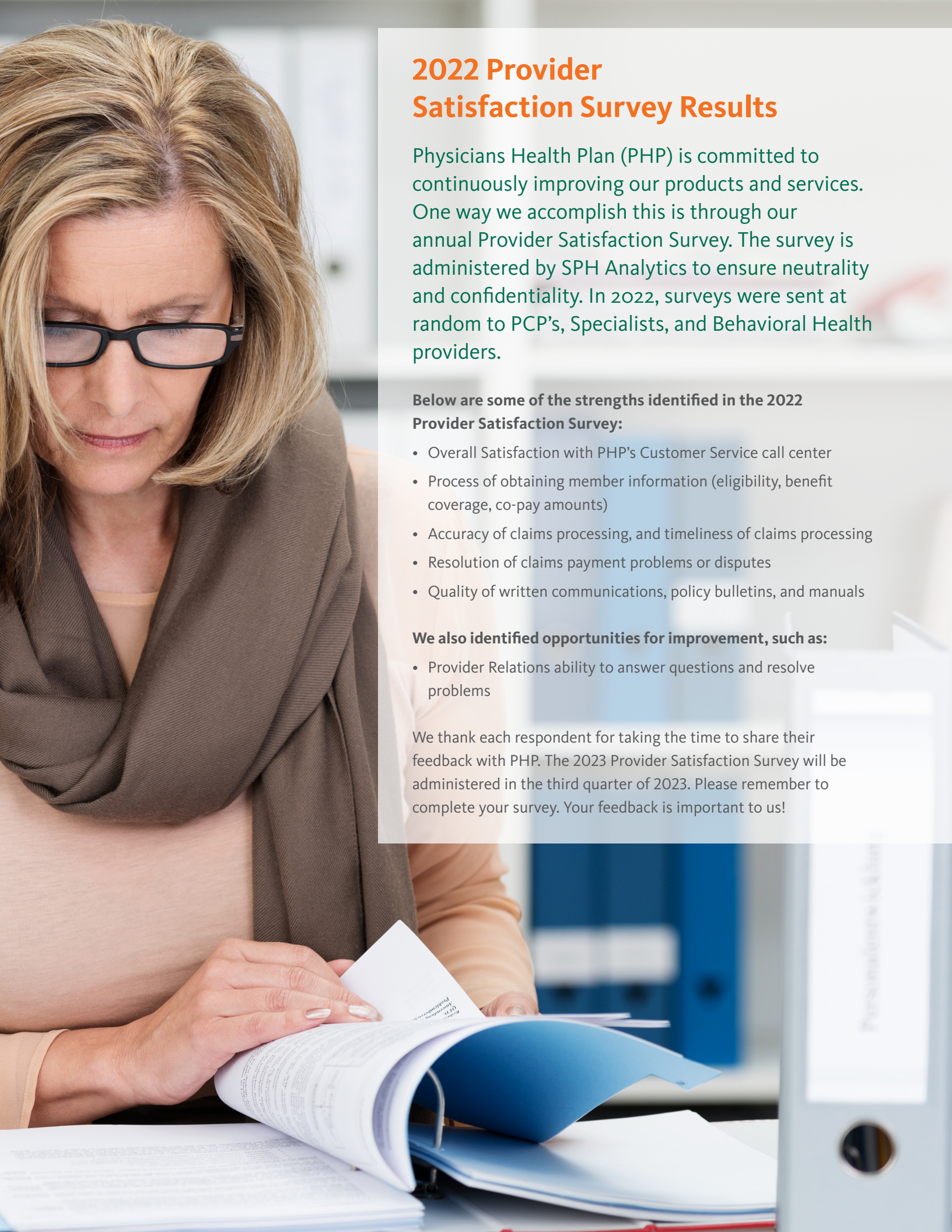
87502: Influenza, first two types (Infectious agent detection by DNA/RNA)

87634: RSV (Infectious agent detection by DNA/RNA, amplified probe technique)

Please contact PHP Provider Relations at PHPProviderRelations@phpmm.org if you have any questions about the laboratory test list.

Fee Schedule

Rates for PHP's standard fee schedule have been updated as of Apr. 1, 2023. These fees remain market competitive and align with reimbursement rates within our service area. If you have any questions or would like an updated fee schedule, please send a list of codes you are inquiring about, along with your billing NPI and TIN to PHPProviderRelations@phpmm.org.



2022 Provider Satisfaction Survey Results

Physicians Health Plan (PHP) is committed to continuously improving our products and services. One way we accomplish this is through our annual Provider Satisfaction Survey. The survey is administered by SPH Analytics to ensure neutrality and confidentiality. In 2022, surveys were sent at random to PCP's, Specialists, and Behavioral Health providers.

Below are some of the strengths identified in the 2022 Provider Satisfaction Survey:

- Overall Satisfaction with PHP's Customer Service call center
- Process of obtaining member information (eligibility, benefit coverage, co-pay amounts)
- Accuracy of claims processing, and timeliness of claims processing
- Resolution of claims payment problems or disputes
- Quality of written communications, policy bulletins, and manuals

We also identified opportunities for improvement, such as:

- Provider Relations ability to answer questions and resolve problems

We thank each respondent for taking the time to share their feedback with PHP. The 2023 Provider Satisfaction Survey will be administered in the third quarter of 2023. Please remember to complete your survey. Your feedback is important to us!

New Provider Appeals Timeframe and Form

PHP recently extended the time limit required to file an appeal from 90 to 180 calendar days from the date of an initial claim denial or adverse benefit decision to file a provider appeal. PHP also updated the provider appeal form to capture key details about your appeal.

PHP has also added the option for you to now email your completed provider appeal form directly to PHP. The updated form is available online at PHPMichigan.com/Providers/General-Forms-and-Information.

Make sure you are accessing the most up-to-date PHP information and resources, including forms. Previous versions of forms may be missing fields for required information, or contain submission instructions that are no longer correct, like old mailing addresses or fax numbers. Additionally, submitting forms without the required information, or sending forms to the wrong place can result in your request being delayed or not being processed.

PHP values your feedback as an essential part of our continuous improvement process, and we thank you for your continued compliance with our provider appeal process.

PHP Medicare Quick Reference Guide

Department	Contact information
Provider Services	For inquires such as claim status checks, member eligibility, benefit verification, or confirmation of referrals/prior authorization, login to the PHP Provider portal, MyPHP, at PHPMichigan.com/MyPHP, and follow the single sign in to PHP Medicare. **Or call PHP Medicare:** 844.529.3757 **Provider Services email address:** CustomerService@PHPMedicare.com **Fax:** 844.529.3759 **Provider correspondence/claims mailing address:** PHP Medicare P.O. Box 7119, Troy, MI 48007
Client/Provider Technical Support	**Assistance with technical questions relating to registration, login, or web application access** **Call:** 866.397.2812 Available from 8 a.m. to 7 p.m. **Technical Support email address:** CustomerSupport@Lumeris.com
Electronic Claims	**Change Healthcare (payor # 83276). Call:** 866.924.4634 Option 4, Option 1 ChangeHealthcare.com/Support/Customer-Resources/Enrollment-Services
Web/Provider portal	**Assistance with Member Eligibility, Claims and Referral Inquiry, Online Referral and Prior Authorization:** PHPMichigan.com/MyPHP, and follow the single sign in to PHP Medicare
Non-emergent Transportation Services	**Contracted provider is Medical Transportation Management (MTM). Members can call:** 877.930.1485 to schedule or MemberPortal.net Limited to 20 one-way trips. PHP Advantage Plus limited to 30 one-way trips.
Preventive Dental Care	**Contracted providers for Routine Dental Services can be found by calling Delta Dental:** 800.330.2732 | Fax: 517.381.5527 | DeltaDentalMI.com No referral is needed. Members can self-refer. **Claims mailing address:** P.O. Box 9230, Farmington Hills, MI 48333 or **Claims Delta Dental:** P.O. Box 9298 Farmington Hills, MI 48333
Routine Eye Care	**Contracted providers for Routine Eye Exams can be found by calling EyeMed** at 844.230.6498 No referral is needed. Member can self-refer. **Claims mailing address:** First American Administrators, Attn: OON Claims PO Box 8504 Mason, OH 45040
Behavioral Health Services	**Contracted providers for in/out-patient mental health/substance abuse services can be found by calling Mercy Managed Behavioral Health:** 833.729.4607 **Claims Questions:** Call our Provider Services number listed above.
Medical Services	**Assistance with prior authorization of procedures, benefit determination, notification** **Call:** PHP Medicare 844.529.3757 **Fax:** 855.229.2187 for Medical Requests Only **Fax:** 844.527.9402 for Inpatient Clinical Only
Pharmacy	**Pharmacy Prior Authorization for Part B Drugs Call:** 844.529.3757 or fax to the number on the forms located on the Provider Portal. **Pharmacy Prior Authorization for Part D Drugs:** Contact information is located on the forms available on the Provider Portal Pharmacy. **Pharmacy Prior Authorization email address:** Pharmacy@PHPMedicare.com

SilverSneakers	Complimentary fitness program/classes can be found by calling 888.423.4632 or visit the website at SilverSneakers.com No referral needed. Member can self-refer.
HealthHelp	**For Radiation Therapy, Advanced Imaging (CT, CTA, MRI, MRA, PET & Cardiac Nuclear), Medical Oncology, and Facility Based Sleep Studies, Contact HealthHelp: 800.652.4958** **Fax**: 800.695.4997 **Expedited fax**: 855.546.7092 **Go to the website** HealthHelp.com/PHPMedicare.com/PHPMedicare for specific codes requiring PA/Notification.
Over-the-counter Benefit	**Over-the-counter (OTC) medications and products can be ordered by the member:** **Online**: PHPMedicareOTC.com **Calling**: 855.299.5415 (TTY:711), or mailing the order form
Audiology-TruHearing	**For Hearings Aids, Fittings and Evaluations call: 844.554.6104**
Meal Benefit	**For additional information on meal benefit call:** 844.830.1602 (TTY 800.955.1339) **Online:** SunMeadow.com

Referrals are only required for out-of-network providers.

Prior Authorization/Notification is required for these services:

- All Inpatient Admissions (notification required within 1 business day)
- All admissions to SNF, acute rehab, and LTAC
- Non-emergency Ambulance Transfers, EXCEPT those between hospital and SNF inpatient
- Behavioral Health Inpatient, Intensive Outpatient, Partial Hospitalization, Electroconvulsive Therapy, TMS. Please contact Mercy Managed Behavioral Health for specific services/codes.
- Radiation Therapy, Advanced Imaging, Medical Oncology, Facility Based Sleep Studies.
- Please contact HealthHelp for specific services/codes.
- Please see Prior Authorization list posted on provider portal under “Forms and Resources” for additional services/items requiring prior authorization

Miscellaneous information:

- Laboratory: No referral or prior authorization required unless related to genetic testing. Select tests may be performed in the specialist office.
- Hospice: Any Medicare-approved agency can be used.
- Telehealth: Referral/ prior authorization rules that apply to in-person visits apply to virtual visits as well.

Physicians Health Plan

MAILING ADDRESS INFO
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Contact Us.

PHPMichigan.com

Department	Contact information
Customer Service • Verify a covered person's eligibility, benefits or to check claim status to report suspected member fraud and abuse • Obtain claims mailing address • Claims and EDI questions • Request a copy of our Preferred Drug List	517.364.8500 800.832.9186 (toll-free) 517.364.8411 (fax)
Medical Resource Management • Notification of procedures and services outlined in the Notification/Authorization Table • Request benefit determinations and clinical information • Obtain clinical decision-making criteria • Behavioral Health/Substnace Abuse Services, for information on Behavioral Health and/or Substance Abuse Services including Prior Authorizations, Case Management, Discharge Planning and referral assistance	517.364.8560 866.203.0618 (toll-free) 517.364.8409 (fax)
Network Services • Credentialing • Provider data: Report changes in practice demographic information • Provider/Practitioner education • Report suspected Provider/Practitioner Fraud and Abuse • Initiate electronic claims submission	517.364.8312 800.562.6197 (toll-free) 517.364.8412 (fax) **Report suspected fraud and abuse:** 866.PHPCOMP (866.747.2667) **Credentialing:** PHP.Credialing@phpmm.org **Data:** PHPProviderUpdates@phpmm.org **Provider Relations team:** PHPProviderRelations@phpmm.org
Quality Management Quality Improvement Programs, HEDIS, URAC, CAHPS	517.364.8408 (fax) PHPQualityDeparment@phpmm.org
Pharmacy Services • Request drug coverage • Fax medication prior authorization forms • Medication Therapy Management Program	517.364.8545 877.205.2300 (toll-free) 517.364.8413 (fax) Pharmacy@phpmm.org
Change Healthcare (CHC) When medical records are requested	Change Healthcare Attn: Pre-Pay 1849 West Drake Dr., StE 101A Tempe, AZ 85283 952.224.8650 949.234.7603 (fax) MedicalRecords@changehealthcare.com

Commercial plans

Where to send claims:

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

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

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

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

Medicare plans

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