Provider Connection

FIRST QUARTER 2019

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Physicians Health Plan

A health plan that works for you.

Working with PHP

General Training 101

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

Learning opportunities include a review of the Provider manual, checking eligibility and benefits, claim status, authorizations/approvals, and much more. Attendees should include management and all office staff.

April 18 | noon–1:30 p.m.

July 18 | 8:30–10 a.m.

Oct. 17 | noon–1:30 p.m.

Please email your RSVP at least one week prior to the event. All trainings take place at PHP, are free of charge, and include a light meal.

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

Accreditation news from PHP's Quality Department

PHP has achieved full accreditation in URAC's Health Plan accreditation for our Commercial/HMO population and URAC's Health Plan Health Insurance Marketplace accreditation for our exchange population. These accreditations are valid for a three-year cycle and expire in July of 2021.

The URAC accreditation process demonstrates a commitment to quality services and serves as a framework to improve business processes through benchmarking organizations against nationally recognized standards. "PHP should be commended for meeting strict quality standards," said URAC President and CEO Kylanne Green, "It is critically important for healthcare organizations to make a commitment to quality and accountability. URAC accreditation is a demonstration of that commitment."

Accreditation is just one way to support our mission of improving the health status of our Members by facilitating access to quality, compassionate, accessible and cost-effective health services through organized health delivery systems.

Important change to obtaining ACA Patient Rosters

This year, Physicians Health Plan (PHP), is continuing the Adult ACA Wellness Visit Incentive Program. To help your office identify if your member is part of our ACA membership, PHP has made some changes that make determining who is an ACA Member easier and more convenient! Patient rosters are currently available on the MyPHP Provider Portal for Primary Care Providers (PCP) for all PHP members. To access your PCP Eligibility Patient Roster, you must first make sure that you are registered with MyPHP for Providers. Once signed in, hover over Coverage & Benefits in the top tool bar and click PCP Eligibility Patient Roster from the dropdown menu. Select the Provider for whom you wish to obtain the PCP Eligibility Patient Roster and click Search. Your PCP Eligibility Patient Roster will populate. We have implemented a new feature identifying ACA Members so that you can better service these Members. The results can be printed or downloaded into an Excel format and sorted by ACA Members so that you can reach out to Members to schedule needed visits, such as annual wellness exams. The ACA Members carry the ACA indicator, see red rectangle below:

Name	Member ID	Group	ACA	Network	Date of Birth	Gender	Benefit Plan	Effective Date
		L0001925	ACA	PPO			PFH00501	01/01/2016
		L0001925	ACA	PPO			PFH00501	01/01/2016
		L0001699	ACA	PHP Exclusive Network			BNN00100	08/01/2016
		L0001699	ACA	PHP Exclusive Network			BNN00100	08/01/2016
		L0001637		PPO			DPW20501	01/01/2014
		L0001269		Sparrow Provider Network/SPN			DAS01601	06/27/2015
		L0001269		Sparrow Provider Network/SPN			DAS01601	06/07/2013
		L0001269		Sparrow Provider Network/SCN			DAS02701	09/01/2012
		L0001269		Sparrow Provider Network/SCN			DAS03001	05/01/2007
		L0001269		Sparrow Provider Network/SCN			DAS03001	05/01/2007

As a reminder, the Adult ACA Wellness Visit Program is available for adult ACA Members 18 years of age and older. To get credit for the $100 incentive, the appropriate CPT code of G0438 or G0439 must be submitted on the claim for the wellness visit. If you have any additional questions regarding the Adult ACA Wellness Visit Program, please contact your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

For additional assistance on how to access your PCP Eligibility Patient Roster, go to **PHPMichigan.com**, click on the Providers tab in the tool bar, then click on MyPHP Provider Portal. You'll find tutorials that explain many of the useful features of the site. You can find a tutorial on how to register and how to obtain your PCP Eligibility Patient Roster. If you have questions, please contact your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Pharmacy Department news and updates

First Quarter 2019

PHP's Prescription Drug List (PDL) is available online at **PHPMichigan.com/Providers**. Select "Forms" to find the current PDL.

Criteria for medications requiring prior authorization are also available online at **PHPMichigan.com/Providers** and then select "Pharmacy Services."

If you have any pharmacy questions, please call the Pharmacy Department at **517.364.8545** or email us at **PHPPharmacy@phpmm.org**.

Drug	New to Market	Effective Date
Zemdri (plazomicin for IV administration)	Prior Authorization required	10/24/18
Orilissa (elagolix tablet)	Tier 3, Prior Authorization required	10/24/18
Lokelma Pak (sodium zirconium cyclosilicate for suspension)	Tier 3, Prior Authorization required	10/24/18
Mektovi (binimetinib tablet)	Tier 3/4, Prior Authorization required	10/24/18
Braftovi (encorafenib capsule)	Tier 3/4, Prior Authorization required	10/24/18
Fulphila (biosimilar to Neulasta)	Tier 3/4, Prior Authorization required	10/24/18
Onpattro (patisiran sodium IV solution)	Prior Authorization required	10/24/18
Galafold (migalastat capsule)	Tier 3/4, Prior Authorization required	10/24/18
Epidiolex (cannabidiol oral solution)	Tier 3, Prior Authorization required	12/05/18
Xofluza (baloxavir marboxil tablet)	Tier 3, Quantity Limit of 2 tabs per 24 days	12/05/18
ZTlido (lidocaine patch 1.8% (36mg))	Tier 2	12/05/18
Xerava (eravacycline IV)	Prior Authorization required	12/05/18
Ajovy (fremanezumab-vfrm for SQ)	Tier 2 with Step Edit through 1 abortive agent and 1 preventative agent	12/05/18
Emgality (galcanezumab-gnlm for SQ)	Tier 2 with Step Edit through 1 abortive agent and 1 preventative agent	12/05/18
Pifeltro (doravirine tablet)	Tier 3	12/05/18
Delstrigo (doravirine/lamivudine/TDF tablet)	Tier 3	12/05/18
Nivestym (filgrastim -aafi SQ prefilled syringe)	Tier 2, Quantity Limit of 10 syringes per 24 days	12/05/18
Takhzyro (lanadelumab-flyo injection)	Tier 3/4, Prior Authorization required	12/05/18
Mulpleta (lusutrombopag tablet)	Tier 3/4, Prior Authorization required	12/05/18
Poteligeo (mogamulizumab-kpkc IV infusion)	Prior Authorization required	12/05/18
Azedra (iobenguane I 131 IV 15 MCI/ML (555MBQ/ML))	Exclude from formulary	12/05/18
Lumoxiti (moxetumomab pasudotox-tdfk IV)	Prior Authorization required	12/05/18

Drug	Formulary	Effective Date
Viagra	Generic Viagra (sildenafil) added back to formulary (Quantity Limit of 5 tabs per month)	01/01/19

Utilization Management news and updates

First Quarter 2019

A comprehensive list of procedures and services requiring prior authorization is available online. Visit **PHPMichigan.com/Providers** and select "Notification and Prior Approval."

If you have any authorization questions, please call the Customer Service Department at **517.364.8500** or **800.832.9168** between the hours of 8:30 a.m. and 5:30 p.m., Monday through Friday.

Reminder: Prior Authorization requests may be submitted via the Utilization Management fax at **517.364.8409** from 8 a.m. to 5 p.m., Monday through Friday.

Changes to Coverage for Services			
Code(s)	**Procedure or Service**	**Action**	**Implementation Date**
80305, 80306, 80307, G0480, G0481, G0659	BCP-78 Drug Testing in Pain Management and Substance Use Disorder Treatment	New policy – codes are covered with an annual limit	01/01/2019
99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236, G0378, G0379	BCP-04 Observation Care Services	New policy – codes are covered within policy guidelines	01/01/2019

Opioid maximum dosage limits

Tapering opioids for chronic pain

By Shelley Zhang

While many healthcare professionals are taught that there is no analgesic ceiling effect for opioids and therefore no maximum dose, overdose risk has been shown to increase in a dose-response manner.[1] In fact, the risk of death from overdose nearly doubles when increasing a dose from below 20 morphine milligram equivalents (MME) per day to above 50 MME/day.[1] One study estimates that 1 in 32 Patients receiving doses of 200 MME or higher dies of opioid-related causes.[1] In addition, clinical trial evidence has not been able to show improvement in function or pain control with dose escalation.[2] As the incidence rate of opioid overdose has quadrupled in the past 15 years, guidance is needed on appropriate opioid dosing and when to consider tapering or discontinuation.[1]

In the 2018 Final Call Letter published in April, the Centers for Medicare & Medicaid Services announced new measures to curb chronic overuse of opioids among beneficiaries prescribed high doses.[3] The rule states that all Medicare Part D sponsors will be expected to implement formulary-level safety edits for opioid prescriptions with doses > 90 MME/day. These safety alerts will be triggered at the point-of-sale at pharmacies and may be overridden by the Pharmacist once prescriber consultation is documented. Sponsors may choose to include prescriber and/or pharmacy count, add hard edits which may only be overridden by the sponsor, or set the threshold at 200 MME or more.[3] Many states and institutions have implemented similar dosage limits. For example, the Engrossed Substitute House Bill 1427 law enacted by Washington State Legislature in 2017 sets a mandatory consultation threshold for opioid prescriptions with doses >120mg MME for Patients who are not already maintained on a stable dose.[4]

In accordance with these findings, the CDC Guideline for Prescribing Opioids for Chronic Pain recommends: [1,2,5]

- Considering non-opioid medications and non-pharmacologic therapies (physical and behavioral modalities) for chronic non-cancer pain outside of palliative or end-of-life care.
- Prescribing the lowest effective dose and shortest duration needed with preference for immediate-release formulations.
- Avoiding doses of opioids >90 MME/day and carefully assessing evidence of individual benefits and risks when considering increasing doses beyond >50 MME/day.
- Co-prescribing naloxone for Patients on doses >50 MME/day, Patients who have a history of overdose or substance use disorder, or Patients on concurrent benzodiazepines, muscle relaxants, or hypnotics.
- Routinely evaluating safety and effectiveness of chronic opioid therapy, at least every 3 months for Patients on >90 MME/day. Consider using an assessment tool such as PEG-3 (See Appendix A).

Odds Ratios of Overdose Risk[2]

(relative to dose 1-19 MME/day)

Risk of Death	MME Per Day
1.3	20-49
1.9	50-99
2.0	100-199
2.9	≥200

Appendix A. Pain intensity, interference with enjoyment of life, and interference with general activity (PEG) 3- item tool for documenting pain and function.[5]

1. What number best describes your **pain on average** in the past week?

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your **enjoyment of life**?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your **general activity**?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

References

1. *Frieden TR, Houry D. Reducing the Risks of Relief – The CDC Opioid-Prescribing Guideline. N Engl J Med. 2016;37(4):1501-2*
2. *Dowell D, H. T. (2016). Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. MMWR Recomm Rep , 65 (No. RR-1), 1-49.*
3. *Centers for Medicare & Medicaid Services. 2019 Medicare Advantage and Part D Rate Announcement and Call Letter. Accessed at https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-rate-announcement-and-call-letter on October 2, 2018.*
4. *Engrossed Substitute HB 1427, Washington State Legislature. 2017. Accessed at http://apps2.leg.wa.gov/billsummary?BillNumber=1427&Year=2017&BillNumber=1427&Year=2017 on October 3, 2018.*
5. *Foundation Health Plan of Washington. Patients on Chronic Opioid Therapy for Chronic Non-Center Pain Safety Guideline. 2010. Accessed at https://wa.kaiserpermanente.org/static/pdf/public/guidelines/opioid.pdf on October 3, 2018.*

The truth about medication samples and copayment savings cards

- Giving Patients samples and coupon cards* for drugs can inadvertently increase the cost to the health plan which will potentially increase the Patient's premiums when their plan renews.
- Drugs for which samples are given tend to be higher cost, non-preferred drugs. Once the Patient becomes stable on the sample drug and tries to fill the prescription at the pharmacy, they may find that the drug requires Prior Authorization, which can potentially cause an interruption in therapy.
- Most copay assistance cards have fine print detailing the card's limitations. For example, they may only contribute a certain dollar amount per month or per year or only allow the card to be used once per lifetime. This may leave your Patient unable to afford their drug.

How can I help my Patients avoid these issues?

- Take advantage of ePrescribing. When ePrescribing, you are able to determine right away if the drug has any limitations or requires Prior Authorization. The system also suggests lower-cost alternatives, if applicable.
- Avoid giving drug samples until you know the drug is covered and is affordable for your Patient.
- Ensure that Patients understand the fine print on copay assistance cards
- Using the most cost-effective drug results in lower costs for your Patient as well as the Patient's health plan. Patients usually have a lower copayment for preferred drugs, and the overall cost savings may drive their premiums down.

** The IRS has indicated that the use of a pharmaceutical discount card that entitles a Member to receive healthcare discounts (including discounts on prescription drugs) will not affect the Member's eligibility to participate in an Health Savings Account (HSA), so long as the Member is responsible for paying all costs of coverage (taking any discount provided by the card into account) until his or her deductible is satisfied.*
(See IRS Notice 2004-50, Q/A-9)

Medical record documentation reminders

Documentation of health services rendered to Members is an important aspect of medical care. Claims submitted to Physicians Health Plan (PHP) must support the level of service billed and be accurately documented in the medical record. In addition, time-based codes must include the time spent performing the services. See below for some common errors found in medical record documentation:

Diagnosis coding

The diagnosis code does not identify the reason services were provided. PHP recommends that all diagnoses discussed or found at that specific visit be billed along with the corresponding CPT code. If a Provider is ruling out a condition, that condition is not the appropriate billing diagnosis. Until the condition can be determined by the Provider, the symptom is the appropriate billing diagnosis. To ensure proper claim processing, each diagnosis code billed must be coded to the highest specificity, using current ICD-10-CM codes.

History of Present Illness (HPI)

According to Centers for Medicare and Medicaid Services (CMS), only the Provider can perform and document the HPI portion of the Patient's history. Ancillary staff can document other parts of the history but not the HPI. It is not acceptable to have ancillary staff document the HPI and then have the Provider review the document later.

Who can perform the History of Present Illness (HPI) portion of the Patient's history?

- The history portion refers to the subjective information obtained by the Physician or ancillary staff. Although ancillary staff can perform the other parts of the history, that staff cannot perform the HPI. Only the Physician can perform the HPI.

If the Nurse takes the HPI, can the Physician then state, "HPI as above by the Nurse" or just "HPI as above in the documentation"?

- No. The Physician billing the service must document the HPI.

PHP routinely audits medical records to ensure compliance with all guidelines.

Please refer to your current CPT Manual, ICD-10-CM Manual and/or CMS 1995 and 1997 Documentation Guidelines on Evaluation and Management Services for any questions regarding documentation.

Regardless of the practitioner's specialty, PHP expects that all claims submitted for reimbursement are billed with the appropriate CPT and/or HCPCS codes representing the level of service provided and all services are accurately documented in the medical record. Failure to follow these practices could result in a reduction of claims payment.

Ensure your medical records vendor complies with your contract

Physicians Health Plan (PHP) completes claims audit/medical record reviews on both a pre-payment and post-payment basis. Post-payment audits include claims processed six months to one year prior to the audit/review date to identify billing trends and Provider billing outliers. However, this may be expanded as needed, based on the situation and findings. Providers receive written notification of a request for records from either PHP and/or the audit firm. Providers should submit all necessary documentation such as Patients' medical records, as requested, within fourteen (14) days or as specified in the letter to ensure a successful audit.

If your practice or facility utilizes the services of a medical records vendor, please make sure that the vendor is aware of the contractual parameters surrounding requesting, copying, and supplying medical records to PHP. Your participation agreement has specific stipulations on how medical records are to be delivered, copied, and stored. This also includes your responsibility to supply these records to PHP when requested and within specified timelines.

Claims payment may also be dependent on the timely submission of medical records to PHP or to Change Healthcare. Please discuss these concerns with your medical records vendor, as you are ultimately responsible for supplying these records to PHP. If you have any questions regarding medical records submission, please contact the Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Insufficient documentation denials

Why they occur

Insufficient documentation related denials may occur for the following reasons:

- Incomplete or unsupported progress notes (unsigned, undated, procedure not fully documented to support coding, partial notes, missing med logs, etc.).
- Unauthenticated medical records (missing supervising signature, missing attestation, electronic signature without EMR protocol or policy to support process).
- Missing or incomplete intent to order services or procedures (missing detailed written/signed order).

Written orders for equipment and supplies

A detailed written order for Durable Medical Equipment (DME) must include:

- Beneficiary name
- A description of the item that includes all items, options, or additional features that are separately billed and support the coding being billed. This may include brand name, model number, and/or HCPC code narrative.
  - For equipment - all options or accessories that will be separately billed or that will require additional coding. List each separately.
  - For supplies - all supplies that will be separately billed. List each separately and include frequency of use (if applicable) and quantity to be dispensed.
- Date of the order
- Physician/Practitioner signature

A supplier must have an order (meeting order requirements) from the treating Physician before dispensing DME items to beneficiary. A CMN may act as an order if it meets the detailed written order requirements and is signed and dated prior to dispensing the items.

Signatures

If the handwritten signature is illegible, include a signature log, and if electronic, the protocol should also be submitted.

Third-party documentation

Upon request for a review, it is the billing Provider's responsibility to obtain supporting documentation as needed from a referring Physician's office.

- For example, Physician order or notes to support medical necessity

The treating Physician, another clinician, Provider, or supplier should submit the requested documentation. However, because the Provider selected for review is the one whose payment is at risk, it is this Provider who is ultimately responsible for submitting, within the established timelines, the documentation requested.

Diagnosis codes "paint the whole picture"

Clinical documentation is critical for the Patient, the Physician, and Physicians Health Plan. As an organization, we are dependent upon the healthcare Provider to supply appropriate documentation to comply with CMS regulations around quality and coding specificity. You have probably heard the saying, "A picture is worth a thousand words." The same logic applies to ICD-10 coding. While you probably will not need a thousand ICD-10 codes to paint a complete picture of a Patient's diagnosis, there is a good chance you will need more than one. There are 12 spaces for diagnosis codes on a CMS-1500 form, and a UB04 has space for 41, so why not use more than one diagnosis when appropriate?

Your Patient population is identified with claims data. It is important to help define a true, accurate image of who you are treating. When selecting unspecified diagnoses, or not listing complications and co-morbidities, this fails to tell a Patient's clinical story and cannot reflect the severity of the Patient's condition. For example, when treating a Patient with an infection and their co-morbidities affect how you are treating, your treatment plan explains that information through the diagnosis codes you place on the claims.

Diagnosis codes tell the Patient's story, allow for accurate data collection, and establish medical necessity for services provided. As value-based payments become a reality, it is of the utmost importance that you "paint the whole picture."

Why did I receive a 1099 and what am I supposed to do with it?

Form 1099 is one of several IRS tax forms used in the United States to report various types of income other than wages, salaries and tips. An IRS 1099 is sent to taxpayers who received payments that were at least $600 or more for services provided during the prior tax year. Depending on the structure of your company or organization, you may receive several 1099s, one, or even none at all.

Your 1099 information should be included as directed by the IRS when you file your tax return. How and where this is reported on your tax return, however, will depend on how your organization is structured. Primarily, 1099s are for documentation to support your tax filing in the event of an audit. You should discuss any 1099s you receive with your tax specialist or visit **IRS.gov** for more details.

How to avoid receiving a B-Notice from Physicians Health Plan

A "B-Notice" is a notification that the taxpayer identification number (TIN) or name on file with a company does not match the Internal Revenue Service's (IRS) records. The IRS considers a TIN incorrect if either the name or number shown on an account does not match a name and number combination in their files or the files of the Social Security Administration (SSA).

You can avoid receiving a B-Notice by making sure PHP has an accurate and up-to-date W-9 on file for you. (Fax your updated W-9 to **517.364.8412**) The W-9 is an IRS form used to confirm your company's TIN. It is the information on your W-9 that we use to report the 1099-MISC to the IRS. If the business name and TIN are an invalid combination according to the IRS database, the IRS will notify us and require that we send you a B-Notice to obtain the correct information.

Health coverage basics

There are several types of health insurance policies and healthcare plans with many different features that are available to consumers in Michigan. Individual coverage can be purchased on your own, group health coverage can be obtained through an employer, or association coverage can be obtained through your membership in an organization or association. Additionally, there are government programs such as Medicare and Medicaid, which are available to those who qualify.

Health insurers provide health coverage through several different entity types. The most common are health insurance companies and health maintenance organizations (HMOs). The term, "health insurer" means any of these entity types. When specific differences occur for a given entity, we specify the type of health insurer.

Group Coverage

If an employer offers group health coverage to employees and dependents, the coverage must be made available to all eligible employees. In accordance with state and federal law, the employer is the master policyholder and the employees are certificate holders. The master policyholder negotiates the terms of the group policy with the health insurer. The master policyholder can reduce or change the benefits and coverage, increase your share of the premium cost, switch health insurers, or stop providing coverage entirely. However, if an employer provides health coverage, the contract must include certain minimum benefits required by Michigan law. If you lose group health coverage through your employer, you may have federal Consolidated Omnibus Budget Reconciliation Act (COBRA) rights or you may be eligible for a special enrollment period through the Health Insurance Marketplace to purchase an individual policy.

Many large employers provide health coverage for employees by creating self-funded health care plans. This means that the employer pays employees' health claims instead of going through a health insurer. Typically, employers contract with entities such as insurance companies and third-party administrators to administer the self-funded healthcare plan by paying health claims on behalf of the employer. The Department of Insurance and Financial Services (DIFS) does not have authority over self-funded healthcare plans created by employers; however, DIFS has authority over the administrators of such plans and, in some cases, DIFS handles external appeals for these plans. The United States Department of Labor has authority over self-funded healthcare plans.

Any health insurer may offer wellness coverage. Many employer group plans include wellness programs as an option. The health insurer may offer a reduction in premium, copayments, coinsurance, or deductibles, or a combination of these incentives, in exchange for employees' participation in any health behavior wellness, maintenance, or improvement program offered by the employer. The employer and health insurer must agree to certain indicators of employees' health status. The employer must then provide the health insurer with evidence of improvement or maintenance of the employees' health status and health behaviors under the program. Health insurers are not required to continue indefinitely any wellness programs or incentives associated with the program. See Michigan state law, MCL 500.3426.

Individual Coverage

If you do not have access to group health coverage and are not eligible for the Healthy Michigan Plan, Medicaid or Medicare, individual health coverage may be purchased through a licensed agent, directly from the health insurer, or through the Health Insurance Marketplace. For more information on how to shop for coverage, see Shopping for Health Coverage. You are the policyholder on an individual policy. Your policy can cover you and your eligible dependents.

Individual policies must include specific minimum healthcare benefits required by the Michigan Insurance Code and federal law. Individual plans can have varying copayments, coinsurance and deductibles including health plans with high deductibles that are used in conjunction with Health Savings Accounts. These deductibles are subject to limits set by the Internal Revenue Service.

Medicare

Medicare is a federal program providing health coverage for people age 65 or older, or under 65 with certain disabilities and any age with permanent kidney failure.

Medicaid

Medicaid is a federal program administered by the states currently providing health coverage to those meeting certain income requirements: pregnant women, people with disabilities, people in need of nursing home care, and others.

The Healthy Michigan Plan

Some Michigan residents may be eligible for the Healthy Michigan Plan. To be eligible for the Healthy Michigan Plan, you must be:

- Ages 19-64
- Not currently eligible for Medicaid
- Not eligible for or enrolled in Medicare
- Not pregnant when applying for the Healthy Michigan Plan
- Earning up to 133% of the federal poverty level
  - The federal poverty level is adjusted annually.
  - In 2018, 133% of the poverty level for an individual was $16,146 or $33,383 for a family of four.
- A resident of Michigan

Student Health Plans

Student health plans are often purchased by students when coverage from parents is not available or is unaffordable. As with employer group coverage, the higher learning institution chooses the plan and benefits, with no individual options for students. The benefits covered by these student health plans, as well as how they are regulated, vary widely. Under the Affordable Care Act (ACA), student health plans must eliminate lifetime limits, can no longer drop coverage when an enrollee gets sick or because of an unintentional mistake on an application, cannot deny or exclude coverage for students because of a pre-existing condition, and must provide coverage for preventive services.

Documentation found at Michigan.gov/DIFS.

FCA policy summary

Requirement for Providers to maintain and disseminate written fraud & abuse and false claims act policies

All Providers that participate with federal programs such as Medicaid or Medicare have a responsibility to detect and prevent fraud and abuse and to understand and comply with the Federal False Claims Act. Additionally, the Michigan Department of Health and Human Services (MDHHS) and Section 1902(a) (68) (A) of the Social Security Act* requires that Providers who receive $5 million or more in Medicaid funds annually must maintain and disseminate written policies to their employees that include:

- Methods of identifying and detecting fraud, waste and abuse by employees, Providers, and Members
- A process to guard against (prevent) fraud, waste and abuse committed by employees, Providers and Members
- Detailed information about the Federal False Claims Act and the Michigan Medicaid False Claims Act and other provisions named in Section 1902(a)(68)(A) of the Social Security Act*
- Rights of employees to be protected as whistleblowers

Under Section 6032 of the Deficit Reduction Act of 2005, any employer who receives more than $5 million per year in Medicaid payments is required to provide information to its employees about the Federal False Claims Act, any applicable state False Claims Acts, the rights of employees to be protected as whistleblowers, and the employer's policies and procedures for detecting and preventing fraud, waste and abuse. This information must be provided to the employees through written policies and included in the employee handbook (if one exists).

**Section 1902(a)(68)(A) of the Social Security Act: Provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall— (A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal healthcare programs (as defined in section 1128B(f))*

Summary of the Federal False Claims Act

The Federal False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare or Medicaid program. The act establishes liability for any person who knowingly submits or causes to be submitted a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" is defined to mean a person who:

- Has actual knowledge of falsity of information in a claim
- Acts in deliberate ignorance of the truth or falsity of the information in a claim or
- Acts in reckless disregard of the truth or falsity of the information in a claim

The act does not require proof of a specific intent to defraud the U.S. government. Instead, healthcare Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government or its contractors, such as knowingly making false statements, falsifying records, double-billing for supplies or services, submitting bills for services never performed or supplies never furnished, or otherwise causing a false claim to be submitted.

For purposes of the Federal False Claims Act, a "claim" includes any request or demand for money that is submitted to the U.S. government or its contractors.

Healthcare Providers and suppliers who violate the False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted. If a Provider or supplier is convicted of a False Claims Act violation, the OIG may seek to exclude the Provider or supplier from participation in federal healthcare programs.

To encourage individuals to come forward and report misconduct involving false claims, the False Claims Act includes a "qui tam" or whistleblower provision. This provision essentially allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. government, and the individual may be eligible for a financial award.

Summary of the Michigan False Claims Act

The Deficit Reduction Act of 2005 offered an incentive to states to enact their own False Claims Act requirements. Michigan has enacted both the Medicaid False Claim Act (MCL §§400.601 - 400.615) and the Health Care False Claim Act (MCL §§752.1001 - 752.1011). Persons who violate either the Medicaid False Claim Act or the Health Care False Claim Act are guilty of a felony punishable by imprisonment, a monetary fine or both. Under the State False Claim Acts, an employer is prohibited from discharging, demoting, suspending, threatening, harassing or discriminating against an employee because the employee initiates, assists or participates in an investigation under these Acts.

PHP's compliance plan and policies

Physicians Health Plan (PHP), through its compliance plan, policies and actions, is committed to the highest standards of ethical behavior, the payment of accurate claims to all Providers, and adhering to mandates by federally-funded payers such as Medicaid.

PHP has an established Compliance Plan that includes policies to detect and prevent fraud, waste and abuse. No Provider is exempt from review of fraud, waste, and abuse activities. Claims that violate developed edits or fraud, waste and abuse standards will result at a minimum in a reduction of payment and at a maximum, termination of your participation agreement; these are independent of any actions that the state or federal Government may take. This Plan helps to ensure appropriate claims are submitted to government programs such as Medicaid.

PHP has an established Billing Integrity Program, which is a systematic method to audit and review Provider records to detect Provider billing fraud, waste and abuse. Additionally, PHP utilizes Code Edit Compliance software hosted by Change HealthCare. This software applies nationally recognized coding standards to validate correct coding initiatives and identify claims where these standards have not been applied. Change HealthCare has developed edits for both facility and professional claims. These claim edits are based on specific criteria that include: CPT codes, HCPCS codes, ICD-10 codes and place of service codes.

PHP has established expectations related to acceptable business practices for Providers of healthcare services and their associates. These expectations have been communicated in the PHP Provider Manual.

It has always been a requirement that claims submitted for payment represent the services provided, and that documentation is complete, accurate and timely.

Examples of false claims include: billing for supplies or services not rendered, double billing resulting in duplicate payment, up-coding claims, miscoding claims to allow for billing services not covered, excluding diagnoses that could impact claim payment, etc.

How to report suspicious or fraudulent actions

Reporting to PHP

If you have any knowledge of, or suspicion that, someone within your practice is involved in fraudulent actions, you may report this to PHP by any of the following methods:

- Call the Sparrow Health System Compliance Hotline: **517.267.9990**;
- Send a letter to: Physicians Health Plan, PO Box 30377, Lansing, MI 48909-7877;
- Contact the PHP Compliance Department at **800.562.6197**; or
- Email PHP Compliance Directly at: **PHPCompliance@phpmm.org**.

All reports are anonymous and confidential.

Reporting Medicaid fraud to the State of Michigan

If you have any knowledge of, or suspicion that, someone within your practice is involved in fraudulent actions involving Medicaid claims or services, you may report this directly to the Michigan Department of Health and Human Services (MDHHS) or Inspector General Administration Provider Enforcement Bureau (IGA-PEB) at the following:

In Writing:
Inspector General Administration
Provider Enforcement Bureau
PO Box 30062
Lansing, MI 48909

Online Complaint Form:
Michigan.gov/Fraud

By Phone:
855.MI.FRAUD (643.7283)

All reports can remain anonymous and confidential. You can report directly to the Michigan IGA-PEB before or without reporting to PHP.

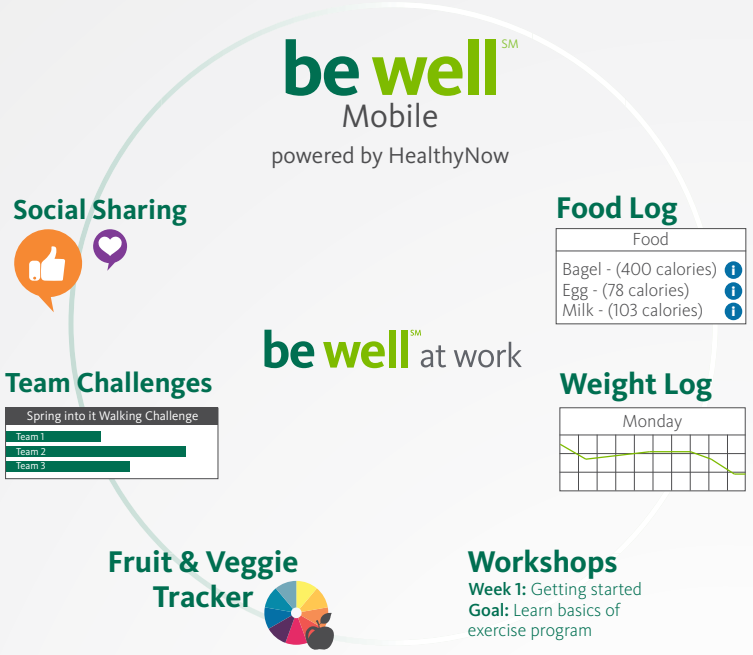
be well℠

PHP is pleased to announce the be well℠ at work Health Portal.

It's an innovative tool that helps you easily plan fitness, dietary and health goals to achieve healthy lifestyles via an extensive array of interactive features.

Key features of the portal include:

- Health Assessment
- Individualized meal plans and food logs
- Physical activity tracker
- Wellness workshops
- Personalized progress reports
- Corporate challenges
- Smartphone mobile access and Apps



To register for your free account:

- Go to **PHPMichigan.com/MyPHP**
- Click "MyPHP Member Portal"
- Log in and click "Be Well"

Physicians Health Plan


14:22
Heart Rate
BPM
82
93 BPM, 5m ago
Activity
563
CAL
1916
STEPS
2,01
Km

Physicians Health Plan

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

Contact us

Department	Contact Purpose	Contact Number	Email Address
Medical Resource Management	» Notification of procedures and services outlined in the Notification/Authorization Table » To request benefit determinations and clinical information » To obtain clinical decision-making criteria » Behavioral Health/Substance Use Disorders Services, for information on mental health and/or substance use disorders 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 - report changes in practice demographic information » Coding » Provider/Practitioner education » To report suspected Provider/Practitioner fraud and abuse » EDI claims questions » Initiate electronic claims submission	517.364.8312 800.562.6197 (toll free) 517.364.8412 (fax)	**Credentialing** PHP.Credentialing@phpmm.org **Provider Relations Team** PHPProviderRelations@phpmm.org
Quality Management	» Quality Improvement programs » HEDIS » CAHPS » URAC	517.364.8000 877.803.2551 (toll free) 517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org
Customer Service	» To verify a covered person's eligibility, benefits, or to check claim status » To report suspected Member fraud and abuse » To obtain claims mailing address	517.364.8500 800.832.9186 (toll free) 517.364.8411 (fax)	
Pharmacy Services	» Request a copy of our Preferred Drug List » Request drug coverage » Fax medication prior authorization forms » Medication Therapy Management	517.364.8545 877.205.2300 (toll free) 517.364.8413 (fax)	**Pharmacy** PHPPharmacy@phpmm.org
Change Healthcare (TC3)	» When medical records are requested	**Mail To:** Change Healthcare 5755 Wayzata Blvd, St. Louis Park, MN 55416 952.949.3713 949.234.7603 (fax)	MedicalRecords@changehealthcare.com