

High Deductible Health Plans

A High Deductible Health Plan (HDHP) is a coverage option that generally doesn't start paying for enrollees' healthcare expenses until a deductible threshold is met (usually a several thousand dollar deductible). Benefit guidelines for HDHPs are different than traditional benefit plan designs. The basic coverage highlights of HDHPs are:

- **HDHPs have higher annual deductibles** and out-of-pocket (OOP) limits than most traditional plans.
For calendar year 2016, the OOP maximum limits will be:
\$6,550 for self-only coverage
\$13,100 for family coverage
There is no change to the HDHP minimum deductible levels for calendar year 2016:
\$1,300 for self-only coverage
\$2,600 for family coverage
- **Preventive services coverage** - Many preventive services are covered 100 percent before annual deductible is met. There is no coverage for preventive services out of network.
- **Coinsurance** - After the annual deductible limit is reached, the member pays a percentage of the costs for both medical services and prescription drugs.
- **Specified out-of-pocket maximum** - The plan has a built-in cap on annual healthcare expenses; the deductible applies to the maximum. Deductibles, coinsurance and prescription copays all apply to the out-of-pocket (OOP) maximum. The family deductible and out-of-pocket (OOP) maximum are nonembedded, meaning no individual in the family has satisfied the deductible or OOP maximum until the entire family amount has been satisfied.
- **Integrated deductible** - Since health plan and pharmacy benefits share the same deductible, prescription cost helps meet the deductible and out-of-pocket maximum faster. The HDHP has its own list of covered drugs. There are separate accumulators for in-network and out-of-network deductibles and out-of-pocket maximums.
- **Lower premiums** - High Deductible Health Plans usually have lower premiums than other kinds of health plans.

Deductibles, coinsurance percentages, and out-of-pocket maximums vary. To help members pay for medical expenses until their deductible is met, employers can set up a health savings account (HSA) for employees. Employers, employees or both can contribute to the HSA.

The annual Health Savings Account (HSA) contribution limitations for calendar year 2016 were also included in the guidance released on May 4:

- \$3,350 annual contribution limit for self-only coverage
- \$6,750 annual contribution limit for family coverage

If you would like to learn more about HDHPs please contact your Provider Relations Coordinator.

PHP Holiday Observation

PHP will be closed for observation of the upcoming holidays on the following days:

- * November 26, 2015 & November 27, 2015
- * December 24, 2015 & December 25, 2015
- * January 1, 2016

If you have an issue that requires immediate assistance, our answering service will be available to assist you.

Enclosures

- PHP Notification/Prior Authorization/Prior Approval Table-All Products Effective November 1, 2015
- Continuous Glucose Monitors Policy
- DME Request Form
- Home Health Care Request form
- Outpatient Request Form
- Out of Network Request

Facet injections Updates

Effective 11/1/15 diagnostic injections up to the first 3 dates of service per calendar year are covered without prior notification. Diagnostic injections greater than 3 dates of service per calendar year & all neurolysis procedures require prior authorization. Please call the Medical Resource Management Department with any questions at 517.364.8560.

Please contact a Provider Relations Coordinator if you have any questions about the details or articles in this publication.

We welcome your comments and article ideas for future publications.

This Update is Produced By:

PHP, Network Services Department
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Visit our website at: www.phpmichigan.com

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Physicians Health Plan

Fourth Quarter 2015
Provider Connection



Physicians Health Plan Achieves Phase II Core Certification!

Physicians Health Plan (PHP) is part of an initiative to reduce unnecessary and costly health care administrative processes, making health care a more efficient and responsive experience for Patients and Caregivers. PHP recently earned its Council for Affordable Quality Healthcare (CAQH®) Committee on Operating Rules for Information Exchange (CORE®) Phase 2 Endorser Seal, demonstrating its commitment to streamlining electronic health care administrative data exchange.

"PHP reached a huge milestone on Tuesday, Nov. 3, when it met the challenging requirements for this certification," said PHP President and CEO Dennis Reese. "By processing real-time eligibility and claim status electronically, PHP will benefit from reduced operating costs and increased provider satisfaction."

CAQH, a nonprofit alliance of health plans and trade associations, launched CORE to improve operations between health plans and providers, and enhance provider access to administrative information.

To date, the voluntary industry-wide initiative has brought together more than 100 health care industry stakeholders – covering more than 130 million people, or more than 75 percent of the commercially insured plus Medicare and state-based Medicaid beneficiaries– to make electronic administrative data communications seamless, streamlined and predictable, regardless of the technology. In many cases the CORE rules eliminate the need for practice staff phone calls. "The CORE rules represent a cutting-edge approach to improving electronic communication between providers and payer organizations," said Robin J. Thomashauer, CAQH executive director. "By becoming a CORE Endorser, PHP is demonstrating its support for an initiative that is reducing unnecessary health care administrative burden, and helping U.S. health care become more efficient and responsive to patient concerns."

About CAQH: CAQH serves as a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers. CAQH solutions help promote quality interactions between plans, providers and other stakeholders, reduce costs and frustrations associated with healthcare administration and facilitates administrative healthcare information exchange. Visit CAQH.org for more information.

Begin submitting Electronic transactions Today!

To get started with submitting your electronic eligibility (270/271) and claims status (276/277) transactions to PHP, simply contact your Provider Relations Coordinator at 517.364.8312.

New Medication Management Therapy Program Saving Lives, Improving Patient Health

Physicians Health Plan is pleased to announce the launch of its newest service to help improve patient care. Medication Therapy Management is now available free of charge to all PHP patients. Medication Therapy Management (MTM) is an innovative pharmacist-directed program to help patients understand and manage their medication regimen and to assist prescribers in avoiding potential medication-related problems. This program is especially helpful for patients transitioning home after leaving the hospital or those with chronic illnesses that require multiple medications.

Participation is voluntary and the patient may choose to take advantage of MTM as little or as often as they like. MTM appointments are conducted in person at the Medical Arts Building or via phone. The patient will not be charged a copay or fee of any sort. MTM services are 100 percent funded by PHP to help improve patients' overall health.



Joy Wahawisan, Pharm. D. BCPS

Joy Wahawisan, Pharm. D., BCPS, launched the program in July at a Sparrow Brunch with a Doctor event, "10 Tips and Tricks to Get the Most out of Your Medications." The goal was to educate patients in the proper use and interactions of prescription and over-the-counter medications & supplements.

Once enrolled, patients regularly meet one-on-one with a Pharmacist to evaluate all of their medications for efficacy, side effects, compliance, and other drug therapy issues.

If you think your patient would benefit from MTM or would like brochures please contact (or refer the patient to) Haley in the PHP Pharmacy Department at 517.364.8376 to set up an appointment.

How will enrollment in the MTM program benefit your patient?

- ⇒ All prescriptions, over-the-counter and herbal medications will be reviewed by a clinical pharmacist to evaluate effectiveness, side effects, therapy duplications, drug interactions, and under/over dosing.
- ⇒ Private, personal communications with a clinical pharmacist helps patients better understand their drug therapy and can help prevent and manage side effects and drug interactions.
- ⇒ Appointments are conducted at the patient's own pace. They will be encouraged to ask questions and discuss their medication concerns with the pharmacist to help them better understand their medications and the role they play in their overall health.

It's Not Too Late For A Flu Shot!

The timing of influenza season is often unpredictable. Flu outbreaks can occur as early as October and continue until as late as May. A flu shot is the safest, most effective way to protect our region against the flu. Please protect yourself by giving the flu vaccine today. PHP members, with a PHP Pharmacy benefit, can receive at no charge from In-Network Pharmacy the Injectable Flu Vaccine, Pneumonia Vaccine and/or the Shingles Vaccine. The Pharmacy must be able to administer the medication on-site. Pharmacies will be reimbursed for the vaccine and the administration fee.

*Shingles Vaccine is only covered for members that are 50 years of age and older

Prescription Updates!

Information regarding Physicians Health Plan's formulary and prescription drug criteria is now easier to access! PHP's Provider website has been updated adding many new documents, making it more user friendly. Updates include:

- Provider & Member Prescription Drug Lists.
- Prior authorization criteria - The website now features a list of the drugs that have criteria used during the Prior Authorization Request process. Clicking on the drug name will open a document that displays the information we require for a review, as well as information regarding authorization renewals.
- The Medicaid Carve-Out list - A list of the drugs that are "carved out" and paid for by the state. Prior Authorization Requests for drugs on this list must be submitted directly to MDCH.
- An easier to read Medication Prior Authorization form
- PHP's Notification Table - An easy to read table that lists many of the drugs and procedures requiring Authorization.
- Links to appeals forms.
- Links to forms for specialty pharmacies such as Accredo and Walgreen's Specialty Pharmacy.

Visit the PHP Provider website at :
[http:// www.phpmichigan.com/Providers](http://www.phpmichigan.com/Providers)

Prior Authorization Change for Continuous Glucose Monitoring (CGM)

Effective January 1, 2016, PHP is implementing a new Continuous Glucose Monitor (CGM) Policy for prior authorization of monitors and supplies. To ensure a seamless transition for members, Please submit for the following information 30 days prior to the end of the members current authorization period:

- A prescription and attestation from the ordering provider who will be managing the CGM's
- A copy of the diabetic treatment plan and/or progress notes
- Frequency of blood sugars tested with a glucometer
- Date the glucometer was received
- HgbA1c results within the last 3 months
- Type of insulin pump, if applicable
- Date of onset for Type 1 Diabetes

Fax the needed information to the PHP Medical Resource Management Department at: 517.364.8409 or complete the prior authorization request form available on our website at www.phpmichigan.com. A copy of the policy is enclosed for your reference.

PHP's Prescription Drug List for all products is available in electronic formats. All Prescription Drug Lists can be accessed at www.phpmichigan.com by clicking on *Providers* and then selecting *General Forms and Information*. Hardcopy lists are available upon request by contacting PHP's Customer Service at 1.800.832.9186.

To report any suspected fraud or abuse by either a PHP member or provider, please call 517.267.9990 and press 1 to reach PHP's Compliance Department.

Provider Satisfaction Survey 2015

PHP would like to thank the providers that were able to send back our annual provider satisfaction survey. The feedback we receive is used to develop enhancements to existing programs, improve processes and improve our services to you. Your feedback will ensure that we continue to perform in a collaborative partnership. PHP Network Services encourages you to take a few minutes to let us know how we are doing, and if you ever have a concern or a question please contact us directly at 517.364.8312.

Reminder:

As part of PHP's routine review of claims processing, systematic processes are put in place to capture items paid or processed resulting in an overpayment. If it is determined that overpayments have been made as a result of these audits, PHP will deduct the amount of overpayments from future claim payments.

Outpatient Rehabilitation Request Form

Instructions: All requests must be accompanied by a copy of the physician order/script, initial evaluation, and assessment of progress towards goal. Please fax this form and relevant chart notes to 517.364.8409.

Coverage requests for dates of service prior to Oct 1, 2015 must utilize ICD-9 codes. Dates of service on or after Oct 1, 2015 must utilize ICD-10 codes.

Patient Information	Prescriber Information
Today's date:	Provider name:
Member name:	Office phone:
Member's PHP ID#:	Office fax:
Date of birth:	Office address: <i>(include city, state, zip)</i>
Patient's phone number:	Office contact:

Treatment/Request Information	
ICD 9/10 Diagnosis code:	Date of Initial Evaluation:
Visit type: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> Pulmonary Rehab <input type="checkbox"/> Cardiac Rehab	Number of Visits Requested:
Starting date of service:	Ending date of service:
Number of visits already provided for this diagnosis/episode:	PHP authorization number (if this request is an extension of service):

Treating Facility Information	
Facility name:	Contact person:
Phone number:	Fax number:
Facility address:	

OUTCOME (PHP use only)	
Review determination: <input type="checkbox"/> Approved as requested <input type="checkbox"/> Approved with changes Authorization number: _____	
Visit type: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> Pulmonary Rehab <input type="checkbox"/> Cardiac Rehab	
Number of therapy visits approved: _____ Dates of service From: _____ To: _____	
PHP Reviewer Name: _____ Date: _____	



Medical Prior Authorization and/or Out of Network Request Form

Instructions: Please fill out this form completely and fax to 517.364.8409.

Documentation that must be submitted with the request includes:

- (1) Clinical documentation that supports the need for the service(s)
- (2) Clinical documentation that supports the need for the service(s) to be performed out-of-network
- (3) Consult report from the in-network specialist who evaluated the member for the requested service
- (4) Any other pertinent information for the review of this request.

Coverage requests for dates of service prior to Oct 1, 2015 must utilize ICD-9 codes. Dates of service on or after Oct 1, 2015 must utilize ICD-10 codes.

Patient Information		Referring Prescriber Information	
Today's date:	Referring Provider name:		
Member name:	Office phone:	Fax:	
Member's PHP ID#:	Office contact:		
Date of birth:	Patient's Primary Physician:		
Out of Network Provider/Facility Information (if applicable)			
Out of Network Provider name:		Specialty:	
Phone #:		Fax #:	
Address: <i>(include city, state, zip)</i>		Out of network contact person:	
If the request is a procedure , and will be performed at a facility :			
Facility name:		Facility contact person:	
Phone:		Fax:	
Address: <i>(include city, state, zip)</i>			
Was the member evaluated by an in-network specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are the requested services available in the network? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Services Requested			
ICD 9/10 Diagnosis code:		CPT Procedure code (s):	
<input type="checkbox"/> Initial Request <input type="checkbox"/> Extension Request <input type="checkbox"/> Non-urgent service <input type="checkbox"/> Clinically urgent service <input type="checkbox"/> Retroactive service			
<input type="checkbox"/> DOS not scheduled yet <input type="checkbox"/> DOS scheduled on: _____ <input type="checkbox"/> Retrospective DOS: _____			Number of visits:
Service location: <input type="checkbox"/> Office <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Home			

Policy Subject: Continuous Glucose Monitors
Policy Number: MRMBD 30
Policy Type: Medical Pharmacy

Responsible Dept: Medical Resource Management

Product (check all that apply)

- Physician Health Plan (Group HMO/POS)**
- PHP Insurance Company (PPO)**
- PHP Service Company (ASO)**
- Sparrow PHP (Medicaid/ Healthy MI/ MICHild)**
- Individual HMO/POS**

Effective Date: January 1, 2016
Revision Date: September 2015
Approval Date: October 14, 2015
Next Review Date: October 2016
Approved By:
Executive Medical Director

Peter Graham, M.D.

**Quality Improvement/Medical Resource
Management Committee**

Peter Graham, M.D.

Policy Statement:

Physicians Health Plan (PHP) will cover a continuous glucose monitor and supplies when established criteria is met and is supported by clinical evidence, national standards or guidelines utilizing the following clinical determination guidelines. Continuous glucose monitors and supplies require prior authorization.

Product Application:

With respect to Medicaid enrollees, this policy applies unless Michigan Department of Health and Human Services (MDHHS) guidelines contain different requirements.

For self-insured plans, consult individual plan sponsor benefit documents for specific information. If there is a discrepancy between a utilization management policy and a self-insured benefit plan, the provision of the benefit plan governs.

Experimental, Investigational or Unproven Services are exclusions in the member's coverage document.

General Background:

A proposed adjunct to intermittent self-monitoring blood glucose (SMBG) is continuous glucose monitoring (CGM). CGM devices provide ongoing, real-time monitoring and recording of glucose levels by measurement of interstitial fluid which generally lags from three (3) to 20 minutes behind finger-stick values. Therefore, CGM is only to be used with finger-stick blood glucose monitoring. The continuous glucose monitoring system (CGMS) consists of a monitor, disposable sensors, a transmitter and receiver. Some monitors provide real-time information, while others require that data be downloaded and reviewed retrospectively. Depending on the device, a sensor can continuously measure glucose for 3 to 7 days, providing real-time data every 1 to 10 minutes.

The Food and Drug Administration (FDA) approved indications for CGMS are for continuous or periodic monitoring of glucose levels in the fluid under the skin, in adults, age 18 and over, and in children and adolescents, age 7 to 17, with diabetes mellitus, for the purpose of improving diabetes management. Values are not intended to be used directly for making therapy adjustments, but rather to provide an indication of when a fingerstick may be required. All therapy adjustments should be based on measurements obtained using a home blood glucose monitor. The FDA has not yet been approved as a stand-alone device for monitoring blood glucose levels and requires calibration with SMBG.

Clinical Determination Guidelines:

- A. PHP considers ≤ 6 sessions per 12-month period of short-term (up to 72 hours) diagnostic use of continuous glucose monitoring devices medically necessary for persons when ALL of the following are met:
 1. Diagnosis of Type 1 diabetes mellitus
 2. Age 8 years or older
 3. Intensive insulin regimen (3 or more insulin injections per day, or use of a continuous subcutaneous insulin infusion pump)

4. Optimal glycemic control has not been achieved as evidenced by an A1C greater than 7% within 90 days prior to the request.
5. Patient is adherent, motivated, knowledgeable, and is monitoring blood glucose three (3) or more times per day as evidenced by blood glucose test results entered into a documentation log
6. Documented hypoglycemic unawareness, hypoglycemic seizures, or nocturnal hypoglycemia
- B. For a newly prescribed monitor, both of the following criteria must also be met:
 1. Attestation the ordering provider will be managing the CGMS, **and**
 2. Member to meet with a diabetes specialist or certified diabetes educator within 6 months prior to receiving the new CGMS device
- C. For a replacement monitor, both of the following must be met:
 1. Attestation that the ordering provider will be managing the CGMS, **and**
 2. Member must meet with a participating specialist or certified diabetes educator for diabetes self-management education if:
 - a. A1C is greater than 7% within the previous 90 days prior to request
 - b. Recurrent hypoglycemia
 - c. Diabetes related ER or inpatient admission in the 12 months prior to receiving a replacement CGMS device
 3. Consult member's benefit document for coverage of DME replacement
- D. When approved for diagnostic use of ≤ 6 short-term continuous glucose monitoring periods within a 12-month period, supplies approved would be:
 1. Continuous glucose monitor x1
 2. Sensors x1 box/12 months
 3. Transmitter x1/6 months
 4. Receiver x1/365 days
- E. For use in pregnancy, use of a CGMS is at the discretion of the maternal medicine specialist. For continued use after pregnancy, criteria listed above must be met.

CPT or HCPCS Codes Associated with Services:	
A9275*	Home glucose disposable monitor, includes test strips
A9276*	Sensor invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply
A9277*	Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278*	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
*Not covered for Medicare or Medicaid	

ICD – 9 Codes Associated with Services: (for dates of service on or before September 30, 2015)	
249.00 – 249.91	Secondary diabetes
250.00 – 250.93	Diabetes mellitus
648.00 – 648.04	Maternal diabetes mellitus
648.80 – 648.84	Abnormal maternal glucose tolerance

ICD – 10 Codes Associated with Services: (for dates of service on or after October 1, 2015)	
E08.00 – E08.9	Diabetes mellitus due to underlying condition
E09.00 – E09.9	Drug or chemical induced diabetes mellitus
E10.10 – E10.9	Type diabetes mellitus
E11.00 – E11.9	Type 2 diabetes mellitus
E13.00 – E13.9	Other specified diabetes mellitus
O24.011 – O24.93	Diabetes mellitus in pregnancy, childbirth, and puerperium
O99.810 – O99.815	Abnormal glucose complicating pregnancy, childbirth and the puerperium

Terms Associated with Diabetes mellitus

A1C – a blood test that measures average blood glucose over the past 2 to 3 months and is the best way to measure overall glucose control. It should be measured 2 to 4 times a year with the goal of less than 7%.

Basal insulin – the insulin that controls blood glucose levels between meals and overnight. It controls glucose in the fasting state.

Beta cells – cells that produce insulin. They are located within the islets of Langerhans in the pancreas.

Blood glucose – a type of sugar that is created when the carbohydrate that one eats is broken down in the body. During digestion, glucose passes through the wall of the intestine into the bloodstream to the liver and eventually into the general circulation. From there glucose can then enter individual cells or tissue throughout the body to be used for fuel and provide energy.

Blood glucose - A blood glucose test measures the amount of a type of sugar, called glucose, in your blood. Glucose comes from carbohydrate foods. It is the main source of energy used by the body.

Carbohydrate – the main source of fuel for the body. Carbohydrates include starches and sugars and are found in bread, pasta, fruits, vegetables, milk, and sweets. Carbs are broken down into a sugar called glucose.

Dawn phenomenon – a rise in blood glucose levels that occurs in the early morning hours.

Gastroparesis – a condition in which neuropathy affects the nerves controlling the digestive tract and causes difficulty processing or disposing of food. It can cause nausea, vomiting, bloating or diarrhea.

Glucose tolerance test – a blood test done every hour or at the 2-hour point after drinking a concentrated sugar liquid. This is one test used to diagnosis diabetes. If at 2 hours, the blood glucose rises to over 200 mg/dl you have diabetes.

Hyperglycemia – blood glucose is generally considered “high” when it is 160 mg/dl or above the individual’s blood glucose target.

Hypoglycemia – blood glucose that is below 80 mg/dl or without symptoms or below 90 mg/dl with symptoms.

Intermediate-acting insulin – a type of insulin that begins to work to lower blood glucose within 1 to 4 hours with a peak action of 4 to 15 hours after injection. These include NPH and lente.

Interstitial fluid glucose – a thin layer of fluid which surrounds the body’s cells. Interstitial fluid glucose measurements lag behind blood glucose monitoring by 10-25 minutes. The intent of interstitial glucose monitoring is to assist in detection of trends or patterns in glucose levels.

Long-acting peaking – a type of insulin that begins to work 4 to 6 hours after injection with a peak action of 8 to 30 hours and lasts for 24-36 hours. This includes ultralente.

Long-acting peakless – a type of basal insulin that begins working within 1-2 hours after injection and lasts for 24 hours. This includes glargine.

Short-acting insulin – a type of insulin that begins working within 30 to 60 minutes and peaks 1 to 5 hours after injection. The common form of short-acting insulin is “regular.”

References and Resources:

Aetna Clinical Policy Bulletin 0070: Diabetes Tests, Programs and Supplies, July 17, 2015.

Hayes, Inc. Medical Technology Directory, Continuous Glucose Monitoring Systems, August 13, 2015.

MCG Ambulatory care 19th Edition; Continuous Glucose Monitoring ACG: A-0126, January 29, 2015.

Priority Health Medical Policy No 91466-R6, Continuous Glucose Monitoring. Last review date May 2015.

Approved by:	
	
Peter Graham, MD – Executive Medical Director Chairman of Quality Improvement/Medical Resource Management Committee	October 14, 2015
Date	

Revision History	
Revision Date	Reason for Revision
September 2015	Policy created



P.O. Box 30377
 Lansing, MI 48909-7877
 Phone: 517.364.8560 Fax:517.364.8409

Home Health Care Request Form

Instructions: All sections must be completely filled out for review. Please fax the completed form and relevant chart notes to 517.364.8409.

Coverage requests for dates of service prior to Oct 1, 2015 must utilize ICD-9 codes. Dates of service on or after Oct 1, 2015 must utilize ICD-10 codes.

Patient Information		Prescriber Information	
Today's date:	Referring Provider's name:		
Member name:	Office phone:	Fax:	
Member's PHP ID#:	Office contact:		
Date of birth:	Patient's Primary Physician:		
Treatment/Request Information			
<input type="checkbox"/> New Request <input type="checkbox"/> Extension, authorization # _____			
ICD9/10 Diagnosis code:	Anticipated start of care date:		
Visit type: <input type="checkbox"/> SN Number of Visits Requested: _____ Dates of service: from _____ to _____ <input type="checkbox"/> PT Number of Visits Requested: _____ Dates of service: from _____ to _____ <input type="checkbox"/> OT Number of Visits Requested: _____ Dates of service: from _____ to _____ <input type="checkbox"/> ST Number of Visits Requested: _____ Dates of service: from _____ to _____ <input type="checkbox"/> SW Number of Visits Requested: _____ Dates of service: from _____ to _____ <input type="checkbox"/> Aide Number of Visits Requested: _____ Dates of service: from _____ to _____			
Home Health Contact Person & Title:	Agency: <i>(include address, city, state, zip)</i>		
Provider #:	Phone:	Fax:	
Description of skilled services <i>(e.g. SNV dressing changes daily for wound, IV therapy – drug/dose/frequency, PT for gait training, OT for upper body strength)</i> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>			
OUTCOME (PHP use only)			
<input type="checkbox"/> Approved as requested <input type="checkbox"/> Approved with changes Authorization number: _____			
_____ Number of visits approved: _____ Dates of service From: _____ To: _____			
_____ Number of visits approved: _____ Dates of service From: _____ To: _____			
_____ Number of visits approved: _____ Dates of service From: _____ To: _____			
PHP MRM Reviewer Name: _____			Date: _____

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 Phone: 517.364.8560 Fax:517.364.8409

DME Request Form

Instructions: To process your request without delay, this form must be completely filled out including the physician order/ script and the necessary documents attached. Please fax this form and relevant chart notes to 517.364.8409.

Coverage requests for dates of service prior to Oct 1, 2015 must utilize ICD-9 codes. Dates of service on or after Oct 1, 2015 must utilize ICD-10 codes.

Patient Information	Prescriber Information
Today's date:	Provider name:
Member name:	Office phone:
Member's PHP ID#:	Office fax:
Date of birth:	Office contact:

Treatment/Request Information		
<input type="checkbox"/> New Request <input type="checkbox"/> Extension, authorization # _____		
ICD 9/10 Diagnosis code:	HCPCS Code:	
DME Description:	Retail price:	
If new request, date item(s) dispensed:	Dates of service:	Quantity:
DME Vendor:	DME Vendor Contact Person:	
Phone:	Fax:	
Address: <i>(include city, state, zip)</i>		
Other documents attached:		

OUTCOME (PHP use only)		
<input type="checkbox"/> Approved as requested	<input type="checkbox"/> Approved with changes	Authorization number: _____
Items approved: _____		
Dates of service: From: _____ To: _____		
PHP MRM Reviewer Name: _____		Date: _____

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PHYSICIANS HEALTH PLAN NOTIFICATION/PRIOR AUTHORIZATION TABLE-ALL PRODUCTS

PHP Notification/Prior Authorization/Prior Approval Table-All Products Effective November 1, 2015																
	Physicians Health Plan		Physicians Health Plan		Sparrow PHP		Sparrow PHP		Physicians Health Plan		Sparrow Physicians Health Network		Sparrow Physicians Health Network		PHP Insurance Company	
	Commercial & Market Place Plans		Lansing Board of Water and Light		Medicaid		MIChild		Self Funded (L0000264; DAS00100, 200, 300)		SPHN (MNA, IUE, UAW & SEIU. DAS00600, 900, 1000, 1200)		SPHN (Non-Union, DAS01100)		PPO	
SERVICES / ITEMS / PROCEDURES	Within 1 business day	Prior to Service	Within 1 business day	Prior to Service	Within 1 business day	Prior to Service	Within 1 business day	Prior to Service	Within 1 business day	Prior to Service	Within 1 business day	Prior to Service	Within 1 business day	Prior to Service	Within 1 business day	Prior to Service
Abortion services	**** N/A	**** N/A	N/A	N/A		√		√	**** N/A	**** N/A	**** N/A	**** N/A	**** N/A	**** N/A	**** N/A	**** N/A
Acute admissions that are urgent or emergent (including direct admissions) except maternity services for delivery (see below for exception)	√		√		√		√		√		√		√		√	
Acute maternity admissions that exceed federal mandated LOS (48 hours after delivery for vaginal delivery & 96 hours after cesarean section delivery)	√		√		√		√		√		√		√		√	
Acute pre-operative days admission		√		√		√		√		√		***√		***√		√
Acute psychiatric/substance abuse admissions that are urgent or emergent (facility notification)	√ *		√		√ *		Refer to CMH		**** N/A	**** N/A	√		√		√	
Acute rehabilitation admission		√		√		√		√		√		***√		***√		√
Acute scheduled admissions	√			√	√		√		√			***√		***√		√
Acute scheduled psychiatric or substance abuse admissions (facility notification)		√ *		√		√ *		√ *		√		√		√		√
Autism & Autism Spectrum Disorder Treatment		√ *	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	√
Bariatric surgery		**√		√		**√		**√		**√		**√		**√		Δ√
Behavioral Health Services- certain outpatient services		√ *		√ (ECT)		√	Refer to CMH	Refer to CMH	**** N/A	**** N/A		√		√		√
Behavioral Health Services- day treatment		√		√	N/A	N/A	Refer to CMH	Refer to CMH	**** N/A	**** N/A		√		√		√
Dental anesthesia: pediatric/adult		√	N/A	N/A		√		√		√	**** N/A	**** N/A	**** N/A	**** N/A		√
Dental services-accidental		√		R		√		√		√	**** N/A	**** N/A	**** N/A	**** N/A		√
Durable medical equipment: Implantable devices, e.g. insulin and infusion pumps, bone stimulators; power wheelchairs and/or mobility devices; automatic external defibrillators; chest wall oscillation vest		√	N/A	N/A		√		√		√		√		√	**** N/A	**** N/A
Endoscopy and intestinal imaging (capsule only)		√	N/A	N/A		√		√		√	**** N/A	**** N/A		√	**** N/A	**** N/A










PHYSICIANS HEALTH PLAN NOTIFICATION/PRIOR AUTHORIZATION TABLE-ALL PRODUCTS

	Physicians Health Plan		Physicians Health Plan		Sparrow PHP		Sparrow PHP		Physicians Health Plan		Sparrow Physicians Health Network		Sparrow Physicians Health Network		PHP Insurance Company	
	Commercial & Market Place Plans		Lansing Board of Water and Light		Medicaid		MICHild		Self Funded (L0000264; DAS00100, 200, 300)		SPHN (MNA, IUE, UAW & SEIU. DAS00600, 900, 1000, 1200)		SPHN (Non-Union, DAS01100)		PPO	
Facet Injections: diagnostic injections up to 3 dates of service/cal year are covered; diagnostic injections > 3 dates of service per calendar year & all neurolysis procedures-prior authorization required.		√	N/A	N/A			√		√			√		√		√
Gamma knife procedures		√	N/A	N/A			√		√			√		√	**** N/A	**** N/A
Genetic testing		√		√			√		√			√		√		√
Home care visits		√	N/A	N/A			√		√			√		√	**** N/A	**** N/A
Hospice services		√	N/A	N/A			√		√		**** N/A	√ Non-network	**** N/A	√ Non-network	**** N/A	**** N/A
Hyperbaric oxygen therapy		√	N/A	N/A			√		√			√		√	**** N/A	**** N/A
Infertility treatment	**** N/A	**** N/A	N/A	N/A	**** N/A	**** N/A	**** N/A	**** N/A	**** N/A	**** N/A		√		√	**** N/A	**** N/A
Long term acute care admission		√		√			√		√			*** √		*** √		√
Neuropsychiatric testing		√ *		R			√		√		**** N/A	**** N/A		√		√
Non-urgent ambulance requests		√	N/A	N/A			√		√			√		√	**** N/A	**** N/A
Outpatient home infusion services		√	N/A	N/A			√		√			√ Non-network		√ Non-network	**** N/A	**** N/A
Outpatient speech therapy		√		√			√		√			N/A		N/A		√
Outpatient rehab therapy (PT/OT/Cardiac/ Pulmonary)		√	N/A	N/A			√		√			N/A		N/A		√
Procedures that under some conditions may be considered cosmetic: Abdominoplasty, Breast Reduction, Procedures for Gynecomastia, Breast Reconstruction, Gender Reassignment, Jaw Surgeries, Photodynamic Therapy & Special Dermatologic Procedures, Sclerotherapy, Vein Surgery, including stripping and ligation, Eyelid Repair (blepharoplasty, brow ptosis, blepharoptosis), Rhinoplasty, Keloid Scar Revision.		√		R			√		√			√		√		√
Surgical Treatment of Femoroacetabular Impingement (FAI)		√		R			√		√			√		√		√
Private duty nursing				√												
Prosthetic devices over \$1000		√	N/A	N/A			√		√			√		√	**** N/A	**** N/A
Psychodiagnostic testing		√ *		R			√		√			√		√		√
Referral to or services by any non-network or referral network provider including scheduled surgery		**** N/A	N/A	N/A			√		√		**** N/A	**** N/A		**** N/A		**** N/A
Skilled nursing facility, subacute nursing & rehabilitation services		√		√			√		√			√		√		√
Spinal cord stimulation & sacral nerve stimulation		√	N/A	N/A			√		√			√		√	**** N/A	**** N/A









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	Commercial & Market Place Plans		Lansing Board of Water and Light		Medicaid		MICHild		Self Funded (L0000264; DAS00100, 200, 300)		SPHN (MNA, IUE, UAW & SEIU. DAS00600, 900, 1000, 1200)		SPHN (Non-Union, DAS01100)		PPO	
		√ for Metal Plans	N/A	N/A												
Temporomandibular Joint Dysfunction/Syndrome Treatment		√	N/A	N/A												
Transplant services including screening and evaluation (If benefit: includes travel and lodging)		√		√		√		√		√		√		√		√
Unproven/investigational services including emerging technology/category III codes		√		R		√		√		√		√		√		√
Low-dose computed tomography (CT) for lung cancer screening		√				√		√		√		√		√		
Uvulopalatopharyngoplasty (UPPP)		√	N/A	N/A		√		√		√	**** N/A	**** N/A	**** N/A	**** N/A	**** N/A	**** N/A
Vision services (contact lenses)	N/A	N/A	N/A	N/A	N/A	N/A		√	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Weight management services including evaluation, management, surgery & post-surgical procedures		√	N/A	N/A		√		√		√		√		√		Δ √
code NAME		√		√		√		√		√		√		√		√
C9023 # testosterone undecanoate, 1 mg (Andriol)		√		√		√		√		√		√		√		√
C9025 # ramucirumab, 5 mg (Cyramza)		√		√		√		√		√		√		√		√
C9026 # vedolizumab, 1 mg (Entyvio)		√		√		√		√		√		√		√		√
C9135 # antihemophilic factor, recombinant Factor IX, Alprolix, per 10 IU		√		√		√		√		√		√		√		√
C9445 # C-1 esterase inhibitor (Reconest)																
C9448 # netupitant (Akynzeo)																
C9449 # blinatumomab (Blincyto)																
C9450 # fluocinolone acetonide (Iluvien)																
C9451 # peramivir (Rabivab)																
C9452 # ceftolozane and taxobactam (Zerbaxa)																
90378 # palivizumab (Synagis)		√		√		√		√		√		√		√		√
J0129 # abatacept (Orencia)		√		√		√		√		√		√		√		√
J0135 # adalimumab (Humira) 		√		√		√		√		√		√		√		√
J0178 # aflibercept Eylea		√		√		√		√		√		√		√		√
J0180 # agalsidease beta (Fabrazyme)		√		√		▲		▲		√		√		√		√
J0205 # alglucerase (Ceredase)		√		√		▲		▲		√		√		√		√
J0220 # alglucosidase alfa (Myozyme)		√		√		▲		▲		√		√		√		√
J0221 # alpha alglucosidase alfa (Lumizyme)		√		√		√		√		√		√		√		√
J0256 # alpha 1 - proteinase inhibitor - human, (Aralast, Aralast NP, Prolastin, Prolastin-C, Zemaira)		√		√		√		√		√		√		√		√
J0257 # alpha 1 Antitrypsin-AAT (Glassia)		√		√		√		√		√		√		√		√
J0365 # aprotinin (Trasylol)		√		√		▲		▲		√		√		√		√
J0401 # aripiprazole (Abilify)		√		√		▲		▲		√		√		√		√
J0485 # belatacept (Nulojix)		√		√		√		√		√		√		√		√
J0490 # belimumab (Benlysta)		√		√		√		√		√		√		√		√

PHYSICIANS HEALTH PLAN NOTIFICATION/PRIOR AUTHORIZATION TABLE-ALL PRODUCTS

		 Physicians Health Plan	 Physicians Health Plan	 Sparrow PHP	 Sparrow PHP	 Physicians Health Plan	 Sparrow Physicians Health Network	 Sparrow Physicians Health Network	 PHP Insurance Company
		Commercial & Market Place Plans	Lansing Board of Water and Light	Medicaid	MiChild	Self Funded (L0000264; DAS00100, 200, 300)	SPHN (MNA, IUE, UAW & SEIU. DAS00600, 900, 1000, 1200)	SPHN (Non-Union, DAS01100)	PPO
J3490	# Unclassified drugs is a list of drugs without a specific HCPCs or CPT code assigned to it-PA is required for all of the following medications (the list is subject to change) : Bevacizumab/Avastin billed with J3490 for the eye: Notification required for all diagnoses other than 362.07, 362.35, 362.36, 362.52, 362.53, 362.62), Corifact/Factor XIII, glucarpidase (Voraxaze) testosterone undecanoate (Andriol), ramucirumab (Cyramza), vedolizumab (Entyvio), antihemophilic factor (Alprolix Factor IX), epoetin beta & siltuximab (Sylvant), Irecombinant factor IX (Ixinity), paliperidone palmitate ER (Invega Trinza), dinutuximab (Unituxin)								
		√	√	√	√	√	√	√	√
J3590	# Unclassified biologics	√	√	√	√	√	√	√	√
J7178	# human fibrinogen concentrate (RiaStap)	√	√	▲	▲	√	√	√	√
J7180	# Factor products	√	√	▲	▲	√	√	√	√
J7181	# factor XIII A-subunit	√	√	▲	▲	√	√	√	√
J7182	# factor VIII (NovoEight)	√	√	▲	▲	√	√	√	√
J7183- J7187	# Factor products	√	√	▲	▲	√	√	√	√
J7189- J7199	# Factor products	√	√	▲	▲	√	√	√	√
J7200	# factor IX (Rixubis)	√	√	▲	▲	√	√	√	√
J7201	# factor IX FC fusion protein	√	√	▲	▲	√	√	√	√
J7308	# aminolevulinic acid HCl (Levulan Kerastick)	√	√	√	√	√	√	√	√
J7309	# methyl aminolevulinatate (MAL), (Metvixia)	√	√	√	√	√	√	√	√
J7312	# dexamethasone (Ozurdex)	√	√	√	√	√	√	√	√
J7316	# ocriplasmin (Jetrea)	√	√	√	√	√	√	√	√
J7508	# tacrolimus (Prograf)	√	√	√	√	√	√	√	√
J7527	# everolimus (Zortress) 	√	√	√	√	√	√	√	√
J7686	# trestatinil	√	√	√	√	√	√	√	√
J7699	# NOC drugs, inhalation solution administered through DME	√	√	√	√	√	√	√	√
J7799	# NOC drugs, other than inhalation drugs, administered through DME	√	√	√	√	√	√	√	√
J8498	# antiemetic drug, rectal/suppository, not otherwise specified	√	√	√	√	√	√	√	√
J8499	# prescription drug, oral, non chemotherapeutic, NOS	√	√	√	√	√	√	√	√
J8562	# fludarabine phosphate (Oforta)	√	√	√	√	√	√	√	√
J8565	# gefitinib (Iressa)	√	√	▲	▲	√	√	√	√
J8700	# temozolomide (Temodar)	√	√	√	√	√	√	√	√

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Not otherwise classified, unspecified, unlisted, miscellaneous CPT or HCPCS services- services will be reviewed prior to claim payment and may be denied as cosmetic, investigational, experimental, unproven, or not medically necessary services.								
* Non-emergent/urgent requests for benefit review are to be submitted >14 days in advance of the service or as soon as the service is determined to be appropriate by the practitioner. Urgent requests are requests for care or treatment for which a routine application of time periods for making the determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function or in the opinion of a practitioner would subject the member to severe pain that cannot be adequately managed without the care or treatment that is included in the request.								
** Bariatric surgery candidates must participate in the case management program with PHP's approved designee for a case management evaluation and interventions.								
*** Notification must occur at least five (5) business days before surgery is scheduled to occur.								
**** N/A - prior authorization is not required but the service may have a limited benefit, be covered at the non-network benefit level, not be a covered benefit. For inpatient mental health/substance use disorder services for Medicaid members contact Community Mental Health.								
# Medications that are reviewed and processed by the Pharmacy Department.								
Services requiring prior authorization must be reviewed in advance of the service even if PHP is a secondary payor.								
△ Weight management and surgical treatment of obesity is covered for PPO products ONLY with a rider and, if rider is purchased, prior authorization is required.								
+ Covered as a pharmacy benefit only with quantity limits								
▲ All Home Care Providers must bill claims for Medicaid/FamilyCare, Childrens Special Health Care Services (CSHCS) or MICHild CSHCS to Magellan/Michigan Department of Community Health (MDCH) for the services indicated. MDCH may have authorization requirements. You must contact Magellan at 1-877-864-9014. All other Providers must submit an authorization form to PHP for review. If the request is approved claims are billed to PHP. The PHP billing information is on the member's card.								
√ * Check member's identification card to determine who is to be notified of service.								
R - Lansing Board of Water and Light: It is recommended the service be reviewed to determine medical necessity in advance of the service. If it is not clinically reviewed prior to the service medical necessity will be determined when the claim is received for processing.								