Provider Connection

FOURTH QUARTER 2016

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A health plan that works for you.

Pharmacy and Therapeutics Committee

The collaborative Physicians Health Plan and Sparrow Health System Pharmacy and Therapeutics Committee (P&T) meets every other month to review new and existing medications for formulary tier placement. Medications are discussed and voted upon for inclusion and tier placement on the Plan's formulary based on safety, efficacy, cost and current clinical literature. Expert opinion and input regarding local practices is always appreciated and taken into consideration from members of the healthcare community. Prior authorization requirements and restrictions (such as age and quantity limits) are discussed as well. The committee is comprised of PHP and local area Pharmacists, Physicians, and Nurses, as well as union representatives.

Benefit determination criteria are also reviewed on a rotating annual basis to evaluate for new literature on drug indications, usage, or safety considerations. Benefit determination criteria are used when reviewing medication prior authorization requests for members. The criteria are intended to ensure that the member receives the safest, most effective treatment for their condition. The committee values the input of local Physicians that are experts in their field. If you feel your expertise could be used to contribute to the Plan's benefit determination guidelines, please contact the PHP pharmacy department at **pharmacy@phpmm.org.**

Medication Fill History Reports Aim to Help Manage Patient Care

The first Medication Fill History Reports have been mailed to Primary Care Physicians that have Patients with a combination of Diabetes and Hypertension. As most Patients with both conditions are generally prescribed an ACEI or ARB, this report identifies Patient adherence through medication fill history within the last 12 months. PHP is providing this information to assist you in managing the care of these Patients. We plan to distribute this report to providers every six months.

The Medication Fill History Report is informational only - serving as a resource about the importance of taking medications as prescribed and the complications that can arise from not following your treatment plan.

If you have received this report and would like further assistance feel free to reach out to your Provider Relations team at **PHPProviderrelations@phpmm.org.**

Holiday Hours

Physicians Health Plan will be closed Dec. 23 and Dec. 26, 2016 and Jan. 2, 2017 in observation of the upcoming holidays. If you have an issue that requires immediate assistance, our answering service will be available to assist you.

Pharmacy Department News and Updates

November 2016

PHP's Prescription Drug List (PDL) is available online. Please visit **PHPMichigan.com/providers** and select "General Forms and Information" to find the current drug list.

Criteria for medications requiring prior authorization are also available online by selecting "Pharmacy Prior Authorization Criteria."

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

Below is a list of recent changes to the PHP PDL.

Changes to the PDL:

<table>
<tr><th>Drug</th><th>Action</th><th>Implementation Date</th></tr>
<tr><td>Single Source Brand Testosterone Gel pkt & pump (manufactured by Abbvie & Upsher Smith)</td><td>Moved to Tier 3. Now requires PA</td><td rowspan="2">11/18/16</td></tr>
<tr><td>Generic Testosterone Gel pkt & pump (manufactured by Actavis, Par Pharmaceuticals & Perrigo)</td><td>Available on Tier 1. No PA</td></tr>
<tr><td>Xrylix Kit</td><td>Exclude from PDL</td><td>11/18/16</td></tr>
<tr><td>Clobetasol (all topical forms)</td><td>Added Qty limit max 120gm/30 days.
Add'l Qty requires PA</td><td>11/18/16</td></tr>
<tr><td>Nexium (esomeprazole)</td><td>1/1/17 preferred product will switch from brand Nexium to generic esomeprazole</td><td>1/1/17</td></tr>
<tr><td>All Tretinoin Microsphere products (brand & generic)</td><td rowspan="3">PA if member
is over the age of 29</td><td rowspan="3">11/18/16</td></tr>
<tr><td>Fabior</td></tr>
<tr><td>Epiduo Forte</td></tr>
<tr><td>Zurampic (lesinurad)</td><td>Add to PDL. Tier 3 with PA</td><td>11/18/16</td></tr>
<tr><td>Ethacrynic Acid tabs</td><td>Add to PDL with PA</td><td>11/18/16</td></tr>
<tr><td>Methoxsalen</td><td>Add PA</td><td>11/18/16</td></tr>
<tr><td>Trintellix (formerly Brintellix)</td><td>Add PA</td><td>11/18/16</td></tr>
<tr><td>Targadox (doxycycline)</td><td>Add to PDL. Tier 3 with PA</td><td>11/18/16</td></tr>
<tr><td>Yosprala (asprin/omeprazole</td><td>Add to PDL. Tier 3 with PA</td><td>11/18/16</td></tr>
</table>

****Clarification of coverage of zoledronic acid: The prior authorization was removed for zoledronic acid J3489 as of 4/1/16, however this only applies to the generic product. The branded product Reclast requires prior authorization.*

Holidays and Family: Time to Talk.

It's the holiday season and families gather together to celebrate and catch up. Is healthcare on the list of discussion topics? Physicians Health Plan is encouraging members and Providers to put this important subject at the top of their list. Sharing wishes with family and friends means loved ones won't be burdened with guessing about important healthcare decisions. The holiday season is the perfect time to sit down together to share this gift of knowledge and peace of mind.

As a Physician

Patients have a right to take an active role in their own healthcare. Unfortunately there are times, such as a sudden illness or accident, when this is not possible. As their Physician, you can play an important role in initiating and guiding the advance care planning process by making it a routine part of care for all Patients. And, it is important to revisit it regularly, exploring any changes a Patient may have in his or her wishes over time. This process ultimately benefits Patients by providing them with a sense of control and peace of mind with regard to their future healthcare needs. It is also advisable for Physicians to do their own advance care planning.

It is important to support advance care planning decisions with formal documents, such as an advance directive. An advance directive might include a living will, through which a person indicates whether specific medical interventions would be desired, or a durable power of attorney for healthcare, whereby a Patient designates a specific person to act as their agent for healthcare decisions in the event the Patient is incapable of making such decisions.

Advance care planning affords Patients the opportunity to exercise their right to make determinations regarding their medical care in advance in the event they become incapable of active participation in their healthcare decisions. The process provides individuals with the opportunity to determine their goals regarding health and medical treatment based on personal values, attitudes, and beliefs surrounding healthcare, illness, and death. It also enables individuals to communicate their wishes to their Primary Care Physician, their proxy, and loved ones. As a result of this process, if a Patient becomes incapacitated, parties involved in the Patient's care should have a common understanding of the Patient's healthcare wishes.

If you would like additional information or to print an advanced care plan please visit: **Caringinfo.org**

January 2016

Michigan Quality Improvement Consortium Guideline

Advance Care Planning

The purpose of this guideline is to assist the practitioner in engaging the patient in a discussion of goals, preferences, and priorities regarding the patient's care at different stages of life. The guideline recommends tools and interventions to address Advance Care Planning across the patient population.

Eligible Population	Key Components	Recommendation
Patients whose death in the next twelve months would not be surprising Patient with New or Established Diagnosis of a Serious **Illness** Consider patients aged 18 and over, in any stage of health	Advance Care Planning Process	**Relevant topics include:** • The value of making one's goals preferences and choices for care and treatment known both verbally and in writing • The importance of early conversations with family in a non-crisis situation • The value of identification of a surrogate decision-maker, with consent • The value of cultural sensitivity • For appropriate patients, the value of having a Physician's Orders for Life-Sustaining Treatment (POLST)[1] • Discussion should include family members, the surrogate decision-maker, and others who are close to the patient • Any individual can start the conversation (patient, family, physicians, nurses, behavioral health providers, social workers, clergy, trained facilitator, etc.) • Evidence-based training in advance care planning is recommended for any person facilitating ACP conversations[2] • At the later stages, the facilitator should have experience with/knowledge of the patient's specific condition (e.g. CHF, cancer)
	Assist patient in Advance Care Planning	**Use an Advance Care Planning tool[2] to:** • Help the patient identify a surrogate who would make decisions on their behalf if they did not have decision-making capacity • Encourage the patient to complete an Advance Directive[3] (including Healthcare Power of Attorney and Patient Advocate Role Acceptance) • Incorporate the patient's goals preferences and choices into the Treatment Preferences portion of the Advance Directive • Encourage the patient to discuss their preferences and care plan with the surrogate, family member, spiritual counselor and others
	Revision of Advance Care Plan	• Review the patient's goals and preferences for end-of-life care and advance directives at least annually • With a significant change in prognosis, work with the patient to update his/her advance directives, giving consideration to specific potential scenarios • If patient has limited life expectancy, consider using the POLST[1] tool to address the patient's specific requests for end-of-life care
	Documentation and Implementation	• Place a copy of the Advance Directive documenting the designation of a surrogate/decision maker, patient's values and beliefs and goals for end of life care, and POLST[1], in the health record and in retrievable electronic format when available • Incorporate the Advance Directive into the person's plan of care • Make the Advance Directive and POLST[1] accessible throughout the health system, to emergency departments, EMS companies, nursing homes, and share with family

[1] Physician's Orders for Life-Sustaining Treatment (POLST)
[2] Respecting Choices   Making Choices Michigan   Five Wishes
[3] In Michigan, the only legally recognized advance directives are Durable Power of Attorney for Health Care (DPOA) and Do Not Resuscitate (DNR). Living wills are not legally recognized by the State of Michigan.

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the Institute of Medicine Dying in America, Improving Quality and Honoring Individual Preferences Near the End of Life Key Findings and Recommendations (**http://iom.nationalacademies.org/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx**); The American Medical Association: E-2.225 Optimal Use of Orders Not To Intervene and Advance Directives (**http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/about-ethics-group/ethics-resource-center/end-of-life-care/ama-policy-end-of-life-care.page**); NCCN Clinical Practice Guidelines in Oncology: Palliative Care, Version 2.2011 (**http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#palliative**); Physician Orders for Life-Sustaining Treatment Paradigm; and The National Committee for Quality Assurance: 2010 Special Needs Plan (**http://www.ncqa.org/Programs/OtherPrograms/SpecialNeedsPlans.aspx**); Institute for Clinical Systems Improvement, Palliative Care for Adults health care guideline, Updated November 2013 (**https://www.icsi.org/_asset/k056ab/PalliativeCare.pdf**); Advance Care Planning Decisions (**http://www.acpdecisions.org/**). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Approved by MQIC Medical Directors January 2012, 2014, 2016

Utilization Department News and Updates

Procedures and services requiring prior authorization are available online. Please visit **PHPMichigan.com/providers**, select "General Forms and Information", then "Prior Authorization Forms" to locate the **Prior Authorization Notification Table** and **Prior Authorization Request Forms**.

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.pm., Monday through Friday.

Below are recent changes to PHP's prior authorizations:

Changes to Coverage/Authorization Requirements			
Procedure or Service	**Codes**	**Action**	**Implementation Date**
Implantable cardiac event recodrers	33282	Requires PA	01/01/2017
Glaucoma surgery - iStent Trabecular Micro-bypass Stent	0191T 0376T	Requires PA	01/01/2017
Fecal Bacteriotherapy (Fecal Microbiota Transplant)	44705 G0455	Requires PA	01/01/2017
Peripheral Nerve Neurostimulators (placement, replacement or removal)	64553 64561 64566	Requires PA	01/01/2017
Total disc arthroplasty, cervical	22856	Requires PA	01/01/2017

New Year's Resolutions: Tobacco Cessation

Every Jan. 1, people all over the world make New Year's resolutions. Smoking is still the number one cause of preventable death and disease in the United States. Statistics show that seven in 10 U.S. smokers want to quit. Why not help them make a resolution to get started?

PHP would like to encourage you to help our members choose this year as their time to quit. We believe that it's important to provide you, and our members, with the tools needed to quit smoking. Knowledge is power, and we're here to help our members get to where they want to be.

PHP provides tobacco cessation educational materials, healthcare reminders, and a tobacco cessation coach to help your Patients work through challenges and keep them motivated to quit.

Our Tobacco Cessation program:

- Helps build confidence about quitting
- Offers support
- Helps with staying on track
- Helps the member think positively about quitting
- Helps pinpoint triggers
- Helps to develops skills and tools to cope

Your Patients will learn to:

- Deal with triggers
- Use new strategies
- Cope with cravings
- Plan for success
- Develop a new self-image

To help a PHP member get started on their journey to better health, have them call Healthyroads at **1.877.330.2746**

Diabetes Medications: Coverage Considerations

Department of Pharmacy

The number of medications, including new drug classes to treat diabetes mellitus, on the market has grown considerably in the past few years. In order to provide cost-effective healthcare to our members, some medications used for diabetes have step therapy or prior authorization requirements. As new medications come to market they are reviewed by the PHP Pharmacy and Therapeutics Committee. Existing medications are reviewed yearly for coverage status and when new clinical data is released.

Here is a summary of the current coverage at PHP:

- Common oral medications used for diabetes covered at a Tier 1 copay: metformin, metformin ER (generic to Glucophage® XR only), glyburide, glipizide, and pioglitazone
- Byetta® and Bydureon® do not require prior authorization within the GLP-1 agonist class (Victoza®, Tanzeum®, and Trulicity® require prior authorization)
- Januvia® does not require prior authorization within the DPP-4 inhibitor class (Nesina®, Tradjenta®, and Onglyza® require prior authorization)
- All SGLT-2 agents require prior authorization (Invokana®, Farxiga®, and Jardiance®)
- Many commonly used insulins are covered at a Tier 2 copay, including: Lantus®, Levemir®, Humulin® products, Novolin® products, and Novolog® products

Please refer to our website **PHPMichigan.com/providers** under the tab "Pharmacy Prior Authorization Criteria" for more information.

Working to Reverse the US Diabetic Epidemic

The rate of new cases of diagnosed diabetes in the United States has begun to fall, but the numbers are still very high. More than 21 million Americans are living with diabetes, and 8.1 million people are undiagnosed for a total of 29.1 million people or 9.3 percent of the population. Identifying and connecting with people at high risk of Type 2 diabetes is critical to preventing it. For people with diabetes, better health management can increase lifespan and enhance quality of life.

Type 2 diabetes accounts for about 95 percent of all diagnosed cases of diabetes, and Type 1 diabetes accounts for about five percent. The health and economic costs for both are enormous:

» Diabetes was the seventh leading cause of death in the United States in 2013 (and may be underreported).

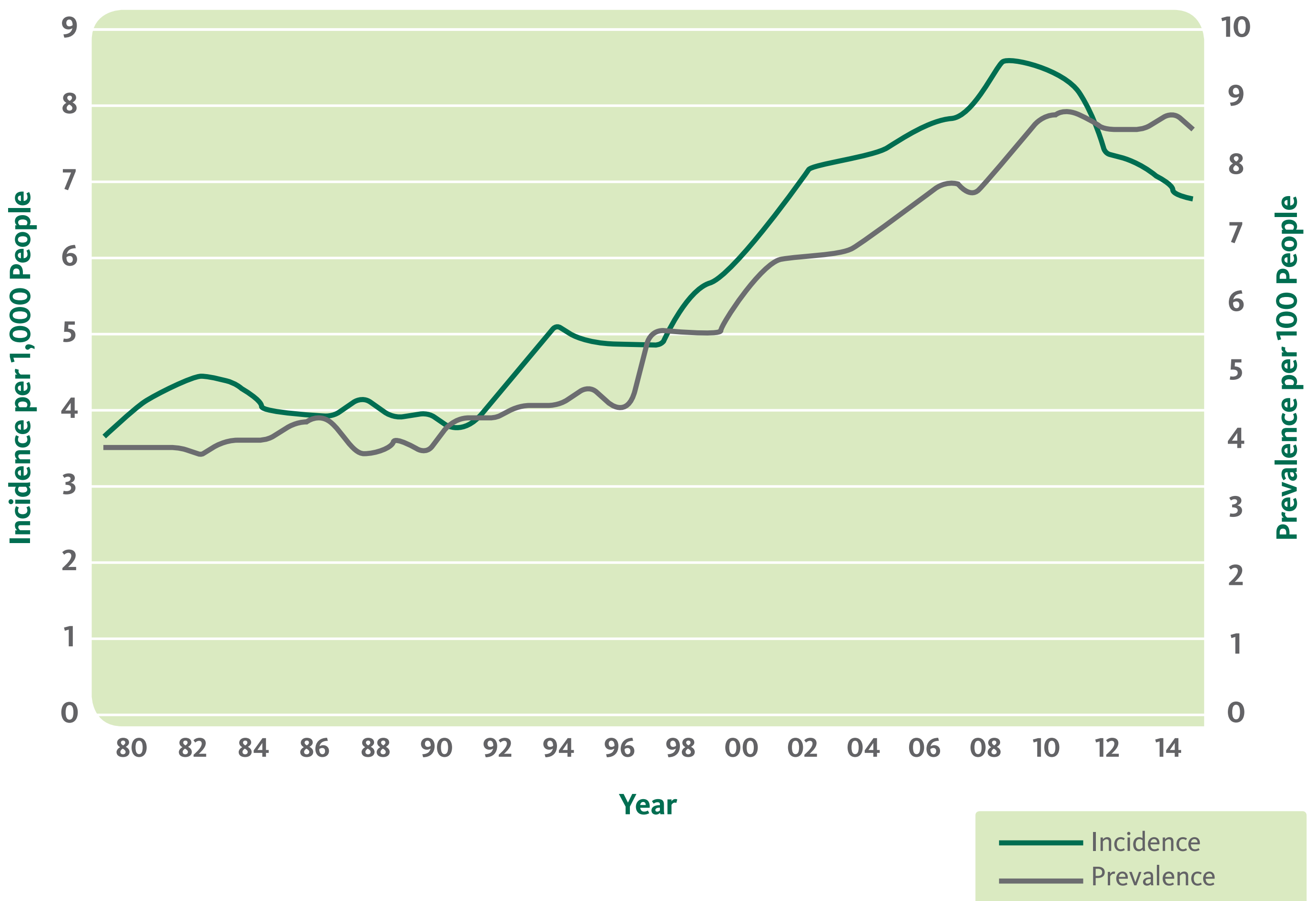
» Diabetes is the leading cause of kidney failure, lower-limb amputations, and adult-onset blindness.

» More than 20 percent of healthcare spending is for people with diagnosed diabetes.

Physicians Health Plan offers Health Management (Life360) Living with Diabetes, a program to help our members better understand and control their diabetes. Together, we work to help our members confront diabetes head-on, with educational and self-management plans to better manage their disease. PHP can help direct our members to diabetic classes through certified ADA programs at Sparrow Diabetes Center (adults), Sparrow Pediatric Subspecialty clinic, or through McLaren Greater Lansing. A referral from a Physician is required for diabetes education classes. There may be a charge for classes so have members call PHP Customer Service to verify their coverage.

For more information visit: **PHPMichigan.com/Members/Take-Charge-of-Your-Health/Health-Management-Life360**

Source: Center for Disease control and Prevention **cdc.gov/diabetes/data/**



Focus on: High Deductible Health Plans

High Deductible Health Plans are becoming more and more prevalent. HDHPs are a coverage option that generally don't start paying for enrollees' healthcare expenses until a deductible threshold is met — usually several thousand dollars. Benefit guidelines for HDHPs are also different than traditional benefit plan designs. The basic coverage highlights of HDHPs are:

- **Higher annual deductibles and out-of-pocket (OOP) limits.**
- For calendar year 2017, 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 2017:
  - $1,300 for self-only coverage
  - $2,600 for family coverage
- **Preventive services coverage -** Many preventive services are covered at 100 percent before the annual deductible is met. There is no coverage for preventive services from an out-of-network provider.
- **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. Deductibles, coinsurance, and prescription copays all apply to the out-of-pocket (OOP) maximum. The family deductible and out-of-pocket (OOP) maximum are not embedded, 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 costs help 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 -** HDHPs 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 2017:

- $2,600 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 to Require Use of the JW Modifier

Effective Jan. 1, 2017, in accordance with CMS guidelines and requirements, PHP will require documentation of medication waste with the use of the JW modifier. For medications that come in single-use vials where the full amount is not used, please use the JW modifier when billing for discarded product. In addition, providers must document the amount of administered as well as wasted medication within the Patient's medical record. Please refer to CMS CR9603 for more details.

Billing Example Using the JW Modifier

A single-use vial that is labeled to contain 100 units of a drug has 95 units administered to the Patient and 5 units discarded. The 95 unit dose is billed on one line, while the discarded 5 units may be billed on another line with the JW modifier. Both line items would be processed for payment.

Appropriate use of the JW Modifier

- Multi-use vials are not subject to payment for discarded amounts of medication
- If a single-use vial comes in multiple sizes, use the smallest vial size(s) in order to minimize waste
- If the full amount of a single-use vial is administered to a Patient, there is no need to use the JW modifier

Grace period for Marketplace Health Insurance Members

For Marketplace product members that have their coverage terminated due to non-payment of premium, Physicians Health Plan (PHP) allows a three month grace period for enrollees to make a premium payment on their plan. PHP will notify the appropriate providers once a member has entered a grace period. Below is a list of details that include what you can expect from PHP if a member becomes impacted by the grace period.

During the grace period:

- PHP will notify members of premium payment delinquency
- Providers will be paid for all eligible services provided during the first month of the grace period
- Claims will be pended for the second and third months of the grace period
- If the member does not pay all outstanding premiums, then they will be held financially responsible for any claims incurred during the second and third month of the grace period. PHP will not pay eligible claims that are incurred in the second and third month.

NCCI (National Correct Coding Initiative) Edits

PHP uses clinical edits in the processing and payment of all medical claims. All providers' medical claims for payment are subject to PHP clinical edits. Clinical edits focus upon correct coding methodologies and accurate adjudication of claims.

One of the top 10 reasons for a claim denial includes procedures disallowed without appropriate modifiers. NCCI edits define when two procedure codes may not be reported together except under special circumstances. Under these circumstances it may be appropriate to add applicable modifiers to the codes billed. In order to ensure you are using the appropriate modifier please reference the NCCI website at **CMS.gov/Medicare/NationalCodingInitiativeEdits/PTPcodingEdits**. Choose Hospital or Physician and select the code you are reviewing.

When looking at the NCCI table, the paired codes are listed in column 1 and column 2. There are indicators of "0" modifier not allowed, "1" modifier is allowed, "9" codes can be billed together without a modifier.

Example: Modifier -59

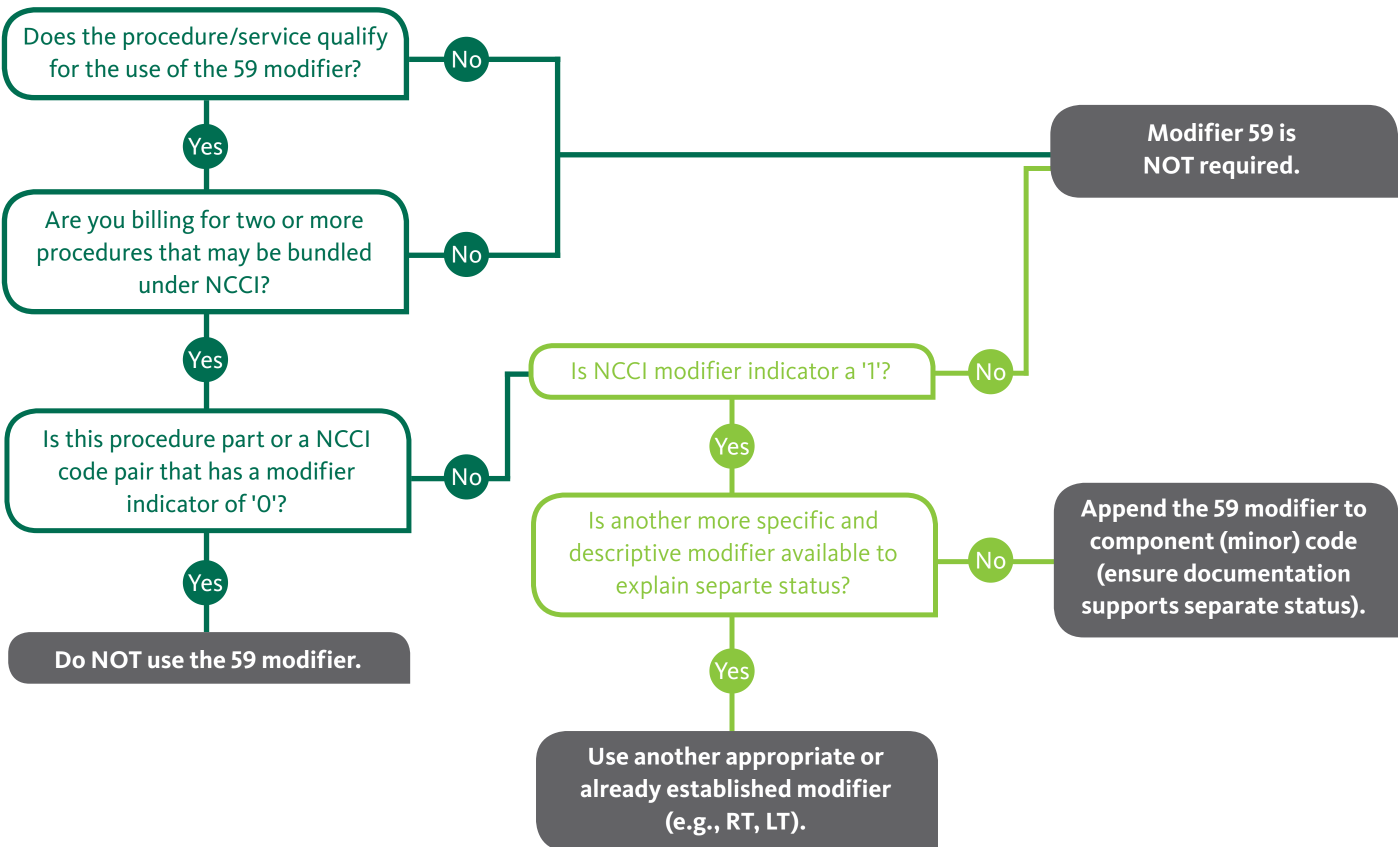
Two procedure codes may be reported together if there is documentation in the medical record that satisfies the criteria required by the NCCI-associated modifier used, and the procedure code pair has a status indicator of "1" Please keep in mind the following when considering the use of modifier -59. Modifiers –XE, -XP, -XS, or –XU may be used in place of modifier -59.

» A practitioner should not report multiple codes corresponding to component services if a single comprehensive code describes the services performed.

» A practitioner should not unbundle services that are integral to a more comprehensive procedure or bilateral procedure code.

» When modifier -59 is applied, documentation must support that both services are distinct or independent of one another.

Is the Modifier 59 Appropriate



More Extensive Procedures

Not separately reportable if performed at the same Patient encounter on the same anatomic site.

- A partial procedure is not separately reportable with a complete or total procedure.
- A unilateral procedure is not separately reportable with a bilateral procedure.
- A single procedure is not separately reportable with a multiple procedure.
- A with procedure is not separately reportable with a without procedure.

PHP clinical edits are processed with an explanation code defining the reason for the denial. Any services denied due to PHP's clinical edits such as bundling, clinical daily maximums, or other payment logic may not be billed to the member.

When billing PHP, please make sure to review general industry billing standards prior to submitting your claim, including, but not limited to, the American Medical Association's (AMA) CPT Manual, Centers for Medicare and Medicaid Services (CMS) and National Correct Coding Initiative for Medicare Services (NCCI). Claims submitted in accordance with appropriate coding and clinical edit rules are more likely to process without delay!

Change in PHP Pharmacy Benefit Manager

On Jan. 1, 2017, Physicians Health Plan (PHP) is transitioning its pharmacy benefit services to CVS Caremark. You can expect smooth and consistent service during this transition, as well as access to a full range of pharmacy benefits and support.

What's changing:

When PHP transitions its pharmacy benefit services to CVS Caremark, your Patients may experience the following:

- Your Patients will receive a new 2017 ID card with CVS Caremark information prior to Jan. 1.
- Due to the transition, PHP will not be able to process requests for ID cards between Dec. 1 and Dec. 14, 2016. ID card requests will be fulfilled after Dec. 15, 2016. However, if your Patients need a temporary card prior to Dec. 15, they may print one through HealthWeb under "Order ID Card."
- Mail service pharmacy will be CVS Caremark and the CVS Caremark call center will support mail service pharmacy inquiries as of Jan. 1, 2017.
- A new online member portal – **Caremark.com** – will be available as of Jan. 1, 2017.

Frequently asked questions regarding the transition to CVS Caremark

- If my Patients have a new or refill retail prescription on Jan. 1 – can they get it filled?
  - *Yes, there are over 60,000 pharmacies nationwide that are Network pharmacies.*
- Will my Patients still have access to mail order prescriptions?
  - *If your Patient uses mail order, their mail order refill prescriptions will transfer to CVS Caremark unless they are a compound, controlled substance, or the refill has expired.*
- A prior authorization is in place. Will that change?
  - *All active prior authorizations through Express-Scripts will transfer to CVS Caremark on Jan. 1, 2017.*
- Will the Prescription Drug List (PDL) change?
  - *No, the prescription drug list will not change as a result of the transition to CVS Caremark.*
- Will copays or benefits change?
  - *No, copays and benefits will not change as a direct result of the transition to CVS Caremark. However benefits may change as a result of your Patient's open enrollment choice.*
- Will PHP still review requests for authorization?
  - *Yes, PHP will still review requests for quantity limit overrides, non-covered drugs, and dosage exceptions.*

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General Training 101

Are you interested in learning more about PHP? Your Provider Relations Coordinator Team is offering training sessions in 2017 for management and all office staff. Learning opportunities include; review of provider manual, auditing, checking eligibility and benefits, claim status, authorizations, and much more. Training takes place at PHP and a light meal will be provided during the presentation.

Please email your RSVP or questions to:
PHPProviderRelations@PHPMM.org

Available 2017 training dates:

- » **Jan. 26** 8:30 – 10 a.m.
- » **April 27** noon – 1:30 p.m.
- » **July 27** 8:30 – 10 a.m.
- » **Oct.19** noon – 1:30 p.m.

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