Provider Connection

FOURTH QUARTER 2017

In this issue

Working with PHP 2
- Holiday Hours
- General Training 101
- TAIP Training
- New signature solution

Advance Care Planning 4

Expectant Mother? 5

Pharmacy news and updates 6

Prior Authorizations.
You spoke. We listened. 8

Clinical documentation.
Unspecified ICD-10-CM 8

Utilization Management news and updates 9

Newborn Eligibility 10

Claims 12
- Timely filing
- Right to Appeal

HEDIS Corner. Antibiotic Awareness 13

UPDATED. APP billing guidelines 14

Contact us 15

Physicians Health Plan

A health plan that works for you.

2017 Holiday Hours

Physicians Health Plan will be closed

- Christmas Day, Monday, Dec 25

2018 Holiday Hours

Physicians Health Plan will be closed

- New Year's Day, Monday, Jan. 1
- Memorial Day, Monday, May 28
- Independence Day, Wednesday, July 4
- Labor Day, Monday, Sept. 3
- Thanksgiving, Thursday, Nov. 23
- Christmas Day, Tuesday, Dec. 25

If you have an after-hours emergency that cannot wait until the next business day, please contact the answering service at **517.364.8500** for assistance.

General Training 101

The Provider Relations Coordinator 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.

Feb. 1 | 8:30-10 a.m.

April 26 | noon-1:30 p.m.

July 19 | 8:30-10 a.m.

Oct. 25 | noon-1:30 p.m.

TAIP Training

2017

Dec. 12 | 8-10 a.m.

Dec. 13 | 8-10 a.m. and 2:30-4:30 p.m.

Dec. 14 | 8-10 a.m. and 1-3 p.m.

2018

Jan. 18 | 8-10 a.m. and 1-3 p.m.

Jan. 24 | 8-10 a.m. and 1-3 p.m.

Please email your RSVP at least one week prior to the event. Questions? Contact **PHPProviderRelations@phpmm.org**. All trainings take place at PHP, are free of charge, and include a light meal.

New Signature Solution

In support of PHP's continuous efforts toward increasing the efficiency and timeliness of handling business processes for our network of providers and members, PHP is eager to announce the upcoming addition of our new digital signature process!

This process will be accessible via a secure-online portal operated by Adobe Sign®. This portal will enable Providers to receive, review, and digitally sign PHP required documents in an individually-generated user account. Examples of documents you will be able to access within this portal may include: credentialing paperwork, network participation contracts, and provider manual updates.

Some of the benefits that we expect this system to produce are: decreased turnaround times for processing documents; additional levels of security for documents sent & received; and an overall increased convenience factor for internal and external parties.

PHP is currently working internally to implement this process; our goal is to have it launched and available for providers' use by the end of 2017. More information to come on when and how you can use this system. We look forward to bringing this advanced format for conducting business operations to you.

If you have questions directly related to the new signature process through Adobe Sign®, please contact the Provider Relations team at **PHPProviderRelations@phpmm.org**.

Source: theblog.adobe.com

Advance Care Planning

It's the holiday season and your family is gathered together to celebrate and catch up. Is healthcare on the list of discussion topics? Physicians Health Plan is encouraging members to put this important subject at the top of the list this holiday season, and to share the gift of knowledge with family and friends. No one wants to leave loved ones with the burden of having to guess about important healthcare decisions.

The Role of Physicians

Patients have a right to take an active role in their own healthcare. Unfortunately, there are times, such as sudden illness or an 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, which should be revisited regularly to explore any changes a Patient may have in his or her wishes. 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.

Advance Directives

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.

Plan for the Future

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 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.

Expectant Mother?

Prenatal classes

Prenatal classes are covered by PHP when taken through Expectant Parents Organization (EPO). Members can register by calling **517.337.7365** or via the website at **epobaby.org**.

There is a $20 cost share for the one day Saturday Prenatal Seminar, but all other Prenatal Classes are covered with no cost share for the Member.

Online classes are only covered if the Member lives out of the area or is on bedrest. Prior registration is required for online classes. Member needs to contact EPO about this option.

Prenatal vitamin copay benefit

Select formulary prenatal vitamins are available through your pharmacy benefit with one copay for a 90-day supply for expectant members. If applicable, the annual deductible must be met prior to receiving a 90-day supply for one copay.

Pharmacy news and updates

PHP's Prescription Drug List (PDL) is available online at **PHPMichigan.com/providers**. Simply select "General Forms and Information" to find the current drug list. Additionally, criteria for medications requiring prior approval 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**.

Drug	Action	Implementation Date
Auvi-Q (epinephrine auto-injector)	Drug now excluded from formulary	5/31/17
Lyrica (pregabalin capsules)	Added quantity limit of 3 capsules daily for all strengths	8/1/17
Premarin (conjugated estrogen oral tablets)	Added quantity limit of 3 capsules daily for all strengths	8/1/17
Xermelo® (telotristat ethyl tablets)	Added drug to formulary (Tier 3, requires PA)	7/14/17
Eucrisa (crisaborole 2% ointment)	Added drug to formulary (Tier 3, requires PA)	7/14/17
Ingrezza (valbenazine)	Added drug to formulary (Tier 3, requires PA)	7/14/17
Austedo (deutetrabenazine)	Added drug to formulary (Tier 3, requires PA)	7/14/17
Rhofade (oxymetazoline 1% cream)	Added drug to formulary (Tier 3, requires PA)	7/14/17
Emflaza (deflazacort tablets)	Added drug to formulary (Tier 3, requires PA)	7/14/17
Kisqali (ribociclib tablet)	Added drug to formulary (Tier 3, requires PA)	7/14/17
Bavencio (avelumab)	Added drug to formulary (requires PA)	7/14/17
Spinraza (nusinersen)	Added drug to formulary (requires PA)	7/14/17
Dupixent (dupilumab)	Added drug to formulary (requires PA)	7/14/17
Ocrevus (ocrelizumab)	Added drug to formulary (requires PA)	7/14/17
Intrarosa (prasterone vaginal inserts)	Added drug to formulary (requires Tier 3)	8/23/17
Xatmep (methotrexate oral solution)	Added drug to formulary (requires PA)	8/23/17
Kevzara (sarilumab SQ injection)	Added drug to formulary (Tier 3/4, requires PA)	8/23/17
Rituxan Hycela (rituximab-hyaluronidase SQ injection)	Added drug to formulary (requires PA)	8/23/17
Siliq (brodalumab SQ injection)	Added drug to formulary (Tier 3/4, requires PA)	8/23/17

Drug	Action	Implementation Date
Renagel (sevelamer capsule)	Moved brand name to Tier 3	9/1/17
Brand Name Absorica (isotretinoin capsules)	Added Step Edit to branded drug only	9/1/17
Actoplus Met (pioglitazone/metformin)	Moved brand name to Tier 3	9/1/17
Androgel 1.62% pump (testosterone gel)	Added a quantity limit of 450gm per 72-day period	9/1/17
Doxepin 5% cream	Added PA requirement to drug	9/1/17
Gleevec (Brand Name Only)	Added PA requirement to brand name drug only	9/1/17
Horizant (gabapentin enacarbil)	Drug now excluded from formulary	9/1/17
Linzess (linaclotide)	Added quantity limit of 1 capsule daily	9/1/17
Oxycontin (Brand Name Only)	Moved brand name to Tier 3	9/1/17
Subsys (fentanyl sublingual spray)	Drug now excluded from formulary	9/1/17
Xarelto	» No longer requires PA » Drug moved to preferred status (Tier 2)	7/1/17
Trulicity/Victoza	» Moved to preferred status (Tier 2) » Now has a metformin step-edit instead of requiring PA	10/1/17
Byetta/Bydureon	Drugs now excluded from formulary	10/1/17
Farxiga/Xigduo/Jardiance	» Moved to preferred status (Tier 2) » Now has a metformin step-edit instead of requiring PA	10/1/17
Invokana	Drug will be excluded from formulary	10/1/17
Viagra	Drug will be excluded from formulary (preferred agent will be Cialis)	12/1/17
Basaglar/Levemir/Tresiba	Will become preferred drugs in class	1/1/18
Lantus/Toujeo	Drugs will be excluded from formulary	1/1/18
C9399	Code will require PA	1/1/18

Prior Authorizations. You spoke. We listened.

Physicians Health Plan (PHP) received feedback from Providers and Members that the time between submitting a request for prior approval (for medical services) until final notification is received can result in delays in care.

In 2015 and 2016, the PHP Utilization Management Team launched a plan to decrease the turn-around time by 10% on prior approval (for medical services). Through a series of process improvements and staff focus throughout 2017, the team has been able to reduce turn-around times significantly. Urgent requests now have a response time within 24 hours and non-urgent requests are being resolved within five days or less.

This has been a huge success for our Utilization team and has increased our Provider and Member satisfaction.

Utilization Management news and updates

Procedures and services requiring prior authorization/approval are available online. Visit **PHPMichigan.com/providers** and 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/approval 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 approval requests may be submitted via the Utilization Management fax: **517.364.8409** from 8 a.m. to 5 p.m., Monday through Friday.

Changes to Coverage for Services

Code	Procedure or Service	Action	Implementation Date
36470, 36471	Injection sclerotherapy	Changed from not covered to covered with PA	10/11/2017
0295T, 0296T, 0297T, 0298T	Added quantity limit of 3 capsules daily for all strengths	Changed from not covered to covered with PA	01/01/2018
K0553	Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service	New code 7/1/2017 – requires PA	New policy effective 1/1/2018
K0554	Receiver (monitor), dedicated, for use with therapeutic glucose continuous monitor system	New code 7/1/2017 – requires PA	New policy effective 1/1/2018
Q4131	Epifix or epicord, per square centimeter	Changed from not covered to PA	01/01/2018
HCPCS codes for non-emergent ambulance transport		No longer requires PA	New policy effective 1/1/2018

Will add "Skin substitutes" to the Notification Table. Most of the codes are currently experimental (last reviewed 2013), but are now considered medically necessary when criteria is met.

Clinical Documentation. Unspecified ICD-10-CM

With the implementation of ICD-10-CM, there are now five times as many codes than ICD-9-CM. The expectation from Physicians Health Plan is that providers are being as specific as possible to assure the best quality information regarding their Patient's condition when coding ICD-10-CM. Unspecified is defined as a coding that does not fully define important parameters of the patient's condition that could otherwise be defined given information available to the provider and the coder. Unspecified is simply coding that is too vague when there is information available that would allow for greater specificity. Instances when it may be acceptable to use an unspecified code are:

- The Patient is in the early course of evaluation and the provider may not know enough to apply a more specific code.
- The claim may be from a provider who is not directly related to the diagnosis of the Patient's condition.
- The provider seeing the Patient may be more of a generalist who is not able to define the condition at a level of detail expected by a specialist.

Providers should avoid using unspecified codes when there is sufficient information to accurately define the Patient's condition and the provider can account for basic concepts such as: laterality, anatomical locations, trimester of pregnancy, type of diabetes, known complications or comorbidities, description of severity, acuity or other known parameters.

Coding is about justification and if you are simply selecting an unspecified code as a time-saving measure, or if you are unsure if the unspecified code is appropriate for a specific diagnosis, then you probably should not use it. CMS has a complete list of the most current ICD-10-CM as well as transmittals that contain code updates for National Coverage Determinations (NCDs). Local Coverage Determinations (LCD's) can be found in the Medicare Coverage Database and are searchable in a number of ways, including "Quick Search" function. CMS also has provider resources available regarding successful ICD-10 billing. Learn more at **cms.gov**.

Newborn Eligibility

Effective Jan. 1, 2018, Physicians Health Plan (PHP) is updating the newborn eligibility requirements in accordance with the State Insurance Code amended in 2016.

As of Jan 1, 2018, newborns need to be enrolled with PHP prior to any claims processing against the member's eligible benefits.

All newborns need to be enrolled within the first 31 days of life to be eligible for services. Subscribers need to facilitate the appropriate paperwork to enroll their newborn in their benefit plan. Newborns enrolled within 31 days from the date of birth will be effective as of the date they are born. Newborns not enrolled within 31 days from the date of admission are not eligible for coverage until the next open enrollment period for their benefit plan.

PHP will reject any claims submitted for newborns who have not yet enrolled as dependents of their parent/guardian's benefit plan. Members can appeal rejected claims following the standard appeal process outlined on the PHP website at **PHPMichigan.com**. Verification of member eligibility can be obtained through your MyPHP Provider Portal 24 hours a day. Please contact the Provider Relations Team if you have any questions on how to obtain eligibility information.

PHP has communicated this change to our employer groups and reminders are sent to members. We encourage our providers to share this requirement at the first date of service. PHP has flyers available to assist you with this communication. If you would like a supply of flyers for your office, please contact your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Timely Filing

Beginning with dates of service Jan. 1, 2018, and after, all claims, including adjusted claims, must be received by PHP no later than 180 days from the date healthcare services are rendered. Claims received for dates of service Jan.1, 2018, and after, that are over 180 days from the date of service or the date of discharge, will be rejected for being over the filing time limit. When PHP is not the primary carrier, claims need to be submitted within 180 days from the date on the primary carriers' Explanation of Payment (EOP).

PHP has taken steps to ensure accuracy and efficiency of our claims processing and part of this is to ensure that claims data is collected and processed in a timely manner. By reducing our filing process time to 180 days, we hope to achieve quick turnaround times and faster payment to you, the Providers.

Claim Adjustments

If it becomes necessary to adjust a claim, you can request an adjustment of a claim previously processed by PHP by using the Claim Adjustment Request form. This form can be obtained through our website. We require that requests for adjustment be submitted within the 180-day timeframe.

After a claim is processed, if the determination is not what was expected and/or the Customer Service Department is unable to assist in the processing/reprocessing of the claim, you as a Provider can submit an appeal. The appeal request must be in writing asking for a change in the decision made by PHP. The appeal time frame is 90 days from the date the claim processed.

For the most up-to-date information, please utilize the MyPHP Provider web portal, which has the following capabilities:

- Eligibility and Coverage - Search Patients to verify eligibility and coverage information (effective dates, Primary Care Physician and member profile information).
- Benefits - View and download a member's benefit plan and documents (summary of benefits-coming soon).
- Prior Approvals – View the status of an approval request and obtain the prior authorization number.
- Claims - Search and view claims (status, amount paid, paid dates and claim history).
- Explanation of Payment (EOP) – Search, view, and print EOPs.
- Accumulators - View member's out-of-pocket and deductible balances.
- View and print Primary Care Physician Patient Rosters.
- Self-registration and password re-sets.

Right to Appeal

Providers have the right to appeal a rejected claim payment in writing within ninety (90) days from the date of rejection. You may submit a letter or use a printed copy of the appeal form located in the Provider Section of the PHP website. It is recommended that you submit your appeal request with a paper copy of the claim attached. It is important to include additional information that would support the reason for the appeal. This would include information not previously submitted regarding the reason and rationale for the appeal. Additional information may include charts and office notes, radiology or lab/pathology report(s), operative notes or surgery reports.

You may mail or fax the appeal to:

Physicians Health Plan
ATTN: Customer Service, Provider Appeals
PO Box 30377
Lansing, MI 48909
Fax: 517.364.8411

It is important to note that claim appeal requests received after ninety (90) days from the date of rejection will not be eligible for review and consideration.

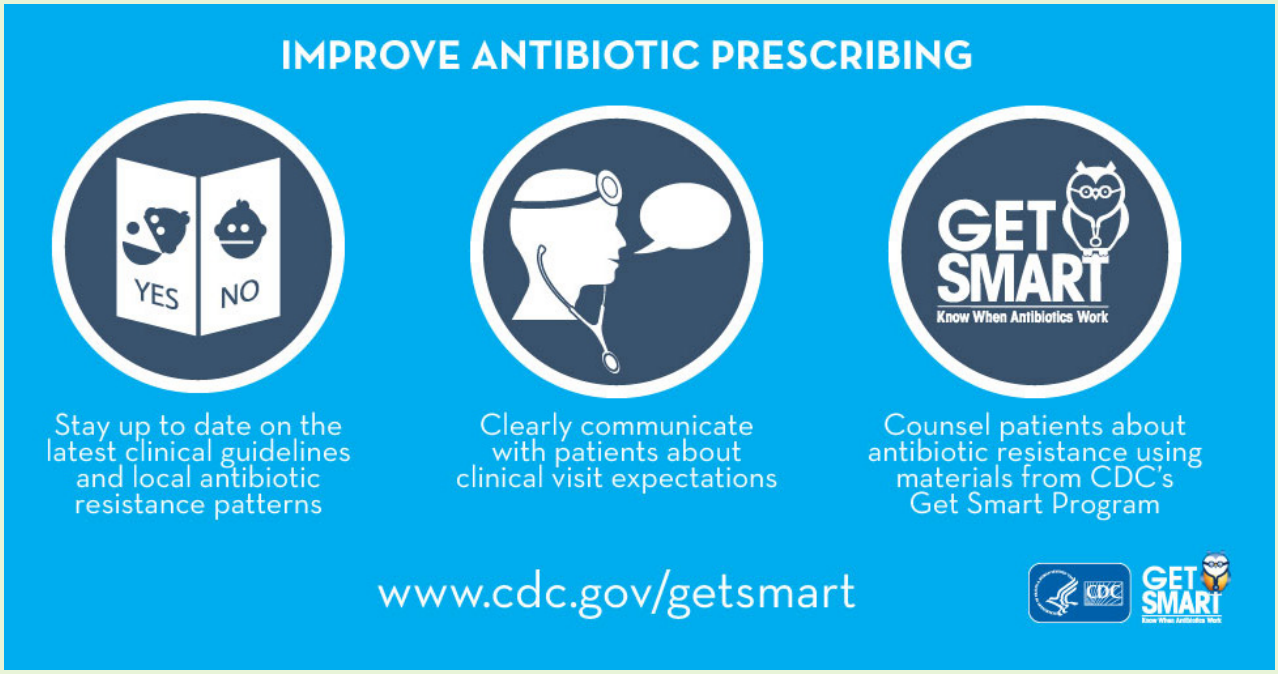
HEDIS CORNER

Antibiotic Awareness

U.S. Antibiotic Awareness Week (held each year in November) raises awareness of antibiotic resistance and the importance of appropriate antibiotic prescribing and use.

Each year in the United States, at least 2 million people become infected with bacteria that are resistant to antibiotics and at least 23,000 people die as a direct result of these infections. Many more people die from other conditions that were complicated by an antibiotic-resistant infection.

The use of antibiotics is the single most important factor leading to antibiotic resistance around the world. Antibiotics are among the most commonly prescribed drugs used in human medicine. However, up to 50% of all the antibiotics prescribed are not needed or are not optimally effective as prescribed.



Reference: Centers for Disease Control and Prevention.

UPDATED. APP billing guidelines

Below are PHP's "incident to" billing guidelines and protocols billed by Physicians and non-Physician practitioners. These guidelines should be followed to ensure appropriate documentation for reimbursement.

To qualify as "incident to," services must be part of a Patient's normal course of treatment, during which a M.D./D.O. personally performed the initial service and determines the Plan of Care and remains actively involved in the course of treatment. Subsequent services provided by an APP must be related to established Plan of Care. Services provided by the APP that qualify for "incident to billing" as defined should be billed under the supervising physicians NPI.

If there is a change in the Plan of Care, the service would no longer meet the requirement for incident to and the Patient must be re-evaluated by the M.D./D.O. and services should be billed under the M.D./D.O.'s NPI number.

Signature Requirements

The supervising Physician is not required to co-sign the Patient's record when a PA/NP provides the service, however the supervising Physician must remain actively involved in the course of treatment and documentation must support review and involvement in the oversight of the Patient's care.

For example, Patient's record must indicate that the supervising Physician reviewed and agreed with the course of diagnosis or treatment of an injury or illness.

Physician Assistants (PA)

PHP does not credential Physician Assistants. They would be required to meet "incident to" billing guidelines in an office and outpatient setting. The services may be rendered by a PA and considered reimbursable as long as the following requirements are met:

- Supervising Physician does not have to be physically present in the Patient's treatment room, but must be readily available to render assistance, if necessary.
- Qualifying "incident to" services must be provided by a PA/NP whom the M.D./D.O. directly supervises, and who represents a direct financial expense to the M.D./D.O.'s practice (such as a "W-2" or leased employee, or an independent contractor).
- For New Patients the Physician must personally review history, examine the Patient and make medical decisions regarding the Patient's treatment, and drug protocols.
- The PA must be licensed to render the services.
- PA must bill under supervising Physicians NPI number.

Nurse Practitioners (NP)

PHP does credential Nurse Practitioners. Any NP credentialed by PHP must bill their services under their own provider NPI. Non-credentialed NP's must meet "incident to" billing guidelines in an office and outpatient setting. The services rendered may be rendered by a NP and considered reimbursable as long as the following requirements are met:

- Supervising Physician does not have to be physically present in the Patient's treatment room, but must be readily available to render assistance, if necessary
- Qualifying "incident to" services must be provided by a PA/NP whom the M.D./D.O. directly supervises, and who represents a direct financial expense to the M.D./D.O.'s practice (such as a "W-2" or leased employee, or an independent contractor).
- For New Patients the Physician must personally review history, examine the Patient and make medical decisions regarding the Patient's treatment, and drug protocols.
- The NP must have a Master's Degree in nursing.
- The NP must be a registered professional Nurse, authorized by the State in which their services are furnished to practice as a nurse practitioner, in accordance with state law.
- The NP must be certified as a nurse practitioner by the American Nurses Credentialing Center (ANCC) or other recognized national certifying entities that have established standards for nurse practitioners.
- Non-credentialed NP's must bill under supervising Physicians NPI number.
- Credentialed NP's must bill under their own NPI number.

Failure to comply with the above Physician Assistant and Nurse Practitioner guidelines may result in financial adjustments.

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 obtain clinical decision-making criteria » Behavioral Health/Substance Abuse Services. For information on mental health and/or substance abuse services including prior authorizations, case management, discharge planning and referral assistance.	517.364.8560 866.203.0618 (toll free) 517.364.8409 (fax)	
Network Services	» Credentialing - 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	517.364.8466 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** pharmacy@phpmm.org
Change HealthCare (TC3)	» When medical records are requested	Fax: 952.949.3713 or 949.943.8843 **Mail To:** Change HealthCare 5720 Smetana Drive, Suite 400 Minnetonka MN 55343	