Provider Connection

THIRD QUARTER 2017

In this issue

Physicians Health Plan

A health plan that works for you.

Marketplace open enrollment

Physicians Health Plan will follow the 2018 open enrollment period beginning Nov. 1 through Dec. 15 for Marketplace plans. This open enrollment period is available for members who:

- Enrolled with Physicians Health Plan as an insurance carrier through **HealthCare.gov**;
- Are members who are currently enrolled in one of our off-Marketplace plans; or
- Are potential new enrollees seeking healthcare coverage for the 2018 plan year.

Information regarding insurance premiums and plan options will be available on **HealthCare.gov** as well as **PHPmichigan.com** starting Nov. 1.

If you or your Patients need additional help with benefits plans, please utilize the MyPHP portal, or call customer service at **517.364.8500**.

Online and interactive. New Provider Manual coming soon

A new Provider Manual is in the works and almost ready. The new approach will allow you direct access to the content you need... no longer will you have to scroll through a lengthy .pdf in search of the answer. It will be simple to navigate and an essential tool to obtain important information and answers when the time is convenient for you.

- Referral/notification/authorization processes
- Credentialing and re-credentialing
- Standard of Care guidelines
- Responsibilities/expectations of healthcare professionals
- General guidelines (admission services, emergency care, etc.)
- Reimbursement for healthcare services
- How to submit a claim
- Clinical edits
- Copay, co-insurance, deductibles and non-covered services
- Fraud and abuse

Watch for an announcement in the next few months when the new manual is ready for you!

MyPHP training and notices now online

Newly added to the Providers' section of the PHP Website, you will now see training opportunities to view online tutorials for MyPHP. We've broken them down into categories so you can easily navigate from one topic to another or skip the ones that might not pertain to you. PHP will continue to add to the website as new training documents are developed. If you would like additional training on a specific category please contact your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

We have also added notices to the website. Now you can find the most recent notices that have been sent to our Provider Network in one convenient spot. Keeping you up-to-date is our goal!

2017 Provider Satisfaction Survey

PHP has recently mailed the 2017 Provider Satisfaction Survey. You have the opportunity to submit your responses either online, by paper or by phone. The feedback we receive is used to assist us in developing enhancements to existing programs and processes so we can improve our services for you and our members. Your feedback will ensure that we continue to perform in a collaborative partnership.

As a result of last year's survey, PHP initiated changes that include:

- Improved claim processing times
- Increased frequency of check writes to twice a week
- Increased visits from the Provider Relations Team
- Initiated a new web portal, MyPHP
- Updated website to include notices, web trainings, and more
- Decreased hold times and improved communication response times

PHP Network Services encourages you to take a few minutes to let us know how we are doing. If you have an immediate concern or a question, please contact us directly at **PHPProviderRelations@phpmm.org**.

Meet Your Provider Relations Team

Rachel DeSantis
Provider Relations Coordinator

Bethany Dumond
Provider Relations Coordinator

Robin Classens
Manager

PHP's Provider Relations team is your connection to PHP. Whether by phone or in person, our team is here to work with you and other PHP departments to answer questions or concerns, assist with problem resolution and project management, guide you through PHP processes, and ensure your office is up-to-date on PHP changes and procedures.

The Provider Relations Team is available to conduct for training and education either in your office or at PHP.

PHP's Customer Service Representatives can answer most of your calls and concerns, however if they are not able to assist you, you can reach Rachel or Bethany by phone:

Rachel DeSantis: 517.364.8316 | Bethany Dumond: 517.364.8323

Or email **PHPProviderRelations@phpmm.org**. This mailbox is monitored frequently to ensure issues get directed to the correct team for resolution.

MyPHP, PHP's new online tool, offers 24/7 access to claim status, eligibility inquiries, and general benefit information as well. You can register for the MyPHP Provider Portal by visiting the PHP website at **PHPMichigan.com** or you can contact our Customer Service Team at **517.364.8500** or **1.800.832.9186**.

Prior Authorizations

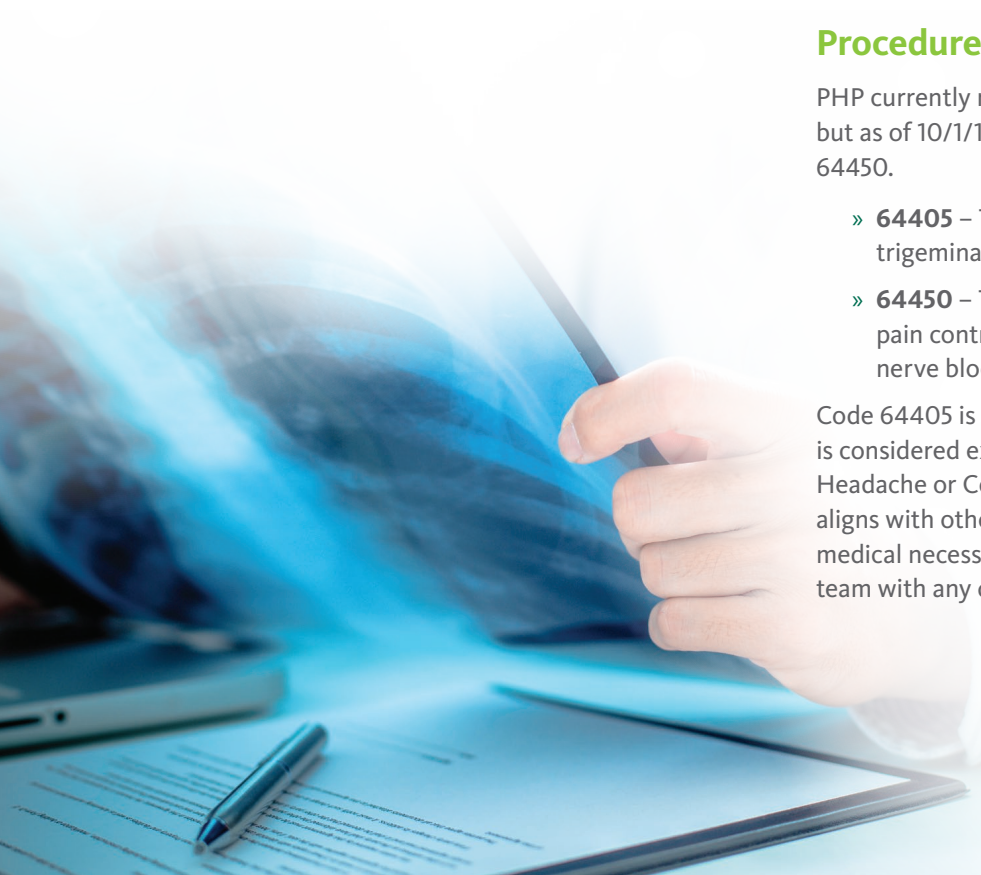
Prior authorization is the process in which the Patient's health plan must approve a service for the Patient before it can be performed and reimbursed. PHP depends on Physicians and facilities for notification of the services listed on the Prior Authorization table. These notifications allow PHP to facilitate access to needed care and support a positive outcome for your Patients, our Members.

Failure to comply with Prior Authorization requirements creates personal financial responsibilities for the members, along with a referral to the Network Education and Integrity Program (NEIP) for monitoring purposes.

The Prior Authorization table and forms can be found under the Provider tab on the website to help guide you on what services need prior authorization. If you have further questions, you can contact the Medical Resource Management (MRM) Team at **517.364.8560** or fax your request to **517.364.8409**.

Urgent and non-urgent

Providers are encouraged to call PHP Customer Service to determine if medications, services, or specific codes require prior approval. A request must include all required information to complete the review. If the required information is not received, PHP will reach out to the office to request the specific information that is needed to process the request. If the requested information is not received within the specified time frame, a denial will be issued for the requested service.



Time frames for processing requests:

- **Non-urgent (routine)** – A non-urgent request for care must be processed within 14 calendar days of receipt of the request.
- **Urgent** – A request for care in which the routine time period for making a determination could:
  - Seriously jeopardize the life or health of the member
  - Jeopardize the member's ability to regain maximum function

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.

Low Dose CT Scan

Code G0297, Low Dose CT scan (LDCT) for lung cancer screening, requires a prior authorization.

Genetic testing services

All genetic testing requires prior authorization which begins with communication from the Physician ordering the genetic testing.

Please be sure to contact our Authorizations Team to request prior authorization for genetic testing.

Procedure Codes 64450 and 64405

PHP currently requires prior authorization for code 64405 but as of 10/1/17 will also require prior authorization for code 64450.

- **64405** – The Physician anesthetizes a branch of the trigeminal nerve; greater occipital
- **64450** – The Physician anesthetizes a nerve to provide pain control or blockage. This code is used to report nerve blocks of other nerves not specifically listed.

Code 64405 is considered experimental and code 64450 is considered experimental for the diagnosis codes of Headache or Cervicalgia. PHP's prior authorization process aligns with other payors in using clinical criteria to determine medical necessity. Please contact your Provider Relations team with any questions.

PHP Case management services

At PHP, our Case Management Team works hard to help your Patients get the coverage, care, and personal support they deserve. That means ensuring they have access to the care prescribed by their Physicians, hospital care team, and other healthcare Providers to achieve their healthcare goals.

At your request, the PHP Case Management Team can help your Patient following an inpatient hospital stay.

What can your Patients expect?

A PHP Case Manager will call the member to discuss their healthcare needs. Together with the Patient, their family, and their Physicians, we formulate a plan to meet their healthcare goals and follow up to ensure they are met. We advocate on the Patient's behalf to find resources and connect them with the services they need, including:

- Medications
- Home Health Care
- Rehabilitation Services
- Finding a Primary Care Physician
- Referrals when seeking care from an Out-of-Network Specialist
- Education on medical conditions
- Community resources
- Transplant support
- Behavioral Health
- Substance Use Disorders (SUD)

How can you refer one of your Patients to Case Management at PHP?

Provide the PHP Case Management team the Patient's name, phone number, reason for referral, and whether or not the member is aware of the referral to Case Management.

- Call: **517.364.8588** or **1.866.203.0618**;
- Email: **PHPCaseManagement@phpmm.org**.

PHP Case Management services are provided as part of a member's coverage with PHP. There are no costs for using this service.

Utilization Management news and updates

- As of Oct. 1, 2017, prior authorization is no longer required for Lap-band adjustments (S2083) when conducted in the office setting. Effective Oct. 1, 2017, S2083 will apply an Office Visit cost share when done in the office.
- Anesthesia services specific for gastric restrictive procedures (00797) will apply toward the member's bariatric surgery benefit and cost share effective Oct. 1, 2017.
- Revision to Hematopoietic Stem Cell Transplant (HSCT) policy: As of June 14, 2017, PHP revised this policy to reflect the changes in the transplant industry. HSCT is utilized for treatment of cancers of the blood, bone marrow, and genetic diseases. Research is expanding the potential use of HSCT in treating other conditions such as multiple sclerosis and some solid tumors. PHP policy now identifies specific criteria for HSCT by diagnosis and type of stem cell transplant. PHP has a Transplant Case Manager who can assist you in navigating the process of prior authorization for solid organ or stem cell transplants. To reach a Transplant Case Manager please call Medical Resource Management at **517.364.8560**.

Clinical Documentation

Documentation of services is an important aspect of medical care. Claims submitted to Physicians Health Plan must support the level of service billed and be accurately documented in the medical record. In addition, time based codes must include the time spent performing the services.

The following are common errors to avoid in medical record documentation.

Diagnosis Coding

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

History of Present Illness (HPI)

According to Centers for Medicare and Medicaid Services (CMS), only the provider can perform and document the HPI portion of the Patient’s history. Ancillary staff can document other parts of the history, but not the HPI. Nor is it acceptable to have ancillary staff document the HPI and the provider later document that they reviewed it.

The following questions/answers were taken from the CMS WPS Insurance Corporation Provider’s Guide for Michigan Physicians:

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

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

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

» *No. The Physician billing the service must document the HPI.*

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

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

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

Modifier 53

Modifier 53 is reported on a professional claim to indicate that a Physician has elected to terminate a surgical or diagnostic procedure for the Patient's well-being or due to circumstances beyond the Physician's or Provider's control.

Facilities reporting a discontinued outpatient procedure should use Modifier 73 or 74.

Physicians Health Plan pays at a 50% reduction when Modifier 53 is applied to the service. This is not an inclusive reduction. Multiple Surgical Reduction (MSR), bilateral pricing, and other edits may still apply.

Appropriate Usage

- Procedure discontinued after induction of anesthesia
- Bill modifier 53 with the CPT code for the service furnished

Inappropriate Usage

- On an Evaluation and Management (E/M) procedure code
- Discontinued surgeries prior to the anesthesia being induced
- On time based procedure codes (i.e. critical care and psychotherapy)
- On an elective cancellation of a procedure

If you have additional questions regarding the appropriate use of Modifier 53, you can reach out to the Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Paint the whole picture

Clinical Documentation is critical for the Patient, the Physician, and Physicians Health Plan. You have probably heard the saying, "A picture is worth a thousand words." The same logic applies to ICD-10 coding. While you probably will not need a thousand ICD-10 codes to paint a complete picture of a Patient's diagnosis, there is a good chance you will need more than one. As an organization, we are dependent upon the healthcare provider to supply appropriate documentation to comply with CMS regulations around quality and coding specificity.

There are 12 spaces for diagnosis codes on a CMS-1500 form, and a UB04 has space for 41. Why not use more than one diagnosis when appropriate?

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

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

Pharmacy news and updates

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

Additionally, 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**.

Changes to the Formulary

Drug	Action	Implementation Date
Jalyn (Brand and Generic)	Removing PA	Removing PA
Orenitram ER	Add to formulary with PA	10/1/16
Velphoro	Add to formulary with PA	9/1/16
Pennsaid	Drug now requires PA	9/1/16
Alocortin A, MuGard, Gelclair	Excluding from formulary	8/12/16
Genvoya	Removing PA	9/1/16
Arestin	Add to formulary with PA	7/15/16
Calcipotriene	Qty limit - max 120gm/month	10/18/16
Dezicol	Qty limit - max 6 tabs/day	10/18/16
Denavir	Adding PA	10/18/16
Edecrin	Adding PA	10/18/16
Lidocaine Ointment	Qty limit - max 120gm/month	10/18/16
Metformin ER Osmotic	Moving to Tier 3	10/18/16
Dyrenium	Add to formulary with PA	10/18/16
Santyl	Qty limit - max 90gm/month	10/18/16

Changes to the Multiple Sclerosis medication class

PHP is making some changes effective 7/1/2017 to the multiple sclerosis medication class that will improve Patient accessibility and ease of use by prescribers.

Tier changes

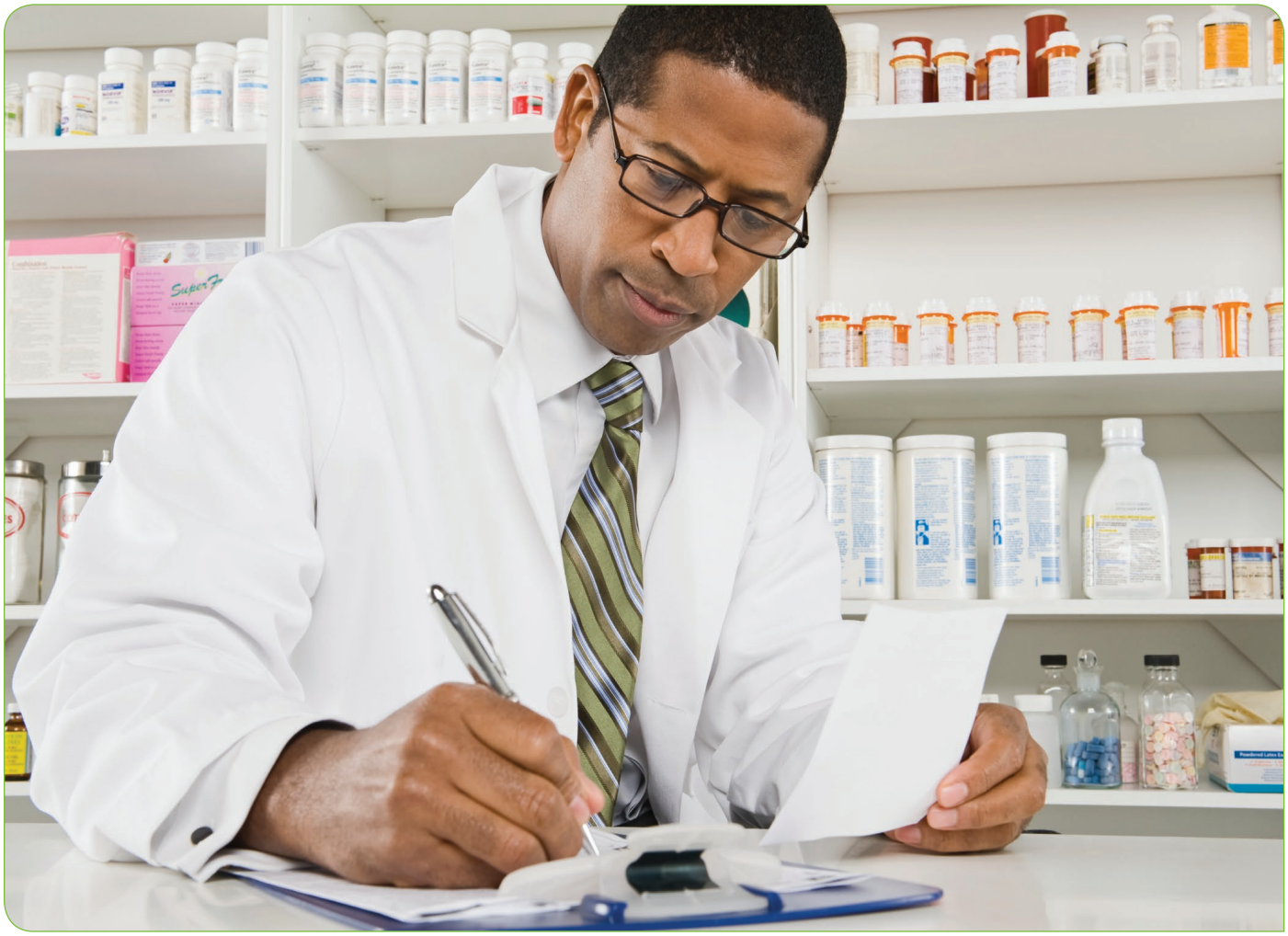
- Gilenya®, Tecfidera®, and Aubagio® are moving from a non-preferred status (Tier 3 or Tier 4) to preferred status (Tier 2) with lower Patient copays
- Ocrevus® has been added to the formulary on Tier 3

Relaxed prior authorization criteria:

- Betaseron®, Rebif®, and Rebif Rebidose® no longer require prior authorization
- Gilenya®, Tecfidera®, and Aubagio® no longer require a trial of two preferred agents

Tier 1	Tier 2	Tier 2, prior authorization required	Tier 3, prior authorization required
Glatopa	Copaxone 40 mg	Gilenya	Ocrevus
	Betaseron	Tecfidera	
	Rebif	Aubagio	
	Rebif Rebidose		

You can find PA criteria and the PA form on the PHP website under Providers/General Forms and Information.



APP billing guidelines

Below are PHP's "incident to" billing guidelines and protocols billed by Physicians and non-Physician practitioners such as PAs and NPs, collectively referred to as Advance Practice Providers or APPs. 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, determined the Plan of Care, and remains actively involved in the course of treatment. Subsequent services provided by an APP must be related to the established Plan of Care. Services provided by the APP that qualify for "incident to" billing as defined, should be billed under the supervising Physician's 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 an APP 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, the 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 PAs. They would be required to meet "incident to" billing guidelines in an office and outpatient setting. The services rendered 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);
- 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;
- The PA must bill under the supervising Physician's NPI number.

Nurse Practitioners (NP)

PHP does credential NPs. 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);
- 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 NP, in accordance with state law;
- The NP must be certified as a NP by the American Nurses Credentialing Center (ANCC) or other Recognized national certifying entities that have established standards for NPs;
- 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 PA and NP guidelines may result in financial adjustments.

Requesting a Leave of Absence

PHP allows participating providers to maintain their participation status during an approved leave of absence. A request for a leave of absence from participation must be for one of the following reasons:

- Medical leave
- Family leave
- Sabbatical
- Notification of call to active military service

The provider must submit a request for the leave of absence to PHP's Medical Director for approval. Failure to notify PHP in advance may result in termination of participation. Notification of any change in a Physician or provider's ability to provide covered services to PHP members is required. For more details about how to request a leave of absence or if you would like a copy of the PHP leave of absence policy, please contact our Credentialing team at **PHP.Credentialing@phpmm.org**.

PCP Patient rosters go digital

Getting your Primary Care Patient Rosters is easier and more convenient with our new MyPHP Provider portal.

To access your PCP Eligibility Patient Roster, sign in to the MyPHP Provider portal, hover over Coverage & Benefits in the tool bar, and click on PCP Eligibility Patient Roster. Select the Provider for which you wish to obtain the roster for and click Search. Your roster will populate and you can print or download your results into an excel format.

For additional assistance on how to access your PCP Eligibility Patient Roster click on MyPHP Provider Portal in the Providers' section of your website. There you will find a list of tutorials that explain many of the useful features of the site including one on how to register and how to obtain your PCP Eligibility Patient Roster. If you have questions please contact your Provider Relations Team at **PHPProviderRelations@phpmm.org**

Please note, with this new availability to provide you with instant access through MyPHP, paper rosters will no longer be sent to PCP offices.

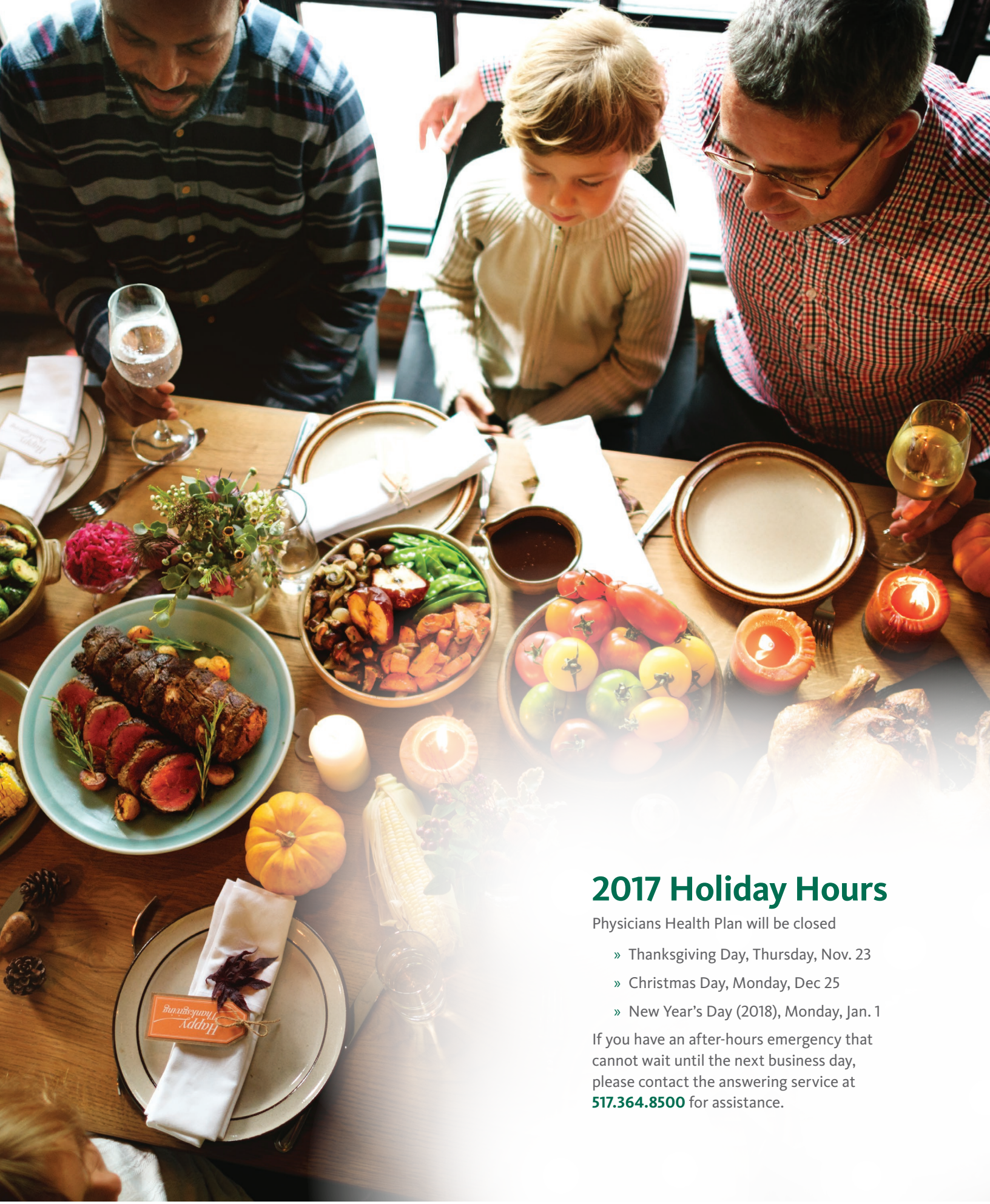
Name change or merger?

If so, it is important that PHP has an accurate and up to date W-9 on file for you. The W-9 is an Internal Revenue Service (IRS) form used to confirm your company's tax identification number or "TIN." It is the information on your W-9 that we use to report the 1099-MISC to the IRS. If the business name and tax identification number are an invalid combination according to the IRS database, the IRS will notify us and require that we send you a B-Notice to solicit the correct information. If we file the incorrect information a second time, IRS regulations require that we withhold 28% from any future payments made to you until the correct information is provided to us.

If you need any further assistance, please contact the Credentialing Team at **517.364.8312** or email them at **PHP.Credentialing@phpmm.org**.

Locum Tenens Participation

A Locum Tenens provider is defined as a provider replacing a network provider for a specified period, while the network provider is absent from his/her practice. PHP follows an application process for participation by any Locum Tenens providers and they must be credentialed in accordance with PHP's credentialing processes prior to providing care. Please contact PHP's Credentialing Team at **PHP.Credentialing@phpmm.org** for the details on how to get your Locum Tenens provider credentialed by PHP.



2017 Holiday Hours

Physicians Health Plan will be closed

- Thanksgiving Day, Thursday, Nov. 23
- Christmas Day, Monday, Dec 25
- New Year's Day (2018), Monday, Jan. 1

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.

How to contact us

Department	Contact Purpose	Contact Number	Email address
Medical Resource Management	» Notification of procedures and services outlined in the Notification/Authorization Table » To request benefit determinations and clinical information » To obtain clinical decision-making criteria » Behavioral Health/ Substance 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	

Physicians Health Plan

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

PRESORTED STANDARD
US POSTAGE
PAID
LANSING, MI
PERMIT 28