Provider Connection

FOURTH QUARTER 2022

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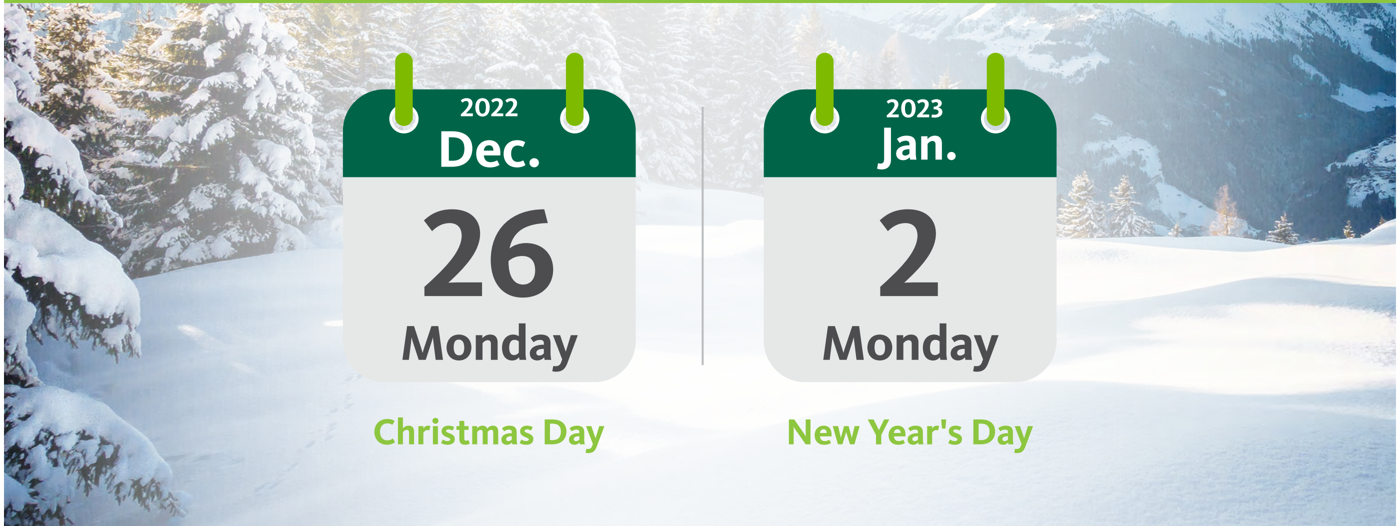
Physicians Health Plan

2022 Holiday Hours

Physicians Health Plan will be CLOSED in observation of the following holidays:



Meet Your Provider Relations Team

The PHP Provider Relations Team is your connection to PHP. Avesta, Shannon, Amanda, and Bethany are available for training in your office, by webinar, or at Physicians Health Plan. It is our goal to assist with any of your needs, address any issues you may come across, and ensure your office is kept up to date on PHP news, procedures, and changes.

Provider Relations Email: PHPProviderRelations@phpmm.org

Provider Relations Fax: 517.364.8412

Customer Service: 517.364.8500 or 800.832.9186 (toll-free) (8:30 a.m. to 5:30 p.m. EST, excluding major holidays)

PHP provides easy-to-use online tools, including the MyPHP Provider Portal, available for self-service review on claims status, eligibility inquiries, and general benefit information. PHP Provider Relations is available to assist in registering and training your office for the MyPHP Provider Portal, including the EZ authorization/Referral Tool, which is available inside the portal.

Provider Portal: **PHPMichigan.com/MyPHP**

Our team is available for all your training needs. Sign up for any scheduled upcoming training, by visiting **PHPMichigan.com/Providers** and selecting "Training Opportunities"

Avesta Johnson

Provider Relations Coordinator

Shannon Blake

Provider Relations Coordinator

Amanda Hanks

Provider Relations Coordinator

Bethany Dumond

Provider Relations Supervisor

Physicians Health Plan General Training 101

The 2022 General Training 101 sessions have been a huge success with the Provider network. The PHP Provider Relations Team will continue to offer training sessions throughout 2023.

Training opportunities include PHP Commercial and PHP Medicare requirements, 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.

Register today by visiting **PHPMichigan.com/Providers** and selecting "Training Opportunities."

Prior to the training date, all registered attendees will receive login information to the email used to register.

Questions? Contact PHPProviderRelations@phpmm.org

When to Submit an Appeal Versus a Claim Adjustment Form

A provider appeal is a written request submitted by a provider to reconsider a decision made by PHP about a specific member. The decision may be about a member's medical benefit or a specific request to change a complete or partial claim denial. These types of decisions are referred to as Adverse Benefit Determinations. Several types of Adverse Benefit Determinations may be appealed. Adverse Benefit Determination Provider Appeals are categorized into three general types:

- Benefit Level Appeal: An appeal of the benefit level that the claim processed at (e.g., network vs. non-network).
- Administrative Appeal: An appeal based on a provision in the member's Certificate of Coverage, other benefit documents, or the provider's contract with PHP.
- Claim Appeal: An appeal of how a claim was processed (e.g., reimbursement amount, clinical code edits, denial, reduction, timely filing, etc.).

Appeals must be submitted no later than 90 days from the date of the initial claim denial or Adverse Benefit Determination. Appeals can be submitted by completing the Provider Appeal Form, located under "General Forms and Information" in the MyPHP Provider Portal, or at **PHPMichigan.com/Providers** by clicking on Forms and then choosing the Provider Appeal Form. The completed Provider Appeal Form should be returned to PHP by mail or fax:

Physicians Health Plan

Attn: Provider Appeals
PO Box 30377
Lansing, MI 48909-7877

Fax: 517.364.8517 (Mon .- Fri. 8 a.m. to 5 p.m.)

Documentation to support your reasoning for the appeal should accompany the appeal form. Documentation must include supporting records such as clinical notes, hospital itemization, invoices, correspondence regarding the claim in question (including names of who you spoke to, dates and times of calls, etc.), reference to the member's benefit language, your specific provider contract language, and any other additional information that you believe is relevant.

Once PHP receives your Provider Appeal Form, you will receive a letter of acknowledgment in five to ten calendar days. After a thorough investigation, a notification of a decision will be mailed within 30 days of the receipt of your appeal. If a letter or communication from PHP is not received, please reach out to PHP Customer Service at 800.832.9186. Only one appeal can be requested for each date of service, claim, or denied authorization. Any appeal that is received by PHP after the 90-day submission timeline will not be considered.

Claims Adjustment

It may become necessary to adjust a claim to reflect the correct payment determination. To request an adjustment of a claim previously allowed by PHP, use the Claim Adjustment Request Form. This form must be submitted to:

Physicians Health Plan
PO Box 313
Glen Burnie, MD 21060-0313

Some examples of why you may need to submit a claim adjustment form may include:

- The correction of claim details such as codes, charges, units, or dates of service
- Identifying an incorrect payment
- Attaching another carrier's EOP
- Incorrect provider or member information

PHP requires that requests for adjustment(s) be submitted within the timeframe identified in the Participation Agreement or within 6 months from the date that services are rendered or the date of discharge, or as required by law. When PHP is not the primary carrier, claims must be submitted within 6 months from the date on the primary carriers' Explanation of Payment (EOP).

When submitting the Claim Adjustment Request Form, it is important to fill the form out in its entirety. If information is missing from the form, it may delay your request.

If you have any claim questions, you can contact the PHP Customer Service department by calling 517.364.8500 or 1.800.832.9186.

Directory Adequacy

To remain compliant with CMS, State, and Federal guidelines, PHP requires that you provide prompt notification of the following changes:

- Physicians joining or leaving the practice or taking a leave of absence
- Change in the status of accepting new patients
- Changes in telephone number
- Address information
- Changes in Tax ID number
- Changes in privileges
- Changes in licensure
- Changes in your prescribing
- Sanctions or debarment status
- Malpractice cases, filed or closed
- Renewal of professional liability coverage
- After-hours availability for PCP offices

Notifying PHP of these changes will ensure that you are compliant with the required guidelines. It will also ensure that a PHP member / your patient have the most up to date information when trying to find a practitioner who is accepting new patients, contacting your office to schedule an appointment or locating your office for an appointment. It will also assist with quicker claim payment.

You can find the applicable form by visiting the Forms section on the PHP website at **PHPMichigan.com/Providers/General-Forms-and-Information** and selecting Provider Information Update Form.

Please return the completed form to:

Physicians Health Plan
Attn: Network Services
PO Box 30377 Lansing, MI 48909

Fax: 517.364.8412 or
Email: PHPProviderUpdates@phpmm.org

Please refer to your participation agreement and the provider manual for the specific notification requirements.

Auto Authorization

Physicians Health Plan implemented auto authorization in June 2022. This is an exciting enhancement for the PHP Provider Network.

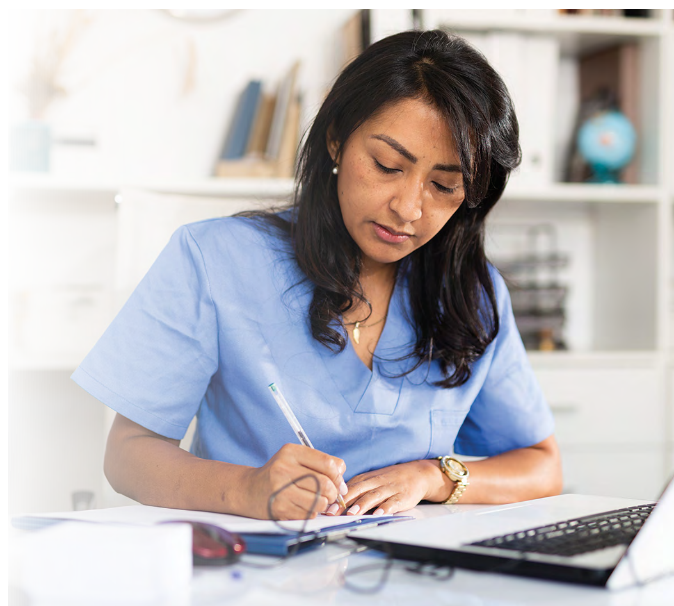
Auto Authorization allows you to:

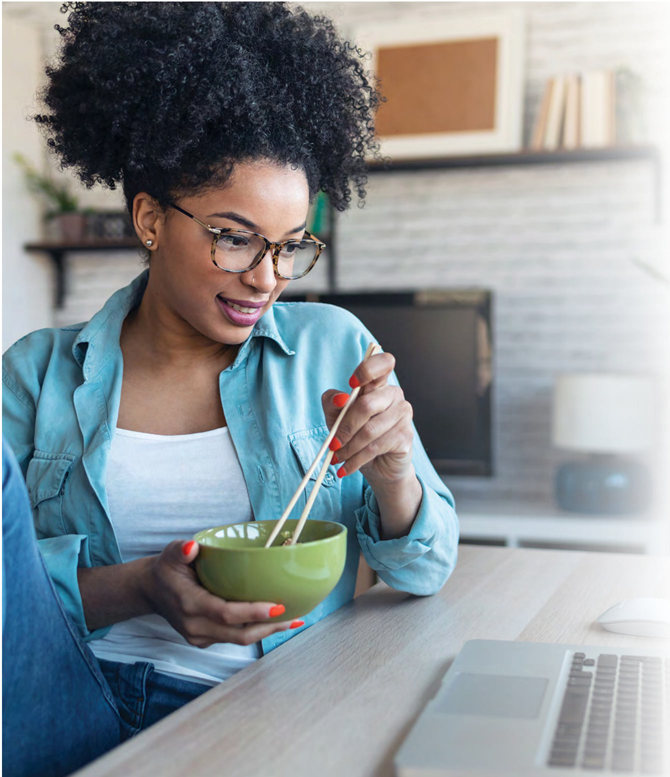
- View patient eligibility
- Submit authorization requests electronically
- Attach and send clinical documentation
- Receive automatic approval for certain medical services when criteria are met

To utilize PHP's Auto Authorization, you will need to sign into PHP's Provider Portal, MyPHP. Once logged onto the portal, click on EZ Authorization and Referrals, which can be found in the PHP Commercial Quick Links on the right side of the home page.

If you are not already registered for the PHP Provider Portal, you will need to do so before you can use auto authorization. Visit **PHPMichigan.com/MyPHP**, select "MyPHP Provider Portal," and then follow the on-screen instructions.

If you or your office need training on auto authorization, you can email the PHP Provider Relations Team at PHPProviderRelations@phpmm.org.





Lunch and Learn

PHP would like to thank you for participating in our Lunch and Learn series during 2022 and making it a success. We are excited to continue our Lunch and Learn sessions in 2023. These quarterly, one-hour events are targeted at a variety of PHP providers and their staff. Our focus during these sessions is to provide helpful information, training, and educational materials on our "hot topics." These often come from frequently asked questions and trends currently affecting our network providers. We will also leave time for a question-and-answer session at the end of each session.

Register today by visiting, **PHPMichigan.com/Providers** and selecting "Training Opportunities."

We look forward to working with you and welcome your suggestions on topics you would like to see covered. Please email any suggestions to PHPProviderRelations@phpmm.org.

Pharmacy Communication

To access information regarding our pharmaceutical authorization criteria and policies, utilize the link:

PHPMichigan.com/MedicalAndDrugPolicies

To access information regarding preferred medications, changes to the prescription drug list (PDL), pharmaceutical management procedures, medication limits, authorization forms, generic substitution, therapeutic interchange, step therapy, specialty medications, preventive medications, drug recalls, and electronic prescribing information, use the following link to access our PHP Provider Pharmacy Services page:

PHPMichigan.com/Providers/General-Forms-And-Information/Pharmacy_Services

PHP Medical and Drug Policies

PHP applies objectives and evidence-based criteria when determining the medical appropriateness of health care services. To access information from PHP regarding Utilization Management Criteria and Medical Benefit Policies, you can use the following link: **PHPMichigan.com/MedicalandDrugPolicies**

Upon request, PHP can provide criteria or policies by mail, fax, or email.

Call PHP Medical Resource Management with your request and direction for submission

517.364.8560 or 866.203.0618 (toll-free)

Monday-Friday 8:00 a.m. to 5:00 p.m. EST, excluding major holidays

PHP's Self-Registering Provider Portal

We know that your time is limited in today's busy world. PHP makes it easy to check eligibility, status a claim, submit a referral or authorization, review a policy, and more.

To register for the provider portal, visit PHPMichigan.com/MyPHP and select the MyPHP Provider Portal.

Physicians Health Plan | MICHIGAN CARE A PHP Health Plan | COVENANT SELECT A PHP Health Plan

Welcome to the MyPHP Provider Portal, a unique online tool for accessing benefit, eligibility, and claims data.

Our portals will receive scheduled maintenance during the times listed below (Eastern Standard Time). This maintenance may prevent you from logging in and using the portal for routine functions. We appreciate your patience while we maintain the integrity of our systems.

Oct. 22, 2022 Midnight to 4 a.m.
Nov. 19, 2022 Midnight to 4 a.m.

Log in to:

- View Patient's eligibility status and benefit information
- Verify Patient claims
- Review prior authorizations
- And more!

Login

Username

Password

SUBMIT

Forgot your username or password?

First-time users must create a new account to access MyPHP.

Need a username and password?
Proceed to our sign up process.

Making updates to your portal account

It may be appropriate for you to update your portal account from time to time. To make updates to your account, go to "Profile" in the upper right-hand corner of the landing page.

You are currently logged in as: Your Name
Messages (0) Profile Logout

Updates may include:

- » Account name
- » Password reset
- » Security questions
- » Contact information
- » PHP provider ID
- » TIN or individual NPI updates

As a reminder, to view remits and check information, you must have all three required fields completed in your account: TIN, individual NPI, and individual PHP Provider ID. This information can be found on the provider's "Welcome Letter" or the Explanation of Payment (EOP). If you do not know your PHP Provider ID, you can request this information by emailing PHP Provider Relations at PHPProviderRelations@PHPMM.org.

When adding a PHP provider ID, enter the 2XXXXXXXXXXX number in the Org Provider ID box using a comma to separate as indicated. When entering the individual NPI under the appropriate TIN, use a comma followed by space as indicated. Access will be available the following day after changes occur.

Org Provider ID

Org Provider ID Numbers (comma separated)

ADD ORG PROVIDER IDS

Associated TINs

NPIs

ADD TIN | ADD MULTIPLE TINS

Not All Services are Eligible for Telemedicine

The COVID-19 public health emergency greatly accelerated the availability and acceptance of telemedicine services.

According to a Feb. 2022 report from the Assistant Secretary for Planning and Evaluation (ASPE), one in four respondents (23.1%) reported use of telehealth services in the previous four weeks. While rates of telehealth utilization are trending down from their peak in 2020, there is no doubt that telehealth is here to stay as an important tool for improving patient access to care, and preventing the spread of illness by allowing some patients to be seen without travelling to their doctor's office for a visit.

However, it is important to understand which services are eligible for payment when performed via telehealth. Please refer to Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS ®) to identify eligible Telehealth codes. Codes that are eligible for Telehealth are indicated by a star (★) symbol in the CPT® and HCPCS® coding manuals and are reviewed annually.

The COVID-19 emergency also allowed health plans to offer additional temporary coverage for certain telehealth services to help ensure members could still access the healthcare services they needed while limiting further spread of the virus. Please note that some services that were previously allowed when billed with modifiers 95 or GT for telehealth, are no longer allowed as telehealth services. Charges for services that are denied as ineligible for telehealth are not billable to PHP members.

An example of services that are NOT allowed when billed with modifier 95/GT include:

- Preventive Medicine E/M codes
- Remote Patient Monitoring
- Prenatal and Postnatal Services and PT/OT (Effective Jan. 1, 2022 PHP no longer allows these services to be billed as telehealth)

The medical record must also properly support the billing of telehealth modifiers 95 or GT, and place of service indicators 02 or 10. The record should clearly indicate the location of the patient and the provider, as well as documentation of the patient's consent to the telehealth service and method (phone, video, etc.).

For more information, please refer to the PHP Payment and Reimbursement Policy for Telemedicine Services, PRP-15, available online at Payment Reimbursement Policies (PRP) - Physicians Health Plan (**PHPMichigan.com**).

Services Provided Prior to Confirmation of Provider Participation are Ineligible for Reimbursement

When new practitioners join your group practice, they must go through the PHN and Payor credentialing process before they are accepted as participating providers and can begin seeing PHP members.

Participation in the network requires submission, review, and acceptance of the provider and facility credentials as outlined in the PHP Credentialing and Re-credentialing Plan (Credentialing Plan). A copy of the Credentialing Plan is located on PHP's website **PHPMichigan.com**, or a copy may be requested by contacting PHP Network Services at 517.364.8312.

Once an application is received, it will be reviewed in accordance with applicable Michigan laws regarding HMO Provider panels. Then, you will be sent either an application acknowledgment letter or, if PHP has a sufficient number of practitioners in your specialty, a letter declining your participation request.

The PHP Application Acknowledgement letter from Credentialing reminds practitioners that they cannot see members until their credentialing is complete. The letter states that "acceptance of your application does not guarantee participation; therefore, services provided to PHP members prior to confirmation of your participation are not eligible for reimbursement by PHP."

New providers are notified of their enrollment with the network with the PHP Welcome Letter. The welcome letter includes the PHP provider networks the practitioner is enrolled in, their effective date, their PHP Provider ID, and instructions for finding PHP tools and resources.

You can obtain your application status by contacting PHP Credentialing:

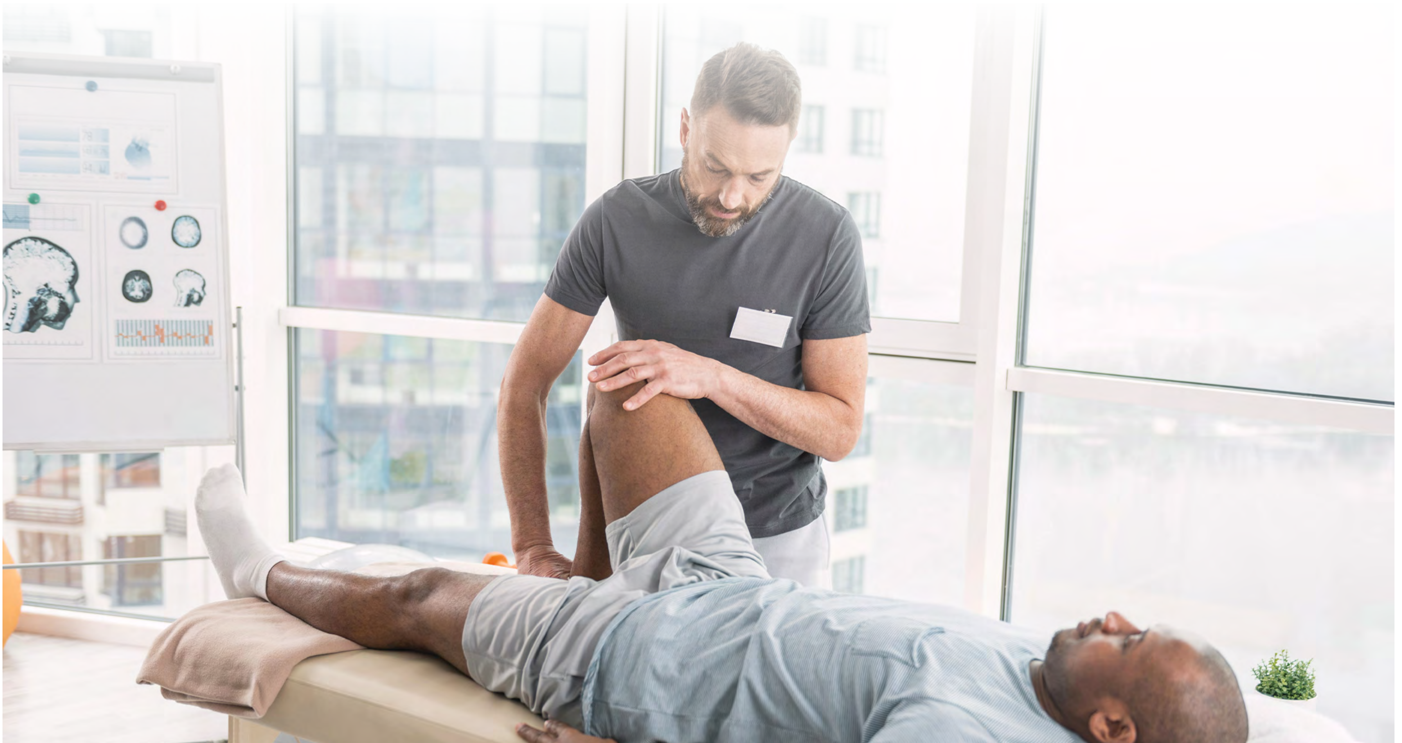
» Email: PHP.Credentialing@phpmm.org

» Phone: 517.364.8312

» Fax: 517. 364.8412

» Written Correspondence: Physicians Health Plan, PO Box 30377, Lansing, MI 48909-7877

Information that can be shared includes what status the application is in, such as; verification status, researching data discrepancies, missing information, or if the application is ready for the committee. Credentialing staff will respond to requests for application status in the manner it was requested by return email, phone, or fax.



Zelis ePayment Center

Beginning July 26, 2022, Physicians Health Plan (PHP) introduced a new electronic payment (ePayment) platform to accelerate and add efficiency to our claims payment process. Zelis ePayment Center offers a no-fee Automated Clearinghouse (ACH) delivery of claim payments and access to view and download remittance files in their secure portal. Delivery of the 835 electronic remittance advice (ERA) files to your clearinghouse are also available directly through the ePayment Center enrollment portal.

If you currently receive a paper check but want to receive payment by ACH, please enroll with Zelis ePayment Center. If you are already enrolled with Zelis, you may register for the no-fee ACH option for PHP and maintain your existing relationship with Zelis.

How do I register for Zelis ePayment Center?

1. Visit PhysiciansHealthPlan.ePayment.Center
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a Zelis customer service representative, and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and set up your account
5. Log in to the Zelis ePayment Center portal
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click “Submit”

After registration, your bank account will undergo a pre-notification process to validate the account prior to commencing the EFT delivery. This process may take up to six business days to complete.

What do I need to register for the ePayment Center?

- 9-digit Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
- Practice’s corporate name and principal information
- Bank account routing transit number (RTN) or ABA Routing Number

Where can I find more information/assistance on the registration process?

Additional enrollment instructions and a detailed question-and-answer guide are available for download at **PhysiciansHealthPlan.ePayment.Center**.

Need additional help?
Call 855.774.4392 or email Help@ePayment.Center.

Member's Rights and Responsibilities

Statement of Member's Rights and Responsibilities, which include:

Member Rights

Enrollment with Physicians Health Plan (PHP) entitles you to the right to:

1. Receive information about your rights and responsibilities as a member in terms you can understand
2. Have access to culturally and linguistically appropriate language interpretation services free of charge
3. Always be treated with respect and recognition of your dignity and right to privacy
4. Expect privacy of your personal health information (PHI)
5. Choose and change a primary care physician (PCP) from a list of network physicians or practitioners
6. Information on all treatment options that you may have in terms you can understand so that you can give informed consent before treatment begins
7. Refuse treatment to the extent permitted by law and be informed of the consequences of your refusal
8. Openly discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage
9. Participate with providers in making decisions involving your healthcare
10. Voice concerns or complaints about your healthcare by contacting PHP Customer Service or submitting a formal, written grievance through PHP's appeals process
11. Be given information about PHP, its services, and the healthcare providers in its network, including their qualifications
12. Make suggestions regarding PHP's member rights and responsibilities policies
13. Receive covered benefits consistent with your plan summary and state and federal regulations

Member Responsibilities

As a PHP member, you have the responsibility to:

1. Select or be assigned a primary care physician from PHP's list of network healthcare providers if required by your plan and notify PHP when you have made a change
2. Be aware that all hospitalizations must be approved in advance by PHP, except in emergencies or for urgently needed health services
3. Use emergency department services only for treatment of a serious or life-threatening medical condition
4. Always present your PHP ID card to healthcare providers each time you receive health services, never let another person use it, report its loss or theft to PHP, and destroy any old cards
5. Be considerate and courteous to PHP associates, your providers, their staff, and other patients
6. Notify PHP of any changes in address, eligible family members, marital status, or if you acquire other health care coverage
7. Provide complete and accurate information (to the extent possible) that PHP and healthcare providers need in order to provide care
8. Understand your health problems and develop treatment goals you agree on with your healthcare provider
9. Follow the plans and instructions for care that you agree on with your healthcare provider
10. Understand what services have cost shares to you and to pay them directly to the health care provider who gives you care
11. Read your PHP member materials and become familiar with your provider network
12. Follow your health plan benefits and PHP policies and procedures
13. Report suspected health care fraud or wrongdoing to PHP, by contacting PHP Customer Service

Colorectal Cancer Screening

The U.S. Preventive Services Task Force has adjusted the standard of care for Colorectal Cancer Screening. The recommendation for screening has been expanded to adults age 45-75 years of age (previously, it was 50-75 years of age).

There are several screening tests available. Providers and patients may select which test is best for them considering their individual health history, prior screening history, and preferences.

- Fecal occult blood test (FBOT or gFBOT) every year
- Stool DNA-FIT (Cologuard) every 1-3 years
- Computed tomography (CT) colonography every 5 years
- Flexible sigmoidoscopy every 5 years
- Colonoscopy every 10 years

Coding for these tests includes the following:

Test	Code	Code Type
Colonoscopy	44388 - 44394 44397 44401- 44408 45355 45378 - 45393 45398	CPT®
	G0105 G0121	HCPCS
CT Colonoscopy	74261 - 74263	CPT
FIT DNA Lab Test	81528	CPT
	G0464	HCPCS
Flexible Sigmoidoscopy	45330 - 45335 45337 45338 45340 - 45342 45346 45347 45349 45350	CPT
	G0104	HCPCS
FOBT Lab Test	82270 82274	CPT
	G0328	HCPCS

Documentation in the medical record may include a note indicating the date and type of screening performed, a pathology report indicating the date and type of screening, a procedure/operative report, or gFOBT, FIT, or DNA-Fit laboratory reports.

The earlier screening age will require increased vigilance in addressing these important screening tools with your patients starting at 45 years of age. Please ensure that patient records are flagged for this discussion.

The full recommendation statement and supporting documentation, including research findings, can be found at: uspreventiveservicestaskforce.org

Feel free to contact the Quality Department if you have any questions.

Current Procedural Terminology (CPT) codes copyright 2021 American Medical Association. All rights reserved. CPT is a trademark of the AMA.

2023 E/M Changes and Documentation Requirements

In 2021, the American Medical Association (AMA) Current Procedural Terminology (CPT®) Editorial Panel approved and published new documentation guidelines for Office and Other Outpatient Evaluation and Management (E/M) CPT® codes (99202-99215, deleting 99201). CPT code descriptions and documentation standards were updated in consideration of the administrative burden, complexity of exam templates, and clarification of Medical Decision Making as it relates to an E/M. However, this left many practices with having to manage two sets of documentation guidelines for E/M services that were not included in the initial changes.

The AMA CPT® Editorial Panel approved additional coding and documentation revisions to include hospital inpatient, hospital observation, consultation, emergency department, nursing facility, domiciliary, and rest home E/M services, effective Jan. 1, 2023. Therefore the 2021 AMA Documentation Guidelines will now apply to the full E/M Section. Some highlights of the Jan. 1, 2023 revisions are:

Inpatient & Observation Care Services

- Hospital Observation Services E/M codes 99217-99220 deleted
- Revision of Hospital Inpatient and Observation Care Services E/M codes 99221-99223, 99231-99239 and guidelines

Emergency Department Services

- Revision of Emergency Department Services E/M codes 99281-99285 and guidelines
- Time is NOT a descriptive component for emergency department level of E/M services

Consultations

- Deletion of Consultations E/M codes 99241 and 99251
- Revision of Consultations E/M codes 99242-99245, 99252-99255, and guidelines
- PHP aligns with CMS billing guidelines and does not accept consult codes. The appropriate outpatient E/M (99202-99215), inpatient services initial (99221-99223), inpatient subsequent (99231-99233), or Emergency Department (99281-99285) should be reported instead.

Nursing Facility Services

- Deletion of Nursing Facility Services E/M code 99318
- Revision of Nursing Facility Services E/M codes 99304-99310, 99315, 99316 and guidelines

Home and Residence Services

- Deletion of Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services E/M codes 99324-99238, 99334-99337, 99339, 99340
- Deletion of Home or Residence Services E/M code 99343
- Revision of Home or Residence Services E/M codes 99341, 99342, 99344, 99345, 99347-99350 and guidelines

Prolonged Services

- Deletion of Prolonged Services E/M codes 99354-99357
- Revision of guidelines for Prolonged Services E/M codes 99358, 99359, 99415, 99416
- Revision of Prolonged Services E/M code 99417 and guidelines
- Establishment of Prolonged Services E/M code 993X0 and guidelines
- The total time on the date of the encounter spent caring for the patient must be documented

Reminder:

For those E/M services that allow code selection based on time, the medical record must include a clear time qualification statement with sufficient information to support the amount of time reported. The statement should be unique to the patient and not a copy-and-paste statement with general terms. An adequate time qualification statement should include a description of the activities performed on the date of the encounter. Total time alone does not support time-based billing.

It is recommended that coding staff review templates with their providers at this time and make any necessary updates to ensure alignment with the 2021 AMA changes and Jan. 1, 2023 revisions.

Inpatient Only Procedures

The Centers for Medicare and Medicaid (CMS) Inpatient Only List (IPO) identifies procedures that Medicare only reimburses when performed in the inpatient setting. The list was developed in consideration of patient safety, the complexity of the surgery, and recovery time. In Dec. 2020, CMS, under the former administration, finalized the elimination of the IPO list over a three-year span. The phase-out began on Jan. 1, 2021, with the removal of 298 procedures from the IPO list. However, under the current administration, CMS restored the IPO list under the final rule of an outpatient prospective payment system (OPPS) for 2022 and placed most of the procedures removed in 2021 back on the IPO list.

PHP follows reimbursement methods in accordance with the American Medical Association (AMA), CPT (Current Procedural Terminology) guidelines, and the Centers for Medicare and Medicaid Services (CMS). Clinical Edits are derived from these nationally recognized entities and specialty societies. PHP may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but which are covered by PHP to support covered benefits available through one of the Plan's products. Clinical Editing rules are effective based on the date of service, and services will be denied payment when the edit is applied.

CMS designates IOP with an OPPS status indicator of "C" in the OPPS Addendum B. For the most current list, please refer to **CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.**

Effective Jan. 1, 2023, PHP will apply code editing to professional claims in addition to facility claims. The service will be denied if an inpatient-only code is billed with an outpatient place of service or outpatient Type of Bill. In instances where an otherwise covered inpatient procedure on the IOP list is going to be performed in an outpatient setting, a written request for consideration of coverage in this setting as an exemption may be submitted for review by PHP Medical Resource Management. Please submit these requests using the prior authorization form. The form should be submitted at least two weeks prior to the date of surgery and indicate clearly that the request is for consideration of an IOP procedure to be performed in an outpatient setting. The provider's office that is responsible for scheduling the procedure should submit this request, along with supporting documentation, for consideration.

Provider Audits

Claims Audit and Medical Record Review Process

Physicians Health Plan (PHP) completes claim audits requiring medical record reviews on both a pre-payment and post-payment basis. Post-payment audits include claims processed six months to one year before the audit review date to identify billing trends and outliers. However, this time frame may be expanded as needed based on initial findings. Providers will receive written notification of the request for records from either PHP or an audit firm if warranted. The provider should submit all supporting documentation and patient medical records, as requested, within fourteen (14) days or as specified in the letter to ensure a successful and timely audit. Before submission, it is recommended that the documents are reviewed to ensure all necessary components are provided to support the reported service(s). The lack of response to a request for documentation may result in payment adjustments to claims previously paid. On occasion, an on-site audit may be requested. The provider will receive an initial letter of notification and a follow-up call from a PHP representative to schedule the on-site review.

Upon receipt of records, they will be reviewed by certified professional coding staff in accordance with nationally recognized billing guidelines developed by the Centers for Medicare and Medicaid Services (CMS), including the National Correct Coding Initiative (NCCI), the American Medical Association (AMA), specialty societies, and PHP policies. Once an audit is complete, findings will be summarized and outlined in an audit findings letter, sent via certified mail to the mailing address on file.

The facility/practice coding and billing staff should review the audit results thoroughly and identify any missing documentation that may have been omitted. If you disagree with the audit findings, a written appeal must be submitted within thirty (30) calendar days of the date on the audit findings letter. The written appeal should clearly address the findings, include missing documentation, and detailed justification to support coding, units, etc. Significant findings may result in an expanded audit, and failure to correct identified issues may result in additional follow-up audits.

PHP recommends that providers have internal audits performed regularly to identify gaps in documentation, review payer policies, and identify areas of education and/or areas of improvement regarding practice standards. Providers should also respond appropriately to detected offenses and develop a corrective action plan.

2023 PHP Primary Care Management Incentive Program

PHP is excited to announce the 2023 PHP Primary Care Management Incentive Program, formally known as the Primary Care Incentive Program (PIP). The program will focus on both preventive care, to maintain and improve wellness, and care aimed at managing chronic conditions. Primary care practitioners (PCPs) of the Physicians Health Network (PHN) are eligible to participate in this program. Please see the Primary Care Management Incentive Program Technical Guide in the PHP Provider Portal under “Provider Incentive Program” in the green toolbar for more details about how the program works.

Provider Quick Reference Guide for PHP Medicare (HMO-POS)

Provider Services	For inquires such as claim status checks, member eligibility, benefit verification, or confirmation of referrals/prior authorization, login to the PHP Provider portal, MyPHP, at **PHPMichigan.com/MyPHP**, and follow the single sign in to PHP Medicare or call PHP Medicare 844.529.3757 Provider Services email address: CustomerService@PHPMedicare.com Fax: 844.529.3759 Provider correspondence/claims mailing address: PHP Medicare PO Box 7119, Troy, MI 48007
Client/Provider Technical Support	Assistance with technical questions relating to registration, login, or web application access Call: 866.397.2812 Available from 8 a.m. to 7 p.m. Technical Support email address: CustomerSupport@Lumeris.com
Electronic Claims	Change Healthcare (payor # 83276). Call: 866.924.4634 Option 4, Option 1 **ChangeHealthcare.com/Support/Customer-Resources/Enrollment-Services**
Web/Provider Portal	Assistance with Member Eligibility, Claims and Referral Inquiry, Online Referral and Prior Authorization: **PHPMichigan.com/MyPHP**, and follow the single sign in to PHP Medicare
Non-Emergent Transportation Services	Contracted provider is: Medical Transportation Management (MTM) Members can call: 877.930.1485 to schedule or MemberPortal.net Limited to 20 one-way trips. PHP Advantage Plus limited to 30 one-way trips.
Preventive Dental Care	Contracted providers for Routine Dental Services can be found by calling Delta Dental: 800.330.2732 | Fax: 517.381.5527 | **DeltaDentalMI.com** No referral is needed. Members can self-refer. Claims mailing address: P.O. Box 9230, Farmington Hills, MI 48333 or Claims Delta Dental P.O. Box 9298 Farmington Hills, MI 48333
Routine Eye Care	Contracted providers for Routine Eye Exams can be found by calling EyeMed at 844.230.6498 No referral is needed. Member can self-refer. Claims mailing address: First American Administrators, Attn: OON Claims | PO Box 8504 | Mason, OH 45040
Behavioral Health Services	Contracted providers for in/out-patient mental health/substance abuse services can be found by calling: Mercy Managed Behavioral Health 833.729.4607 Claims Questions: Call our Provider Services number listed above.
Medical Services	Assistance with prior authorization of procedures, benefit determination, notification Call: PHP Medicare 844.529.3757 | Fax: 855.229.2187 for Medical Requests Only OR 844.527.9402 for Inpatient Clinical Only
Pharmacy	Pharmacy Prior Authorization for Part B Drugs Call: 844.529.3757 or fax to the number on the forms located on the Provider Portal. Pharmacy Prior Authorization for Part D Drugs — contact information is located on the forms available on the Provider Portal Pharmacy email address: Pharmacy@PHPMedicare.com
SilverSneakers	Complimentary fitness program/classes can be found by calling 888.423.4632 or visit the website at **SilverSneakers.com** No referral needed. Member can self-refer.
HealthHelp	Radiation Therapy, Advanced Imaging (CT, CTA, MRI, MRA, PET & Cardiac Nuclear), Medical Oncology, and Facility Based Sleep Studies: Contact HealthHelp at 800.652.4958 or fax at 800.695.4997 or expedited fax 855.546.7092. Go to the website **HealthHelp.com/PHPMedicare.com/PHPMedicare** for specific codes requiring PA/Notification.
Over-the-Counter Benefit	Over-the-counter (OTC) medications and products can be ordered by the member: Online at **PHPMedicareOTC.com**, by calling 855.299.5415 (TTY:711), or mailing the order form.
Audiology-TruHearing	For Hearings Aids, Fittings and Evaluations Call: 844.554.6104
Meal Benefit	For additional information on meal benefit Call: 844.830.1602 TTY 800.955.1339 | Online: **SunMeadow.com**

Referrals are only required for out-of-network providers

Prior Authorization/Notification is Required for These Services:

- All Inpatient Admissions (notification required within one business day)
- All admissions to SNF, acute rehab, and LTAC
- Non-emergency Ambulance Transfers, EXCEPT those between hospital and SNF inpatient
- Behavioral Health Inpatient, Intensive Outpatient, Partial Hospitalization, Electroconvulsive Therapy, TMS. Please contact Mercy Managed Behavioral Health for specific services/codes.
- Radiation Therapy, Advanced Imaging, Medical Oncology, Facility Based Sleep Studies.
- Please contact HealthHelp for specific services/codes.
- Please see Prior Authorization list posted on provider portal under “Forms and Resources” for additional services/items requiring prior

Miscellaneous Information:

- Laboratory – No referral or prior authorization required unless related to genetic testing. Selected tests may be performed in the specialist office – see PHP Medicare Healthcare Provider Manual.
- Hospice – Any Medicare-approved agency can be used.

Telehealth:

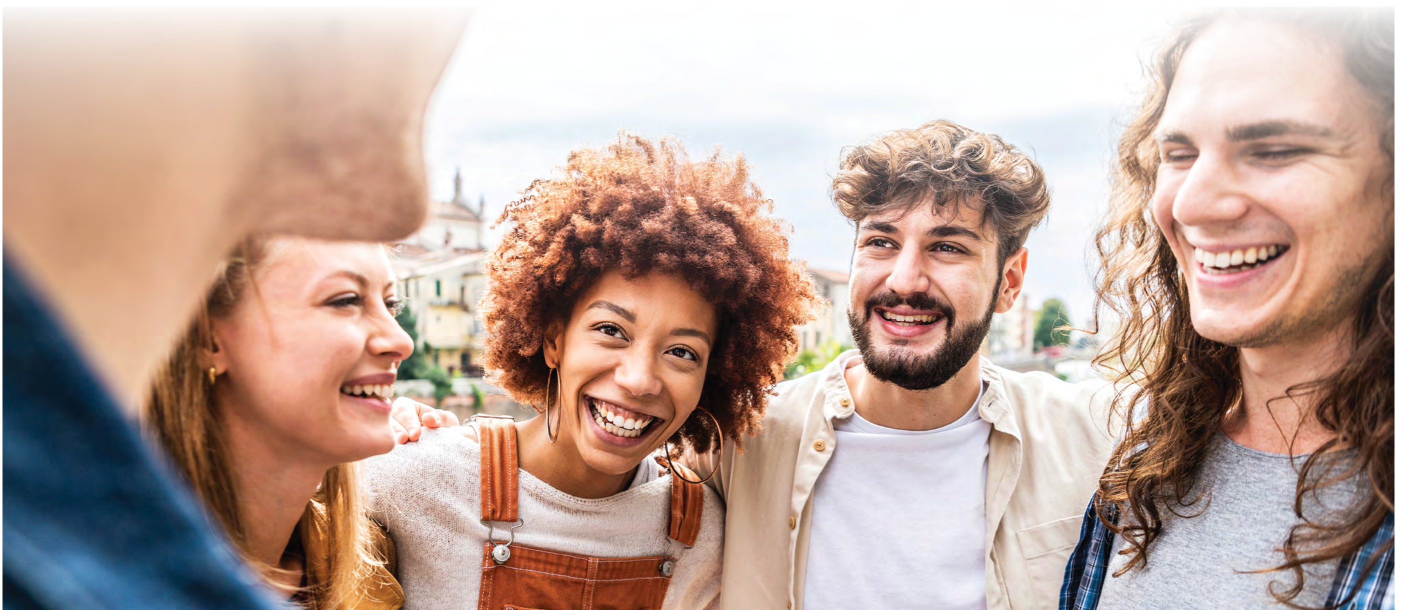
- Referral/ prior authorization rules that apply to in-person visits apply to virtual visits as well.

The information above is subject to change periodically throughout the year. For the most up-to-date list of services and drugs requiring prior authorization please check for updated versions of the Provider Quick Reference Guide and/or Prior Authorization list on the Provider Portal.

Cultural Competency Training

Physicians Health Plan (PHP) is excited to partner with you to offer Cultural Competency Training. This new training offered by PHP is free and available to all registered users on the MyPHP Provider portal. PHP encourages you to complete the Culture Competency Training annually. To access the training, log into the MyPHP Provider Portal at **PHPMichigan.com/MyPHP**. Once you are logged into the portal you can select Cultural Competency Training on the right hand side of your screen under PHP Commercial Quick Links.

Please contact the PHP Provider Relations team at PHPProviderRelations@phpmm.org if you need assistance registering for the MyPHP Provider portal.



Formulary Changes Effective Jan. 1, 2023

Formulary Coding Changes:

Therapeutic Category	Medication	Action
Stimulants	Concerta	Brand up tiering to Non-Preferred Tier (3)
Amphetamines	Adderall XR	Brand up tiering to Non-Preferred Tier (3)
Amphetamines	Mydayis	Down tiering to Preferred Tier (2)
CGRP (Migraine)	Aimovig	Down tiering to Preferred Tier (2); no PA
CGRP (Migraine)	Emgality	Down tiering to Preferred Tier (2); no PA
CGRP (Migraine)	Ajovy	Down tiering to Preferred Tier (2); no PA
Atopic Dermatitis	Dupixent	Down tiering to Preferred Specialty Tier
Antineoplastic	Gavreto	Down tiering to Preferred Specialty Tier
Antineoplastic	Retevmo	Down tiering to Preferred Specialty Tier

Additions to Formulary:

Therapeutic Category	Medication	Action
Stimulants	Amphetamine/ Dextroamphetamine XR	Adding to Tier 1
Stimulants	Methylphenidate HCL (OSM) ER	Adding to Tier 1
CGRP (Migraine)	Ubrelvy	Adding to Preferred Specialty Tier
CGRP (Migraine)	Qulipta	Adding to Preferred Specialty Tier

Medications Removed from Formulary:

Therapeutic Category	Medication	Status	Preferred Medication
Kinase Inhibitors	Sutent	Excluded	Nexavar
Kinase Inhibitors	Votrient	Excluded	Nexavar
PARP Inhibitors	Rubraca	Excluded	Lynparza
PARP Inhibitors	Talzenna	Excluded	Lynparza
Nasal Steroids	Budesonide Nasal Spray	Excluded	Fluticasone (RX) Nasal Spray
Nasal Steroids	Triamcinolone Nasal Spray	Excluded	Fluticasone (RX) Nasal Spray
Acne Products	Benzoyl Peroxide 10% Topical Wash	Excluded	OTC medication exclusion – recommend OTC products outside of Rx benefit

**For patients that have an active prior authorization for any of the above excluded medications, that authorization will remain in place through the end of the prior authorization period on the authorization letter. Note that providers may submit a prior authorization coverage request for excluded medications for medical necessity review to the PHP Pharmacy Department.*

Update: Locum Tenens Arrangement

A Locum Tenens physician/practitioner is defined as a physician/practitioner replacing a network physician/practitioner for a specified period while the network physician/practitioner is absent from his/her practice.

Effective Jan. 1, 2023, PHP is updating the Locum Tenens arrangement requirements. To align with industry standards, PHP will not require a Locum Tenens provider to be credentialed if covering for a provider for less than 60 days. Locum Tenan provider claims must be submitted with the Q6 modifier when covering for a provider within those 60 days. Provider covering greater than 60 days will require plan credentialing.

If you have questions about plan credentialing, you can email the PHP Credentialing team at PHP.Credentialing@phpmm.org.

Pharmacy Updates

Drug	Formulary Placement
Pyrukynd (mitapivat)	Prior Authorization, Non-Preferred Specialty Tier
Enjaymo (sutimlimab)	Prior Authorization, Medical Benefit
Carvykti (ciltacabtagene autoleucel)	Prior Authorization, Medical Benefit
Opdualag (nivolumab-relatlimab)	Prior Authorization, Medical Benefit

For up-to-date information on drug recalls, please visit **PHPMichigan.com/Providers**. A link to the FDA's drug recall website is available under the Pharmacy Services tab.

Important Things to Remember When Submitting a Prior Authorization Request Form

- The Medication Authorization Form is located on the Provider Pharmacy Services page on the website **PHPMichigan.com**.
- Fill out the form completely and legibly.
- If requesting an infusion drug, please include the name of the office and/or facility and the NPI number for the location where the drug will be administered.
- Provide accurate provider contact information:
  - Contact person's name
  - Phone number
  - Fax number
- Include the patient's most current chart notes documenting their status as well as clinical documentation of previous medication trials related to the request.
- Submissions from Cover My Meds are routinely transmitted with incomplete information, which delays care for the patient. Sending requests directly to PHP will reduce the time it will take to process the request. If you have issues sending authorization requests for PHP Members through Cover My Meds, please reach out directly to PHP Customer Service at 1.800.562.6197 or 517.364.8400.

Update: Bundling of Urinalysis CPT Codes

Physicians Health Plan (PHP) has reevaluated the bundling edit when CPT code 81002 or 81003 is billed with an Evaluation and Management (E/M) CPT code, on the same date of service for the same patient by the same provider/group. Effective Jan. 1, 2023, PHP will no longer apply the bundling edit of CPT code 81002 or 81003 when billed with an E/M CPT code. These CPT codes will be reimbursed separately from the E/M CPT code.

Physicians Health Plan

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

Contact Us

PO Box 30377 Lansing, MI 48909-7877 517.364.8400 PHPMichigan.com

Department	Contact Purpose	Contact Number	Email Address
Customer Service	» Verify a covered person's eligibility, benefits or to check claim status to report suspected member fraud and abuse » Obtain claims mailing address » Claims and EDI questions » Request a copy of our Preferred Drug List	517.364.8500 800.832.9186 (toll-free) 517.364.8411 (fax)	
Medical Resource Management	» Notification of procedures and services outlined in the Notification/ Authorization Table » Request benefit determinations and clinical information » Obtain clinical decision-making criteria » Behavioral Health/ Substance Abuse Services, for information on Behavioral 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 » Provider Data - report changes in practice demographic information » Provider/Practitioner education » Report suspected Provider/Practitioner Fraud and Abuse » Initiate electronic claims submission	517.364.8312 800.562.6197 (toll-free) 517.364.8412 (fax) **Report Suspected Fraud and Abuse:** 866.PHPCOMP (866.747.2667)	**Credentialing** PHP.Credentialing@phpmm.org **Data** PHPProviderUpdates@phpmm.org **Provider Relations Team** PHPProviderRelations@phpmm.org
Quality Management	» Quality Improvement Programs » URAC » HEDIS » CAHPS	517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org
Pharmacy Services	» Request drug coverage » Fax medication prior authorization forms » Medication Therapy Management Program	517.364.8545 877.205.2300 (toll-free) 517.364.8413 (fax)	**Pharmacy** Pharmacy@phpmm.org
Change Healthcare (CHC)	» When medical records are requested	**Mail To:** Change Healthcare Attn: Pre-Pay 1849 West Drake Drive STE 101 Tempe, AZ 85283 952.224.8650 949.234.7603 (fax)	MedicalRecords@changehealthcare.com

	Physicians Health Plan (PHP) Commercial Plans	PHP Medicare Plans
Where to Send Claims	Physicians Health Plan **In-Network:** PO Box 313 Glen Burnie, MD 21060-0313 **Non-Network:** PO Box 247 Alpharetta, GA 30009-0247 Electronic Claims **In Network:** Payer ID: 37330 **Non-Network:** Payer ID: 07689	Physicians Health Plan PO Box 7119 Troy, MI 48007
Where to Send Refunds	Physicians Health Plan Attn: Provider Refund PO Box 30377 Lansing, MI 48909-7877	Physicians Health Plan PO Box 7119 Troy, MI 48007