Provider Connection

FIRST QUARTER 2020

In this issue

Physicians Health Plan

Working with PHP

General Training 101

The Provider Relations 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.

April 16, 2020 | noon to 1:30 p.m.
July 14, 2020 | 8:30–10 a.m.
Oct. 15, 2020 | noon to 1:30 p.m.

Please email your RSVP to the address below at least one week prior to the event. All trainings take place at PHP, are free of charge, and include a light meal.

Questions? Contact **PHPProviderRelations@phpmm.org**.

Pharmacy news and updates

Newly Released Drugs to Market	
Drug Name	**Formulary Action**
Diacomit (stiripentol) capsule/packet	Added to Tier 4, Prior Approval required
Vyndamax (tafamidis) capsule	Added to Tier 4, Prior Approval required
Polivy (polatuzumab vedotin) IV solution	Medical Prior Approval required
Sunosi (solriamfetol) tablet	Added to Tier 3, Prior Approval required
Xpovio (selinexor) tablet	Added to Tier 4, Prior Approval required
Baqsimi (glucagon) nasal powder	Added to Tier 2 with a quantity limit of 6 doses per 365 days
Vyleesi (bremelanotide) SQ auto-injector	Added to Tier 3, Prior Approval required Quantity limit of 5 doses per month
Nayzilam (midazolam) nasal spray	Added to Tier 3, Prior Approval required
Inrebic (fedrastinib) capsule	Added to Tier 4, Prior approval required

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.

ACA Wellness Visit Incentive Program continues in 2020

New feature on MyPHP portal helps your practice identify ACA members to serve them through this important program

Physicians Health Plan (PHP) will continue the Adult ACA Wellness Visit Incentive Program in 2020. To help your office capitalize on the incentive program, PHP's online portal offers a downloadable roster that identifies your ACA Members. These Patient rosters are currently available on MyPHP exclusively for Primary Care Providers (PCP).

To access your PCP Eligibility Patient Roster, you must first be registered on MyPHP, our Provider Portal. Once signed in, hover over Coverage & Benefits in the top tool bar, and click PCP Eligibility Patient Roster from the dropdown menu. Select the Provider you wish to obtain the PCP Eligibility Patient Roster for, and click Search. Your PCP Eligibility Patient Roster will populate.

We have implemented a new feature which identifies ACA Members so that you can better serve those Members by contacting them to schedule an Annual Wellness Exam. You can print or download your results into an Excel format and sort by ACA Members. ACA Members are identified with an ACA identifier, as shown in the red box below.

Search View All Patients

Name	MemberID	Group	ACA	Network	Date of Birth	Gender	Benefit Plan	Effective Date
		L0001925	ACA	PPO			PFH00501	1/1/2016
		L0001925	ACA	PPO			PFH00501	1/1/2016
		L0001699	ACA	PHP Exclusive Network			BNN00100	8/1/2016
		L0001699	ACA	PHP Exclusive Network			BNN00100	8/1/2016
		L0001637		PPO			DPW20501	1/1/2014
		L0001269		Sparrow Provider Network/SPN			DAS01601	6/27/2015
		L0001269		Sparrow Provider Network/SPN			DAS01601	6/7/2013
		L0001269		Sparrow Provider Network/SCN			DAS02701	9/1/2012
		L0001269		Sparrow Provider Network/SCN			DAS03001	5/1/2007
		L0001269		Sparrow Provider Network/SCN			DAS03001	5/1/2007

Page

As a reminder, the Adult ACA Wellness Visit Program is open to adult ACA Members 18 years of age and older. To obtain credit for the $100 incentive, the appropriate CPT code of G0438 or G0439 must be submitted on the claim for the wellness visit. If you have questions regarding the Adult ACA Wellness Visit Program or need help registering for MyPHP, please contact the Provider Relations Team at **PHPProviderRelations@phpmm.org.**

For additional assistance to access your PCP Eligibility Patient Roster, go to **PHPMichigan.com**, click on the Portal Login *in the tool bar*, then click on MyPHP Provider Portal. A list of tutorials are available on the website that will explain the many useful features of the site.

PHP Primary Care Incentive Program

Primary Care Physicians (PCP) of Physicians Health Network (PHN) may be eligible for an incentive payment in accordance with Physicians Health Plan (PHP) PCP Incentive. Eligibility for an incentive payment shall be based on quality and health management factors and not referral services. This PCP Incentive applies to PHP HMO Members in the Physicians Health Plan Commercial HMO Product only.

The program has been divided into Pediatric and Adult Measures. All measures are calculated and based on NCQA HEDIS® specifications. The Pediatric measures only apply to the Physician specialty of Pediatrics. The Adult measures apply to the Physician specialties of Family Practice, Internal Medicine, and General Practice. The incentive methodology remains the same as the 2019 Primary Care Incentive Program. PCPs can review the full 2020 Program Description on the MyPHP Provider Portal, located at **PHPMichigan.com/MyPHP.**

Pediatric Measures consist of:

- Human Papillomavirus Vaccine for Adolescents
- Appropriate Testing for Pharyngitis (CWP)
- Appropriate Treatment for Upper Respiratory Infection (URI)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)

Adult Measures consist of:

- HbA1c Testing
- Retinal Eye Exam
- Controlling High Blood Pressure (CBP)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Breast Cancer Screening (BCS)

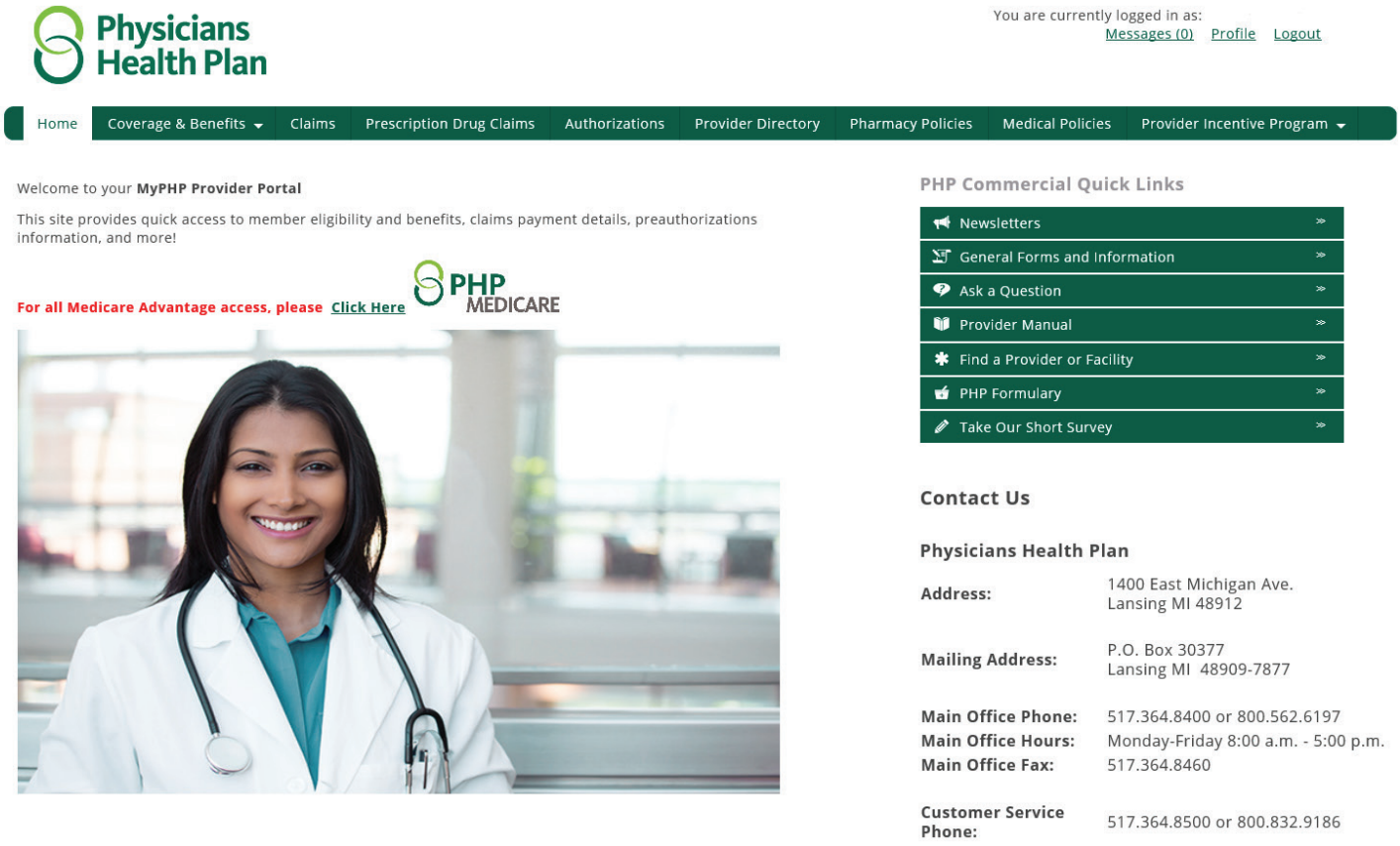
These improvements have been made to ensure all primary care specialties are included in the performance payouts and to align Patient care with our quality performance objectives.

If you have questions regarding the Primary Care Incentive Program or would like additional training to maximize your incentive reimbursement, please contact Provider Relations at **PHPProviderRelations@phpmm.org.**

MyPHP, your Medicare Advantage Provider Portal

The Physicians Health Plan (PHP) Provider Portal, MyPHP, makes it simple to verify eligibility, check claim status, view Member benefits, access our Medical and Pharmacy Policies, and much more! MyPHP is quick, easy, and provides 24/7 access to information.

With the launch of PHP Medicare, your office is able to access the Medicare Provider Portal by using a single sign on process. There is an initial information verification process in the Medicare Portal, which is required during your first visit to the portal. Users access the Medicare Advantage Provider Portal from the Home Page of the MyPHP Provider Portal. A link has been added as shown below. After selecting the "click here" link near the PHP Medicare icon, users will be routed to the Medicare Advantage Portal.



The first time users access the Medicare Provider Portal, they go through a verification process. The user's current information will auto-populate from the MyPHP Provider Portal. Any fields not populated must be completed by the user. Upon completion, an auto-generated email will be sent from the Customer Support Group at CustomerSupport@lumeris.com. Users will be notified via email that they can visit the site in order to access the PHP Medicare Provider Portal using the MyPHP Provider Portal single sign on.

Amendments, corrections and delayed entries in medical documentation

All services provided to Members are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or completed after rendering the service.

Physician's Health Plan (PHP) will consider submitted entries that comply with the record keeping principles described below. PHP will not consider any entries that do not comply with the principles listed below, even if such exclusion would lead to a claim denial. For example, undated or unsigned entries handwritten in the margin of a document will not be considered. An amendment should not be used to prove medical necessity nor the fact that a service was performed; instead, use it to support the original information.

Record keeping principles

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to PHP containing amendments, corrections or addenda must:

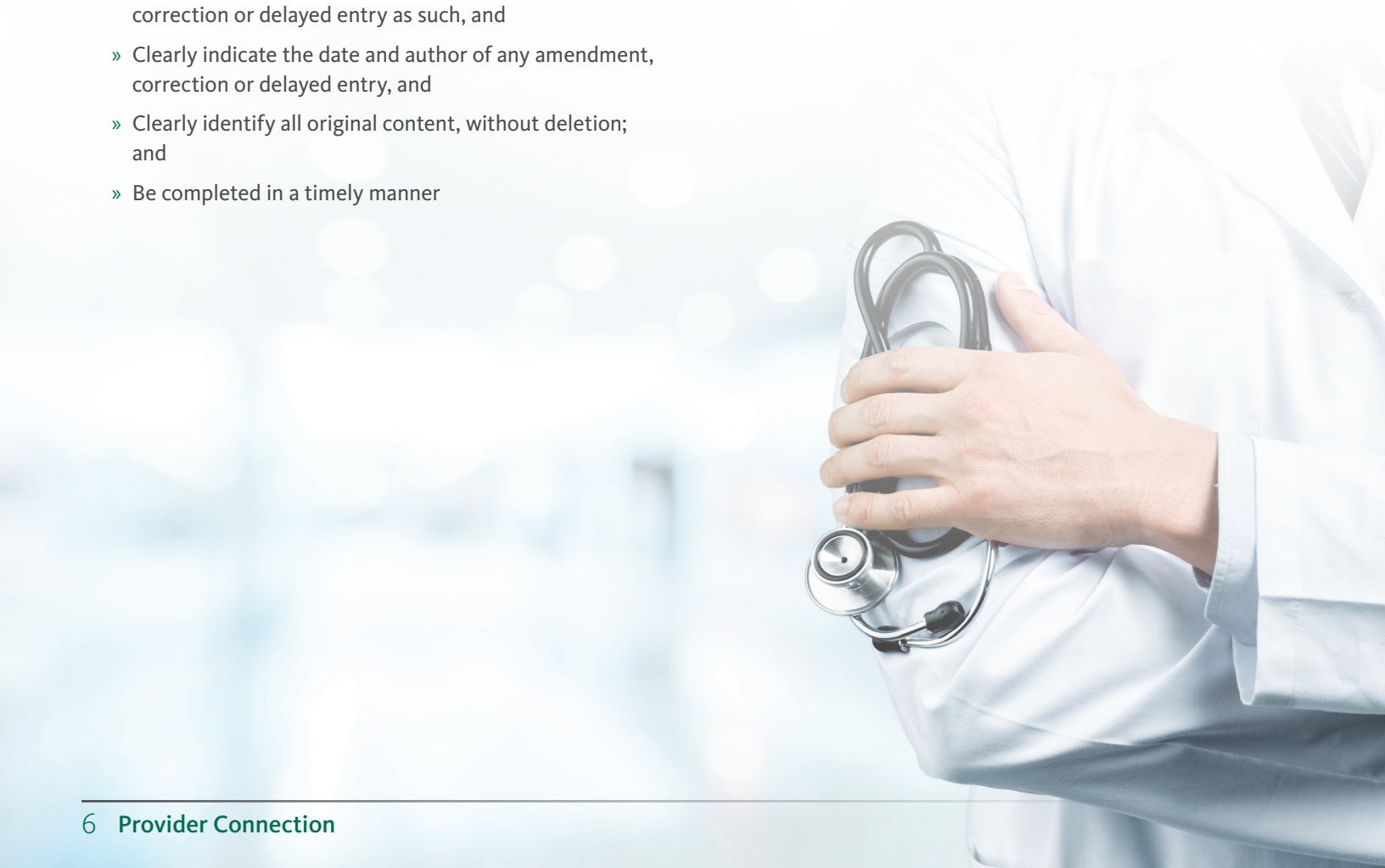
- Clearly and permanently identify any amendment, correction or delayed entry as such, and
- Clearly indicate the date and author of any amendment, correction or delayed entry, and
- Clearly identify all original content, without deletion; and
- Be completed in a timely manner

Paper medical records

When correcting a paper medical record, these principles are generally accomplished by:

- Using a single line strike through so the original content is still readable, and
- The author of the alteration must sign and date the revision. Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the Provider's initials with their name

Source: CMS Pub 100-08 Medicare Program Integrity, 3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation (Rev. 615, Issued: 10-02-15, Effective: 10-02-15, Implementation: 11-02-15)



Utilization Management news and updates

First Quarter 2020

A comprehensive list of procedures and services requiring prior approval is available on the Physicians Health Plan (PHP) website at **PHPMichigan.com/providers**. Select "Notification and Prior Approval Table" to access the list. This information is also available on the Provider portal, MyPHP.

If you have questions about the Prior Approval process, please call the PHP 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 at **517.364.8409**, from 8 a.m. to 5 p.m., Monday through Friday.

New Policies

BCP-21 Hearing Aids and Hearing Services
BCP-23 Inpatient Rehabilitation (IPR) Facility
BCP-26 Home Health Care Services
BCP-29 Complementary and Alternative Medicine (CAM)
BCP-50 Telemedicine Services
BCP-61 Sub-acute Rehabilitation (SAR) / Skilled Nursing Facility Services

Policy Updates

BCP-64 Continuous Glucose Monitors – now provided for Type 2 diabetics when coverage criteria are met

Changes to Coverage for Services

Code(s)	Procedure or Service	Action	Implementation Date
30465	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)	Covered, no longer requires prior approval	1/1/2019
53854	Transurethral destruction of prostate tissue; by radio frequency generated water vapor thermotherapy	Covered, no longer considered experimental	1/1/2020
92597, 92605 – 92609, 92618	Evaluation for speech generating devices	Not covered	10/1/2019
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	Covered, no longer considered experimental	1/1/2020
0450T	... each additional device	Covered, no longer considered experimental	1/1/2020
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified	Requires prior approval, no longer considered experimental/unproven	11/1/2019
L8614, L8616, L8617, L8618, L8619, L8625, L8627, L8628, L8629	Replacement components for cochlear implant device	Covered, no longer requires prior approval	1/1/2020

*Any Provider or Member that was directly impacted by these changes received a direct mailer explaining the changes.

Helping Patients get with the guidelines: using Heart Month as a time to talk about controlling hypertension

February is American Heart Month

Support a healthy conversation with your Patients about hypertension and set a plan for a heart-healthy lifestyle.

- Hypertension increases the risk for heart disease and stroke, which are leading causes of death in the United States
- Hypertension was a primary or contributing cause of death for more than 410,000 Americans in 2014 – That's more than 1,100 deaths each day
- About 75 million American adults (32%) have high blood pressure
- About 1 in 3 American adults have prehypertension
- Only about half (54%) of people with hypertension have their condition under control
- Hypertension costs the nation $48.5 billion each year. This total includes the cost of health care services, medications to treat high blood pressure, and missed days of work (cdc.gov/blood pressure)

Discussing these statistics with Patients will help set the stage for a plan to reduce their risk of developing hypertension and improve their compliance with the treatment plan once diagnosed. Health promotion activities should include the elimination of unhealthy behaviors. Patient education for lifestyle modifications include:

- Weight reduction (BMI goal < 25)
- Reduction of dietary sodium to less than 2.4 gm/day
- DASH diet (diet high in fruits and vegetables, reduced saturated fat and total fat)
- Aerobic physical activity ≥ 30 minutes most days of the week
- Tobacco avoidance
- Increased dietary potassium and calcium
- Moderation of alcohol consumption (mqic.org)

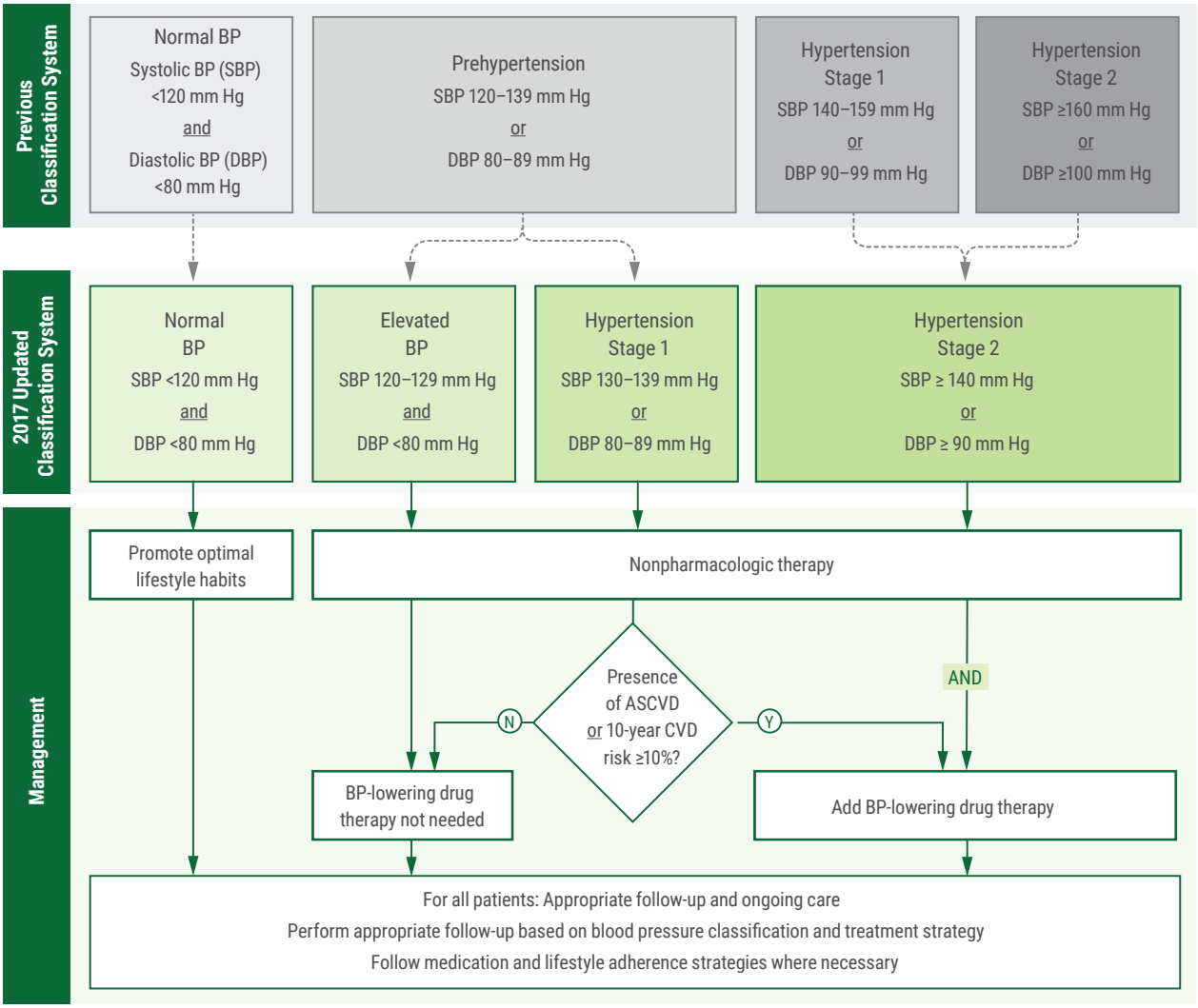
The Michigan Quality Improvement Consortium (MQIC) provides the ACC HBP Guideline tool below:

HBP

HBP GUIDELINE TOOL: UPDATED CLASSIFICATION AND MANAGEMENT OF HIGH BLOOD PRESSURE IN ADULTS

Based on the 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

Use this figure to identify the changes in blood pressure classification and treatment for adults.



ACC.org/HBPTool

B18056

AMERICAN COLLEGE of CARDIOLOGY

Diagnosis codes "paint the whole picture"

With the new year, please remember to document all established or new diagnoses and co-morbidities.

With the start of each year, the clinical history of your Patient is wiped clean in regards to documentation and reporting for areas such as HEDIS or Risk scores. Going into the 2020 calendar year, please remember to document all established or new diagnoses and co-morbidities. Remember that the history of the Member is unknown until you code and re-establish the condition.

Clinical documentation is critical for the Patient, Physician and Physicians Health Plan. As an organization, we are dependent upon the healthcare provider to supply appropriate documentation to comply with CMS regulations surrounding quality and coding specificity. 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. There are 12 spaces for diagnosis codes on a CMS-1500 form, and a UB04 has space for 41, so why not use more than one diagnosis when appropriate?

Do you ever feel like you see an increase in more complicated Patient care? 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 Patients' clinical story and cannot reflect the severity of the Patient's condition. For example, when treating a Patient with an infection and their co-morbidities affect how you are treating, your treatment plan explains that information through the diagnosis codes you place on the claims.

In summary, 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 to "paint the whole picture."

Bilateral procedures/ services

Using modifiers for accurate encounter and claims information

Incorrect use of modifiers is a common billing error, and coding for bilateral services is uniquely challenging and complex. Bilateral procedures are performed on both sides of the body during the same encounter and when appropriate, modifier -50 is applied to these services for an indication that a bilateral procedure/service was provided. It is recommended that the code terminology is reviewed in full before applying modifier -50 as it not only reports bilateral procedures/services performed during the same encounter but also serves as a payment modifier.

Some coding terminology specifically includes the terms "bilateral," "unilateral," or "unilateral or bilateral". When the code terminology specifically states "bilateral," the procedure is inherently bilateral and should not be reported with modifier -50 as it is already implied and considered in the RVU for the code. When the code terminology specifically states "unilateral," but the service was performed bilaterally, validate that there isn't a code for the service provided bilaterally. If a "bilateral" code is not available for the service, bill two separate lines, once with the modifier -LT and once with the modifier -RT. When the code terminology specifically states "unilateral or bilateral," it is implied that there is no change in RVU when performed either unilaterally or bilaterally, therefore modifier -50 would not be appropriate. If the code description for a procedure does not include any of these specific terms, it may be appropriate to report the procedure with modifier -50 as a single line item or as two separate lines, once with modifier -LT and once with modifier -RT to designate the service as bilateral. When bilateral services are billed with two separate lines with the -LT and -RT modifiers, a multiple procedure code payment adjustment may apply instead of a modifier -50 payment adjustment. Since the addition of modifier -50 may affect payment depending on the procedure code it is also important to review the BILAT SURG indicator. The BILAT SURG indicator for each procedure can be found on the Medicare Physician Fee Schedule Relative Value File. This file is updated at a minimum on a quarterly basis.

Source:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

Appropriate usage of modifier -50

- The BILAT SURG indicator is 1 or 3

Inappropriate usage of modifier -50

- The BILAT SURG indicator is 0, 2, or 9
- Do not use modifier 50 for multiple procedures on one organ, such as the skin
- On a procedure code that is described as bilateral or unilateral or bilateral in its CPT description
- Do not report a bilateral procedure on two lines of service appending modifier 50 to the second line of service
- Reporting this modifier when performing the service on different areas of the same side of the body

Special circumstances

DME

The -RT and -LT modifiers must be applied when billing two of the same item or accessory on the same date of service when the intent is for the items to be used bilaterally. Suppliers should bill each item on two separate lines using the -LT and -RT modifiers and corresponding units for each side. Do not use the combination RTLT modifier on the same claim line with multiple units of service, this may be rejected as incorrect coding.

Ambulatory Surgical Centers (ASCs)

While the use of modifier -50 is not prohibited, the modifier is not recognized for payment adjustments and if applied on an ASC claim may result in incorrect payment or denials to the ASCs. Please report bilateral procedures performed at and billed by an ASC as two separate lines, once with modifier -LT and once with modifier -RT or a single line with "2" in the unit field. A multiple procedure payment adjustment will apply to all bilateral procedures subject to Multiple Procedure Discounting

Sources:

CMS Internet-Only Manual, Publication 100-04, Chapter 12, Section 40.7

CMS Medicare Physician Fee Schedule (MPFS)

Physician's Health Plan PRP-16 Bilateral and Multiple Procedures Reimbursement Policy

http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ASCPayment/index.html

Bundling of urinalysis CPT codes

Physician Health Plan's (PHP) Clinical Edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA) and specialty societies. Clinical Edits including bundling, clinical daily maximums, or other payment logic may not be billed to the Member.

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, CPT codes 81002 and 81003 will not be separately reimbursed and are considered incidental to the E/M service. Incidental procedures are provided at the same time as a more complex primary procedure. These additional procedures require minimal additional resources and/or considered clinically integral to the primary procedure.

Urinalysis is frequently used as an indicator of health and disease and is essential in diagnosis and detection. Urinalysis without microscopy (e.g., by dipstick or tablet reagent) represents a readily available adjunctive component of a physical examination; like the measurement of blood pressure, it is considered an inherent component of an E/M service performed in an outpatient setting. The very limited practice resources required for this examination should be properly included, along with consideration of the obtained data, in the selection of the appropriate intensity level of an E/M service. CPT instruction for E/M codes states that medical decision making refers to "the amount and/or complexity of medical records, diagnostic tests, and or other information that must be obtained, reviewed and analyzed." Therefore, CPT 81002/81003 is considered an incidental procedure when performed with an E/M service.

The application of a modifier will not bypass or override this edit. Only the E/M service is eligible for reimbursement.

Compliance corner: Billing unspecified diagnoses (ICD-10-CM)

Complete and thorough documentation is the foundation for proper coding. The expectation of Physicians Health Plan is that Providers document in a manner that is as specific as possible to assure the best quality information regarding their patients' conditions when coding ICD-10-CM. "Unspecified" is defined as coding that does not fully define important parameters of the Patient's condition that could otherwise be defined by the information available. The assignment of an unspecified code is vague and may be inaccurate if there is information available that would allow for greater specificity. Documentation should clearly reflect all details such as type of encounter, onset, location, external causes, etc.

Instances when it may be acceptable to use an unspecified diagnosis code are:

- The Patient is in the early course of evaluation and the Provider may not have a complete diagnosis to document
- The claim may be from a Provider who is not directly involved in 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

Instances when it is not acceptable to use an unspecified diagnosis code are:

- When there is sufficient information to accurately define the Patient's condition
- The Provider can account for basic concepts such as laterality, anatomical locations, trimester of pregnancy, type of diabetes, known complications or co-morbidities, description of severity, acuity or other known parameters
- To save time on documentation
- Uncertainty if the unspecified code is appropriate for a specific diagnosis (coders should send an inquiry to the rendering physician for clarification in these instances)

Documentation needs to be very specific for the following conditions:

- Asthma
- Coma
- Diabetes
- Fractures
- Pregnancy
- Stroke

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 (LCDs) can be found in the Medicare Coverage Database and are searchable in a number of ways, including the "Quick Search" function. Additional resources can be found on the CMS website regarding successful ICD-10 billing.

Advance directive standard

Advance directives allow Patients to make their own decisions regarding the care they would prefer to receive if they develop a terminal illness or a life-threatening injury.

Physicians Health Plan requires documentation that advance directives have been discussed with adult Patients. Documentation should include whether the Member has declined an offer to receive additional information or, if an advance directive has been executed, a copy must be maintained in the Patient's medical record.

Ways to accomplish compliance with this standard: A question concerning advance directives could be included on your Patient registration form or health history form. Having a question that asks if the Patient has an advance directive with a box to check yes or no along with a statement that they may obtain more information regarding the subject from you, their Provider, would meet PHP's standard.

Begin the conversation: Talk to your Patient about end of life medical care. The Michigan Dignified Death Act (Michigan law) and the Patient Self-Determination Act (federal law) recognizes the rights of Patients to make choices concerning their medical care, including the right to accept, refuse, or withdraw medical and surgical treatment, and to write advance directives for medical care in the event they are unable to express their wishes.

Advance care directives can reduce:

- Personal worry
- Futile, costly, specialized interventions
- Overall healthcare costs

For questions call:

PHP Compliance Department: **800.562.6197**

Or visit:

MDHHS Patient Advocate Form (DCH-3916: Michigan.gov/MDHHS/Michigan's Advance Directive Registry: MIPeaceofMind.org/

Types of advance directives

- A durable power of attorney for healthcare allows the Patient to name a "Patient Advocate" to act for the Patient and carry out their wishes
- A Living Will allows the Patient to state their wishes in writing, but does not name a Patient advocate
- A do-not-resuscitate (DNR) declaration allows a Patient to express their wishes in writing that if their breathing and heartbeat cease, they do not want anyone to resuscitate them

Laws

Michigan Dignified Death Act

Patients have the right to be informed by their Physician about their treatment options.

- This includes the treatment you recommend and the reason for this recommendation
- You must tell your Patients about other forms of treatment. These must be treatments that are recognized for their specific illness. They must be within the standard practice of medicine
- You must tell your Patients about the advantages and disadvantages of the any treatments, including any risks
- You must tell your Patients about the right to limit treatment to comfort care, including hospice
- You should encourage your Patients to ask any questions about their illness

Patient

Federal Patient Self-Determination Act

Patients have the right to be informed by their Physician about their treatment options.

- Patients have the right to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives
- Doctors must maintain written policies and procedures with respect to advance directives and to inform Patients of the policies
- You must document in the Patient's medical record whether they have executed an advance directive
- You must ensure compliance with the requirements of Michigan laws respecting advance directives
- You must provide education for staff and the community on issues concerning advance directives
- The Act also requires providers not to condition the provision of care of an individual based on whether the individual has executed an advance directive

Medical record documentation reminders

Documentation of services is an important aspect of medical care. Claims submitted to Physicians Health Plan (PHP) must be supported by documentation in the medical record. In addition, time-based codes must include the time spent performing the services.

Common errors found 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. It is not acceptable to have ancillary staff document the HPI and then the provider later documents 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, that staff 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(s) representing the level of service provided and is accurately documented in the medical records. Failure to follow these practices could result in a reduction of claims payment.

Insufficient documentation denials

Denials related to insufficient documentation may occur for the following reasons:

- Incomplete or unsupported progress notes (unsigned, undated, procedure not fully documented to support coding, partial notes, missing med logs, etc.)
- Unauthenticated medical records (missing supervising signature, missing attestation, electronic signature without EMR protocol, or policy to support process)
- Missing or incomplete intent to order services or procedures (detailed written/signed order)

Written orders for equipment and supplies

A detailed written order for Durable Medical Equipment (DME) must include:

- The Patient name
- A description of the item that includes all items, options or additional features that are separately billed and support coding billed. This may include brand name, model number, HCPC code narrative, etc.
  - For equipment – include all options or accessories that will be separately billed or that will require additional coding, making sure to list each separately
  - For supplies – include all supplies that will be separately billed, listing each separately and including frequency of use (if applicable), as well as the quantity to be dispensed
- Date of the order
- Physician/Practitioner signature

A supplier must have an order (meeting the above order requirements) from the treating physician ***before*** dispensing DME items to the patient. A Certificate of Medical Necessity (CMN) may act as an order if it meets the detailed written order requirements and is signed and dated prior to dispensing the items.

Signatures

If the handwritten signature is illegible, include a signature log, and if electronic, the protocol should also be submitted.

Third-party documentation

Upon request for a review, it is the billing provider's responsibility to obtain supporting documentation as needed from a referring physician's office, such as the physician's order or notes to support medical necessity.

The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested.

Notice of privacy practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

If you have any questions about this notice, please contact our Customer Service Department at 800.832.9156.

Physicians Health Plan (PHP) provides health benefits to you as described in your Certificate of Coverage. PHP receives and maintains your medical information in the course of providing these benefits to you. When doing so, PHP is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. PHP (we) will follow the terms of this notice.

The effective date of this notice is September 23, 2013. We must follow the terms of this notice until it is replaced. We reserve the right to change the terms of this notice at any time. If we make substantive changes to this notice, we will revise it and send a new notice to all subscribers covered by us at that time. We reserve the right to make the new changes apply to all your medical information maintained by us before and after the effective date of the new notice.

You have the right to get a paper copy of this notice from us, even if you have agreed to accept this notice electronically. Please contact our Customer Service Department to receive a paper copy.

Generally, federal privacy laws regulate how we may use and disclose your health information. In some circumstances, however, we may be required to follow Michigan state law. In either event, we will comply with the appropriate law to protect your health information (for example, in accordance with the Genetic Information Nondiscrimination Act (GINA), we will not use genetic information for underwriting purposes) and to grant your rights with respect to your health information in oral, written or electronic form.

Your protected health information

Ways we may use or disclose your health information without your permission: We must have your written authorization to use and disclose your health information, except for the following uses and disclosures.

To you or your personal representative: We may release your health information to you or to your personal representative (someone who has the legal right to act for you).

For treatment: We may use or disclose health information about you for the purpose of helping you get services you need. For example, we may disclose your health information to healthcare Providers in connection with disease and case management programs.

For payment: We may use or disclose your health information for our payment-related activities and those of healthcare Providers and other health plans, including, for example:

- Obtaining premiums and determining eligibility for benefits
- Paying claims for healthcare services that are covered by your health plan
- Responding to inquiries, appeals and grievances
- Deciding whether a particular treatment is medically necessary and what payment should be made
- Coordinating benefits with other insurance you may have

For healthcare operations: We may use and disclose your health information in order to support our business activities. For example, we may use or disclose your health information:

- To conduct quality assessment and improvement activities including peer review, credentialing of Providers and accreditation
- To perform outcome assessments and health claims analyses
- To prevent, detect and investigate fraud and abuse
- For underwriting, rating and reinsurance activities
- To coordinate case and disease management services
- To communicate with you about treatment alternatives or other health-related benefits and services
- To perform business management and other general administrative activities, including system management and customer service

We may use or disclose parts of your health information to offer you information that may be of interest to you. For example, we may use your name and address to send you newsletters or other information about our activities.

We may also disclose your health information to other Providers and health plans that have a relationship with you for certain aspects of their healthcare operations. For example, we may disclose your health information for their quality assessment and improvement activities or for healthcare fraud and abuse detection.

To others involved in your care. We may under certain circumstances disclose to a Member of your family, a relative, a close friend or any other person you identify, the health information directly relevant to that person's involvement in your healthcare or payment for healthcare. For example, we may discuss a claim determination with you in the presence of a friend or relative, unless you object.

As required by law. We will use and disclose your health information if we are required to do so by law. For example, we will use and disclose your health information in responding to court and administrative orders and subpoenas, and to comply with workers' compensation or other similar laws. We will disclose your health information when required by the Secretary of the US Department of Health and Human Services.

For health oversight activities. We may use and disclose your health information for health oversight activities such as governmental audits and fraud and abuse investigations.

For matters in the public interest. We may use and disclose your health information without your written permission for matters in the public interest, including, for example:

- Public health and safety activities, including disease and vital statistic reporting and Food and Drug Administration oversight
- To report victims of abuse, neglect or domestic violence to government authorities, including a social service or protective service agency
- To avoid a serious threat to health or safety by, for example, disclosing information to public health agencies
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and the protective services for the president and others
- To provide information regarding decedents. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties
- For organ procurement purposes. We may disclose information for procurement, banking or transplantation of organs, eyes or tissues to organ procurement and tissue donation organizations

For research. We may use your health information to perform select research activities (such as research related to the prevention of disease or disability), provided that certain established measures to protect the privacy of your health information are in place.

To business associates. We may release your health information to business associates we hire to assist us. Each business associate must agree in writing to ensure the continuing confidentiality and security of your medical information.

To group health plans and plan sponsor (enrolling group). If you participate in one of our group health plans, we may release summary information, such as general claims history, to the employers or other entities that sponsor these plans. This summary information does not contain your name or other distinguishing characteristics. We may also release to a plan sponsor the fact that you are enrolled or disenrolled from a plan. Otherwise, we may share health information with plan sponsors only when they have agreed to follow applicable laws governing the use of health information in order to administer a plan.

Uses and disclosures of health information based upon your written authorization. If none of the above reasons apply, then we must get your written authorization to use or disclose your health information. For example, your written authorization is required for most uses and disclosures of psychotherapy notes, and for disclosures of your health information for remuneration and for most marketing purposes. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, unless we have already acted based on your authorization. Also, you may not revoke your authorization if it was obtained as a condition for obtaining insurance coverage and other law provides an insurer with the right to contest a claim under the insurance policy. We may condition your enrollment or eligibility for benefits on your signing an authorization, but only if the authorization is limited to disclosing information reasonable for underwriting or risk rating determinations needed for us to obtain insurance coverage. To revoke an authorization, or to obtain an authorization form, call the Customer Service Department at the number on your identification card.

Your rights

You have the following rights. To exercise them, you must make a written request on one of our standard forms. To obtain a form, please call the Customer Service Department.

You have the right to inspect and copy your health information. This means you may inspect and obtain a paper or electronic copy of the health information that we keep in our records for as long as we maintain those records. You must make this request in writing. Under certain circumstances, we may deny you access to your health information – for instance, if part of certain psychotherapy notes or if collected for use in court or at hearings. In such cases, you may have the right to have our decision reviewed. Please contact our Customer Service Department if you have questions about seeing or copying your health information.

You have the right to request an amendment of your health information. If you feel that the health information we have about you is incorrect or incomplete, you can make a written request to us to amend that information. We can deny your request for certain limited reasons, but we must give you a written reason for our denial.

You have the right to an accounting of disclosures we have made of your health information. Upon written request to us, you have the right to receive a list of our disclosures of your health information, except when you have authorized those disclosures or if the releases are made for treatment, payment or healthcare operations. This right is limited to six years of information, starting from the date you make the request.

You have the right to request confidential communications of your health information. You have the right to request that we communicate with you about health information in a certain way or at a certain location. Your request must be in writing. For example, you can ask that we only contact you at home or only at a certain address or only by mail.

You have the right to request restrictions on how we use or disclosure of your health information. You may request that we restrict how we use or disclose your health information. We do not have to agree to your request except for requests for a restriction on disclosures to another health plan if the disclosure is for payment or healthcare operations, is not required by law and pertains only to a healthcare item or service for which you or someone on your behalf (other than a health plan) has paid for the item or service in full.

You have the right to receive notice of a breach. If your unencrypted information is impermissibly disclosed, you have a right to receive notice of that breach unless, based on an adequate risk assessment, it is determined that the probability is low that your health information has been compromised.

How to use your rights under this notice. If you want to use your rights under this notice, you may call us or write to us. In some cases, we may charge you a nominal, cost-based fee to carry out your request.

Complaints

You may complain to PHP or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Customer Service Department in writing of your complaint. We will not retaliate against you for filing a complaint.

To complain to the federal government, write to:
Region V, Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Or Call:
Voice mail: 312.886.2359
Fax: 312.886.1807
TDD: 312.353.1807
There will be no negative consequences to you for filing a complaint to the federal government.

You may write to our Customer Service Department at:
Physicians Health Plan
Attn: Customer Service
PO Box 30377
Lansing, MI 48909-7877
You may also call our Customer Service Department at 800.832.9186.

Website privacy practices

PHP works hard to protect your privacy. Listed below are ways that PHP protects your privacy while you are on our website:

Using email: If you send PHP an email using any of the email links on our site, it may be shared with a Customer Service Representative or agent in order to properly address your inquiry.

Once we have responded to your email, it may be discarded or archived, depending on the nature of the inquiry. The email function on our website provides a completely secure and confidential means of communication. All emails are sent under 128-bit encryption on a secure server.

Obtain a quote: Some employers request quotes online for PHP health coverage. If your employer does this, it may enter the following information into the PHP website: employee name and date of birth, employee gender, spouse's date of birth and whether you have Medicare.

This information is used only to prepare an accurate quote for your employer. PHP does not use this information for any other reason.

Website visitor data: At no time are internet "cookies" placed on the computer hard drives of visitors to the PHP website.

Disease management programs: You may enroll in one of our disease management programs online. If you do, you may have to enter the following information into the PHP website: name, Member number, address and telephone number.

This information is used only for your enrollment into the program of your choice and is not used by PHP for any other purpose.

Links to other sites: The PHP website contains links to other websites. PHP is not responsible for the privacy and security practices used by other website owners or the content of those sites.

Contact us

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact our Customer Service Department at PO Box 30377, Lansing, MI 48909-7877. You may also call our Customer Service Department at 800.832.9186.

Physicians Health Plan

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

Contact us

Department	Contact Purpose	Contact Number	Email Address
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)	
Medical Resource Management	» Prior authorization of procedures and services outlined in the Notification/Authorization Table » To request benefit determinations and clinical information » To obtain clinical decision-making criteria » Information on mental health and/or substance use disorders services including prior approval, 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
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** PHPPharmacy@phpmm.org
Quality Management	» Quality Improvement programs » HEDIS » CAHPS » URAC	517.364.8000 877.803.2551 (toll free) 517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org
External Vendor	**Contact Purpose**	**Contact Number**	**Email Address**
Change Healthcare (TC3)	» When medical records are requested	**Mail To:** Change Healthcare 5755 Wayzata Blvd, St. Louis Park, MN 55416 949.234.7603 (fax)	MedicalRecords@changehealthcare.com