Provider Connection

SECOND QUARTER 2021

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WORKING WITH PHP

QUALITY CORNER

UPDATES

Physicians Health Plan

PHP COVID-19 Updates

COVID-19 continues to be an evolving pandemic. PHP is committed to providing regular plan updates. All COVID-19 updates are located within the MyPHP Provider Portal. Once you are logged in, all notices can be viewed on the home page.

PHP Commercial Members

PHP will extend $0 member cost share through Dec. 31, 2021 for members* for the following COVID-19 related services:

Facility Transfers

- Beginning Apr. 1, 2021, prior authorizations will be required for in-network facility transfers.

COVID-19 Testing

- For member cost share to be waived and the cost of the test to be covered:
  - The test must be considered medically necessary, which is determined and appropriately coded by the ordering medical provider.
  - PHP has extended its waiver of member cost share (copays, coinsurance, and deductibles) for COVID-19 E/M codes related to COVID-19 testing when rendered in the provider's office, emergency department or urgent care.
  - The cost of COVID-19 testing is not covered as a condition of employment or returning to work, as outlined in the member's Certificate of Coverage.
  - Member cost share for COVID-19 testing will be waived for in- and out-of-network providers.

COVID-19 Treatment

- Member cost share (copays, coinsurance, and deductibles) is waived for the in-network treatment of COVID-19. This is not applicable to all plans.

COVID-19 Vaccination

- Member cost share is waived for COVID-19 vaccine and vaccine administration provided by in- or out-of-network providers. If the member has a pharmacy benefit with PHP, the cost share is waived at an in-network pharmacy as well. It must be administered in the pharmacy.

Telemedicine Visits

- PHP will waive member cost share and continue to offer **expanded telemedicine coverage, which includes:**
  - Applied Behavioral Analysis Therapy for the Treatment of Autism Spectrum Disorder.
  - Physical Therapy, Occupational Therapy, and Speech Therapy.
  - Prenatal Care.
  - Telemedicine services will be a covered benefit for all PHP members when the service is rendered by an in-network PHP provider. This includes telemedicine visits rendered telephonically.
  - For a list of eligible telemedicine codes, please review PHP's Telemedicine Services Policy on the Provider Portal under Medical Policies. Prior authorization rules and guidelines will still apply, if applicable.

*(*Note: Applicable for all fully-insured PHP members. Please be sure to check eligibility for all PHP members to ensure the appropriate member cost share is applied.)*

If you have questions, please contact the PHP Provider Relations Team by emailing **PHPProviderRelations@phpmm.org**.

MyPHP Provider Portal

MyPHP Provider Portal is available 24/7 and contains many helpful resources.

MyPHP has the following features:

- **Eligibility and Coverage** – Search patients to verify eligibility and coverage information (effective dates, primary care physician, and member profile information).
- **Benefits** – View and download a member's benefit plan, documents, and summary of benefits and coverage.
- **Prior Authorizations** – View the status of an authorization and obtain the prior authorization number.
- **Claims** – Search and view claims (status, amount paid, paid dates, and claim history).
- **Explanation of Payment (EOP)** – Search, view, and print EOPs.
- **Accumulators** – View a member's out-of-pocket or deductible balances.
- **Patient Rosters** – View and print Primary Care Physician Patient Rosters.
- **Policies** – Access PHP's Medical and Pharmacy Policies.
- **Incentives** – Access to Provider Incentive Program.
- **Single-sign-on access** to the PHP Medicare Portal.
- **Announcements** – Important PHP Notices and Announcements.

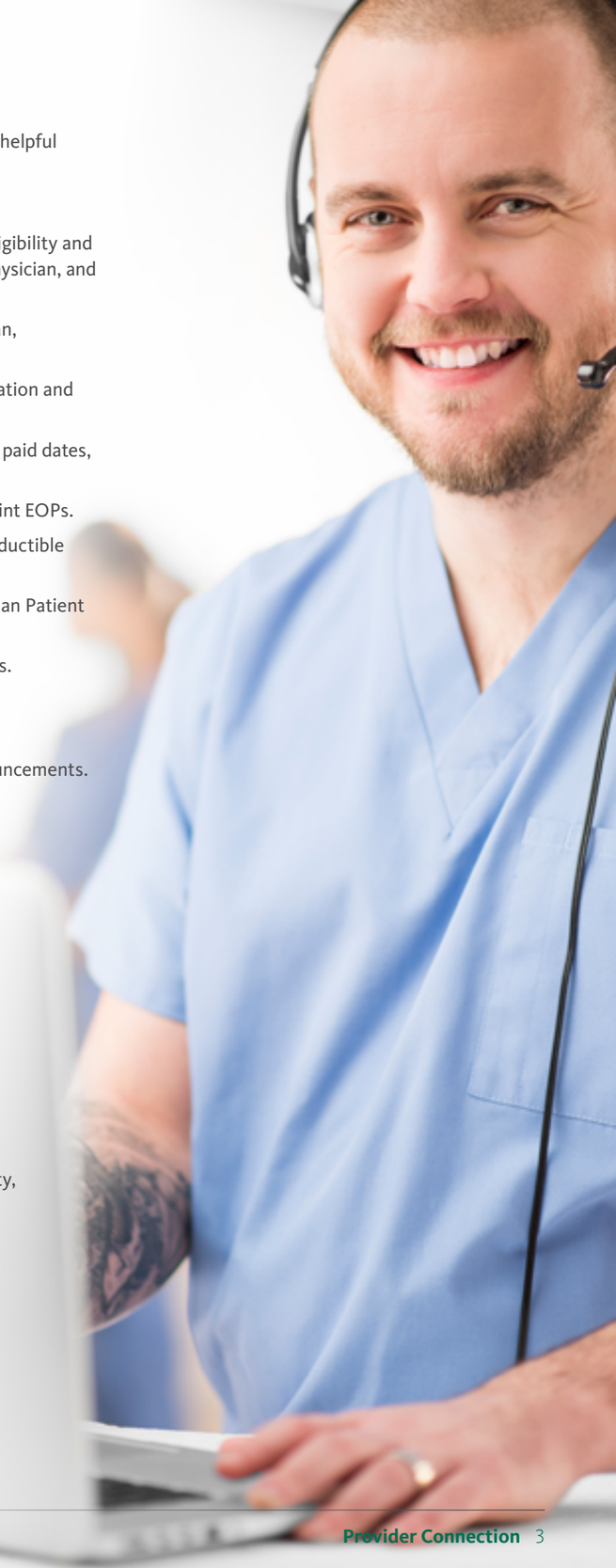
To access MyPHP:

1. Click on the link for MyPHP on the PHP website at **PHPMichigan.com**.
2. Review the instructions.
3. Create your username and password.
4. Answer the security questions.

You will need the provider tax identification number (TIN), NPI, and PHP Provider ID number to register. Your PHP Provider ID number can be found on an EOP or obtained by contacting the Provider Relations Team. Once you are registered, you will have immediate access to the portal.

Users that have not logged into MyPHP within 90 days will be disabled. If your access has been disabled due to inactivity, email your PHP Provider Relations Team.

If you would like more information or need assistance with an existing account, please send an email with your practice information, including the practice TIN, and all individual provider NPIs to **PHPProviderRelations@phpmm.org** for assistance.



Facility Reviews for Credentialing of Hospital and Ancillary Providers (HAAP)

If you are a Hospital and Ancillary Provider seeking credentialing or are due for re-credentialing with PHP, you may be required to participate in a facility review. When a facility review is required, you will be notified by the PHP Credentialing Coordinator reviewing your application and then contacted by a PHP Provider Relations Coordinator who will schedule the review.

Facility Review Elements

There are two elements to the facility review: verification of your documented policies and procedures, and a walkthrough of your facility. You will be provided with the facility review standards when the scheduling process is initiated, and the Provider Relations Coordinator will be able to answer any questions you may have before the review. A letter with your score and any recommended actions will be sent to your facility within 30 days of the review date.

Preparing for the Facility Review

When preparing for the facility review, it is helpful to have your policy and procedure documents in printed and in digital format for regular review and updates. The facility review can be conducted by any designated member of your office staff who is available to provide access to documentation and/or be present for the physical or virtual walkthrough.

Requirements for Remote Facility Review

Currently, all facility reviews are being conducted remotely, as a precaution for the health and safety of our communities due to the ongoing COVID-19 pandemic. In order to facilitate remote reviews, access to a portable device capable of streaming video and audio between yourself and the reviewer is required. WebEx and Zoom are popular video conference platforms and can be accessed on most smartphones.

If you have any questions about the facility review process, please send an email to your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

2020 Provider Satisfaction Survey Results

Claims Processing, Call Center, Referrals, Care Management, and Overall Provider Satisfaction Received High Scores

PHP sends around 1,300 surveys to network providers, including primary care physicians (PCPs), specialists and behavioral health providers, on an annual basis. The survey is administered by SPH Analytics, ensuring a neutral, confidential mechanism by which providers can report on their experiences with PHP.

Results of the 2020 Provider Satisfaction Survey are in. PHP is pleased to announce that overall Provider Satisfaction increased to 75.5% from 68.9% in 2019.

The survey results reveal strengths as well as opportunities for improvement.

Below are a few strengths identified in the 2020 Provider Satisfaction Survey:

- Improved claims processing time.
- Overall satisfaction with PHP Call Center.
- Helpfulness of PHP staff obtaining referrals for patients.
- Improved access to a case/care manager from PHP.

Below are a few improvements PHP is working on to improve provider satisfaction:

- Focused outreach phone calls to network PCPs and behavioral health providers.
- Improving the provider orientation process.
- Implementing Auto Auth.

PHP's Provider Satisfaction Survey for 2021 will be administered during the third quarter of 2021. Please remember to complete your survey. Your feedback is important to us!

General Training 2021

The Provider Relations team offers training sessions throughout the year to help you and your office staff work more efficiently with PHP.

Training opportunities include PHP Commercial and PHP Medicare requirements, a review of the Provider Manual, checking eligibility and benefits, medical and pharmacy claim status, authorizations/approvals, and much more. Practice management and all office staff are encouraged and welcome to attend.

2021 Training Dates

Tuesday, Aug. 10, noon

Thursday, Nov. 11, 8:30 a.m.

Register today! Go to **PHPMichigan.com/Providers** and select "Training Opportunities."

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

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

Utilization Management News and Updates

COVID-19 Testing and Treatment, Gender Confirmation Surgery, Glucose Monitors and Supplies, and Infertility Services Among New Policies and Policy Updates

A comprehensive list of procedures and services requiring prior approval is available on our website at **PHPMichigan.com/Providers**. Select "Notification and Prior Approval Table" to access the list. This information is also available on the MyPHP Provider Portal.

If you have any questions about the prior approval process, please call PHP Customer Service at **517.364.8500** or **800.832.9186**, Monday - Friday, 8:30 a.m. - 5:30 p.m.

Prior approval requests may also be faxed to Utilization Management at **517.364.8409**, Monday - Friday, 8 a.m. - 5 p.m.

New Policies

- BCP-15 Covid-19 Testing and Treatment.

Policy Updates

- BCP-24 Gender Confirmation Surgery – change to InterQual criteria. Updates to specify coverage for plan L0002184.
- BCP-45 Preventive Health Services – pharmacy updates.
- BCP-57 Outpatient Rehabilitation – Speech Therapy – code updates.
- BCP-50 Telemedicine – expanded benefits extended to June 30, 2021.
- BCP-63 Varicose Vein Treatment – change to InterQual criteria.
- BCP-64 Continuous Glucose Monitors & Supplies – quantity limit for Dexcom G6 transmitters = 4/year.
- BCP-72 Infertility Services – updates to specify coverage for group L0002184.
- BCP-74 Facet Joint Injections and Facet Neurotomy for Pain Management – change to InterQual criteria effective Aug. 1, 2021.

Changes to Coverage for Services

Code(s)	Procedure or Servivce	Action	Effective Date
31570 - 31573	Laryngoscopy with vocal cord injections	Change from PA to Covered	Jan. 1, 2021
37184, 37220 - 37236	Arterial mechanical, thrombectomy, revascularization	Change from Covered to PA	June 1, 2021
93356	Cardiac strain imaging	Change from Not Covered to Covered	Jan. 1, 2021
95992, S9476	Canalith repositioning, vestibular therapy	Change from PA to Covered	Aug. 1, 2020
L6883, L6884, L6885	Replacement socket; below-the-elbow, above-the-elbow, shoulder	Change from Not Covered to PA	June 1, 2021
Q4133	Grafix skin substitute	Change from Not Covered to Covered	Jan. 1, 2021

**Any provider or member that was directly impacted by these changes received a direct mailing explaining the changes.*

Identify and Prioritize Important Health Screenings with AHRQ Tool

Keeping up with all of the recommendations for screening tests can be overwhelming. The Agency for Healthcare Research and Quality (AHRQ) offers a website to help both you and your patients identify and prioritize important health screenings.

AHRQ's Electronic Preventive Services Selector (ePSS) uses a few simple inputs, such as sex, age, and behavioral risk factors, to provide current, evidence-based screening recommendations from the U.S. Preventive Services Task Force (USPSTF).

The ePSS tool is available on the AHRQ website at **https://ePSS.ahrq.gov** and is also available via mobile app. This tool is not meant to replace clinical judgment and individualized patient care. When using this tool, please refer to the specific recommendations to determine if the preventive service is appropriate for your patient.

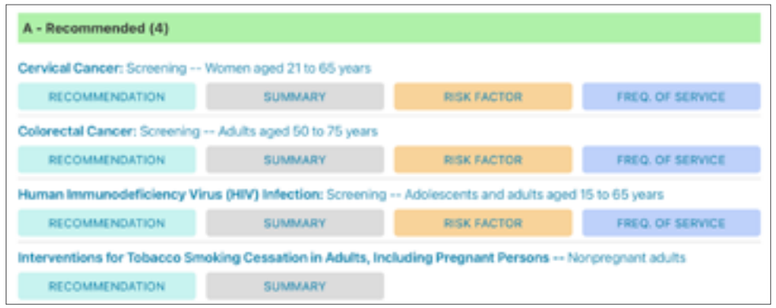
For the purpose of this article, we'll use a 65-year-old female who is not a tobacco user, and not sexually active as our example patient.

Select "Search for Recommendations" and enter patient details as as shown in Fig. 1.

Select "Show Recommendations".

Shown below is a portion of the results screen. Recommendations are graded "A", "B", "C", "D", or "I" which indicate the value of the screening with "A" being a high certainty that the screening provides substantial benefit to the patient, and "I" indicating that current evidence is insufficient to determine the value of the screening.

Fig. 1



Select "Risk Info" for more information regarding the need for the screening. The information can also be printed and shared with the patient.

"Details" provides recommendations, rationale, clinical considerations, screening tools, and additional resources for clinicians and patients.

PHP values your feedback, and would like to know if you found this tool helpful or what other resources you may need to help your patients follow through with recommended screenings for a healthier life. Contact the PHP Quality Department with questions and feedback by emailing **PHPQualityDepartment@phpmm.org**.

Check-Up to Keep Blood Pressure Down

May is National High Blood Pressure Education Month. Resources are available to help support patient education and blood pressure goals.

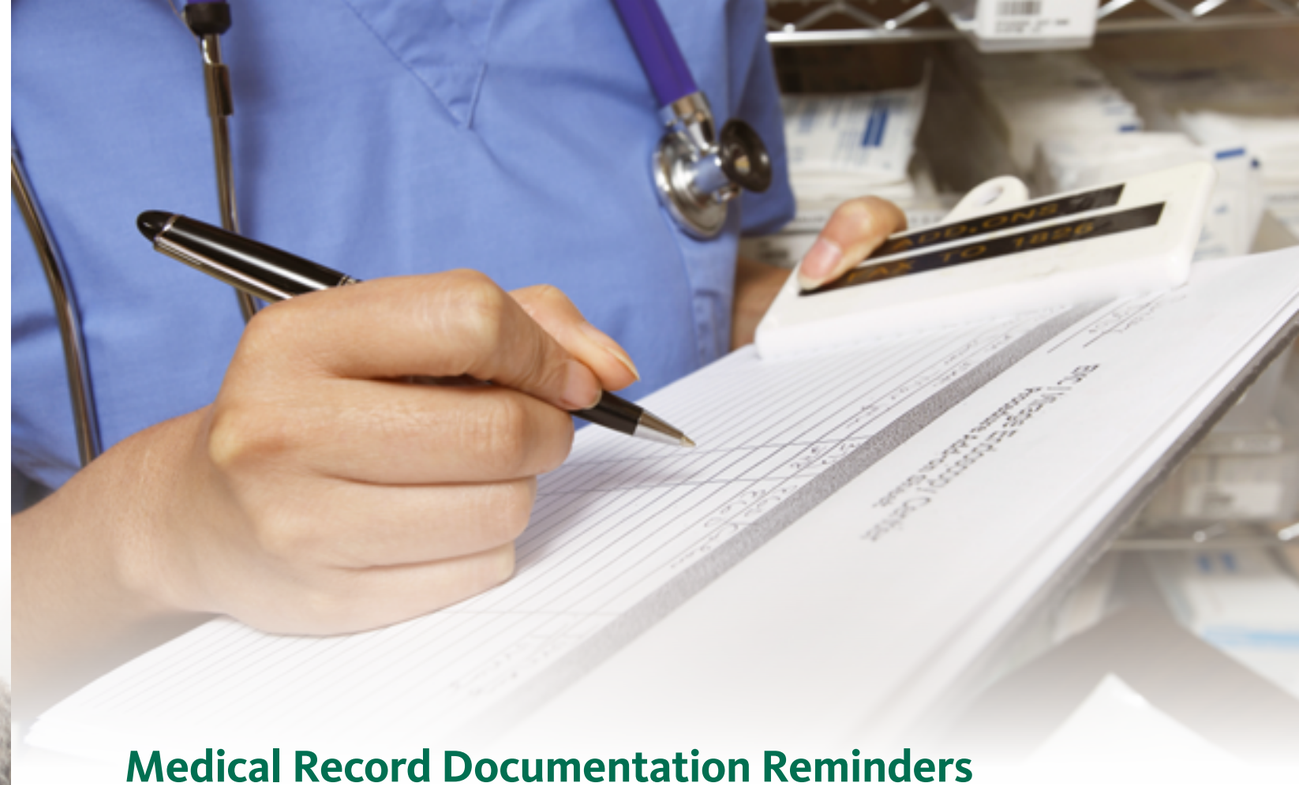
Hypertension impacts many aspects of a patient's health—from heart health to vision and kidney function. Blood pressure control is an essential component to overall health.

During the month of May, National High Blood Pressure Education Month is observed and there are several resources available to provider offices for patient education.

The Centers for Disease Control and Prevention (CDC) offers a hypertension communication kit, including sharable graphics for social media and hypertension education materials for sharing with patients. Visit **CDC.gov/BloodPressure/Communications_Kit.htm** to find easy-to-use materials and more information.

The American Heart Association provides several communication toolkits and printable documents available for your use at **https://www.Heart.org/en/Professional/Million-Hearts/Resources-and-Messaging/Messaging-Support**.

If your office needs additional assistance, please contact our Medical Resource Management Department at **517.364.8560**.



Medical Record Documentation Reminders

Documentation of services is an important aspect of medical care. Claims submitted to PHP must be supported by documentation in the medical record. Medical records should identify the services provided during an encounter completely and clearly. Current Procedural Terminology (CPT®) code selection and appropriate reimbursement are dependent on details within the medical record.

Documentation Required is Based on Services Provided

PHP applies CMS documentation guidelines as best practice when reviewing medical records to ensure all pertinent medical record components are reviewed, and the services billed are supported. The documentation required for support varies based on the services provided. For example, supporting documentation for a lab service should include:

- Lab order/requisition
- Lab reports
- Time and date of draw

Using outpatient surgery as an example, supporting documentation should include an itemization of supply charges and the operative report.

A Note of Caution for Electronic Medical Records

Use caution when entering information into electronic medical records. Repeated and outdated notes lead to an unreliable and inaccurate record of events and services. Medical records could be considered cloned documentation when multiple entries in a patient chart are identical or similar to other entries in the same chart or in other patient charts without the expected variations in time, diagnosis, and treatment.

Preparation for Audits

PHP routinely audits medical records to ensure compliance with all documentation and coding guidelines. Regardless of the practitioner's specialty, PHP expects that all claims submitted for reimbursement will contain the appropriate CPT and/or HCPCS code(s) representing the level of service provided and have been accurately documented in the medical records. Submission of incomplete, illegible, or missing documentation may result in the delay or denial of payment.

Amendments, Corrections, and Delayed Entries in Medical Documentation

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

PHP considers submitted entries that comply with the record keeping principles described below. PHP does not consider any entries that do not comply with the principles listed below. Failure to adhere to these record keeping principles may result in a claim denial. For example, undated or unsigned entries with handwritten notes in the margin of a document are not considered. An amendment should not be used to prove the medical necessity or the fact that a service was performed; it should be used only 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;
- Clearly indicate the date and author of any amendment, correction, or delayed entry;
- Clearly identify all original content, without deletion, and
- Be completed in a timely manner.

When correcting a paper medical record, these principles are generally accomplished by using a single line strikethrough so the original content is still readable. The author of the alteration must also sign and date the revision. Any amendments or delayed entries to paper records must be:

- Signed and dated upon entry into the record or
- Initialed and dated if the medical record contains clear 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)

Place of Service 02

Place of Service (POS) Codes are two-digit codes applied to Field 24b of the CMS 1500 form for professional claims as an indicator of the setting in which a service was provided. The National POS Code Set is standard throughout the medical coding industry and maintained by the Centers for Medicare & Medicaid Services (CMS). The current COVID-19 public health emergency has presented a need for shifts in service locations resulting in an increase and expansion of services performed in a telehealth setting. Telehealth services are performed through telecommunication systems and allow for services to be performed while the patient is in a different location than the provider. When reporting telehealth services delivered through telecommunication systems, the place of service reported should be POS 02.

Place of Service 02

The location where health services and health-related services are provided or received through a telecommunication system.

- When a patient receives telemedicine services in a facility setting, bill with the appropriate place of service, (e.g. 21,22) and modifier 95.
- When a patient receives telemedicine services in a non-facility setting, bill with Place of Service code 02 and modifier 95.

COVID-19

Due to COVID-19, PHP has expanded coverage of telemedicine services. Additional services to be covered via telemedicine from Mar. 1, 2020 - June 30, 2021* are:

- ABA therapy
- PT/OT/ST
- Prenatal care

PHP routinely audits claims for correct coding. CPT and CMS maintain a list of codes that are considered telehealth codes and any code that is not part of this list will be reviewed for appropriateness to bill under the telehealth place of service. For example, it is not appropriate for lab services to be billed with the POS 02 due to the nature of the service. On occasion records may be requested to validate correct billing of telehealth services. Documentation must indicate services were performed through secure telecommunication systems (e.g., online or telephone) and support the codes reported.

**Dates may be extended*

Claims Submission for Continuous Overnight Pulse Oximetry

Pulse oximetry is a common screening test that evaluates blood oxygen levels. This test is often done to evaluate common sleep disorders and may be performed continuously overnight while a patient is at home or at a facility. The provider places a sensor on the patient's earlobe or fingertip. The sensor uses a light shining through the body part to measure the oxygen saturation, detecting the differences in the ways blood cells with and without oxygen reflect light. Oxygen saturation, sometimes called O2 sat, is the percentage of hemoglobin-carrying oxygen molecules. Hemoglobin is the protein in the red blood cell that carries oxygen to the tissue and returns carbon dioxide to the lungs. The sensor transmits the data to a computer unit that displays the result. A noninvasive pulse oximetry for oxygen saturation by continuous overnight monitoring may be reported with CPT code 94762. Before reporting CPT code 94762, review documentation and the following billing guidelines to ensure appropriate claims submission.

Technical Component Only Code

Providers must lease, rent, or own the oximeter to meet the CPT billing criteria. CPT 94762 carries a CMS indicator of 3 in the TC/PC column of HCFAs national relative value units (RVU) file, which indicates it represents the staff and equipment costs associated with the service. CPT 94762 is therefore identified as a technical-component-only code. The -TC modifier is therefore unnecessary and should not be reported. Professional claims may be submitted when the provider owns the equipment. If the service is provided in a facility and the facility owns the equipment, the facility should bill for the service.

Separate Procedure

The code definition indicates this service is a separate procedure. This code should not be reported when the provider performs the service as an integral component of a larger procedure.

Medically Unlikely Edits (MUE)

PHP applies current Medicare MUE limitations to this service. In addition, this CPT code has a Medicare Adjudication Indicator (MAI) of 2. A MAI of 2 is an absolute date of service (DOS) edit based on Medicare policy. If the sum of units billed for a DOS exceeds the MUE value, the additional units will be denied. CMS has not identified any instances in which exceeding a MAI 2 MUE is correct.

NCCI Edits

CPT 94762 is considered both a column one and column two code for multiple services. Review NCCI edits, clinical circumstances, and supporting documentation prior to the application of a modifier to unbundle procedure to procedure code edits.

Location of patient

Facility

- Patient would be in the facility over at least one midnight.

Home

- Includes private residence, assisted living facility, etc.
- Service includes overnight monitoring.

Medical Necessity

- Medical record must contain the physician/practitioner order.
- Medical record must indicate the rationale for continuous overnight monitoring.
- Medical record must indicate monitoring results/ findings.

Drugs New to Market	
Drug Name	**Formulary Action** *(PA-Prior Authorization)*
Orladeyo (berotralstat capsule)	Non-preferred specialty Tier, PA
Oxlumo (lumasiran subcutaneous)	Medical PA
Danyelza (naxitamab-gqgk IV infusion)	Medical PA
Evrysdi (risdiplam oral solution)	Non-preferred specialty Tier, PA
Inqovi (decitabine/cedazuridine 35/100mg tablets)	Non-preferred specialty Tier, PA
Blenrep (belantamab mafodotin-blmf intravenous infusion)	Non-preferred specialty Tier, PA
Enspryng (satralizumab-mwge SQ prefilled syringe)	Non-preferred specialty Tier, PA
Gavreto (pralsetinib capsule)	Non-preferred specialty Tier, PA
Kesimpta (ofatumumab SQ auto-injector)	Preferred specialty Tier

Changes to Current Formulary	
Drug Name	**Formulary Action** *(PA-Prior Authorization)*
Aimovig (erenumab)	Moving to non-preferred brand name tier, removing step therapy and adding PA. Effective Apr. 1, 2021
Ajovy (fremanezumab)	Moving to non-preferred brand name tier, removing step therapy and adding PA. Effective Apr. 1, 2021
Emgality (galcanezumab)	Moving to non-preferred brand name tier, removing step therapy and adding PA. Effective Apr. 1, 2021
Botox (onabotulinumtoxin A)	Removing medication trial requirements for migraine prevention. Effective Apr. 1, 2021
ProAir & ProAir Respiclick	Moving to non-preferred brand name tier

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 page by selecting Pharmacy Services on the left side of the page within the website **PHPMichigan.com**.
- Fill out form completely and legibly.
- If requesting an infusion drug, please include the name of the office and/or facility and NPI number of 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 to PHP 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.

Real-Time Prescription Benefits

Providers have the ability to view member-specific plan and drug cost information provided across multiple points of care

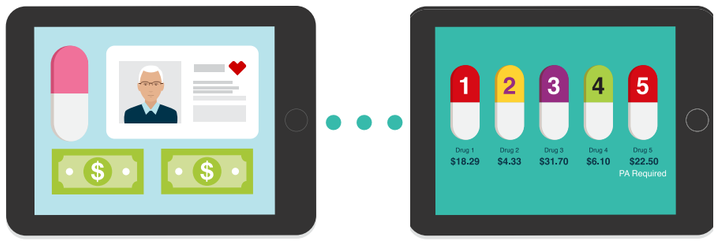
The cost of health care is a major source of worry for consumers across the nation, especially for those enrolled in high deductible health plans who may pay thousands of dollars out of pocket (OOP) each year.

Consumers must navigate their health and prescription benefit plans to make the most cost-effective choices. As a result, they are demanding greater cost transparency and easier access to the information they need to make these health care decisions.

CVS Health is committed to helping plan members find the most affordable options to keep them healthy.

We continue to help lower member OOP costs through formulary and plan design strategies. The majority of members — 85 percent — spent less than $300 on their medications last year.

We also offer real-time prescription benefits to provide greater visibility to member OOP costs and available lower-cost options to help members and their providers make more informed treatment decisions.



By utilizing member-specific benefit information, including formulary, plan design, deductible status, and other accumulators, our solution lets providers and members:

- **Know if a drug is covered** and the member's OOP cost
- **See up to five** clinically appropriate lower-cost brand and generic alternatives

Information Provided Across All Member Touchpoints

At the doctor's office
Information is integrated into the e-prescribing workflow, so physicians can take action to help patients save right at the point of prescribing. Market projections estimate we will be connected with nearly 400,000 physicians by the end of 2020.

At the pharmacy
CVS pharmacists use our proprietary search tool, Rx Savings Finder, to quickly identify available opportunities for members to save money on their medications.

Directly to members
Our online tool lets members check what their OOP costs are and find possible lower-cost alternatives to talk about with their doctor.

Calling in to Customer Care
Customer Care representatives have access to the same real-time benefit and cost information, and can tell members exactly what they will pay OOP based on their plan design, formulary, and where they are in their deductible.

Source: CVS Health Enterprise Analytics, 2019. Market projections provided by Surescripts P1002380719.

Physicians Health Plan

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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 » Behavioral Health/Substance Use Disorders Services, for information on mental health and/or substance use disorders services including prior authorizations, case management, discharge planning, and referral assistance	517.364.8560 866.203.0618 (toll-free) 517.364.8409 (fax)	
Network Services	» Credentialing - report changes in practice demographic information » Coding » Provider/Practitioner education » To report suspected Provider/Practitioner fraud and abuse » EDI claims questions » Initiate electronic claims submission	517.364.8312 800.562.6197 (toll-free) 517.364.8412 (fax) **Report Suspected Fraud and Abuse:** 866.PHPCOMP (866.747.2667)	**Credentialing** PHP.Credentialing@phpmm.org **Provider Relations Team** PHPProviderRelations@phpmm.org **Provider Data** PHPProviderUpdates@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	517.364.8408 (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 Attn: Pre-Pay 1849 West Drake Drive, Suite 101 Tempe, AZ 85283 952.224.8650 949.234.7603 (fax)	MedicalRecords@changehealthcare.com