Provider Connection

FIRST QUARTER 2018

In this issue

Physicians Health Plan

A health plan that works for you.

Raising awareness for Antibiotic Awareness Week

Thank you to all the provider offices that participated in our Antibiotic Awareness Week efforts in November. By raising awareness of the threat of antibiotic resistance and the importance of appropriate antibiotic prescribing and use, together we can make a difference in the health of our community.

We had five offices that showed their support by posting a picture of their staff wearing buttons to our Facebook page. Capital Area Pediatrics was the grand prize winner, receiving a catered lunch by Olive Garden for their entire office. Lansing Urgent Care – West, Eaton Rapids Family Medicine, Henry Ford Allegiance Family Medicine – East Michigan, and Pittsburg Family Healthcare PC, all received a consolation prize of a Cravings Popcorn Gift Basket. Antibiotic resistance is a growing problem, and we appreciate our provider offices taking the time to recognize and combat this issue by participating in our annual Antibiotic Awareness Week Campaign.

Capital Area Peds

Eaton Rapids Family Medicine

Henry Ford Allegiance Staff

Lansing Urgent Care Staff

Pittsburg Family Medicine

Prior approval changes:
Hip Surgery

Effective April 1, 2018, the medical policy for Femoro-Acetabular Impingement Hip Surgery will require prior approval for CPT codes: 29862, 29914, 29915, 29916.

The Notification and Authorization Table has been updated and is always available on the PHP website at **PHPMichigan.com**.

If you have benefit questions or concerns please contact Medical Resource Management at **517.364.8560** during office hours Monday through Friday, 8 a.m. to 5 p.m.

Medical Policies now online

PHP's Provider portal, MyPHP, has been updated to make our Medical Policies available to you whenever and wherever you need them. To access the policies through the Provider portal, log into your MyPHP account and click on Medical Policies in the green toolbar. PHP will monitor and update the portal monthly to ensure the Medical Policies are accurate and up to date. Any changes or updates to the Medical Policies will be reflected here in the quarterly Provider Connection. If you have any questions about these updates please email your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Newborn eligibility requirements

PHP has updated the newborn eligibility requirements in accordance with the State Insurance Code amended in 2016.

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

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

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

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

HEDIS CORNER

2018 Medical Record collection

PHP is committed to improving the health of individuals, families, and communities. As part of this commitment, PHP participates annually in the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a standardized set of performance measurement criteria that relies on medical claims data and medical record review. The health plan requires assistance from our provider network to obtain this information for the 2018 review.

All practitioners are receiving this letter as notification of the upcoming HEDIS 2018 review period. The HEDIS 2018 audit process will be conducted from February through May. If medical record information is needed for health plan members under your care, your office or facility will be contacted directly by a PHP HEDIS Review Nurse to verify that record(s) exists and to make arrangements for obtaining the necessary information. Arrangements for data collection may include on-site chart reviews or requests for information by fax. During on-site reviews the PHP HEDIS Review Nurse will be required to photocopy any relevant portions of the medical chart(s) as required by our auditing firm. PHP appreciates your assistance and cooperation in meeting requested timelines and providing medical record information.

HIPAA Privacy Regulations

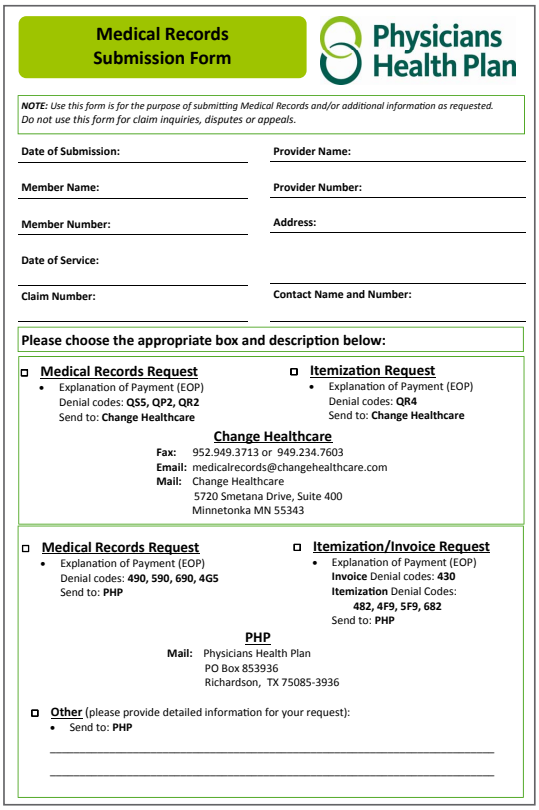
Under HIPAA requirements, HEDIS data collection is a quality assessment and improvement activity, and is therefore included in the definition of healthcare operations, and may be provided to PHP without authorization from members.

If you have any questions or concerns about the HEDIS medical record data collection process, please contact Shelly Marsh at **517.364.8332**.

PHP appreciates all the excellent care you provide to our members, and thanks you in advance for your help during the HEDIS 2018 audit process.

Sincerely,

Peter Graham, M.D.
PHP Executive Medical Director



Medical Records Submission Form

Physicians Health Plan

NOTE: Use this form is for the purpose of submitting Medical Records and/or additional information as requested. Do not use this form for claim inquiries, disputes or appeals.

Date of Submission: | Provider Name:

Member Name: | Provider Number:

Member Number: | Address:

Date of Service:

Claim Number: | Contact Name and Number:

Please choose the appropriate box and description below:

☐ **Medical Records Request**
- Explanation of Payment (EOP)
  Denial codes: **QS5, QP2, QR2**
  Send to: **Change Healthcare**

☐ **Itemization Request**
- Explanation of Payment (EOP)
  Denial codes: **QR4**
  Send to: **Change Healthcare**

Change Healthcare
Fax: 952.949.3713 or 949.234.7603
Email: medicalrecords@changehealthcare.com
Mail: Change Healthcare
5720 Smetana Drive, Suite 400
Minnetonka MN 55343

☐ **Medical Records Request**
- Explanation of Payment (EOP)
  Denial codes: **490, 590, 690, 4G5**
  Send to: **PHP**

☐ **Itemization/Invoice Request**
- Explanation of Payment (EOP)
  Invoice Denial codes: **430**
  Itemization Denial Codes: **482, 4F9, 5F9, 682**
  Send to: **PHP**

PHP
Mail: Physicians Health Plan
PO Box 853936
Richardson, TX 75085-3936

☐ **Other** (please provide detailed information for your request):
- Send to: **PHP**

New Medical Record Submission Form

PHP has created a new Medical Record Submission Form to help route your medical records to the appropriate place for the fastest claims processing possible. To access this form, go to **PHPMichigan.com**, click the Providers Tab, and click Forms.

Change Healthcare:

PHP's Code Edit Compliance software, Change Healthcare, has developed edits for both facility and professional claims.

- Edits are based on specific criteria that include: CPT codes, HCPCS code, ICD -10 and place of service.
- A review is triggered when a claim matches such criteria.
- When such criteria is met, Change Healthcare will send a letter on behalf of PHP requesting the applicable medical record or an itemization request.
- The requested medical record or itemization request documentation is then sent directly to Change Healthcare via fax or mail.
- If a claim is denied for lack of medical records or itemization, one of the following codes will be on the EOP; QL1: TC3 C18 Records Not Received, QS5: TC3 F10 Records Not Received, or RS5: TC3 F10 Records Not Received.

PHP's Claims Processing System

PHP's claims processing system will also require medical records or an itemization request when a claim matches specific criteria.

- If a claim is denied for lack of medical records or itemization, one of the following codes will be on the EOP:
  - 430 Invoice Required, 482 Submit Itemization, 490/590/690 Notes Required, 4F9/5F9 Itemization Required, 4G5 Submit Itemization and Medical Records, 4G6 Submit Medical Records, or 682 Submit Itemized.
- The requested medical records or itemization request is sent directly to PHP via mail to:

  P.O. Box 853936
  Richardson TX 75085-3936

HEDIS

HEDIS is a standardized set of performance measurement criteria that relies on medical claims data and medical record review.

- PHP participates annually in the Healthcare Effectiveness Data and Information Set (HEDIS).
- The health plan requires assistance from our Provider Network to obtain the required medical record information for the HEDIS 2018 review.
- The HEDIS 2018 audit process will be conducted from February through May.
- If medical record information is needed for health plan members under your care:
  - Your office or facility will be contacted directly by a PHP HEDIS Review Nurse to verify that record(s) exist.
  - The HEDIS Review Nurse will make arrangements for obtaining the necessary information. Medical records can be sent directly to PHP via fax at **517.364.8408**.

Medical Resource Management

PHP's Medical Resource Management Department requires medical record documentation when responding to requests for prior authorization/approval.

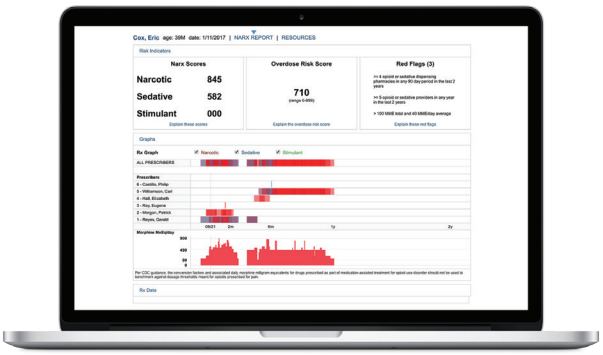
- Be sure when requesting prior authorization/approval that you are using the appropriate form.
- You can obtain a copy of the Prior Authorization Request Form on the PHP website by clicking on the Providers Tab, click Forms, then click Prior Authorization Request Form for Services.

Michigan Automated Prescription System (MAPS) updated to include risk score calculation

On Dec. 4, 2017, the appearance of MAPS changed with the launch of NarxCare. The new module provides advanced analytics and additional information including NarxScores, a 3-digit risk score for the prescribing of narcotics, sedatives, and stimulants, predictive risk scores, and Rx graphs. NarxCare has an additional Resources tab that can be used by practitioners to look up Medication Assisted Therapy and informational flyers for Patient resources.

With NarxCare incorporated into MAPS, users must submit Patient prescription history requests with a search time frame of at least two years to calculate these important risk scores. The risk score will be zero if there are less than two years of prescription history available for the requested Patient.

If you have any questions, please contact our MAPS support team at **517.373.1737** or by email at **BPL-MAPS@michigan.gov**.



* Image 1.0: The Narx Report

Diabetes PATH Program improves member outcomes

The Diabetes PATH program, a six-week workshop presented by the Tri-County Office on Aging for PHP members, allows participants to learn more about healthy eating, fitness and exercise, preventing complications, monitoring blood sugar, communication with Physicians, and more, and includes weekly incentives to encourage Member attendance.

With the successful completion of PHP's first Diabetes PATH program, and a second series currently underway, we're excited to see this ongoing effort improve the health of our diabetic Members. Please watch for future session dates to share with your Patients.

The first sessions have been successful in helping diabetic Members realize the importance of nutritional and lifestyle choices in managing their blood sugar. Many Members who completed the program commented that the instructors were very knowledgeable, and the information was presented in an interesting and relevant manner. One participant commented that she was able to get a better grip on her diabetes by learning more about healthy eating, reading food labels, and how to handle and decrease stress.

We encourage our pre-diabetic and diabetic Members to attend upcoming sessions. PHP will be contacting previous attendees and analyzing claims data to get a complete picture of the success of the program and the improvement to Member outcomes.

MATCH (Managing Asthma Through Case-management in Home)

PHP will now cover services provided through the MATCH (Managing Asthma Through Case-management in Home) program, which allows for intensive home-based asthma case management services for individuals with uncontrolled asthma.

The visits by Certified Asthma Educators involve assessment of asthma triggers, consultation about how to reduce asthma triggers, medication management, evaluation of asthma exacerbations and connection to resources to create an asthma-friendly home.

The Certified Asthma Educator also coordinates care with family members, healthcare providers, school staff, and employers to assure the Patient's individualized asthma action plan is utilized. Long-term impacts include fewer Emergency Department visits and hospitalizations related to asthma as well as decreased healthcare costs and improved quality of life.

Contact PHP Disease Management at **PHPDiseaseManagement@phpmm.org** or **517.364.8466** with referrals. Please include Patient name, date of birth, and pertinent history that prompted the referral in the message. PHP Disease Management staff will manage submission of the referral to the MATCH program.

Requirement for providers to maintain and disseminate written fraud and abuse policy requirements and False Claims Act policies

All providers that participate with federal programs such as Medicaid or Medicare have a responsibility to detect and prevent fraud and abuse and to understand and comply with the federal False Claims Act. Additionally, the Michigan Department of Health and Human Services (MDHHS) and Section 1902(a) (68) (A) of the Social Security Act* requires that providers that receive $5 million or more in Medicaid funds annually maintain and disseminate written policies to their employees that include:

- Methods of identifying and detecting fraud, waste, and abuse by employees, providers and members;
- A process to guard against (prevent) fraud, waste, and abuse committed by employees, providers and members;
- Detailed information about the federal False Claims Act and the Michigan Medicaid False Claims Act and other provisions named in Section 1902(a)(68)(A) of the Social Security Act*;
- Rights of employees to be protected as whistleblowers.

Under Section 6032 of the Deficit Reduction Act of 2005, any employer who receives more than $5 million per year in Medicaid payments is required to provide information to its employees about the federal False Claims Act, any applicable state False Claims Act, the rights of employees to be protected as whistleblowers, and the employer's policies and procedures for detecting and preventing fraud, waste, and abuse. This information must be provided to the employees through written policies and included in the employee handbook (if one exists).

PHP'S compliance plan and policies

Physicians Health Plan (PHP), through its compliance plan, policies, and actions, is committed to the highest standards of ethical behavior, the payment of accurate claims to all providers, and adhering to mandates by federally-funded payers such as Medicaid.

PHP has an established compliance plan that includes policies to detect and prevent fraud, waste, and abuse. No provider is exempt from a review of fraud, waste, and abuse activities. Claims that violate developed edits or fraud, waste, and abuse standards will result, at a minimum, in the reduction of payment and, a maximum, termination of your participation agreement. These are independent of any actions that the state or federal government may take. This plan helps to ensure appropriate claims are submitted to government programs such as Medicaid.

PHP has an established Billing Integrity Program, which is a systematic method to audit and review provider records to detect provider billing fraud, waste, and abuse. Additionally, PHP utilizes Code Edit Compliance software hosted by Change HealthCare. The Code Edit Compliance software applies nationally recognized coding standards to validate correct coding initiatives and identify claims where these standards have not been applied. Change HealthCare has developed edits for both facility and professional claims. These claim edits are based on specific criteria that include: CPT codes, HCPCS codes, ICD-10 codes, and place of service codes.

PHP has established expectations related to acceptable business practices for providers of healthcare services and their associates. These expectations have been communicated throughout the PHP Provider Manual.

It has always been a requirement that claims submitted for payment represent the services provided, and that documentation is complete, accurate, and timely.

Examples of false claims include: billing for supplies or services not rendered, double billing resulting in duplicate payment, up-coding claims, miscoding claims to allow for billing services not covered, excluding diagnoses that could impact claim payment, etc.

How to report suspicious or fraudulent actions

Reporting to PHP

If you have any knowledge of, or suspicion that, someone within your practice is involved in fraudulent actions you may report this to PHP by any of the following methods:

- Call the Sparrow Health System Compliance Hotline: **517.267.9990**
- Send a letter to: Physicians Health Plan, P.O. Box 30377, Lansing, MI 48909-7877
- Contact the PHP Compliance Department at **800.562.6197**, or
- Email PHP Compliance directly at **PHPCompliance@phpmm.org**.

All reports can remain anonymous and confidential.

Reporting Medicaid fraud to the state of Michigan

If you have any knowledge of, or suspicion that, someone within your practice is involved in fraudulent actions involving Medicaid claims or services; you may report this directly to the Michigan Department of Health and Human Services (MDHHS) or Inspector General Administration Provider Enforcement Bureau (IGA-PEB) at the following:

In Writing:

Inspector General Administration Provider Enforcement Bureau
P.O. Box 30062
Lansing MI 48909

Online Complaint Form:

Michigan.gov/Fraud

By Phone:

855.MI.FRAUD (855.643.7283)

All reports can remain anonymous and confidential. You can report directly to the Michigan IGA-PEB before or without reporting to PHP.

Summary of the federal False Claims Act

The federal False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare or Medicaid program. The act establishes liability for any person who knowingly submits or causes to be submitted a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" is defined to mean a person who:

- Has actual knowledge of falsity of information in a claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, healthcare providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government or its contractors, such as knowingly making false statements, falsifying records, double-billing for supplies or services, submitting bills for services never performed or supplies never furnished, or otherwise causing a false claim to be submitted.

For purposes of the federal False Claims Act, a "claim" includes any request or demand for money that is submitted to the U.S. government or its contractors.

Healthcare providers and suppliers who violate the False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted. If a provider or supplier is convicted of a False Claims Act violation, the OIG may seek to exclude the provider or supplier from participation in federal healthcare programs.

To encourage individuals to come forward and report misconduct involving false claims, the False Claims Act includes a "qui tam" or whistleblower provision. This provision essentially allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. government, and the individual may be eligible for a financial award.

Summary of the Michigan False Claims Act

The Deficit Reduction Act of 2005 offered an incentive to states to enact their own False Claims Act requirements. Michigan has enacted both the Medicaid False Claim Act (MCL §§400.601 - 400.615) and the Health Care False Claim Act (MCL §§752.1001 - 752.1011). Persons who violate either the Medicaid False Claim Act or the Health Care False Claim Act are guilty of a felony punishable by imprisonment, a monetary fine or both. Under these state False Claim Acts, an employer is prohibited from discharging, demoting, suspending, threatening, harassing or discriminating against an employee because the employee initiates, assists or participates in an investigation under these Acts.

***Section 1902(a)(68)(A) of the Social Security Act:**

Provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall— (A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

New Michigan Quality Improvement Consortium (MQIC) guideline

Opioid Prescribing in Adults Excluding Palliative and End-of-Life Care

The Michigan Quality Improvement Consortium develops and implements evidence-based clinical practice guidelines. Guidelines are designed to produce evidence-based recommendations that will improve the quality of care for Michigan residents.

The Consortium is comprised of Physicians, Michigan health plan representatives, researchers, and specialty societies. PHP is a participant in the Consortium and endorses the guidelines with a goal of assisting our providers and members with making decisions about their health care.

MQIC has 31 guidelines, including the new Opioid Prescribing in Adults Excluding Palliative and End-of-Life Care.

For information about MQIC guidelines or to receive website updates, visit mqic.org.

New Sparrow Provider Network brings changes to Nurse Practitioner billing

Physicians Health Plan (PHP), the plan administrator for Sparrow Health System (Sparrow), would like to introduce the new provider network called Sparrow Provider Network (SPN). The effective date for SPN was Jan. 1, 2018. This network is for all Sparrow employees and their families who selected the Sparrow Self-Funded Benefit Plan for their healthcare coverage. Members who selected the Sparrow Self-Funded Benefit Plan and the new network have received a new ID card identifying SPN as their network.

Previously under the SPHN network, Nurse Practitioners were required to bill "incident to" under their supervising Physician. With the new network of SPN, Nurse Practitioners are credentialed and listed in the SPN directory. It is important that claims for services provided by Nurse Practitioners are submitted under their own National Provider Identifier (NPI) and that they are no longer billing "incident to" under their supervising Physician.

If there are questions regarding these changes, please contact Our Provider Relations Team at **PHPProviderRelations@phpmm.org** or at **517.364.8316** or **517.364.8323**.

Fee Schedule to change March 1

PHP has completed the annual review of our standard fee schedules for 2018. Rates for the PHP standard Commercial and PPO fee schedules will be updated effective March 1, 2018. These standard fee schedules remain market competitive and align with reimbursement within our service area.

Thank you for your continued support of the health plan. Should you have any questions, your Provider Relations Team is available to assist you by email, **PHPProviderRelations@phpmm.org**, or call **517.364.8316** or **517.364.8323**.

Diagnosis codes: Paint the whole picture

Clinical Documentation is critical for the Patient, the Physician, and Physicians Health Plan. As an organization we are dependent upon the healthcare provider to supply appropriate documentation to comply with CMS regulations regarding 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?

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

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

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 either that 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 the 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 would meet PHP's standard.

Begin the conversation: Talk to your Patient about end-of-life medical care. The Michigan Dignified Death Act (state law) and the Patient Self-Determination Act (federal law) recognize 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 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**

THREE 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.

TWO Laws

Michigan Dignified Death Act

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

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

Federal Patient Self-Determination Act

- 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.
- Doctors must document in the Patient's medical record whether or not they have executed an advance directive.
- Doctors must ensure compliance with the requirements of Michigan laws respecting advance directives.
- Doctors 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 individuals based on whether or not the individual has executed an advance directive.

ONE Patient

Physicians Health Plan

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

PRESORTED STANDARD
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PERMIT 28

Contact us

Department	Contact Purpose	Contact Number	Email Address
Medical Resource Management	» Notification of procedures and services outlined in the Notification/Authorization Table » To request benefit determinations and clinical information » To obtain clinical decision-making criteria » Behavioral Health 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)	**Credentialing** PHP.Credentialing@phpmm.org **Provider Relations Team** PHPProviderrelations@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
Customer Service	» To verify a covered person's eligibility, benefits, or to check claim status » To report suspected member fraud and abuse » To obtain claims mailing address	517.364.8500 800.832.9186 (toll free) 517.364.8411 (fax)	
Pharmacy Services	» Request a copy of our Preferred Drug List » Request drug coverage » Fax medication prior authorization forms » Medication Therapy Management	517.364.8545 877.205.2300 (toll free) 517.364.8413 (fax)	**Pharmacy** phpwebpharmacy@phpmm.org
Change HealthCare (TC3)	» When medical records are requested	Fax: 952.949.3713 or 949.943.8843 **Mail To:** Change HealthCare 5720 Smetana Drive, Suite 400 Minnetonka, MN 55343	