# Provider Connection

FOURTH QUARTER 2021

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### QUALITY CORNER



### UPDATES



Physicians Health Plan

# 2021 Holiday Hours

**Physicians Health Plan will be closed:**


**Thanksgiving Day** | **Christmas Eve Day** | **New Year's Eve Day**

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# Lunch and Learn Series

### Grab Your Lunch and Log On for Our New Lunch and Learn Series

Physicians Health Plan (PHP) is excited to announce a new Lunch and Learn series for 2022! The goal of this new program is to offer meaningful updates on a variety of hot topics in brief. This 60-minute program will be scheduled quarterly from 12 - 1 p.m. Dates and information on the upcoming sessions and how to register will be listed on PHP's website. In addition, there will be time for a question and answer session at the end of each program. If you are unable to make the live virtual session, we will also be offering a link so that you can view the program at your convenience. If you have topics you would like covered, we invite you to send an email to: **PHPProviderRelations@phpmm.org**. PHP is dedicated to making this new program valuable to the Provider Network.

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# Working with PHP

### General Training 101

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

The training will include PHP Commercial and PHP Medicare requirements. 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.

2022 trainings will take place via webinar.

Please visit our website, **PHPMichigan.com/Providers**, and click on Training Opportunities to view 2022 training opportunities and to register.

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

# New Provider Information Update Form

Network providers are required to notify PHP in writing of any demographic or status changes within their Practice or Facility. These notices are required at a minimum of 60 days prior to the effective date, or as outlined in your participation agreement with PHP. In an effort to simplify this notification process, PHP has updated the format for which these notifications will be accepted.

Effective Jan. 1, 2022, PHP will require all changes to be provided using the new Provider Information Update Form. The form can be found on our PHP Provider website at **PHPMichigan.com/Providers/General-Forms-And-Information**.

Some examples of changes requiring the Provider Information Update Form include:

- Tax ID change
- Address Change
- Status of acceptance of new patients change
- Office Hour changes
- Telephone or Fax Number changes
- Practitioners leaving the practice
- Location closure

Any requests received without the required form will be returned to the requestor for form completion. The form is an important tool to ensure your information is up to date and accurately reflected in our provider directory, claims adjudication system, and online search tools.

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

# Have You Registered for the Provider Portal?

**The MyPHP Provider Portal is available to you 24/7 and contains many helpful resources. Register for your account today!**

## Provider Portal Features

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 member benefits
- 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
- View and print Primary Care Physician Patient Rosters
- Access to PHP's Medical and Pharmacy Policies
- Single-sign-on access to the PHP Medicare Portal

Providers participating with PHP Commercial and PHP Medicare Advantage plans can access information for both with a single sign-on, so there is no need to register with multiple sites. Log in to your MyPHP portal account and scroll down to find the words, 'For all Medicare Advantage access, please Click Here,' and the PHP Medicare logo. If it is your first time logging in to the portal, you must accept the End User License Agreement and verify your provider information.

To register, go to **PHPMichigan.com/MyPHP** and select the **MyPHP Provider Portal**. You will need your Tax ID, individual NPI, and PHP Provider ID (e.g., 2000000XXXXX). If you do not know your PHP Provider ID, please email your Tax ID and NPI(s) to **PHPProviderRelations@phpmm.org**. You may also email Provider Relations to request account reactivation, password resets, or additional training with the portal.

## How to Register

To access MyPHP:

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

You will need the provider Tax Identification Number (TIN), National Provider Identifier (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.

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.

# Utilization Management News and Updates

## 4th Quarter 2021

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 Customer Service at **517.364.8500** or **800.832.9168**, Monday through Friday, 8:30 a.m. to 5:30 p.m.

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

### New Policies

» BCP-39 High Tech Radiology and Nuclear Medicine

### Policy Updates

» BCP-27 Home Infusion - as of 1/1/2022, supplies and DME associated with home infusions will no longer require PA. Home nurse visit codes will continue to require PA.

**Changes to Coverage for Services**

| Code(s) | Procedure or Service | Action | Effective Date |
|---|---|---|---|
| 15847 | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure) | Change from "Prior Approval" to "Not Covered" | 1/1/2022 |
| 17340 | Cryotherapy (CO2 slush, liquid N2) for acne | Change from "Covered" to "Prior Approval" | 1/1/2022 |
| 69705, 69706 | Nasopharyngoscopy, surgical, with dilation of eustachian tube (e.g. balloon dilation); unilateral / bilateral | Change from "Not Covered" to "Prior Approval" | |
| 92065 | Orthoptic or pleoptic training, w/continuing medical direction and evaluation | Change from "Covered" to "Not Covered — Specific Exclusion" | 10/1/2021 |
| 93784, 93786, 93788, 93790 | Ambulatory BP monitoring; recording, analysis, and report | Change from "Not Covered" to "Covered" | 10/1/2021 |
| A9274 | External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories | Change from "Prior Approval" to "Covered" | 10/1/2021 |
| L8614 | Cochlear device, includes all internal and external components | Change from "Prior Approval" to "Covered" | 10/1/2021 |

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

# Billing Guidance for Fluoroscopy

Fluoroscopy is used with a variety of procedures for either diagnostic or treatment purposes. Physicians Health Plan follows CMS billing guidance including but not limited to the National Correct Coding Initiative (NCCI) Policy Manual for Medicare Service. The manual is periodically revised. Revisions will be applied based on the date of service reported. Prior to reporting fluoroscopy/fluoroscopic guidance services the following should be taken into consideration:

- Physicians may only report the professional component when fluoroscopic service is performed in a facility setting
- Review the full CPT® code description to confirm radiology guidance and imaging are not included
- Review CPT® parenthetical notes for guidance and appropriateness of applying fluoroscopic guidance add on codes as these are only reportable with a limited set of services
- Fluoroscopy is integral to many radiological supervision and interpretation procedures
- Fluoroscopy should not be reported separately, unless otherwise indicated by CPT® code descriptions
- NCCI Procedure to Procedure (PTP) Coding Edits based on date of service
- National Correct Coding Initiative Policy Manual for Medicare Services

*Source - https://www.cms.gov/files/document/chapter9cptcodes70000-79999final112021.pdf*

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# COVID-19 Testing

Physicians Health Plan (PHP) covers COVID-19 testing and waiver of member cost-share* (copays, coinsurance, and deductibles) for in-network COVID-19 testing through Dec. 31, 2021. Please note, for member cost-share to be waived and the costs of the test covered, the following requirements must be met:

- The test must be ordered by an in-network medical provider
- The test must be considered medically necessary, which is determined by and appropriately coded by the ordering medical provider
- Documentation of symptoms or exposure to support medical necessity

As outlined in the member evidence of coverage and PHP reimbursement policy *PRP-17 COVID-19 Testing & Treatment*, the following exclusions apply to coverage of COVID-19 testing:

- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when:
  - Required solely for purposes of career, education, sports, camp, travel, employment, insurance, marriage, or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research, except for qualified clinical trials
  - Required to obtain or maintain a license of any type

Periodically, PHP may request supporting documentation from providers for review of appropriate coding and billing of services. Misrepresenting a diagnosis to ensure health coverage for the patient is considered a fraudulent, wasteful, and abusive billing practice. In addition, intentionally providing false or misrepresented information may be cause for termination from the network.

*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.

# Evaluation and Management Services Reminders

## Consultations

Physicians Health Plan (PHP) follows CMS guidelines regarding consultation coding. PHP does not reimburse the billing of outpatient (99241-99245) or inpatient (99251-99255) CPT consultation codes. Instead, providers should report the service with the E/M code representing the location, patient status (new/established), and the complexity of the visit performed.

## Incidental Services

Incidental services are minor services provided incident to another professional service, and they are commonly included in the primary service used to diagnose or treat injury or illness. For example, urinalysis procedures (81002 or 81003), ; when these services are billed in conjunction with any E/M service they are not separately reimbursed. Application of modifier 25 to the E/M service or a modifier 59 to the urinalysis procedure, on the same day, for the same member, by the same provider, on the same or different claims will not override the edit.

## Multiple E/M Services - Same Date of Service

PHP follows CMS guidelines regarding same day E/M services. When physicians are of the same group practice and same specialty, services must be billed, and reimbursement received as if they were performed by a single physician. When more than one E/M service is performed on the same date of service, only one E/M service may be reported unless the E/M services are for an unrelated diagnosis/treatment. When more than one encounter for related services occurs on the same date of service, the physicians should select a level of service representative of the combined evaluation and management services. Documentation for both encounters should be submitted when documentation is requested for claim review.

## Prolonged E/M Services

The Health Plan reimburses for prolonged services when appropriately billed and supported in documentation.

1. As of Jan. 1, 2021, CPT code 99417 replaces CPT codes 99354 and 99355.
   - CPT 99417 is reportable only with level 5 visits (CPT codes 99205 and 99215)
2. Documented time must exceed the minimum time for primary E/M service.
3. Time alone must be the basis for coding.

Effective Jan. 1, 2021, time represents total provider time spent on the date of service and may include the following when documented and not otherwise reported separately.

- Preparing to see the patient (e.g., review of tests)
- Obtaining or reviewing the separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals
- Documenting clinical information in the electronic or other health record
- Independently interpreting results and communicating results to the patient/family/caregiver
- Care coordination

For more information, please refer to PHP's Current Payment and Reimbursement Policies available inside the MyPHP Provider Portal or contact Provider Relations at **PHPProviderRelations@phpmm.org**.

# Formulary Changes

## Effective Jan. 1, 2022

### Tier Changes

| Therapeutic Category | Medication | Action |
|---|---|---|
| Multiple Sclerosis | Avonex | Down tier from non-preferred specialty to preferred specialty tier |
| Weight Loss | Saxenda | Down tier from non-preferred to preferred tier |

### New Benefit Coverage

| Therapeutic Category | Medication | Status |
|---|---|---|
| Multiple Sclerosis | Avonex | Down tier from non-preferred specialty to preferred specialty tier |
| Weight Loss | Saxenda | Down tier from non-preferred to preferred tier |

### Medications Removed from Formulary

| Therapeutic Category | Medication | Status | Action |
|---|---|---|---|
| PCSK9 Inhibitor | Repatha | Excluded | Praluent |
| Asthma/COPD | Asmanex | Excluded | Arnuity, Flovent Diskus, Flovent HFA, Pulmicort, Qvar |
| | Incruse Ellipta | Excluded | Spiriva, Spiriva Respimat |
| | Bevespi | Excluded | Anoro Ellipta, Stiolto Respmat |
| Multiple Sclerosis | Extavia | Excluded | Avonex |

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

# Reporting of Operating Room Services & Supplies

When reporting operating room services and any corresponding medical, surgical, sterile supplies, or implants, the documentation must support the charges billed. If documentation is requested for claims submitted with revenue codes 270, 272, and/or 278, the supporting documentation must include an itemization of charges, the operative report, the implant log (if applicable), and pertinent chart notes.

An itemization of charges is required supporting documentation used to identify items billed under routine services that are not separately billable. A complete itemization of services performed must include patient identifier(s), date of service, revenue codes, clear description of each service/item, quantity, and charges for each corresponding service/item. Routine, reusable, and convenience items are not separately reportable and are considered inclusive of charges for operating room services. Routine services include, but are not limited to, instrument trays, gowns, personal care items, and surgical kits. Equipment used more than once for multiple patients is not separately reportable and considered inclusive of facility charges. This equipment includes but is not limited to monitors, lasers, scopes, and video equipment. Itemizations with descriptions that are generic, such as "Surgery Supply," may result in denials.

In addition, Physicians Health Plan (PHP) monitors and audits claims billed for supplies and implants to identify potential abusive charging. Abuse is defined as excessive or improper use of services or actions inconsistent with the acceptable business or medical practice. These are incidents that, although not fraudulent, directly or indirectly cause financial loss, including intentionally charging in excess for services or supplies.

Usual, customary, and reasonable (UCR) charges represent the base amount considered the standard or common charge for a defined medical service performed in a geographic region. When a service isn't assigned a fee schedule rate and priced as a percent of charge, the UCR may be used to determine the final allowable amount for a service. PHP considers supplies and devices billed in excess of UCR to be possible abuse. Pricing is differentiated by the region the provider is billing from to accommodate geographical pricing variations when applicable. National UCR database ImplantDX is utilized to determine the UCR for supplies and implantable devices.

Audits may be performed on a pre-payment or post-payment basis. If an audit determines the services were billed in excess of usual, customary, and reasonable charging per unit, the final allowable amount may be reduced. If appeal documentation is submitted with a detailed invoice to justify the cost and charges billed, PHP may reconsider the allowable reduction.

# Transitional Care Management

Transitional Care Management (TCM) services represent the coordination of care between the discharge from a qualifying facility care setting and the community setting. TCM oversees the management and coordination of services needed for all medical conditions, psychosocial needs, and activities of daily living support for the full 30-day post-discharge period as the patient transitions back into the community setting with the goal of preventing facility readmission. A qualifying facility care setting may be an inpatient acute care hospital, inpatient psychiatric hospital, long-term care hospital, skilled nursing facility, inpatient rehabilitation facility, hospital outpatient observation, or partial hospitalization, including partial hospitalization at a community mental health center. The patient must be discharged to one of the following community settings: the patient's home, a domiciliary center, a rest home, a nursing home, or an assisted living facility. Skilled nursing facilities are not eligible as discharge locations.

## Who Can Provide TCM?

- Physicians including MDs, DOs, and Mid-Level Practitioners including Nurse Practitioners, Physician Assistants, Certified Nurse Specialists, and Certified Nurse-Midwives

## CPT® Codes

- 99495 TCM with moderate medical decision complexity with a face-to-face visit within 14 calendar days of discharge
- 99496 TCM with high medical decision complexity with a face-to-face visit within 7 calendar days of discharge

## Required Elements for reporting

1. Interactive Contact: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge (not same day) that must include:
    - » Obtaining and reviewing all discharge information given to the patient
    - » Reviewing the need for any follow-up diagnostic tests or treatment
    - » Interaction with other healthcare professionals involved in the patient's aftercare
    - » Education provided to the patient, family members, or caregivers
    - » Establishment of referrals/arrangement of community resources related to regaining activities of daily living
    - » Assistance with scheduling the follow-up visit to the physician
2. Face to Face Visit
    - » 99495 Face to face visit must be completed within 7 days of discharge
    - » 99495 Face to face visit must be completed within 14 days of discharge
    - » The date of the face-to-face visit is the reportable date of service for TCM billing
3. Medical Decision Making
    - » 99495 Moderate complexity
    - » 99496 High complexity

TCM is not billable if these elements are not met or the patient passes away within 30-days post-discharge . In these instances, an appropriate E/M service code may be billed for any face-to-face visits provided.

## Frequency

TCM is reportable once by only one provider during the 30-days post-discharge and used only when this provider assumes responsibility for a patient's post-discharge care. Additional practitioners may report other services, including E/M services during the 30-days according to CPT® guidelines and PHP policies.

## Documentation

PHP has implemented TCM Code Editing to ensure proper reporting of TCM services. When submitting appeals, medical records must clearly identify and support the date of discharge, the date that interactive contact was made with the patient and/or their caregiver, the date of the face-to-face visit, and the documented complexity of medical decision making.

# PHP's Commercial Interactive Voice Response System

Accessing member eligibility and primary care physician (PCP) information is made more accessible by using the Customer Service Interactive Voice Response (IVR) system. This feature is available by calling Physicians Health Plan's (PHP) Customer Service, indicating you are a provider, and choosing the prompt to verify eligibility or PCP information. When calling, please make sure to have the following information available:

- Tax ID or NPI number
- Subscriber number of the patient, including the two-digit suffix (i.e., 500012345-00)

The PHP Commercial IVR system is updated Monday through Friday with the previous business day's activity. PHP's Customer Service department can answer any other questions Monday through Friday from 8:30 a.m. to 5:30 p.m. If you have a question about eligibility, benefits, or claim status for 5 or more PHP members, please fax your request to **517.364.8411** or visit PHP's Provider Portal, MyPHP, at **PHPMichigan.com/MyPHP**.

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# Submit Claims and Appeals to the Correct Address

Physicians Health Plan (PHP) accepts claims and appeals submitted to two different addresses: one for all commercial business (HMO, PPO, TPA/ASO, Exchange) and another for PHP Medicare business. Each location can only process claims appropriate for that address. When a claim is submitted to the incorrect address, processing delays will occur. Check to ensure the correct address is used for the plan type for the claims and appeals.

Physicians Health Plan

### PHP Commercial

HMO, PPO, TPA/ASO, Exchange

**Claims:**
Physicians Health Plan
PO Box 853936
Richardson, TX 75085-3936

**Appeals:**
Physicians Health Plan
Attention: Provider Appeals
PO Box 30377
Lansing, MI 48909

PHP MEDICARE

### PHP Medicare

Sparrow Advantage, Covenant Advantage, PHP Advantage, U-M Health + St. Joe's Advantage

**Claims:**
PHP Medicare
PO Box 7119
Troy, MI 48007

**Appeals:**
PHP Medicare
PO Box 7119
Troy, MI 48007

# PHP Medicare Quick Reference Guide (QRG)

| | |
|---|---|
| **Provider Services** | For inquires such as claim status checks, member eligibility, benefit verification, or confirmation of referrals/prior authorization check our website at **PHPMichigan.com** or call PHP Medicare **844.529.3757**<br>Provider Services email address: CustomerService@PHPMedicare.com Fax: **844.529.3759**<br>Provider correspondence/claims mailing address: PHP Medicare PO Box 7119, Troy, MI 48007 |
| **Client/Provider Technical Support** | Assistance with technical questions relating to registration, login or web application access<br>Call: **866.397.2812** Available from 8 a.m. to 7 p.m.<br>Technical Support e-mail address: CustomerSupport@Lumeris.com |
| **Electronic Claims** | Change Healthcare (payor # 83276). Call **866.924.4634** Option 4, Option 1<br>**ChangeHealthcare.com/support/customer-resources/enrollment-services** |
| **Web/Provider Portal** | Assistance with Member Eligibility, Claims and Referral Inquiry, Online Referral and Prior Authorization<br>**PHPMichigan.com/MyPHP** |
| **Non-Emergent Transportation Services** | Contracted provider is: Medical Transportation Management (MTM)<br>Members can call: **877.930.1485** to schedule or **MemberPortal.net**<br>Limited to 20 one-way trips. PHP Advantage Plus limited to 30 one-way trips. |
| **Preventive Dental Care** | Contracted providers for Routine Dental Services can be found by calling Delta Dental at **800.330.2732**<br>Fax: **517.381.5527** **DeltaDentalMI.com**<br>No referral is needed. Members can self-refer.<br>Claims mailing address: PO Box 9230, Farmington Hills, MI 48333 or Claims Delta Dental PO Box 9298 Farmington Hills, MI 48333 |
| **Routine Eye Care** | Contracted providers for Routine Eye Exams can be found by calling EyeMed at **844.230.6498**<br>No referral is needed. Member can self-refer.<br>Claims mailing address: First American Administrators,<br>Attn: OON Claims PO Box 8504, Mason, OH 45040 |
| **Behavioral Health Services** | Contracted providers for in/out-patient mental health/substance abuse services can be found by calling: Mercy Managed Behavioral Health<br>**833.729.4607**<br>Claims Questions: Call our Provider Services number listed above. |
| **Medical Services** | Assistance with, pre-authorization of procedures, benefit determination, notification<br>Call: PHP Medicare **844.529.3757** |
| **Pharmacy** | Pharmacy Prior Authorization for Part B Drugs Call: **844.529.3757** or fax to the number on the forms located on the Provider Portal.<br>Pharmacy Prior Authorization for Part D Drugs – contact information is located on the forms available on the Provider Portal<br>Pharmacy email address: Pharmacy@PHPMedicare.com |
| **SilverSneakers** | Complimentary fitness program/classes can be found by calling **888.423.4632** or visit the website at **SilverSneakers.com**.<br>No referral needed. Member can self-refer. |
| **HealthHelp** | Radiation Therapy, Advanced Imaging (CT, CTA, MRI, MRA, PET & Cardiac Nuclear), Medical Oncology and Facility Based Sleep Studies: Contact HealthHelp at **800.652.4958** or fax at **800.695.4997** or expedited fax **855.546.7092**.<br>Go to the website **HealthHelp.com/PHPMedicare** for specific codes requiring PA. |
| **Over-the-Counter Benefit** | Over-the-counter (OTC) medications and products can be ordered by the member:<br>Online: **OTCBenefitSolution.com**, by calling **855.299.5415** (TTY:**711**), or mailing the order form. |
| **Audiology-TruHearing** | For Hearings Aids, Fittings and Evaluations Call: **844.554.6104** |
| **Meal Benefit** | For additional information on meal benefit<br>Call: **844.830-1602** TTY: **800.955.1339**<br>Online: **SunMeadow.com** |

## Referrals are only required for out-of-network providers

## Prior Authorization/Notification is Required for These Services:

- All Inpatient Admissions (notification required within one business day)
- Observation (notification required when greater than 48 hours)
- SNF, Inpatient Specialty Care Programs (acute rehab/LTAC)
- Non-emergency Ambulance Transfers, EXCEPT those between hospital and SNF inpatient
- DME/ Orthotic and Prosthetic Devices: Refer to the listing on the provider portal for specifics. This includes non-covered items and up-grades for equipment and supplies.
- Unlisted/Unclassified/Not otherwise classified services/ items
- Emerging technology, services and procedures
- Bio-engineered Skin Substitute
- Genetic Testing including associated lab work
- Peripheral Tibial Nerve Stimulation/Interstim
- Behavioral Health Inpatient, Intensive Outpatient, Partial Hospitalization, Electroconvulsive Therapy, TMS-contact Mercy Behavioral Health Phone: 833.729.4607
- Telehealth - authorization rules apply based on category of service

## Surgeries that Require Prior Authorization:

- Artificial disc
- Autologous Chondrocyte Implantation Procedures
- Balloon Sinuplasty (BSP)
- Bariatric Surgery
- Blepharoplasty
- Bone Anchored Hearing Device/Cochlear Implant
- Breast Reduction/Reconstruction/Augmentation, Mastectomy for Gynecomastia
- Deep Brain Stimulation
- Eyelid Ptosis Repair
- Facial Osteotomy, Genioplasty, Orthagnathic Surgery, Maxillofacial Surgery
- Hyperbaric Oxygen Therapy
- Nasal Reconstruction/Rhinoplasty
- Platelet-Rich Plasma (PRP)
- Panniculectomy/Abdominoplasty
- Percutaneous Image-Guided Lumbar Decompression for Lumbar Stenosis
- Percutaneous Left Atrial Appendage Closure –
- Watchman Procedure and Others
- Spinal Cord Stimulators
- Transcatheter Valve Procedures - TAVR and TMVR Transgender Surgery
- Transplants
- Uvulopalatopharyngoplasty (UPPP)
- Vertebroplasty/Kyphoplasty
- Veins (ablation, ligation, stripping, sclerotherapy)

## Part B Drugs that Require Prior Authorization:

Actemra, Aduhelm, Aldurazyme, Aranesp, Avsola, Benlysta, Boniva Injection, Botox, Cerezyme, Cinqair, Cinryze, Duopa, Dysport, Elitek, Entyvio, Epogen, Evenity, Fabrazyme, Factor Products, Fasenra, Feraheme, Flolan, Hyaluronan Intra-articular Injection, Ilaris, Immune Globulin (Human) IM/IV/SC, Inflectra, Injectafer, Ixifi, Krystexxa, Lemtrada, Mircera, Myobloc, Nplate, Ocrevus, Orencia, Procrit, Remicade, Remodulin, Renflexis, Retacrit, Revatio Injection, Simponi Aria, Soliris, Stelara, Tysabri, Ultomris, Veletri, Ventavis, VPRIV, Xeomin, Xiaflex, Xolair (Specific Criteria for these drugs can be found on the Provider Portal)

## Miscellaneous Information:

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

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

# Where to Send Change Healthcare Records

All documentation requested for processing claims must be received within the timely file limit of 6 months as defined in the PHP Provider Manual or as stated otherwise in your participation agreement with PHP. Sending documents to the wrong location can cause delays in processing and repeated denials if the claim is resubmitted without appropriate documentation. Please make sure you visit **PHPMichigan.com/Providers** for the most up to date information regarding submitting these documents.

To complete the Medical Records Submission Form:

- Use a separate form for each claim
- Complete all form fields in their entirety
- A fillable pdf form is available at **PHPMichigan.com/Providers** Select "Forms" from the left menu
- Check the Box that corresponds to the specific claim denial code

## Records can be mailed, faxed or emailed:

**Mail:** Change Healthcare
Attn: Pre-Pay
1849 West Drake Drive
Ste 101
Tempe, AZ 85283

**Email:** MedicalRecords@ChangeHealthcare.com

**Fax:** 949.234.7603

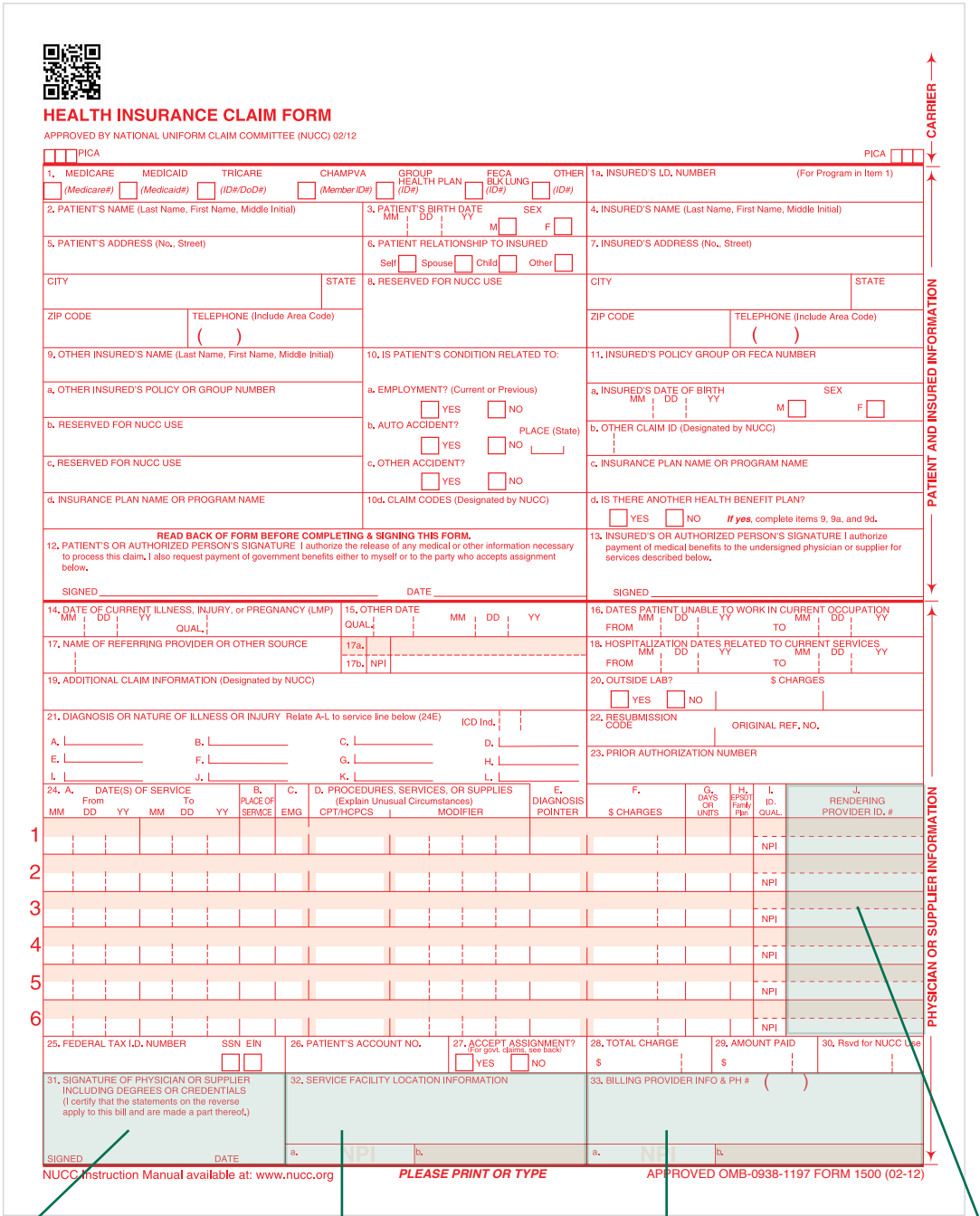
**Remarks Explanations Examples *(Submit documents to Change Healthcare)***

| Code | Message Description |
|---|---|
| Q21/R21 | Per national physicians fee schedule, documentation is required to establish medical necessity for Co-Surgeon |
| QH0/RH0 | Documentation received does not support billed service |
| QR7/RR7 | No documentation was submitted for the billed date of service |
| QR8/RR8 | Missing element to support service |
| QN3/RN3 | Requested operative note not received |
| QN4/RN4 | Requested pathology or laboratory report(s) not received |
| QN5/RN5 | Requested diagnostic imaging report(s) not received |
| QN6/RN6 | Requested itemized statement not received. |
| QN7/RN7 | Requested implant log not received. |
| QN8/RN8 | Requested physician order(s) or requisition(s) not received. |
| QP2/RP2 | Requested medication administration record(s) not received. |
| QR2/RR2 | Requested medication administration record(s) not received. |
| QR4/RR4 | Requested itemized statement not received. Fax to 949.234.7603 |
| QT1/RT1 | Incomplete records response |
| QT3/RT3 | Incomplete consult report |
| QT4/RT4 | Incomplete therapy report |

| Code | Message Description |
|---|---|
| QW5/RW5 | Records not received |
| QW6/RW6 | Requested physician order(s) or requisition(s) not received |
| QW7/RW7 | Records not received |
| QX1/RX1 | Requested pathology or laboratory report(s) not received. |
| QX2/RX2 | Requested diagnostic imaging report(s) not received. |
| QX3/RX3 | Requested itemized statement not received. |
| QX4/RX4 | Requested implant log not received. |
| QX5/RX5 | Requested physician order(s) or requisition(s) not received. |
| QX6/RX6 | Requested medication administration record not received |
| QX7/RX7 | Requested itemization not received |
| QX8/RX8 | Submitted documentation does not support the items were delivered |
| QX9/RX9 | Incomplete/invalid physician order or requisition |
| QY1/RY1 | No documentation for billed date of service |
| QY2/RY2 | Missing element to support service |
| QY4/RY4 | Requested documentation not received |
| QY6/RY6 | Incomplete record response |

# Filling Out Your Claim Form Correctly

It is important when you are filling out a CMS 1500 form, that the proper information is entered correctly. If a claim form is not filled out correctly, it could potentially cause claim processing issues such as denials. In order for your claims to be processed correctly, please keep in mind which information needs to be placed in each box.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

*PLEASE PRINT OR TYPE*

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

**Box 31:** Enter the rendering

**Box 32:** Please enter the location at which the services were rendered

**Box 33:** Please enter the provider's group information.

**Box 24J:** Enter the rendering provider's individual NPI number.

Physicians Health Plan

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

# Contact Us

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

| Department | Contact Purpose | Contact Number | Email Address |
|---|---|---|---|
| Customer Service | » Verify a covered person's eligibility, benefits or to check claim status to report suspected member fraud and abuse<br>» Obtain claims mailing address | 517.364.8500<br>800.832.9186 (toll-free)<br>517.364.8411 (fax) | |
| Medical Resource Management | » Notification of procedures and services outlined in the Notification/ Authorization Table<br>» Request benefit determinations and clinical information<br>» Obtain clinical decision-making criteria<br>» Behavioral Health/ Substance Abuse Services, for information on Behavioral Health and/or Substance Abuse Services including Prior Authorizations, Case Management, Discharge Planning and referral assistance | 517.364.8560<br>866.203.0618 (toll-free)<br>517.364.8409 (fax) | |
| Network Services | » Credentialing<br>» Provider Data - report changes in practice demographic information<br>» Provider/Practitioner education<br>» Report suspected Provider/Practitioner Fraud and Abuse<br>» Claims and EDI questions<br>» Initiate electronic claims submission | 517.364.8312<br>800.562.6197 (toll-free)<br>517.364.8412 (fax)<br>**Report Suspected Fraud and Abuse:**<br>866.PHPCOMP<br>(866.747.2667) | **Credentialing**<br>PHP.Credentialing@phpmm.org<br>**Data**<br>PHPProviderUpdates@phpmm.org<br>**Provider Relations Team**<br>PHPProviderRelations@phpmm.org |
| Quality Management | » Quality Improvement Programs » URAC<br>» HEDIS » CAHPS | 517.364.8408 (fax) | **Quality**<br>PHPQualityDepartment@phpmm.org |
| Pharmacy Services | » Request a copy of our Preferred Drug List<br>» Request drug coverage<br>» Fax medication prior authorization forms<br>» Medication Therapy Management Program | 517.364.8545<br>877.205.2300 (toll-free)<br>517.364.8413 (fax) | **Pharmacy**<br>Pharmacy@phpmm.org |
| Change Healthcare (CHC) | » When medical records are requested | **Mail To:**<br>Change Healthcare<br>Attn: Pre-Pay<br>1849 West Drake Drive<br>STE 101<br>Tempe, AZ 85283<br>952.224.8650<br>949.234.7603 (fax) | MedicalRecords@changehealthcare.com |

| | Physicians Health Plan | PHP Service Company | PHP Insurance Company |
|---|---|---|---|
| Where to Send Claims | Physicians Health Plan (PHP)<br>In Network: PO Box 853936<br>Richardson, TX 75085-3936<br><br>Non-Network: PO Box 247<br>Alpharetta, GA 30009-0247<br><br>Electronic Claims In Network: Payer ID: 37330<br>Non-Network: Payer ID: 07689 | PHP Service Company<br>In Network: PO Box 853936<br>Richardson, TX 75085-3936<br><br>Non-Network: PO Box 247<br>Alpharetta, GA 30009-0247<br><br>Electronic Claims<br>In Network: Payer ID: 37330<br>Non-Network: Payer ID: 07689<br><br>Includes SPN and MCN | PHP Insurance Company<br>In Network: PO Box 853936<br>Richardson, TX 75085-3936<br><br>Non-Network: PO Box 247<br>Alpharetta, GA 30009-0247<br><br>Electronic Claims<br>In Network: Payer ID: 37330<br>Non-Network: Payer ID: 07689 |
| Where to Send Refunds | Physicians Health Plan<br>Attn: Provider Refund<br>PO Box 30377<br>Lansing MI 48909-7877 | Physicians Health Plan<br>Attn: Provider Refund<br>PO Box 30377<br>Lansing MI 48909-7877 | Physicians Health Plan<br>Attn: Provider Refund<br>PO Box 30377<br>Lansing MI 48909-7877 |