Physicians Health Plan

Provider Connection

Q3 2023

In this issue...

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WORKING WITH PHP

QUALITY

UPDATES

Cultural Competency Training

Physicians Health Plan (PHP) offers Cultural Competency Training. This training is free and available to all registered users on the MyPHP Provider portal. PHP encourages all providers to complete the Culture Competency Training annually.

To access the training, log into the MyPHP Provider Portal at **PHPMichigan.com/MyPHP**. Once you are logged into the portal, you can select Cultural Competency Training on the right-hand side of your screen, under PHP Commercial Quick Links. Please contact PHP Provider Relations at PHPProviderRelations@phpmm.org if you need assistance registering for the MyPHP Provider Portal.

Credentialing New Group Providers

PHP requires individual applicants to complete the New Provider Request Form and the Council for Affordable Quality Healthcare (CAQH) credentialing application. Facility applicants must complete the HAAP Ancillary Provider Application. Applications for participation are located in the Forms section of the PHP provider website, PHPMichigan.com/Providers.

All provider applications are reviewed in accordance with applicable Michigan laws regarding HMO provider panels. Once an application is received, it will be reviewed and you will either be emailed a participation agreement for your signature (for solo practices), or if PHP has adequate providers in your specialty area, you will be sent a letter declining your participation request.

Applications must be returned to the health plan for consideration within 60 calendar days. Applications not returned within 60 calendar days are considered closed files and are returned to the applicant. A request for re-application is necessary.

An application for participation may be closed for the following reasons:

1. Application is not returned within 60 calendar days.
2. Application is not complete, and requested information is not received within the requested time frame.

Physicians Health Network and PHP networks may be closed to some specialties. Prior to sending PHP a request to participate, please note that occasionally due to network size and utilization, Physicians Health Plan may close network participation to new providers.

PHP reviews Medicare and Medicaid sanctions through the NPDB online query to identify sanction activity. Providers who have opted out of Medicare or signed a private contract with a Medicare beneficiary for participation in the Medicare product are not eligible to participate with PHP.

It is important that you do not schedule patients with providers that have not completed the credentialing process. Please communicate this to your clinical and scheduling staff, as effective dates for participation are as of the date of approval and are not retroactively assigned.

Keeping Your Demographics Up To Date

It is important to notify Physicians Health Plan (PHP) of any changes within your practice. Network providers must notify PHP in writing and in advance by using the Provider Information Update Form which can be obtained online at PHPMichigan.com/Providers/General-Forms-and-Information. These changes could include, but are not limited to:

- Provider Name Change
- Update Facility/Group Services
- Location Closing
- Update Telehealth Services Provided
- Changing Office Hours

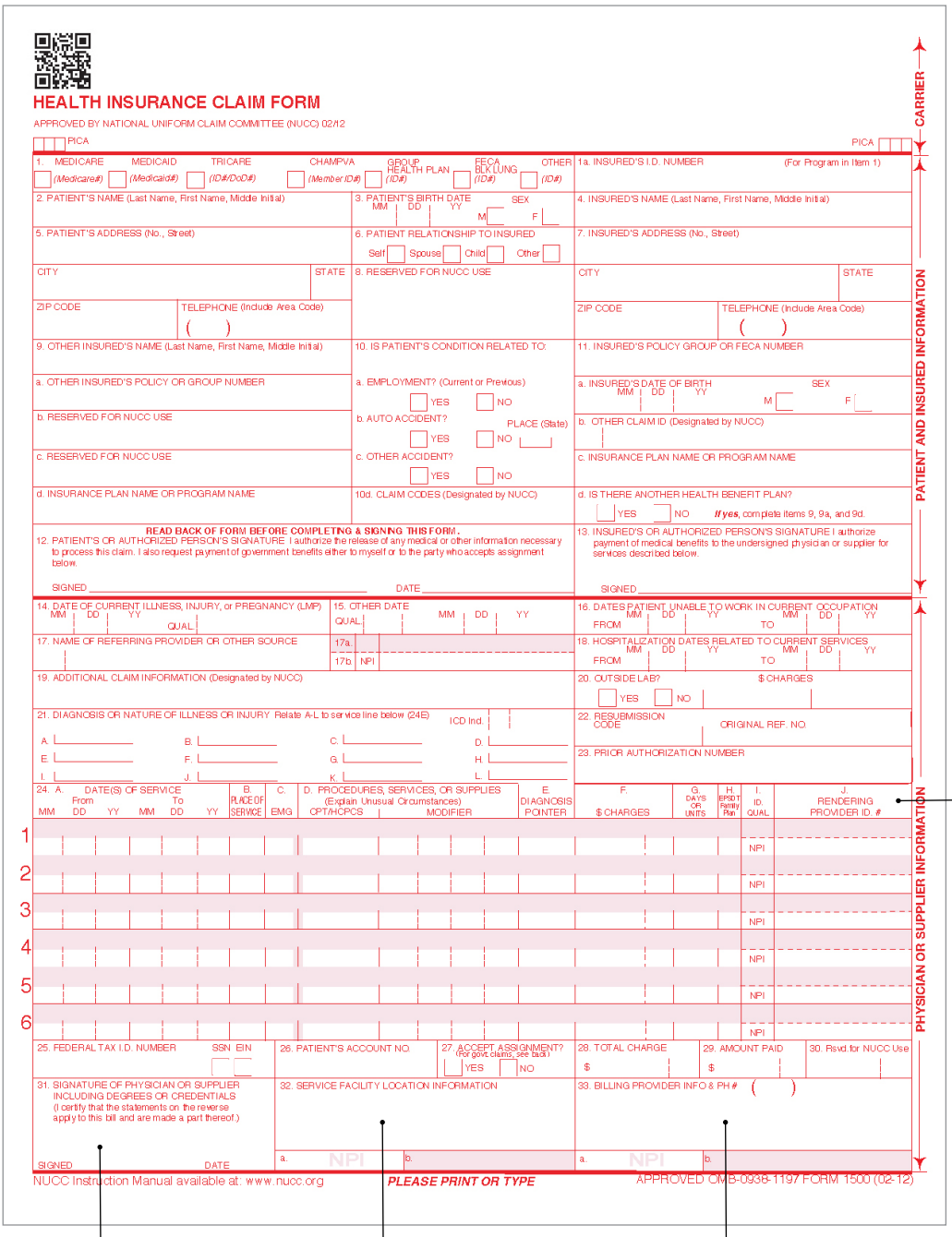
Once the form is filled out it can be mailed, emailed, or faxed to PHP.

Physicians Health Plan Attn: Network Services
PO Box 30377
Lansing MI 48909
Fax: 517.364.8412 or
Email: PHPProviderUpdates@phpmm.org

Failure to notify PHP could cause delays in claim processing. Please refer to your participation agreement and the Provider Manual for the specific notification requirements. If you have any questions, please call 517.364.8312 and press option 1.

Filling Out Your Claim Form Correctly

When you are filling out a CMS 1500 form, it is important that the information is entered correctly. If forms are not filled out correctly, it can cause claim processing issues such as denials or delays in payments. In order for your claim to be processed accurately, please be attentive as to what information you are placing in each box. Also remember if you have a group NPI, it must be on the claim.



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? PLACE (State) YES NO

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 24J: Enter the rendering Provider's NPI

Box 31: Enter the rendering Provider's name

Box 32: Enter the location where services were rendered

Box 33: Enter the Provider's group information, including the Provider Group's NPI

Improving Provider Response Time

Patient satisfaction, availability, and access to healthcare are three of the most crucial pieces to improve patient care.

Making sure your patients have an accurate and expeditious way to obtain requested information and reducing response times is critical to your success. The average first time response (FTR) is an important service tool to understand how your office is performing. To calculate the FTR you will need 2 pieces of information:

1. The total time it took to respond during a selected time period.
2. The total number of responses sent in that selected time period.

A reliable, fast response makes patients feel important and it is what they expect. If you're looking to improve customer service, then remember these 8 easy-to-implement techniques to help set your office apart as an organization that values your patients:

1. Reduce your average first response rate (FTR).
2. Implement customer service software to make your inbox more manageable.

AVERAGE 1ST RESPONSE TIME = $\frac{\text{Total time it took to send the 1st response within a selected time period}}{\text{Number of tickets within 1st responses sent within a selected time period}}$

3. Use email autoresponders to keep your customers in the loop and manage expectations.
4. Use time-based alerts to make sure no emails go missing or are delayed.
5. Use templates and text shortcuts to reduce the time it takes to write each email.
6. Categorize all incoming patient correspondence and respond based on priority.
7. Invest in employee training and development.
8. Streamline your current business and customer service operations.

Reducing your customer service response time is incredibly important. Not only can it make your patients happy and enhance your brand's reputation, but when done properly, it can also improve efficiency throughout your entire organization.

Overpayment Recoveries

Claim overpayments can occur when the health plan receives new information, such as changes to the member's coordination of benefits order, medical record review findings, or other information after a claim was originally paid.

Providers may also become aware of overpayments that have occurred. If you discover that PHP has overpaid a claim, you must report this by mailing a corrected claim with a completed Claim Adjustment Request Form. The Claim Adjustment Request Form is available online at **PHPMichigan.com/Providers/General-Forms-and-Information**.

When a claim adjustment results in an overpayment, PHP will initiate an auto-recovery process to recover funds whenever possible. Funds are then recovered by deducting the overpaid amount(s) from subsequent claim payments. The Explanation of Payment (EOP) for the adjusted claim will provide specific details of the overpayment. You can access the PHP EOP in your MyPHP Provider Portal account. The MyPHP Provider Portal also has detailed claim information and claims history to assist you in the research and resolution of outstanding overpayment balances. You can self-register for the MyPHP Provider Portal at **PHPMichigan.com/ProviderPortal**. If you need assistance with registration, please email PHP/Provider Relations at PHPProviderRelations@phpmm.org.

Sometimes, the only way to resolve an overpayment balance is to submit a check to PHP. This can occur when the payee information has changed, for example, due to a change in the provider's tax identification number, when a practitioner has left the practice, or in other scenarios that prevent auto-recovery from future payments. When submitting a check to PHP, please ensure that the claim has been adjusted and that the overpayment has been created. If a manual check is required to resolve an overpayment, please mail the refund check to:

Physicians Health Plan
Attn: Provider Refund
PO Box 30377
Lansing, MI 48909-7877

If PHP cannot fully recoup a balance within three months of the EOP mail date, the account will be referred to Optum PRS. You may receive letters and/or phone calls about the overpayment collection. If you have questions about your EOP or the overpayment recovery process, please contact PHP Customer Service at **517.364.8500**, Monday through Friday, 8:30 a.m. to 5:30 p.m., EST, excluding holidays.

Paid To	Michigan Hospital
Tax #	123456789
Payment Date	06/08/2023
Reference #	2023060801234567
Check Amount	$250.00
Prior Overpayment Balance	$575.00
Auto-Recovered this Check	$250.00
Current Overpayment Balance	$325.00

Questions?

Please contact us:
PO Box 30377
Lansing, MI 48909-7877

(800) 832-9186 **OR** (517) 364-8500

www.PHPMichigan.com

Explanation of Payment Tools

Amount Billed	Allowed	Provider Adjustment	Patient Ineligible	Deductible	Copay/ Co-Ins	Other Ins	Net Paid
$700.00	$500.00	$200.00	$0	$0	$0	$0	$500.00

Interest Amount	$0
Auto-recovered Amount	$250.00
Payment to Provider	$250.00
Prior Overpayment Balance	$575.00
Check Amount	$250.00

Claim#/ Ref#	Member Name	Patient Acct#	Recovery Type	Adjusted Date	Original Amt Pd	Original Overpay	Prev. Recovered	Recovered this check	Remaining balance	Original Date Paid	Original Check#
23000E00 XXXX	Jane Smith	1234567	B	6/8/2023	$575.00	$575.00	$575.00	$0	$375.00	4/6/2023	6XXXXX

Real-Time Prescription Benefit Tool for CVS

Physicians can take action to help their patients with the click of a button.

PHP has an exciting tool that will save your team time and extra work when ePrescribing medications – it's called the Real-Time Prescription Benefit tool.

STEP 1:
Your Electronic Medical Record (EMR) vendor may have access to the Real-Time Prescription Benefit Tool provided by CVS Caremark for Physicians Health Plan Members. Surescripts is the vendor that connects your EMR to CVS Caremark. You can review the list to see if your EMR vendor can connect to the Real Time Benefits Tool.

Surescripts.com/Network-Connections/Real-Time-Prescription-Benefit-Technology-Vendors

STEP 2:
Contact your EMR vendor and request access to the CVS Caremark Real-Time Prescription Benefit Tool. Once connected, you'll be able to:

- Confirm if the patient is active with PHP.
- View the cost of a medication based on the member's benefit.
- Compare prices between medications.
- Find out if a drug requires authorization, step therapy, or has quantity limits, and obtain alternatives for these medication(s).

Please contact PHP Provider Relations if you have any questions by emailing PHPProviderRelations@phpmm.org.

CVS Health

Real-Time Prescription Benefits

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

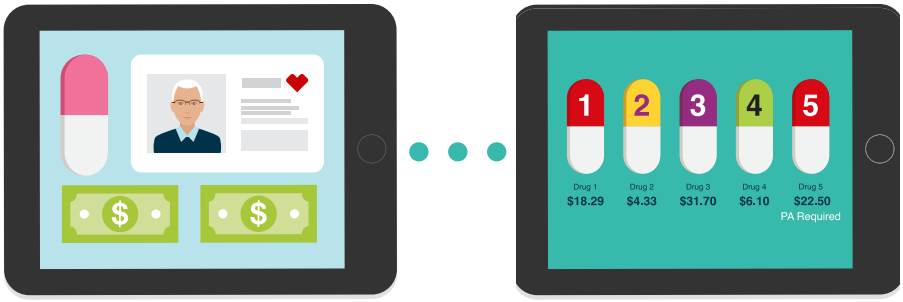
The cost of health care is a major source of worry for consumers across the nation, especially for those enrolled in high deductible health plans who may pay thousands of dollars out of pocket (OOP) each year.

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:

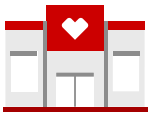
- **Know if a drug is covered** and the member's OOP cost
- **See up to five** clinically appropriate lower-cost brand and generic alternatives

Physicians Health Plan

continued >>

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.

CVSHealth

Source: CVS Health Enterprise Analytics, 2019. Market projections provided by Surescripts P1002380719.
CVS Health uses and shares data as allowed by applicable law, and by our agreements and our information firewall.

Pharmacy Resources

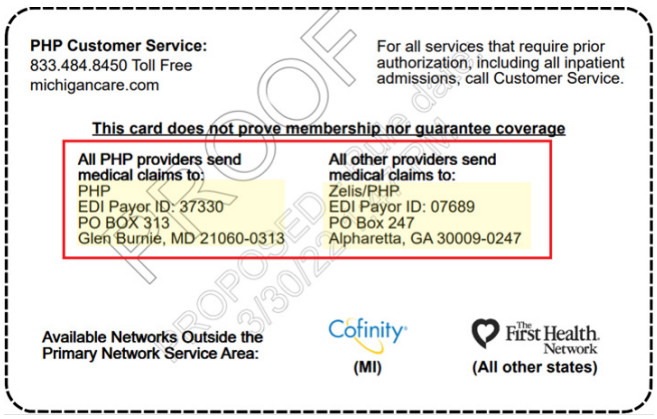
To access information regarding our pharmaceutical authorization criteria and policies utilize the link: **PHPMichigan.com/MedicalandDrugPolicies**

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

Use the Correct Payor ID

The Payor ID or EDI is a unique ID assigned to each insurance company. It allows provider and payor systems to talk to one another to verify eligibility, benefits and submit claims. Ensuring you have the correct payor ID is essential when submitting claims and can help prevent rejections and denials.

PHP Commercial plans use two different payor IDs; one for in-network claims processing and one for out-of-network claims processing. Each ID is five digits long and can be found on the back of the member ID cards:



PHP Commercial payor IDs can also be found on our provider website at **PHPMichigan.com/Providers/Claims-and-Provider-Reimbursements**.

Network providers may submit electronic claims to:

Payor ID: 37330

Payor Name: PHP

Non-network providers may submit electronic claims to:

Payor ID: 07689

Payor Name: PHP

PHP Medicare Advantage plans use a different payor ID which is the same for both in-network and out-of-network claim submission. This payor ID can be referenced in the PHP Medicare Advantage Quick Reference Guide or the PHP Medicare Provider Administrative Manual.

All PHP Medicare providers may submit electronic claims to:

Payor ID: 83276

Payor Name: PHP Medicare

If you have any questions about which payor ID you should use, you can contact PHP Commercial Customer Service at 517.364.8400, toll-free at 800.562.6197, or PHP Medicare Customer Service at 844.529.3757.

Physicians Health Plan is proud to offer Medicare Advantage plans to the communities we serve

As a PHP Medicare provider, your executed agreement includes all four PHP Medicare Advantage plans.

- Sparrow Advantage (HMO-POS)
- Covenant Advantage (HMO-POS)
- PHP Advantage (HMO-POS)
- University of Michigan Health Advantage (HMO-POS)

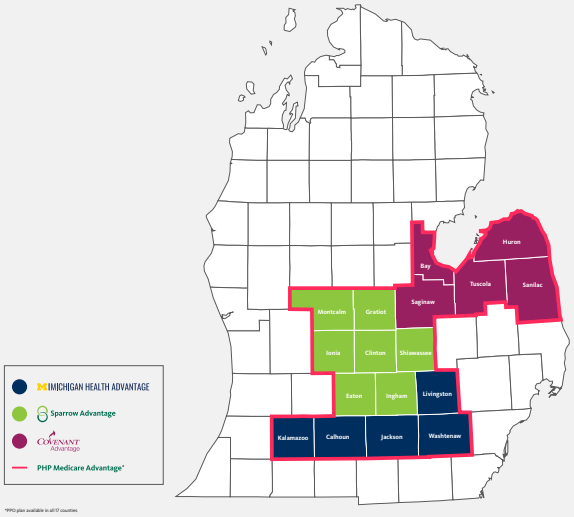
This means you are in-network and can render services to any member that has Sparrow Advantage, Covenant Advantage, PHP Advantage, or U-M Health Advantage.

MICHIGAN HEALTH ADVANTAGE
A PHP MEDICARE HMO-POS PLAN

COVENANT Advantage
A PHP Medicare HMO-POS Plan

Sparrow Advantage
A PHP Medicare HMO-POS Plan

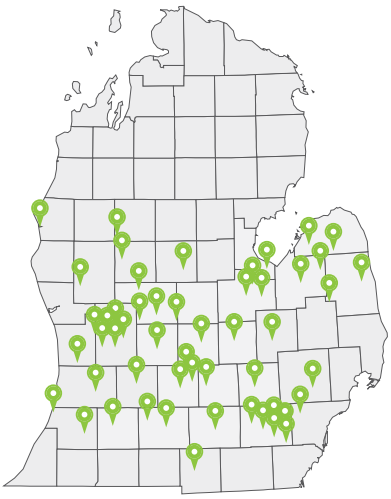
PHP Medicare Advantage
A PHP Medicare PPO Plan



Members who live in the PHP Medicare 17-county service area can enroll in one of 4 plans depending on which county they live in. All plans provide the same great benefits; only their names are different.

Regardless of where members live, or which PHP Medicare plan they enroll in, members have access to more than 12,000 providers at nearly 50 hospitals throughout the state of Michigan.

BRONSON
Corewell Health
COVENANT HealthCare
McLaren
Memorial Healthcare
Sparrow Health System
Trinity Health
UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE



Requesting a Leave of Absence

To ensure member care is directed appropriately and that your participation status is not impacted, it is imperative that you notify PHP of any change in your ability to provide care to your patients due to a leave of absence.

PHP allows participating providers to maintain their participation status during an approved leave of absence for up to six months. A request for a leave of absence must be for one of the following reasons:

- Medical leave
- Family leave
- Sabbatical
- Notification of call to active military service

The provider must submit a request for leave of absence to PHP for approval. The request for a leave of absence must contain:

- Reason for the leave of absence
- Date the leave of absence is to begin
- Expected date of return (except in the case of military leave)
- Patient arrangements

The provider requesting the leave of absence will be notified of the approval or denial of the request and provided with options for termination or continued participation.

Providers on a leave of absence will be removed from PHP provider directories and deactivated as of the date the leave of absence begins.

When ending a leave of absence, it is required to notify PHP within 30 days of returning. Notification of any change in a provider's ability to provide covered services to PHP members is required. Failure to notify PHP in advance may result in termination of participation.

Please send your request for a leave of absence to PHP Credentialing at PHP.Credentialing@phpmm.org.

Maternal Depression Screening

During an infant's first six well-child visits, pediatricians and primary care providers can help determine if the mother requires evaluation for depression treatment or continued monitoring by having the mother complete a standardized maternal screening instrument such as the Edinburgh Postpartum Depression Scale (EPDS). A copy of the tool and instructions for use can be found on the American Academy of Pediatrics website (**aap.org**).

When a depression screening tool is completed, it is important to code the encounter properly.

- If the encounter is infant focused and there is a concern for maternal depression, and the Edinburgh postpartum screen is done, report CPT code 96161.
- If the caregiver is the patient and depression is suspected, report CPT code 96160.

In the event of a documented positive screen, providers may refer the caregiver and infant to a participating Behaviorial Health Specialist for definitive diagnosis and treatment. To locate a specialist, please visit the PHP online Provider Directory at **PHPMichigan.com/Providers**. Click on "Find a Doctor" on the menu bar or "Provider Search" to the left, as shown below.

Significant, Separately Identifiable E/M Services

The relative value units assigned to CPT® codes for minor procedures include an inherent E/M component. A minor procedure is defined as a procedure with a global period of 0 or 10 days. Before any procedure is performed, it's expected that the provider will evaluate the patient to ensure the procedure is appropriate for the patient's condition.

For example, when a patient arrives for a scheduled injection that was ordered at a previous visit, the provider will ask the patient questions about their status to ensure the injection is still the correct course of treatment. The procedure also inherently includes a review of the patient's relevant past medical history, assessment of the problem, review of the procedure, discussion of alternative treatments, consent, postoperative instructions, and discussion of further treatment and follow-up post-procedure. The E/M component must go beyond that which is normally included with the primary service to report a separate E/M service.

Modifier 25

CPT® definition: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

- Not applicable for E/M service that results in a decision to perform surgery.
- Two E/M services for the same patient on the same day:
  - The medical record must justify performing the separate E/M service.
  - Append modifier 25 to the second E/M service.
- E/M for a patient on the same day as a procedure:
  - The medical record must justify performing an E/M service in addition to the procedure.
  - E/M service was provided above the usual pre- and post-service work of other reported service(s)
  - Append modifier 25 to the E/M service.
- Inpatient or Observation admission on the same calendar day as an encounter in another site of service (e.g., office, nursing facility):
  - Services provided at the initial site may be separately reported.

Example

An established patient is seen for a scheduled annual physical. During this encounter, the patient indicates they have been experiencing shoulder pain for a few days following a fall from their bike.

Documentation Scenario A:
In this instance, the medical records include an indication of scheduled physical, noted shoulder pain, and that pain is being managed with the use of NSAIDs. The record provides no further indication of a distinct evaluation and management regarding shoulder pain. The record does not include any indication in the assessment and care plan of any orders or performed x-rays, prescription for pain medication, or any documented medical decision-making specific to the noted shoulder pain. Additional work was not required and, therefore, not documented. The documentation does not support billing a separate E/M visit in addition to a scheduled physical exam or application of modifier 25 to the E/M service.

Documentation Scenario B:
In this instance, the medical record includes an indication of scheduled physical and noted shoulder pain that has been persistent despite the use of NSAIDs. The physician performs and documents a distinct problem-focused evaluation of the shoulder in the assessment and care plan, advises the use of a shoulder immobilizer, provides a script for an immobilizer, orders an x-ray, and discusses referral to an orthopedic provider. The documentation supports a distinct, significant, identifiable service; therefore, billing a separate E/M of the appropriate level with modifier 25 is reportable.

Modifier FT

Unrelated Evaluation & Management (E/M) visit on the same day as another E/M visit or during a global procedure as applicable.

Report when an E/M visit for unrelated care is furnished within the global period or when one or more additional E/M visits furnished on the same day are unrelated to the critical care service.

As a best practice, documentation, and coding should be reviewed before claim submission to ensure the full details of services provided are recorded. Prevent the reporting of unsupported services by reviewing any templates or practice policies regarding the use of templates and carrying forward of chart details to ensure that records completely and accurately reflect the reason for the encounter, medical necessity, and medical decision-making that occurred during the current encounter. If you disagree with a denial of an E/M service as inclusive of another E/M service or procedure performed on the same day, please submit a complete appeal narrative and documentation supporting the significant and identifiable services. The PHP Provider Manual outlines additional information regarding clinical editing and PHP's Appeal Process.

*AMA CPT® (Current Procedural Terminology) 2023

Antidepressant Medication Management

Follow-up visits and continued monitoring of adult patients who have been newly prescribed an antidepressant for major depression are important for adherence and continued support.

Pharmacy claims data shows that while new medications have been prescribed and retrieved from the pharmacy, they are not always being continued by the member. Evidence supports that one in three patients discontinue treatment within one month, and nearly one in two discontinues treatment within three months.

The American Psychiatric Association (APA 2010) maintains that successful treatment of patients with major depressive disorder is promoted by both a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of a subsequent major depressive episode.

During the acute phase of treatment, patients should be carefully and systematically monitored on a regular basis. A follow-up visit is recommended within the first 84 days of starting the medication to assess their response to pharmacotherapy, identify the emergence of side effects (e.g., gastrointestinal symptoms, sedation, insomnia, activation, changes in weight, and cardiovascular, neurological, anticholinergic, or sexual side effects), and assess patient safety. If antidepressant side effects do occur, an initial strategy is to lower the dose of the antidepressant or to change to an antidepressant that is not associated with that side effect.

During the continuation phase of treatment, the patient should be carefully monitored for signs of possible relapse. An additional follow-up visit is recommended at or before 180 days of the initial treatment date to systematically assess symptoms, side effects, adherence, and functional status, and may be facilitated using clinician and/or patient-administered rating scales. To reduce the risk of relapse, patients who have been treated successfully with antidepressant medications in the acute phase should continue treatment with these agents for 4-9 months.

During the maintenance phase, an antidepressant medication that produced symptom remission during the acute phase and maintained remission during the continuation phase should be continued at a full therapeutic dose.

Current Primary Care Appointment Standards

PHP maintains guidelines for accessibility and a policy and procedure for access to and availability of health care as identified in the standards below.

Standards for Accessibility for Primary Care

Initial appointment with PCP: The frequency of physical exams is at the Licensed Independent Practitioner's (LIP) discretion. Initial prenatal visits should occur within the 1st trimester. The wait time for scheduling should be within 8 weeks.

Routine non-symptomatic: A non-problem related visit (e.g., well baby care, Pap smear, family planning services, routine re-check of blood pressure). This may also include an initial prenatal visit if it would allow the patient to be seen within the first trimester. The wait time for scheduling should be within 4 weeks.

Non-Urgent symptomatic: A problem related visit, however, the condition is not urgent.. The wait time for scheduling should be within 5 days.

Urgent Care: Symptoms of recent onset and/or increasing in severity which prevents normal work or school activities. The wait time for scheduling should be within 24 hours.

Emergency Crisis Care: Examples include new/persistent bleeding, injury resulting in persistent pain/disability, new/severe pain onset within 24 hours, and new/increasing difficulty breathing. The patient should be immediately seen in the office or referred to an emergency department as appropriate.

24 Hour Access to Medical Care: Participating Licensed Independent Practitioners (LIP) shall have appropriate methods for directing members to seek medical care when the LIP is not available. The LIP shall provide or arrange for advice and assistance to members in emergency situations 24 hours per day, 7 days per week. The LIP office shall provide information/communication to members on how they may seek medical care when the LIP is not available (e.g., during normal business hours, vacation/lunch or after hours). The Primary Care Practitioners (PCP) shall arrange for access to medical care through a phone number which is answered during office hours by LIP staff and at other times automatically transfers to another location to be answered, an answering service, or a recording directing members how to reach the PCP or another medical LIP whom the PCP has designated to treat PHP members. Access should be available 24 hours per day, 7 days per week.

Infusion Coding

Understanding the hierarchy of reporting is key when coding for infusions, hydration, and injections. Establishing the hierarchy of services provided during an encounter begins with a thorough review of the record to identify why the patient was present, what services were received during the encounter, how services were administered, and the total time of the administration. Once the initial service code is captured, subsequent or sequential Intravenous pushes (IVPs) are coded as appropriate. Only one initial service is reportable per patient encounter unless there are two medically necessary IV sites or a return visit for a separate encounter on the same day. These exceptions must be supported by documentation and reported with modifier 59 or XE on the second service.

Hierarchy

Service category

- Chemotherapy services are primary to therapeutic, prophylactic, and diagnostic.
- Therapeutic, prophylactic, and diagnostic are primary to hydration services.

Administration type

- Infusions are primary to pushes.
- Pushes are primary to injections.

Service Category
Chemotherapy (96401-96425)

- "Chemo" includes other highly complex drugs or biological agents such as non-radionuclide anti-neoplastic drugs, anti-neoplastic agents provided for the treatment of non-cancer diagnoses, certain monoclonal antibody agents, or other biologic response modifiers.
- Requires direct supervision due to the need to monitor the patient and adjust the infusion rate as needed.
- Report codes for each method of administration
- Administration of substances (e.g., steroids, anti-emetics), either independently or sequentially, as supportive management for chemotherapy is reported with codes 96360, 96361, 96365, and 96379 as appropriate.
- These codes are not reported by the provider in a facility setting.

Therapeutic (96365-96379)

- Report for the administration of drugs and other substances (other than hydration).
- Do not report these codes for chemotherapy or other highly complex drugs/biological or when fluids are used to administer the drug(s); the fluid administration is incidental hydration and is not separately reported.
- These codes are not reported by the physician in a facility setting.

Hydration (CPT 96360, +96361)

- Defined as the replacement of necessary fluids via an IV infusion which consists of pre-packaged fluid and electrolytes.
- Separately reportable when documentation supports signs and symptoms such as dehydration, fluid loss, or abnormal lab studies confirming elevated levels (i.e., BUN, creatinine, glucose, or lactic acid).
- Not reportable when the purpose is to keep an IV line open, it serves as the vehicle for drug administration, used to accommodate a therapeutic IV piggyback through the same IV access, used for routine administration of IV fluids, administered 30 minutes or less, or given concurrently to other services.

Time

Only the time when a substance is being actively administered is used to calculate infusion time. Do not use the start and stop times of the encounter. An infusion of 15 minutes or less is reported as a push. The documented time must support a minimum of 31 additional minutes beyond the initial 60 minutes to report an additional hour. A second hour of infusion can be coded once the infusion time equals one hour and 31 mins or 91 mins, and a third hour of infusion time can be coded once the infusion time equals two hours and 31 mins or 151 mins. Before submitting the claim, review the administration type and route of administration, and ensure documentation clearly identifies and supports the coding of time-based services.

	Therapeutic Infusions	Hydration
1st Hour	16-90 minutes	31-90 minutes
2nd Hour	91-150 minutes	91-150 minutes
3rd Hour	151-210 minutes	151-210 minutes

Administration

Administration includes the use of local anesthesia, IV start, access to indwelling IV, SQ catheter or port, port flush at the conclusion of infusion, standard tubing, syringes, supplies, preparation, and provision of chemotherapy agent.

Documentation Requirements

Problems arise with insufficient or incomplete documentation, such as missing order, incomplete notation of administration, and missing start and stop times. A thorough and complete MAR is a key documentation component for support of coding infusion services.

Medication Administration Record (MAR) or Infusion Log that includes the following:

- Drug/Substance administered.
- Route/Mode of administration.
- Access site.
- Rate of administration.
- Dose and volume of drug administered.
- Wasted amount from single-dose vials (if applicable, apply-modifier JW).
- Documentation that the line was flushed when complete.
- Start and stop time of each infusion.
- Actual time each infusion is administered.

Obstetrical Billing Guidelines

Obstetric care is generally reported as packaged care or "Global OB Care," which includes antepartum, delivery services, and postpartum care. The global OB package code must be reported when the same group physician and/or other health care professional provides all components of the OB package. However, there are instances where physicians of different groups provide distinct portions of obstetric care. Providers must only bill for the portion(s) of obstetric care provided. It is essential for correct coding that documentation is reviewed to confirm the servicing provider(s) for each component of obstetric care, method of delivery, previous methods of delivery when applicable, the number of antepartum care visits provided, any transfer in care, and any change in insurance.

OB Global Coding

- One-time billing includes antepartum, delivery, and postpartum services provided by the same provider or group reported with one unit of service.
- The patient is seen for four or more prenatal visits prior to delivery.
- Reimbursement includes all obstetric services.
- The claim must be submitted with the date of delivery as the date of service.
- The appropriate global code should be reported with the delivery date as the date of service.

59400 Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy and/or forceps), and postpartum care.

59510 Routine obstetric care, including antepartum care, cesarean delivery, and postpartum care.

59610 Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy and/or forceps), and postpartum care, after previous cesarean delivery.

59618 Routine obstetric care, including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

Antepartum Only Global Coding

- Billed with global CPT code for either four to six visits or seven or more visits.
- Bill on one unit of service.
- Bill one line of service with the date of service as the last date antepartum services were rendered.
- E/M Office visit codes; for visits 1-3.

59425 Antepartum care only; 4-6 visits.

59426 Antepartum care only; 7 or more visits.

Delivery and Postpartum Care Only Coding

- The same physician or group practice does not provide antepartum care.
- Includes hospital care provided during the delivery confinement period, uncomplicated outpatient visits related to the pregnancy up to six weeks post-delivery, and discussion of contraception.
- Bill on one unit of service.
- The claim must be submitted with the date of service as the date of delivery.

59410 Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care.

59614 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care.

59515 Cesarean delivery only; including postpartum care.

59622 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care.

Delivery Only

- The physician performs the delivery component only of the OB care.
- The same physician or group does not provide the total OB package.
- The claim must be submitted with the date of service as the date of delivery.
- Bill on one unit of service.

59409 Vaginal delivery only (with or without episiotomy and/or forceps).

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps).

59514 Cesarean delivery only.

59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.

Delivery services include hospital admission, exam, management of uncomplicated labor, delivery, external and internal fetal monitoring, intravenous induction of labor (96365-96367), delivery of the placenta, repair of first or second-degree lacerations, and insertion of cervical dilator (59200) when performed on the same date of delivery.

Postpartum Care Only

- Report only once with one unit of service for all outpatient care following delivery.
- This includes one or more visits for uncomplicated care and discussion of contraception provided up to six weeks following delivery.
- The claim must be submitted with the date of service as the date of an office visit.

59430 Postpartum care only (separate procedure)

The following services will not be reimbursed when submitted separately(unbundled) from the global OB code:

- Routine prenatal visits until delivery, after the first three antepartum visits.
- Recording of weight, blood pressure, and fetal heart tones.
- Admission to the hospital, including history and physical.
- Inpatient Evaluation and Management (E/M) service is provided within 24 hours of delivery.
- Management of uncomplicated labor.
- Vaginal or cesarean section delivery.
- Delivery of placenta (CPT code 59414).
- Administration/induction of intravenous oxytocin (CPT code 96365-96367).
- Insertion of a cervical dilator on the same date as delivery (CPT code 59200).
- Repair of first or second-degree lacerations.
- A simple removal of cerclage (not under anesthesia).
- Uncomplicated inpatient visits following delivery.
- Routine outpatient E/M services provided within 42 days following delivery.
- Postpartum care after vaginal or cesarean section delivery (CPT code 59430).

The following services may be reimbursed when submitted in addition to the global OB code:

- First three antepartum E&M visits.
- Laboratory tests.
- Maternal or fetal echography procedures (CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76820, 76821, 76825, 76826, 76827 and 76828).
- Amniocentesis, any method (CPT codes 59000 or 59001).
- Amniofusion (CPT code 59070).
- Chorionic villus sampling (CPT code 59015).
- Fetal contraction stress test (CPT code 59020).
- Fetal non-stress test (CPT code 59025).
- External cephalic version (CPT code 59412).
- Insertion of cervical dilator (CPT code 59200) more than 24 hours before delivery.
- E&M services unrelated to pregnancy (e.g., UTI, Asthma) during antepartum or postpartum care.
- Additional E/M visits for complications or high-risk monitoring that results in more than the typical 13 antepartum visits.
  - Not reportable until after the patient delivers.
  - Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits.
- Inpatient E/M services are provided more than 24 hours before delivery.
- Management of surgical problems arising during pregnancy (e.g., Cholecystectomy, appendicitis, ruptured uterus).

Clinical Editing

PHP claims processing incorporates clinical editing to analyze professional and facility claims for reimbursement, ensuring clinical data's accuracy and completeness, including potential coding errors and rule infractions based on codes submitted on the same or different claims. Clinical Edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The PHP Provider Manual outlines additional information regarding clinical editing and PHP's Appeal Process.

*AMA CPT® (Current Procedural Terminology) 2023

How to Locate the Correct Bill Type

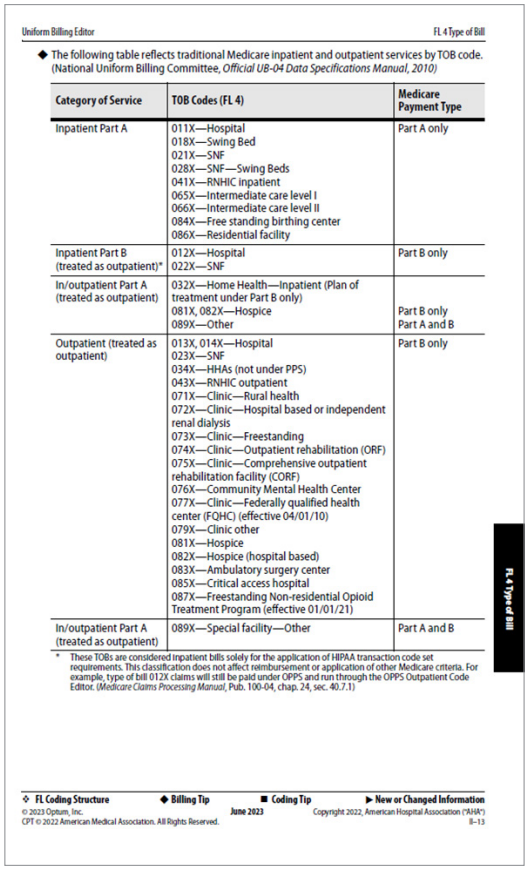
The Uniform Billing (UB) Editor is an excellent tool to reference to properly submit claims for efficient billing. The use of this tool will allow your claims to be correctly processed on the initial submission. The screenshots below are taken from the UB Editor and will show the correct methodology to be used when submitting claims.

The link to the Optum Coding website and password are provided in this article for easy access. It is important to make sure that you keep your UB Editor updated, as changes occur quarterly. The first image (below, on the left) shows the form locator in chapter two of the UB Editor on pages 11-13. This will help you to select the second, third, and fourth digits for proper billing. The next table shows the inpatient and outpatient services that require a Type of Bill (TOB). The next image is the Form Locator (FL4) for the TOB and explains each option. This information will allow you to get your claims processed correctly with a shorter turnaround time. If you have any questions or concerns, please contact PHP Provider Relations at PHPProviderRelations@phpmm.org.

Optum created a website for users of the Uniform Billing Editor:

optumcoding.com/support/product-update/?updateid=UBE/

Enter the password: UBE20. The password will change periodically and can be found on the first few pages of the UB book.



Uniform Billing Editor — FL 4 Type of Bill

◆ The following table reflects traditional Medicare inpatient and outpatient services by TOB code. (National Uniform Billing Committee, *Official UB-04 Data Specifications Manual, 2010*)

Category of Service	TOB Codes (FL 4)	Medicare Payment Type
Inpatient Part A	011X—Hospital 018X—Swing Bed 021X—SNF 028X—SNF—Swing Beds 041X—RNHIC inpatient 065X—Intermediate care level I 066X—Intermediate care level II 084X—Free standing birthing center 086X—Residential facility	Part A only
Inpatient Part B (treated as outpatient)*	012X—Hospital 022X—SNF	Part B only
In/outpatient Part A (treated as outpatient)	032X—Home Health—Inpatient (Plan of treatment under Part B only) 081X, 082X—Hospice 089X—Other	Part B only Part A and B
Outpatient (treated as outpatient)	013X, 014X—Hospital 023X—SNF 034X—HHAs (not under PPS) 043X—RNHIC outpatient 071X—Clinic—Rural health 072X—Clinic—Hospital based or independent renal dialysis 073X—Clinic—Freestanding 074X—Clinic—Outpatient rehabilitation (ORF) 075X—Clinic—Comprehensive outpatient rehabilitation facility (CORF) 076X—Community Mental Health Center 077X—Clinic—Federally qualified health center (FQHC) (effective 04/01/10) 079X—Clinic other 081X—Hospice 082X—Hospice (hospital based) 083X—Ambulatory surgery center 085X—Critical access hospital 087X—Freestanding Non-residential Opioid Treatment Program (effective 01/01/21)	Part B only
In/outpatient Part A (treated as outpatient)	089X—Special facility—Other	Part A and B

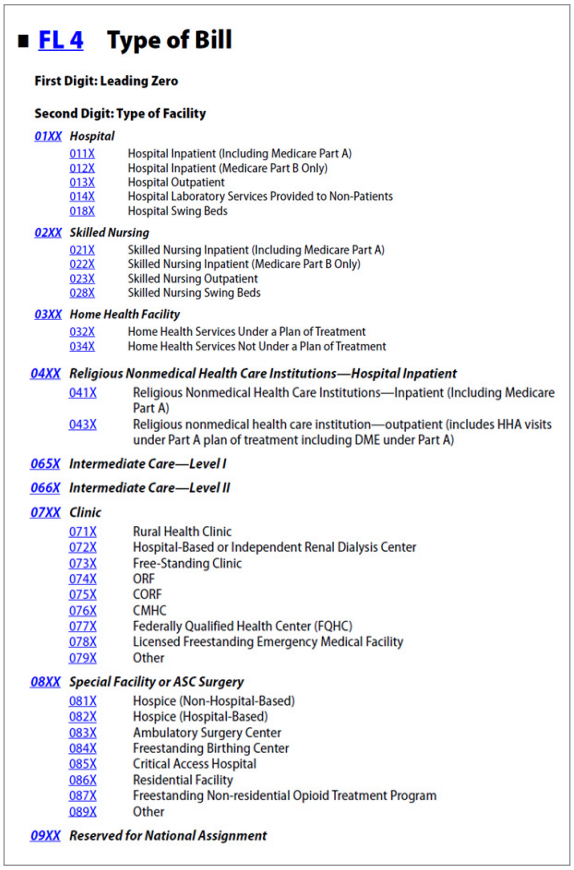
* These TOBs are considered inpatient bills solely for the application of HIPAA transaction code set requirements. This classification does not affect reimbursement or application of other Medicare criteria. For example, type of bill 012X claims will still be paid under OPPS and run through the OPPS Outpatient Code Editor. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 24, sec. 40.7.1)

FL 4 Type of Bill

✧ FL Coding Structure ◆ Billing Tip ■ Coding Tip ▶ New or Changed Information

June 2023

B–13



■ FL 4 Type of Bill

First Digit: Leading Zero

Second Digit: Type of Facility

01XX Hospital
- 011X Hospital Inpatient (Including Medicare Part A)
- 012X Hospital Inpatient (Medicare Part B Only)
- 013X Hospital Outpatient
- 014X Hospital Laboratory Services Provided to Non-Patients
- 018X Hospital Swing Beds

02XX Skilled Nursing
- 021X Skilled Nursing Inpatient (Including Medicare Part A)
- 022X Skilled Nursing Inpatient (Medicare Part B Only)
- 023X Skilled Nursing Outpatient
- 028X Skilled Nursing Swing Beds

03XX Home Health Facility
- 032X Home Health Services Under a Plan of Treatment
- 034X Home Health Services Not Under a Plan of Treatment

04XX Religious Nonmedical Health Care Institutions—Hospital Inpatient
- 041X Religious Nonmedical Health Care Institutions—Inpatient (Including Medicare Part A)
- 043X Religious nonmedical health care institution—outpatient (includes HHA visits under Part A plan of treatment including DME under Part A)

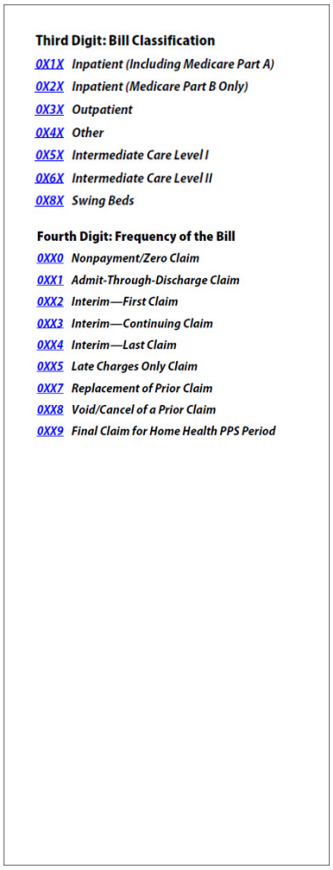
065X Intermediate Care—Level I

066X Intermediate Care—Level II

07XX Clinic
- 071X Rural Health Clinic
- 072X Hospital-Based or Independent Renal Dialysis Center
- 073X Free-Standing Clinic
- 074X ORF
- 075X CORF
- 076X CMHC
- 077X Federally Qualified Health Center (FQHC)
- 078X Licensed Freestanding Emergency Medical Facility
- 079X Other

08XX Special Facility or ASC Surgery
- 081X Hospice (Non-Hospital-Based)
- 082X Hospice (Hospital-Based)
- 083X Ambulatory Surgery Center
- 084X Freestanding Birthing Center
- 085X Critical Access Hospital
- 086X Residential Facility
- 087X Freestanding Non-residential Opioid Treatment Program
- 089X Other

09XX Reserved for National Assignment



Third Digit: Bill Classification

0X1X Inpatient (Including Medicare Part A)
0X2X Inpatient (Medicare Part B Only)
0X3X Outpatient
0X4X Other
0X5X Intermediate Care Level I
0X6X Intermediate Care Level II
0X8X Swing Beds

Fourth Digit: Frequency of the Bill

0XX0 Nonpayment/Zero Claim
0XX1 Admit-Through-Discharge Claim
0XX2 Interim—First Claim
0XX3 Interim—Continuing Claim
0XX4 Interim—Last Claim
0XX5 Late Charges Only Claim
0XX7 Replacement of Prior Claim
0XX8 Void/Cancel of a Prior Claim
0XX9 Final Claim for Home Health PPS Period

Medication Updates

Medication	Formulary action	Justification
Analpram	Exclude	Not an FDA Approved Product Effective 7/1/23
Anusol	Exclude	Not an FDA Approved Product Effective 7/1/23
Zerbaxa	Remove PA	PA no longer required Effective 3/1/23

HCPCS Code	Medication	Formulary action	Justification
Q0220	Tixagevimab and Cilgavimab, 300 mg	Requires Prior Approval 11/1/23	No longer FDA Approved
Q0221	Tixagevimab and Cilgavimab, 600 mg	Requires Prior Approval 11/1/23	No longer FDA Approved
Q0222	Bebtelovimab, 175 mg	Requires Prior Approval 11/1/23	No longer FDA Approved
Q0240	Casirivimab and Imdevimab, 600 mg	Requires Prior Approval 11/1/23	No longer FDA Approved
Q0243	Casirivimab and Imdevimab, 2400 mg	Requires Prior Approval 11/1/23	No longer FDA Approved
Q0244	Casirivimab and Imdevimab, 1200 mg	Requires Prior Approval 11/1/23	No longer FDA Approved
Q0245	Bamlanivimab and Etesevimab, 2100 mg	Requires Prior Approval 11/1/23	No longer FDA Approved
Q0247	Sotrovimab 500 mg	Requires Prior Approval 11/1/23	No longer FDA Approved
Q0249	Tocilizumab, 1 mg	Requires Prior Approval 11/1/23	No longer FDA Approved

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

Important Things to Remember When Submitting a Prior Authorization Request Form

- The Medication Authorization Form is located on the Provider Pharmacy Services page on the website **PHPMichigan.com**
- Fill out the form completely and legibly.
- 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.
- If requesting an infusion drug, please include the name of the office or facility and the NPI number for where the drug will be administered.
- Submissions from CoverMyMeds are routinely transmitted with incomplete information which delays care for the patient. Sending requests directly to PHP will reduce the time it will take to process the request. If you have issues sending authorization requests for PHP members through CoverMyMeds, please reach out directly to PHP Customer Service at 800.562.6197 or 517.364.8400.

Physicians Health Plan General Training 101

PHP Provider Relations offers training sessions throughout the year to help you and your office staff work successfully with PHP.

The information presented in these training courses will include an overview of PHP Commercial and PHP Medicare Advantage plan requirements, a review of PHP's online resources and how to navigate the MyPHP Provider Portal. This includes checking eligibility and benefits, claim status, prior authorization request, and much more. All office administration and staff are encouraged to attend.

All registered attendees will receive login information sent to the email used to register prior to the training date.

Questions?
Contact PHP Provider Relations at PHPProviderRelations@phpmm.org.

2023 Training Dates

Thursday, Nov. 9, 2023
12–1:30 p.m.

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

Network Adequacy Report Summary

Each year, PHP assesses the access and availability of Primary Care Providers (PCPs), Behavioral Health Providers, Essential Community Providers (ECPs), and high-volume key specialties in our network. We also examine provider turnover rates, PCP change rates, and drive times to ensure that the PHP network has enough providers available to meet the needs and preferences of our members.

We celebrate the following achievements from our 2022 Network Adequacy assessment:

- Our network grew tremendously with 1,143 new providers added, and only 354 existing providers departing.
- The overall PCP rate change for 2022 was 3.52%, and the rate change related to provider network is .56%, this is low compared to a plan standard of less than 5.00%.
- The drive times for all medical specialties and facilities were within PHP's established performance goals, shown in the tables accompanying this article.
- All PHP Commercial plans met goals for member-to-provider ratios, geographical access, and volume requirements.
- All specialties and facilities met the requirements for PHP's Qualified Health Plan (QHP) members.
- In 2022, our average credentialing turnaround time was cut in half in comparison to 2021. Our turnaround time in 2022 was 94 days.
- Our network also met or exceeded performance standards for PCP after-hours access and meets the cultural and linguistic needs of our members.

PHP extends our gratitude to our participating providers for contributing to a strong network capable of supporting the health needs of our members. Thank you! There were also areas for opportunity identified from our 2022 Network Adequacy Assessment:

- We are monitoring appointment access for new patient physicals, behavioral health, routine care, non-urgent care, urgent care, and emergency care in the office to help us meet our performance goal of 90% adherence with defined standards for waiting times, also shown in the tables accompanying this article.
- We have noted that our networks open/closed status is not clear on the PHP website which specialties are accepting new provider applications for participation.

In response to these challenges, we are expanding our network open/closed status to ensure behavioral health pediatric specialties are accepted, as we found this was a majority of behavioral health access requests. We will also be obtaining feedback from PCP and behavioral health providers on why the wait time to obtain routine appointments cannot be met. We will also continue to regularly validate our provider directory through outreach from the Provider Relations team and targeted audits to improve accuracy.

Our Network Adequacy reporting relies on the information reported to us by you, our provider network. Please help ensure that our reporting accurately reflects the strengths and opportunities in our network by keeping all your information up to date. PHP recommends that all practitioners periodically review their information in our directory for accuracy and completeness. Keeping this information current can also help members who reach out to PHP Medical Resource Management for assistance with locating practitioners and other service providers to meet their needs and can help direct new patients to your practice. PCP offices are encouraged to regularly check their provider rosters by logging into the MyPHP Provider Portal at **PHPMichigan.com/MyPHP**, and report any changes to PHP Customer Service by phone at 517.364.8500 or 800.832.9186 (toll free), 8:30 a.m. - 5:30 p.m., EST, Monday through Friday, excluding holidays.

Thank you again for your continued commitment to the health and wellness of our members as a valued participating provider in the PHP Network!

Lunch and Learn

PHP Provider Relations will continue to offer Lunch and Learn sessions throughout the remainder of 2023.

In addition to our quarterly General Training 101, PHP Provider Relations offers quarterly Lunch and Learn sessions. During these sessions you will have the opportunity to learn helpful information about specific PHP programs and processes. We also welcome requests for topics that you would like to know more about. The topic for each session will be announced closer to the training date, and a flyer will be posted to provide additional information.

Please join us on the remaining 2023 Training Date

Tuesday, Oct. 24, 2023, from 12–1 p.m.

If you would like to submit suggestions, please email PHPProviderRelations@phpmm.org

To register, visit **PHPMichigan.com/Providers** and select "Training Opportunities."

Utilization Management News and Updates

3rd Quarter 2023

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., EST, excluding holidays.

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

New Policies

BCP-81 Sacral Nerve Neuromodulation-Stimulation; effective 7/1/2023.

Policy Updates

- BCP-06 Outpatient Rehabilitation/Habilitation Services: PT/OT removal of prior authorization for Group L0002011, effective 4/01/2023 and Group L0002193, effective 7/1/2023.
- BCP-12 Applied Behavioral Analysis (ABA) Therapy for Treatment of Autism Spectrum Disorders: Removal of age requirement, per federal mandate, for all HMO/PPO groups and the following ASO groups: Group L0002011, effective 4/01/2023 and Group L0002193, effective 7/1/2023.

Changes to Coverage for Services

Code(s)	Procedures or Service	Action	Effective Date
K0134	Provision of COVID-19 test, nonprescription self-administered and self-collected use, FDA approved, authorized, or cleared, one test count	Change from "Covered" to "Not Covered" due to the end of the Public Health Emergency	5/12/2023
37236	Transcatheter placement of an intravascular stent(s) open or percutaneous, including radiological supervision and interpretation, and including angioplasty within the same vessel when performed; initial artery	Change from "Prior Authorization" to "Covered"	4/1/2023

Any provider or member directly impacted by these changes has been sent a direct mailing explaining the changes.

Physicians Health Plan

MAILING ADDRESS INFO
MAILING ADDRESS INFO
MAILING ADDRESS INFO

Contact Us.

PHPMichigan.com

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

Commercial plans

Where to send claims:

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

Non-network
Physicians Health Plan
PO Box 247
Alpharetta, GA 30009-0247

Electronic
In-network: Payor ID 37330
Non-network: Payor ID 07689

Where to send refunds:
Physicians Health Plan, Attn: Provider Refund
PO Box 3377, Lansing, MI 48909-7877

Medicare plans

Where to send claims and refunds:
Physicians Health Plan
PO Box 7119
Troy, MI 48007