Provider Connection

FOURTH QUARTER 2018

In this issue

Physicians Health Plan

A health plan that works for you.

2018 Holiday Hours

Physicians Health Plan will be closed

- Christmas Day, Dec. 25

2019 Holiday Hours

Physicians Health Plan will be closed

- New Year's Day, Jan. 1
- Memorial Day, May 27
- Independence Day, July 4
- Labor Day, Sept. 2
- Thanksgiving, Nov. 28
- Friday, Nov. 29
- Christmas Day, Dec. 25

If you have an after-hours emergency that cannot wait until the next business day, please contact the answering service at **517.364.8500** for assistance.

Training documents, notices, and MyPHP

Under the Providers tab on the PHP website you will now see Training Opportunities on the left-hand side of your screen. Here, is where you can access online tutorials for the MyPHP web portal. The tutorial is broken down into categories so you can easily navigate from one topic to another or skip the ones that might not pertain to you. As new training documents are developed, PHP will continue to add tutorials to the website. If you would like training on a specific category please contact your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Another option added to the website is Notices, where you can find the most recent notices that have been sent out to our Provider Network. To locate the Notices, click on the Providers Tab, on the left side of your screen you will see Notices. Keeping you up-to-date is our goal!

MyPHP

Please remember the most effective way to obtain information about eligibility, claims data, rosters, and much more is through the MyPHP Provider portal. If you have questions about obtaining a Provider login or how to use the Portal reach out to your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Working with PHP

General Training 101

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

Learning opportunities include a review of the provider manual, checking eligibility and benefits, claim status, authorizations/approvals, and much more. Attendees should include management and all office staff.

Jan. 17 | 8:30–10 a.m.

April 18 | noon–1:30 p.m.

Jul. 18 | 8:30–10 a.m.

Oct. 17 | noon–1:30 p.m.

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

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

Open enrollment for Marketplace health plans

Open enrollment for our Individual On and Off Marketplace health plans began Nov. 1, 2018, and will run through Dec. 15, 2018. The last day to make a plan selection during open enrollment is Dec. 15, 2018. To view PHP health plan options and enroll, please visit **ChoosePHPmi.com**.

New signature solution

In support of PHP's continuous effort towards increasing the efficiency and timeliness of handling business processes for our network of Providers and Members, PHP has implemented a digital signature process!

This process is accessible via a secure online portal operated by Adobe Sign®. This portal enables Providers to receive, review, and digitally sign PHP required documents in an individually-generated user account. Examples of documents you will be able to access within this portal may include: credentialing paperwork, network participation contracts, and Provider manual updates.

The benefits of this system are: decreased turnaround time to process documents; additional levels of security for documents sent & received, and an overall increased convenience factor for internal and external parties.

If you have questions directly related to the new signature process through Adobe Sign®, please contact the Provider Relations team at **PHPProviderRelations@phpmm.org**.

Source: theblog.adobe.com

Things to remember when filling out claim forms

Per the American Medical Association, administrative tasks in medical claims processing (which can include avoidable errors, inefficiency and waste) cost an average of $2.36 per claim for Providers and payers.

It has been estimated that roughly $12 billion dollars in unintended administrative costs could be saved when medical claims are properly processed. Billing offices and health plans can effectively work together to save 21 percent of a Physician's total administrative costs and ensure accurate payments.

By accurately completing claim forms and submitting claims in a timely manner, you will save time and money, as well as expediting payment for services rendered. The following are some tips to keep in mind when filling out claim forms:

- When submitting a 1500 claim form, enter the provider of service/supplier's billing name, address, zip code and telephone number into box 33.
- Box 32 should only be completed when the address for payment is different than the address in 33.
- On the 1500 claim form you will find the Insured's I.D. Number in Box 1a or on the UB04 in box 60. Please remember to always use all nine digits in the member ID along with the additional two digits for the suffix.

You have probably heard the saying, "a picture is worth a thousand words." The same logic applies to ICD-10 coding. While you probably will not need a thousand ICD-10 codes to paint a complete picture of a Patient's diagnosis, there is a good chance you will need more than one. There are 12 spaces for diagnosis codes on a CMS-1500 form, and a UB04 has space for 41, so why not use more than one diagnosis when appropriate?

For additional pointers on CMS 5010 compliance guidelines please visit: **WPSHealth.com/resources/files/npi_1500_crosswalk.pdf**

Enhanced clinical editing in 2019

PHP is expanding the current Change Healthcare clinical editing software to include ClaimsXten integrated functionality in 2019.

The ClaimsXten software will be integrated into our claims payment system and will allow us to better align payment policy with national rules and coding guidelines. Once the enhancements are fully implemented, the software will:

- Improve accuracy of industry edits
- Improve claims processing and timeliness of payment
- Improve consistent payment policy which aligns with state and national standards

Please look for more information about ClaimsXten and implementation timelines in future Provider Connections or visit our website at **PHPMichigan.com**.

From the Compliance Desk: documentation reminders

Surgical Anesthesia

The Centers for Medicare & Medicaid Services (CMS) defines surgical anesthesia time as the continuous, actual presence of the anesthesiologist or CRNA. Surgical anesthesia time begins when the Physician or CRNA starts preparing the Patient for the anesthesia procedure — in the operating room or equivalent area — and ends when the anesthesia practitioner is no longer in personal attendance.

Documentation should include:

- Pre-anesthesia record completed by the anesthesia provider
- Anesthesia report completed by the anesthesia provider
- Post-anesthesia record completed by the anesthesia provider and the post-anesthesia care unit (PACU) team
- Surgeon's operative report
- Consistent start and stop times across documentation

Moderate Sedation

According to CPT, "moderate sedation time begins with the administration of the sedating agent(s), ends when the procedure is completed, the Patient is stable for recovery status, and the Physician or other qualified healthcare professional providing the sedation ends personal continuous face-to-face time with the Patient."

Documentation should include:

- Operative report
- Statement in operative report establishing the following
  - the Physician performing the surgery administered moderate sedation
  - the presence of an independent trained observer (if required)
  - how long the moderate sedation was administered
- Start and stop times
- Nursing record

Do not include any of the preservice and post service work when calculating the interservice time.

If same Provider performs both the primary procedure and the moderate sedation

- Provider should bill for the moderate sedation; however, there must be a trained observer to assist.

If different Provider performs primary procedure and moderate sedation

- The Provider performing the moderate sedation should bill for the moderate sedation and an independent observer is not necessary to monitor the Patient.

Infusions

Documentation/Medication Administration Record should include:

- Physician order
- Name and dosage for each medication
- Route and site of administration
- Duration (start/stop) for each infusion
- Signature and credentials/licensure of the person administering the drug

When billing Infusion Administration CPT codes that are inclusive of a time span, documentation should include corresponding start/stop times. Please note that initial hour is up to 90 minutes. Once an infusion lasts longer than 90 minutes you can use the "additional hour" code. "Each additional hour" means increments greater than 30 minutes over the initial hour. Do not include time spent keeping veins open.

Establishing a formal compliance plan will help your office maintain compliant medical records. It is recommended that offices regularly review records to they ensure complete and accurate as part of an internal review process. This will assistant in being prepare record retrieval request and external audits.

NCCI (National Correct Coding Initiative) edits: separately identifiable procedures

PHP uses clinical edits in the processing and payment of all medical claims. All medical claims are subject to PHP clinical edits. Clinical edits focus upon correct coding methodologies and accurate adjudication of claims. The NCCI edits include edits for Physicians/Practitioners and outpatient hospital services.

NCCI edits define when two procedure codes may not be reported together except under special circumstances. When looking at the NCCI table, the paired codes are listed in column 1 and column 2. There are indicators of "0" modifier not allowed, "1" a modifier is allowed, "9" codes can be billed together without a modifier.

Two procedure codes may be reported together if there is documentation in the medical record that satisfies the criteria required by the NCCI-associated modifier used. Please keep in mind the following when considering the use of modifier -59. Modifiers -XE, -XP, -XS, or -XU may be used in place of modifier -59.

- A practitioner should not report multiple codes corresponding to component services if a single comprehensive code describes the services performed.
- A practitioner should not unbundle services that are integral to a more comprehensive procedure or bilateral procedure code.
- When modifier -59, -XE, -XP, -XS, or -XU is applied, documentation must support that both services are distinct or independent of one another.

When billing PHP, please review general industry billing standards prior to submitting your claim, including, but not limited to, the American Medical Association's (AMA) CPT Manual, Centers for Medicare and Medicaid Services (CMS) and National Correct Coding Initiative for Medicare Services (NCCI).

Note: Modifiers can only be appended if the circumstances of the procedure require a modifier to accurately describe the services rendered and only when documented in the medical record. Procedures appended with modifiers will be subject to review and documentation may be required for validation of separately identifiable procedures.

The most current NCCI Edit table is available at **CMS.gov**.

Using modifiers 54, 55, and 56

Split surgical care

When components of a global surgical procedure are provided by different Providers, each Provider is expected to report only the service(s) they provided and apply the appropriate modifier in accordance with correct coding guidelines established by the Centers for Medicare and Medicaid Services (CMS).

Modifier 54: Surgical care services only

When using modifier 54 the Surgeon is billing for surgical care only: pre, intra and inpatient postoperative care.

- When all or part of the post-operative care is relinquished to a Physician who is not a member of the same group and does not apply to assistant surgery services.
- Use modifier 54 when the CPT code has a global surgical period of 10- or 90-days surgical care only.
- Do not bill the global surgical code when another healthcare Provider provides post-operative care.

Do not include any of the preservice and post service work when calculating the interservice time.

If same Provider performs both the primary procedure and the moderate sedation

- Provider should bill for the moderate sedation; however, there must be a trained observer to assist.

If different Provider performs primary procedure and moderate sedation

- The Provider performing the moderate sedation should bill for the moderate sedation and an independent observer is not necessary to monitor the Patient.

Modifier 55: Postoperative services only

Modifier 55 indicates that a Physician other than the Surgeon is billing for the outpatient postoperative care. Or could be used if a Surgeon is providing a portion of the post discharge post-operative care.

- Post-operative period begins the day after surgery.
- The billing date of service must be the date of the surgery. In addition, the date care was assumed and relinquished must be on the 1500 form or the electronic equivalent.
- When two different Physicians share in the postoperative care, each bill for their portion - reporting modifier 55 and indicating the assumed and relinquished dates on the claim.
- Use modifier 55 when the CPT code has a global surgical period of 10- or 90-days surgical care only.

Modifier 56: Pre-operative management only

When a Physician performs the pre-operative care and evaluation only (another Physician performs the surgical procedure), the pre-operative component may be identified by adding modifier 56 to the appropriate surgical CPT code(s).

- If there is no global package, the appropriate E&M service may be more appropriate to report.
- It is known that the surgical services/post-operative care will be performed by or transferred to another healthcare provider.
- Use modifier 56 when the CPT code has a global surgical period of 10- or 90-days surgical care only.
- Do not submit modifier 56 on E&M services.

Note: Modifiers 54, 55, and 56 are not appropriate for obstetric care procedure codes, as specific codes already exist to identify when more than one Provider provides antepartum, delivery, and postpartum care. In addition, these modifiers are not considered valid for the following Provider types:

- Assistant Surgeon
- Ambulatory Surgery Centers
- Inpatient/Outpatient Hospitals

Resource: WPSGHA.com

Top denial reasons for service requests

In Utilization Management (UM), we are continually working to get our Members the care and services they need. However, there are times when a request is denied. The following are the top three reasons for denial of a service request:

- Non-notification or no Prior Approval: this refers to a request for services that was not received prior to the service being rendered.
- Criteria not met: a denial is issued when the case is reviewed by a UM Nurse and the Medical Director and determined the medical criteria for the requested service was not met.
- Specific exclusion per benefit policy: this indicates that the service is excluded from the Member's benefit coverage.

To ensure the services and care rendered to our Members is covered and reimbursable, please consult our Notification and Prior Approval Table located on our website at **PHPMichigan.com/Providers** and select "Notification and Prior Approval Table" from the menu on the left.

If you have any authorization/approval questions, please call the Customer Service Department at **517.364.8500** or **800.832.9168** between the hours of 8:30 a.m. and 5:30 p.m., Monday through Friday.

Reminder: Prior authorization requests may be submitted via the Utilization Management fax at **517.364.8409** from 8 a.m. to 5 p.m., Monday through Friday.

Utilization Management news and updates

4th Quarter 2018

A comprehensive list of procedures and services requiring prior authorization/approval is available online. Visit **PHPMichigan.com/Providers** then select "Notification and Prior Approval Table" from the menu on the left.

If you have any authorization/approval questions, please call the Customer Service Department at **517.364.8500** or **800.832.9168** between the hours of 8:30 a.m. and 5:30 p.m., Monday through Friday.

Reminder: Prior Authorization requests may be submitted via the Utilization Management fax at **517.364.8409** from 8 a.m. to 5 p.m., Monday through Friday.

Changes to Coverage for Services			
Code(s)	**Procedure or Service**	**Action**	**Implementation Date**
S0265	Genetic counseling, under Physician supervision, each 15 minutes	Change from not covered to covered without review	1/1/2019
15777	Implantation of biologic implant (e.g., cellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk)	Remove prior approval, covered without review when service is due to a breast cancer diagnosis	1/1/2019
77293	Respiratory motion management simulation (list separately in addition to code for primary procedure)	Change from not covered to covered without review	Retro to 1/1/2018
33282	Implantation of Patient-activated cardiac event recorder	Remove prior approval requirement, covered without review	7/1/2018
C1764	Event recorder, cardiac (implantable)	Remove prior approval requirement, covered without review	7/1/2018
E0616	Implantable cardiac event recorder with memory, activator and programmer	Remove prior approval requirement, covered without review	1/1/2019
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	Remove prior approval requirement, covered without review	1/1/2019
E0485, E0486	Pre-fabricated or custom oral appliance	Change from covered to prior approval	1/1/2019
E0935, E0936	CPM exercise device for use on knee only and other than knee	Change from covered to not covered as unproven benefit	1/1/2019

Changes to Coverage for Services			
Code(s)	**Procedure or Service**	**Action**	**Implementation Date**
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	New policy – BCP 76 - Repair of Brow Ptosis; change from clinical edit review to prior approval	1/1/2019
97150	Therapeutic procedure(s), group (two or more individuals)	Change from prior approval required to not covered	1/1/2019
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment modification analysis, work task analysis, use of assistive technology device/ adaptive equipment), direct one-on-one contact, each 15 minutes	Change from prior approval required to not covered	1/1/2019
97545	Work hardening/conditioning; initial two hours	Change from prior approval required to not covered	1/1/2019
97546	Work hardening/conditioning; each additional hour (list separately in addition to code for primary procedure)	Change from prior approval required to not covered	1/1/2019

Urgent Care for when it isn't an emergency

People often visit the Emergency Room for situations that are not life threatening, even though they usually pay more and wait longer. Why? Because they don't know where else to go. There are options, however, that provide a better Patient experience and significant cost savings. Try to offer same-day appointments when the Patient has an urgent problem that is not life threatening. For those times when your office is closed or they can't get in to an opening, consider directing Patients to a Physicians Health Plan participating Convenience Care Facility or Urgent Care Center rather than the Emergency Room, when appropriate. Please visit our website at **PHPMichigan.com/Members/Find-a-Doctor**, to search the Provider directory for participating Physicians and facilities. When Patients receive the right care, in the right healthcare setting, Patient outcomes are improved and healthcare costs are reduced.

HEDIS Corner

Register Now: Free continuing education on Antibiotic Stewardship

The CDC's Office of Antibiotic Stewardship has launched the second section of a four-part web-based training course about antibiotic stewardship. While this particular course is primarily for clinicians who prescribe antibiotics, CDC recognizes that everyone plays an important role in improving antibiotic use. Physicians, Nurse Practitioners, Physician Assistants, Certified Health Education Specialists, Nurses, Pharmacists, and Public Health Practitioners with a master's degree in public health are all eligible to receive up to eight hours of free continuing education credit (CE). The first and second sections are available now, with sections three and four releasing later this year.

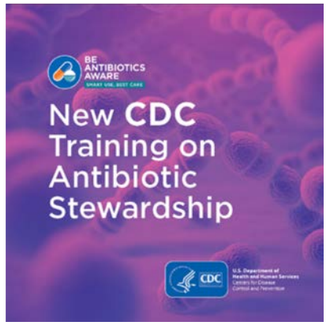
Topics in section two include:

- Background and errors in outpatient antibiotic use in the United States
- Inappropriate antibiotic use and opportunities for improvement
- The Core Elements of Outpatient Antibiotic Stewardship
- Communication training to improve clinician-Patient communication about appropriate antibiotic use

Visit the CDC Antibiotic Use Continuing Education page to learn more about this course and other continuing education opportunities.

Create an account and register for this course directly on CDC Train.

This course fulfills Improvement Activities (IA) Patient Safety and Practice Assessment (PSPA)_23 and PSPA_24 under the Centers for Medicare & Medicaid Services (CMS) Merit-Based Incentive Programs, or MIPS.



Working together to educate Patients on infection prevention

U.S. Antibiotic Awareness Week was Nov. 12-18 and Physicians Health Plan (PHP) joined in the effort to raise awareness of antibiotic resistance and appropriate prescribing and use.

According to the Centers for Disease Control and Prevention at least 30 percent of antibiotic courses prescribed in the outpatient setting are unnecessary, meaning no antibiotic was needed at all. Most of this unnecessary use is for acute respiratory conditions, such as colds, bronchitis, sore throats caused by viruses, and even some sinus and ear infections.

PHP's participation in this year's antibiotic awareness campaign focused on the public. The promotion of basic infection prevention included simple actions like covering coughs and sneezes and hand hygiene. Numerous Providers partnered with PHP in distributing hundreds of gift bags to Patients that contained soap sheets, tissue, hand sanitizer and information on why antibiotics aren't always the answer. Together we can improve antibiotic utilization with infection prevention.

Thank you to all who combined efforts to raise awareness and combat antibiotic resistance.

Michigan Quality Improvement Consortium (MQIC) develops and implements evidence-based clinical practice guidelines. Guidelines are designed to produce evidence-based recommendations that will improve the quality of care for Michigan residents. MQIC has guidelines for management of uncomplicated acute bronchitis in adults and Acute pharyngitis in children 3 – 18 years old.

Pregnancy, delivery, and post delivery classes to help with it all

PHP is now offering additional prenatal education classes at no cost through the Expectant Parent Organization (EPO). The following classes are now fully covered for PHP and SPN Members. Visit **Sparrow.org/EPO** to get more information and register for a class.

One-day Prenatal Seminar

- Third trimester; preparing your body for childbirth, labor and delivery, pain relief, comfort measures, medical interventions, postpartum care, newborn care and feeding

Prenatal Series (evening or Saturday morning)

- Third trimester; preparing your body for childbirth, labor and delivery, pain relief, comfort measures, medical interventions, postpartum care, newborn care and feeding

Labor & Delivery Refresher

- Third trimester; stretching and getting your body ready for labor, warning signs, preterm labor, labor and delivery, breathing, relaxation, comfort measures for labor, childbirth interventions

Prenatal E-class (30-day access)

- For moms on bed rest
- Covers same information as prenatal class

Natural Childbirth Series

- Recommended for those seeking natural childbirth with little to no medical intervention
- Labor and delivery, comfort and coping techniques, creating a support team, medical interventions, birth planning and informed decision making, helpful techniques to manage pain and unexpected interventions

The Best Newborn Care Class Ever

- Newborn care, crying baby, infant sleep
- Infant CPR and safety, safe sleep, car seat safety, sick baby, adjusting to parenthood
- Infant feeding, bottle and formula feeding, breastfeeding

Breastfeeding/Lactation Class

- How your body makes milk, making enough milk, positioning and latch, feeding cues
- Knowing when baby is getting enough, managing problems, pumping and storing, returning to work, community resources

Infant Safety with Infant CPR

- Infant CPR, choking, car seat safety, safe sleep, pet safety, home safety, safe formula preparation, managing crying for both infant and parent

Advance care planning

Patients have a right to take an active role in their own healthcare. Unfortunately, there are times - such as sudden illness or an accident - when this is not possible. As their Physician, you can play a key role in initiating and guiding the advance care planning process by making it a routine part of care for all Patients and revisiting their plan regularly to explore any changes a Patient may have in his or her wishes. This process ultimately benefits Patients by providing them with a sense of control and peace of mind about their future healthcare. It is also advisable for Physicians to do their own advance care planning.

It is important to support advance care planning decisions with formal documents, such as an advance directive. An advance directive might include a living will, through which a person indicates whether specific medical interventions would be desired, or a durable power of attorney for healthcare, whereby a Patient designates a specific person to act as their agent for healthcare decisions in the event the Patient is incapable of making such decisions.

Advance care planning affords Patients the opportunity to express their wishes regarding their medical care in the event they become incapable of active participation in healthcare decisions. The process provides individuals with the opportunity to determine their goals regarding health and medical treatment based on personal values, attitudes, and beliefs surrounding healthcare, illness, and death. It also enables individuals to communicate their wishes to their primary care Physician, their proxy, and loved ones. As a result of this process, if a Patient becomes incapacitated, parties involved in the Patient's care should have a common understanding of the Patient's healthcare wishes and what the Patient would want.

If you would like additional information or to print an advanced care plan please visit **CaringInfo.org**.

Medical record requests

Why records are requested

- High dollar review
- Pre/post payment audits

What to provide

Please provide all documentation supporting the item/service billed for corresponding date(s) of service on the request. Certain types of services may require specific documentation in addition to notes. Please use the chart below as a reference when compiling documentation for requests.

Things to remember

- Be sure to submit records by deadline.
- Failure to provide complete information may result in reduced and/or delay of reimbursement.
- The person who is requesting records. Notes may be requested on the behalf of the Health Plan by one of our vendors. Please submit documents to the address on the request.
- Failure to submit notes to the requested address may result in a delay of reimbursement.
- Documentation must support the service(s) billed and be accurately documented in the medical record.
- Time Based Codes require documented start and stop times.

Acceptable Documentation	
Type of Service	**Supporting Documentation**
Ambulance Services	Ambulance log/trip sheet (mileage, point of pick up, point of destination...)
Anesthesia Services	Start/stop times for time-based services, what drugs were administered, dose, physical status, Patient response, monitoring of vitals, and any complications
Behavioral Health Services	Start/stop times for time-based services, who is present during session (group/individual)
DME	Description, manufacturer's invoice, unit cost, proof of delivery
Drugs/Drug Administration	Medication reports, dosing, prescribing Physician, requisition order, administration report (Infusion start/stop times, single/initial...)
Implantable Devices	Implant log, manufacturer's invoice
Lab/Pathology Service(s)	Physician order, lab/path report (including full detail-date and time of collection/receipt, results, margins, descriptions)
Radiology	Order, date and time of study
Skin Grafts	Clinical notes, medication record, operative report, invoice and the name of graft used
Surgical Supplies	Invoice, Itemized statement including Revenue Codes
Unlisted Drugs	NDC number, drug name, dosage, medication report & documented waste, if applicable
Unlisted Surgical Procedure	Operative report, consult notes

Tobacco cessation and New Year's resolutions

Every Jan. 1, people all over the world make New Year's resolutions. Statistics show that seven in 10 U.S. smokers want to quit. Why not help them make a resolution to quit smoking? Smoking is still the number one cause of preventable death and disease in the United States.

PHP would like to encourage Providers to help our Members choose this New Year as their time to quit. We believe that it's important to provide you and our Members with the tools needed to quit smoking. Knowledge is power, and we're here to help our Members get to where they want to be.

PHP provides, through our tobacco cessation program, educational materials, healthcare reminders and a Healthy Roads Coach to help your Patients work through challenges and keep them motivated to quit.

Our Tobacco Cessation program

- Helps build confidence about quitting
- Offers support
- Helps with staying on track
- Helps the Member think positively about quitting
- Helps pinpoint triggers
- Helps to develops skills and tools to cope

Your Patients learn to deal with triggers by

- Using new strategies
- Coping with cravings
- Planning for success
- Developing a new self-image

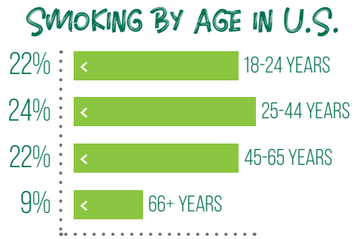
To help a PHP Member get started on their journey to better health, have them call Healthy Roads at 1.877.330.2746 or visit HealthyRoads.com. This program is offered free of charge to PHP Members through Healthy Roads.

QUIT SMOKING

5 TRILLION
cigarettes are sold each year to the
1,350,000,000
people who smoke worldwide.

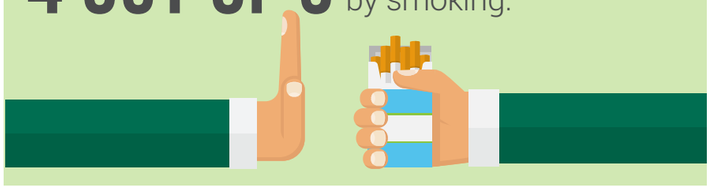
COPD Chronic obstructive pulmonary disease
is a chronic infammatory lung disease caused by long-term exposure to irritating gasses, most often **cigarette smoke**. It is the **4th** leader in deaths in the US.

SMOKING BY AGE IN U.S.

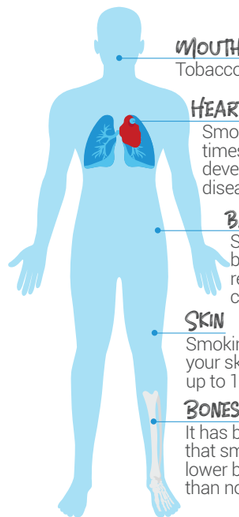


LUNG CANCER

is the leading cause of cancer deaths in the United States. It is one of the easiest to prevent.
4 OUT OF 5 cases are caused by smoking.



REASONS TO QUIT SMOKING



MOUTH
Tobacco stains teeth.

HEART
Smokers are 2-4 times more likely to develop coronary disease.

BLOOD
Smoking damages blood vessels, resulting in poor circulation.

SKIN
Smoking ages your skin by up to 19 years.

BONES
It has been found that smokers have a lower bone density than non-smokers.

LIFE EXPECTANCY
Within a year of quitting, your risk of heart attack declines by 50 percent. Within 10 years, your risk of lung cancer will be about the same as if you'd never smoked at all.

TASTE
Without smoke to interfere with your taste buds and sense of smell, food will taste better.

ENERGY LEVELS
An increased amount of oxygen to the bloodstream results in higher energy levels.

CHOLESTEROL
Smoking reduces HDL ("good") cholesterol and may alter LDL ("bad") cholesterol, leaving plaque in arteries.

Sources:

American Cancer Society | Cancer.org
American Heart Association | AmericanHeart.org
American Lung Cancer Association | Lung.org
Center for Disease Control and Prevention | CDC.gov
Healthline Networks | HealthLine.com
Health Watch Center | HealthWatchCenter.com
Mayo Clinic | MayoClinic.org
National Cancer Institute | Cancer.gov
The National Center for Biotechnology Information | NCBI.nlm.nih.gov
Quit | Quit.org

Physicians Health Plan

Local. Personal. Flexible.

Pharmacy Department news and updates

Every Jan. 1, people all over the world make New Year's resolutionsas through Healthy Roads.

PHP's Prescription Drug List (PDL) as well as criteria for medications requiring prior authorization/approval (PA) are available online. Please visit **PHPMichigan.com/Providers** and select "Pharmacy Services."

If you have any pharmacy related questions, please call the Pharmacy Department at **517.364.8545** or email us at **pharmacy@phpmm.org.**

New to market drugs and additions to formulary

Drug Class	Drug	Coverage Decision	Effective Date
Glaucoma	Rhopressa (netarsudil)	» New medication to market » Added to formulary at Tier 3 with step Therapy » Step Therapy: trial of preferred ophthalmic prostaglandin	7/1/2018
HIV	Symfi, Symfi Lo (efavirenz, lamivudine, TDF)	» New medications to market » Added to formulary at Preferred Specialty Tier	7/1/2018
	Cimduo (lamivudine, TDF)		
	Trogarzo (ibalizumab-uiyk)	» New medication to market » Added to formulary at Non-Preferred Specialty Tier with prior authorization/approval required	
Migraines	Aimovig (erenumab-aooe)	» New medication to market » Added to formulary at Preferred Tier 2 with step Therapy » Step Therapy: trial of both a preventative migraine agent and a triptan within the last 180 days	9/1/2018
Opioid dependence	Buprenorphine/naloxone sublingual film	» New generic to market » Added to formulary at Tier 1	9/1/2018
Autoimmune	Xeljanz, Xeljanz XR (tofacitinib)	» Added to formulary at Preferred Specialty Tier 2 with prior authorization/approval required	1/1/2019
Asthma/COPD	Fluticasone/salmeterol (generic to Airduo)	» New generic to market » Added to formulary at Tier 1	1/1/2019

Formulary changes

Drug Class	Drug	Coverage Decision	Effective Date
Opioid Dependence	Zubsolv (buprenorphine/naloxone) sublingual tablet	» Removal of prior authorization/ approval requirement	9/1/2018
Atopic Dermatitis (eczema)	Eucrisa (crisaborole)	» Removal of prior authorization requirement » Implementation of step therapy through topical calcineurin inhibitors	9/1/2018
Asthma/COPD	Incruse Ellipta (umeclidinium)	» Down-tier to preferred Tier 2	1/1/2019
	Spiriva Respimat (tiotropium)		
	Bevespi (glyco-pyrrolate/formoterol)		
	Arnuity Ellipta (fluticasone)		
	Tudorza (aclidinium)	» Up-tier to non-preferred Tier 3 » Preferred agents within the class: Spiriva, Spiriva Respimat, Incruse Ellipta	
	Dulera (mometasone/ formoterol)	» Exclude from formulary » Formulary alternatives: Advair Diskus, Advair HFA, fluticasone/salmeterol, Breo, Symbicort	
Cholesterol	Livalo (pitavastatin)	» Exclude from formulary » Formulary alternatives: atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, and simvastatin	1/1/2019
Diabetes	Tradjenta (linagliptin)	» Exclude from formulary » Formulary alternatives: Janumet, Januvia	1/1/2019
	Jentadueto, Jentadueto XR (linagliptin/metformin)		
	Actoplus Met XR (pioglitazone/metformin)	» Exclude from formulary » Formulary alternatives: generic pioglitazone and metformin	
Dry Eye	Xiidra (lifitegrast)	» Down-tier to preferred Tier 2	1/1/2019
IBS-C	Linzess (linaclotide)	» Down-tier to preferred Tier 2	1/1/2019
NSAID	Naprelan (naproxen)	» Exclude from formulary » Formulary alternatives: naproxen generics	1/1/2019
Overactive Bladder	Myrbetriq (mirabegron)	» Down-tier to preferred Tier 2 » Remove step therapy requirement	1/1/2019
	Vesicare (solifenacin)		
	Oxytrol Patch (oxybutynin)	» Exclude from formulary » Formulary alternatives: tolterodine, oxybutynin (oral), darifenacin, Myrbetriq, Vesicare, Toviaz	
Topicals	Selenium sulfate 2.25% shampoo	» Removal of non-FDA approved products from formulary	1/1/2019
	Salicylic acid 6% shampoo		

Drug coverage within the HIV class	
Protease Inhibitors	
Tier 1 Generics:	atazanavir, fosamprenavir, lopinavir-ritonavir, ritonavir
Preferred Brands:	Prezista, Prezcobix
Non-preferred Brands:	Evotaz, Lexiva, Crixivan, Kaletra, Invirase, Aptivus, Viracept
NNRTIs	
Tier 1 Generics:	efavirenz, nevirapine
Preferred Brands:	Odefsey, Complera, Intelence, Symfi, Symfi Lo
Non-preferred Brands:	Rescriptor, Atripla, Edurant
INSTIs	
Preferred Brands:	Biktarvy, Genvoya, Isentress, Isentress HD
Non-preferred Brands:	Tivicay, Juluca, Triumeq, Viteka, Stribild
NRTIs	
Tier 1 Generics:	abacavir, abacavir-lamivudine-zidovudine, lamivudine, lamivudine-zidovudine, tenofovir DF, zidovudine
Preferred Brands:	Emtriva, Descovy, Truvada, Cimduo
Non-preferred Brand:	Epzicom
Fusion Protein Inhibitor	
Non-preferred Brand:	Fuzeon
CCR5 Antagonist	
Non-preferred Brand:	Selzentry
Post-attachment inhibitor, monoclonal antibody	
Non-preferred Brand:	Trogarzo IV (PA required)

Did You Know?
PHP covers generic statins at no cost to Members*:

Beginning Jan. 1, 2018, the following medications have been available to Members 40-70 years of age for **$0 copay**:

- Atorvastatin 10 mg and 20 mg
- Fluvastatin 20 mg and 40 mg
- Fluvastatin ER 80 mg
- Lovastatin 10 mg, 20 mg, and 40 mg
- Pravastatin 10 mg, 20 mg, 40 mg, and 80 mg
- Rosuvastatin 5 mg and 10 mg
- Simvastatin 5 mg, 10 mg, 20 mg, and 40 mg

** Note: for Members through 39 years of age, and Members age 71 and greater, the copay will still apply at the tier 1 benefit*

Physicians Health Plan

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Department	Contact Purpose	Contact Number	Email Address
Medical Resource Management	» Notification of procedures and services outlined in the Notification/Authorization Table » To request benefit determinations and clinical information » To obtain clinical decision-making criteria » Behavioral Health/Substance Use Disorders Services, for information on mental health and/or substance use disorders services including prior authorizations, case management, discharge planning and referral assistance	517.364.8560 866.203.0618 (toll free) 517.364.8409 (fax)	
Network Services	» Credentialing - report changes in practice demographic information » Coding » Provider/Practitioner education » To report suspected Provider/Practitioner fraud and abuse » EDI claims questions » Initiate electronic claims submission	517.364.8312 800.562.6197 (toll free) 517.364.8412 (fax)	**Credentialing** PHP.Credentialing@phpmm.org **Provider Relations Team** PHPProviderRelations@phpmm.org
Quality Management	» Quality Improvement programs » HEDIS » CAHPS » URAC	517.364.8000 877.803.2551 (toll free) 517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org
Customer Service	» To verify a covered person's eligibility, benefits, or to check claim status » To report suspected member fraud and abuse » To obtain claims mailing address	517.364.8500 800.832.9186 (toll free) 517.364.8411 (fax)	
Pharmacy Services	» Request a copy of our Preferred Drug List » Request drug coverage » Fax medication prior authorization forms » Medication Therapy Management	517.364.8545 877.205.2300 (toll free) 517.364.8413 (fax)	**Pharmacy** PHPPharmacy@phpmm.org
Change Healthcare (TC3)	» When medical records are requested	**Mail To:** Change Healthcare 5755 Wayzata Blvd, St. Louis Park, MN 55416 949.234.7603 (fax) 952.949.3713	medicalrecords@changehealthcare.com