Provider Connection

THIRD QUARTER 2020

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When to Appeal a Claim vs. Submit a Claim Adjustment

Provider Appeals

A provider appeal is a written request, submitted by a provider, to reconsider a decision made by PHP about a specific member. The decision may be about a member's medical benefit or a specific request to change a complete or partial claim denial. These types of decisions are referred to as Adverse Benefit Determinations.

Several types of Adverse Benefit Determinations may be appealed. Adverse Benefit Determination Provider Appeals are categorized into three general types.

- » **Benefit Level Appeal:** An appeal of the benefit level that the claim processed at (e.g., network vs. non-network).
- » **Administrative Appeal:** An appeal based on a provision in the member's Certificate of Coverage, other benefit documents, or the provider's contract with PHP.
- » **Claim Appeal:** An appeal of the way a claim processed (e.g., reimbursement amount, clinical code edits, denial, reduction, timely filing, etc.).

Appeals must be submitted no later than **90 days** from the date of the initial claim denial or Adverse Benefit Determination. Appeals can be submitted by completing the **Provider Appeal Form**, located under "Forms" in the MyPHP Provider Portal, or at **PHPMichigan.com/Providers/General-Forms-and-Information**. The completed Provider Appeal Form should be returned to PHP by:

- » Mail | P.O. Box 30377, Lansing, MI, 48909, or
- » Fax | 517.364.8411

Documentation to support your reasoning for the appeal should accompany the appeal form. Documentation could include clinical notes, hospital itemization, invoices, correspondence regarding the claim in question (including names of who you spoke to, dates and times of calls, etc.), reference to the member's benefit language, your specific provider contract language, and any other additional information that you believe is relevant.

Once your Provider Appeal Form is received by PHP, you will receive a letter of acknowledgment in five to 10 calendar days. If additional documentation is needed by PHP, you will receive a fax or phone call, and will be provided two weeks to respond. After a thorough investigation, a notification of a decision will be mailed within 30 days of the receipt of your appeal. If a letter or communication from PHP is not received, please reach out to PHP Customer Service at 800.832.9186.

Only one appeal can be requested for each date of service, claim, or denied authorization. Any appeal that is received by PHP after the 90-day submission timeline will not be considered.

Claim Adjustments

To resubmit corrected claims data that was previously submitted incorrectly, a **Claim Adjustment Request** is the correct tool to use. To request an adjustment of a claim previously allowed by PHP, use the Claim Adjustment Request Form, which can be found under "Forms" in the MyPHP Provider Portal, or at **PHPMichigan.com/Providers/General-Forms-and-Information**. A corrected claim must accompany the Claim Adjustment Request. Requests for adjustment(s) must be submitted within the six-month period from the date of service or date of discharge. When PHP is not the primary carrier, claims need to be submitted for adjustment within six months from the date on the primary carrier's Explanation of Payment (EOP).

Some of the primary reasons to request a **Claim Adjustment** are:

- » **Coordination of Benefits:** Be sure to include the Primary Carrier EOP.
- » **Incorrect Provider or Member Information:** Make sure a new claim with the correct information is attached.
- » **Corrected Code(s):** Attach the corrected claim and provide a written description of the correction.

Top Denial Reasons of 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 service requests:

- **Non-Notification:** this refers to a request for services that were not requested prior to the service being rendered.
- **Criteria Not Met:** this reason is issued when a review of the case was done by a UM nurse and the medical director, and the medical criteria for the requested service were not met.
- **Specific Exclusion per Benefit Policy:** this indicates that this service is excluded from the member's benefit coverage.

**Information on policies is also available inside the MyPHP Provider Portal.*

Why are Prior Approvals Required?

Certain healthcare services require prior approval from PHP for coverage of services or products. Healthcare providers must get prior approval from PHP before services can be provided. If prior approval is not obtained, benefits for a covered health service may be reduced or not covered entirely. The member may be responsible for non-covered charges.

To request prior approval, call the number on the member's ID card or 517.364.8500 to reach Customer Service. By calling PHP prior to a treatment or service being rendered, you can verify if the service

- is considered cosmetic,
- has a benefit limit,
- is experimental, investigational, or unproven, or
- is specifically excluded under a benefit plan.

A prior approval is not a guarantee of benefits. Coverage depends on the services that are received, a member's eligibility status at the time of service, and any benefit limitations or exclusions.

To ensure that services and care rendered to our members are covered and reimbursable, please review our Notification and Prior Approval Table located on our website at **PHPMichigan.com/Providers** and select "Notification and Prior Approval Table" from the left sidebar.

Remember to Check Member Benefits

It is important to also check the member's benefits, as some members do not have non-network benefits or may have specific exclusions. To find a network facility or practitioner, please refer to the online PHP Provider Directory at **PHPMichigan.com/Members/Find-a-Doctor**. To check member benefits, review the Member Reference Desk at **PHPMichigan.com/MyPHP**.

If you have any questions regarding authorization, denial, benefits, or exclusions, please call PHP Customer Service at 517.364.8500 or 800.832.9168, 8:30 a.m. to 5:30 p.m., Monday through Friday.

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

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. Practice managers and all office staff are welcome to register for these trainings. Due to COVID-19, the trainings will be conducted through webinars.

Oct. 15, 2020 | noon to 1:30 p.m.

Please email your RSVP at least one week prior to the event to **PHPProviderRelations@phpmm.org**. Please include the date of the training as well as the first and last names and roles of those attending from your office.

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

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

MyPHP Provider Portal Tips, Tricks, and Frequently Asked Questions

MyPHP is an online tool available for you to:

- » Verify member benefit information including eligibility, copays, coinsurance, and deductibles
- » Check the status of an outpatient or inpatient authorization/approval
- » Check the status of your submitted claims
- » Review EOP, ERA, and EFT information
- » Search for network providers
- » Obtain 24/7 access to the forms and information you need
- » And much more!

Questions you may have the during registration process

What are the character requirements for my username and password?

Your username must be at least three characters in length and start with a letter. Characters accepted are alpha-numeric, . (dot), - (dash), _ (underscore), and @ (at sign).

Your password must be a minimum of eight characters in length and include one letter, one number, and one special character. Special characters accepted are -_.!#$%&*@~^\?/+

I have multiple providers in my office. Do I need a separate account for each provider?

No. You can add as many providers as required to a single profile for easy and convenient access to the MyPHP Provider Portal account.

I have multiple providers. Which TIN, NPI, and PHP Provider ID should I use?

It does not matter which provider information you choose to enter first, but you must enter each provider's TIN, NPI, and PHP provider ID that you need access for. After entering the first provider's information and for every additional provider, you must click "add" until you have entered in the information for all of the providers that you need to access. After the last provider is added, you will click "next" to continue completing the registration process.

What role should I select (PCP, PCP Office Staff, Specialists, Specialists Office Staff, Billing Specialists)?

The role you select is dependent on your position in the office:

- » **PCP:** Credentialed primary care physician.
- » **PCP Office Staff:** Anyone who works in an office for a credentialed PCP including on-site billing personnel.
- » **Specialist:** Credentialed specialty physician.
- » **Specialist Office Staff:** Anyone who works in an office for a credentialed specialist including on-site billing personnel.
- » **Billing Specialist:** Anyone who works in a billing capacity, not part of a PCP or specialist office staff, or third-party billing company.

Please choose the role that best describes your position within the office as your options in the portal are determined by the role you select.

I received an error stating "unable to match information", what does this mean?

The provider's TIN, NPI, and PHP provider ID must all match exactly with what PHP was provided with during the credentialing process. If you are having trouble locating this information, it is found on the provider's Explanation of Payment (EOP). If you are still receiving an error message, please contact the Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Troubleshooting

My access is denied, but I am sure my username and password are correct. Why?

Users must log in every 90 days or their account will be suspended (to protect PHI within the portal). To reactivate your account, please email Provider Relations at **PHPProviderRelations@phpmm.org**.

I am unable to view the patient information I am trying to access. Why?

There are a number of reasons the information may not be available:

- » Please verify that the member information is entered exactly as it appears on the member's PHP ID card.
- » MyPHP is real time data including current deductibles, copayments, and effective/termination dates. The amounts shown in the Accumulators are cumulative as of the date of viewing.
- » PHP Medicare Advantage member information is available in the PHP Medicare Advantage Provider Portal. The PHP Medicare Advantage Provider Portal can be easily accessed from the link on your MyPHP Provider Portal landing page.

» Carefully read the detailed instructions that appear under search fields:

Member ID(s):

Please enter the member's ID including the suffix. For example 123456789-00.

I am unable to search for claims with check number or EFT reference number. Why?

Please make sure that you entered the information exactly as it appears on your provider's EOP, paper check, or EFT payment reference ID. Entering more than the required number of characters is a common reason for the search to show "No Claims Found."

If you are still having difficulty and require further assistance with the MyPHP Provider Portal, please reach out to your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Incidental Services

Incidental services are performed during the same session as a more complex primary service. While most codes are reimbursable when billed independently they become incidental when billed with a more complex procedure. These services are not required to be performed at the same time but routinely are. Incidental procedures do not require significant additional work and require minimal additional provider resources.

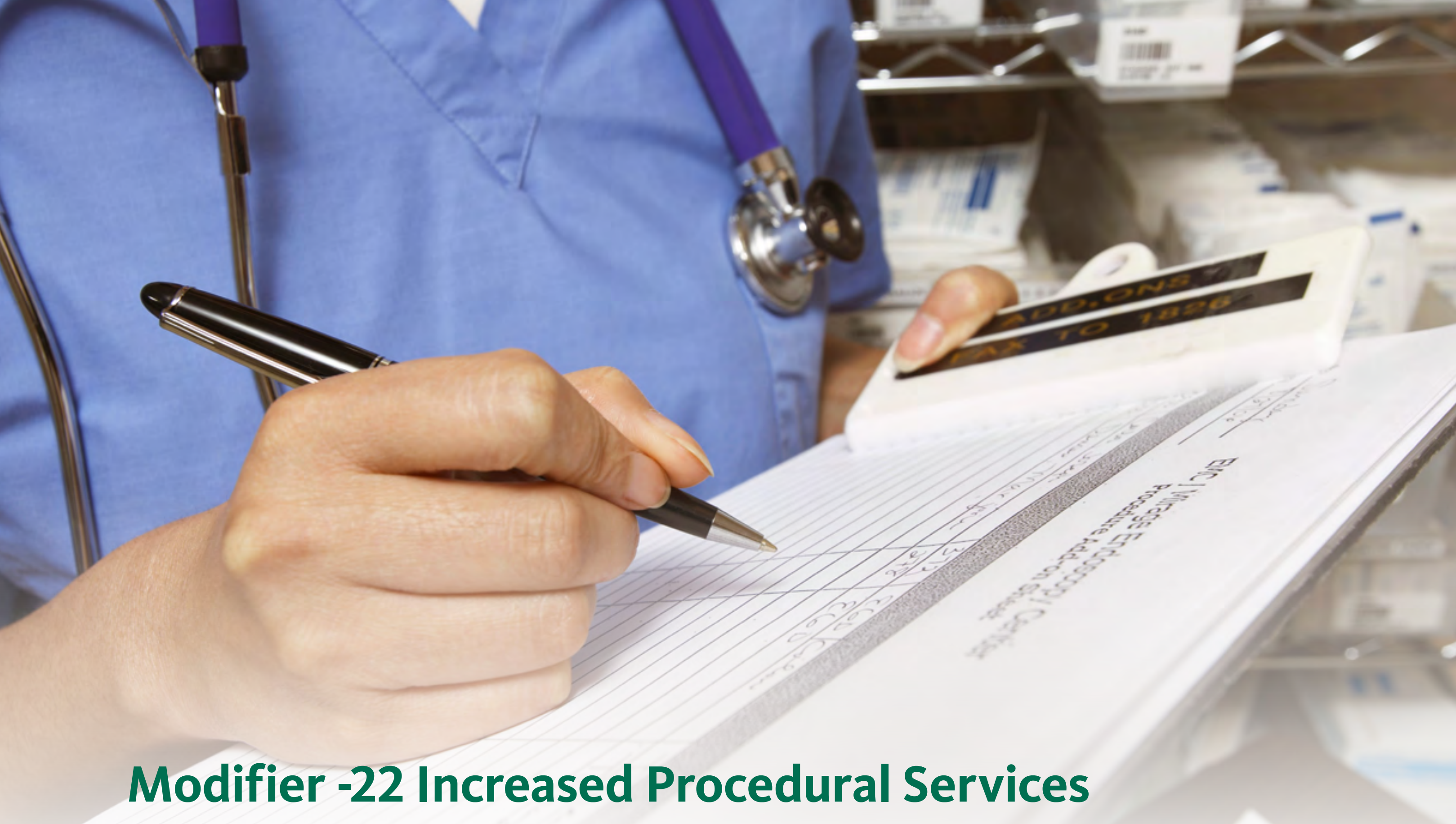
An example of this is when a urinalysis is performed during the same session as an Evaluation and Management (E/M) service. Urinalysis without microscopy (e.g. by dipstick or tablet reagent) represents a readily-available adjunctive component of an E/M service performed in an outpatient setting. The evaluation of these tests is inclusive of the medical decision making section component of an E/M service.

"Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by... The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed."

Therefore, the review and analysis of common diagnostic tests are included in the medical decision making component of the E/M service and should be appropriately documented in the patient's medical record.

While these codes are reportable, incidental services do not receive separate reimbursement when billed with an E/M service or more complex primary service.

Reference: Current Procedural Terminology (CPT)®



Modifier -22 Increased Procedural Services

When a service is provided that is substantially greater than typically required, it may be identified by adding modifier -22 to the usual procedure code. Difficulty alone does not justify appending modifier -22. The procedure must be unusually difficult in relation to other procedures of the same type. Documentation must support the substantial additional work and the reason for the additional work (e.g., increased intensity, time, technical difficulty of the procedure, and severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an Evaluation and Management (E/M) service.

PHP considers additional reimbursement when documentation supports the application of modifier -22.

Correct Use of Modifier -22

- The service provided required work effort substantially greater than what is standard to perform the service (e.g. time, technical difficulty, severity of patient condition).
- Anatomical variants.
- Assistant surgeon claims where a procedure is significantly greater than usual.
- Procedures having a global surgery indicator of 000, 010, or 090 on the Medicare Physician Fee Schedule Database.

Incorrect Use of Modifier -22

- If a complication occurs as a direct result of the approach selected by the performing physician.
- To describe services that are otherwise integral and inclusive of the procedure.
- When there is a more appropriate code that represents the additional work performed.
- Additional time alone, without proper support of the additional time.
- With E/M services.

Appropriate Documentation Needed

- Must be specific and clearly indicate substantially greater services than what is normally provided for the service:
    - Rationale for increased reimbursement.
    - Operative, pathology, radiology reports and other documentation that supports the increased procedure.
    - Complications, severity of patient status, or unexpected findings during procedure.

Examples of Cases Where the Application of Modifier -22 May Be Considered

- Anatomical irregularities requiring additional time (organ on opposite side of the body, e.g., Dextrocardia).
- Technical effort not normally required in other cases.
- Extensive trauma including complications and unusual circumstances.

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Usual, Customary, and Reasonable Charging

Usual, Customary, and Reasonable (UCR) charges represent a base amount that is considered the standard or common charge for a defined medical service performed in a particular geographic region. When a service isn't assigned a fee schedule rate and priced as a percent of charge, the UCR may be used to determine the final allowable amount for a service. Services should be billed within a reasonable percentage of the nationally established UCR charges based on their geographic region. Charges that exceed UCR charges for a defined service may be considered a billing error (e.g., coding, quantity) or abusive charging and will be considered for a reduction in allowable reimbursement.

In an effort to identify these potential billing errors and abusive charging, PHP monitors and audits claims on a pre-payment and/or post-payment basis as part of our Fraud, Waste, and Abuse Program. If an audit determines the services were billed in error or in excess of UCR charging per unit, the allowable amount may be reduced. This reduction is evaluated based on the type of service, and the pricing is differentiated by the region the provider is billing from to accommodate geographical pricing variations. Our Fraud, Waste, and Abuse Program utilizes national databases such as Red Book, ImplantDX, and Context4 to determine a service's UCR based on service category and geographic region. These national databases are updated regularly, comprised of current provider charges from around the country and segmented by percentile and geo-zip regions.

Surgical Services

PHP considers surgical services billed in excess of the 90th percentile of UCR by area zip code as possible abuse.

Drug Services

PHP considers drug charges in excess of 130% of Average Wholesale Pricing (AWP) as possible abuse.

Implantable Supplies/Devices (effective September 1, 2020)

PHP considers supplies and devices billed in excess of UCR, plus 15% to be possible abuse.

Claims and Appeals Documentation and Forms

This guide will assist your office team in selecting and completing claims and appeals forms.

Purpose	Form to use	Items to include	Items to review prior to submitting appeal	Where to send
› Primary EOP › Claim corrections › Billed incorrect provider › Incorrect member › Information incorrect › Codes or dates billed › Authorization on file claim needs to be reprocessed	**Claim Adjustment**	› Claim number › Anything you're adjusting › Primary EOP › Hard copy of the claim for UB or 1500	› Do I have all documentation? › Do I have my form filled out completely? › Do I have a hard copy of a UB or 1500 if needed?	Claim Adjustments Physicians Health Plan P.O. Box 853936 Richardson, TX 75085-3936
› Denial for notes › Denial for invoice › Request/letter for notes › Request/letter for invoice	**Record Request**	› Where is this being sent? › Is it going to CHC or PHP? › Look at denial and form for directions. › Do I have all of the information on invoice? › Do I have my invoice blacked out? › Invoice must be legible › Notes must be legible		**Physicians Health Plan** P.O. Box 853936 Richardson, TX 75085-3936 **Change Healthcare** Fax: 949.234.7603 **Email:** medicalrecords@changehealthcare.com **Mail:** Change Healthcare 5755 Wayzata Blvd St. Louis Park, MN 55416
› Timely file denial › Questioning claim edits › Reimbursement rate discrepancy › Non-covered codes › Denied authorizations › Benefit level › Misinformation	**Appeal**	› Medical records for that date of service or related to this service › Itemized invoices › Claim edit research › Timely filing documentation showing claims submission or correspondence › Reimbursement rate discrepancy › Provide contract language › Provide Auth and date range of approval	› Do I have everything? › Is my appeal within 90 days from date on last EOP – if it is over you are past your appeal rights › Have I already appealed this claim – you only have one appeal right per DOS/ Claim ID	**Mail to:** P.O. Box 30377 Lansing, MI 48909 **Fax to:** 517.364.8411
› Claim status would like you to have 5 or more inquires	**Claim Inquire**	› Name, DOS, Subscriber number, Claim number, Information needed, Legible fax back number › Have you looked at MyPHP for a Status?		Physicians Health Plan P.O. Box 30377 Lansing, MI 48909 Or **Fax to:** 517.364.8411

Drugs New to Market

Drug Name	Formulary Action
Recarbrio (imipenem, cilastatin, relebactam IV solution)	Medical PA
Caplyta (lumateperone capsule)	Tier 3, Step Therapy
Ayvakit (avapritinib tablet)	Tier 3/4, PA
Padcev (enfortumab vedotin IV solution)	Medical PA
Tepezza (teprotumumab IV infusion)	Medical PA
Tazverik (tazemetostat tablet)	Tier 3, PA
Fetroja (cefiderocol sulfate tosylate IV solution)	Medical PA
Xcopri (cenobamate tablet)	Tier 3/4, PA
Nexletol (bempedoic acid tablet)	Tier 2, PA
Nurtec (rimegepant disintegrating tablet)	Tier 4, PA, Quantity Limit #15 per month
Ubrelvy (ubrogepant tablet)	Tier 4, PA, Quantity Limit #15 per month
Reyvow (lasmiditan succinate tablet)	Tier 4, PA, Quantity Limit of #4 per month for 50mg dose, #8 per month for 100mg dose
Koselugo (selumetinib sulfate capsule)	Tier 4, PA
Isturisa (osilodrostat phosphate tablet)	Tier 4, PA

PA – requires Prior Authorization

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.

Changes to Current Formulary

Drug Name	Formulary Action
Truvada & Descovy	Cover PrEP drugs at $0 copay of all ACA qualified plans

Important Things to Remember When Submitting a Prior Authorization Request Form

- The Medication Authorization Form is located at **PHPMichigan.com/providers** on the Pharmacy Services tab.
- Fill out form completely and legibly.
- If requesting an infusion drug, please include the name of the office and/or facility and NPI number of where the drug will be administered.
- Provide accurate provider contact information:
  - Contact person's name
  - Phone number
  - Fax number
- Include the patient's most current chart notes documenting their status as well as clinical documentation of previous medication trials related to the request.
- Submissions from CoverMyMeds are routinely transmitted with incomplete information or we have experienced delays which impacts care for the patient. Sending requests directly to PHP will reduce the time it takes to process the request.

New Specialty Drug Site-of-Care Policy

Update: Ocrevus added effective Oct. 1, 2020

PHP encourages a strong relationship between our members and providers, while providing cost-effective care. On July 1, 2019, to provide consistency and to align with industry practices, PHP implemented new site-of-care requirements. The following list of medications requires administration to occur in a non-facility setting, such as in your office or by a home infusion provider.

Medication brand names	Generic name	HCPCS codes
Benlysta	belimumab	J0490
Xgeva, Prolia	denosumab	J0897
Privigen, GamaSTAN, Cuvitru, Bivigam, Gammaplex, Hizentra, Gamunex-C, Gammaked, Carimune, Octagam, Gammagard, Flebogamma, Hyqvia, others	immune globulin	J1459, J1460, J1555, J1556, J1557, J1559, J1560, J1561, J1562, J1566, J1568, J1569, J1572, J1575, J1599
Simponi Aria	golimumab	J1602
Remicade, Inflectra, Renflexis	infliximab	J1745, Q5103, Q5104
Xolair	omalizumab	J2357
Stelara	ustekinumab	J3357
Entyvio	vedolizumab	J3380
Ocrevus	ocrelizumab	J2350

Place of service exceptions may be made when submitting a prior approval request. **Prior approval of the medication is required before outpatient administration, regardless of the site of service.** Members with active authorizations are not subject to the program requirements until prior approval renewal on or after July 1, 2019. This program does not include oncology medications. This program does not apply to the self-funded SHS products (groups L0001269 or L0000264).

If you have questions regarding the PHP site-of-care policy, please visit our website at **PHPMichigan.com/Providers** or contact PHP Customer Service at 800.832.9186.

Evaluation and Management Coding: Office and Other Outpatient Services

On occasion claims billed with Evaluation and Management (E/M) services are audited to ensure proper reimbursement for services rendered. These audits may be done pre-payment, post-payment, for a single claim, or for multiple claims. When an audit is performed by Physicians Health Plan (PHP), the provider first receives a request for medical records. When PHP receives the medical records, the documentation is reviewed against the E/M level billed.

The following is reviewed when determining the correct E/M CPT® Code:

- E/M coding for office and other outpatient services is first identified as either a new patient or established patient visit. A patient is considered established if they have received services from a provider or provider within the same group in the last three years.
- **Patient History:** Documentation of History of Present Illness (HPI) elements, Review of System (ROS), and Past Medical, Family, Social History (PFSH).
- **Physical Examination:** Documentation of organ systems reviewed, body areas examined, and findings.
- **Medical Decision Making:** Documentation of the following (including but not limited to) established and new problems, the state of these problems being treated, additional work up ordered, medical record review, lab/imaging test results reviewed, risk factors, surgery, therapy, medication administration, and independent visualization as applicable to the visit.
- If the visit is to be considered for time-based coding, documentation needs to clearly state the total face-to-face time between physician and patient and the amount of time spent counseling and/or coordination of care.
- The extent of documentation regarding these components determines support of the visit as problem focused, detailed, or comprehensive and the complexity level of medical decision making. For example, a new patient level 5 code (99205), requires all three of the following components to be met: comprehensive history, comprehensive exam, and medical decision making of high complexity.

Submission of claims with services billed at a higher level than what is documented in the medical record is considered up-coding. The majority of up-coding occurs due to miscoded claims by one level. PHP has traditionally denied the service line in full and requested a corrected claim

when an audit results in findings of "up-coded" services. In an effort to minimize the time and cost associated with the back and forth of denials and corrections, PHP is implementing a new process where the allowable claim will be adjusted to the level of E/M supported by the documentation. This allows for providers to receive proper payment in a timelier manner. For example, a claim is submitted with CPT 99205, but an audit of the office visit notes only supports a comprehensive history, comprehensive exam, and low complexity medical decision making. Instead of denying the service with $0 allowable, the claim will be adjusted to the supported E/M level 99204, priced at the contracted allowable for 99204, and the Explanation of Payment (EOP) will include explanation text indicating EM Level 4 Supported: Documentation audited and does not support the E/M billed, Records support level 4, payment reduced. If the adjusted level and payment are accepted by the provider, no further action is needed. If the adjusted level and payment are not accepted, providers may follow the provider appeal process as stated in PHP's Provider Manual found on our website. A clear narrative must be provided as to why the higher level is supported along with additional supporting documentation.

Referring Provider NPI Required for DME Encounters

Invalid or missing referring provider National Provider Identifiers (NPIs) are common for DME encounters. However, according to the *Encounter Data Submission Processing Guide*, section 6.2.10, the referring physician NPI is required for all DME encounters. As such, PHP also requires submission of the referring provider NPI for DME services.

The referring provider's NPI is also commonly missing or invalid for lab, imaging center, and home health agency encounters. While not a required submission, PHP encourages including the referring provider NPIs for these types of encounters as well.

1 Encounter Data Submission and Processing Guide Version 3.0 March 2019. https://csscoperations.com/internet/cssc4.nsf/files/ED_Submission_Processing_Guide_20190321.pdf/$FIle/ED_Submission_Processing_Guide_20190321.pdf, Accessed March 20, 2020

Therapy Minutes Required for Skilled Nursing Facility Authorizations

Coverage for Sub-Acute Rehabilitation (SAR) services provided in a Skilled Nursing Facility (SNF) or a hospital setting with beds licensed as a SNF requires prior authorization. During a SNF admission, a combination of physical, occupational, and speech therapy may be provided with the number of hours the patient receives generally between one and two hours a day.

Documentation of planned therapy minutes is required in order to determine the anticipated level of care for prior authorization, and is also required to support any changes in the level of care during the SNF admission.

To avoid potential delays when obtaining prior authorization for SAR services, always include in the request:

- **Physical, occupational, and speech therapy *time per day*, for at least five days per week and *total therapy minutes* for each week.**

In addition to including therapy minutes in the prior authorization request, the following should be supported on an ongoing basis in the medical record:

- Patient requires skilled services (i.e., services that must be performed by, or under the supervision of, licensed personnel for safety and to achieve the medically desired result).
- **Physical, occupational, and speech therapy time per day, for at least five days per week.**
- Services can only be safely provided in an inpatient SNF and cannot be safely provided in a less restrictive clinical setting (e.g., at home with skilled home health services, or in an outpatient setting).
- Service Specific Level of Care (LOC) criteria are met.
- Legible physician and/or clinician signatures.
- Dated physician or Non-Physician Practitioner (NPP) order(s).

Ensuring that the level of care approved is the level of care billed can help avoid unnecessary claim processing delays and denials.

For more information, please refer to the Benefit Coverage Policy for Sub-Acute Rehabilitation (SAR) Services in a Skilled Nursing Facility (SNF), which is available on the MyPHP Provider Portal or reach out to the Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Time-Based Physician Services

Time matters when assigning CPT© codes. Several code categories include time-based codes such as psychiatry and physical medicine services. Code detail should be reviewed in full to identify specific time parameters within the descriptions.

When selecting codes with time parameters review and assess the following:

- » Minimum amount of documented time to support the billing of the code.
- » Face-to-face interaction for the duration of time billed.
- » Supporting documentation of time.
- » Total duration of encounter, face-to-face time, and start and stop times for procedures.

Psychiatry Services and Procedures

Example:

90837 Psychotherapy, **60 minutes** with patient

- » This code should be billed only when there is **53 to 60** minutes of face-to-face interaction with the patient.
- » If documented face-to-face time does not meet a minimum of 53 minutes this code should not be billed.

Physical Medicine and Rehabilitation Services

PHP follows the Centers for Medicare & Medicaid Services (CMS) methodology for counting minutes for timed codes in 15-minute units. This is commonly known as the 8-minute rule. PHP recognizes that other commercial payers accept the Substantial Portion Methodology (SPM) rule for calculation of units, however PHP has elected to follow CMS documentation and billing guidelines. This calculation process can be found in full detail within CMS Pub 100-04, chapter five, section 20.2.

In addition to the 8-minute rule, chapter five of the CMS Medicare Claims Processing Manual also states a provider cannot bill units totaling more than the actual overall time spent treating the patient. If more than one CPT® code is billed for same date of service, the total number of units that can be billed are constrained by the total treatment time spent with the patient.

Example:

If 24 minutes of code 97112 and 23 minutes of code 97110 are provided during the same encounter, the total treatment time is 47 minutes; a maximum of three total units can be billed. The correct coding is two units of code 97112 and one unit of code 97110 (assign more units to the service that took the most time). For an additional unit to be supported, total treatment time would need to be 53-60 mins.

- » 97110 Therapeutic procedure, one or more areas, **each 15 minutes**; therapeutic exercise to develop strength and endurance, range of motion and flexibility
  - » 15 minutes, equals one billing unit

Evaluation and Management Services

While E/M services are not billed based on documented time alone, the code descriptions indicate typical face-to-face time spent. In most cases the level of an E/M service is determined by three key components: history, exam, and medical decision making. However, if the provider spends greater than 50% of the total visit time counseling/coordinating care, the time can be used as a key factor. Documentation must include: total face-to-face time, a clear narrative of the counseling/coordination (e.g. care plan, peer communication), and the time spent dedicated to counseling/coordination. In addition, a summary of time should be noted.

Example:

Total visit time = 40 minutes (face-to-face); > 50% spent counseling/coordinating care or 25 of 40 minutes spent counseling/coordinating care.

- » 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:
  - » A detailed history;
  - » A detailed examination;
  - » Medical decision making of moderate complexity.

Usually, the presenting problem(s) are of **moderate to high severity**. Typically, **25 minutes are spent face-to-face (bedside)** with the patient and/or family.

Type 2 Diabetes

More than 34 million Americans have diabetes (about 1 in 10), and approximately 90-95% of them have Type 2 Diabetes. Type 2 Diabetes most often develops in people over age 45, but more and more children, teens, and young adults are also developing diabetes.

Those at risk for developing Type 2 Diabetes include:

- Diagnosed with prediabetes
- Overweight
- 45 years or older
- Have a parent, brother, or sister with Type 2 Diabetes
- Are physically active less than 3 times a week
- Have ever had Gestational Diabetes Mellitus (GDM) or given birth to a baby who weighed more than 9 pounds
- African American, Hispanic/Latino, Native American, or Alaskan Native (some Pacific Islanders and Asian Americans are also at higher risk)

The recommended testing for prediabetes and future diabetes risk in asymptomatic adults includes:

- Testing should be considered in adults of any age who are overweight or obese (BMI ≥ 25 kg/m or ≥ 23 kg/m in Asian Americans) and have one or more risk factors.
- Risk factors include:
    - First-degree relative with diabetes
    - High risk race/ethnicity (African American, Hispanic/Latino, Native American, Alaskan Native, Asian American, Pacific Islander)
    - History of Cardiovascular Disease
    - Hypertension
    - High-Density Lipoproteins (HDL) DL <35 mg/dL and/or a triglyceride level >250 mg/dL
    - Women with polycystic ovary syndrome
    - Physical inactivity
    - Other conditions associated with insulin resistance (e.g. severe obesity, acanthosis nigricans)
- Women who were diagnosed with GDM should be tested at least every three years.
- For all people beginning at age 45.
- If tests are normal, repeat at a minimum of three-year intervals.
- Testing should also be considered in children and adolescents who are overweight or obese (BMI ≥85th percentile for age and sex) and who have additional risk factors (ADA Standards of Medical Care in Diabetes 2018, available at MQIC.org/guidelines).

Type 2 Diabetes can be prevented or delayed with proven lifestyle changes. The CDC offers a patient-friendly downloadable guide to preventing Type 2 Diabetes online at:

https://www.cdc.gov/diabetes/pdfs/prevent/On-your-way-to-preventing-type-2-diabetes.pdf

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Quality Corner

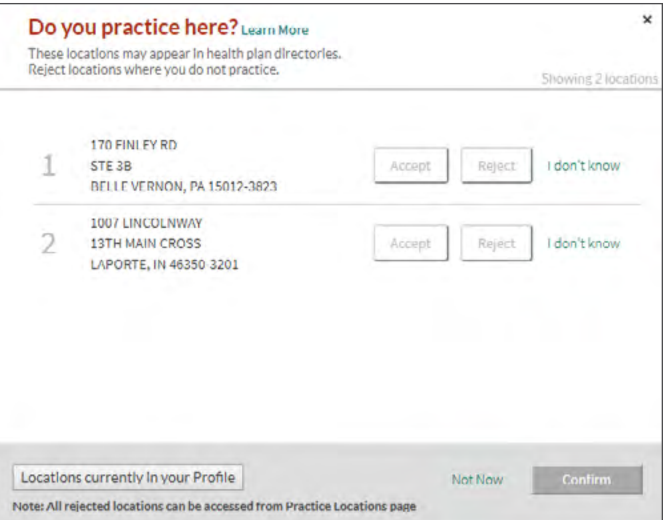
Physicians Health Plan wants to help patients find you.

Physicians Health Plan (PHP) is committed to ensuring we have the most up-to-date provider data. This helps members find your practice in directories when seeking care.

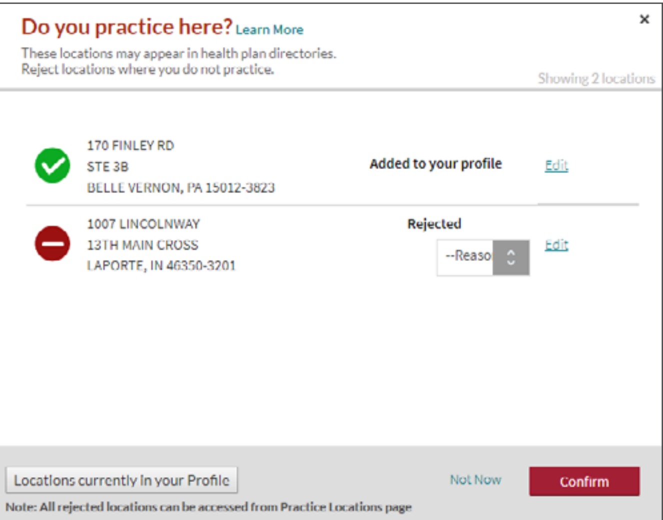
CAQH ProView® is the healthcare industry's resource for self-reporting practice information to health plans and other healthcare organizations. CAQH ProView® allows providers to submit directory updates to PHP and many of the nation's leading health plans.

Beginning in September 2020, CAQH ProView® will present to providers a list of locations previously submitted to PHP to include in the provider directories. Providers will be required to either **accept**, and include the listing in your profile, or **reject**, and remove the listing from your profile and PHP's provider directory.

Example: PHP presented '1007 Lincolnway' to the provider as an active practice in the PHP provider directory.



If this is correct, the provider will accept the location. If this is incorrect, the provider will **reject** the location and PHP will remove it from their directory.



If you would like to prepare for your next attestation, you can review the CAQH training video at **caqhproviderdirectory.org**. There is also a **Best Practice Checklist** you can use to ensure you are submitting accurate directory information through your CAQH ProView Profile.

If you have any questions, contact the PHP Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Documentation for Provider Refunds

Physicians Health Plan (PHP) would like to remind providers to include all pertinent information when submitting a refund check for the overpayment of claims. Please submit all appropriate supporting documentation to ensure that your refund checks are processed timely and accurately.

The necessary documentation required:

- Name of member/patient
- Date of service
- PHP claim number
- For partial refunds – please indicate the CPT/HCPCS and/or claim line that is being refunded
- PHP Explanation of Payment (EOP) or other carrier EOPs if refund is due to a coordination of benefits explanation for the refund

Manual refunds that are received with insufficient information may result in your refund being returned for additional information.

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

Contact us

Department	Contact Purpose	Contact Number	Email Address
Customer Service	» To verify a covered person's eligibility, benefits, or to check claim status » To report suspected member fraud and abuse » To obtain claims mailing address	517.364.8500 800.832.9186 (toll-free) 517.364.8411 (fax)	
Medical Resource Management	» Prior authorization of procedures and services outlined in the Notification/Authorization Table » To request benefit determinations and clinical information » To obtain clinical decision-making criteria » Behavioral Health/Substance Use Disorders Services, for information on mental health and/or substance use disorders services including prior authorizations, case management, discharge planning, and referral assistance	517.364.8560 866.203.0618 (toll-free) 517.364.8409 (fax)	
Network Services	» Credentialing - report changes in practice demographic information » Coding » Provider/Practitioner education » To report suspected Provider/Practitioner fraud and abuse » EDI claims questions » Initiate electronic claims submission	517.364.8312 800.562.6197 (toll-free) 517.364.8412 (fax) **Report Suspected Fraud and Abuse:** 866.PHPCOMP (866.747.2667)	**Credentialing** PHP.Credentialing@phpmm.org **Provider Relations Team** PHPProviderRelations@phpmm.org
Pharmacy Services	» Request a copy of our Preferred Drug List » Request drug coverage » Fax medication prior authorization forms » Medication Therapy Management	517.364.8545 877.205.2300 (toll-free) 517.364.8413 (fax)	**Pharmacy** PHPPharmacy@phpmm.org
Quality Management	» Quality Improvement programs » HEDIS » CAHPS » URAC	517.364.8000 877.803.2551 (toll-free) 517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org
External Vendor	**Contact Purpose**	**Contact Number**	**Email Address**
Change Healthcare (TC3)	» When medical records are requested	**Mail To:** Change Healthcare 5755 Wayzata Blvd, St. Louis Park, MN 55416 952.949.3713 949.234.7603 (fax)	MedicalRecords@changehealthcare.com