Provider Connection

FOURTH QUARTER 2020

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Physicians Health Plan

Holiday Hours

Physicians Health Plan will be closed in observation of the following holidays.

Christmas

Friday, Dec. 25

New Year's

Friday, Jan. 1, 2021

PHP Provider Directory Enhancements

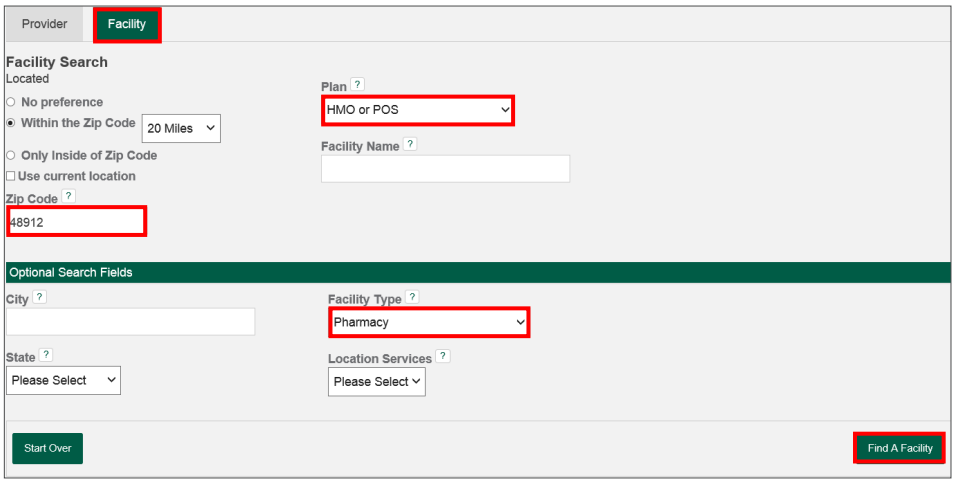
Finding an In-Network Pharmacy Faster and Easier

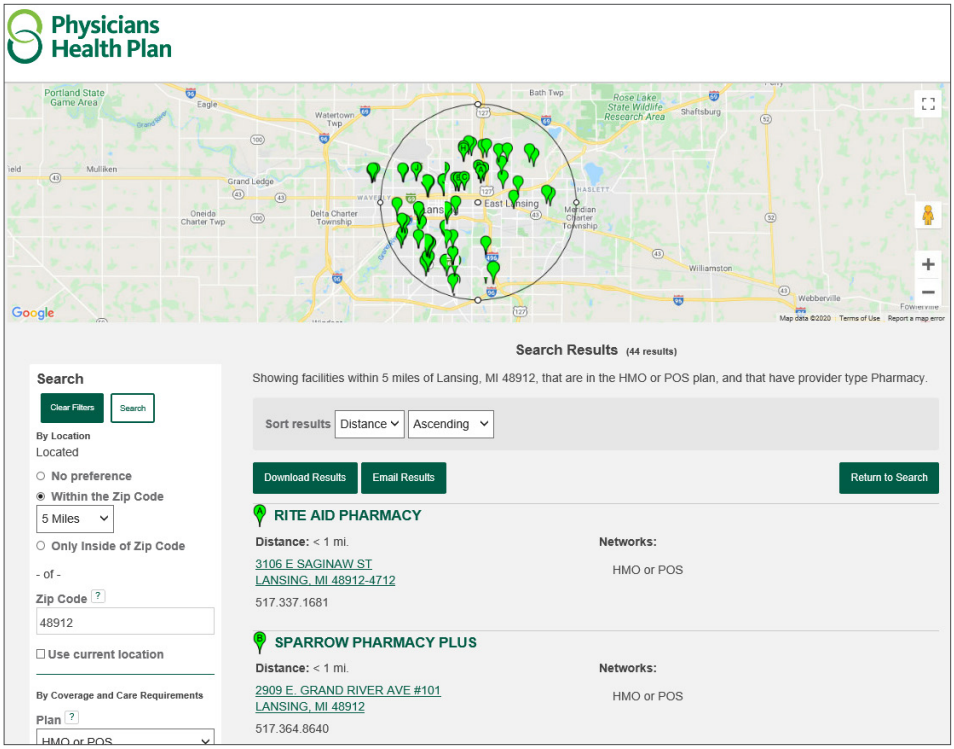
Directing patients to in-network services can reduce costs and increase value and satisfaction. In order to better serve you and our members, PHP has made it even easier to find participating pharmacies in the PHP Network.

New enhancement to Pharmacy search: "Pharmacy" is now listed as a "Facility Type" to better assist members with locating network pharmacies.

To find the online searchable directory, visit **PHPMichigan.com** and select "Find a Doctor." After the Provider Directory has loaded, click on the "Facility" tab and then:

- Select the member's plan from the drop down menu (refer to the member's ID card)
- Enter the zip code and the distance range
- Select "Pharmacy" from the Facility Type drop down menu
- Click on "Find a Facility" to search for pharmacies in the CVS Caremark network





Keep PHP Informed: Update Practice or Facility Information in a Timely Manner

PHP requires all network providers notify PHP in writing of any demographic or status changes within your Practice or Facility. Failure to notify PHP can cause claim payment delays and denials. To update demographic and practice information for **providers who are already credentialed** with PHP, please utilize the *Physicians Health Plan Demographic/Practice Information Update Form*:

- Navigate to **PHPMichigan.com/Providers**
- Select "Forms" from the menu on the left
- Select "Provider Demographic Update Form"

This form should be completed for changes which include:

- Tax ID Number (TIN)*
- Telephone number
- Billing address
- Office address
- Office hours
- Open/closed status regarding new members
- After hours availability
- Physicians/Practitioners joining or leaving your practice

**TIN changes may require additional processing time. Please notify PHP as soon as possible for any changes to your TIN. A W-9 with the updated tax id and/or tax name must accompany the demogrpahic update form.*

It is also important to inform PHP of any practitioners who join a practice or who are joining a practice. If a provider who is **not currently credentialed** with PHP will be joining your practice, please utilize the *New Provider Request Form*.

- Navigate to **PHPMichigan.com/Providers**
- Select "Forms" from the menu on the left
- Select the "New Provider Request Form"

If you have any questions about updating your practice information, please email 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 more efficiently with PHP.

Training opportunities include PHP Commerical and PHP Medicare requirements, 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.

Please visit our website, **PHPMichigan.com/Providers**, and click on "Training Opportunities" to view the training opportunities and to register. Until further notice, trainings will be offered by webinar. Registration is required in order to receive the webinar link.

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

Register for the MyPHP Provider Portal for Access to Member Eligibility and Coverage, Claims, EOPs, Accumulators, and More

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

Provider Portal Features

MyPHP has the following features:

- Eligibility and Coverage - Search "Patients" to verify eligibility and coverage information (effective dates, primary care physician, and member profile information)
- Benefits - View and download a member's benefit plan, documents, and summary of benefits
- Prior Authorizations – View the status of an authorization and obtain the prior authorization number
- Claims - Search and view claims (status, amount paid, paid dates, and claim history)
- Explanation of Payment (EOP) – Search, view, and print EOPs
- Accumulators - View a member's out-of-pocket or deductible balances
- View and print Primary Care Physician Patient Rosters
- Access to PHP's Medical and Pharmacy Policies
- Access to Provider Incentive Program
- Single-sign-on access to the PHP Medicare Portal

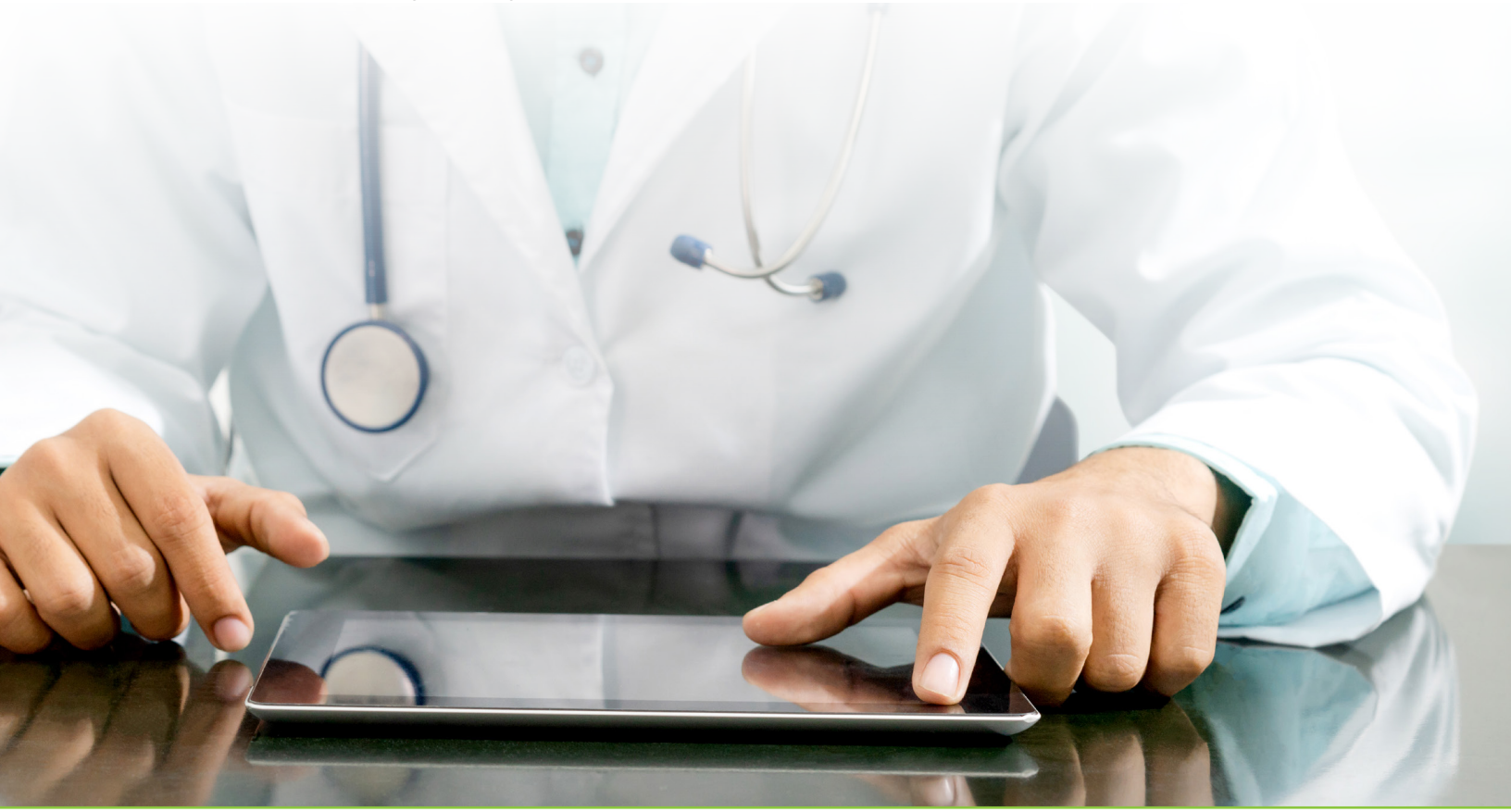
How to Register

To access MyPHP:

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

You will need the provider tax identification number (TIN), NPI, and PHP provider ID number to register. Your PHP provider ID number can be found on an EOP, or obtained by contacting the Provider Relations Team. Once you are registered, you will have immediate access to the portal.

If you would like more information or need assistance with an existing account, please send an email with your practice information including the practice TIN, and all individual provider NPIs to **PHPProviderRelations@phpmm.org** for assistance.



Do You Know About PHP Medicare?

PHP Medicare was the Fastest Growing New Medicare Advantage Plan

After an extremely successful launch in 2019, PHP Medicare became one of the country's fastest growing new Medicare Advantage- Part D plans, according to CMS* enrollment data. PHP Medicare includes three plans: Sparrow Advantage, Covenant Advantage, and PHP Advantage. The PHP Medicare service area includes the counties of Bay, Calhoun, Clinton, Eaton, Gratiot, Ingham, Ionia, Kalamazoo, Montcalm, Saginaw, Shiawassee, and Tuscola.

PHP Medicare offers all the benefits of original Medicare plus prescription drug coverage, vision, dental and hearing benefits, free fitness memberships, and so much more.

We thank our providers who participated with our provider affiliation letter mailings. Letters from the PCP announced affiliation with the Sparrow Advantage and Covenant Advantage plans.

Below are a few of the highlights of the plans. For more information about PHP Medicare, please visit **PHPMedicare.com**. If you would like PHP Medicare information to share with your patients, please contact your PHP Provider Relations Team at **PHPProviderRelations@phpmm.org**.

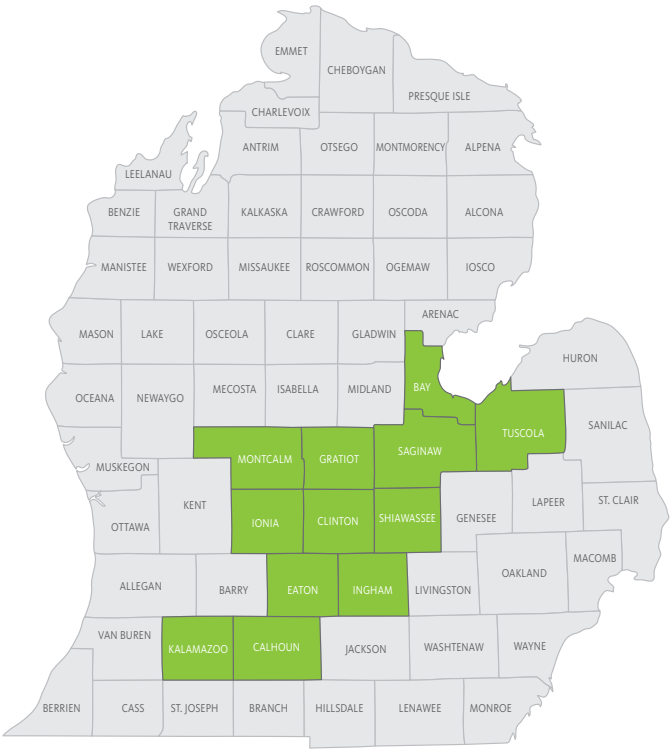
PHP Medicare Benefits

- 12 counties, 1 network
- PHP Medicare network includes Sparrow Health System, Covenant HealthCare, Bronson, McLaren, Michigan Medicine, Spectrum Health, and others.
- $0 or $25 monthly premium for Advantage or Advantage Plus plans
- $5 PCP copay
- No deductible
- $3,800 in-network maximum out-of-pocket limit
- Tier 1 and 2 meds $0 at an in-network pharmacy
- New for 2021! No referral needed to see an in-network specialist, and a home delivery meal benefit following a qualified inpatient discharge.

Annual Key Enrollment Dates

- Initial Enrollment Period (IEP)
  - For people turning 65 or who are otherwise first eligible for Medicare benefits
  - Seven-month window begins three months before your birth/eligibility month and ends three months after
- Jan. 1 – March 31: Open Enrollment Period (OEP)
  - Limited to Medicare Advantage enrollees
  - Can make a one-time election to leave current plan and switch to another Medicare Advantage plan or original Medicare
  - Can add or drop Part D coverage
- Oct. 15 – Dec. 2: Annual Enrollment Period (AEP)
  - Anyone can make a change during this time
  - Coverage will be effective Jan. 1, 2021
- Special Enrollment Period (SEP)
  - In certain special cases, as defined by CMS, people may enroll in a PHP Medicare plan outside of regular enrollment periods.

**Based on the highest volume of 2020 new Medicare Advantage membership in the counties of Clinton, Eaton, Gratiot, Ingham, Ionia, Montcalm, and Shiawassee from CMS enrollment data published February 2020 (cms.gov)*



Utilization Management News and Updates

Stay Up to Date with Procedures and Services Requiring Prior Approvals

4th Quarter 2020

A comprehensive list of procedures and services requiring Prior Approval is available at **PHPMichigan.com/Providers**. Select "Notification and Prior Approval Table" to access the list.

If you have any questions about the Prior Approval process, please call the PHP Customer Service Department at 517.364.8500 or 800.832.9168, Monday through Friday, 8:30 a.m. to 5 p.m.

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

New Policies

- BCP-80 Ambulatory EEG and Video Monitoring

Policy Updates

- BCP-22 Hospice Services – prior approval requirement removed. Effective 10/01/2020.
- BCP-63 Varicose Vein Treatment – removed criteria embedded in policy and use InterQual® criteria. Effective 1/1/2021.
- BCP-64 Continuous Glucose Monitors and Supplies – removed criteria embedded in policy and use InterQual® criteria. Effective 1/1/2021.
- BCP-73 Spinal Cord Stimulator for Pain Management – six-month timeframe added for conservative pain treatment prior to implementing spinal cord stimulation treatment. Effective 10/01/2020.

Changes to Coverage for Services

Code(s)	Procedure or Service	Action	Implementation Date
64611, 64612, 64615, 64616	Chemodenervation for various areas	Prior approval removed for the administration codes. Botox continues to require prior approval from Pharmacy.	Retro 1/1/2020

PHP Helping Members Be Well

Engaged patients are more likely to maintain treatment plans, track their health, and communicate with their providers. PHP is your partner in promoting patient engagement with the Be Well health portal.

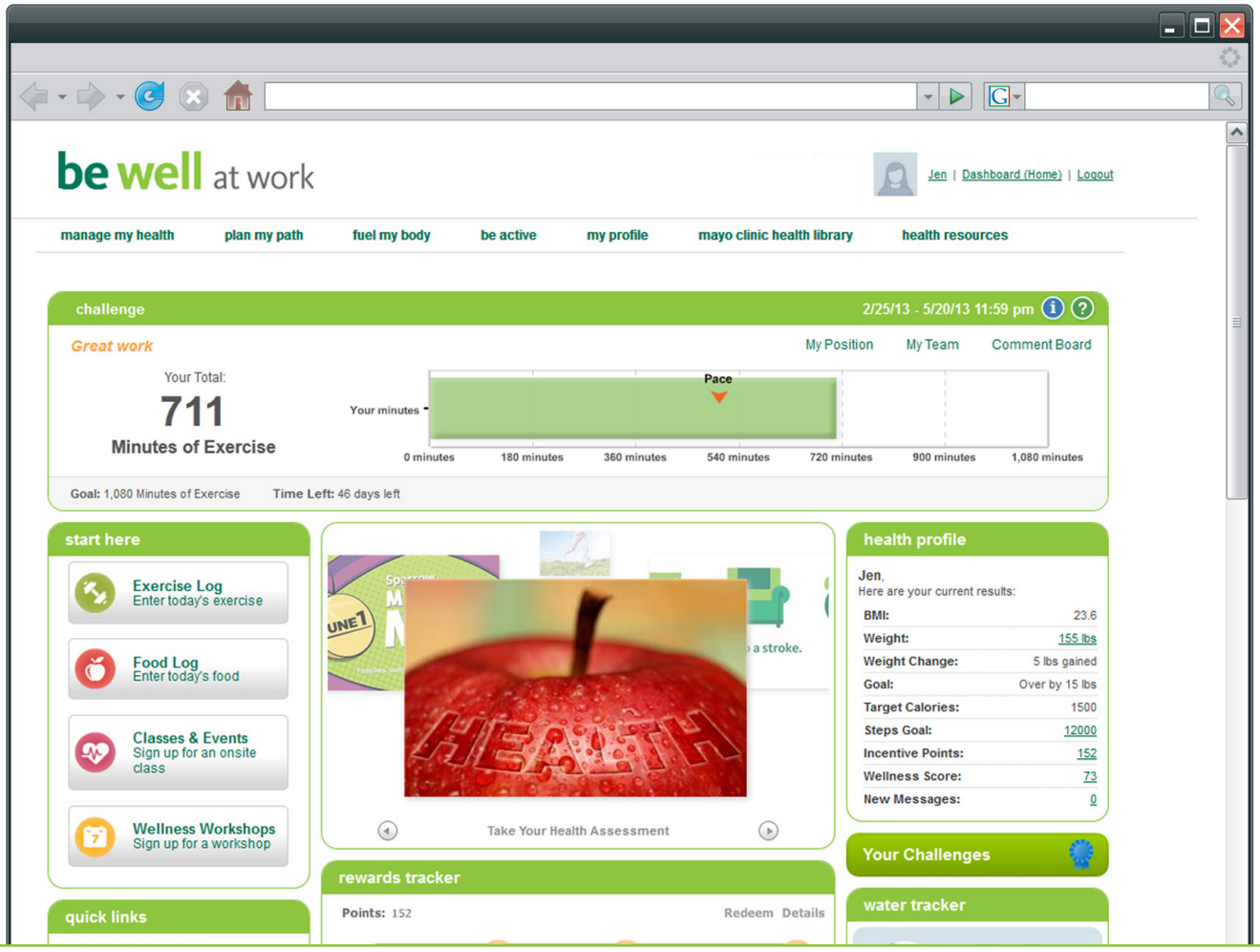
Be Well is a health management platform with tools designed to help patients manage their health and wellness goals.

After accessing Be Well through the PHP Member Portal, members can take an online personal health assessment questionnaire. Once complete, the member is given an online report containing their relative risk levels for chronic health issues and tips for health-related behavior changes to improve their overall health. Members also have access to health information and resources, including workshops with strategies for improving physical health, nutrition, mental wellness, exercise and food logs, a personalized health dashboard, and more!

Be Well empowers PHP members to get started on the path to healthier living. Encourage PHP members to get started today by registering for a free account:

- Go to **PHPMichigan.com/MyPHP**
- Click "MyPHP Member Portal"
- Log in and select "Click here to access your Be Well Health Assessment"

You can help your patients complete the Be Well Health Assessment by providing them with their most recent blood pressure, BMI, blood glucose, and cholesterol information.



MATCH

(Managing Asthma Through Case-management in Home)

The MATCH self-management education program reduces hospitalizations, ER visits, missed school and work days.

PHP covers services provided through the MATCH program, which allows for intensive home-based asthma case management services for individuals with uncontrolled asthma.

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

A certified asthma educator with Ingham Health Plan coordinates care with family members, healthcare providers, school staff, and employers to assure the patient's individualized asthma action plan is utilized. Long-term impacts include reduced ED visits and hospitalizations related to asthma as well as decreased healthcare costs and improved quality of life.

The visits are currently being provided virtually. Referrals can be submitted directly to Ingham Health Plan for PHP and SPN members that would benefit from participation in the program at **IHPMI.org/carehub-MATCH**.

PHP Case Management Team New Outreach Strategy

The PHP Case Management team has implemented a new outreach strategy to contact members that have been identified as potentially needing case management services. The PHP Analytics department has been enlisted to identify members with four or more emergency department visits and/or observation visits within a twelve-month period. A case manager will be assigned to reach out to these members after a high-level overview of their history has been completed.

The PHP case manager will assist with helping members find a primary care physician (PCP) if one is needed. The PHP Case Management team has identified another opportunity in which they will be assisting patients who have a new diagnosis of diabetes with educational opportunities, prescription assistance programs, and equipment needs. Also, the assigned PHP case manager will assist with answering benefit questions and concerns to help patients make healthcare choices with knowledge and confidence.

Drugs New to Market

Drug	Formulary Action
Scenesse (afamelanotide implant)	*Medical Benefit, PA*
Trodelvy (sacituzumab govitecan IV infusion)	*Medical Benefit, PA*
Balversa (erdafitinib tablet)	*Preferred Specialty Tier, PA*
Jelmyto (mitomycin for pyelocaliceal)	*Medical Benefit, PA*
Pemazyre (pemigatinib tablet)	*Preferred Specialty Tier, PA*
Oriahnn (elagolix/estradiol/norethindrone capsule)	*Non-Preferred Brand Tier, PA*
Kynmobi (apomorphine sublingual film)	*Non-Preferred Brand Tier, PA*
Uplinza (inebilizumab-cdon IV solution)	*Medical Benefit, PA*
Zepzelca (lurbinectedin IV solution)	*Medical Benefit, PA*
Fensolvi (leuprolide acetate for SQ injection)	*Medical Benefit*
Fintepla (fenfluramine oral solution)	*Preferred Specialty Tier, PA*
Phesgo (pertuzumab/trastuzumab/hyaluronidase SQ injection)	*Medical Benefit, PA*
Rukobia (fostemasavir tromethamine tablet)	*Non-Preferred Specialty Tier, PA*
Monjuvi (tafasitamab-cxix IV solution)	*Medical Benefit, PA*
Tecartus (brexucabtagene autoleucel IV infusion)	*Medical Benefit, PA*
Breztri (budesonide/glycopyrrolate/formoterol fumarate)	*Preferred Brand Tier*

Changes to Current Formulary

Drug	Formulary Action
Trintellix (vortioxetine) & Viibryd (vilazodone)	*Move to Preferred Brand Tier*
Crinone (progesterone gel)	*Up to 112 days supply available without PA*
Symbicort (budesonide/fomoterol fumarate dihydrate)	*Brand name now on Preferred Generic Tier. Generic product excluded*
Trelegy (fluticasone furoate/umeclidinium/vilanterol)	*Removed PA requirement. Moved to Preferred Brand Tier*
Dovato (dolutegravir/lamivudine)	*Moved to Preferred Specialty Tier*
Triumeq (abacavir/dolutegravir/lamivudine)	*Moved to Preferred Specialty Tier*
Ibrance (palbociclib)	*Moved to Preferred Specialty Tier*
Verzenio (abemaciclib)	*Moved to Preferred Specialty Tier*
Kisqualí (ribociclib)	*Excluded medication*
Nurtec (rimegepant)	*Moved to Preferred Specialty Tier*
Ubrelvy (ubrogepant)	*Excluded medication*
Reyvow (lasmiditan)	*Excluded medication*
Genotropin (somatropin)	*Move to Preferred Brand Tier*
Norditropin (somatropin)	*Excluded medication (members currently on Norditropin will not have to switch agents)*

PA - 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.

Important Things to Remember When Submitting a Prior Authorization Request Form

- The Medication Authorization Form is located on the Pharmacy Services page on our provider website **PHPMichigan.com/Providers**.
- Fill out the form completely and legibly.
- If requesting an infusion drug, please include the name and NPI of the office or facility where the drug will be administered.
- Provide accurate provider contact information:
  - Contact person's name
  - Phone number and extension, if applicable
  - 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 the transmission is delayed, which can lead to delays in care for the patient. Sending requests directly to PHP will reduce the time it will take to process the request.

Formulary Changes to Select Albuterol Inhalers

Tier Changes effective Oct. 1, 2020:

Proair HFA Inhaler

is being moved to Tier 2 (Preferred Brand)

» Albuterol HFA (generic) inhaler is available on Tier 1

Proventil HFA Inhaler

is being moved to Tier 3 for Sparrow formularies (Non-Preferred Brand)

» Albuterol HFA (generic) inhaler is available on Tier 1

Ventolin HFA Inhaler

is being moved to Tier 3 for Sparrow formularies (Non-Preferred Brand)

» Albuterol HFA (generic) inhaler is available on Tier 1

Proair RespiClick

is being moved to Tier 2 (Preferred Brand)

» No generic available

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

Formulary Changes to Select Brand Name Medications

Effective Oct. 1, 2020

Excluded Medications				
Noxafil®	Valtrex®	Plaquenil®	Ranexa®	Altace®
Benicar®	Benicar HCT®	Crestor®	Viagra®	Cialis®
Protonix®	Xanax®	Xanax XR®	Lexapro™	Prozac®
Zoloft®	Cymbalta®	Effexor XR®	Wellbutrin SR®	Wellbutrin XL®
Invega™	Lunesta™	Strattera®	Celebrex®	Relpax®
Topamax®	Topamax Sprinkle®	Myfortic®	Lidoderm Patch®	

The generic formulations of the listed medications are still available for coverage on the PHP formularies, only the branded medication is excluded.

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

2021 Outpatient Evaluation and Management Changes

Beginning Jan. 1, 2021, there will be changes implemented by the American Medical Association (AMA) regarding the coding of Evaluation and Management (E/M) services. These changes will impact the code selection and auditing processes for E/M services. The most significant change is that the history and exam portions of the E/M office and outpatient visit levels will no longer be scored as they have been prior to Jan. 1, 2021. Coding selection will be established based on time or medical decision making (MDM). However, these changes do not affect the standards of documentation. Documentation should still include details of history and exam even though it will no longer be scored. PHP's standards of documentation include a thorough narrative of the patient's current problems and the actual acuity of the patient's condition for the date of service billed.

What CPT Codes Are Impacted?

- 99201-99215
  - CPT 99201 will be deleted and no longer valid for reimbursement
- New Prolonged Service add on code CPT 99417 established for use in conjunction with 99205 and 99215

What Is Changing?

Medical Decision Making (MDM)

- Three elements of MDM
  - Number and complexity of problems addressed
  - Amount and/or complexity of data reviewed and analyzed
  - Risk of complications and/or morbidity or mortality of patient management
- Two of the three elements for that level of decision making must be met or exceeded
  - Straightforward (99202/99212)
  - Low (99203/99213)
  - Moderate (99204/99214)
  - High (99205/99215)

Time

- Time alone may be used to select the appropriate code level for outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215)
- Counseling and coordination greater than 50% will no longer be a requirement for time consideration
- Ancillary staff time is not included in the total time; however, non-face-to-face work performed by the physician or other qualified healthcare professional on the same date may be included
- Total time of the encounter must be documented

Additional information will be made available to our providers at **PHPMichigan.com/Providers** if the AMA directives change prior to implementation on Jan. 1, 2021. We encourage providers to review their current practice policies regarding code selections and documentation in preparation for the upcoming E/M changes. This article is not meant to replace official AMA directives regarding E/M changes for 2021.

For more information, visit the AMA at **AMA-ASSN.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf**.

PHP's "Incident to" Billing Guidelines for Advanced Practice Providers, Mid-Level Practitioners, Limited Licensed Behavioral Health Providers

PHP's "incident to" billing guidelines and protocols for physicians and non-physician practitioners should be followed to ensure appropriate documentation for reimbursement.

To qualify as "incident to," services must be part of a patient's normal course of treatment, during which a supervising physician personally performs the initial service, determines the plan of care and remains actively involved. Subsequent services provided by the rendering practitioner must be related to the plan of care. Services provided by the rendering practitioner that qualify for "incident to billing," as defined, should be billed under the supervising physician's NPI.

If there is a change in the plan of care, the service would no longer meet the requirement for "incident to." The patient must be re-evaluated by the supervising physician, and services should be billed under the supervising physicians NPI number.

The supervising physician is not required to co-sign the patient's record; however, the supervising physician must remain actively involved, and documentation must support review and involvement in the oversight of the patient's care.

For example, the patient's record as a whole must indicate that the supervising physician has periodically reviewed and agreed with the course of treatment and re-evaluated as necessary when there has been a change to the care plan.

Physician Assistants

PHP does not credential physician assistants (PA). They are required to meet "incident to" billing guidelines in an office and outpatient setting. The services may be rendered by a PA and considered reimbursable as long as the following requirements are met:

- Supervising physician does not have to be physically present in the patient's treatment room, but must be readily available to render assistance, if necessary.
- Qualifying "incident to" services must be provided by a PA/NP whom the MD/DO directly supervises, and who represents a direct financial expense to the MD/DO's practice (such as a "W-2" or leased employee, or an independent contractor).
- **For new patients**, the physician must personally review history, examine the patient, and make medical decisions regarding the patient's treatment and drug protocols.
- The PA must be licensed to render the services.
- PA must bill under supervising physician's NPI number.

Nurse Practitioners

PHP does credential nurse practitioners (NP). Any NP credentialed by PHP must bill their services under their own provider NPI. Non-credentialed NPs must meet "incident to" billing guidelines in an office and outpatient setting. The services provided may be rendered by a NP and considered reimbursable as long as the following requirements are met:

- Supervising physician does not have to be physically present in the patient's treatment room, but must be readily available to render assistance, if necessary.
- Qualifying "incident to" services must be provided by a PA/NP whom the MD/DO directly supervises, and who represents a direct financial expense to the MD/DO's practice (such as a "W-2" or leased employee, or an independent contractor).
- **For new patients**, the physician must personally review history, examine the patient and make medical decisions regarding the patient's treatment, and drug protocols.
- The NP must have a master's degree in nursing.
- The NP must be a registered professional nurse, authorized by the state in which their services are furnished to practice as a nurse practitioner, in accordance with state law.
- The NP must be certified as a nurse practitioner by the American Nurses Credentialing Center (ANCC) or other recognized national certifying entities that have established standards for nurse practitioners.
- Non-credentialed NPs must bill under a supervising physician's NPI number.
- Credentialed NPs must bill under their own NPI number.

Limited Licensed Behavioral Health Providers

Rendering Providers

The following Limited Licensed Behavorial Health Providers (LLBHP) are allowed to provide services "incident to" a qualifying supervising physician:

- Limited Licensed Social Worker (LLMSW).
- Limited Licensed Psychologist (LLP)
- Limited Licensed Marriage and Family Therapist (LLMFT)
- Limited Licensed Professional Counselor (LLPC)

Supervising Physicians

The following clinicians are allowed to bill "incident to" services under their NPI as the supervising physician:

- MD, DO
- Fully Licensed Psychologist

Supervisory Requirements

- The rendering provider must be directly supervised by the billing provider.
- Direct supervision means the billing provider is within the same office as the rendering provider.
- The supervising provider **must first** evaluate the patient personally and then initiate the course of treatment.
- If there is a change in the course of treatment, the documentation must support review and involvement in the oversight of the patient's care by the supervising physician.

Claim Submission

- The NPI entered in box 24J, and the provider signature entered in box 31 should both belong to the supervising provider.
- If a provider is credentialed under their own NPI, they are not eligible for "incident to" and must bill under their own NPI, **not** a supervising physician.
- Modifiers AJ and HO should be applied for indication of "incident to" billing.

Modifiers

AJ- Service Rendered by a Clinical Social Worker

- Required on claims where the rendering provider is billing "incident to" a supervising behavioral health provider

HO- Service Rendered by a Master's Level Clinician

- Required on claims where the rendering provider is billing "incident to" a supervising behavioral health provider

Outstanding Overpayment Balances

When overpayments occur, PHP will attempt to recover funds via auto-recovery. In the event that you realize PHP has made an overpayment, you must submit a Claim Adjustment Request form and a corrected claim if one is needed. The Claim Adjustment Request form can be found at **PHPMichigan.com/Providers**. Once your adjustment is processed, PHP will execute the recovery on future claims payments, which are shown on an Explanation of Payment (EOP). Specific overpayment detail(s) are indicated in the Recovery Detail section of your EOP. See the example below:

Amount Billed	Allowed	Financial Allowance	Prov. Adjust	Patient Ineligible	Deductible	Copay/ Co-Ins	Other Ins	Net Paid
120.00	100.00	0.00	20.00	0.00	0.00	0.00	0.00	100.00

Interest Amount:	0.00
Refund Requested:	0.00
Auto-Recovered Amount:	-85.06
Prior Overpayment Balance:	0.00
Check Amount:	14.94

Overpayment Recovery Detail (adjustment - Retractions could be applied to the net payment)

Claim#/ Ref#	Member Name	Patient Acct #	Recovery Type	Adjusted Date	Original Amt Paid	Original Overpay	Previously Recovered	Recovered This Check	Remaining Balance	Orig. Date Paid	Orig. Check Number
19000E000XXX	John Smith	1234567	B	12/14/2019	85.06	85.06	0.00	85.06	0.00	5/29/2018	654321

In certain situations, PHP may determine that a refund check is the only way to resolve an overpayment, such as a change in a tax identification number, a physician who is no longer practicing, or when changes have been made to payee information. In these situations, funds cannot be recovered automatically. The outstanding overpayment amount will appear as a "Remaining Balance" on your EOP. It is important to pay attention to the Prior Overpayment Balance, or Remaining Balance noted in the example (right); it may be necessary to send a refund check to PHP for an outstanding remaining balance. When submitting a manual check, please mail to the address below:

Physican Health Plan
Attn: Provider Refunds
P.O. Box 30377
Lansing, MI 48909-7877

Questions? Please Contact us at
PO Box 30377
Lansing, MI 48909-7877
800-661-8299 or 517-364-8540
www.phpmichigan.org

Paid To: Michigan State Hospital
Tax #: 123456789
Reference #: 201611221023456
Check Amount #: 123456
Check Amount: $250.00
Prior Overpayment Balance: $575.00
Auto-Recovered this Check: $250.00
Current Overpayment Balance: $325.00
Year To Date Financial Allowance: $0.00

Overpayment Recovery Detail (adjustment - Retractions could be applied to the net payment)

Claim#/Ref#	Member Name	Patient Acct #	Recovery Type	Adjusted Date	Original Amt Paid	Original Overpay	Previously Recovered	Recovered This Check	Remaining Balance	Orig. Date Paid	Orig. Check Number
19000E000XXX	John Smith	1234567	B	12/14/2019	700.00	700.00	125.00	250.00	325.00	5/29/2018	654321

If a balance is unable to be recouped by PHP within three months of the Explanation of Payment (EOP) mail date, you may then receive letters and/or phone calls related to the overpayment collection process. Additional information is available to assist you in the resolution of overpayment balances via the Provider Portal, MyPHP.

If you have questions about your EOP or the overpayment recovery process, please contact Customer Service at 517.364.8500.

Avoid Claim Rejections and Denials

When claims are rejected for missing/incorrect provider information or are unexpectedly denied due to provider non-participation, out-of-date practice or provider information could be the culprit. Please review your claims, both paper and electronic, to ensure all information matches what has been reported to PHP. Use the information below to help troubleshoot potential problems.

Review your CMS-1500 claims to ensure:

1. The Federal Tax ID Number reported in box 25 is the same tax ID number used by the billing provider reported in box 33
2. Box 33 includes the billing provider's NPI, service address, and ZIP code with the 4-digit extension

Review your enrollment file to ensure all billing NPIs are credentialed with PHP, specifically:

1. All service locations are enrolled with the correct address, including zip with the four-digit extension
2. All rendering providers practicing at a location must be actively linked to that service location for the date of service billed

Tip: PHP does not credential physicians assistants (PA). Please refer to the article PHP's "Incident to" Billing Guidelines for APP, MLP, and LLBHP, for specific information regarding "incident to" claim submission.

Confirm that your billing software and clearinghouse are EDI compliant and transmitting the proper data. It is important that you check with your clearinghouse or PHP for data accuracy to ensure quick payment resolution.

Additional information regarding the 1500 Claim Form can be found at the National Uniform Claim Committee website **NUCC.org/index.php/1500-claim-form-mainmenu-35**.

Status "B" Procedure Codes

Bundled services are those that are ineligible for separate reimbursement as they are considered part of another service billed on either the same or different date of service. Physician's Health Plan's code editing process aligns with the Centers for Medicare and Medicaid Services (CMS) status "B" Procedure Code indication of bundled services. This is not an indication of coverage, only reimbursement. While the services represented by a CPT/HCPCS® code assigned a status indicator of "B" may be considered covered services, they will not receive separate reimbursement. Whether a Status "B" Procedure Code is billed with other services or alone they will be denied as provider liability unless otherwise designated as a non-covered service in the member benefit summary.

Assignment of Status "B" Procedure Codes can be found at CMS.gov

- Addendum B for Facility Outpatient services
- PFS RVU file for Professional Outpatient services

Examples of Status "B" Procedure Codes

- 15850-Removal of sutures under anesthesia (other than local), same surgeon
- 99050-Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
- 99080-Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form

Submitting Requested Documentation for Claims Processing

When you receive a Medical Record Request Letter or Explanation of Payment (EOP) denial code that indicates Medical Records, Itemization, Invoice, or Implant Log are required, following the correct process will help to achieve a quick payment resolution.

- Carefully review your EOP Remarks Explanations, or 835 Remittance Advice Remarks Codes.
  - See the tables below for examples of EOP remark codes and their explanations. Please note that remark codes are case sensitive, and you may receive remark codes other than the ones listed here.
- Identify any Remark Codes with Message Descriptions that indicate documentation is required.
- Gather all relevant documentation (refer to the Acceptable Documentation by Type of Service table).
- Complete the Medical Records Submission Form:
  - Use a separate form for each claim
  - Complete all form fields in their entirety
  - A fillable pdf form is available at PHPMichigan.com/Providers. Select “Forms” from the left menu
  - Check the Box that corresponds to the specific claim denial code
- Send all documents to the correct address indicated on the form – Change Healthcare or PHP.

Sending documents to the wrong location can cause significant delays in processing and repeated denials if the claim is resubmitted. All documentation requested for processing claims must be received within the timely file limit of six months as defined in the PHP Provider Manual or as stated in your agreement. After submitting documents, please allow several business days before requesting a claim status update.

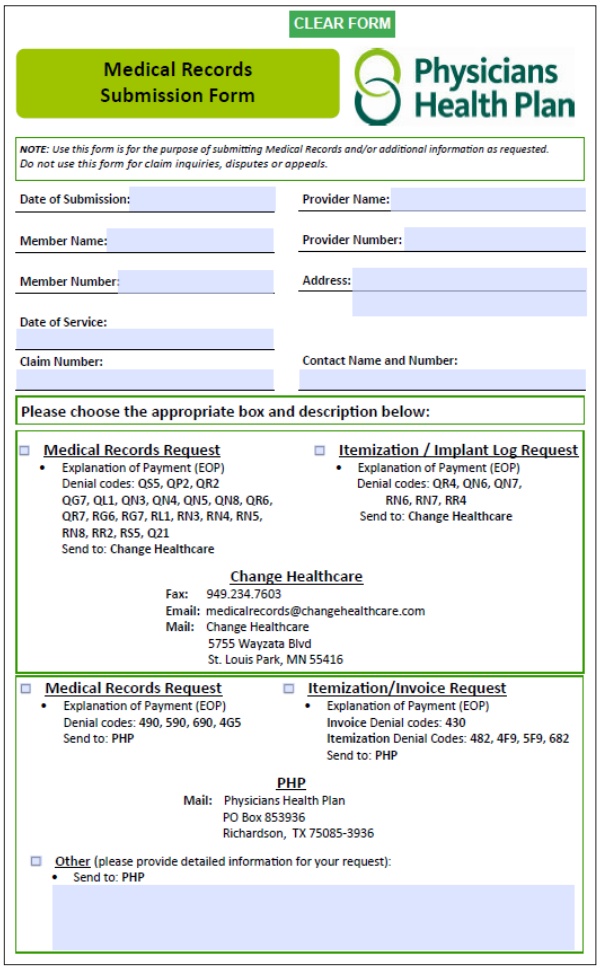
Remarks Explanations Examples *(Submit documents to Change Healthcare)*

Code	Message Description
Q21	Per Nat’l Phys Fee Schedule, documentation is required to establish medical necessity for Co-Surgeon.
QN4	Requested pathology or laboratory report(s) not received.
QN5	Requested diagnostic imaging report(s) not received.
QR2	Requested medication administration record(s) not received.
QR4	Requested itemized statement not received. Fax to 949.234.7603.
RN3	Requested operative note/report not received.
RR2	Requested medication administration record(s) not received.

Remarks Explanations Examples *(Submit documents to PHP)*

Code	Message Description
430	The invoice is required.
482	Please submit itemization of services.
490	Please submit corresponding operative, radiology or office notes.

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 and documented waste, if applicable
Unlisted Surgical Procedure	Operative report, consult notes



CLEAR FORM

Medical Records Submission Form

Physicians Health Plan

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

Date of Submission: | Provider Name:

Member Name: | Provider Number:

Member Number: | Address:

Date of Service:

Claim Number: | Contact Name and Number:

Please choose the appropriate box and description below:

☐ **Medical Records Request**
- Explanation of Payment (EOP)

Denial codes: QS5, QP2, QR2 QG7, QL1, QN3, QN4, QN5, QN8, QR6, QR7, RG6, RG7, RL1, RN3, RN4, RN5, RN8, RR2, RS5, Q21
Send to: Change Healthcare

☐ **Itemization / Implant Log Request**
- Explanation of Payment (EOP)

Denial codes: QR4, QN6, QN7, RN6, RN7, RR4
Send to: Change Healthcare

Change Healthcare
Fax: 949.234.7603
Email: medicalrecords@changehealthcare.com
Mail: Change Healthcare
5755 Wayzata Blvd
St. Louis Park, MN 55416

☐ **Medical Records Request**
- Explanation of Payment (EOP)

Denial codes: 490, 590, 690, 4G5
Send to: PHP

☐ **Itemization/Invoice Request**
- Explanation of Payment (EOP)

Invoice Denial codes: 430
Itemization Denial Codes: 482, 4F9, 5F9, 682
Send to: PHP

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

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

Physicians Health Plan

1400 E. Michigan Ave.
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)	**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	517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org

Department	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