Provider Connection

SECOND QUARTER 2019

In this issue

Physicians Health Plan

A health plan that works for you.

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.

July 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**.

Medically Unlikely Edits

Medically Unlikely Edits (MUEs) for a HCPCS/CPT code are the maximum number of Units Of Service (UOS) under most circumstances allowable by the same Provider for the same Member on the same date of service. For example, there is only one unit allowed for an appendectomy. Not all HCPCS/CPT codes have an MUE. PHP's clinical editing does include MUEs. For more information on MUEs, go to the CMS website or email your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Modifier 25 guidelines

Definition

Significant, separately identifiable Evaluation and Management (E/M) service by the same Physician* or other qualified healthcare professional on the same day of a procedure or other service.

Purpose

Indicates that on the day of a procedure, the Patient's condition required a significant, separately identifiable E/M service, above and beyond the usual pre- and post-operative care associated with the procedure or service performed.

Appropriate Usage

- Applies to the E/M service when the Provider renders an E/M to a Patient on the same day as another service or procedure.
- The procedure performed has a global period listed on the Medicare Fee Schedule Relative Value File. This global period could be 000, 010, or 090 days.
- If an E/M occurs on the same day as a procedure and within the post-operative period of a previous procedure, the documentation must support Modifier 25 and Modifier 24.
- If an E/M service is performed the day before a major surgery, was not related to the decision for surgery, and represents a significant, separately identifiable service.

Inappropriate Usage

- A Physician other than the Physician performing the specified procedure.
- Documentation shows the amount of work performed is consistent with that normally performed with the procedure.

Different diagnoses are not required for reporting the E/M services on the same date.

Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented in the Patient's medical record to support the claim for these services. Documentation may be requested for pre- or post-pay review to validate appropriate usage.

*Same Physician or Physicians in the same group practice and/or practicing the same specialty.

PHP ClaimsXten implementation update

Physicians Health Plan is in the process of expanding the current Change Healthcare clinical editing software to include ClaimsXten integrated functionality starting mid 2019.

The ClaimsXten software will be integrated into our claims adjudication system, allowing 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
- Improvie payment policy alignment with state and national standards

Some of the changes you will notice include:

- **Frequency Validation**: Identifies claim lines that contain procedures that have exceeded the maximum number of times allowed for a single date of service.
- **Medically Unlikely Edits (MUE)**: Identifies claim lines where the MUE has been exceeded for a CPT/HCPCS code with MUE adjudication indicator {(MAI) =1, 2 or 3,} reported by the same Provider, for the same Member and same date of service.
- **Hospital Discharge Services**: Identifies claim lines when one or more submissions of a hospital discharge service are billed across Providers for same Member, same date of service, one day before and/or one day after.

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

Are you coding the whole clinical picture?

It's important to be as specific as possible in documentation and diagnosis coding. One of the best ways to improve continuity of care for your Patients is to document and code all chronic conditions. This can be done at the Patient's yearly physical or during sick visits. This helps to complete the whole clinical picture of a Patient's health needs. Documenting all the diagnoses allows PHP to collaborate and fully understand a Patient's medical history, current health status, and treatment recommendations or outcomes.

Risk adjustment is a payment system that reimburses based on the complexity of a Member's conditions. Risk adjustment incorporates diagnoses from inpatient and outpatient hospital services, and Physician services, into yearly adjusted capitated payments to health plans. These payments offset the costs of taking on the health risks of Members. Risk adjustment is a key component in encouraging the growth of marketplace offerings at fair prices for our community Members.

The Risk Adjustment Disease Model is based on Condition Categories (CC). Hierarchies stratify certain chronic conditions, so the Patient is only categorized for the most severe manifestation among related diseases. Coding to the highest level of specificity with accurate ICD-10 code selection is extremely important to ensure the Patient is placed in the appropriate condition category.

What is fraud, waste, or abuse?

There are a variety of situations that can be considered fraud, waste, or abuse. An important thing to keep in mind is that not all fraud, waste, or abuse is intentional. It is often simple coding and billing errors that lead to audits. PHP's Billing Integrity Program (BIP) serves to help Providers prevent fraud, waste, or abuse and is managed by PHP's Compliance Department. The primary objective of the BIP is to ensure that Providers bill accurately and that documentation supports the medical necessity of the service(s) and level of service(s) billed. Complete and accurate documentation is the cornerstone of correct coding and helps prevent fraud, waste, or abuse situations for Providers.

PHP completes claims audit/medical record reviews on both a pre-payment and post-payment basis.

Pre-payment audits are completed prior to claim adjudication and payment. Providers receive a written notification of request for records from PHP's audit firm. The Provider should submit all necessary documentation as requested in the letter within 30 days or as specified in the letter to ensure a successful audit. Documentation should be sent to the address referenced on the letter.

Post-payment audits include claims processed six months to one year prior to the audit/review date to identify billing trends and Provider billing outliers. However, this may be expanded as needed based on the situation and findings. Providers receive written notification of request for records from either PHP and/or our audit firm. The Provider should submit all necessary documentation such as Patients' medical records, as requested, within 14 days or as specified in the letter to ensure a successful audit. On-site audits may be requested. Providers receive an initial letter of notification and a follow-up call from a PHP representative to schedule the on-site review.

- PHP does not pay administrative fees for or relating to any audit.
- PHP sends written notification to the Provider, including a detailed explanation of the post-payment audit result.
- For pre-payment reviews, the detailed explanation of the results of review is provided on your Explanation of Payment.
- PHP has the right to recover payments from Providers that participate with the health plan if such payments made are determined erroneous pursuant to an audit and/or medical record review conducted under the BIP and in accordance with Provider's participation agreement.

Examples of Fraud, Waste, or Abuse

Fraud

- Billing for services that were never rendered
- Billing for services not supported within encounter documentation
- Billing for services at a higher rate than is justified

Waste

- Billing for unnecessary or excessive services
- Performing laboratory tests on large numbers of Patients when the Provider knows only a few tests should have been performed

Abuse

- Charging in excess for drugs, services, or supplies
- Providing medically unnecessary services
- Billing for items or services that should not be separately billed

PHP also monitors and audits claims billed with HCPCS codes for potential abusive charging. The audit determines if each claim is billed with the appropriate number of units and charges within reasonable and customary per unit pricing. PHP considers charges for drugs in excess of 130% of AWP as possible abuse.

A Provider or their personnel must notify PHP of any fraud, waste, or abuse that may be suspected, even if you are not sure that it is fraud, waste, or abuse. PHP can help to investigate and determine if any action is warranted. You can notify PHP confidentially using one of the methods below:

- Compliance Hotline at **517.267.9990**
- Written correspondence mailed to the Health Plan Compliance Department at P.O. Box 30377, Lansing, MI 48909-7877 or e-mailed to **PHPCompliance@phpmm.org**
- Contact your Provider Relations Team at **PHPProviderRelations@phpmm.org**

All reports made to PHP are anonymous and confidential.

Pharmacy news and updates

PHP's Prescription Drug List (PDL) and criteria for medications requiring prior approval (PA) are available on our website at **PHPMichigan.com/Providers**, Click on "Pharmacy Services" to access these tools.

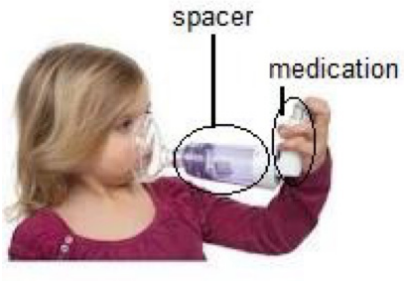
If you have any pharmacy questions, please call the Pharmacy Department at **517.364.8545** or email us at **PHPPharmacy@phpmm.org**.

New to market drugs		
Drug	**Coverage Decision**	**Effective Date**
Tolsura (plazomicin for IV administration)	Requires Prior Approval	02/28/19
Nuzyra (omadacycline tablet, IV solution)	Requires Prior Approval	02/28/19
Oxervate (cenegermin ophthalmic solution)	Requires Prior Approval	02/28/19
Vitrakvi (larotrectinib capsule)	Requires Prior Approval	02/28/19

Formulary changes		
Drug	**Coverage Decision**	**Effective Date**
Conzip (tramadol ER capsule)	Excluding from Formulary. Formulary Alternative: Tramadol/Tramadol ER tablets (Tier 1)	06/01/19
Vicodin 5/300 (hydrocodone/APAP tablets)	Excluding from Formulary. Formulary Alternative: Hydrocodone/APAP 5/325 (Tier 1)	06/01/19
Butrans (buprenorphine patch)	Excluding Brand Name only from Formulary: Formulary Alternative: Generic (Tier 1)	06/01/19
Diabetic test strips, lancets and syringes/needles	Adding quantity limit of 7 per day	07/01/19
Ajovy, Emgality	Moving to preferred status (Tier 2, Step Therapy)	07/01/19
Farxiga, Xigduo, Glyxambi, Januvia, Jardiance, Ozempic, Synjardy, Tanzeum, Trulicity, Victoza	Will require a 90 day trial of metformin	07/01/19

Expanded access for spacer coverage

Effective July 1, 2019, coverage of spacers, or Valve Holding Chambers (VHC), will be available to all Physicians Health Plan (PHP) Members who have a pharmacy benefit with PHP. These devices improve delivery of inhaled medications. Currently, spacers are available as a medical benefit for PHP Members. This change will expand access to spacers through the pharmacy benefit in addition to the existing and continuing medical benefit.



Some plans allow members to receive spacers at no cost when filled at a pharmacy.

If your SPN or PHP Patient needs a prescription for an inhaled medication, determine if they also need a spacer and write a prescription for both at the same time.

New genetic testing partnership with InformedDNA

PHP is pleased to announce a new genetic testing partnership effective June 1, 2019.

We've entered a new era of precision medicine where treatments can be targeted and disease risks identified for individuals based on their unique genetic makeup. Today, there are more than 80,000 genetic tests available, and the number is growing. Navigating this rapidly advancing area of medicine can be a challenge for your practice and your Patients.

Here are a few pieces of information to introduce you to the program:

- PHP has partnered with InformedDNA to provide genetic expertise to our processes for an appropriate clinical review. As part of this program, genetic experts from InformedDNA may contact Providers to discuss requests for genetic testing. The goal is to educate and obtain clinical details to support particular requests. The genetic analysts will share this information with the PHP medical reviewers for final coordination.
- The program promotes evidence-based, high-value care for our Members who require molecular genetic testing.

We value your participation and look forward to working with you to help improve the health of our Members.
If you have any questions, please contact your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

How are Morphine Milligram Equivalents (MMEs) calculated?[1, 2]

By Shelly Zhang

Calculating a Patient's total daily dose of opioids helps to identify Patients who may benefit from a reduction or tapering of opioids, co-prescription of naloxone, or closer monitoring.

- Determine total daily dose of each opioid medication;
- Convert each daily amount to MMEs using the following conversion factors [Strength per Unit x (Number of Units / Day Supply) x Conversion Factor = MME / Day];
- Add converted MMEs together for total daily dose of opioids.

Morphine Mg Equivalents (MME) Conversion Factor

Type of Opioid[a]	MME Conversion Factor[d, e]
Butorphanol (mg)	7
Codeine (mg)	0.15
Dihydrocodeine (mg)	0.25
Fentanyl buccal or sublingual tablets, or lozenge/troche (mcg)	0.13
Fentanyl film or oral spray (mcg)	0.18
Fentanyl nasal spray (mcg)	0.16
Fentanyl patch (mcg)b	7.2
Hydrocodone (mg)	1
Hydromorphone (mg)	4
Levorphanol tartrate (mg)	11
Meperidine hydrochloride (mg)	0.1
Methadone (mg)[c]	3
1-20mg/day	4
21-40mg/day	8
41-60mg/day	10
≥61-80mg/day	12
Morphine (mg)	1
Opium (mg)	1
Oxycodone (mg)	1.5
Oxymorphone (mg)	3
Pentazocine (mg)	0.37
Tapentadol (mg)	0.4
Tramadol (mg)	0.1

Chart Notes

- a. Buprenorphine products prescribed as part of medication-assisted treatment for opioid use disorder should not be included in dosage thresholds for opioids prescribed for pain. Buprenorphine products do not have associated MME conversion factors.
- b. The MME conversion factor for fentanyl patches assumes 1 mg of parenteral fentanyl is equivalent to 100 mg of oral morphine and one patch delivers dispensed mcg per hour over a 24-hour day. Conversion factor accounts for days of use. For example, 10 25 µg/hr fentanyl patches dispensed for use over 30 days would work out as follows: 25 ug/hr fentanyl patch * (10 patches/30 days)* 7.2 = 60 MME/day.
- c. The CDC uses a conversion factor of 3 to calculate methadone dose when analyzing the Medicare population for opioid use, whereas a sliding scale approach is often used clinically.
- d. Note: MME values should not be used to convert Patients from one opioid analgesic to another. Consult the manufacturer's full prescribing information for guidance on conversions.
- e. Morphine mg equivalents are also known as morphine equivalent dose or MEDs.

References

1. U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Calculating Total Daily Dose of Opioids For Safer Dosage. Accessed at https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf on October 2, 2018.
2. Centers for Medicare & Medicaid Services. Opioid Morphine Equivalent Conversion Factors. Accessed at https://www.cms.gov/ Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-vFeb-2018.pdf on October 2, 2018.

New specialty drug site-of-care policy

PHP encourages a strong relationship between our Members and Providers, while providing cost-effective care. Beginning July 1, 2019, to provide consistency and align with industry practices, PHP is implementing new site-of-care requirements. The following list of medications require 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	golimumab	J1602
Remicade, Inflectra, Renflexis	infliximab	J1745, Q5103, Q5104
Xolair	omalizumab	J2357
Stelara	ustekinumab	J3357
Entyvio	vedolizumab	J3380

Site-of-care 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 an active approval 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**.

Utilization Management news and updates

Some behavioral health neurological testing and cognitive testing will no longer require prior approval as of July 1, 2019. Please see table below. If you have questions, please reach out to our Customer Service Department.

A comprehensive list of procedures and services requiring prior approval is available online. Visit **PHPMichigan.com/Providers** and select "Forms" to locate the Authorization-Notification Table.

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 Approval 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
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes	Added to BCP-45 Preventive Services policy	10/01/18
97802, 97803, 97804, S9449, S9452, S9470	Medical nutritional therapy, Weight management classes, nutrition classes and counseling	Removed from BCP-45 Preventive Services policy (codes are included in BCP-60 Weight Management Services policy)	10/01/18
G0447, G0473	Face-to-face behavioral counseling for obesity.	Removed from BCP-60 Weight Management Services policy (codes are included in BCP-45 Preventive Services policy)	10/01/18
96116, 96121, 96132, 96133, 96136, 96137, 96138, 96139, 96146	Neurobehavioral status exam; Neuropsychological testing; Psychological or neuropsychological test administration	Change from Prior Approval to Covered	01/01/19

Coming Soon: PHP Case Management materials for your Patients

These brochures provide information about PHP Case Management including:

- Who benefits from case management
- What Members can expect from case management
- How to contact the PHP Case Management Department

If you would like copies for your office, email your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Medical and pharmacy policies on MyPHP

Did you know you can obtain PHP's medical and pharmacy policies from the Provider portal, MyPHP? To access the policies through the Provider portal, log into your MyPHP account and click on Medical Policies or Pharmacy Policies in the green toolbar. PHP routinely monitors and frequently updates the portal to ensure that policies are accurate and up-to-date. If you have any questions about these updates, please email your Provider Relations Team at **PHPProviderRelations@phpmm.org**.

Asthma Education

Managing Asthma Through Case-management at Home (MATCH) provides intensive home-based asthma case management services for Members with uncontrolled asthma.

The visits involve:

- Assessment of asthma triggers
- Consultation on how to reduce asthma triggers
- Medication management
- Evaluation of asthma exacerbations
- Connection to resources to create an asthma-friendly home

The Certified Asthma Educator also coordinates care with family members, healthcare Providers, school staff, and employers to ensure the Member's individualized asthma action plan is utilized.

Long-term impacts include reduced Emergency Department visits and hospitalizations related to asthma, decreased healthcare costs, and improved quality of life.

Referrals can be submitted to **ihpmi.org/carehub-MATCH**.

PHP tobacco cessation program expands to address growth in vaping

PHP's Tobacco Cessation program aims to give participants the support they need to kick the tobacco habit. Even though vaping does not include the tobacco element, it still contains nicotine. Healthyroads is an online tool which includes a personal coach, which combined with self-motivation enable participants to break the habit and learn new, healthier habits to take its place. Your Patients can get started on a journey to better health by calling Healthyroads at **877.330.2746** or registering at **Healthyroads.com**. Once registered, information about vaping can be found by searching smoking cessation/ tobacco/e-cigarette.

Studies show vaping rises among teens

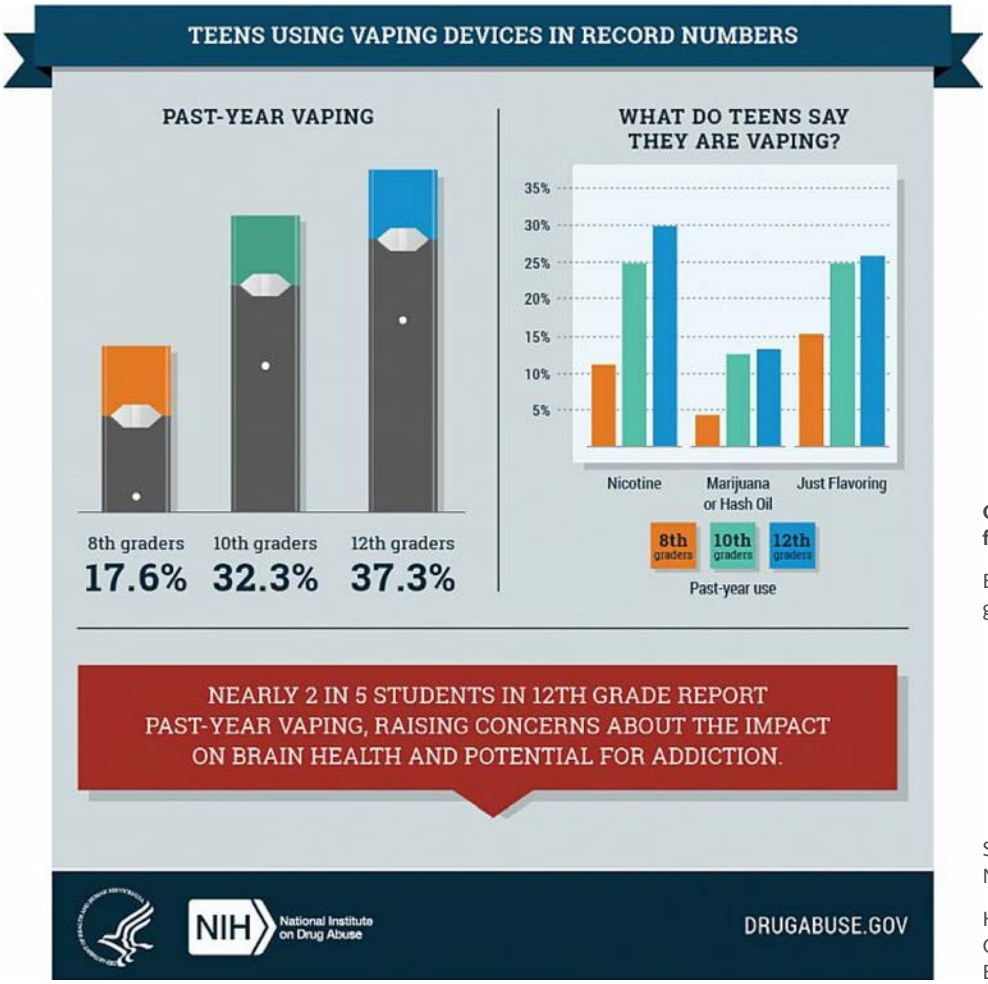
A new survey found an alarming rise in the number of American teens who tried vaping last year. This study suggests that vaping may be driving an increase in nicotine use for teens.

In vaping, a battery-powered device called an e-cigarette heats a liquid into a vapor that can be inhaled. The vapor may contain nicotine (the addictive chemical in tobacco), flavoring, and other chemicals. E-cigarettes can also be used with marijuana, hash oil, or other substances.

More than 44,000 students from the 8th, 10th and 12th grades took part in the 2018 annual survey of drug, alcohol, and cigarette use. About 37% of 12th graders reported vaping in 2018, compared with 28% percent in 2017. Vaping of each substance that was asked about increased. This includes nicotine, flavored liquids, marijuana, and hash oil.

"Vaping is reversing hard-fought declines in the number of adolescents who use nicotine," says Dr. Richard Miech, who led the study at the University of Michigan. [1] "These results suggest that vaping is leading youth into nicotine use and nicotine addiction, not away from it."

"Teens are clearly attracted to the marketable technology and flavorings seen in vaping devices," explains Dr. Nora D. Volkow, director of NIH's National Institute on Drug Abuse. "However, it is urgent that teens understand the possible effects of vaping on overall health, the development of the teen brain, and the potential for addiction."



Get e-cigarette facts and resources to facilitate Patient education at:

E-cigarettes.surgeongeneral.gov/getthefacts.html

» 1. Evans-Polce, Rebecca J.; Patrick, Megan E.; Lanza, Stephanie T.; Miech, Richard A.; O'Malley, Patrick M. and Johnston, Lloyd D. (2018). Reasons for Vaping among U.S. 12th Graders. Journal of Adolescent Health, 62(4), 457-462.

Source: NIH News in Health, February 2019, NewsInHealth.hih.gov

HealthyRoads.com/OnlineClasses/details/QuittingTobacco/WhyQuitTobacco/ECigarettesAreTheySafe

Appeals

An appeal is a written request submitted by a Physician/Practitioner/Provider to change a decision that was made by PHP regarding a specific Member. The decision may be related to the Member's medical or pharmacy benefit, or a request to change a complete or partial claim denial. It is recommended that you contact Customer Service prior to filing an appeal to address any questions about how the claim was processed originally. An appeal must be submitted no later than **90 days** from the date the last claim was processed.

For services that are urgent, life threatening, or if the Member is in the middle of treatment, an urgent or expedited appeal may be initiated by the Member or Provider. Please contact PHP's Customer Service Department to request an urgent or expedited appeal. PHP responds to urgent or expedited appeals within **3 calendar days**.

If you would like to submit a Provider appeal, please submit your request in writing and include any pertinent documentation to support your appeal. You may use the Provider Appeal Form located on our website at **PHPMichigan.com/Provider/Forms**. You may mail or fax the appeal to:

Physicians Health Plan
Attn: Customer Service, Provider Appeals
PO Box 30377 Lansing MI 48909-7877
(P): 517.364.8500 or 800.832.9186
(F): 517.364.8411

Coordination of Benefits

Coordination of Benefits (COB) is a methodology used to pay healthcare expenses when a Member is covered by more than one insurer or plan. PHP applies certain rules to decide which carrier pays first (primary). The objective is to make sure the combined payments of all carriers are no more than the allowable expense.

Prior to submitting a claim to PHP, it is important to determine who is primarily responsible for payment of the claim. If it is determined that another payor is primary, that payor should be billed prior to billing PHP. After receipt of payment, submit a paper claim including the following information to PHP:

- The original billed charges
- The amount received from the primary plan
- A copy of the other plan's Explanation of Benefits (EOB) or Explanation of Payment (EOP)

How primary and secondary benefits are determined:

- The plan having no COB provision or non-duplication coverage exclusion is always primary
- When a Member is covered by two plans, the plan covering them as a subscriber rather than the plan covering them as a dependent is primary

Coverage for dependent children of parents who are not divorced or separated, and the child is covered by both parents' plans, is determined as follows:

- The plan of the parent whose month and date of birth fall earlier in the year is primary for the child
- If both parents have the same month and date of birth, the plan that has covered the child for a longer period of time is primary for the child

Coverage for dependent children of separated or divorced parents when the child is covered by both parents' plans is determined as follows:

- The plan of the parent who is required by court decree to provide healthcare coverage to a dependent child is the primary plan in all instances
- The plan of the "natural" parent who has custody applies next
- The plan of the stepparent where the "natural" parent has custody applies next
- The plan of the "natural" parent who does not have custody applies next
- The plan of the stepparent where the "natural" parent without custody applies next

If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period is primary. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

Billing for Advance Practice Providers (APPs)

Nurse Practitioners credentialed with PHP must submit claims under his/her own National Provider Identifier (NPI). Credentialled Nurse Practitioners should not bill "incident to" under your supervising Physician. If you are not credentialed with PHP, you may submit claims under "incident to" billing guidelines. Nurse Practitioners can start the credentialing process by reaching out to **PHP.Credentialling@phpmm.org**.

At this time, PHP does not credential Physician Assistants (PA). PA's should continue to bill using "incident to" billing guidelines. If you have additional questions, please reach out to the Credentialing Department at **PHP.Credentialing@phpmm.org**.

Electronic Funds Transfer (EFT)

Are you receiving your PHP payments electronically? Electronic Funds Transfer (EFT) is available through our partnership with PNC Bank. Signing up for EFT is quick and easy.

Requirements for receiving payments electronically include:

- Receive your ERA electronically via the 835 files;
- Obtain your unique ID number from PHP; and
- Register with PNC Bank.

Email your Provider Relations Team to get started at **PHPProviderRelations@phpmm.org**.

Physicians Health Plan

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P.O. Box 30377
Lansing, MI 48909-7877

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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	» 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
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