Provider Connection

THIRD QUARTER 2021

In this Issue

WORKING WITH PHP

QUALITY CORNER

UPDATES

Physicians Health Plan

Quality Corner — Thank You for Your Participation with the 2020 HEDIS Audit

The 2020 HEDIS measure year audit process has come to a close. Physicians Health Plan's (PHP) HEDIS Review Team would like to extend a sincere "thank you" to you and your office staff for assistance in the process. While every year your office staff responds to our requests for records, our gratitude is heightened this year with the recognition of the challenges and stress that the COVID-19 pandemic created. We appreciate your timely response and your courtesy in allowing us into your office to review and gather records.

The performance scores will provide comparative data that will be used to focus on quality improvement activities in the next year as we strive to improve the health of individuals, families, and communities.

Thank you for all you do for our members.

Please feel free to contact the Quality Department if you have questions. **PHPQualityDepartment@phpmm.org**

Physicians Health Plan General Training 2021

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 Commercial and PHP Medicare requirements, a review of the Provider Manual, checking eligibility and benefits, claim status, authorizations/approvals, and much more. Practice management and all office staff are encouraged and welcome to attend.

2021 Training Dates

Thursday, Nov. 11, 8:30 a.m.

Register today! Go to **PHPMichigan.com/Providers** and select "Training Opportunities."

All registered attendees will have their login information sent to the email used to register before the training date.

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

Electronic Fund Transfer is Available for PHP Commercial and PHP Medicare Payments

PHP Commercial ERA and EFT

With electronic fund transfer (EFT) you can receive your payments electronically through a partnership with PNC bank. PHP has implemented the 835 electronic remittance advice (ERA), which generates the electronic version of the Explanation of Payments (EOP).

To receive your payments electronically, there are just a few simple requirements:

1. Receive your ERA electronically by way of the 835 files.
2. Obtain your unique Provider ID number from PHP by emailing **PHPProviderRelations@phpmm.org**.
3. Register with PNC at the PNC Remittance Advantage website at **rad.pnc.com**.

To sign up for ERA, contact your claims clearinghouse. Your clearinghouse will need the following information: National Provider Identifier (NPI), Taxpayer Identification Number (TIN) as well as a physical address (not a P.O. Box).

The initial set-up typically takes two to three weeks. First time providers receiving 835 and EFT files will receive the paper EOP for 31 days following the initial registration. After the 31-day period, the paper EOP will be discontinued. EOP information can be obtained using the MyPHP Provider Portal.

PHP Medicare ERA and EFT

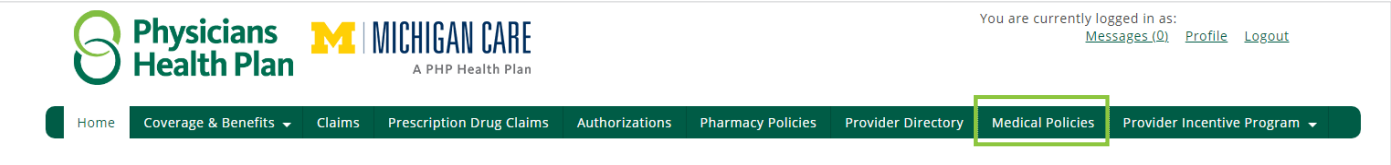
To receive your payments electronically from PHP Medicare, the registration steps are slightly different than for PHP Commercial plans. In order to register for PHP Medicare
ERA and EFT, please follow these steps:

- Contact your clearinghouse to validate or initiate their connection to Change Healthcare. Provide Payer ID number 83276 for their use.
- Register at **ChangeHealthcare.com/Support/Customer-Resources/Enrollment-Services**, or Change Healthcare at **866.924.4634**, select option 4, then option 1.
- Finally, enroll with VPay, PHP Medicare's designated payment portal vendor, for EFT. Contact VPay either by accessing the enrollment form on the PHP Medicare Provider Portal or by contacting VPay customer service at **844.224.7568**. Once this portion of the process is completed, it will typically take up to two weeks to process your enrollment.

How to Find Payment and Reimbursement Policies

Did you know that Physicians Health Plan (PHP) has Payment and Reimbursement Policies on the MyPHP Provider Portal?

Go to the PHP website at **PHPMichigan.com**, select "Portal Login" from the top menu, and then select MyPHP Provider Portal.



From the Medical Policies page, scroll down to the section, "Current PHP Payment and Reimbursement Policies." All payment and reimbursement policies applicable to PHP are listed.

Policies are updated regularly, so please make sure you are accessing information directly from the portal.

If you have any questions, please contact the Provider Relations team at **PHPProviderRelations@phpmm.org** for assistance.

PHP Obtains URAC Health Plan Accreditation

In April 2021, Physicians Health Plan (PHP) successfully completed their URAC reaccreditation survey, achieving full accreditation status for two separate lines of business: Health Plan (Commercial HMO line of business) and Health Plan with Insurance Marketplace (On-Exchange line of business). The current accreditation is valid through July 1, 2024.

URAC is a nonprofit organization founded in 1990, which uses evidence-based measures and develops standards through inclusive engagement with a range of stakeholders committed to improving the quality of healthcare. The accreditation process demonstrates a commitment to quality services and serves as a framework to improve business processes through benchmarking organizations against nationally recognized standards. URAC accreditation includes a specific set of standards that are applicable to the specific function or set of functions within the organization. As part of the accreditation process PHP's policies and procedures, as well as other organizational information, is reviewed for compliance with the standards. This review is followed by a validation visit, which includes file reviews, presentations, and multiple interviews with staff to determine compliance with PHP's own policies as well as URAC standards.

Compliance with URAC's rigorous standards proves that PHP does possess the ability to adhere to the mandates of the Affordable Care Act, to compete in insurance marketplaces nationwide, demonstrates alignment with key components of healthcare industry trends, illustrates compliance with standards that align with state and federal expectations for a more value-based delivery of care, and possesses a willingness to track performance and strive for continual improvement of services.

urac®
ACCREDITED
Health Plan
Expires 07/01/2024

urac®
ACCREDITED
Health Plan-
Health Insurance
Marketplace
Expires 07/01/2024

MyPHP Provider Portal

PHP encourages all providers and their office staff to register for and use the MyPHP Provider Portal. The provider portal gives you convenient access to the information you need when you need it.

You can view member eligibility and benefits, claims payment details, and preauthorization information. PHP's Pharmacy and Medical Policies, information about the primary care incentive program, and important updates from PHP can all be accessed in the portal. There is also a "Quick Links" section to help you quickly navigate to our Newsletters, Forms, Provider Manual, Provider Directory, and Pharmacy Services. You can also send messages and questions directly to the Provider Relations Team.

Providers who are participating with PHP Commercial and PHP Medicare Advantage plans can access information for both with a single sign-on, so there is no need to register with multiple sites. Simply log in to your MyPHP portal account and scroll down to find the words, 'For all Medicare Advantage access, please Click Here,' and the PHP Medicare logo. If it is your first time logging in to the portal, you must accept the End User License Agreement and verify your provider information.

To register, go to **PHPMichigan.com/MyPHP** and select the MyPHP Provider Portal. You need your Tax ID, individual NPI, and PHP Provider ID (e.g., 2000000XXXX). If you do not know your PHP Provider ID, please email your Tax ID and NPI(s) to **PHPProviderRelations@phpmm.org**. You may also email Provider Relations to request account reactivation, password resets, or additional training with the portal.

Provider Satisfaction Survey

We thank you for your participation in the Physicians Health Plan (PHP) network. The PHP provider satisfaction survey is now available. PHP is committed to quality improvement and wants to understand how our services impact your staff and practice on a daily basis. Upon receiving the survey, we kindly ask that you please take a few minutes to complete the survey.

Results from the survey are used to help direct administrative and operational changes and identify areas that may need improvement.

Utilization Management News and Updates

3rd Quarter 2021

A comprehensive list of procedures and services requiring prior approval is available on our website at **PHPMichigan.com/Providers**. Select "Notification and Prior Approval Table" to access the list. This information is also available on the MyPHP Provider Portal.

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

- N/A

Policy Updates

- BCP-32 Bariatric or Metabolic Surgery – move to using InterQual criteria.
- BCP-73 Spinal Cord Stimulation for Pain Control – clarification that trial & permanent placement of SCS require prior approval.
- BCP-67 Hematopoietic Stem Cell Transplantation, BCP- 70 Lung Transplantation, BCP-71 Pancreas Transplantation, and BCP-75 Liver Transplantation – all are moving to using InterQual criteria.

Changes to Coverage for Services

Code(s)	Procedure or Servivce	Action	Effective Date
G0248, G0249	Home INR monitor; demo for use, test materials & equipment, physician review & interpretation.	Change from "Not Covered" to "Prior Approval"	10/1/2021
21116	Injection for TMJ	Change from "Not Covered" to "Covered"	1/1/2020
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	Change from "Covered" to "Prior Approval"	10/1/2021
52287	Chemodenervation of bladder	Change from "Prior Approval" to "Covered"	1/1/2021
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	Change from "Not Covered" to "Prior Approval"	10/1/2021
56620	Vulvectomy, simple, partial	Change from "Prior Approval" to "Covered"	1/1/2021
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Change from "Not Covered" to "Covered"	1/1/2021
64566	Percutaneous tibial neurostimulation (PTNS), single treatment	Change from "Prior Approval" to "Covered"	10/1/2021
81541	Oncology (prostate), mRNA gene expression profiling by real-time of 46 genes, algorithm reported as a disease-specific mortality risk score	Change from "Not Covered" to "Covered"	10/1/2021

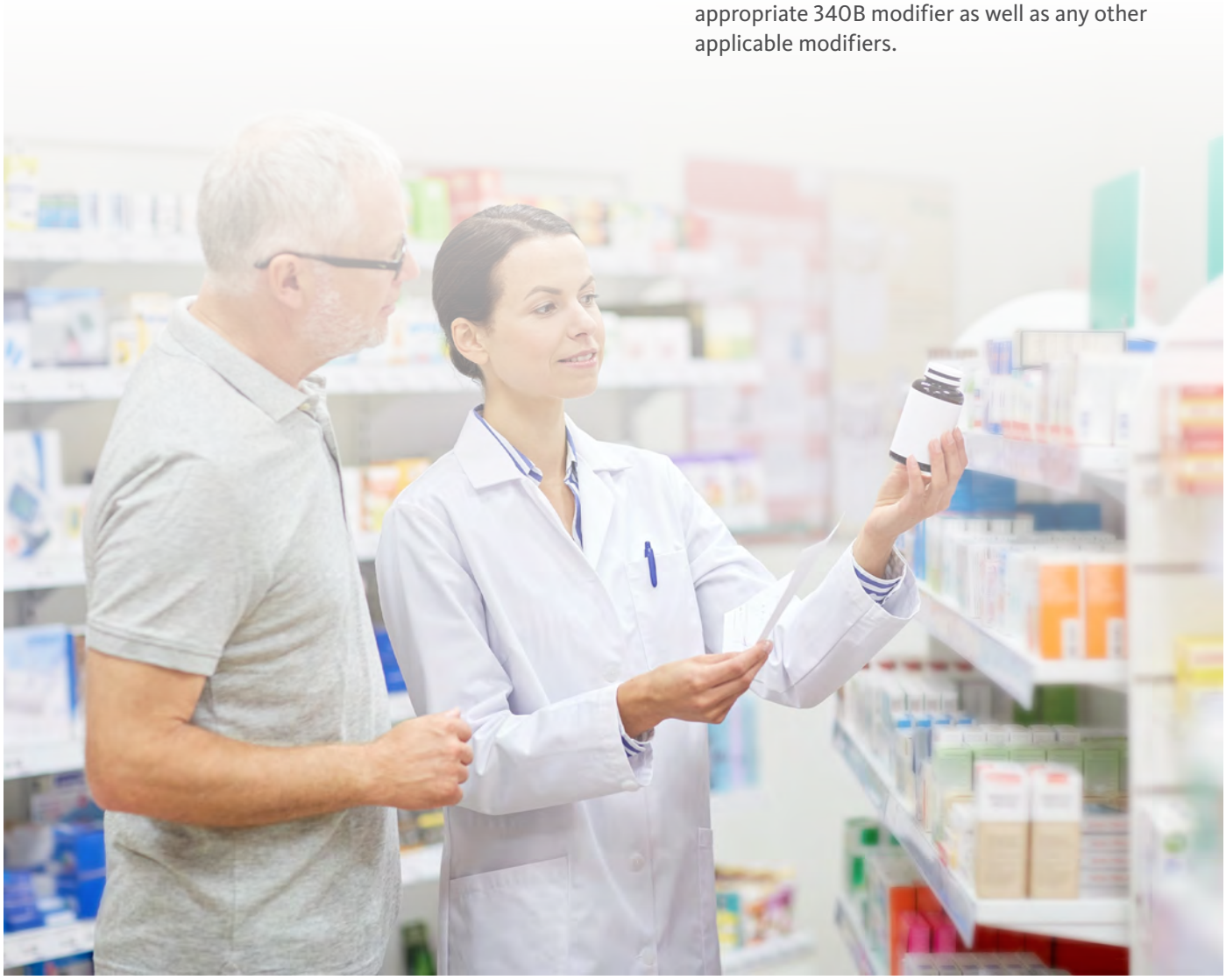
**Any provider or member that was directly impacted by these changes received a direct mailing explaining the changes.*

340B Pricing Program Covered Entities

The Federal 340B Drug Pricing Program allows qualifying entities, such as hospitals, specialty clinics, and associated outpatient facilities that serve uninsured and low-income patients, the option to purchase outpatient prescription drugs from manufacturers at discounted rates. These qualified entities are also known in the program as Covered Entities (CEs). The savings created by the discounts are then expected to be used towards the reduction in financial burden of the uninsured, underinsured, or low-income patients in the community. Eligible entities must obtain approval through the Office of Pharmacy Affairs (OPA) located within the Health Resources and Services Administration (HRSA). Additional information is available at **340BHealth.org** and **CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitaloutPatientPPS/Downloads/Billing-340b-Modifiers-Under-Hospital-Opps.pdf**.

How to Bill PHP for these discounted drugs:

- When billing for outpatient facility services the following type of bill should be selected with appropriate frequency (X)
  - 013X Hospital Outpatient
- NDC Codes must be reported with exact NDC from medication packaging
- NDC units must be reported
- Applicable Modifier(s)
  - JG - drug or biological acquired with 340B drug pricing program discount
    TB - drug or biological acquired with 340B drug pricing program discount, reported for informational purposes.
- Discarded drug amounts must be billed on a separate claim line with JW modifier and the appropriate 340B modifier as well as any other applicable modifiers.



Add-On Codes

An add-on code describes additional intra-service work associated with the primary service/procedure. Physicians Health Plan (PHP) follows the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) concerning the reporting of add-on CPT and HCPCS codes. Add-on codes are identified by AMA CPT with a plus sign (+) and descriptions include key phrases such as "list separately in addition to primary procedure", "each additional", or "done at time of other major procedure."

With few exceptions, add-on codes are not eligible for payment when billed alone. PHP may apply a clinical edit and deny reimbursement when an add-on code is billed alone. In instances where services cross date spans or one practitioner performs the primary service/procedure and another practitioner performs the add-on portion, documentation may be required to support separate billing.

In 2020, the AMA modified its guidelines regarding the application of modifier 50 to add-on codes for services performed bilaterally. While the 2020 CPT guidance indicates modifier 50 should no longer be applied, PHP will continue to follow the CMS Medicare Physician's Fee Schedule (MPFSDB) bilateral indicators. If an add-on procedure code has a MPFSDB bilateral indicator of "1" the MUE limit of "1" unit will continue to be applied. The bilateral service must be reported on one line with one unit and modifier 50 for correct claims processing.

Allergy Immunotherapy Serum Prep

Each patient's immunotherapy care plan is customized to their specific antigens and requires a tailored administration schedule including build-up and maintenance.

The preparation and provision of antigens for allergen immunotherapy is billed and reimbursed separately under Current Procedural Terminology (CPT) code 95165. Physicians Health Plan (PHP) covers the treatment of allergies through allergen immunotherapy including the preparation and injections. The AMA definition of CPT code 95165, professional services for the provision of antigens for allergen immunotherapy; single or multiple antigens, per dose, does not define dose. In general, it has been defined as the amount of serum administered via each injection. In contrast, CMS has defined a dose as "a one cc aliquot [part] from a single multidose vial." PHP follows CMS guidelines regarding National Correct Coding Initiative Edits (NCCI), Payment Status Indicators, and Medically Unlikely Edits (MUE). In a continued effort to align policy and guidelines, PHP will follow the CMS definition of a dose for the billing of CPT 95165. Effective Oct. 1, 2021, claims received on this date and forward with CPT 95165 reports will be subject to the CMS definition of a dose in correlation with the units billed on these claims.

This does not require a physician to remove 1cc aliquot doses from a multidose vial. It does however indicate that the practice expense payable for the preparation of a 10cc vial does not change if the size or number of aliquots removed from the vial is greater than 10. Therefore, if a physician removes ½ cc aliquots from a 10 cc multidose vial for a total of 20 doses, only 10 doses may be billed. When medically necessary, physicians may bill for preparation of more than one multidose vial.

This does align MUE limits already applied with the additional billing guidelines identified in the CMS Pub 100-04 Medicare Claims Processing, transmittal 2997 for CPT 95165. Please note that the MUE limit for 95165 is 30 units. This is a date of service edit based on clinical benchmarks. If the units billed exceed this MUE value, denials may be appealed with supporting documentation of medical necessity.

Documentation of services must include evaluation and care plan or prescription for immunotherapy, addressing both the build-up phase and the maintenance phase. Specifically, documentation should clearly identify initial concentration, reasoning, target concentration, and changes.

Source - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2997CP.pdf

New Collections Vendor for Outstanding Overpayment Balances

We all like to keep balanced books, but overpayments still happen. Physicians Health Plan (PHP) has employed a new vendor, Optum PRS, to collect overpayments that have not been recovered via auto-recovery. In the near future, Optum PRS will begin sending letters to providers to recover these overpayments.

When overpayments occur, PHP makes every attempt to recover these funds through auto-recovery. In the event that you realize PHP has made an overpayment, it is required to report this with a claim adjustment form and a corrected claim, if needed. Claim adjustment forms can be found on PHP's website at **PHPMichigan.com/Providers/General-Forms-and-Information**. Once your adjustment is processed, PHP initiates the adjustment (take back) on future claims payments, which is evidenced on an Explanation of Payment (EOP). Specific overpayment details are indicated in the recovery detail portions of your EOP. See the example below:

Amount Billed	Allowed	Financial Allowance	Prov. Adjust	Deductible	Copay/ Co- Ins	Other Ins	Net Paid
120.00	100.00	0.00	20.00	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 #
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 (TIN), a physician who is no longer practicing or there have been changes to payee information. In these situations, money cannot be recovered automatically. You will notice that an outstanding overpayment amount will remain 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 at right; it may be necessary to send a refund check to PHP for an outstanding remaining balance.

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 #
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, the account will be referred to Optum PRS. You may then receive letters and/or phone calls related to the overpayment collection process. Detailed claim information and claim history is available on the MyPHP Provider Portal to assist you in the research and resolution of outstanding overpayment balances.

If you have questions about your EOP or the overpayment recovery process, please contact PHP Customer Service at **517.364.8500**, Monday through Friday, 8:30 a.m. to 5:30 p.m.

PHP Behavioral Health Provider Attestations

Complete Area of Interests/Specialty Attestation to Aid Patients in Behavioral Health Provider Search

PHP members who are seeking behavioral health services can begin their search with the PHP Provider Directory. Attesting to your behavioral health area of interest or specialty can help members select the right provider. Behavioral health specialists can attest to their additional training and professional certifications in areas of practice or specialties, including age groups seen, and conditions or disorders treated. Behavioral health practitioners can also attest to having a multi-media, HIPAA-compliant system for rendering telehealth visits.

Complete a separate attestation form for each PHP-enrolled provider in your practice. If attestation forms are needed, please contact the Data and Delegation Team at **PHPProviderUpdates@phpmm.org**

State and Federally Supplied Vaccines

Physicians Health Plan (PHP) does not reimburse for vaccine(s) obtained at no cost to the provider through state or federal programs. Modifier SL is used to identify vaccines obtained at no cost to the provider.

When billing for vaccines obtained at no cost to the provider, services must be reported as follows to ensure proper claims adjudication:

- Report appropriate vaccination procedure code(s) with modifier SL
- Report appropriate administration code(s)
- All vaccines administered during an encounter must be reported on the same claim

COVID-19 (SARS-CoV-2) Vaccine and Administration

Currently COVID-19 (SARS-CoV-2) vaccine(s) are being reimbursed by the Federal government.

- PHP *does not* separately reimburse for the COVID-19 (SARS-CoV-2) vaccine(s) as long as the Federal government is providing reimbursement or supply without cost to providers.
- PHP *does* separately reimburse for the administration(s) of the vaccine(s) in accordance with the member's benefit coverage.

CVS Health

Real-Time Prescription Benefits

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

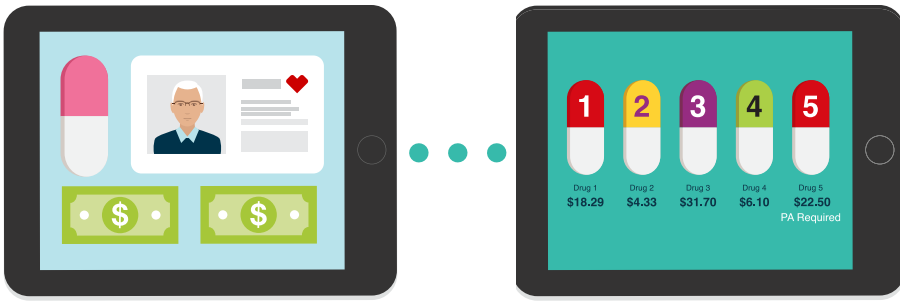
The cost of health care is a major source of worry for consumers across the nation, especially for those enrolled in high deductible health plans who may pay thousands of dollars out of pocket (OOP) each year.

Consumers must navigate their health and prescription benefit plans to make the most cost-effective choices. As a result, they are demanding greater cost transparency and easier access to the information they need to make these health care decisions.

CVS Health is committed to helping plan members find the most affordable options to keep them healthy.

We continue to help lower member OOP costs through formulary and plan design strategies. The majority of members — 85 percent — spent less than $300 on their medications last year.

We also offer real-time prescription benefits to provide greater visibility to member OOP costs and available lower-cost options to help members and their providers make more informed treatment decisions.

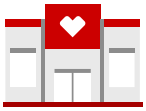


By utilizing member-specific benefit information, including formulary, plan design, deductible status, and other accumulators, our solution lets providers and members:

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

Information Provided Across All Member Touchpoints

At the doctor's office
Information is integrated into the e-prescribing workflow, so physicians can take action to help patients save right at the point of prescribing. Market projections estimate we will be connected with nearly 400,000 physicians by the end of 2020.



At the pharmacy
CVS pharmacists use our proprietary search tool, Rx Savings Finder, to quickly identify available opportunities for members to save money on their medications.

Directly to members
Our online tool lets members check what their OOP costs are and find possible lower-cost alternatives to talk about with their doctor.

Calling in to Customer Care
Customer Care representatives have access to the same real-time benefit and cost information, and can tell members exactly what they will pay OOP based on their plan design, formulary, and where they are in their deductible.

CVSHealth®

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

Drugs New to the Market

Drug	Formulary Action
Klisyri (tirbanibulin 1% ointment)	Non-preferred specialty tier, PA
Verquvo (vericiguat tablet)	Preferred traditional tier, PA
Imcivree (setmelanotide SQ injection)	Non-preferred specialty tier, PA
Orgovyx (relugolix tablet)	Non-preferred specialty tier, PA
Zokinvy (lonafarnib capsule)	Non-preferred specialty tier, PA
Bronchitol (mannitol for oral inhalation)	Non-preferred specialty tier, PA
Cabenuva (cabotegravir and rilpirine IM suspension)	Medical benefit, PA
Breyanzi (lisocabtagene maraleucel IV infusion)	Medical benefit, PA

PA = Prior Authorization

For up-to-date information on drug recalls please visit **PHPMichigan.com/Providers**, and **select Pharmacy Services** for a link to the FDA's drug recall website.

Important Things to Remember When Submitting a Prior Authorization Request Form

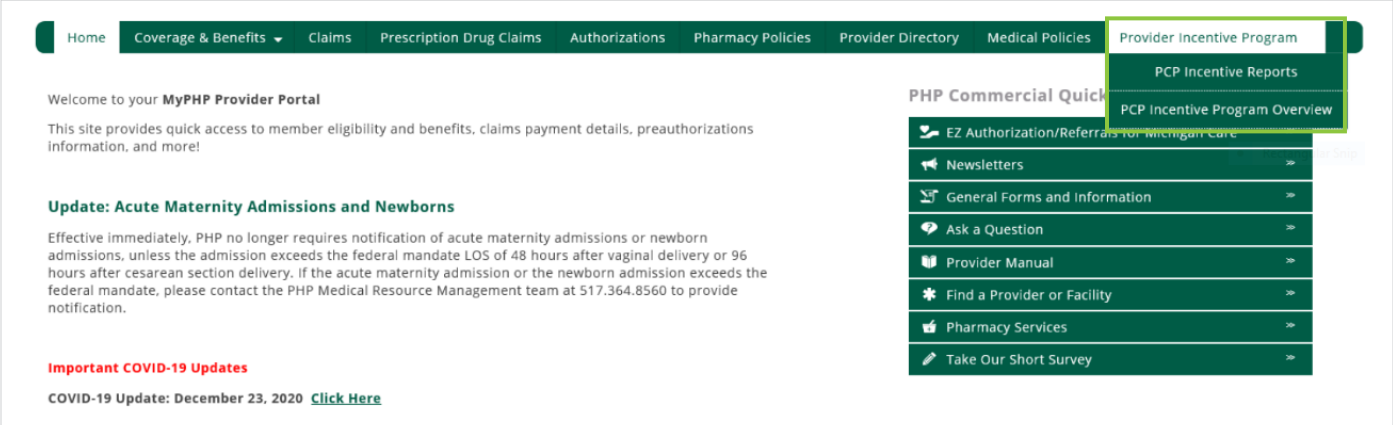
- The Medication Authorization Form is located at **PHPMichigan.com/Providers** and selecting Pharmacy Services.
- Fill out form completely and legibly.
- If requesting an infusion drug, please include the name of the office and/or facility and NPI number of where the drug will be administered.
- Provide 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 Cover My Meds are routinely transmitted with incomplete information which delays care for the patient. Sending requests directly to PHP will reduce the time it will take to process the request.

PHP Primary Care Incentive Program Reminders

Primary Care Physicians (PCPs) may be eligible for an incentive payment in accordance with the Physicians Health Plan (PHP) PCP Incentive. The 2021 Primary Care Incentive Program concludes on Dec. 31, 2021. Knowing where to find the tools and resources to assist you is key to success.

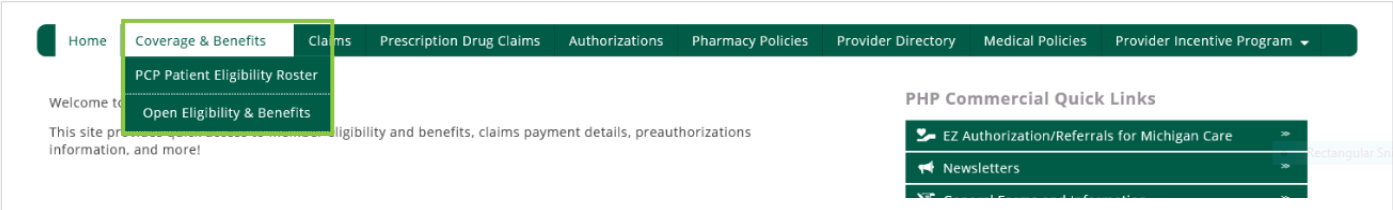
» Ensure that you're registered for a MyPHP Provider Portal account at **PHPMichigan.com/MyPHP**.

- After logging in, hover over the **Provider Incentive Program** at the top menu and select PCP Incentive Report. The roster includes eligible HMO commercial membership and can easily help identify those patients with a gap-in-care within the measure. Providers can also track their progress throughout the incentive year with individual reporting and visual graphs. Selecting PCP Incentive Program Overview can provide a detailed description of the measures and what's encompassed within each measure.



» **Nov. 1, 2021** is the deadline to notify PHP of PCP membership roster assignment changes. Reviewing your roster each month can help identify new membership as well as potential changes to your exiting membership. If you identify changes, please contact PHP's Customer Service Department at **517.364.8500** or **800.832.9186**, Monday through Friday, 8:30 a.m. to 5:30 p.m., or contact the Provider Relations team at **PHPProviderRelations@phpmm.org**.

» Obtaining a Physicians Health Plan PCP membership roster is quick and easy. Once registered and logged into **PHPMichigan.com/MyPHP**, select Coverage & Benefits from the top menu, then select PCP Patient Eligibility Roster. Add the PCP's ID and select View all Patients.



If you have questions regarding the Primary Care Incentive Program or would like additional training to maximize your incentive reimbursement, please contact the Provider Relations team at **PHPProviderRelations@phpmm.org**.

Physicians Health Plan

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	517.364.8408 (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 Attn: Pre-Pay 1849 West Drake Drive STE 101 Tempe, AZ 85283 952.224.8650 949.234.7603 (fax)	MedicalRecords@changehealthcare.com