



Physicians Health Plan

PROVIDER MANUAL

About Physicians Health Plan

Physicians Health Plan (PHP) welcomes you as a Network Physician/Practitioner or Health Care Provider (Network Provider).

PHP began in 1980, when Sparrow Health System and a group of visionary Physicians began Mid-Michigan's first broad-based Independent Practice Association (IPA) model Health Maintenance Organization (HMO). An IPA is made up of a network of local Physicians, hospitals and other professionals who deliver a full continuum of care. PHP's first products were introduced to the market in 1982. PHP's Network of Providers, known as the Physicians Health Network (PHN), provides healthcare services to Members in various PHP products. The Network Program Description is applicable to the following HMO products:

- Traditional Commercial HMO Products which means all commercial HMO products offered by Physicians Health Plan
- Preferred Provider Organization (PPO) Products, which means all products offered by PHP Insurance Company
- Third party administrator (TPA) products through the PHP Service Company

Service Areas

PHP Commercial	PHP Exclusive
<ul style="list-style-type: none">• Clinton County• Eaton County• Gratiot County• Hillsdale County• Ingham County• Ionia County• Isabella County• Jackson County• Lenawee County (partial)• Montcalm County• Saginaw County (partial)• Shiawassee County• Washtenaw County (partial)	<ul style="list-style-type: none">• Clinton County• Eaton County• Ingham County• Ionia County• Montcalm County (partial)• Shiawassee County

Our Mission

To improve the health status of our Members by facilitating access to quality, compassionate, accessible, and cost-effective health services through organized health delivery systems.

Our Vision

To be the premier health financing organization, known for its ability to improve the health status of its Members and for its service, quality, innovative and cost-effective financing solutions for employers, individuals, purchasers and governmental agencies.

We Will Achieve Our Vision By:

- Holding our health delivery networks accountable for improving the health status of our Members through the promotion of healthy lifestyles and disease prevention
- Maintaining exceptionally high Member and purchaser satisfaction levels
- Advocating for the health needs of the membership
- Providing portfolio of products that are value-driven and deliver measurable quality, compassionate, accessible cost-effective healthcare
- Working collaboratively with healthcare Providers by aligning incentives to focus on quality, cost-effective care
- Achieving active and significant community participation in governance
- Finding solutions from the employer's human resource perspective
- Working collaboratively with brokers and agents
- Ensuring financial viability by maintaining appropriate medical cost to premium ratios in all health plan products
- Providing meaningful information to purchasers and Providers

Our Values

To improve the health status of our Members by providing quality, compassionate, accessible, cost-effective health services through an organized health delivery and financing system.

Our Brand

The interlocking rings in PHP's logo represent relationships – between community and healthcare, quality and Member experience, PHP heritage and vision, Members and their health plan, and PHP and its network of Providers. They further

reflect the importance of PHP's relationship with Sparrow and our shared goal to improve the health of the people in our communities by providing quality, compassionate care. Our mark in the community stands as a testament to what we believe, what we practice, and what we strive to become every day.

Our Network Providers play a key role as we pursue our commitment to improve the health and well-being of the individuals we serve. This manual is designed to provide information you need to know when treating a Member in your office or facility. It contains information regarding PHP products, medical resource management and quality improvement programs, billing and claim procedures, ID cards, and eligibility verification. To the extent that any provision in your participation agreement differs from the requirement(s) described in this manual, the provisions of your participation agreement shall take precedence. The procedures and descriptions of health benefit plans outlined in this manual are intended to cover most contracting situations you and your office staff will encounter.

The manual should not be used for determining coverage for a specific procedure. To verify more specific benefit information, the PHP website is located at, PHPMichigan.com and the PHP Portal. You may also call our Customer Service Department if you have specific questions.

This manual is reviewed periodically and may be changed by PHP in its sole discretion. This manual replaces manuals previously issued to your office or organization by PHP.

Please note: If you are a Network Provider who participates with certain PHP products through an IPA, hospital, medical group, PHO, or other organization which has contracted with Physicians Health Network (PHN), please look to that contracting organization for policies and procedures specific to those products that may take precedence over those outlined in this manual.

Product Overview- Plan Definitions

This section contains information about current PHP products. This manual is general in nature; therefore, there may be sections that do not apply. If you have any questions about PHP products, please contact your Provider Relations Team at the telephone number indicated on the ["How to Contact Us"](#) page.

Commercial Products

HMO

The HMO product provides coverage for a comprehensive list of health care services, including preventive health services, such as health maintenance exams, immunizations and well-child check-ups. Members are required to select a Primary Care Physician/Practitioner that will coordinate the Member's care. Members are required to seek services with a Network Provider.

PHP Plus – Select Plus

The Plus product provides coverage for a comprehensive list of health care services, including preventive health services, such as health maintenance exams, immunizations and well-child check-ups when seeking services from Network Providers. It also gives Members the opportunity to seek services outside the Network. The PHP Plus product has a deductible that applies for services provided outside the PHP network of Providers.

High Deductible Health Plan (HDHP)

HDHP is a product with benefit plan designs determined by the Internal Revenue Service (IRS). These plans usually have higher deductibles than traditional benefit plans and assist employer groups to qualify for a Health Savings Account (HSA) for their employees.

Self-Funded

The PHP Self-Funded product offers groups the same benefits available under all the PHP products. It allows the employer to choose the coverage and assume the financial risk for providing benefits to its employees. Rather than obtaining medical coverage from PHP, an employer elects to fund the risk directly. PHP acts as a third-party administrator for the Self-Funded product. This product is administered through the PHP Service Company.

PPO

PHP Insurance Company, administrated by PHP, offers various Point of Service (POS) product allowing Members to utilize both Network and Non-Network Providers while still receiving the benefits of great coverage for health services.

Marketplace Products

Exclusive Network Plans - Sparrow PHP Silver Select Exclusive and Sparrow PHP Gold Select Exclusive

Our Exclusive Network Plans work with a broad HMO (Health Maintenance Organization). Members can receive health care from any Provider within the Exclusive Network if the Member resides in the counties of Clinton, Eaton, Ingham, Montcalm, or Shiawassee County.

Traditional Network Plans

PHP offers six trusted and traditional network plans on the Marketplace. Each of the plans below includes coverage for essential health benefits, pre-existing conditions and preventative care:

Sparrow PHP Platinum Select

Sparrow PHP Gold Premier

Sparrow PHP Silver Premier

Sparrow PHP Silver

Sparrow PHP Bronze Premier

Sparrow PHP Bronze

Department Services

Customer Service

Our Customer Service Department is your first contact for all issues. Please call the Customer Service Department to:

- Verify a covered Member's eligibility
- Confirm a Member's PCP assignment
- Confirm Member benefits
- Verify Provider participation status
- Check the status of a claim
- Update Member Coordination of Benefits

Medical Resource Management (MRM)

The goal of our MRM Department is to provide our Members with a focused and specialized support system which is designed to help facilitate and coordinate requested health care services. MRM provides toll-free telephone access to its review staff from 8:30 a.m. to 5:00 p.m. ET during the normal workweek (Monday through Friday). The department responds to communications within one business day. Additional availability is provided during after-business hours, weekends, and holidays by an on-call process utilizing an answering service. Incoming fax communication is not available outside of regular business hours. MRM staff identify themselves by name, title and organization name when receiving, initiating or returning calls. Inbound and outbound communications from Utilization Management staff regarding inquiries about MRM are made during regular business hours unless otherwise specifically agreed upon in advance.

The Medical Resource Management (MRM) Department consists of three unique programs:

- Case Management
- Utilization Management
- Disease Management

Case Management Program

Case Management is one component of a strategic approach to improve our Members overall health status. Case Management services are provided to Members using evidenced based best practices and quality outcomes that contribute to the optimal health, function, safety and satisfaction of our Members. Within the Case Management Program, PHP provides 2 levels of Case Management Services with focused strategies related to Transitions of Care, Transplants, and Behavioral Health. The Case Management program allows Members to have one single point of contact with a Case Manager who can help facilitate and coordinate care while addressing multiple conditions and needs. Members have the right to decline participation (opt-out) with any case management program.

Common reasons to contact our Case Management Program:

- To request Case Management services
- To obtain information about Case Management Programs
- To obtain information about Transplants Services

Complex Case Management (CCM)

The CCM program includes coordination of services for identified high-risk Members whose condition(s) or needs are described as persistent, substantially disabling or life threatening, and who require treatment and interventions across a variety of domains of care, such as medical, social, and/or behavioral health. The conditions often require treatment from multiple Providers of care and sites of service.

Referrals for CCM are identified by the following criteria:

- Use of software to combine medical, behavior health, and pharmacy claims creating current and prospective risk scores
- Data supplied by PCP, Practitioners, PHP utilization nurse or Case Managers, hospital Case Managers/discharge planners, data from Members or Member's caregivers who are identified and approved for CCM program based on:
 - Greater than four chronic co-morbidities
 - New diagnosis or disability e.g., head injury, spinal cord trauma, Type 1 diabetes

- Severe, persistent disability and/or special needs, e.g., congenital anomalies, cerebral palsy

If a Member does not meet criteria for CCM program and unmet needs exist, the Member is provided case management through the General Case Management (GCM) program and/or Disease Management program (DM).

General Case Management (GCM)

The GCM Program addresses unmet health care needs of Members that do not meet the criteria for Complex Case Management. The GCM program provides Members with a team to contact within the health plan who can help facilitate and coordinate care while addressing multiple conditions and needs.

Members who may benefit from GCM include, but are not limited to, those with:

- Unmet health or social needs
- Frequent emergency room use
- Chronic, unmanaged disease condition(s)
- History of inpatient readmissions
- Transplant
- Transitions of Care

Disease Management (DM)

The DM Program is focused on improving quality of life for individuals with chronic conditions by preventing or minimizing the effects of diseases through integrated care. DM Programs are designed to improve the health of persons with chronic conditions and reduce associated costs from avoidable complications by identifying and treating chronic conditions quickly and more effectively.

Disease Management Members are identified by relevant claims data. PHP addresses five areas of focus:

- Diabetes
- Asthma
- Tobacco Cessation
- Emergency Room Utilization
- Healthy Mom Healthy Baby

Members have the right to decline participation (opt-out) with any Disease Management services. PHP provides identified Members with:

- Knowledge on selected chronic diseases, e.g., asthma, diabetes
- Information to assist Members with making health care choices
- Education on improving self-management of chronic illnesses
- Information to guide Members in ways to avoid complications of chronic illnesses
- Guidance toward the importance of establishing a Medical Home
- Resources needed to improve health, e.g., tobacco cessation program
- Education about covered benefits related to chronic disease(s)
- Education on community programs

Disease Management Programs

AsthmaWatch Program

The AsthmaWatch Program is provided to Members of all ages with asthma and includes information, educational materials, and Case Management.

Program Enrollment: PHP Members with a diagnosis of asthma are automatically enrolled in the AsthmaWatch Program based on claims for services and medication. Physicians and Health Care Providers can request and receive individual Member medication/pharmacy usage profiles. At any time, Members with asthma may be referred to the AsthmaWatch program by calling 517.364.8560 or 1.866.203.0618.

How the AsthmaWatch Program Works with PHP Members:

- Asthma special equipment: Members can obtain nebulizers, spacers, and peak flow meters
- Asthma education materials: Members are mailed educational materials to help them learn about and manage their asthma. Materials include information to address prevention and lifestyle issues such as: triggers, exercise, etc. Information is also available on the PHP website regarding the AsthmaWatch program at www.phpmichigan.com
- Case Management Services may be provided by a Case Manager. The Case Manager works with the Member to assess areas of education, equipment, transportation, and psychosocial needs

Key Resources for Physicians and Health Care Providers:

- The program is supported by guidelines for the diagnosis and management of asthma, established by the National Heart Lung and Blood Institute. For more information visit: www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines
- The program is supported by the PHP Clinical Practice Guidelines for Asthma. The guideline was developed by the Michigan Quality Improvement Consortium (MQIC) and based on the 2016 General Principles for the Diagnosis and Management of Asthma
- National Asthma Education and Prevention Program (NAEPP). For more information visit: www.nhlbi.nih.gov/about/org/naepp
- American Lung Association. For more information visit: www.lung.org

Physician and Provider Expectations

- If you are treating a PHP Member with asthma, each Member should have a(n):
 - Annual office visit for asthma care
 - Evaluation and prescription for short-acting asthma medication per guidelines
 - Evaluation and prescription for long-term asthma control medications per guidelines
 - Referral to an asthma specialist, when appropriate

Living with Diabetes Program

The Living with Diabetes Program is provided to PHP Members of all ages with diabetes. The program offers information for Members to promote awareness and self-management of diabetes for blood glucose control, educational materials, and Case Management.

Program Enrollment: PHP Members with diabetes are automatically enrolled in the Living with Diabetes program based on claims for services. Physicians and Health Care Providers can request and receive individual Member medication/pharmacy usage profiles. At any time, Members with diabetes may be referred to the Living with Diabetes program by calling 517.364.8560 or 1.866.203.0618.

How the Living with Diabetes Program Works with PHP Members:

- Diabetes Education Classes: Members are encouraged to attend a diabetes education class provided by an approved certified diabetes educator with a referral from their Physician
- Diabetes Special Equipment: Members can obtain a glucose meter, test strips, needles, lancets and syringes

- Diabetes Education Materials: Members are mailed educational materials to help them manage their diabetes. Materials include information to address prevention and lifestyle issues. Information is also available on the PHP website regarding the Living with Diabetes program at www.phpmichigan.com
- Case Management Services may be provided by a Case Manager. The Case Manager works with the Member to assess areas of education, equipment, transportation, and psychosocial needs
- Monitoring: All Members in the Living with Diabetes Program are monitored for HbA1c testing, and for annual dilated eye exams with reminders mailed to Members

Key Features for Physicians and Health Care Providers:

- The program is supported by guidelines for Management of Diabetes Mellitus
- The program is supported by the PHP Clinical Practice Guidelines for Diabetes. The guideline was developed by the Michigan Quality Improvement Consortium (MQIC) and based on the 2016 Management of Diabetes Mellitus Guideline
- Clinical practice recommendations for the treatment of diabetes American Diabetes Association. For more information visit: http://professional.diabetes.org/CPR_search.aspx
- National Institute of Diabetes and Digestive and Kidney Diseases. For more information visit: www.niddk.nih.gov/Pages/default.aspx
- American Diabetes Association. For more information visit: www.diabetes.org
- Michigan Department of Health and Human Services Diabetes, Prediabetes and Chronic Kidney Disease. For more information visit: http://michigan.gov/mdch/0,1607,7-132-2940_2955_2980---,00.html

Healthy Mom Healthy Baby

The Healthy Mom Healthy Baby Program is provided to Members who are pregnant. The program includes information and educational materials for all known expectant mothers.

PHP pregnant Members are enrolled in the Healthy Mom Healthy Baby Program by calling PHP and requesting to be enrolled into the Healthy Mom Healthy Baby program. Physician and Health Care Providers can request and receive individual Member medication/pharmacy usage profiles. You may refer a Member to the Healthy Mom Healthy Baby program at any time by calling 517.364.8560 or 866.203.0618.

How the Healthy Mom Healthy Baby Program Works:

- Prenatal Vitamins: Members can obtain a 90-day supply of prenatal vitamins for a one-month co-pay with a special authorization if allowed under Members benefit document
- Pregnancy Education Material: Educational materials are sent to Members. The materials are designed to answer specific questions about health and pregnancy, and encourage the establishment of a Medical Home for prenatal and postpartum care. Information is also available on the PHP website regarding the Healthy Mom Healthy Baby program at www.phpmichigan.com
- Prenatal Class: Members may attend prenatal classes through Expectant Parent Organization. Most prenatal classes are free, but certain classes have a cost share for the Member. i.e. all-day Saturday class

Key Features for Physicians and Health Care Providers: The program is supported by the PHP Clinical Practice Guidelines for Routine Prenatal and Postnatal Care. The guideline was developed by the Michigan Quality Improvement Consortium (MQIC) and based on the 2016 Routine Prenatal and Postnatal Care Guideline.

Physician and Provider Expectations: If you are treating a PHP Member that is pregnant:

- Have the Member come in for her initial visit within the first 14 weeks of pregnancy
- Have the Member come in 21-56 days following delivery for her postpartum visit

Tobacco Cessation

PHP has partnered with Healthyroads® to provide smoking cessation education and support. Services provided are personal coaching sessions, online tools and resources, and smoking cessation medications. Members can call Healthyroads® at 1.877.330.2746 to enroll or online at www.healthyroads.com

Emergency Room ReUtilization

PHP monitors Members' use of the emergency room. Educational mailings are provided when a Member reaches an identified threshold. PHP encourages Members to establish a relationship with a Primary Care Provider.

Utilization Management (UM) Program

The Utilization Management (UM) Department supports the health care delivery services provided by Physicians, Hospitals, Behavioral Health Practitioners, Home Care Agencies, and others as appropriate. UM is a key component of PHP's strategic approach of the design and management of healthcare. UM has highly structured and clinically sound processes that facilitate access to healthcare resources and seek to improve Members overall health status.

The Utilization Management Department uses written criteria to help evaluate medical necessity and appropriateness of care. The UM staff must verify and use the Member's benefit document when reviewing a benefit determination. Clinical review process is done using an approved algorithm with either evidence based criteria or internally developed medical policies. When needed, the PHP Medical Director will review the medical treatment plan of a Member's care with the treating Physicians and/or Practitioners.

- PHP has written utilization management decision-making criteria that is objective and based on medical evidence
- Involves appropriate Physicians/Practitioners in developing, adopting and reviewing criteria
- Annually reviews and updates utilization management criteria and the procedures for applying them

Criteria used in making decisions is available through the Utilization Management Department, for Physicians/Practitioners and Health Care Providers upon request.

Contact Utilization Management Department for the following:

- To provide notification for certain procedure and services
- To request prior authorization for services that are located on the Notification Table
- To obtain clinical decision-making criteria
- To ask questions about the utilization management process for notification or approval of care
- To schedule a Peer to Peer conversation with the Medical Director after a non-approval of medical necessity benefit determination
- To discuss with nurse reviewer or other appropriate clinician when a requested service is not approved

Access to Utilization Management: The Medical Resource Management Department Staff will identify themselves by name, title and organization name when they initiate or return calls regarding utilization management. The Medical Resource Management Department provides access to staff for Members and Practitioners/Providers who seek information about the utilization management process and the authorization of care including:

- Availability of utilization management nurses for urgent and emergent calls after normal business hours through the on-call process. To access the utilization management nurse on-call, call Customer Service at 800.832.9186 or 517.364.8500.

Decision Making Criteria

PHP applies objective and evidence-based criteria, taking individual circumstances and the local health delivery system into account when determining the medical appropriateness of health care services. PHP's decision making is based only on appropriateness of care and service and existence of coverage. PHP does not specifically reward Practitioners or other individuals for issuing denials of coverage or service. Financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization. PHP has written utilization management decision-making criteria that is objective and based on medical evidence. Which involves appropriate Physicians/Practitioners in developing, adopting and reviewing criteria. PHP annually reviews and updates utilization management criteria and the procedures for applying them.

Criteria used to make decisions is available through the Utilization Management Department, for Physicians/Practitioners and Health Care Providers upon request. Treating Physicians can discuss medically necessary adverse determinations with the Medical Director in a Peer to Peer Review. If a requested service is not approved, Physicians/Practitioners and Health Care Providers have the opportunity to discuss the case with the nurse reviewer or other appropriate clinician/s.

Network Services

The Network Services Department is available to assist Providers with network related issues including Contracting, Credentialing, Provider Review and Provider Relations services, such as:

- Status of credentialing application or process
- Reporting changes in your Practice, such as office hours, office address or phone number, hospital staff privileges
- Notification of a change in your federal tax identification number
- Notification of a change in your payment address
- Notification of a name change
- To request Provider education or in office orientations
- To learn about online verification services, such as Member eligibility, claims status and more
- Research and resolution of complex payment/processing issues
- Clarification on contractual obligations
- Other network related issues

Quality Management (QM)

The QM Department includes responsibility for the PHP's Quality Improvement Program, Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Qualified Health Plan (QHP), Enrollee Experience Survey, and Quality Rating System (QRS) star ratings. QM also provides quality compliance oversight for PHP's URAC Accreditation. Refer to the External Regulations and Standards page for additional information regarding URAC, HEDIS, CAHPS, QHP, Enrollee Experience Survey and QRS star ratings.

Quality Improvement Program

PHP's Quality Improvement Program is based on a written description that is reviewed and updated annually. The written program provides the integrated framework for all quality improvement activities and overall guidance to the activities of the various PHP standing quality committees.

The objective of the Quality Improvement Program is effective and efficient implementation of the quality improvement process defined as:

- Program structure development
- Measurement
- Communication and coordination
- Evaluation
- Compliance with external quality regulations and standards

To request information on PHP's quality goals and progress please call the Customer Service Department at the number listed on the ["How to Contact Us"](#) page.

Quality Improvement Suggestions

PHP supports continuous quality improvement and is continually looking for ways to improve services. PHP welcomes your ideas. Please submit your ideas to the Quality Management Department, at the email address listed on the ["How to Contact Us"](#) page.

Standard of Care Guidelines

Guidelines for clinical care are a fundamental component of managed health care quality improvement standards. PHP supports and follows the Michigan Quality Improvement Consortium (MQIC) guidelines which are based on national sources. PHP's Standard of Care

Guidelines are listed inside the Provider Manual. If you would like to obtain a paper copy of these guidelines, please contact the Quality Management Department at the number located on the "[How to Contact Us](#)" page.

Requirements and Rights of Participation

Credentialing and Recredentialing

PHP's goal is to maintain and deliver to its Members a quality network of Physicians/Practitioners and Health Care Providers. Participation in the network requires submission, review and acceptance of Physician/Practitioner and Facility credentials as outlined in the PHP Credentialing and Recredentialing Plan (Credentialing Plan). A copy of the Credentialing Plan is located on PHP's website www.PHPMichigan.com or a copy may be requested by contacting Network Services at the number listed on the "[How to Contact Us](#)" page. PHP credentials all Physicians/Practitioners/Facilities that are listed in PHP's provider directory. PHP credentials, Medical Doctors, Doctors of Osteopathy, Certified Nurse Midwives, Podiatrists, Oral Surgeons, Optometrists, Chiropractors, Behavioral Health Providers, Nurse Practitioners and as determined by the Plan, Certified Nurse Specialists. Locum Tenens Providers in any of these specialties would also require credentialing. PHP does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnical/national identity, gender, age, sexual orientation or the types of procedures or patients in which the Physician/Practitioner or Facility specializes.

PHP will ask for credentialing information with your application for initial network participation. Network Facilities and Physicians/Practitioners are re-credentialed every three years. The Credentialing and Peer Review Committee (Committee) may request information more frequently. PHP accepts the Council for Affordable Quality Healthcare (CAQH), Mid-Michigan Uniform Credentialing or Michigan Association of Health Plans (MAHP) applications. The Credentialing Staff determines compliance with the administrative criteria of the Credentialing Plan when evaluating applications. It is important that Physicians/Practitioners sign, date and return this information to the Credentialing email, fax number or mailing address listed in the "[How to Contact Us](#)" page of this manual. The initial credentialing application is forwarded to the Committee for review and recommendation in accordance with the Credentialing Plan.

Applicants have the right to be informed of the status of their application, to correct erroneous information, and to review information submitted in support of their application. Requests may be made in writing or by calling PHP at the number listed on the "[How to Contact Us](#)" page. PHP will respond to a request within two (2) business days. PHP is not required to allow an applicant to review personal or professional references or other information that is peer review protected or is otherwise prohibited from disclosure by law.

At the time of recredentialing, PHP will verify that Physicians/Practitioners and facilities continue to satisfy the administrative and professional standards as described in the Credentialing Plan. The recredentialing application is forwarded to the Committee for review and recommendation in accordance with the Credentialing Plan.

In addition to the information on the recredentialing application, the Committee review may include, but is not limited to the following:

- Member complaints
- Results of quality reviews
- Compliance with PHP policies and protocols
- Member satisfaction surveys, where applicable
- Medical record reviews, where applicable
- Clinical efficacy, efficiency and appropriateness
- Medical outcomes
- Results of office and facility site visits, where applicable
- Appropriate limits for malpractice and general liability insurance
- Adverse action reported to the National Practitioner Data Bank (NPDB)

Participating Physicians/Practitioners in the recredentialing process will be recredentialed unless otherwise notified.

Physician/Practitioner Disciplinary Action, Restriction, Suspension, or Termination

If PHP receives information that appears to warrant the restriction, suspension, or termination of a Physician/Practitioner for reasons relating to the Physician/Practitioner's professional competence or conduct, or a business or administrative related decision, it will compile pertinent information and refer the matter to the Committee. Alternatively, if the Committee directly receives information, which it believes, in its sole discretion, suggests that discipline or termination may be appropriate; the Committee may ask PHP staff to investigate the matter.

If the Committee believes that further information is needed, PHP may obtain such information from the Physician/Practitioner or other sources. The Committee may request or permit the Physician/Practitioner to appear before the Committee to discuss any issue relevant to the investigation. The Committee will consider the information received and determine whether disciplinary action, restriction, suspension or termination is appropriate. The Committee has complete discretion regarding restriction, suspension, or termination of a Physician/Practitioner's participation status and may base its action on any factors it deems appropriate.

The Committee's actions regarding the restriction, suspension and/or termination of a Physician/Practitioner will be forwarded to PHP's Compliance Council for notification, subject to any appeal that the Credentialing and Peer Review Committee in its sole discretion allows.

- PHP, in its sole discretion, may administratively terminate the participation of any Network Physician/Practitioner/Provider without referring the matter to the Committee. Reasons for administrative terminations include, but are not limited to: Failure to comply with the administrative requirements of the Credentialing Plan
- Failure to adhere to the terms of the written participation agreement
- Change in the organizational structure following a merger or acquisition or change in the products offered by PHP
- Change in PHP's need for a Physician/Practitioner/Provider given a reduction in the size of membership

Physician/Practitioner Credentialing Appeals

If the Committee restricts, suspends, or terminates Physician/Practitioner's participation status and offers the Physician/Practitioner an opportunity to appeal the action, the Health Plan will give the Physician/Practitioner written notice of the Committee's action, which:

- States the specific criteria that the Committee considered in making its decision
- The proposed effective date of the disciplinary action or termination
- Summary of the basis for the Committee's decision
- Physician/Practitioner's option to request, in writing, a hearing on the action, the time limit within which to request such a hearing and a general description of the appeals process

The Physician/Practitioner must submit a written request for an appeal. PHP must receive the written appeal request within 30 days from the date the of the proposed action and the opportunity to appeal was sent to the Physician/Practitioner. Appeals will be heard by the Appeals Committee appointed by the Health Plan. If the Physician/Practitioner does not request an appeal within 30 days of the date PHP sent notice of the action to the Physician/Practitioner, the action of the Committee regarding any discipline or termination matter shall be final and effective.

Physician/Practitioner Corrective Action

The Committee, in its sole discretion, may identify and recommend education or other support for a Network Physician/Practitioner who demonstrates inadequate compliance with the Credentialing Plan. The Network Physician/Practitioner will be given an opportunity to voluntarily work with PHP staff in developing and implementing a work plan. If PHP Staff and the Network Physician/Practitioner cannot agree on a work plan, the matter shall be referred back to the Committee for further action.

The Committee may recommend an action to be incorporated in the work plan that it deems appropriate to improve and monitor the Network Physician/Practitioner's non-compliance with the Credentialing Plan. These recommended actions may include, but are not limited to, the following:

- Supplying the Network Physician/Practitioner with clinical guidelines, quality improvement “tools” and techniques, benchmarking information, or other reference materials
- Monitoring the Network Physician/Practitioner for a specified period of time, followed by a Committee determination as to whether the inadequate compliance has been corrected
- Requiring the Network Physician/Practitioner staff to use peer consultation for specified types of care
- Requiring the Network Physician/Practitioner staff to obtain training in specified types of care

If the Network Physician/Practitioner fails to cooperate with PHP Staff in developing and or implementing a work plan, PHP Staff shall advise the Committee and shall refer the matter to the Committee for further action.

Requesting a Leave of Absence

PHP allows participating Practitioners/Physicians to maintain their participation status during an approved leave of absence for up to six months. A request for a leave of absence from participation must be for one of the following reasons:

- Medical leave
- Family Leave
- Sabbatical
- Notification of call to active military service

The Physician/Practitioner must submit a request for the leave of absence to PHP's Medical Director for approval. The request for leave of absence must contain:

- Reason for the leave of absence
- Date the leave of absence is to begin
- Expected date of return (except in the case of military leave)
- Patient arrangements.

The Provider requesting the leave of absence will be notified of the approval or denial of the request and provided with options for termination or continued participation. Providers on the leave of absence will be removed from the PHP provider directories and will be

deactivated as of the date the leave of absence begins. When returning from a leave of absence, it is required to notify PHP within 30 days of returning. Notification of any change in Physicians/Practitioners ability to provide covered services to PHP members is required. Failure to notify PHP in advance may result in termination of participation.

Locum Tenens Providers

PHP follows an application process for participation for any Locum Tenens Physicians/Practitioners. A Locum Tenens Physician/Practitioner is defined as a Physician/Practitioner replacing a network Physician/Practitioner for a specified period, while the network Physician/Practitioner is absent from his/her practice. All Locum Tenens Physicians/Practitioners must be credentialed in accordance with PHP's credentialing processes prior to providing care. Services provided by a Locum Tenens Provider should be billed under the Locum Tenens Provider's own National Provider Identification (NPI) number.

Responsibilities of Health Care Professionals

Provider Protocols and Requirements

- Refer Members only to other Participating Providers unless Health Services are not available through a Participating Provider and are authorized by PHP
- Be bound by PHP's Provider Manual and Credentialing Plan as modified from time to time by PHP
- Obtain prior authorization for certain Health Services as defined by PHP
- Follow approved industry standard billing procedures
- Provider shall comply with the following requirements when admitting Members to a hospital:
 - Provider has obtained prior authorization from PHP, as appropriate
 - Notify PHP, as appropriate, by telephone at least five (5) days prior to a scheduled admission
 - Notify PHP, as appropriate, immediately if Provider admits a Member to a hospital for an emergency
 - If the Provider providing the Health Services is a Referral Physician, the Provider must also notify the Member's Primary Care Provider of all admissions in accordance with the above time frames
- Comply with PHP's drug formulary policy
- Comply with PHP's office laboratory lists and billing procedures
 - Provider may elect to perform all, or part of the laboratory services listed in PHP's office laboratory list. Laboratory services not listed in PHP's office laboratory list, or laboratory services not performed by Provider, shall be performed by PHP's

designated laboratory. Provider shall be reimbursed only for those laboratory services listed in PHP's office laboratory list and performed, in whole or in part, for a Member being treated directly by Provider

- Provider shall comply with PHP's Policies and Procedures as outlined in this Provider Manual

Practitioner/Provider Changes

Network Provider must notify PHP in writing and in advance of any demographic or status changes within the Practice/Facility. Failure to notify PHP can cause claim payment delays and/or denials. This includes:

- Tax ID number
- Telephone number
- Billing address
- Office address
- Office hours
- Open/closed status regarding new Members
- After hours availability
- Physicians/Practitioners joining or leaving your Practice
- Any direction you would like PHP to offer to Members assigned to Primary Care Physicians leaving your practice

The "[Demographic/Practice Information Update Form](#)" may be used to notify us of demographic/practice information changes. Failure to advise us of changes may result in delayed or incorrect claims processing.

Primary Physician/Practitioner Role

Members select a Primary Care Physician/Practitioner (PCP) who is responsible for providing and coordinating their care with other Physicians. Unless state mandates indicate otherwise, PCP's are defined as:

- Internists
- Family Physicians
- General Physicians
- Pediatricians
- Some Obstetrics/Gynecology Physicians
- Some Nurse Practitioners
- Other Physician Specialist as appropriate

Primary Physician/Practitioner Coverage

The Primary Care Physician/Practitioner ensures continuity and coordination of care for Members and is required to provide 24-hour practice coverage, seven days a week. When the Primary Care Physician/Practitioner is unavailable to provide care for the Member, he or she must arrange for another network Primary Physician to cover and provide appropriate care/services. **A hospital emergency room is not an acceptable substitute for a covering Physician/Practitioner.**

The covering Physician/Practitioner should be a Network PHP Physician/Practitioner, and where applicable, part of the Primary Physician's/ Practitioner's Medical or Specialty Group. The covering Physician/Practitioner must comply with PHP protocols and accept PHP's payment schedules. When the covering Physician/Practitioner is not in the PHP Network, he or she must agree to adhere to PHP administrative procedures as set forth in the Provider participation agreement and this manual.

To locate a PHP Physician/Practitioner to act as a covering Physician, review the Provider directory online at www.PHPMichigan.com or contact the Customer Service Department to determine the participation status of any Physician. Refer to the "[How to Contact Us](#)" page for the telephone number.

Services Primary Physicians/Practitioners are expected to Perform or Provide

Primary Physicians/Practitioners are expected to perform, at a minimum, all of the following functions applicable to their areas of expertise:

- Conduct office visits during regular office hours for the evaluation and management of common areas of medicine.
- Member education may be delegated to appropriately trained staff under the primary Physician's/Practitioner supervision

When initiating care, the Primary Physician/Practitioner must remain accountable for his or her Patient's care in an acute care Facility/Hospital, Nursing Home, and at home.

- Properly coordinate referrals with Network Specialists
- Provide preventive care and physical examinations, as appropriate, including breast exams and routine gynecological care with pap smear and pelvic exam
- Provide 24-hour, seven (7) days per week telephone access and on-call coverage including on-call arrangements with Network Physicians/Practitioners as needed
- Supervise Physician Assistants (PA) and advanced Nurse Practitioners (NP) in accordance with State licensing and regulatory requirements
- Follow up and coordinate care with Specialists, ensuring that the consultation notes are filed in the Member's chart, proper actions are taken, and follow-up care is provided
- Work collaboratively with PHP Care Coordinators and Medical Directors
- Conduct laboratory services in a Clinical Laboratory Information Act (CLIA) certified office laboratory. Laboratory work not performed in the office must be sent to a Network laboratory

24 Hour Access

Network Primary Care Physicians/Practitioners (PCP) must have appropriate methods for directing a Member to seek medical care when the Primary Physician/Practitioner is not available. The Primary Care Physician/Practitioner must arrange for the assistance to Members in emergency situations 24 hours per day, 7 days per week. When the office is closed, the Primary Care Physician/Practitioner has either a well-informed answering service or a detailed answering machine message that provides instruction for access to after-hour coverage and emergency care. PCPs will need to include instruction for access to emergency care and how to contact the Primary Care Physician/Practitioner, or another Network Provider/Practitioner whom the Primary Care Physician has designated to treat PHP Members.

Eligibility

It is the responsibility of the Network Provider to verify eligibility at the time of service. We encourage the use of electronic eligibility verification. To initiate electronic eligibility, contact the number listed on the "[How to Contact Us](#)" page. Electronic eligibility verification is easy and will provide your office with information about eligibility. For telephone eligibility inquiries, call the telephone number listed on the ID card. Examples of ID Cards are located in this manual. Refer to section, "Eligibility/Enrollment of Members" for additional information related to Member eligibility and verification procedures.

Provider/Practitioner and Healthcare Provider Expectations

Physicians, Hospitals and other Health Care Providers are expected to perform, all of the following functions applicable to their areas of expertise:

- When initiating care, the Physician/Practitioner must remain accountable for the Patient's care in an Acute Care Facility/Hospital, Nursing Home, and at home
- Properly coordinate referrals to other Physicians/Practitioners and Health Care Providers. [Refer to the Referral/Notification and Prior Authorization](#) table for more information
- Provide 24-hour, seven (7) days per week telephone access and on-call coverage including on-call arrangements with Network Physicians as needed
- Supervise Physician Assistants (PA) and Nurse Practitioners in accordance with state licensing and regulatory requirements.
- Follow up and coordinate care with Physicians and Practitioners, ensuring that the consultation notes are filed in the Member's chart, proper actions are taken, and follow-up care is provided
- Work collaboratively with PHP Utilization staff, Case Management staff and Medical Directors
- Conduct laboratory services in a Clinical Laboratory Information Act (CLIA) certified office laboratory. Laboratory work not performed in the office must be sent to a Network laboratory

Specialty Care Physicians/Practitioners (SCPs)

The PCP must coordinate a Member's medical care; however, PHP Members may self-refer when seeking treatment from a Network Specialist Practitioner. The SCP may then refer directly to another Network Provider without obtaining a referral from the PCP. The SCP should keep the PCP informed of their Member's treatment. There are also specific care/services that require prior notification and compliance with specific timeframes. Refer to the [Referral/Notification and Prior Authorization table](#).

For continuity and coordination of care, it is recommended that the consulting SCP provide the PCP with a written consultation report within seven days, including:

- Diagnosis
- Consultation findings
- Treatment plan
- Responses to specific questions

All communication between the PCP and the SCP should be expedited for urgent/emergent situations when indicated.

Ancillary Providers

Ancillary Providers include; but are not limited to, urgent care, home care, and skilled nursing facilities. Ancillary Providers must send the PCP a written consultation report within seven (7) days of the Member evaluation, including:

- Diagnosis
- Consultation findings
- Treatment plan
- Responses to specific questions
- In addition, the ancillary Provider must update the PCP at least monthly until the ancillary service is discontinued.

Acute and Urgent Care Providers

After any treatment at an urgent care facility or hospital including emergency room, hospitalization and/or surgery, a report must be sent to the PCP that includes:

- Discharge summary
- Operative and test reports
- Consultations
- Treatment plan

Medical Records

Network Providers should maintain a single, permanent medical record for each Member and protect records against loss, destruction, tampering or unauthorized use. Medical records should be available at the time of each Patient visit. Medical records should be maintained in accordance with State and Federal regulations. PHP has the right to request medical records and to receive those records in a timely manner. PHP requires records to be received within fourteen (14) days from the date of the request or as otherwise specified in the Participation Agreement.

Confidentiality of Records

All Members' medical records must be maintained in a secure, locked area that is not accessible to the general public. The office should have a written policy and an established process to maintain record confidentiality at all times.

Additional security measures should be established to protect medical records consistent with the Administration Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or any similar Federal or State statutes and regulations.

PHP has Policies and Procedures in place to preserve the confidentiality of all Members' information and records in accordance with any applicable statutes and regulations. PHP adheres to such Policies and Procedures at all times.

Standards for Medical Record Documentation

PHP requires that Network Providers maintain medical records in compliance with generally accepted CMS 95 and 97 Documentation Guidelines and should include, but are not limited to, the following established medical record keeping standards:

Member Demographic Information

- Member name and/or identification number on every page
- Gender
- Age or date of birth
- Address
- Marital status
- Occupational history
- Home and work phone numbers
- Name and telephone number of emergency contact

General Documentation Guidelines

- All entries are dated and signed by the creator/Provider/author within three (3) business days
- Entries are legible
- Problem list documents significant illnesses and medical conditions with dates of onset and resolution for Patients seen three (3) or more times
- Medication allergies and adverse reactions are prominently noted. If no known allergies or adverse reactions, this is noted
- Past medical history is easily identified and includes serious illnesses, injuries and operations, this expectation is for Members seen three (3) or more times (for anyone 18 years or younger, past history relates to prenatal care, birth, operations and childhood illnesses)
- Medication record includes name of medication, dosage, amount dispensed and dispensing instructions
- Immunization record is present
- Documentation of family or social histories is present
- Tobacco habits, alcohol use and substance abuse (prescribed or over the counter) are documented
- For PCP's with adult Patients, copy of advance directive for Member is included or documentation that the Member does not want advance directives

- History and comprehensive physical examination (including subjective and objective findings) for Members with two or more visits
- Unresolved problems from previous visit(s) addressed in subsequent visits
- Diagnosis and treatment plans consistent with findings
- Presence of growth charts, developmental assessment and measurement of head circumference for all pediatric Patients
- Lab and other studies ordered as appropriate
- Patient education and counseling
- Documentation of coordination of care with other Providers to establish coordination of care
- Consultation, lab, imaging and special studies are initialed by the PCP to indicate review. Consultation and abnormal studies include reason for referral, follow-up plans and documentation of communication from consultant
- Documentation regarding the follow-up visit and plan of care, patient's progress, response to and changes in treatment and revision of diagnosis
- Records include documentation of inpatient and outpatient hospitalizations, services provided by Emergency Rooms, Skilled Nursing Facilities, Surgical-Centers or Home Health Facilities
- History of Present Illness (HPI) must be documented by the Provider in the Member's record, but not documented by the Ancillary Staff and/or the Patient
- The CPT and ICD-10 codes reported on the approved billing claim form should be supported by the documentation in the record.
- The date of service, either start or stop time or total time in session (for time based services), the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS), Revenue (REV) code billed, notation of the sessions attendees, the rendering clinician's name, professional degree, license, and relevant identification number as applicable
- For time based services only, either a start and stop time or a total time in session must be clearly documented
- Clear and uniform amendments to records: any error is to be lined through so the original content is still readable, then dated and initialed by the person making the change. Electronic Health Records (EHR) must provide a reliable means to clearly identify the original content, the modified content, the date and signature of each modification of the record
- The Practitioner must document review of information gathered for the review of systems or past, family, and social history when gathered by someone else or through the use of a template. Information may be carried forward from a previous date of service, but the practitioner must document what they reviewed for the current encounter
- Forms or templates should gather the documentation to support the service, documentation should not be carried forward, cut and pasted or cloned to ensure documentation is for the current encounter
- A medical History and complete psychiatric history including previous treatment dates, clinician or facility identification, therapeutic, interventions and responses, sources of clinical data, and relevant family information must be documented
- For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic)
- Continue to list medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition

- Documentation must support Member (and when indicated family) involved in treatment planning
- Treatment goals must be specific, measurable, and realistic. Must include a time frame for goal attainment. Progress or lack of progress towards treatment goals, rational for estimated length of treatment episode, updates to the treatment plan whenever goals are achieved, or new problems are identified. If a Member is not progressing towards specific goals, the treatment plan should be re-evaluated to address the lack of progress and modify goals and interventions as needed
- A discharge summary is completed at the end of the treatment episodes that includes the following elements:
 - Reason for treatment episode
 - Summary of the treatment goals that were achieved or reasons that goals were not achieved
 - Specific follow up activities/aftercare plan

The medical record must be complete. It must contain sufficient information to identify the Patient, indicate the chief complaint, document any relevant history and pertinent health risks, physical examination findings, support the diagnosis, justify the treatment and document the treatment plan. Providers should submit all documentation to support the medical necessity and level of service(s) billed in accordance with CMS 95 and 97 guidelines.

Appointment Access and Office Wait Time

PHP expects that Physicians/Practitioners will see a Member within the necessary time to ensure appropriate care and outcomes given the clinical situation at hand. PHP access standards are as follows:

<i>Purpose for visit</i>	<i>Member should be seen</i>
Emergency care	Immediately seen in the office or referral to ER as appropriate
Urgent care	Within 24 hours
Non-urgent visit (symptomatic)	Within 5 days
Routine care (non-symptomatic)	Within 4 weeks
Physicals/Periodic Health Assessment	Within 8 weeks
Average office wait time	Within 15 minutes but no more than 30 minutes

Transition of Care

If your Network participation is terminating for any reason, we require that you assist in the transition of care for our Members. This may involve providing service(s) for a reasonable time to enable the Member to transition care to another Physician/ Practitioner. If you or our Member needs assistance with transition, call Customer Service at the telephone number listed on the “[How to Contact Us](#)” page.

Under certain circumstances Members may continue to seek and receive health care services from a terminated Physician/Practitioner. Eligibility and coverage of these services will be determined consistent with Michigan Law. For more information call Customer Service.

Transition of Care Coverage

PHP may provide transition of care coverage to a newly enrolled Member. If a newly enrolled Member’s coverage becomes effective under the care of a non-network Physician, PHP may grant the transition of the Member’s care to facilitate a smooth transition for the Member to a Network Physician. Transition of care coverage may allow a limited interval of continued care with the non-network Physician or Practitioner at a Network level of benefits when it is determined that an immediate transfer of care from one Physician or Practitioner to another could result in medical harm to the Member. Physicians or Practitioners should not encourage Members to request transition of care coverage for reasons of convenience or only to continue an established Physician relationship. For any questions on how to initiate the transition of care process, please contact PHP’s Customer Service Department at the number listed on the Member’s ID card or the number listed on the “[How to Contact Us](#)” page.

Reporting Communicable Disease

Michigan Health Care Providers are required to report Patients with specific conditions to the Patients’ local Health Department. Lab-confirmed and clinical diagnoses are reportable in the time intervals as indicated on the Reporting Communicable Disease section located within the Provider Manual.

Eligibility/Enrollment of Members

Members are assigned a Member ID card. Member ID numbers are randomly assigned. PHP cards will contain the PHP, PHP Insurance Company and PHP Service Company logos. PHP Service Company cards will typically contain the logo of the employer group or covered entity. Samples of Member ID cards are located within the Provider Manual for your reference.

Members should present their ID cards at every visit. In the event a Member is unable to provide their ID card at the time of service, you may verify eligibility by contacting the PHP Customer Service Department at the telephone number listed on the “[How to Contact Us](#)” page or by utilizing the electronic eligibility options. We recommend making a copy of the Member’s ID card at each visit to be sure you have the most current information available.

From time to time, eligibility under a benefit contract may change. The reasons eligibility may change include:

- The Member's policy or benefit contract is terminated by PHP or the employer group or the Member at any time for any reason
- As a result of a Member's final decision regarding State or Federal continuation of coverage
- Eligibility information we receive is later determined to be false or if a change is received at a later date

When verifying eligibility, it is necessary to provide the following information:

- Members name
- Members identification number as written on the card
- Members date of birth

If you provide health care services to an individual and it is later determined that the individual is not a Member at the time health services were rendered, those services will not be eligible for payment. You may directly bill the individual or responsible party for such services.

Lock-In-Program

The Lock-In Program is a pharmacy service designed to "lock-in" or restrict Members to one Pharmacy Provider. This service may be requested in writing by a Member's Health-Care Provider or Case Manager. Members are restricted to a specific pharmacy in order for the Member's Health-Care Providers to better monitor medications filled through PHP, and reduce unnecessary or inappropriate utilization. This program is intended to prevent Members from obtaining excessive quantities of prescribed drugs through multiple visits to prescribers and pharmacies.

Any prescription not provided by the designated pharmacy must be a valid emergency to be reimbursed. A Member wishing to change their designated Pharmacy Provider must first obtain the authorization of the requesting Provider(s).

Referral, Notification/Prior Authorization

When a referral is needed, it is important to confirm that the referral is to a PHP Network Provider. If the Network status of a Physician or Practitioner is unknown, contact the PHP Customer Service Department at the number listed on the "[How to Contact Us](#)" page or visit the PHP online provider directory at our website www.PHPMichigan.com.

Referrals

PHP does not require a referral from the PCP if the Member is seeking services from a Network Provider. It is important to note that even though a referral may not be required, occasionally Specialists will ask the PCP for a referral before setting up an appointment. If Network Specialists require a referral from the treating Network Physician/Practitioner, PHP will provide support for the referral and education to the Member regarding the appropriate referral process.

Although referrals for Network Specialists are not required, certain procedures may require notification. PHP will assign an authorization/reference number for services that require prior notification. Refer to the [Notification/Authorization Table](#) to determine what services require prior notification/authorization.

The notification/authorization process begins with communication initiated by the Physician/Practitioner treating or scheduling specific procedures and/or services. Notifications allow PHP to facilitate access to needed care and support a positive outcome for Members. PHP depends on Physicians/Practitioners and Facilities for notification of the services listed on the notification table. Please refer to the [Notification/ Authorization Table](#) to determine what services require prior notification/authorization. The presence or absence of a procedure, service or item on the notification table does not mean the procedure, service or item is eligible for coverage. The Member's benefit plan will determine covered procedures, services, or items.

Notification/Authorizations requirements for PHP products may be different. Please refer to the appropriate product on the [Notification/Authorization Table](#) for the notification requirements specific to the Members benefit product.

Network Providers are expected to work collaboratively with PHP. PHP requires Network Providers to be responsive to phone calls and requests for clinical information. This includes, but is not limited to; responding to telephone calls from PHP Staff and providing information as requested in a timely manner (see the [Notification/Authorization Table](#)).

When notification is not received, services may not be eligible for coverage. A financial penalty may also apply. Listed below are untimely notification definitions:

- Non-notification –PHP does not receive a request for a service that requires notification

- Late notification –PHP does not receive a request for a service by the time frame outlined in the [Notification/Authorization Table](#)

General Guidelines

Admission Services

Members should generally be admitted on the day of surgery, unless the Member's medical condition requires otherwise. Laboratory work and routine pre-surgical procedures should be completed, whenever feasible, prior to admission or on the day of surgery. Refer to the [Notification/Prior Authorization Table](#) for more information.

Emergency Admission

Admission of a Member to a hospital on an emergency basis should be reported by the hospital, the admitting Physician, or the personal Physician to the Medical Resource Management Department on the same or next business day.

Emergency Care

Members are instructed to contact their PCP office or after-hours emergency number prior to seeking medical services except for emergency care. If the PCP determines that the Member should be examined by a Physician/Practitioner, he or she should use professional discretion in directing the Member to the Physician/Practitioner's office, a Network Urgent Care Facility, or as medically necessary, to the nearest Emergency Facility. If, under the circumstances, a Member cannot contact their PCP before seeking medical attention for an emergency, the Member should go to the nearest Emergency Facility.

The definition of an emergency medical condition is: a serious medical condition or symptom resulting from injury, sickness or mental illness that arises suddenly and, in the judgment of a reasonably prudent person would without immediate medical attention, result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. This includes relief of acute pain to avoid extended or permanent physical impairment or loss of life.

Request for Services with Non-Network Physicians/Practitioners/Providers

Referrals to Physicians, Practitioners or other Health Care Providers that are not in the PHP Network will require prior notification and review. A request for a Non-Network Provider can be submitted to the Medical Resource Management Department with the pertinent

clinical information. The request will be clinically evaluated, and a determination will be communicated. (Applicable to HMO, PPO, Self-Funded and HDHP products) Please refer to the [Out of Network Request Form](#).

Out-of-Area Transfers

Network Providers are required to assist PHP in facilitating the transfer of Members from Non-Network Physicians and Health Care Providers to Network Physicians, Hospitals and other Health Care Providers if the transfer is determined medically acceptable by all involved Health Care Providers.

Process for Benefit or Claim Denials

Physician/Practitioner/Provider Appeal Process related to benefit or claim denial

A Provider appeal is a written request, by a Physician/Practitioner/Provider to change a decision made by PHP about a specific Member. The decision may be about a Member's medical or pharmacy benefit or a specific request to change a complete or partial claim denial. These types of decisions are referred to as Adverse Determinations. Appeals must be submitted no later than 90 days from the date of the initial claim denial or adverse benefit determination.

There are several types of Adverse Determinations that may be appealed. Adverse Determinations may be the result of:

- Member's Certificate of Coverage (COC) benefit language, exclusions, or benefit limitations
- Lack of or incomplete clinical information to support the request at the time the determination was made
- Lack of medical necessity based on current medical or pharmacy policy
- Claims processing denial

An explanation of the Provider appeal process is included in the letter to the Member when services are not approved. Members have the right to discuss the decision with a reviewer by calling the Medical Resource Management Department at the number listed on the ["How to Contact Us"](#) page.

Treating Physicians can discuss medically necessary Adverse Determinations with the Medical Director by calling the Medical Resource Management Department to schedule a telephone conference at the number listed on the ["How to Contact Us"](#) page. Discussion with a reviewer or the Medical Director does not constitute an appeal and the discussion must occur before the Provider appeal is submitted.

If a Physician/Practitioner or Provider disagrees with the decision, they may request an appeal of the Adverse Determination by submitting the request in writing. It is important to include additional information that would support the reason for the appeal. PHP will respond to the Provider appeal in writing within 30 calendar days of receipt of the written appeal.

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 call PHP's Customer Service Department to request an urgent or expedited appeal. PHP will respond to the urgent or expedited appeal within 3 calendar days.

If both a Member and Provider initiate an appeal at the same time for the same benefit or issue, PHP will combine information from the Provider appeal with the Member appeal process. We will send you a letter notifying you that the Member has initiated an appeal. In this situation, the outcome of the Member appeal would be the outcome of the Provider appeal. We will send you a letter with the result of the Member appeal.

If you have a question about an Adverse Determination, please call PHP's Customer Service Department for assistance at the number listed on the "[How to Contact Us](#)" page.

If you would like to submit a Provider appeal, submit your request in writing and include any pertinent documentation to support your appeal. You may submit a letter or use the Provider Appeal Form located on our website. 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

To provide a better understanding of the Member rights under the Member appeal process related to benefit or claim denial, the following explains those rights as made available to Members at time of or during their enrollment.

- I. The Member has a right to:

- (a) Right to request a hearing
- (b) How to file a grievance and appeal and their requirements and timeframes for filing
- (c) Availability of assistance in filing
- (d) Toll-free numbers to file oral grievances and appeals
- (e) Right to request continuation of benefits during an appeal if the Plan's action is upheld in a hearing, the Member may be liable for the cost of any continued benefit

Pharmacy Management Program

Overview

The management of outpatient prescription medications is an integral part of the Pharmacy Program to improve the health and well-being of Members. Physician/Practitioner and Member involvement is critical to the success of the Pharmacy Program. Please follow these guidelines when prescribing medication to a Member. Additional information about the management of outpatient prescription medications can be found in the [Prescription Drug List](#). Questions regarding Pharmacy should be directed to our Pharmacy Department at the number listed on the ["How to Contact Us"](#) page.

Guidelines

- When prescribing medication refer to the Prescription Drug List (PDL)
- Prescribe generic medication whenever therapeutic equivalent medications are available and appropriate
- Inform the Member that an equivalent generic medication may be substituted for the brand-name medication
- When phoning a prescription medication to a Pharmacy, verify it is a Network Pharmacy
- Accept a call from the Network Pharmacy notifying you of a possible problem with the prescribed medication. The Pharmacy's on-line billing system alerts them to potential medication-medication, medication-age, or medication-gender incompatibility. This is an important service offered to Network Physicians/Practitioners and Members
- The standard prescription drug benefit allows up to 31-consecutive-day supply of medication per prescription co-payment. Maximum quantity limits are supported on-line. Some select medications are subject to different quantity limits
- Recommend mail service to Member, if appropriate, for longer-term therapies once Member has been stabilized on the medication. Mail service allows up to a 90-consecutive-day supply of medication per prescription co-payment. The prescription must be written for a 90-day supply
- Certain services require prior notification/authorization. Please refer to the [Notification/ Authorization Table](#).

Copies of the PDL are available online. You can access the PDL from the PHP website at www.PHPMichigan.com or to obtain a paper copy of the PDL, contact Customer Service at the telephone number listed on the [“How to Contact Us”](#) page.

Pharmacy Networks

- PHP offers a National Retail Pharmacy Network which is contracted to provide services to Members. The Network contains approximately 60,000 Retail Pharmacies
- A Mail Service vendor is also available for Members
- To obtain a list of the Network Pharmacies, contact Customer Services at the number listed on the [“How to Contact Us”](#) page
- A Specialty Pharmacy is available for injectable medications

Behavioral Health Services

Behavioral Health Services are managed directly by PHP for all Behavioral Health Services. To request Behavioral Health Services for your Patient, or for specific policies and procedures related to a Behavioral Health Service, refer to the number or website listed on the [“How to Contact Us”](#) page.

Additionally, a Physician/Practitioner may directly refer to a Network Provider. The provider directory should be referenced for the listing of current, affiliated PHP Behavioral Health Practitioners.

Reimbursement for Health Care Services

Reimbursement Methodologies

PHP follows reimbursement methods in accordance with the American Medical Association (AMA) CPT (Current Procedural Terminology) guidelines and Centers for Medicare Services ([CMS](#)). Network Providers are reimbursed in accordance with their signed Participation Agreement with the Health Plan. Billing information submitted is used for reimbursement related to Health Care Services rendered, network reporting, identification of Members for Disease Management, as well as for preventive care and incentive programs.

Ambulance Protocols

1. The base rate billed must reflect the level of service rendered rather than the vehicle used
2. Supplies and waiting time are included in the base rate reimbursement and not reimbursed separately

3. When treatment is rendered, and no other care or transport is necessary, the Provider may bill the base rate procedure code for the level of service performed but not for mileage
4. In situations where an ALS vehicle intercepts with a BLS vehicle and the Member is transferred to the ALS vehicle, only the Provider who delivers the Member to the Hospital may bill for the base rate and mileage
5. Round trip transportation of Members from one Hospital to another for diagnostic and therapeutic services, are not reimbursable services under this Agreement

Mid-Level Providers

PHP follows Industry Standards for the reimbursement of Mid-Level Providers. Mid-Level Providers are reimbursed at 85 percent of the standard Physician fee schedule. PHP recognizes the following Healthcare Professionals as Mid-Level Providers, Physician Extenders, or Non-Physician Practitioners (NPPs):

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Certified Nurse Specialists (CNS)
- Certified Nurse-Midwife (CNM)

“Incident to” Billing Guidelines for Mid-Level Practitioners

To qualify as “incident to,” services must be part of a Patient’s normal course of treatment, during which a M.D./D.O. **personally performed** the **initial service** and **determines the Plan of Care** and remains **actively involved** in the course of treatment. Subsequent services provided by the Mid-Level must be related to the established Plan of Care. Services provided by the Mid-Level 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” and the Patient must be re-evaluated by the M.D./D.O. and services should be billed under the M.D./D.O.’s NPI number.

Signature Requirements

The Supervising Physician is not required to co-sign the Patients record when a PA/NP provides the service, however, the Supervising Physician must remain actively involved in the course of treatment and documentation must support review and involvement in the oversight of the Patient’s care.

For example, Patient's record must indicate that the Supervising Physician reviewed and agreed with the course of diagnosis or treatment of an injury or illness.

Physician Assistants (PA)

PHP does not credential PA's. They would be 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:

- The 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 M.D./D.O. directly supervise, and who represents a direct financial expense to the M.D./D.O.'s practice (such as a "W-2" or leased employee, or an independent contractor)
- For new Patients: A 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
- The PA must bill under Supervising Physician's NPI number

Nurse Practitioners (NP)

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

- The 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 M.D./D.O. directly supervise, and who represents a direct financial expense to the M.D./D.O.'s practice (such as a "W-2" or leased employee, or an independent contractor)
- For new Patients: A 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 NP, 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 NP
- Credentialed NP's must bill under their own NPI number

Failure to comply with the above PA and NP guidelines may result in financial adjustments.

Multiple Procedure Reductions

If you are performing multiple procedures, bill your full normal charge for each individual procedure. Unless your Participation Agreement states otherwise, when multiple procedures are billed on the same date of service, reimbursement for the primary procedure reflects 100% of the contracted rate and reimbursement for the secondary and subsequent procedures procedure reflects 50%. Any amounts determined to be over the PHP allowable are not billable to the Member.

Professional and Technical Component Payment

PHP covers the professional and technical components of global CPT procedures based on professional and technical percentage splits. The appropriate -26 modifier (professional component) and/or -TC modifier (technical component) should be used as applicable for the service rendered.

Preventive Medicine Services

Preventive Medicine Services should be reported using the appropriate preventive medicine CPT code with a Preventive Medicine diagnosis (ICD-10) code. A Preventive Medicine CPT code and an Evaluation and Management (E/M) CPT code may both be submitted for the same Member on the same date of service. Payment will only be allowed for either a Preventive Medicine CPT code *or* an E/M CPT code, unless documentation supports a significantly and separately identifiable procedure. Billing should reflect the appropriate modifier.

Submitting a Claim

PHP accepts paper and electronic claims. All claims need to be submitted to PHP for Health Services in industry standard formats. PHP does not reimburse any charges that may be required for the submission of claims.

Claims with dates of service through December 31, 2017, need to be submitted within 365 days from the date that services are rendered or the date of discharge, or as required by law. When PHP is not the Primary Carrier, claims need to be submitted within 365 days from the date on the Primary Carriers' Explanation of Payment (EOP). If claims are not submitted within that timeframe, a financial penalty may be applied, including non-payment of the claim. The Network Provider is responsible for submitting the claim to the Payer identified on

the Member's ID card. The Member may not be balance billed unless it is indicated as a Member responsibility on the Explanation of Payment or Explanation of Benefits.

Beginning with dates of service Jan. 1, 2018, and after, all claims, including adjusted claims, must be received within 180 days from the date that services are rendered or the date of discharge, or as required by law. When PHP is not the Primary Carrier, claims need to be submitted within 180 days from the date on the Primary Carriers' Explanation of Payment (EOP). If claims are not submitted within that timeframe, a financial penalty may be applied, including non-payment of the claim. The Network Provider is responsible for submitting the claim to the Payer identified on the Member's ID card. The Member may not be balance billed unless it is indicated as a Member responsibility on the Explanation of Payment or Explanation of Benefits.

Unless otherwise directed by PHP, all claims must be submitted using current Centers for Medicare and Medicaid Services ("CMS") National Uniform Claim Committee ("NUCC") CMS form 1500 or UB-04 CMS-1450 ("UB04") form, whichever is appropriate, with applicable coding including, but not limited to, ICD-10 Current Procedural Terminology ("CPT"), Revenue ("Rev") Code and Healthcare Common Procedure Coding System ("HCPCS") coding. Claims must include the Member number, Customary Charges for the Health Services rendered to a Member during a single instance of service, Provider's Federal Tax ID number and/or other identifiers as outlined below.

Acceptable Claim Forms

Claims may be submitted in one of the following formats:

- Electronic Claim Submission
- UB-04
- CMS1500

Electronic Claims

PHP works collaboratively with specific Clearinghouses to receive electronic claims. Providers submitting claims electronically will be required to comply with HIPAA regulations and the standard Electronic Data Interchange (EDI) processing rules. Please refer to the ["Where to Send Claims"](#) page to see the appropriate Payor ID for electronic claims submission and a list of approved Clearinghouses.

If you use a Clearinghouse that is different than those listed, it will be necessary for you to contact your Clearinghouse to ensure that they have a forwarding arrangement to pass your claims on to the accepted Clearinghouses to ensure PHP receives the claims submitted.

EDI Validation

Claims submitted electronically go through various validations throughout the process before they are loaded into our claims processing system. The Clearinghouse may have front end edits established in addition to a data validation process. You should be provided with a rejection report from your Clearinghouse or Vendor for claims PHP does not receive. It is important to check with the Clearinghouse or Vendor to ensure you receive this report. PHP does not receive a copy of this report or have access to what is submitted to your Clearinghouse or Vendor.

Claims submitted with non-HIPPA compliant data will be rejected and returned to the Provider for correction. It is important to submit valid Member ID's as well as billing identification ID's, such as NPI and tax identification numbers and 9-digit zip codes. This will ensure appropriate Member and Provider selection processing.

Completing the Claim Forms

When billing for Services, Providers should bill with normal charges, complete all fields required by HIPPA regulations. Some fields include:

- Patient name, address and date of birth
- Subscriber name and address (if different than patient)
- Patient's PHP Policy/Member number
- Other insurance information
- The name, signature, USPS Standards rendering address, USPS Standards billing address, including 9-digit zip code, and telephone number of the Physician/Practitioner/Provider/Facility performing the service
- The tax ID and NPI number of the Physician/Practitioner/Provider/Facility performing the service
- Appropriate diagnostic codes (ICD-10)
- Appropriate procedure/service codes
 - Current CPT/HCPC code with appropriate modifiers
 - Current 4-digit revenue codes if applicable
- Number of units rendered
- Referring Physicians name
- Dates of Service – day, month and year the service was provided
- Place of Service

- National Drug Code (NDC) for prescription drug therapy, description and dosage
- Identification if service is a job-related injury or accident

Clean Claim

The following conditions must be met for a CMS1500 or UB04 form to be considered a Clean Claim. A Clean Claim must contain all of the following information:

1. It must identify the Health Professional or Health Facility that provided the service to verify, if necessary, affiliation status and includes any identifying numbers
2. It must sufficiently identify the Patient and Health Plan Subscriber
3. It must list the dates and places of service
4. It must be a claim for a covered service for an eligible Member
5. If necessary, it must substantiate the medical necessity and appropriateness of the service provided
6. If Prior Authorization is required for certain Patient services, it must contain information sufficient to establish that Prior Authorization was obtained
7. It must identify the service rendered using a generally accepted system of procedure service coding
8. It must include additional documentation based on services rendered as reasonably required by the Health Plan

Incomplete/Missing Claim Information

Claims missing required information cannot be processed. The Network Provider submitting claims without the required information will be notified that the claim cannot be processed. A Member may not be billed for services for which a claim submission has been returned to the Network Provider for lack of information.

Where to Send Claims

Refer to the "[Where to Send Claims](#)" page for the appropriate address information for claims submissions.

Claim Status

You may check the status of a claim by accessing our online Provider Portal via the PHP website, electronic claim status 276/277 electronic transactions, or by contacting Customer Service at the number listed on the "[How to Contact Us](#)" page. Customer Service will

status up to 5 claims per call. If you have more than 5 claims to status, you can fax in your request to our Customer Service Department, at 517.364.8411.

Claim Adjustments/Corrections

It may become necessary to adjust a claim(s) to reflect the correct payment determination. To request an adjustment of a claim previously processed by PHP, use the [Claim Adjustment Request](#) form. We require that requests for adjustment(s) be submitted within the timeframe identified in the Participation Agreement, or within 365 days from the date that services are rendered or the date of discharge, or as required by law.

Beginning with dates of service Jan. 1, 2018, and after, all claims, including adjusted claims, must be received within 180 days from the date that services are rendered or the date of discharge, or as required by law. When PHP is not the Primary Carrier, claims need to be submitted within 180 days from the date on the Primary Carriers' Explanation of Payment (EOP).

PHP may need to make corrective adjustments to claims, provided the following are:

- Within 12 months from receipt by PHP or PHP designee of a claim
- Part of an annual reconciliation procedure, as mutually agreed to by both parties
- Audit of claims by PHP or PHP designee

Overpayments

If it is determined that Overpayments have been made, it is required that you complete a Claim Adjustment Form for correction. PHP or its representatives will deduct the dollar amount of Overpayments from future claim payments. The Overpayment Recoupment Process may span over a period of time until the total dollar amount to be recovered is recouped by PHP.

Coordination of Benefits

Coordination of Benefits (COB) is the procedure used to pay Health Care expenses when a Member is covered by more than one Insurer or Plan which provides Health Care Benefits. 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.

Identification of the Primary Payor and Claim Submission

Prior to submitting a claim, it is important to determine if any other Payor has primary responsibility for payment of a claim. The identification of the primary Payor prior to claim submission will improve the efficiency and accuracy of the claim payment process. The

“Primary Plan” means a plan whose benefits for a Member’s Health Care coverage must be determined without taking the existence of any other Plan into consideration.

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:

- The original billed charges
- The amount received from the Primary Plan
- Copy of the other plan’s Explanation of Benefits (EOB) or Explanation of Payment (EOP) statement

If a condition is related to the Patient’s employment or is the result of an automobile accident, Workers’ Compensation or No-Fault Auto Insurance may apply.

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 him or her as a Subscriber rather than the Plan covering him or her as a dependent is primary
- Coverage for dependent children of parents who are not divorced or separated is determined as follows when the child is covered by both parents’ Plans:
 - 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 Health Care 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
 - The Plan that covers a Member as the Subscriber who is neither laid off nor retired is primary over a Plan which covers that Member as a retired or laid off Subscriber. This rule also applies when the Member is a dependent under both Plans, but not when the Member is a Subscriber under one plan and a dependent under the other. Refer back to the employer for determination

- 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

Medicare as the Primary or Secondary Payor

Individuals can become eligible for Medicare because of age or disability. Persons aged 65 and over who are entitled to monthly Social Security benefits are automatically eligible for Medicare.

Medicare is primary for Members 65 years and older if they or their spouse are not actively employed. Medicare is the primary Payor for persons under age 65 when the person is covered by Medicare because of a disability (other than End Stage Renal Disease) and the Group Health Plan sponsor employs less than 100 employees and the person is not actively performing services for the employer. Medicare becomes the primary Payor for persons with End Stage Renal Disease, after the 30-month coordination period following the earlier of:

1. The month in which the person begins a regular course of renal dialysis, or
2. The first day of the month in which the person became entitled for Medicare, if they received a kidney transplant without first beginning dialysis. Prior to August 1, 1997, the coordination period (the period of time the Group Health Plan is primary) was 18 months; for persons who reached the 18-month coordination threshold on or before July 31, 1997, the 18-month coordination period will continue to apply; for all other persons, the 30-month coordination period will apply. This applies regardless of the size of the employer group.

Medicare is the secondary Payor for Medicare enrollees who:

1. Are active employees and
2. Are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group

Medicare rules change periodically, and the most recent rules will apply, regardless of whether the rules are specifically described in this manual.

Secondary Reimbursement

If PHP is the Secondary Carrier, PHP will calculate benefits' using the Primary Carrier's allowable. This allowable will either be the Primary Carrier's reasonable and customary allowance, Medicare allowable or the PHP contracted rate. The sum of the Primary Carrier's

payment and the PHP payment will never exceed this allowable expense. Network Providers may not bill the Member for any outstanding balance above the allowable expense which was covered by both Plans.

When the Primary Carrier does not make any payment (i.e., applies everything to Member liability), PHP will pay the claim as though we are the only Payor and process the claim according to the Member's benefit applying deductibles, copayments and co-insurance as applicable.

Provider should follow all rules of Primary Carrier, including but not limited to authorization requirements in order for secondary payment to be considered.

Subrogation

Subrogation is a process through which PHP has the legal right to recover benefits paid when the Member's injury or illness is determined to be a liability of a third party. Many subrogation cases result from injuries incurred in an automobile accident or injuries that constitute a Workers' Compensation claim. Correct coding of claims using the or ICD-10 accident codes assists in identification of these situations.

Subrogation does not change the procedure for processing claims. We process the claim and pay for covered services at established fees. Subrogation activities take place after claims have been processed for payment.

Copayments, Co-Insurance, Deductibles and Non-Covered Services

A copayment, co-insurance or deductible is a specific percentage or dollar amount to be paid by the Member for covered services under their benefit Plan. Amounts may be different among benefit Plans and services. Copayments can be verified using the electronic 270/271 transaction, our Provider Portal, Integrated Voice Response (IVR) system, or by contacting PHP's Customer Service Department at the number listed on the "[How to Contact Us](#)" page.

Billable Copayments and Services

Members whose benefit Plans include a copayment should be collected at the time of service. Copayments should not be collected for:

- Routine maternity care
- Surgical visits included within the global benefits
- Minor services that would normally not be billed
- Dispensing of prescription drugs (allergy serum is not included and does require a copayment)

Copayments, coinsurance, deductibles and any other charges that can be billed to Members will be indicated in the “Patient Ineligible” field on the on the Explanation of Payment (EOP) or Electronic Remittance Advise (ERA).

Deductible and Coinsurance Plans

It is recommended that a Member be billed for applicable deductibles and coinsurance after you receive the Explanation of Payment (EOP). The EOP indicates the amount to be billed to the Member in accordance with the Members benefit Plan.

Copayment/Coinsurance Waiver

It is considered an unacceptable billing practice for a Network Provider to waive a copay or coinsurance obligation.

Non-Covered Services Billable to Members

It may be applicable to bill a Member for non-covered services. Services that are billable to Members will be identified in the “Patient Ineligible” field of the Explanation of Payment (EOP). For any questions related to non-covered services contact the Customer Service Department at the number listed on the [“How to Contact Us”](#) page.

If, through PHP’s grievance procedures, it is determined that a non-covered service will be covered, you must refund to the Member any amounts collected in excess of the applicable copayment, coinsurance or deductible.

Non-Covered Services Not Billable to Members

By entering into a Participation Agreement with Physicians Health Network (PHN), you have agreed to accept payment directly from PHP. Payment from PHP constitutes payment in full for the covered services you render to Members. Some services may be considered ineligible for coverage as part of the claims adjudication processes established by PHP. Services include, but are not limited to: administrative facility fees, clinical edits, clinic fees, lab handling services, amounts over contracted rates, failure to obtain prior authorization, stand by services, venipunctures, services provided for Family Members, amounts denied due to failure to comply with the terms of the Participation Agreement or Provider Manual. These services will be listed in the “Prov Adjust” field of the Explanation of Payment (EOP) and are not billable to Members.

Administrative Facility Admission Fees

PHP does not consider administrative fees associated with admissions of Patient, medical records or other similar fees to be covered expenses. These are not directly related to the treatment of an illness or injury and are not billable to Members.

Clinical Edits

PHP uses Clinical Edits in the processing and payment of all medical claims. All Providers' medical claims for payment are subject to PHP Clinical Edits. Clinical Edits focus upon correct coding methodologies and accurate adjudication of claims. PHP's Clinical Edits follow general industry standards as defined by the American Medical Association's (AMA) CPT Manual, Centers for Medicare and Medicaid Services (CMS), and National Correct Coding Initiative for Medicare Services (NCCI) and other sources as applicable. PHP's Clinical Edits include: bundling rules, Medically Unlikely Edits (MUE's) and other automated logic used during the adjudication process. Any services denied due to PHP's Clinical Edits such as bundling, clinical daily maximums or other payment logic may ***not*** be billed to the Member. The purpose of PHP's Clinical Edits is to prevent improper payments when procedure to procedure (PTP) code combinations are billed or prevent payment for an inappropriate number/quantity for the same service on a single day. PHP's Clinical Edits are applied to ***both*** Professional and Facility claims.

Below is a list of resources used when PHP selects Clinical Edits:

- American Medical Association (AMA) [AMA Website](#)
 - Current Procedural Terminology (CPT)
 - CPT Assistant
 - CPT Changes
 - Centers for Medicare & Medicaid Services (CMS) [CMS Website](#)
 - Healthcare Common Procedure Coding System (HCPCS)
 - Local Coverage Determinations (LCDs)
 - Online Manual System
 - National Physician Fee Schedule
 - National Correct Coding Initiative (CCI) Policy Manual
 - [National Correct Coding Initiative \(NCCI\)](#)
 - [Medically Unlikely Events \(MUE\) Edits](#)
 - National Coverage Determinations (NCDs)
 - Transmittals
- HHS-Office of Inspector General
 - Federal Register
 - Publications

- Fraud Prevention & Detection
- National Library of Medicine – National Institute of Health (NLM-NIH)
- Specialty Society websites and publications, including, but not limited to:
 - American College of Obstetricians and Gynecologists (ACOG)
 - American Academy of Orthopaedic Surgeons (AAOS)
 - American College of Radiology (ACR)
 - American College of Surgeons (ACOS)
 - American Hospital Association (AHA)
- Washington Publishing Company (wpc-edi)
- Health Insurance Portability and Accountability Act (HIPAA) Code Sets

Clinic Fees

PHP does **not** cover any clinic facility fees for commercial Members including those billed under revenue codes 510-529 unless negotiated per your Contract. Reimbursement for Facility fees associated with office services is included in the Physician professional fee and is **not** paid separately.

Contracted Amounts

By entering into a Participation Agreement with Physicians Health Network (PHN), you have agreed to accept payment directly from PHP and have agreed to accept the payment as payment in full. Charges considered ineligible for over the PHP fee schedule or allowable are not billable to the Member. You may not balance-bill Members for the difference between your actual charge and the contracted amount.

Facility Based Private Duty Nursing

PHP does not cover inpatient Private Duty Nursing. Private Duty Nursing rendered in a Hospital or Skilled Nursing Facility is considered included in the room and board payment and are not billable to the Member.

Lab Handling

PHP does not cover laboratory handling charges separately. Lab handling is considered included in the primary evaluation and management service or a routine part of office overhead and are not billable to the Member.

Non-Notification Processing

If Network Provider fails to notify the Medical Resource Management Department of services being provided to a Member that requires Notification/Prior Authorization, payment for those services will be denied, and cannot be billed to the Member. Members are responsible only for their copayment, deductible or co-insurance and may not be billed for the remainder of the charge.

Standby Services

PHP does not generally cover standby services. The standby Physician is reimbursed for those face-to-face services directly rendered to the Member.

Venipuncture

PHP will not reimburse Providers for venipuncture when the same Provider or Provider Group has performed an Evaluation and Management (E&M) service on the same day for the same Member. This rule applies to venipuncture codes 36415 and 36416 when billed with any E&M service (99201 through 99440). Venipuncture performed in the absence of an E&M code when billed without a laboratory service will be paid

Venipuncture performed in a facility setting, (i.e., emergency room, independent lab facilities, ambulatory surgical, or in any inpatient setting including Skilled Nursing Facility (SNF), rehabilitation sites, etc.) are not payable since they are an integral component of all facility fees associated with such settings. The application of this rule in facility settings does not rely upon the presence of an E&M code – this rule is applied regardless of other coding on the claim.

Services Provided for Family Members

PHP does not cover Services performed by a Provider who is a Family Member by birth or marriage, including spouse, brother, sister, parent or child, or performed by a Provider with your same legal residence. This includes any Service the Provider performs on him or herself.

Clinical Editing

Clinical Editing analyzes professional and facility claims for reimbursement, ensuring accuracy and completeness of clinical data, including but not limited to potential coding errors and rule infractions based on codes submitted on the same or different claims. Clinical Edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA) and specialty societies. PHP may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS, but which are covered by the Plan to support covered benefits available through one of the Plan's products. Clinical Editing rules are effective

based on the date of service and services will be denied payment when the edit is applied. Clinical Edits are applied to all claims submitted by facilities and professionals, both In and Out of Network, for all PHP Medical Plans, including self-funded and fully funded.

Any services denied due to PHP's Clinical Edits such as bundling, clinical daily maximums or other payment logic may ***not*** be billed to the Member. The purpose of PHP's Clinical Edits is to prevent improper payments when incorrect code combinations are billed or prevent payment for an inappropriate number/quantity for the same service on a single day.

As a normal business practice, Claims Editing software is updated quarterly to incorporate the most recent coding principles based on Medicare guidelines, specialty society guidelines, National Correct Coding Initiative and changes to AMA's CPT manual. There are NCCI edits for Physicians and Outpatient Facilities. Services that result in an NCCI edit may be denied.

NCCI

NCCI – The CMS developed the NCCI edits to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment. Today, these edits are utilized by nearly every major Payer in healthcare. The coding policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

There are two NCCI edit tables: "Column 1/Column 2 (Component/Comprehensive)" and "Mutually Exclusive Edit Table". Each edit has a column 1 and a column 2 CPT/HCPCS code. The column 2 codes are considered to be included in the column 1 codes. All edits are included in the "Column 1/Column 2 Correct Coding Edit Table" except those that are based on the "Mutually Exclusive" and "Gender Specific" criteria in which case the edits are included in the "Mutually Exclusive Edit Table."

Coding Based on Standards of Medical/Surgical Practice

Most HCPCS/CPT code defined procedures include services that are integral to them such as:

- Cleansing, shaving and prepping of skin
- Insertion of intravenous access for medication administration
- Insertion of urinary catheter
- Local, topical or regional anesthesia administered by the Physician performing the procedure
- Surgical approach including identification of anatomical landmarks, incision, evaluation of the surgical field, debridement of traumatized tissue, lysis of adhesions, and isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring
- Insertion and removal of drains, suction devices, and pumps into same site

- Surgical closure and dressings
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription as necessary to document the services provided
- Surgical supplies, except for specific situations where the Plan's policies permit separate payment

Not Separately Reimbursable Items (NSRs) for Inpatient & Outpatient Facility Claims

- Pharmacy Charges (such as Courtesy Room)
- Emergency Room supply and service charges
- Facility personnel charges
- Instrument trays
- IV sedation and local anesthesia
- Nursing procedures
- Operating Room time and procedure charges
- Personal care items
- IV mixture fees
- Stat charges
- Video equipment used in Operating Room

HCPCS/CPT Procedure Code Definition:

If two HCPCS/CPT codes describe redundant services, they should not be reported separately.

- A “partial” procedure is not separately reportable with a “complete” or “total” procedure
- A “with” procedure is not separately reportable with a “without” procedure CPT “Separate Procedure” Definition

If a CPT code descriptor includes the term “separate procedure,” the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a “separate procedure” when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

More Extensive Procedure: The CPT Manual often describes groups of similar codes differing in the complexity of the service. The less complex service is included in the more complex service and is not separately reportable.

Sequential Procedure: If an initial surgical approach to a procedure fails and a second surgical approach is utilized at the same patient encounter, only the HCPCS/CPT code corresponding to the second surgical approach may be reported. For example, an open and laparoscopic procedure on the same site would be reported with the open procedure code, since that is the approach used last.

Mutually Exclusive Procedures: Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter. An example of a mutually exclusive situation is the repair of an organ that can be performed by two different methods. Only one *method* can be chosen to repair the organ. Another example is a service that can be reported as an "initial" service or a "subsequent" service.

Laboratory Panel: If the services included in a laboratory panel are performed, the individual tests cannot be unbundled and reported separately unless otherwise negotiated per your contract.

Gender-Specific Procedures: Editing will detect inconsistencies between a patient's gender and their diagnosis submitted and/or the procedure(s) billed for the specific date of service represented by the claim. Examples of a gender conflict are:

- Claim for a male patient reported with cervical cancer (diagnosis)
- Claim for a male patient reported with a hysterectomy (procedure)

In both instances, the indicated diagnosis or the procedure conflicts with the stated gender of the patient; therefore, the patient's diagnosis, procedure or gender is presumed to be incorrect, therefore documentation may be required to determine Gender-Specific Procedures.

Procedure to Diagnosis Edit: This edit encompasses all billed professional claims and occurs when the procedure billed is unexpected based on the diagnosis billed.

Example: claim billed with diagnosis code of 424.0 (Mitral Valve Disorders) and procedure code 43500 (gastrotomy; with exploration or foreign body removal). This procedure would be identified as unexpected for the diagnosis and would deny.

Medically Unlikely Edits (MUEs)

On January 1, 2007, CMS incorporated Medically Unlikely Edits (MUEs) into the NCCI program. An MUE for a HCPCS/CPT code is 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.

Billing Multiple lines

- Payment may be denied or delayed when the same procedure code is billed on multiple lines instead of one line with multiple units

- The Centers for Medicare and Medicaid Services defines a Medically Unlikely Edit (MUE) as “... the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.” PHP also defines maximum numbers of services per day that may be billed for specific procedure codes
- Making sure claim lines and units are entered correctly is important for quick processing. The following are examples for billing a pathology exam on three breast biopsy specimens:

Correct way: One line with CPT 88305 and 3 units

Wrong way: Three lines with CPT 88305 with 1 unit each

If the claim includes three lines with one unit for each line, the additional lines appear as duplicates causing the additional lines to deny.

NCCI Modifier Indicator

Each edit also contains a column which indicates whether or not a modifier is allowed to override the edit.

Modifiers that can override an NCCI edit:

- Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC
- Global surgery modifiers: 25, 58, 78, 79
- Other modifiers: 27, 59, 91
- Effective 1/1/2015 – XE, XP, XS, XU

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

Duplicate Claim or Claim Line in History

Claims editing will identify an entire claim or claim lines that is a potential duplicate of a previously submitted claim or service.

Add-on Codes

Some codes in the CPT Manual are identified as “add-on” codes which describe a service that can only be reported in addition to a primary procedure. If an add-on code is submitted without the primary code, the add-on code will be denied.

Basic Validation Edits

Each code is reviewed to determine whether the place of service (POS), type of service (TOS), age and provider specialty are appropriate for the service billed.

Coverage Edits

Each code is processed through code specific guidelines to review for cosmetic or experimental/investigative services and excessive procedure frequency.

Multiple Surgical Reduction (MSR)

When multiple surgical procedures are billed for the same date of service, Multiple Surgical Reduction logic will be applied to the claim. The service with the highest allowed amount will be priced at 100% of the contracted fee max amount. All subsequent surgical procedures performed on the same date of service are allowed at 50% of their respective fee max amounts. Add- on CPT codes and modifier -51 exempt codes within the surgical CPT range of 100000-69999 are not subject to the MSR.

Global Surgical Package

The global day period for each procedure code is found in the Medicare Physician Fee Schedule Data Base (MPFSDB). Payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and sometimes YYY. Codes with 090 are major surgeries. Codes with 000 or 010 are either minor surgical procedures or endoscopies.

Services that violate the following guidelines will be denied:

- Codes with “YYY” are codes, for which the Plan will determine the global period. Components of the global surgical package considered part of a global surgical procedure are as follows:
 - Preoperative visits
 - Intra-operative services
 - Complications following surgery which do not require a return trip to the operating room
 - Postoperative visits
 - Postoperative pain management done by the surgeon
 - Supplies

- Modifiers for physicians furnishing less than the full global package are as follows:
 - Modifier 54 surgical care only
 - Modifier 55 postoperative management only

- Modifier 56 preoperative care only

Both the bill for the surgery and the postoperative care should be billed with the date of the procedure and the same CPT code.

Evaluation and Management (E&M) Services

Visits by the same Physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed, identified by modifier 25.

In general, more than one E&M service on the same day by the same Physician, or Physicians in the same Group Practice who are in the same Specialty, is not reimbursable.

E&M services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately. Modifier 57 (decision for surgery) is used to identify a visit which results in the initial decision to perform major surgery.

Please refer to the Medicare Claims Processing Manual, Chapter 12 and the NCCI Guidelines for additional guidance on E&M billing requirements.

Return Trips to the Operating Room During the Postoperative Period

When treatment for complications requires a return trip to the operating room, Physicians must bill the CPT code that describes the procedure(s) performed during the return trip. CPT modifier 78 is reported for these return trips. A new postoperative period does not start and only the intraoperative portion is paid.

Modifier 58 was established to facilitate billing of staged or related surgical.

Procedures Done During the Postoperative Period of the First Procedure

Reimbursement for these procedures will be eligible for full payment and multiple procedure reductions if applicable, which includes:

- Planned prospectively or at the time of the original procedure
- More extensive than the original procedure
- For therapy following a diagnostic surgical procedure

When the next surgical procedure is billed a new postoperative period begins.

Unrelated Procedures or Visits during the Postoperative Period

Modifier 79 reports an unrelated procedure by the same Physician during a postoperative period. The Physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure. When the next surgical procedure is billed a new postoperative period begins. Modifier 24 is used to report an unrelated E&M service by the same Physician during a postoperative period.

Status Code Indicators

Several status code indicators are present in the Medicare Physician Fee Schedule Data Base (MPFSDB). Payment rules for these procedures apply according to the description of the indicator. Common indicators are defined below and will be denied accordingly.

B - Bundled Code: Reimbursement for these services are covered under the primary service whether billed on the same date of service as the primary code or billed alone on a different date of service.

P - Bundled/Excluded Codes: There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule:

- If the item or service is covered as incidental to a Physician service and is provided on the same day as a Physician service, payment for it is bundled into the payment for the Physician service to which it is incidental. (An example is an elastic bandage furnished by a Physician incidental to Physician service)
- If the item or service is covered as other than incidental to a Physician service, it is excluded from the Physician Fee Schedule (i.e., colostomy supplies) and shall be paid under the terms specified in your contract

T - Injections: There are payment amounts for these services, but they are only paid if there are no other services payable under the Physician Fee Schedule billed on the same date by the same Provider.

N - Non-covered Services: These services are not covered by Medicare. The Plan utilizes some of the above edits to enforce the Plan's payment policies. Please refer to the Member's COC/or SPD for additional information regarding coverage for a specific service or procedure.

Anesthesia/CRNA

Payment for procedures billed for both an Anesthesia and a CRNA on the same date of service will be reimbursed at a shared contracted reimbursement.

Assistant at Surgery Services

The indicators for Assistant at Surgery Services are found in the Medicare

Physician Fee Schedule Data Base (MPFSDB). These indicators are defined below and apply to the surgery for which the indicator is assigned.

- Assistant Surgeon
 - 0 – Payment restriction for Assistants at Surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity
 - 1 – Assistant at Surgery may not be paid
 - 2 – Assistant at Surgery may be paid
- Co-Surgeon
 - 0 – Co-Surgeons not permitted for this procedure
 - 1 – Co-Surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure
 - 2 – Co-Surgeons permitted, and no documentation required if the two- Specialty requirement is met
- Team Surgeon
 - 0 – Team Surgeons not permitted for this procedure
 - 1 – Team Surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report
 - 2 – Team Surgeons permitted; pay by report

For a complete list of status indicators and their descriptions, access the MPFSDB and National Physician Fee Schedule Relative Value File on the CMS website: <http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp>

New Patient Visits

The Plan follows the AMA and CMS guidelines which describe a New Patient as one who has not received any professional services from the Physician or another Physician of the same specialty who belongs to the same Group Practice, within the past three years. If a New Patient code is submitted within three years of a previous Physician service, the New Patient visit will be denied.

After Hours Care

PHP will reimburse after-hours procedure codes, in addition to the basic service, for professional claims when urgent or emergent services are provided outside of the scheduled office hours for Primary Care Physicians (PCP) who participate in PHP's Triple Aim (TAIP) program. Failure to follow the guidelines below may result in unexpected denials or audit retractions. Other Plan policies and contractual arrangements will always supersede the guidelines stated in this policy:

- Services Provided Outside of Normal Business Hours (Including before 8 a.m. and after 5 p.m., Monday through Friday and Weekends)
- Certain urgent conditions may arise where a Provider sees a Patient outside of his/her customary office hours. Providers may receive additional reimbursement by coding CPT code 99050 with the appropriate services rendered. The following rules must be applied to be eligible for the enhanced reimbursement:
 - The Plan will reimburse an after-hours code when billed with an E&M service when the service is urgent or emergent
 - The Plan will reimburse an after-hours code when billed with a preventive medicine visit (CPT codes 99381-99429). After hours codes will be denied when billed with a preventive medicine visit
 - The Member must have an appointment time outside of normal office hours
 - Documentation must support why the service was urgent or emergent

Pulse Oximetry

The Plan has determined that intermittent oximetry measurement codes 94760 and 94761 may be medically necessary but are not separately reimbursed when performed in any Healthcare setting, including but not limited to, a general Physician office setting, Surgical setting (including free standing facilities), outpatient Hospital, emergency room, and inpatient settings. The use of intermittent oximetry is considered incidental to other Physician and/or Facility services and is therefore not separately reimbursed.

Robotic Surgery

The Plan does not offer additional or separate reimbursement for differences in the type of instruments, technique or approach used in a procedure. Utilization of robotic assistance is an alternative method of performing a surgical procedure. Reimbursement of a procedure's approach is included in the reimbursement of the procedure.

Operating Microscope

The NCCI bundles CPT code 69990 into all surgical procedures other than those listed in the Medicare Claims Processing Manual. Most of these edits do not allow use of NCCI- associated modifiers.

Unlisted Codes

PHP requires authorization on most Unlisted Codes, please refer to PHP's Notification Table. When a service or procedure is provided that is not listed the CPT codebook, use of an unlisted code may be appropriate. Plan coverage of unlisted codes is dependent on the services rendered as documented with the claim. Any procedure code submitted with documentation that indicates the service or product was either investigational, experimental, or a code that represents a service or type of service not covered by the Plan will be denied.

Additionally, the Plan will determine the appropriateness of an unlisted code upon review. When it is determined an unspecified code could be more appropriately billed using another code it will be denied.

Required Documentation

Since unspecified codes do not describe a specific procedure, service, or product, Providers must submit supporting documentation with their claim. In general, this information should include:

- A clear description of the nature, extent, and need for the procedure or service
- Whether the procedure or service was performed independent from other procedures or services, or if it was performed at the same surgical site or through the same surgical opening
- Any extenuating circumstances that may have complicated the procedure or service
- Time, effort, and any equipment necessary to provide the procedure or service
- The number of times the procedure or service was provided

This is not a complete list of all clinical edits utilized by the Plan. In general, those edits found in the NCCI Manual, Outpatient Code Editor (OCE) and Medicare Claims Processing Manual are utilized by PHP to ensure proper reimbursement and correct coding. Please refer to these resources for additional information about correct coding and clinical editing.

Legal and Regulatory References

National Correct Coding Initiative - <https://www.cms.gov/NationalCorrectCodInitEd/>

Outpatient Code Editor - <http://www.cms.gov/OutpatientCodeEdit/>

Medicare Claims Processing Manual, Chapter 12 - <http://www.cms.gov/manuals/downloads/clm104c12.pdf>

National Physician Fee Schedule Relative Value File - <http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp>

- American Medical Association (AMA)
- Current Procedural Terminology (CPT)
- CPT Assistant
- CPT Changes

- [AMA Website](#)
- Centers for Medicare & Medicaid Services (CMS)
- Healthcare Common Procedure Coding System (HCPCS)
- Local Coverage Determinations (LCDs)
- Online Manual System
- National Physician Fee Schedule
- National Correct Coding Initiative (CCI) Policy Manual
- [National Correct Coding Initiative \(NCCI\)](#)
- [Medically Unlikely Events \(MUE\) Edits](#)
- National Coverage Determinations (NCDs)
- Transmittals
- [CMS Website](#)
- HHS-Office of Inspector General
- Federal Register
- Publications
- Fraud Prevention & Detection
- National Library of Medicine – National Institute of Health (NLM-NIH)
- Specialty Society websites and publications, including, but not limited to:
 - American College of Obstetricians and Gynecologists (ACOG)
 - American Academy of Orthopaedic Surgeons (AAOS)
 - American College of Radiology (ACR)
 - American College of Surgeons (ACOS)
 - American Hospital Association (AHA)
 - Washington Publishing Company (wpc-edi)
- Health Insurance Portability and Accountability Act (HIPAA) Code Sets

Fraud and Abuse

Billing Integrity Program

PHP's Billing Integrity Program (BIP) is managed by PHP's Compliance Department. The purpose is to prevent Fraud, Waste and Abuse as well as detect billing errors and investigate Fraud when it is detected. The primary objective of BIP is to ensure that Providers bill accurately and documentation supports the medical necessity of the service(s) and level of service(s) billed.

Claims Audit/Medical Record Review Process

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 will receive a written notification of request for records from PHP's audit firm. Provider should submit all necessary documentation as requested in the letter within thirty (30) days or as specified in the letter to ensure a successful audit and return to the address referenced on the letter.
- Post-payment audits will 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 will receive written notification of request for records from either PHP and/or audit firm. Provider should submit all necessary documentation such as Patients' medical records, as requested within fourteen (14) days or as specified in the letter to ensure a successful audit. On-site audits may be requested, Provider will receive an initial letter of notification and follow-up call from a representative from PHP to schedule the on-site review.

PHP will not pay administrative fees for or relating to any audit.

PHP will send written notification to the Provider, providing a detailed explanation of the post-payment audit result. Providers will not be notified via letter for pre-payment reviews, however the detailed explanation of the results of review will be 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.

Fraud, in law, is deliberate deception to secure unfair or unlawful gain, that results in financial or personal gain. Examples include:

- Billing for services that were never rendered
- Billing for services at a higher rate than is actually justified
- Unauthorized use of a member's medical identification card or insurance information
- A member presenting forged or altered prescriptions to pharmacies for drugs

Abuse (WASTE) refers to incidents or practices of physicians, other providers, service and equipment suppliers, or other suppliers that are inconsistent with accepted, sound medical, business, or fiscal practices. Examples include:

- A provider billing for unnecessary or excessive services.
- A provider performing laboratory tests on large numbers of patients when the provider knows only a few tests should have been performed

Abuse is referred to as an excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. This refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss. Examples include:

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

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

A Provider must notify the Health Plan of any Fraud or Abuse that your office may suspect, even if you are not sure that it is Fraud or Abuse. PHP can help to investigate and determine if any action is warranted. You can notify PHP confidentially about your Fraud or Abuse uncertainties by contacting PHP by one of the methods below:

- Compliance Hotline at 517.267.9990
- Written correspondence to the Health Plan Compliance Department at P.O. Box 30377, Lansing, MI 48909-7877 or e-mail: phpcompliance@phpmm.org
- Contact your Provider Relations Team at 517.364.8312

All reports made to PHP are anonymous and confidential.

Explanation of Payment- EOP

The Explanation of Payment (EOP) is the name of the report which gives Physicians/Practitioners and Health Care Providers a detailed listing of the services that have been processed by PHP. One EOP will be issued for each Tax ID and billing address. The Providers will be listed alphabetically, with totals following the end of each Providers claims processing detail. A complete EOP total will be listed at the end of the report indicating the total amounts for all categories along with the Remarks Explanations for any disallows or ineligible charges. The EOP report should be used to accurately reflect payment or claims processing adjustments for accounts receivable reconciliations. Below is detailed listing of the EOP:

1. **CHECKSTOCK NAME:** The Health Plan, Specialty Company or Product DBA (Doing Business As) check stock name
2. **CHECKSTOCK LOGO:** This is the logo for the Health Plan or Self-Funded Group. The same logo displays on the laser checks
3. **PLAN ID TEXT:** Additional Health Plan informational message
4. **PROVIDER/ALT PAYEE:** The mailing name and address for the Physician or Health Care Provider or alternate payee
5. **SUMMARY PAYMENT INFORMATION:**
 - a. **Paid To:** The name for the Physician or Health Care Provider payee
 - b. **Tax #:** Physician or Health Care Provider's Federal Tax Identification number
 - c. **Payment Date:** The date the check was issued
 - d. **Reference #:** Reference number is used internally for report problem resolution. It identifies the site, schedule and system cycle number for the report
 - e. **Check #:** The number of the check that was generated
 - f. **Check Amount:** The total amount of the check
 - g. **Prior overpayment balance:** Amount previously over paid
 - h. **Auto-Recovered this Check:** The total amount recovered or adjusted from the total check
 - i. **Current Overpayment Balance:** Amount in current EOP report reflecting an overpayment
 - j. **Year to Date Financial Allowance:** Physician or Health Care Provider year-to-date total financial allowance withheld from all claims for the reported Payor
6. **PATIENT NAME:** The name of the Covered Persons receiving services
7. **PATIENT ID#:** The 11-digit number for the Covered Person receiving services
8. **ACCOUNT NO:** Covered Person's account number assigned by the Physician or Health Care Provider
9. **PROVIDER NAME:** The name of the Physician or Health Care Provider who performed the services
10. **PROVIDER #:** Twelve-digit number identifying the Physician or Health Care Provider
11. **NPI NO:** Physician or Health Care Provider's National Provider Identification number
12. **PRODUCT: Medical Plan**

13. **CLAIM #:** The number assigned to the claim. (an original claim will end in "00", any adjusted claim will end in "01, 02, etc.)
14. **DIAGNOSIS CODE:** The ICD9 or ICD 10 diagnosis code indicated by the Physician or Health Care Provider
15. **DATE OF SERVICE:** the date the service was performed
16. **PROC:** The code identifying the procedure/service provided
17. **REV:** The revenue code (for facility) identifying the service performed
18. **U:** The number of units for each claim line
19. **AMOUNT BILLED:** The total amount claimed for the procedure performed
20. **ALLOWED:** The amount allowed for payment in accordance with the Fee Schedule or Provider Agreement
21. **FINANCIAL ALLOWANCE:** Column may be blank, or it may indicate the financial allowance or withhold based on the Contractual Agreement
22. **PROV ADJUST:** Services that are not covered and are the Physician or Health Care Provider's responsibility
23. **REMARK CODES:** Reason codes that define any claim adjustments, disallows or denials (Code descriptions can be found on the page at the end of the EOP)
24. **PATIENT INELIGIBLE:** Services that are not covered and are the Covered Person's responsibility
25. **DEDUCTIBLE:** Amount of deductible specified under the Member's Contract (It is the Member's responsibility)
26. **COPAY/CO-INS:** Amount that the Member is required to pay for services (Copayments will be a flat dollar copayment and co-insurance will be a percentage)
27. **OTHER INS:** Amount paid by another Carrier
28. **NET PAID:** Net amount paid to the Physician or Health Care Provider for services after all deductions have been taken
29. **INTEREST AMOUNT:** The amount of interest paid for the specific claim
30. **REFUND REQUESTED: The amount of refunds requested**
31. **AUTO-RECOVERED AMOUNT:** The amount recovered or adjusted from the claim
32. **PAYMENT TO PROVIDER:** The total net payment made to the Provider for that claim
33. **TOTALS FOR PROVIDER:** Summary totals for each Provider with claims reflected on the EOP
34. **EXPLANATION OF PAYMENT TOTALS:** Summary totals for all claims reflected on the EOP and check
35. **REMARK EXPLANATIONS:** The listing of remark codes and definitions identifying reasons for Provider adjustments of ineligible Member charges
36. **ADJUSTMENTS:** Claims being adjusted or recovered will be reflected within the contents of the EOP report as identified above. The amounts being removed will be reflected with a (-) minus reflecting the amount removed from that account. Each column that reflected previous dollars processed will be identified as a subtracted number with the corresponding remarks code for explanation of the adjustment

Electronic Fund Transfer – EFT

With Electronic Fund Transfer (EFT) you can receive your payments electronically through a partnership with PNC. PHP has implemented the 835 Electronic Remittance Advice (ERA) which generates the electronic version of the Explanation of Payments (EOP).

Requirements for receiving your payments electronically include:

- Receive your ERA electronically via the 835 files
- Be a participating Provider with PHP
- Obtain your unique ID number from PHP
- Register with PNC Bank
- PNC Remittance Advantage website at <https://rad.pnc.com>

To sign up for an 835 ERA contact your claims Clearinghouse. Your Clearinghouse will need your National Provider ID (NPI), Tax ID (TIN) as well as a physical address (not a P.O. Box). The initial set-up typically takes 2 - 3 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 PHP's Provider Portal. If you require additional information or training with the Provider Portal, please email your Provider Relations Team at phpproviderrelations@phpmm.org. Receiving electronic payments is fast and easy. Contact your Provider Relations Team today to get started 517.364.8323 or 517.364.8316

Defined Terms

Adverse Determination

Denial of a Healthcare service, procedure or treatment based on the Member's Certificate of Coverage (COC) using approved medical criteria of PHP policies

Benefit Contract

A Benefit Plan that includes Health Care coverage, is sponsored, issued or administered by Payor, contains the terms and conditions of a Member's coverage

Case Management

A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and coordination of available resources to promote quality cost-effective outcomes

Clean Claim

A claim that has all applicable claim fields completed with correct information and with no defect or impropriety, including lack of required substantiating documentation or circumstances requiring special treatment, and any other information as necessary to process the claim

Convenient Care/Urgent Care

Setting for treatment of non-life-threatening conditions

Coordination of Benefits (COB)

Coordination of Benefits is the procedure used to pay Health Care expenses when a Member is covered by more than one Insurer or Plan which provides Health Care benefits

Coinsurance

Percentage dollar amount the Member is responsible for per their Benefit Contract

Copayment

Flat dollar amount Member is responsible for per their Benefit Contract

Dependent

An individual who is properly covered under a Member Benefit Contract

Designated Facility

A transplant Facility that is either a Center of Excellence, or supplemental program within a designated PHP transplant network

Emergency Services

PHP uses the "prudent person" definition as endorsed by the American College of Emergency Physicians when a record is required for review. Your prompt responses to such a request for information will expedite the review of emergency room claims. In some cases, the emergency room ensures a timely determination

Health Services

The Health Care services and supplies covered by the Member's Benefit Contract

HIPAA

Health Insurance Portability and Accountability Act

Network

Collectively, all Physicians/Practitioners and Health Care Providers that have a written Participation Agreement in effect with PHN, directly or through another entity, to provide Health Services to selected groups of Members

Network Education and Integrity Program

Program created to monitor Network Providers who have documented quality issues or who have consistently not followed PHP policies and procedures. The program's intention is to promote quality, ensure compliance with policy and provide guidelines for sanctions

Network Provider

A Physician/Practitioner or Health Care Provider that has a written Participation Agreement in effect with PHN, directly or through another entity, to provide Health Services to selected groups of Members

Payor

An entity or person authorized by PHN to access one or more networks developed by PHN and that has the financial responsibility for payment of Health Services covered by a Benefit Contract

PCP

The Primary Care Physician/Practitioner is responsible for providing and coordinating the care of Members

PDL

Prescription Drug List identifying the drug formulary allowed for Members

Physician Health Network (PHN)

The PHP Network of Providers

Primary Payor

Entity that would pay Member’s claim first in COB situations

Provider Portal

Enhanced online tool available to verify Member eligibility, view claims information and submit medical authorization inquiries and requests

Secondary Payor

Entity that would pay Member’s claim after the Primary Payor has paid in COB situations

How to contact us

PO Box 30377
 Lansing, MI 48909-7877
 517.364.8400
www.PHPMichigan.com

Department	Contact Purpose	Contact Number	Email address
Customer Service	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • 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 Abuse Services, for information on Behavioral Health and/or Substance Abuse 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	<ul style="list-style-type: none"> • Credentialing - report changes in practice demographic information • Coding • Provider/Practitioner education • To report suspected Provider/Practitioner Fraud and Abuse • EDI claims questions • Initiate electronic claims submission 	517.364.8312 800.562.6197 (toll free) 517.364.8412 (fax)	Credentialing PHP.Credentialing@phpmm.org Provider Relations Team PHPProviderrelations@phpmm.org
Quality Management	<ul style="list-style-type: none"> • Quality Improvement Programs • HEDIS • CAHPS • URAC 	517.364.8000 877.803.2551 (toll free) 517.364.8408 (fax)	Quality PHPQualityDepartment@phpmm.org
Pharmacy Services	<ul style="list-style-type: none"> • Request a copy of our Preferred Drug List • Request drug coverage • Fax medication prior authorization forms • Medication Therapy Management Program 	517.364.8545 877.205.2300 (toll free) 517.364.8413 (fax)	Pharmacy PHPweb pharmacy@phpmm.org
Change HealthCare (TC3)	<ul style="list-style-type: none"> • When medical records are requested 	Mail to: Change HealthCare 5720 Smetana Drive, Suite 400 Minnetonka MN 55343 <ul style="list-style-type: none"> • Fax: 952.949.3713 or 949.234.7603 	

Where to Send Claims

PO Box 30377
 Lansing, MI 48909-7877
 517.364.8400
www.phpmichigan.com

	PHYSICIANS HEALTH PLAN (PHP)		PHP SERVICE COMPANY (TPA)	PHP INSURANCE COMPANY (PPO)
WHERE TO SEND CLAIMS	<p>Physicians Health Plan (PHP) In Network: PO Box 853936 Richardson, TX 75085-3936</p> <p>Non-Network: PO Box 247 Alpharetta, GA 30009-0247</p> <p>Electronic Claims In Network: Payer ID: 37330 Non-Network: Payer ID: 07689</p>		<p>PHP Service Company In Network: PO Box 853936 Richardson, TX 75085-3936</p> <p>Non-Network: PO Box 247 Alpharetta, GA 30009-0247</p> <p>Electronic Claims In Network: Payer ID: 37330 Non-Network: Payer ID: 07689</p>	<p>PHP Insurance Company In Network: PO Box 853936 Richardson, TX 75085-3936</p> <p>Non-Network: PO Box 247 Alpharetta, GA 30009-0247</p> <p>Electronic Claims In Network: Payer ID: 37330 Non-Network: Payer ID: 07689</p>
APPROVED CLEARING HOUSES FOR ALL PRODUCTS	<p>AllScripts (PayerPath) Availity (THIN) Capario (MedAvant, ProxyMed) RelayHealth OPTUMInsight Trizetto Provider Solutions (TTPS) Zelis- For Out of Network Providers Only</p>			

Forms

Clicking on the links below will take you directly to the form

- [Claims Adjustment Request Form](#)
- [Claim Inquiry Form](#)
- [Demographic Change Form](#)
- [OON Request Form](#)
- [In Network Prior Authorization Form](#)
- [Provider Appeal Form](#)
- [Out Patient Rehabilitation Prior Authorization Form](#)
- [MyPHP Access Termination Form](#)
- [DME Authorization Request Form](#)
- [Home Health Care Request Form](#)
- [Medication Prior Authorization Form](#)

PHP Notification/Authorization Table and PDL's

You can now click on the links below to access PHP's Notification/Authorization Table and to access the most current up to date Prescription Drug Lists.

[PHP Notification/Authorization Table Link](#)

Clicking on the link above will take you directly to the Notification Table on our website

[PHP Commercial Prescription Drug List \(PDL\) Link](#)

Clicking on the link above will take you directly to the most current and up to date PDL's on our website

PHP INSURANCE COMPANY (PPO)

 **PHP Insurance Company**

 **CVS Caremark**

RXBIN 004336
RXGRP RX1190
RXPCN ADV

Plan Type: **PPO**
Group Number: **L0001457**
Subscriber Number: **500000004**

Name(s):	
MEMBER 1, SAMPLE	00
MEMBER 2, SAMPLE	02
MEMBER 3, SAMPLE	03
MEMBER 4, SAMPLE	04
MEMBER 5, SAMPLE	05

Important Consumer Information

For information, go to: www.phpmichigan.com
Customer Service: 800-203-9519
517-364-8456

For all services that require prior authorization including all inpatient admissions, call Customer Service.

CVS Customer Care: 1-800-378-0973
This card does not prove membership nor guarantee coverage.

All PHP and PCN Providers send Medical claims to:
Electronic Payor ID: 37330
PHP PO BOX 853936
Richardson, TX 75085-3936

All other providers send Medical Claims to:
Zelis Healthcare / PHP
Electronic Payor ID: 07689
PO BOX 247
Alpharetta, GA 30009-0247

To locate in-Network Providers & Hospitals when away from home, call Zelis Healthcare at (866) 807-6193 or go to www.phpmichigan.com

Available Networks Outside the Primary Network Service Area:

 **Cofinity**
(in MI)

 **PHCS**
(All other states)

 **MultiPlan**
(complementary)

 **PCN**
Physician Choice Network

Date Issued: 09/26/2016

Sparrow PHP Marketplace – (defined plans listed)

Sparrow PHP Gold Select Exclusive

Sparrow PHP Platinum Select

Sparrow Silver Premier

Sparrow PHP Bronze Premier

Sparrow PHP Healthy

Sparrow PHP Silver Select Exclusive

Sparrow PHP Gold Premier

Sparrow PHP Silver

Sparrow PHP Bronze



Physicians Health Plan
 CVS caremark

Marketplace-Exclusive-ACA

RXBIN 004336
 RXGRP RX1190
 RXPCN ADV

Plan Type: **Bronze HDHP Exclusive**
 Group Number: **L0001699**
 Subscriber Number: **500000007**

Name(s):
MEMBER 1, SAMPLE **00**

For important information, consumers and providers contact
www.phpmichigan.com

Customer Service: (517)364-8567 (866)539-3342
 CVS Customer Care: 1-800-378-0973

This card does not provide membership nor guarantee coverage.
 For all services that require prior authorization including all inpatient admissions,
 call Customer Service.

All PHP and PCN providers send Medical Claims to:
 Electronic Payor ID: 37330
 PHP PO Box 853938
 Richardson, TX 75085-3938

All other providers send Medical Claims to:
 Zelis Healthcare / PHP
 EDI Payor ID: 07689
 PO Box 247
 Alpharetta, GA 30009-0247

If you need emergency services when away from home,
 call Zelis Healthcare at (866) 807-6193 or go to www.phpmichigan.com



Date Issued: 09/26/2016

Laboratory Tests List

Office/Urgent Care Laboratory Test List

Physicians performing laboratory tests in their office or Urgent Care Facility, and as otherwise required by their Participation Agreement, will be reimbursed for the following:

<u>CPT CODE</u>	<u>DESCRIPTOR</u>
80050	General health panel
80196	Salicylate
81000	Urinalysis, by dip stick or tablet reagent, with microscopy
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, without microscopy, non-automated
81003	Urinalysis, without microscopy, automated
81005	Urinalysis, qualitative or semiquantitative, except immunoassays
81007	Urinalysis, bacteriuria screen, except by culture or dipstick

81015 Urinalysis, qualitative or semiquantitative, except immunoassays
81020 Urinalysis, two or three glass test
81025 Urine pregnancy test, by visual color comparison methods
82044 Albumin; urine, microalbumin, semiquantitative
82270 Blood; occult, by peroxidase activity, feces
82272 Blood; occult, by peroxidase activity, feces, 1-3 determinations
82274 Blood Occult Fecal HGB 1-3 determinations
82565 Creatinine; blood
82670 Estradiol
82947 Glucose; quantitative
82948 Glucose, blood reagent strip
82962 Glucose, blood by glucose monitoring device(s)
83001 Gonadotropin; follicle stimulating hormone (FSH)
83002 Gonadotropin; luteinizing hormone (LH)
83036 Hemoglobin; glycosylated
83861 Microfluid analysis, tear osmolarity
83872 Mucin, synovial fluid (Ropes test)
83986 Molecular diagnostics, nucleic acid probe, each
84132 Potassium; serum
84144 Progesterone
84146 Prolactin
84702 Gonadotropin; chorionic (hCG); quantitative
84703 Gonadotropin, chorionic (hCG); qualitative (urine pregnancy test)
85007 Blood count, blood smear, microscopic examination with manual differential WBC count
85013 Hematocrit, spun
85014 Hematocrit, other than spun
85018 Hemoglobin
85025 Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85027 Hemogram and platelet count, automated
85048 White blood cell (WBC)
85651 Sedimentation rate, erythrocyte; non-automated

85652	Sedimentation rate, erythrocyte; automated
86140	C-Reactive Protein
86317	Immunoassay for infectious agent antibody, quantitative
86329	Immunodiffusion; not elsewhere specified
86403	Particle agglutination, antibody
86406	Particle agglutination, titer, each antibody
86580	Skin test; tuberculosis, intradermal
87081	Culture, presumptive, pathogenic organisms, screening only
87205	Smear, primary source, with interpretation
87210	Wet mount for infectious agents
87220	Tissue examination by KOH slide
87430	Streptococcus, group A (Infectious agent antigen detection by enzyme immunoassay technique)
87804	Influenza
87807	RSV
87880	Streptococcus, group A (Infectious agent detection by immunoassay with direct optical observation)
89260	Sperm ISOL Complex Prep Insemination/DX Semen Analysis
89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis
89300	Semen Analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen Analysis; motility and count (not including Huhner test)
89320	Semen Analysis; complete
89325	Sperm antibodies
89330	Sperm evaluation; cervical mucus penetration test; with or without spinnbarkeit test
89353	Thawing of cryopreserved; sperm/semen, each aliquot

Dermatology Laboratory Test List

In addition to the office test list, Dermatologists may perform these laboratory tests in their office and will be reimbursed for the following; provided the terms of their Participation Agreement are followed:

<u>CPT CODE</u>	<u>DESCRIPTOR</u>
88304	Level III-Surgical pathology, gross and microscopic exam

88305	Level IV-Surgical pathology, gross and microscopic exam
88312	Special stains; Group I for microorganisms, each
88313	Special stains; Group II, all other, except immunocytochemistry and immunoperoxidase stains, each

Rheumatology Laboratory Test List

In addition to the office laboratory test list, Rheumatologists may perform these laboratory tests in their office and will be reimbursed for the following; provided the terms of their Participation Agreement are followed:

<u>CPT CODE</u>	<u>DESCRIPTOR</u>
80076	Hepatic function Panel
82040	Albumin; serum
82550	Creatine kinase (CK), (CPK); total
83615	Lactate dehydrogenase (LD) (LDH)
84075	Phosphatase, alkaline
84450	Transferase; aspartate amino (AST) (SGOT)
84460	Alanine amino (ALT) (SGPT)
84520	Urea nitrogen; quantitative
89050	Cell count, misc. body fluids, except blood
89051	Cell count, misc. body fluids, except blood with differential count
89060	Crystal identification by light microscopy with or without polarizing lens analysis

For a more complete description of the above listed laboratory tests, please refer to a current Physicians' Current Procedural Terminology (CPT).

Member Rights and Responsibilities

PHP Commercial Membership Rights

Enrollment with PHP entitles you to:

1. Be given information about your rights and responsibilities as a Member
2. Be treated at all times with respect and recognition of your dignity and right to privacy

3. Choice of and ability to change a Primary Care Physician (PCP) from a list of Network Physicians or Practitioners
4. Information on the nature and consequence of appropriate or medically necessary treatment options that may be involved in your Health Care, regardless of cost or benefit coverage in terms you can reasonably be expected to understand and so that you can give informed consent prior to initiation of any procedure and/or treatment
5. The opportunity to participate in decisions involving your Health Care, including, making decisions to accept or refuse medical or surgical treatment and to be given information on the consequences of refusing or not complying with treatment
6. Voice complaints or appeals about PHP or the care provided and/or use PHP's Complaint/Appeal Procedure to resolve problems without fear of being penalized or retaliated against and/or without fear of loss of coverage
7. Be given information about PHP, its Services, and the Physicians and Practitioners who provide Health Services, including the qualifications of Network Providers
8. Make suggestions regarding PHP's Member Rights and Responsibilities Policies

...and Responsibilities

As a covered person, you are expected to:

1. Select or be assigned a Primary Care Physician from PHP's list of Network Providers and notify PHP when you have made a change
2. Be aware that all hospitalizations must be authorized in advance by PHP and arranged by your PCP or Network Specialist, except in emergencies or for urgently needed health services
3. Use emergency room services only for treatment of a serious medical condition resulting from injury, sickness or mental illness, which arises suddenly and requires immediate care and treatment (generally within twenty-four [24] hours of onset) to avoid jeopardy to your life or health
4. Always carry your PHP ID card, present it to the Provider each time you receive health services, never permit its use by another person, report its loss or theft to us and destroy any old cards
5. Notify the Health Plan of any changes in address, eligible Family Members and marital status, or if you acquire other Health Insurance Coverage
6. Provide complete and accurate information (to the extent possible) that PHP and Practitioners/Providers need in order to provide care
7. Participate in understanding your health problems and developing treatment goals you agree on with your PHP Provider
8. Follow the plans and instructions for care that you agree on with your PHP Provider

9. Understand what services have deductibles, coinsurance and/or copays, and pay them directly to the Network Physician, Practitioner or Provider who gives you care
10. Read your PHP Certificate of Coverage and other PHP Member materials and become familiar with and follow Health Plan Benefits, Policies and Procedures
11. Report Health Care Fraud or wrongdoing to PHP

Reporting Communicable Disease

Michigan Physicians/Practitioners are required to report Patients with the following conditions to the Patient's local Health Department. Lab-confirmed and clinical diagnoses are reportable in the time intervals specified. This reporting allows for appropriate public health follow-up for the Patients and assists in identifying outbreaks not always evident to a sole Provider.

Immediately

Any unusual occurrence, outbreak, or epidemic of any disease, condition, and/or nosocomial infection

Within 24 Hours

Any unusual occurrence, outbreak, or epidemic of any disease, condition, and/or nosocomial infection

AIDS	H. Influenzae (Meningitis of Epiglottis)	Plague
Anthrax	Hepatitis B in Pregnant Woman	Poliomyelitis
Botulism	Lymphogranuloma Venereum	Syphilis
Chancroid	Measles	Tuberculosis
Diphtheria	Meningococcal Disease (Meningitis or	Viral Hemorrhagic Fevers
Gonorrhea	Meningococemia)	Yellow Fever
Granuloma Inguinal	Pertussis	

Within Three (3) Working Days

Amebiasis
Blastomycosis
Brucellosis
Campylobacter Enteritis
Chlamydia (Genital)
Coccidioidomycosis
Cryptococcosis
Cryptosporidiosis
Cyclosporiasis
Dengue fever
E. coli disease (**Only** shiga toxin producers)
Ehrlichiosis
Encephalitis, Viral
Guillain-Barre' Syndrome
Hantavirus Pulmonary Syndrome
Hemolytic-Rremic Syndrome
Hepatitis
Histoplasmosis
Kawasaki Disease
Legionellosis
Leprosy
Leptospirosis
Listeriosis
Lyme disease
Malaria
Meningitis (Bacterial & Viral)
Mumps
Psittacosis
Q Fever
Reye's Syndrome
Rheumatic Fever
Rocky Mountain Spotted Fever
Rubella (Congenital Syndrome)
Rubella
Salmonellosis
Shigellosis
Staphylococcal Disease, (First 28 Days Post-Partum Mother or Child)
Streptococcal, Invasive Group A (normal sterile sites)
Giardiasis
Tetanus
Toxic Shock Syndrome
Trachoma
Trichinosis
Tularemia
Typhoid Fever
Typhus
Yersinia Enteritis

Within One (1) Week

Chicken pox (Aggregate Numbers)

HIV Infection
 Influenza (Aggregate Numbers)

How to Report - Call, mail or fax your local Health Department. Provide Patient demographics, diagnosis and onset date

County	Health Department	City	Phone	Fax
Clinton	Mid-Michigan DHD	St. Johns	989.224.2195	989.224.4300
Eaton	Eaton DHD	Charlotte	517.543.2430/7110	517.543.7737
Gratiot	Mid-Michigan DHD	Ithaca	989.875.3681	989.875.3747
Ingham	Ingham County	Lansing	517.887.4311	517.887.4310
Ionia	Ionia County	Ionia	616.527.5341	616.527.5361
Isabella	Central Michigan DHD	Mt. Pleasant	989.773.5921	989.773.4319
Montcalm	Mid-Michigan DHD	Stanton	989.831.5237	989.831.5522

Network Education and Integrity Program (NEIP)

It is the intent of PHP to ensure that Network Providers are providing care and services to PHP Members in accordance with their Participation Agreement and PHP Policies and Procedures. Repeated failure to comply with PHP’s Policies and Protocols may result in the Network Provider being placed under review or the initiation of sanctions. The Network Education and Integrity Program has established criteria related to each of the non-compliance penalties as described below:

NEIP Program Definitions

Compliance Improvement Work Plan: A corrective plan of action implemented to assist the Network Provider in reaching compliance within the areas noted as deficiencies.

Monetary Adjustment: A penalty for continued non-compliance with certain PHP protocols involving referrals or non-covered services and products. Monetary Adjustments are as follows:

- Facilities: May result in non-payment or reduction in payment of the per diem amount or contracted payment amount for each hospital day, service, and/or procedure for which the facility is non-compliant
- Physicians/Practitioners: May result in a Monetary Adjustment equal to the amount of the non-covered services or product or the difference between the amount paid by PHP and the PHP Fee Schedule as determined by PHP

Suspension: Temporary loss of participation in PHN

Termination: Permanent loss of participation status in PHN

NEIP Description

A Network Provider may be referred to the NEIP by any department within PHP that becomes aware of a non-compliance issue as defined below by example. The reasons a Network Provider may be placed on review include, but are not limited to, the following:

- Non-compliance with authorization/notification process, which includes rendering non-covered services, with or without retroactive authorization requests (more than three (3) in one quarter or six (6) in one year)
- Referral patterns to Non-Network Providers, including redirects and those without prior notification (more than three (3) in one quarter or six (6) in one year). At the time of notification, if the Physician/Practitioner is aware that a Member is self-referred to a Non-Network Provider, he/she will not be held responsible if he/she notifies PHP in writing of each such occurrence and does not initiate a retroactive authorization
- Non-formulary use (2.0 standard deviations higher than peers over a six (6) month period)
- Physician profile data indicative of significant cost and/or over utilization of services compared to peers (2.0 standard deviation over/under peers)
- Quality issues or repeated quality issues deemed significant by the PHP Quality Improvement/Medical Resource Management Committee (more than three (3) in one (1) quarter or six (6) in one year)
- Deviation from PHP billing standards as defined in CPT coding and this manual (more than three (3) in one quarter or six (6) in one (1) year)
- Exceeding Member or Provider complaint thresholds deemed significant by the Credentialing and Peer Review Committee
- Non-compliance with other protocols as outlined in the PHN Participation Agreement and this manual (more than three (3) in one (1) quarter or six (6) in one year)

PHP will communicate non-compliance issues to the Network Provider in writing and provide specific education related to the appropriate process/policy. If necessary steps are not taken to correct the non-compliance issue once it has been identified and the necessary education has been completed, a notice will be sent to the Network Provider from the PHP Medical Director informing the Network Provider that they have been placed on review. If a Network Provider is placed on a review, PHP may impose restrictions, including, but not limited to:

- A mandatory Compliance Improvement Work Plan with a specified timeframe for correction
- Termination of eligibility for incentive plans or programs of PHP (i.e., Physician Incentive Plan, special Fee Schedule incentives)
- Ceasing to refer Members to the Network Provider

A Network Provider who completes the Compliance Improvement Work Plan with no additional occurrences within 12 months from the date of the initial notification from PHP's Medical Director will be removed from review.

Failure to implement the Compliance Improvement Work Plan requirements will initiate the Network Education and Integrity Program Sanction process. Written notification will be sent to the Network Provider regarding their removal from review or progression to the sanction process.

Possible sanctions by PHP may include, but are not limited to:

- Termination of eligibility for incentive plans or programs of PHP (i.e., Physician Incentive Plan, special Fee Schedule incentives)
- Ceasing to assign new Members (if PCP) or to refer Members to Network Provider for specialty care
- Automatic forfeiture of 5% of the financial allowance per occurrence of non-compliance

External Regulations & Standards

URAC

Health Plan is URAC Accredited for its HMO/POS combined product lines and Marketplace product line. During the accreditation process, PHP was measured against rigorous standards in the areas of:

- Customer service and addressing Member concerns
- Providing high credentialing standards of Providers
- Responding to Member and Practitioner issues
- Listening to and addressing feedback of new Members

For more information visit <https://accreditnet2.urac.org/uracportal/Directory/CompanyView/10172>



Health Plan
Expires 07/01/2021



ACCREDITED
Health Plan-
Health Insurance
Marketplace
Expires 07/01/2021

Michigan Regulatory Agencies

DIFS makes sure that PHP follows state laws that regulate all Michigan HMOs such as prompt claims payment and appeal processes.

Measuring Effectiveness

HEDIS

HEDIS®, a registered trademark of NCQA, is a set of standardized performance measures that ensure Purchasers and Consumers have the information they need to reliably compare health care quality. PHP participates annually in HEDIS reporting. NCQA uses HEDIS measures to evaluate more than 400 Health Plans from across the country every year. Some of the measurements included in HEDIS are:

- Childhood Immunization
- Adolescent Immunization
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Controlling High Blood Pressure
- Persistence of Beta Blocker Treatment After a Heart Attack
- Comprehensive Diabetes Care
- Medication Management for People with Asthma
- Follow-up after Hospitalization for Mental Health Illness
- Antidepressant Medication Management
- Adult Access to Preventative/Ambulatory Health Services
- Children and Adolescents Access to Primary Care Practitioners
- Prenatal and Postpartum Care
- Antibiotic Utilization
- Adolescent Well-Care Visits
- Well-Child Visits First 15 Months of Life
- Well-Child Visit Third, Fourth, Fifth and Sixth Years of Life

PHP obtains data for HEDIS in two ways; administrative services and medical record review. Administrative services are based on claims submitted to PHP and medical record review is based on medical record abstraction. Although most data is collected through

administrative services, there will be times when medical record review is necessary to obtain more accurate data. If this occurs, PHP will contact your office for Member medical records to be pulled for review. Your assistance in this process is greatly appreciated.

CAHPS

PHP is required to survey our Membership on an annual basis. We send the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to eligible Members beginning in February and ending in May every year. The CAHPS survey measures Member's perceptions of their Health Plan and Health Care. It includes relating to the following area:

- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Health Plan Customer Service

Responses are benchmarked against other Health Plans both in Michigan and nationwide. Results are communicated to Members, Providers and other PHP customers. Action plans are developed to improve low scores and to maintain high scores.

Wellness Mailings

Wellness reminders are sent to Members who have not received a wellness visit, screening or test. Reminder mailings include:

Missed Well Child Visits

PHP encourages Members ages 3–6 years to see their PCP for a yearly well child visit. Well child services should be reported using the appropriate preventive medicine CPT codes with a preventive medicine ICD- 10 diagnosis code.

Missed Adolescent Exams

PHP encourages Members ages 12–21 years to see their PCP for a yearly adolescent health examination. Well adolescent services should be reported using the appropriate preventive medicine CPT codes with a preventive medicine ICD- 10 diagnosis code.

Prevention Mailings

Preventive reminders are sent to Members to remind them of needed well visits and/or immunizations. Preventive reminder mailings include:

Cervical Cancer Screening Reminder

Cervical cancer screening reminders target women ages 21-64 with no record of a cervical cancer screening within the past 36 months.

Breast Cancer Screening Reminder

Breast Cancer screening reminders target women ages 50-74 with no record of a mammogram within the past 24 months.

Colorectal Screening

Colorectal cancer screening reminders are sent to Members age 50 and over.

Standards of Care Guidelines

PHP Standards of Care Guidelines assist by providing evidence-based recommendations for you to be able to focus on your Patients' care. If you would like to obtain a paper copy of the PHP Standards of Care Guidelines, please contact the Quality Management Department at the number located on the "[How to Contact Us](#)" page. Below are links of the PHP Standards of Care Guidelines based on Michigan Quality Improvement Consortium (MQIC). For more information on MQIC, you can visit their website at mqic.org

- [Diagnosis of Attention-Deficit/Hyperactivity Disorder \(ADHD\) for children and Adolescents Guideline](#)
- [Treatment of Attention-Deficit/Hyperactivity Disorder \(ADHD\) for Children and Adolescents Guideline](#)
- [Adolescent and Young Adult Health Risk Behavior Assessment Guideline](#)
- [Advance Care Planning Guideline](#)
- [General Principles for the Diagnosis and Management of Asthma Guideline](#)
- [Management of Acute Low Back Pain in Adults](#)
- [Management of Uncomplicated Acute Bronchitis in Adults Guideline](#)
- [Primary Care Diagnosis and Management of Adults with Depression Guideline](#)
- [Management of Diabetes Mellitus Guideline](#)
- [Adults with Heart Failure with Reduced Ejection Fraction Guideline](#)
- [Medical Management of Adults with Hypertension Guideline](#)
- [Diagnosis and Management of Adults with Chronic Kidney Disease Guideline](#)

- [Lipid Screening and Management Guideline](#)
- [In Office Use of Sedation](#)
- [Opioid Prescribing in Adults Excluding Palliative and End-of-Life Care Guideline](#)
- [Medical Management of Adults with Osteoarthritis Guideline](#)
- [Management and Prevention of Osteoporosis Guideline](#)
- [Prevention and Identification of Childhood Overweight and Obesity Guideline](#)
- [Treatment of Childhood Overweight and Obesity Guideline](#)
- [Management of Overweight and Obesity in the Adult Guideline](#)
- [Acute Pharyngitis in Children 3 - 18 Years Old Guideline](#)
- [Routine Prenatal and Postnatal Care Guideline](#)
- [Prevention of Pregnancy in Adolescents 12-17 Years Guideline](#)
- [Prevention of Unintended Pregnancy in Adults 18 Years and Older Guideline](#)
- [Routine Preventive Services for Infants and Children \(Birth - 24 Months\) Guideline](#)
- [Routine Preventive Services for Children and Adolescents \(Ages 2 - 21\) Guideline](#)
- [Adult Preventive Services Guideline \(18-49\)](#)
- [Adult Preventive Services Guideline \(Age≥50\)](#)
- [Screening, Diagnosis, and Referral for Substance Use Disorders Guideline](#)
- [Tobacco Control Guideline](#)
- [Outpatient Management of Uncomplicated Deep Venous Thrombosis Guideline](#)
-