Provider Connection

FIRST QUARTER 2017

In this issue

Survey says? 2

Thank you 2

Working with PHP 3

Is our data up to date? 4

Tools and resources 3

Helpful tips to expedite a medication prior authorization request 5

Useful information: Outpatient Rehab 6

Utilization Management news and updates 7

2017 coding change highlights 8

Claim submission requirements and reminders 8

Medication Therapy Management program available to all members 9

PHP Telehealth benefits 9

Help members keep their New Year's resolutions going 10

Hedis Corner 11

Statement of Member's Rights and Responsibilities 12

Advance directive standard 13

Requirement for providers to maintain and disseminate written fraud and abuse policy requirements and False Claims Act policies 14

How to Contact Us ..... Back Cover

Physicians Health Plan

A health plan that works for you.

Survey says?

Each year we participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, which measures many aspects of member satisfaction. The objective of the study is to capture accurate and complete information about consumer-reported experiences with healthcare. Specifically, the survey aims to measure how well PHP and other plans are meeting their members' expectations and goals. Through this, PHP is able to determine which areas of service have the greatest effect on members' overall satisfaction and identify areas of opportunity for improvement. CAHPS survey questions are focused on the health plan services in addition to the care Patients receive from their doctors.

PHP's 2016 Commercial HMO Adult member satisfaction survey scores showed improvements in percentile rankings in the areas of Claims, Shared Decision Making, and Customer Service, while Rating of the Health Plan remained consistent. Areas decreasing in percentile ranking include, Getting Care Quickly, Getting Needed Care, How Well Doctors Communicate, Rating of Health Care, Rating of Personal Doctor, and Rating of Specialist. It is important to review these results as an opportunity to improve access, improve care, and improve the Patient experience. PHP needs your help to correct the declining results in our members' overall experience with Getting Care and their rating of Personal Doctors and Specialists. Please see the table below for the specific results of the 2016 CAHPS survey compared to previous years.

In 2016 PHP also participated in the Qualified Health Plan Enrollee Survey (QHP). This is a survey of our members with

2014-2016 Commercial CAHPS Comparison

Measure	2016 Rate	2016 Percentile	2015 Rate	2015 Percentile	2014 Rate	2014 Percentile
Claims Processing Composite	93.26%	90th	91.27%	75th	89.01%	50th
Customer Service Composite	NA	NA	93.75%	95th	91.13%	75th
Getting Care Quickly Composite	84.24%	25th	87.63%	50th	89.32%	75th
Getting Needed Care Composite	88.42%	50th	91.05%	75th	91.51%	75th
How Well Doctors Communicate Composite	94.47%	25th	97.09%	75th	97.65%	95th
Rating of Health Care	73.97%	10th	80.07%	50th	86.25%	95th
Rating of Health Plan	75.51%	90th	75.85%	90th	79.51%	90th
Rating of Personal Doctor	78.18%	<5th	84.56%	25th	89.17%	75th
Rating of Specialist Seen Most Often	80.85%	10th	82.01%	25th	86.16%	50th
Shared Decision Making Composite	84.56%	75th	82.11%	50th	ND	

Thank you

Physicians Health Plan (PHP) would like to recognize and thank you in honor of National Doctor's Day on March 30, 2017. You are a vital member of our healthcare community and National Doctor's Day is a formal opportunity for the health plan to show our appreciation and recognize the pivotal role that you play in caring for our community, promoting healthy lifestyles, and advancing medicine.

Your dedication to improving the health and well-being of our members is commendable.

Thank you,

Physicians Health Plan

Marketplace coverage. Since we do not have comparison data from previous years, the graph below measures PHP to the national average. As you can see PHP is at or exceeding the national average in most categories.

Improving the CAHPS and QHP survey results is a strategic goal for PHP in 2017. Our members will be receiving the 2017 CAHPS surveys in the next few weeks. If your office would like to partner with PHP and our provider network to identify ways we can improve our members' experience, please contact your Provider Relations Team at PHPProviderRelations@phpmm.org.

2016 QHP Overall Ratings and Global Measure

QHP Overall Ratings	PHP's Average	National Average	PHP Ranking
Rating of All Healthcare	84.35	81.56	Average
Rating of Personal Doctor	88.40	88.26	Average
Rating of Specialist	89.12	86.65	Average
Rating of Health Plan	77.02	72.21	Above Average
Global Measure: Recommend to Friends and Family	75.10	70.33	Above Average

Working with PHP

General Training 101

The Provider Relations Coordinator Team offers training sessions throughout the year to help you and your office staff work smoothly with PHP.

Learning opportunities include a review of the provider manual, checking eligibility and benefits, claim status, authorizations, and much more. Attendees should include management and all office staff.

April 27 | noon – 1:30 p.m.

July 27 | 8:30 – 10 a.m.

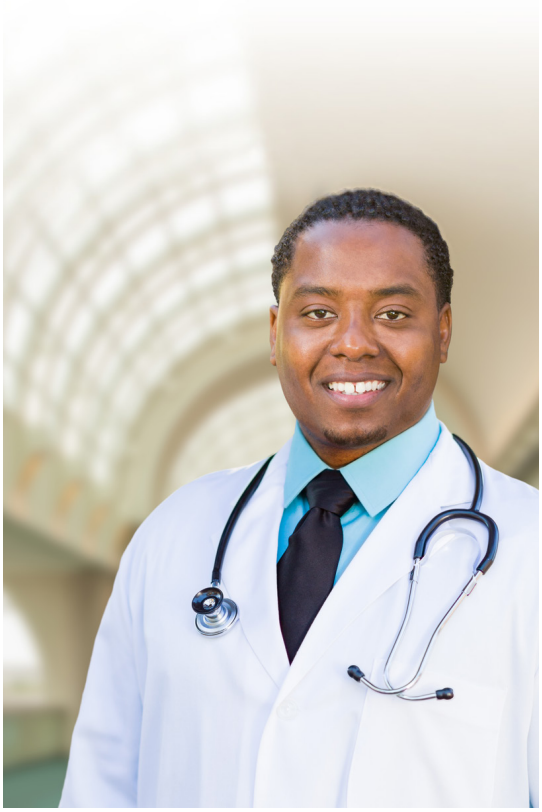
Oct.19 | noon – 1:30 p.m.

Pharmacy Training

Tips and tricks to expediting a pharmacy authorization request, cost-effective prescribing, E-Prescribing, Medication Therapy Management (MTM) Services and the future of prescribing at Physicians Health Plan.

June 14 | noon – 1:30 p.m.

Please email your RSVP at least one week prior to the event. Questions? Contact PHPProviderRelations@phpmm.org. All trainings take place at PHP, are free of charge, and include a light meal.



Is our data up to date?

Address on Claim Submissions

PHP wants to make sure your claims are processed accurately and timely. One area that can delay your claim is if the addresses on your claim form or in your electronic claims file do not use the United States Postal Service (USPS) Address standards. It is important to ensure your billing entity is submitting your data in accordance with these standards. If you have any questions about how to submit your claims address information, please email the credentialing team at PHP.Credentialing@phpmm.org.

Accurate Provider data

Our Credentialing Team is here to ensure that all provider data is accurate and up to date. Has your office moved? Did your remittance address or Tax ID change? Have you welcomed new providers or said goodbye to others? The Credentialing Team needs to be notified of these types of changes to ensure your practice is receiving payments to the appropriate tax ID and address. Please send any updated information, questions, or concerns to PHP.Credentialing@phpmm.org or fax it to PHP Network Services at 517.364.8412. You may also speak to one of our Credentialing Team members by calling 517.364.8312 and selecting option 1.

Tools and Resources

Looking for information? Have a question? PHP's website, PHPMichigan.com, has many useful tools and resources for Providers, including:

The Provider Directory: Locate providers and specialists in the Physicians Health Network (PHN) by clicking on the "Find a Doctor" tab in the green tool bar.

Provider Manual: Information to assist Providers in understanding PHP's Policies and Procedures, along with claims processing information, educational materials, contact information for clinical decision making and criteria along with much more. PHPMichigan.com›Providers

Pharmacy Preferred Drug List (PDL): The PDL is the list of prescription drugs by brand and generic brand that are considered preferred. The PDL applies only to prescription medications dispensed to outpatients and does not include inpatient medications or medication obtained or administered in a Physician's office. The PDL does not define benefit coverage. Benefit coverage is determined by the member's pharmacy benefit plan. PHPMichigan.com›Provider›General Forms and Information

Authorization/Notification Table: The authorization/notification table is a document designed to identify services that require prior notification or authorizations, as well as the notification timeframe requirement. Services not prior authorized in accordance with the notification timeframes are not eligible for reimbursement. PHPMichigan.com›Provider›General Forms and Information

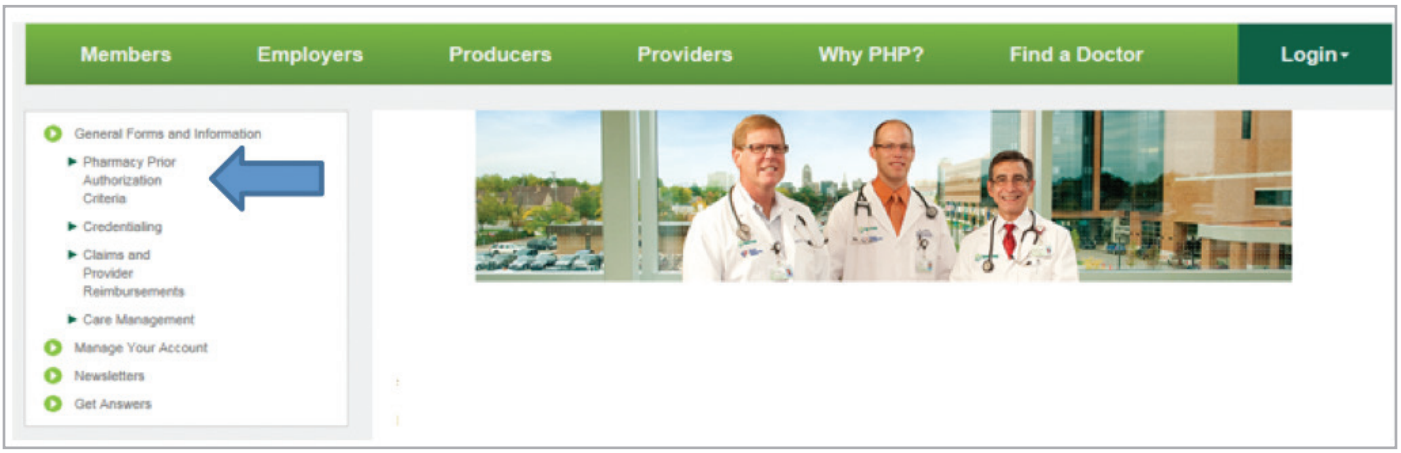
MyHealthweb®: This online provider portal allows you to check member eligibility, view claim information, and submit a prior notification request. PHPMichigan.com›Provider›Manage Your Account

The Provider Connection: Each edition of this quarterly newsletter, which contains important updates and communications for our Provider Network, can be found under PHPMichigan.com›Providers›Newsletter. If you are interested in receiving an electronic version of the Provider Connection, please send an email to PHPProviderRelations@phpmm.org

PHP's website also contains important information regarding **Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)**.

Helpful tips to expedite a medication prior authorization request:

An internal study has shown prior authorization requests that are not filled out completely, or are missing information, take an additional four days to process. Below are tips that will help your office and provide PHP the opportunity to make a benefit determination as quickly as possible. Most of the information that you need is right at your fingertips. Log onto PHPMichigan.com/Providers. The Pharmacy section is listed in the left side navigation.



Tips for Prior Authorization processing:

» Ensure the Patient meets the criteria for specific medications. Criteria are listed on the website under "Pharmacy Prior Authorization Criteria".

» If a drug does not have a specific criteria for approval, refer to the **"Policy on use of formulary alternatives"**:

Document in your chart notes the following information:

A. Trial of formulary alternatives

1. Drug class: Must try more than two agents from within a similar chemical class (e.g. statins)
2. Therapeutic class: If there are not more than two formulary agents within the drug class, then trial of more than two agents with the same therapeutic indication (e.g. agents to treat hyperlipidemia)
3. Requested medication for the intended diagnosis must be:
   a. FDA approved, or
   b. Off-label use: provide at least two supporting articles from major peer-reviewed medical journals that present data supporting the proposed off-label use as generally safe and effective.

B. Lack of efficacy

1. Trial duration: three months at therapeutic dosage (exception for duration may be made for fast onset medications)
2. Fill history: Demonstration of consistent fill history electronically or verbally from pharmacy
3. Documentation: Chart note on lack of efficacy with objective data

C. Clinically significant Adverse Drug Reaction (ADR)

1. Fill history: Demonstration of consistent fill history electronically or verbally from pharmacy
2. Documentation: Chart note on clinically significant ADR with objective data
3. Causality supported: Consistent time course and literature support for ADR

» Fill out the "Medication Prior Authorization Form" in its entirety. The form is also available on the website. Fax the completed form and any appropriate attachments to the PHP Pharmacy Department at 517.364.8413.

» **Chart notes are required**

Questions? Contact PHP's Pharmacy Department at 517.364.8545 for assistance. Our office and fax machines are open Monday through Friday 8 a.m. to 5 p.m., except holidays.

Useful information: Outpatient Rehab

PHP has received several questions about therapy services and thought that it might be helpful if we put together some do's, don'ts, and must haves. Please see the following for additional information.

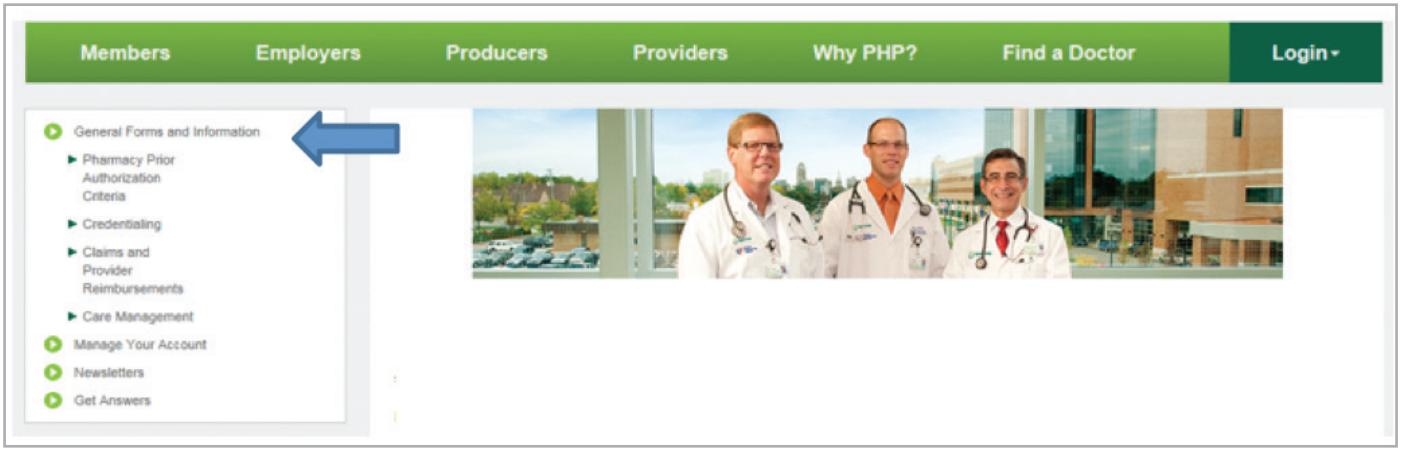
1. A signed script or plan
    a. Signed scripts must specify a diagnosis, "Eval and Treat" or a frequency and duration.
    b. For scripts that are written for a future start of care date related to post-op treatment, treatment is to start within 30 days of the start of care date specified.
    c. Scripts are valid for the frequency and/or duration specified OR up to 90 days.
2. Plan of Care (POC) is based on the evaluation/re-evaluation which includes details of treatment, estimated time frame for treatment, and anticipated results. At a minimum, the POC is to include:
    a. Medical diagnosis
    b. Specific long and short-term treatment goals
    c. Measurable objectives
    d. Type of services or interventions
    e. For a child, the treatment plan includes active participation/involvement of a parent or guardian
    f. Amount (number of times per day the therapist provides treatment; if not specified, it is assumed one treatment session per day)
    g. Frequency (number of times per week; do not use ranges)
    h. Duration (number of weeks or treatment sessions; do not use ranges)
    i. Discharge plan
    j. Dated signature of referring Physician within 30 calendar days (A Physician signed POC is then considered a Certification or Re-certification)

When a Patient is receiving multiple therapy services (PT, OT, ST), there must be a POC for each discipline. Each therapist must independently establish what impairment or dysfunction is being treated and goals for therapy treatment.

If there is a question about the therapy process, please contact Medical Resource Management team at 517.364.8560.

3. Evaluation and Re-Evaluation: A comprehensive evaluation is essential to determine if therapy services are medically necessary, to gather baseline data, establish a treatment plan, and develop goals based on the data. The initial evaluation is usually completed in a single visit and is needed before implementing any therapy treatment. The evaluation must include:
    a. Medical diagnosis – should be specific and as relevant to the problem to be treated as possible
    b. Impairment or dysfunction to be treated
    c. Subjective observation
    d. Objective observation (e.g., identified impairments and severity or complexity)
    e. Assessment (includes rehab potential, long-term and short-term goals, and discharge plan)
    f. Signature of clinician providing service
    g. Re-evaluation is done at least every 30 days
    h. Plan of care should be updated as the individual's condition changes or at least every 90 calendar days
4. A signed script or plan starts on date of evaluation
5. A script or plan of care can be written by a Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), Podiatrist (DPM), Dentist (DDS), Physician Assistant (PA), or a Nurse Practitioner (NP) on behalf of a Physician. A chiropractor cannot order physical therapy in the state of Michigan.
6. Initial request after evaluation must include: copies of the Physician order and initial evaluation with the home exercise plan.
7. Continued visits requests must include: assessment of progress toward goals, plan of care, and Physician signed plan of care for visits after the initial Physician order has expired.
8. Therapy visit totals are determined by the diagnosis code. Please use the appropriate code (Hip surgery vs Hip pain).
9. All outpatient services after the initial evaluation visit requires authorization in advance of the health service being provided.
10. Fax all requests to 517.364.8409 between 8 a.m. and 5 p.m., Monday through Friday.
11. Submit all evaluations as soon as possible so the member can start therapy. All requests will be treated urgently and returned no later than three business days.

Utilization Management (UM) news and updates



Procedures and services requiring prior authorization are available online. Please visit PHPMichigan.com/Providers and select "General Forms and Information", then "Prior Authorization Forms" to locate the **Prior Authorization Notification Table** and **Prior Authorization Request Forms**.

Below is a list of recent changes:

Changes to Coverage for Services:		
Code, Procedure or Service	**Action**	**Implementation Date**
Weight Management Programs	No longer requires PA	12/14/2016
MP 036 Bariatric Surgery	Revised policy; continues to require PA	12/14/2016
MP 037 Gender Reassignment Surgery	New policy; all related services require PA	01/01/2017
CPT 88350 – Immunofluorescence, each additional single antibody stain procedure	No longer requires PA	1/1/2017

Benefits for Gender Reassignment are available as plans renew with PHP. If you have any authorization questions, please call the Customer Service Department at 517.364.8500 or 800.832.9168 between the hours of 8:30 a.m. and 5:30 p.m., Monday through Friday.

2017 Coding Change Highlights

Physical and Occupational Therapy Evaluation

As of Jan. 1, 2017, CPT published new evaluation codes for physical and occupational therapy evaluation services.

Physical Therapy

- New evaluation codes: 97161, 97162, 97163
- New re-evaluation code: 97164

Codes 97001 & 97002 expired 12/31/2016 and are no longer valid.

Occupational Therapy

- New evaluation codes: 97165, 97166, 97167
- New re-evaluation code: 97168

Codes 97003 & 97004 expired 12/31/2016 and are no longer valid.

The new evaluation codes have been broken out into levels of care by complexity: low, moderate and high. When selecting these new codes, please refer to documentation of history, exam, clinical presentation, and clinical decision making. As with all American Medical Association (AMA)® coding changes, please ensure claims are submitted with the correct active codes for the date of service billed. If claims are received with an incomplete or expired code, the claim may be denied.

Telemedicine Coding Changes

New CPT Code Modifier 95

Synchronous telehealth service rendered via real-time interactive audio and video communications system

- This is a new modifier, however it does not replace existing modifier GQ (Telehealth service rendered via asynchronous telecommunications system) or GT (Telehealth service rendered via interactive audio and video telecommunications system). PHP will accept modifiers 95, GT and GQ as applicable.

New Place of Service (POS) Code 02

The location where health services and health related services are provided or received, through a telecommunication system

- Please use this Place of Service code when billing contracted telemedicine services.

For further detail and additional 2017 code changes please refer to your 2017 CPT® and HCPCS® books.

Claim submission requirements and reminders

Data integrity and quality has been a focus for many within the healthcare industry. It is important to remember the appropriate billing requirements when billing for interim or series billing claims.

Interim/Series billing guidelines:

- Use the accurate type of bill as required for each month's services with the accurate billing requirement for the initial, continuous, and discharge claim.
  - Initial Claim – xx2 type of bill
  - Continuing Claims – xx3 type of bill
  - Final/Discharge Claim – xx4 type of bill
  - Final/Discharge Claims for Home Health – xx9 type of bill
- PHP will reject claims if they are not submitted in the appropriate order. If you are experiencing one of these rejections, remember that an xx2 (initial claim) must be on file and billed before any additional continuing claims will be processed. This may require submitting an adjustment claim to get the xx2 on file before any continuing, final, or discharge bill types can be processed.

PHP appreciates your cooperation as we continue to strive for the highest level of data quality related to claims submissions. We will continue to communicate any modifications that are made.

Medication Therapy Management program available to all members

Physicians Health Plan (PHP) offers Medication Therapy Management (MTM) which is a pharmacist-directed program to help members understand and manage their medication regimen and to assist prescribers in avoiding potential medication-related problems. The MTM Program is available free-of-charge to all PHP members. This program is especially helpful when members are transitioning home after a hospital stay or for those with chronic illnesses that require multiple medications.

Does your Patient have a plan with a deductible? As many plans renew at the beginning of the year, it is important to factor in a Patient's deductible and copays. MTM can assist you and your Patient to determine the best medication in regards to safety, efficacy, and cost-effectiveness within a drug category or medical condition.

Participation is voluntary and the Patient may choose to take advantage of MTM as little or as often as they like. MTM appointments are conducted in person at the Medical Arts Building or via phone. MTM services are 100 percent funded by PHP to help improve Patients' overall health.

How will MTM benefit your Patient?

- All prescriptions, over-the-counter, and herbal medications will be reviewed by a clinical pharmacist to evaluate effectiveness, side effects, therapy duplications, drug interactions, and under/over dosing.
- Private, personal communications with a clinical pharmacist helps Patients better understand their drug therapy and can help prevent and manage side effects and drug interactions.
- Appointments are conducted at the Patient's own pace. They will be encouraged to ask questions and discuss their medication concerns with the pharmacist to help them better understand their medications and the role they play in their overall health.
- Cost saving measures are identified when appropriate.
- Self-Referring - Members can contact the Pharmacy department on their own and do not need a referral from their Physician.

For additional information, brochures to display in your office, or to set up an appointment please contact the PHP Pharmacy Department at 517.364.8545 or by secure e-mail at pharmacy@phpmm.org.

PHP Telehealth benefits

On Jan. 1, 2017, PHP partnered with Amwell to offer telehealth services for members with select benefits. Eligible members with PHP can call 844.733.3627 or log on to PHP.amwell.com for a cost-effective, convenient alternative to visiting an office, urgent care, or the emergency department (ED) for non-emergent reasons.

Telemedicine doctors can treat a wide variety of non-emergent conditions, such as cold, flu, allergies, sore throats, vomiting and many more. This care is not meant to replace the member's primary Physician, but rather to supplement care, especially outside of normal office hours.

If you have any questions about this new service please contact your Provider Relations Team at PHPProviderRelations@phpmm.org.

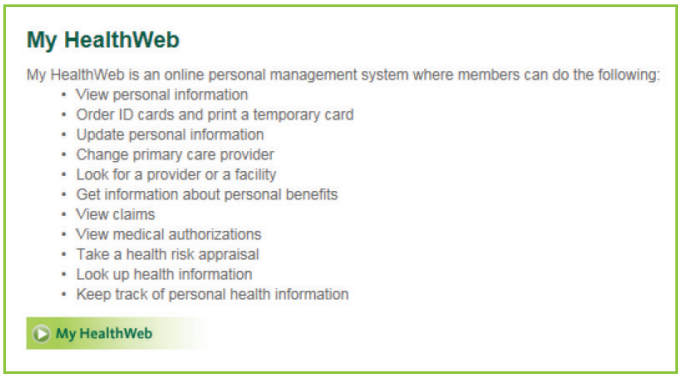
Help members keep their New Year's resolutions going!

About one-third of resolution makers will give up by February. More than half drop out by July.

Promoting positive lifestyle change, regardless of when it starts, can lower the risk of cancer and other life-threatening diseases. It can also give strength to face life's struggles – especially important for those fighting cancer.

With the first weeks of 2017 behind us, now is the perfect time to help your Patients set themselves up for success. If they have the right strategy and encouragement, it is possible to maintain those New Year's pledges through 2017 and beyond.

PHP offers many services to help our members stay on track through the "My Healthweb" portal on the PHP website at PHPMichigan.com. Using "My Healthweb" and the "Personal Health Manger" tool, members can take a Health Assessment that provides an evaluation based on basic, personal health information. The members are asked general questions such as height and weight, as well as questions more specific to their health habits. After filling out the entire questionnaire they receive a final report that estimates potential health risks, including how likely they are to develop a certain disease, what major health risks they are facing or could face in the future, and whether they are in good physical shape. The assessment also provides them with helpful tips on how to reduce their risks, improve their score, and live longer. PHP's Personal Health Manager Tool allows the member to take better control of their health. Patients can easily access these tools from a smart phone or computer.



Members log onto My HealthWeb (shown above) to register. Once registered, they can start their assessment by clicking the "Wellness Assessment (HRA)" link.

Members can also keep track of their BMI with the Adult Body Mass Index Calculator widget found in My HealthWeb and see how their New Year's resolutions are paying off. If they have any questions or would like more information, members can reach out to Customer Service at 800.832.9168.

HEDIS Corner:

Each year Physicians Health Plan (PHP) is required to collect and publically report data through the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a tool used by the managed care industry to compare health plan performance across plans and against benchmarks. The National Committee for Quality Assurance (NCQA) develops and coordinates the HEDIS process and scoring. Performance scores provide comparative data that is used to focus on quality improvement efforts and allows consumers to compare performance of health plans.

Some answers to frequently asked questions about HEDIS are identified below:

Does the Health Information Portability and Accountability Act (HIPAA) permit me to release records to a PHP representative?

Under HIPAA requirements, HEDIS data collection is a quality assessment and improvement activity, and is therefore included in the definition of healthcare operations, and may be provided to PHP without member consent.

Is my participation in HEDIS mandatory?

Yes. Contracted providers are required to participate in PHP's Quality Improvement activities. This includes participation in office reviews, chart, and access audits.

Why does PHP need charts when we submit claims?

Since not all services rendered or results are captured through claims, we collect medical record data to accurately capture the quality of care being provided to our members.

Is your audit looking for wrongdoing?

PHP reviewers are looking for documentation of preventive care, screenings, or lab reports that were not billed or coded for the service rendered.

What types of documentation will PHP collect?

PHP will only collect documentation that is specific to performance measures identified by NCQA.

Some examples of what will be collected are:

- History and Physicals
- Progress notes
- Lab reports
- OB flow charts
- BMI/ growth charts
- Physical activity and nutritional counseling

What are the types of data collection methods?

PHP will come on-site if greater than 10 medical records are required. We collect data through:

- Paper medical records
  - Copy at provider's office
- EMR
  - Transferred to encrypted flash drive
  - Grant remote read-only access
- Other options for remote locations or less than 10 charts
  - Faxing
  - Mailing

If you have any questions about HEDIS or the HEDIS review process, you can email the Quality Management department at PHPQualityDepartment@phpmm.org

Physicians Health Plan

PHP has included a copy of our Statement of Member's Rights and Responsibilities for your reference. Please contact your Provider Relations Coordinator if you have any questions about these statements.

Statement of Member's Rights and Responsibilities, which include:

Member Rights

Enrollment with PHP entitles you to:

1. Receive 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. Choose and change a Primary Care Physician (PCP) from a list of network Physicians or practitioners.
4. Information on all treatment options that you may have in terms you can understand so that you can give informed consent before treatment begins.
5. Participate in decisions involving your healthcare, such as having treatment or not and what may happen.
6. Voice complaints or appeals without fear of punishment or retaliation against and/or without fear of loss of coverage.
7. Be given information about PHP, its services, and the providers in its network, including their qualifications.
8. Make suggestions regarding PHP's member rights and responsibilities policies.

Member 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, except in emergencies or for urgently needed health services.
3. Use emergency department services only for treatment of a serious or life-threatening medical condition.
4. Always carry your PHP ID card and present it to providers each time you receive health services, never let another person use it, report its loss or theft to us, and destroy any old cards.
5. Notify PHP 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 providers need in order to provide care.
7. Understand your health problems and develop 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 cost shares to you, and pay them directly to the network provider who gives you care.
10. Read your PHP member materials and become familiar with and follow health plan benefits, policies and procedures.
11. Report healthcare fraud or wrongdoing to PHP.

Advance directive standard

Advance directives allow Patients to make their own decisions regarding the care they would prefer to receive if they develop a terminal illness or a life-threatening injury.

Physicians Health Plan requires documentation that advance directives have been discussed with adult Patients. Documentation should include either that the member has declined an offer to receive additional information or if an advance directive has been executed, a copy must be maintained in the Patient's medical record.

Ways to accomplish compliance with this standard: A question concerning advance directives could be included on the Patient registration form or health history form. Having a question that asks if the Patient has an advance directive with a box to check yes or no along with a statement that they may obtain more information regarding the subject from you would meet PHP's standard.

Begin the conversation: Talk to your Patient about end of life medical care. The Michigan Dignified Death Act (Michigan law) and the Patient Self-Determination Act (Federal law) recognize the rights of Patients to make choices concerning their medical care, including the right to accept, refuse or withdraw medical and surgical treatment, and to write advance directives for medical care in the event they are unable to express their wishes.

Advance directives can reduce:

- Personal worry
- Futile, costly, specialized interventions
- Overall healthcare costs
- The feeling of helplessness and guilt for family members
- Legal concerns for everyone involved

For Questions call:

PHP Compliance Department: 800.562.6197

Or visit:

MDHHS Patient Advocate Form (DCH-3916): michigan.gov/mdhhs

Michigan's Advance Directive Registry: mipeaceofmind.org

3 Types of Advance Directives

- A Durable Power of Attorney for Healthcare allows the Patient to name a "Patient Advocate" to act for the Patient and carry out their wishes.
- A Living Will allows the Patient to state their wishes in writing, but does not name a Patient Advocate.
- A Do-Not-Resuscitate (DNR) declaration allows a Patient to express their wishes in writing that if their breathing and heartbeat cease, they do not want anyone to resuscitate them.

2 Laws

Michigan Dignified Death Act

Patients have the right to be informed by their doctor about their treatment options.

- This includes the treatment you recommend and the reason for this recommendation.
- You must tell your Patient about other forms of treatment. These must be treatments that are recognized for their illness. They must be within the standard practice of medicine.
- You must tell your Patient about the advantages and disadvantages of the treatments; including any risks.
- You must tell your Patient about the right to limit treatment to comfort care, including hospice.
- You should encourage your Patient to ask any questions about their illness.

Federal Patient Self-Determination Act

- Patients have the right to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
- Doctors must maintain written policies and procedures with respect to advance directives and to inform Patients of the policies.
- You must document in the Patients medical record whether or not they have executed an advance directive.
- You must ensure compliance with the requirements of Michigan laws respecting advance directives.
- Provide education for staff and the community on issues concerning advance directives.
- The Act also requires providers not to condition the provision of care for an individual based on whether or not the individual has executed an advance directive.

1 Patient

Requirement for providers to maintain and disseminate written fraud and abuse policy requirements and False Claims Act policies

All providers that participate with federal programs such as Medicaid or Medicare have a responsibility to detect and prevent fraud and abuse and to understand and comply with the Federal False Claims Act. Additionally, the Michigan Department of Health and Human Services (MDHHS) and Section 1902(a) (68) (A) of the Social Security Act* requires that providers that receive $5 million or more dollars in Medicaid funds annually maintain and disseminate written policies to their employees that include:

- Methods of identifying and detecting fraud, waste and abuse by employees, providers and members;
- A process to guard against (prevent) fraud, waste and abuse committed by employees, providers and members;
- Detailed information about the Federal False Claims Act and the Michigan Medicaid False Claims Act and other provisions named in Section 1902(a)(68)(A) of the Social Security Act*;
- Rights of employees to be protected as Whistleblowers.

Under Section 6032 of the Deficit Reduction Act of 2005, any employer who receives more than $5 million per year in Medicaid payments is required to provide information to its employees about the federal False Claims Act, any applicable state False Claims Act, the rights of employees to be protected as whistleblowers, and the employer's policies and procedures for detecting and preventing fraud, waste and abuse. This information must be provided to the employees through written policies and included in the employee handbook (if one exists).

PHP'S Compliance Plan and Policies

Physicians Health Plan (PHP), through its Compliance Plan, policies, and actions, is committed to the highest standards of ethical behavior, the payment of accurate claims to all providers, and adhering to mandates by federally-funded payers such as Medicaid.

PHP has an established Compliance Plan that includes policies to detect and prevent fraud, waste, and abuse. No provider is exempt from review of fraud, waste, and abuse activities. Claims that violate developed edits or fraud, waste, and abuse standards will result in a minimum a reduction in payment and at a maximum termination of your participation agreement. These are independent of any actions that the State or Federal Government may take. PHP's Compliance Plan helps to ensure appropriate claims are submitted to government programs such as Medicaid.

PHP has an established Billing Integrity Program which is a systematic method to audit and review provider records to detect provider billing fraud, waste and abuse. Additionally, PHP utilizes Code Edit Compliance software hosted by Change HealthCare. The Code Edit Compliance software applies nationally recognized coding standards to validate correct coding initiatives and identify claims where these standards have not been applied. Change HealthCare has developed edits for both facility and professional claims. These claim edits are based on specific criteria that include: CPT codes, HCPCS codes, ICD-10 codes and Place Of Service codes.

PHP has established expectations related to acceptable business practices for providers of healthcare services and their associates. These expectations are outlined in the PHP Provider Manual which can be found on PHPMichigan.com/Providers.

It has always been a requirement that claims submitted for payment represent the services provided, and that documentation is complete, accurate, and timely.

Examples of false claims include: billing for supplies or services not rendered, double billing resulting in duplicate payment, up-coding claims, miscoding claims to allow for billing services not covered, excluding diagnoses that could impact claim payment, etc.

How to Report Suspicious or Fraudulent Actions

REPORTING TO PHP

If you have any knowledge of, or suspicion that, someone within your practice is involved in fraudulent actions you may report this to PHP by any of the following methods:

- Call the Sparrow Health System Compliance Hotline: 517.267.9990
- Send a letter to: Physicians Health Plan, PO Box 30377, Lansing, MI 48909-7877, or
- Contact the PHP Compliance Department at 800.562.6197

All reports can remain anonymous and confidential.

REPORTING MEDICAID FRAUD TO THE STATE OF MICHIGAN

If you have any knowledge of, or suspicion that, someone within your practice is involved in fraudulent actions involving Medicaid claims or services; you may report this directly to the Michigan Department of Health and Human Services (MDHHS) or Inspector General Administration Provider Enforcement Bureau (IGA-PEB) at the following:

In Writing:

Inspector General Administration Provider Enforcement Bureau
PO Box 30062
Lansing MI 48909

Online Complaint Form:

www.michigan.gov/fraud

By Phone:

855.MI.FRAUD (855.643.7283)

All reports can remain anonymous and confidential. You can report directly to the Michigan IGA-PEB before or without reporting to PHP.

Summary of the Federal False Claims Act

The Federal False Claims Act is a Federal Statute that covers fraud involving any federally funded contract or program, including the Medicare or Medicaid program. The act establishes liability for any person who knowingly submits or causes to be submitted a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" is defined to mean a person who:

- Has actual knowledge of falsity of information in a claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, healthcare providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government or its contractors, such as knowingly making false statements, falsifying records, double-billing for supplies or services, submitting bills for services never performed or supplies never furnished, or otherwise causing a false claim to be submitted.

For purposes of the Federal False Claims Act, a "claim" includes any request or demand for money that is submitted to the U.S. government or its contractors.

Healthcare providers and suppliers who violate the False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted. If a provider or supplier is convicted of a False Claims Act violation, the OIG may seek to exclude the provider or supplier from participation in federal healthcare programs.

To encourage individuals to come forward and report misconduct involving false claims, the False Claims Act includes a "qui tam" or whistleblower provision. This provision essentially allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. government, and the individual may be eligible for a financial award.

Summary of the Michigan False Claims Act

The Deficit Reduction Act of 2005 offered an incentive to states to enact their own False Claims Act requirements. Michigan has enacted both the Medicaid False Claim Act (MCL §§400.601 - 400.615) and the Health Care False Claim Act (MCL §§752.1001 - 752.1011). Persons who violate either the Medicaid False Claim Act or the Health Care False Claim Act are guilty of a felony punishable by imprisonment, a monetary fine or both. Under the State False Claim Acts, an employer is prohibited from discharging, demoting, suspending, threatening, harassing or discriminating against an employee because the employee initiates, assists or participates in an investigation under these Acts.

***Section 1902(a)(68)(A) of the Social Security Act:**

Provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall— (A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section 1128B(f));

Physicians Health Plan

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

How to contact us

Department	Contact Purpose	Contact Number	Email Address
Medical Resource Management	• Notification of procedures and services outlined in the Notification/Authorization Table • To request benefit determinations and clinical information • To obtain clinical decision-making criteria • Behavioral Health/ Substance Abuse Services, for information on mental 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	• 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	• Quality Improvement programs • HEDIS • CAHPS • URAC	517.364.8466 877.803.2551 (toll free) 517.364.8408 (fax)	Quality PHPQualityDepartment@phpmm.org
Pharmacy Services	• Request a copy of our Preferred Drug List • Request drug coverage • Fax medication prior authorization forms • Medication Therapy Management	517.364.8545 877.205.2300 (toll free) 517.364.8413 (fax)	Pharmacy pharmacy@phpmm.org
Change HealthCare (TC3)	• When medical records are requested	Mail to: Change HealthCare 5720 Smetana Drive, Suite 400, Minnetonka MN 55343 Fax: 952.949.3713 or 949.943.8843	