INTRODUCTION
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. In 1982 the first PHP’s products were introduced to the market. 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 applies to the following HMO products:

- Traditional Commercial HMO Products which means all commercial HMO products offered by Physicians Health Plan.

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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.

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.

Why We Serve
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 Network Providers play a key role as we pursue our commitment to improving the health and well-being of the individuals we serve. This manual is designed to provide the 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 is not to determine coverage in any particular case. Coverage may be determined by contacting the Customer Service Department at the number listed on the “How to Contact Us” page. While we have tried to make this manual complete, it is not intended to include every administrative policy or procedure.

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 call Network Services 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 healthcare 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 healthcare 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 to 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. These plans usually have higher deductibles than traditional benefit plans and assist employer groups to qualify for a Health Savings Account 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. PHP Service Company is the administrator of this product.

PPO
PHP Insurance Company, administrated by PHP, offers various products, such as PHP Essentials and PHP Basics. The PPO product is a point of service 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, once they have chosen a primary care physician (PCP). This coverage is only offered if the member resides in the counties of Clinton, Eaton, or Ingham County.

Traditional Network Plans –
PHP offers seven trusted and traditional network plans on the Marketplace. Each of the plans below maintains essential health benefits, pre-existing conditions, and preventative care coverage.

- Sparrow PHP Platinum Select
- Sparrow PHP Gold Premier
- Sparrow PHP Silver Premier
- Sparrow PHP Silver
- Sparrow PHP Bronze Premier
- Sparrow PHP Bronze
- Sparrow PHP Healthy

Department Services

Customer Service
The Customer Service Department is available for members and providers and is typically your first contact for all issues. Call the Customer Service Department to:

- Verify a covered person’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
- Arrange member transportation for Sparrow PHP members only

Medical Resource Management
The Medical Resource Management (MRM) Department consists of three main components Utilization Management, Case Management, and Disease Management. 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.

Common reasons to contact our MRM Department:

- Notification of procedures or services that require prior notification
- To request prior authorization for services that require prior authorization
- To obtain clinical decision-making criteria
- To ask questions about the medical resource management process and notification or approval of care
- Case Management
- To schedule a telephone conference with Medical Director after non-approval of medical necessity benefit determination
- To speak with reviewer or other appropriate clinicians when a requested service is not approved

Case Management Program
Case Management is one component of a strategic approach to improving our member’s 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 both Complex and General Case Management, with focused strategies related to Transitions of Care, Children with Special Health Care Needs (CSHCS), Transplants, Behavioral Health and potential misuse of health benefits, e.g., Beneficiary Monitoring Program (BMP). With the exception of the BMP, members have the right to decline participation (opt-out) with any case management services. 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.

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, etc.

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)

General Case Management 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

Disease Management (DM)

Disease Management focus is on improving the quality of life for individuals with chronic conditions by preventing or minimizing the effects of diseases through integrated care. PHP disease management 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 more quickly and more effectively.

Utilization Management Program

The Utilization Management Program (UM) is an essential component of PHP’s strategic approach to the design and management of health care. UM has highly structured and clinically sound processes that facilitate access to health care resources and seek to improve members’ overall health status.

Contact Utilization Management Department for the following:
- To provide notification for particular 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 UM 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 another appropriate clinician when a requested service is not approved

The Utilization Management Department must verify and use the member’s benefit document when making review determinations. They utilize licensed clinical guidelines and internally developed medical policies to review services for our members. When needed, the PHP Medical Director will review the medical treatment plan of a member’s care with the treating physicians and/or practitioners. The PHP Medical Director may discuss the reasoning or indications of the service with the physician or practitioner requesting the service.

Access to Medical Resource Management Staff

The Medical Resource Management Department staff will identify themselves by name, title and organization name when they initiate or return calls regarding utilization management, case management, and disease management issues. 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 staff for calls during normal business hours (Monday through Friday 8:00 a.m.–5:00 p.m.) unless otherwise agreed upon at 517.364.8560 or toll-free: 866.203.0618

• After regular business hours, utilization management nurses are available for urgent and emergent calls through the on-call process. To access the utilization management nurse on-call, call Customer Service at 800.832.9186 or 517.364.8500 and/or Sparrow PHP Customer Service at 800.661.8299 or 517.364.8540

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 are 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 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
The Quality Management (QM) Department includes responsibility for the PHP disease management programs, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS), along with quality improvement initiatives. QM also provides quality compliance oversight for PHP’s URAC accreditation, Michigan Department of Community Health (MDCH) performance monitoring and the Quality Improvement Program (QIP). Refer to the External Regulations and Standards page for additional information regarding the URAC, HEDIS, and CAHPS.

Quality Improvement Program
PHP’s QIP is based on a written description that is reviewed and updated annually. The written QIP description provides the integrated framework for all quality improvement activities and overall guidance to the activities of the various PHP standing quality committees. The QIP description is of sufficient breadth to cover all clinical and service activities of PHP.

The objective of the QIP is an effective and efficient implementation of the quality improvement process defined as:

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

To request a copy of the QIP, information on PHP’s quality goals and progress towards meeting those goals, 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, Attention, and Quality Improvement Team at the 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 Standard of Care Guidelines is available at [www.phpmichigan.com](http://www.phpmichigan.com). If you would like to obtain a paper copy of the guidelines, please contact the Quality Management Department at the number located on the “How to Contact Us” page. A listing of all the PHP standard of care guidelines is listed in the Standard of Care Guidelines.
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. The 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-credited 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 address indicated in the credentialing packet. 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 considered to 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, it 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:

1. a failure to comply with the administrative requirements of the Credentialing Plan;
2. failure to adhere to the terms of the written participation agreement;
3. a change in the organizational structure following a merger or acquisition or change in the products offered by PHP; and
4. a 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 a written notice of the Committee’s action, which:

1. states the specific criteria that the Committee considered in making its decision;
(2) the proposed effective date of the disciplinary action or termination;
(3) a summary of the basis for the Committee’s decision; and
(4) the 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 request within 30 days from the date 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 Compliance Council. 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. In the event that 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 any 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 so 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 providers own National Provider Identification (NPI) number.

Responsibilities of Health Care Professionals

Provider Protocols and Requirements

- Refer Members only to 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.
o 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 carried out 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

**Network Provider Status Changes**

It is the responsibility of the Network Providers to inform PHP of any material change of information supplied to PHP between recredentialing cycles. Failure to inform PHP of status change may result in immediate suspension or administrative termination from PHP’s network. Specifically, a Network Provider shall immediately notify PHP upon the occurrence of any of the following:

- The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntary or involuntary, of the Network Providers license by any state licensing agency;
- The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntary or involuntary, of Network Provider medical staff membership or clinical privileges at any hospital or other health care institution;
- The cancellation, termination, restriction, probation, limitation, or other curtailments, whether voluntary or involuntary, of Network Provider status as a Provider in any managed care organization, network, or preferred provider organization;
- The cancellation or restriction of Network Provider professional liability insurance coverage;
- The revocation, suspension, or voluntary relinquishment of any registration at the state, federal, or district level, which allows Network Provider to prescribe any medications;
- Any adverse determination by a peer review organization concerning Network Provider quality of care;
- The commencement of any formal investigation or the filing of any charges by the Department of Health and Human Services or any law enforcement agency or health care regulatory agency of the United States or any state;
- The filing of any lawsuit or the assertion of any claim against the Network Provider alleging professional liability;
- Any change in Network Provider Office of Inspector General sanction status or Government Services Administration (GSA) department status; or
- Any change in Network Provider ability to provide Covered Services to PHP Covered Persons.

**Practitioner/Provider Changes**

Network Provider must notify PHP in writing and in advance of any demographic or status changes within the practice/facility. This includes:
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, primary physicians 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 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, the online provider listing at [www.phpmichigan.com](http://www.phpmichigan.com) or contact Network Services to determine the participation status of any Physician. Refer to the “How to Contact Us” page for the Network Services 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 to 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 days per week telephone access and on-call coverage including on-call arrangements with Network Physicians/Practitioners as needed.
- Supervise Physician assistants and advanced nurse practitioners 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. You may check member eligibility by accessing our online Provider Portal via the PHP website, using electronic transactions 270/271 through your clearinghouse or clearinghouse portal or by contacting Customer Service at the number listed on the "How to Contact Us" page.

For questions on how to initiate electronic eligibility, contact the number listed on the "How " 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 on page 42. Refer to the 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, at a minimum, 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 days per week telephone access and on-call coverage including on-call arrangements with Network Physicians as needed.
- Supervise physician assistants and advanced 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 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.

**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 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 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 business days
- Entries are legible
- Problem list documents significant illnesses and medical conditions with dates of onset and resolution for patients seen three 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 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 coordinator 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 in-patient 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 of record not ancillary staff and/or the patient
- The CPT and ICD-9/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.

- 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 competed 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.

**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:

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

Transition of Care Coverage

PHP may provide a 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 practitioners 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 Customer Services 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

All members are assigned a member ID card. Member ID numbers are randomly assigned. PHP cards will contain the PHP, PHP Insurance Company, PHP Service Company and Sparrow PHP 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 services, you may verify eligibility by accessing our online Provider Portal via the PHP website, using electronic transactions 270/271 through your clearinghouse or clearinghouse portal or by contacting Customer Service at the number listed on the "How to Contact Us" page.

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

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 program designed to “lock in” members with one primary Physician/Practitioner, one hospital and when appropriate, one pharmacy. Members meeting any of the following criteria will be placed in the Lock-In-Program:

• Those who use more than three prescribing physicians/practitioners in 6 months
• Those receiving more than 10 prescriptions per month
• Those utilizing ER/urgent care services more than two times a month or who have terminated Physician/patient relationship
• Those receiving prescriptions in the following therapeutic drug classes from more than two physicians/practitioners:
  – Analgesics (narcotic or non-narcotic)
  – Psycho stimulants
  – Tranquilizers
  – Sedatives and hypnotics-non barbiturates
  – Barbiturates

Any services not provided by the designated Physician/Practitioner must have been referred by the primary Physician/Practitioner or must be a valid emergency to be reimbursed. Any prescriptions not prescribed by the member’s primary Physician/Practitioner and provided by the designated pharmacy must have been provided as a result of a documented emergency. A member wishing to change his or her designated primary Physician must first obtain the authorization of PHP’s case management coordinator.
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 – when a request for a service that requires notification is not received by PHP.
- Late notification – when notification of a service that requires notification is received late (beyond 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 evaluated
clinically and a determination will be communicated. (Applicable to HMO, PPO, Sparrow PHP, 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:

- A member’s Certificate of Coverage 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
- A 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.

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 our 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 Customer Service 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
(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) A State Fair Hearing and information for how to obtain a hearing, and representation rules at 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 or State Fair Hearing filing and, if the Plans 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 Medical Resource Management 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 Preferred 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 distributed annually and updates are communicated when applicable. 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 the behavioral health management company, refer to the number or website listed on the “How to Contact Us” page.

Members may contact a behavioral health provider for behavioral health and substance abuse services directly with a referral from the behavioral health management company. 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.

For network benefits to apply, notification is required after the first visit except in emergency situations.

Policies and procedures are in place to assist in the coordination of care between PCP and behavioral health and substance abuse physicians/practitioners. Coordination of care is especially important on any diagnosed member with a coexisting condition. A coexisting condition is when both medical and behavioral health and substance abuse diagnoses are present and require co-management.

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/Medicaid 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.

Audits

Audits may be conducted periodically by a PHP representative or an independent audit firm. Please make the necessary documentation available (e.g., Patients’ medical records) records need to be submitted to PHP within 14 days of request to ensure a successful audit. PHP will not pay administrative fees for, or in connection with any audit.

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 physicians 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 PAs. 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);
- 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 Physicians NPI number.

**Nurse Practitioners (NP)**
PHP does credential NPs. 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);
- 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 supervising Physicians NPI number.
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 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-9-CM) 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. In order to receive payment, Clean Claims must be received by PHP no later than twelve (12) months from the date the Health Services are rendered. Claims received after this time period may be rejected for payment.

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 I.D. 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 frontend 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 invalid data by the clearinghouse to PHP will be reviewed by a claims analyst for verification of data to be selected. It is important to submit valid member IDs as well as billing identification IDs, 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 and include the following information on the form:

- 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, rendering address, billing address, including 9 digit zip code, and telephone number of the Physician/Practitioner/provider/facility performing the service
- All address information should be submitted using the exact information provided to PHP and in accordance with the United States Postal Service Address Standards.
- The tax ID and NPI number of the Physician/Practitioner/provider/facility performing the service
- Appropriate diagnostic codes, (ICD-10-CM)
- Appropriate procedure/service codes
  - Current CPT/HCPCS 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 job related injury or accident

Provider Address on Claim
It is important that your address and billing information is submitted exactly as it is provided to PHP. Your address information should be entered using the United States Postal Service (USPS) Address Standards. If provider information submitted in your claims data files or on your paper claim form does not match the PHP information provided, the reimbursement process will be impacted.

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 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 individual.
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.

Timely Claim Submissions
Claims need to be submitted within the timeframe specified in your participation agreement, 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.
Claim Status
You may check the status of a claim by accessing our online Provider Portal via the PHP website, using electronic transactions 276/277 through your clearinghouse or clearinghouse portal 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.

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.

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

(1) within 12 months from receipt by PHP or PHP designee of a claim; or

(2) as part of an annual reconciliation procedure, as mutually agreed to by both parties, or

(3) an audit of claims by PHP or PHP designee

Overpayments
If it is determined that overpayments have been made, complete a claim adjustment form for correction. PHP or its representatives will deduct the overpayment amount from future claim payments.

Coordination of Benefits
Coordination of Benefits (COB) is the procedure used to pay health care expenses when a person 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
Before 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 persons 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 hard copy claim including the following information:
- the original billed charges
- the amount received from the primary plan
- a copy of the other plan’s Explanation of Benefits (EOB) or Explanation of Payment (EOP) 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 parent 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 that covers a member as a 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.
- Medicaid is always the Payor of last resort.

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.

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 ICD-9-CM 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. Copayment amounts may be different among benefit plans and services. Copayments can be verified on the member’s ID card, electronically using our online eligibility system or by contacting Customer Service at the number listed on the “How to Contact Us” page.

Billable Copayments and Services
Members whose benefit plans include a co-payment 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 co-payment)
Copayments, coinsurance, deductibles and any other charges that can be billed to members will be indicated in the “Patient Ineligible” field on the Explanation of Payment.

**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 participation agreement.

**Copayment/Coinsurance Waiver**

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

**Urgent Care Centers**

Urgent Care services are covered as professional services and charges for the use of a facility to render office services are included within the payment for the professional charge. Therefore, “facility charges” are **NOT** covered by PHP and are not billable to a member.

**Fast Track Services**

When a PHP member is seen at a Fast Track for services, the member shall be required to pay one copayment, the urgent care copayment. If the member reports to the Fast Track Department, the Emergency Department may triage the member as appropriate.

Fast Track services may be billed on the UB-04 form according to provisions on your Participation Agreement.

**Non-Covered Services Billable to Members**

It may be applicable to bill a member for non-covered services. Billable services 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 Services 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 applicable copayment, coinsurance or deductible.

**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 provider 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), Michigan Department of Community Health (MDCH) and National Correct Coding Initiative for Medicare Services (NCCI) and other sources as applicable. PHP’s clinical edit 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 incorrect 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)**
  - 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)
Clinic Fees
PHP does **not** cover any clinic facility fees for commercial members including those billed under revenue codes 510-529. Reimbursement for facility fees associated with office services is included in the physician professional fee and is **not** paid separately. Clinic fees **are** reimbursable under the Sparrow PHP Product.

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 does not cover a venipuncture when billed by a network laboratory, as it is considered to be included in the primary procedure. Venipuncture is covered when billed by a Network Provider that did not perform the laboratory service. Venipuncture codes billed in conjunction with a laboratory service will be denied and are not billable to the PHP member.

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.

Fraud and Abuse

Billing Integrity Program
PHP maintains a program for ongoing monitoring of billing error, abuse and fraud. This program contains combinations of prepayment and post payment record reviews. Network Providers are expected to cooperate fully with PHP’s process.

Identification of Fraud and Abuse
State and federal laws require that Medicaid health plans have programs in place to help to identify and detect potential fraud and abuse committed by providers, members, and employees. As a Medicaid health plan, PHP’s program to identify and detect potential fraud and abuse is administered by PHP’s Compliance Department.

Fraud is making false statements or representations of material facts, intently deceiving or misrepresentation in order to obtain some benefit or payment for which no entitlement would otherwise exist. Examples include billing PHP for services not rendered, a member changing the quantity on a prescription, or an employee submitting a false reimbursement request.

Abuse refers to incidents or practices that are inconsistent, with accepted, sound business, fiscal or medical administrative practices. Abuse may, either directly or indirectly, result in unnecessary cost to the health plan, improper payment, or payment for services that fail to meet professional standards of care or that are medically necessary. Examples include ordering more tests than are medically indicated, a member’s overuse of the emergency room, or members letting their friends and family use their PHP cards.
PHP wants to be notified 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 to determine if any action is warranted. You can notify PHP confidentially about your fraud or abuse uncertainties in several different ways:

- Call the Sparrow Health System compliance hotline at 517.267.9990. Option 1 will connect you to PHP’s Compliance Department.
- Call PHP’s Compliance Department directly at 517.364.8553.
- Send PHP a letter at P.O. Box 30377, Lansing MI 48909-7877
- Talk to your provider relations coordinator.

All reports made to PHP can remain confidential and can be made anonymously.

**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:

**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 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 impropery, including lack of required substantiating documentation or particular circumstances requiring special treatment, and any other information as necessary to process the claim.
Coordination of Benefits (COB)
Coordination of Benefits is the procedure used to pay health care expenses when a person is covered by more than one insurer or plan which provides health care benefits.

Co-Insurance
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.

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

Fast Track
Urgent care setting with non-life threatening conditions

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 view the status of medical authorization 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](http://www.phpmichigan.com)

<table>
<thead>
<tr>
<th>Department</th>
<th>Contact Purpose</th>
<th>Contact Number</th>
<th>Email address</th>
</tr>
</thead>
</table>
| **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](mailto:PHP.Credentialing@phpmm.org)  
[Provider Relations Team](mailto:PHPProviderrelations@phpmm.org) |
| **Quality Management**            | • Quality Improvement programs  
• HEDIS  
• CAHPS  
• URAC | 517.364.8466  
877.803.2551 (toll free)  
517.364.8408 (fax) |  [Quality](mailto: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](mailto: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 |                                                     |
# Where to Send Claims

**PO Box 30377**  
Lansing, MI 48909-7877  
517.364.8400  
[www.phpmichigan.com](http://www.phpmichigan.com)

| WHERE TO SEND CLAIMS | In Network:  
|----------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| PHP | PO Box 853936  
Richardson, TX  75085-3936 | Non-Network  
PO Box 247  
Alpharetta, GA  30009-0247 | Electronic Claims  
In-Network: Payer ID:  37330  
Non-Network: Payer ID:  07689 |
| PHYSICIANS HEALTH PLAN (PHP) |  |  |  |  |

### APPROVED CLEARING HOUSES FOR ALL PRODUCTS

- RelayHealth
- OPTUMInsight
- Trizetto Provider Solutions (TTPS)
- Zelis - For Out of Network Providers Only
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

PHP Notification/Authorization Table and PDL’s
You can now click on the links below to access PHP’s notification/authorization table and also 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.
Member ID card Examples

PHYSICIANS HEALTH PLAN (PHP HMO)
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 Gold Premier
Sparrow PHP Silver
Sparrow PHP Bronze

For important information, consumers and providers contact:
www.phpmichigan.com
(517)364-8567  (866)539-3342

This card does not prove membership nor guarantee coverage.

All PHP and PCN providers send Medical Claims to:
GlobalCare, Inc. / PHP
Electronic Payor ID: 37330
Dentistry Payor ID: 07689
PHP PO Box 85306
PO Box 247
Richmond, TX 77466-3038
Alpharetta, GA 30009-0247

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

Date Issued: 01/28/2015
### 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:

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>80050</td>
<td>General health panel</td>
</tr>
<tr>
<td>80196</td>
<td>Salicylate</td>
</tr>
<tr>
<td>81000</td>
<td>Urinalysis, by dip stick or tablet reagent, with microscopy</td>
</tr>
<tr>
<td>81001</td>
<td>Urinalysis, automated, with microscopy</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis, without microscopy, non-automated</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis, without microscopy, automated</td>
</tr>
<tr>
<td>81005</td>
<td>Urinalysis, qualitative or semiquantitative, except immunoassays</td>
</tr>
<tr>
<td>81007</td>
<td>Urinalysis, bacteriuria screen, except by culture or dipstick</td>
</tr>
<tr>
<td>81015</td>
<td>Urinalysis, qualitative or semiquantitative, except immunoassays</td>
</tr>
<tr>
<td>81020</td>
<td>Urinalysis, two or three glass test</td>
</tr>
<tr>
<td>81025</td>
<td>Urine pregnancy test, by visual color comparison methods</td>
</tr>
<tr>
<td>82044</td>
<td>Albumin; urine, microalbumin, semiquantitative</td>
</tr>
<tr>
<td>82270</td>
<td>Blood; occult, by peroxidase activity, feces</td>
</tr>
<tr>
<td>82272</td>
<td>Blood; occult, by peroxidase activity, feces, 1-3 determinations</td>
</tr>
<tr>
<td>82565</td>
<td>Creatinine; blood</td>
</tr>
<tr>
<td>82670</td>
<td>Estradiol</td>
</tr>
<tr>
<td>82947</td>
<td>Glucose; quantitative</td>
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<tr>
<td>82948</td>
<td>Glucose, blood reagent strip</td>
</tr>
<tr>
<td>82962</td>
<td>Glucose, blood by glucose monitoring device(s)</td>
</tr>
<tr>
<td>83001</td>
<td>Gondatropin; follicle stimulating hormone (FSH)</td>
</tr>
<tr>
<td>83002</td>
<td>Gondatropin; luteinizing hormone (LH)</td>
</tr>
<tr>
<td>83036</td>
<td>Hemoglobin; glycosylated</td>
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<tr>
<td>83861</td>
<td>Microfluid analysis, tear osmolarity</td>
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<tr>
<td>83872</td>
<td>Mucin, synovila fluid (Ropes test)</td>
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<tr>
<td>83986</td>
<td>Molecular diagnostics, nucleic acid probe, each</td>
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<tr>
<td>84132</td>
<td>Potassium; serum</td>
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<tr>
<td>84144</td>
<td>Progesterone</td>
</tr>
<tr>
<td>84146</td>
<td>Prolactin</td>
</tr>
<tr>
<td>84702</td>
<td>Gonadotropin; chorionic (hCG); quantitative</td>
</tr>
<tr>
<td>84703</td>
<td>Gonadotropin, chorionic (hCG); qualitative (urine pregnancy test)</td>
</tr>
<tr>
<td>85007</td>
<td>Blood count, blood smear, microscopic examination with manual differential WBC count</td>
</tr>
<tr>
<td>85013</td>
<td>Hematocrit, spun</td>
</tr>
<tr>
<td>85014</td>
<td>Hematocrit, other than spun</td>
</tr>
<tr>
<td>85018</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>85025</td>
<td>Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)</td>
</tr>
</tbody>
</table>
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)
87880 Streptococcus, group A (Infectious agent detection by immunoassay with direct optical observation)
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:

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>88304</td>
<td>Level III-Surgical pathology, gross and microscopic exam</td>
</tr>
<tr>
<td>88305</td>
<td>Level IV-Surgical pathology, gross and microscopic exam</td>
</tr>
<tr>
<td>88312</td>
<td>Special stains; Group I for microorganisms, each</td>
</tr>
<tr>
<td>88313</td>
<td>Special stains; Group II, all other, except immunocytochemistry and immunoperoxidase stains, each</td>
</tr>
</tbody>
</table>

**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:

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

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.

1. Notify the health plan of any changes in address, eligible family members and marital status, or if you acquire other health insurance coverage.

2. Provide complete and accurate information (to the extent possible) that PHP and practitioners/providers need in order to provide care.

3. Participate in understanding your health problems and developing treatment goals you agree on with your PHP provider.

4. Follow the plans and instructions for care that you agree on with your PHP provider.

5. Understand what services have deductibles, coinsurance and/or copays, and pay them directly to the network physician, practitioner or provider who gives you care.

6. Read your PHP certificate of coverage and other PHP member materials and become familiar with and follow health plan benefits, policies and procedures.

7. 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. influence (meningitis of epiglottis)** | **Plague** |
| **Anthrax** | **Hepatitis B in pregnant woman** | **Poliomyelitis** |
| **Botulism** | **Lymphogranuloma vernereum** | **Syphilis** |
| **Chancroid** | **Measles** | **tuberculosis** |
| **Diphtheria** | **Meningococcal disease (meningitis or meningococcemia)** | **Viral hemorrhagic fevers** |
| **Gonorrhea** | **Pertussis** | **Yellow fever** |
| **Granuloma inguinal** | | |

**WITHIN THREE (3) WORKING DAYS**

| **Amebiasis** | **Mumps** | **Shigellosis** |
| **Blastomycosis** | **Psittacosis** | |
| **Brucellosis** | **Q fever** | |
| **Campylobacter enteritis** | **Reye’s syndrome** | |
| **Chlamydia (genital)** | **Rheumatic fever** | |
| **Coccidiodymcosis** | **Rocky Mountain spotted fever** | |
| **Cryptococcosis** | **Rubella (congenital syndrome)** | |
| **Cryptosporidiosis** | **Rubella** | |
| **Cyclosporiasis** | **Salmonellosis** | |
| **Dengue fever** | **Shigellosis** | |
| **E. coli disease (Only shiga toxin producers)** | **Staphylococcal disease, (first 28 days post-partum mother or child)** | |
| **Ehrlichiosis** | **Streptococcal, invasive Group A** | |
| **Encephalitis, viral** | **(normal sterile sites)** | |
| **Giardiasis** | **Tetanus** | |
| **Guillain-Barre’ syndrome** | **Toxic shock syndrome** | |
| **Hantavirus pulmonary syndrome** | **Trachoma** | |
| **Hemolytic-uremic syndrome** | **Trichinosis** | |
| **Hepatitis** | **Tularemia** | |
| **Histoplasmosis** | **Typhoid fever** | |
| **Kawasaki disease** | **Typhus** | |
| **Legionellosis** | **Yersinia enteritis** | |
| **Leprosy** | | |
| **Leptospirosis** | | |
| **Listeriosis** | | |
| **Lyme disease** | | |
| **Malaria** | | |
| **Meningitis (bacterial & viral)** | | |

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WITHIN ONE 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

<table>
<thead>
<tr>
<th>County</th>
<th>Health Department</th>
<th>City</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinton</td>
<td>Mid-Michigan DHD</td>
<td>St. Johns</td>
<td>989.224.2195</td>
<td>989.224.4300</td>
</tr>
<tr>
<td>Eaton</td>
<td>Eaton DHD</td>
<td>Charlotte</td>
<td>517.543.2430/7110</td>
<td>517.543.7737</td>
</tr>
<tr>
<td>Gratiot</td>
<td>Mid-Michigan DHD</td>
<td>Ithaca</td>
<td>989.875.3681</td>
<td>989.875.3747</td>
</tr>
<tr>
<td>Ingham</td>
<td>Ingham County</td>
<td>Lansing</td>
<td>517.887.4311</td>
<td>517.887.4310</td>
</tr>
<tr>
<td>Ionia</td>
<td>Ionia County</td>
<td>Ionia</td>
<td>616.527.5341</td>
<td>616.527.5361</td>
</tr>
<tr>
<td>Isabella</td>
<td>Central Michigan DHD</td>
<td>Mt. Pleasant</td>
<td>989.773.5921</td>
<td>989.773.4319</td>
</tr>
<tr>
<td>Montcalm</td>
<td>Mid-Michigan DHD</td>
<td>Stanton</td>
<td>989.831.5237</td>
<td>989.831.5522</td>
</tr>
</tbody>
</table>
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 in one quarter or six in one year)
- Referral patterns to non-Network Providers, including redirects and those without prior notification (more than three in one quarter or six in one year). At the time of notification, if the physician/practitioner is aware that a member(s) 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-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 in one quarter or six in one year)
- Deviation from PHP billing standards as defined in CPT coding and this manual (more than three in one quarter or six in one 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 in one quarter or six 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. In the event that 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. In the event that 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

The URAC has awarded Physicians Health Plan accreditation for its Commercial HMO/POS combined product lines and Marketplace product line.
URAC evaluates how well a health plan manages all parts of its delivery system -- physicians, hospitals, other providers and administrative services -- in order to continuously improve health care for its members.

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 urac.org

**Michigan Regulatory Agencies**

Michigan Department of Community Health (MDCH) regulates Sparrow PHP. MDCH manages the Medicaid contracts and makes sure changes to contracts are communicated to health plans. MDCH monitors performance standards and reviews the health plan annually.

The Department of Insurance and Financial Services (DIFS) monitors PHP and Sparrow PHP. 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 the NCQA, is a set of standardized performance measures that ensure purchasers and consumers have the information they need to reliably compare health care quality. Accreditation is based in part, on the HEDIS. PHP participates annually in HEDIS reporting. HEDIS is a set of standardized performance measures that provides information enabling the public to compare the performance of health plans. It is a component of NCQA Accreditation. NCQA uses HEDIS measures to evaluate more than 400 health plans from across the country every year. When combined, the results of NCQA Accreditation and HEDIS provide the most complete view of health plan quality currently available to purchasers and consumers. Some of the measurements included in HEDIS are:

- Childhood Immunization
- Adolescent Immunization
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Controlling High Blood Pressure
- Beta Blocker Treatment
- Comprehensive Diabetes Care
- Medications for People with Asthma
- Follow-up after Mental Health Illness
- Antidepressant Medication
PHP obtains data for HEDIS in two ways, administrative services and chart reviews. Administrative services are based on claims submitted to PHP and medical record abstractions. Although most data is collected through administrative services, there will be times when chart reviews are necessary to obtain more accurate data. If this occurs, PHP will contact your office for member records to be pulled for review. Your assistance in this process is greatly appreciated.

**CAHPS**

Consumer Assessment of Healthcare Providers and Systems survey occurs annually and measures areas such as:

- 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

Outcomes are reported annually to providers and members. Appointment access and office wait time standards can be found in the Standards of Care Guidelines.

**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. At any time, members with asthma may be referred to the AsthmaWatch program by calling 517.364.8466 or 877.803.2551.

**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 Features for Physicians and Health Care Providers:**
The program is supported by guidelines for the diagnosis and management of asthma National Heart Lung and Blood Institute. www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines

National Asthma Education and Prevention Program (NAEPP) www.nhlbi.nih.gov/about/org/naepp

American Lung Association www.lung.org

**Physicians and Health Care Providers:**
- Can request and receive individual patient’s medication/pharmacy usage profiles

**Physicians receive:**
- Letter notification of members being cased managed by a RN

**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. At any time, members with diabetes may be referred to the Living with Diabetes program by calling 517.364.8466 or 877.803.2551.

**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 guideline was developed by the Michigan Quality Improvement Consortium (MQIC) and based on the 2014 American Diabetes Association Clinical Practice Recommendations.
- National Institute of Diabetes and Digestive and Kidney Diseases [www.niddk.nih.gov/Pages/default.aspx](http://www.niddk.nih.gov/Pages/default.aspx)
- American Diabetes Association [www.diabetes.org](http://www.diabetes.org)
- Michigan Department of Health and Human Services Diabetes, Prediabetes and Chronic Kidney Disease [http://michigan.gov/mdch/0,1607,7-132-2940_2955_2980---00.html](http://michigan.gov/mdch/0,1607,7-132-2940_2955_2980---00.html)

Physicians and Health Care Providers:

- Can request and receive individual patient’s medication/pharmacy usage profiles

Physicians receive:

- Letter notification of members being cased managed by RN

Physician and Health Care Provider Expectations
If treating a PHP member with diabetes, each member should have a (n):

- Annual office visit for diabetes care
- Annual dilated eye exam
- HbA1c test at least twice a year
- Annual LDL test
- Annual microalbuminuria test
- Foot exam with each doctor’s visit

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. Postpartum follow-up is provided to ensure mother receives postpartum care and family has established a “medical home”.

Program Enrollment
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. You may refer your pregnant patient to the Healthy Mom Healthy Baby program at any time by calling 517.364.8466 or 877.803.2551.
How the Healthy Mom Healthy Baby Program Works with Your Patients

- Prenatal Vitamins: Members can obtain a 90-day supply of prenatal vitamins for a one-month co-pay with a special authorization
- 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
- Members are provided postpartum education regarding the importance of the 6 week follow-up visit, intervals for well child visits, importance of immunizations, and lead screening on or before the age of 2 years. Six-week Incentive Form: A form is mailed to your patient who has recently delivered. If the member completes her postpartum visit between 21 and 56 days following delivery she is eligible to receive a $25.00 gift card.
- Prenatal Class: Members may attend prenatal classes free of charge through Expectant Parent Organization.

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 PHP guideline was developed by the Michigan Quality Improvement Consortium (MQIC) and based on Routine Prenatal Care, and Institute for Clinical Systems Improvement July 2012.

Physician and Health Care Providers:
- Can request and receive individual patient’s medication/pharmacy usage profiles

Physician and Provider Expectations

If you are treating a PHP member that is pregnant:
- Have your PHP patient come in for her initial visit within the first 14 weeks of pregnancy
- Have your PHP patient come in 21-56 days following delivery for her postpartum visit
- Refer Medicaid members to a Network Maternal Infant Health Program (MIHP). If you need assistance in this process call 517.364.8466 or 877.803.2551.

Wellness Mailings

Wellness reminder letters are sent to members who have not received a particular wellness visit, screening or test. Reminder mailings include:

Lead Screening

Lead screening is an element of the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT), which is a federally mandated Medicaid program. EPSDT guidelines were developed to define routine health care that is appropriate for children ages 0-21. Michigan Medicaid policy requires that all Medicaid enrolled children be tested at 12 and 24 months of age, or between 36 and 72 months of age if not previously tested. Public Act 55 of 2004 requires that by October 1, 2007, 80% of Medicaid children enrolled be blood lead tested. MDCH has designed a report, Medicaid Blood Lead Testing, to monitor
compliance with this law. Physician Incentive Plan points are awarded for meeting specific measures related to lead screening.

Missed Well Child Visits
PHP encourages members ages 3–6 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-9 diagnosis code.

Missed Adolescent Exams
PHP encourages members ages 12–21 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-9 diagnosis code.

Missed Adult Preventive Exams
PHP encourages members ages 22-44 to see their PCP for a yearly preventive health examination. Well services should be reported using the appropriate preventive medicine CPT codes with a preventive medicine ICD-9 diagnosis code.

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 52-74 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.

Prevention Mailings
Preventive reminder letters are sent to members to remind them of needed well visits and/or immunizations. Preventive reminder mailings include:

15 Month Proactive Childhood Immunization
Childhood immunization reminders target all children 15 months old of the needed immunizations:

- DTP
- Hepatitis B
- Hib
- Polio
- Prevnar
- MMR
- Varicella
Well Child Visit 3, 5, 8, & 11 Month Reminders
Well child visit reminders target Medicaid children 3, 5, 8, & 11 months old to encourage them to make an appointment for their well child visit within the next month.

Standards of Care Guidelines
PHP Standards of Care Guidelines assist by providing evidence-based recommendations in order 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). PHP will also strongly encourage our providers to utilize the Michigan Childhood Immunization Registry as outline in the MQIC guidelines. 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 Systolic Heart Failure Guideline
- Screening and Management of Hypercholesterolemia Guideline
- Medical Management of Adults with Hypertension Guideline
- Diagnosis and Management of Adults with Chronic Kidney Disease Guideline
- In Office Use of Sedation
- 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 2 - 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