Provider Connection

FIRST QUARTER 2016

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Physicians Health Plan

A health plan that works for you.

Electronic Funds Transfer!

Physicians Health Plan (PHP) is excited to announce that you are now able to receive your PHP payments electronically! We have already implemented the 835 Electronic Remittance Advice (ERA) which generates the electronic version of the Explanation of Payments (EOP). As of March 7, 2016, the Electronic Funds Transfer (EFT) became available through a partnership with PNC Bank.

Requirements for receiving your payments electronically include:

- » Receive your ERA electronically via the 835 files
- » Be a participating provider with PHP
- » Obtain your unique ID number from PHP
- » Register with PNC Bank
- » PNC Remittance Advantage website at RAD.PNC.com

To sign up for an 835 ERA contact your claims clearinghouse. Your clearinghouse will need your National Provider ID (NPI), Tax ID (TIN) as well as a physical address (not a P.O. Box). The set-up time typically takes 2 - 3 weeks.

First-time providers receiving 835 and EFT files will receive the paper EOP for 31 days following the initial registration. After the 31-day period, the paper EOP will be discontinued.

EOP information can be obtained using PHP's Web Portal, HealthWeb®. If you require additional information or training with HealthWeb®, please email your Provider Relations Team at phpproviderrelations@phpmm.org.

Receiving electronic payments is fast and easy. Contact your Provider Relations Team today to get started 517.364.8323 or 517.364.8316!

Requirement for Providers to Maintain and Disseminate Written Fraud & Abuse and False Claims Act Policies

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

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

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

***Section 1902(a)(68)(A) of the Social Security Act:** Provide that any entity that receives or makes annual payments under the State plan of at least $5 million, as a condition of receiving such payments, shall— (A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs – as defined in section 1128B(f));

Summary of the Federal False Claims Act

The Federal False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly submits or

causes to be submitted a false or fraudulent claim to the U.S. government for payment.

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

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

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

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

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

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

Summary of the Michigan False Claims Act

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

PHP's Compliance Plan and Policies

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

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

PHP has an established Billing Integrity Program, a systematic method to audit and review provider records to detect provider billing fraud, waste and abuse. Additionally, PHP utilizes Code Edit Compliance software hosted by TC3. The Code Edit Compliance software applies nationally recognized coding standards to validate correct coding initiatives and identify claims where these standards have not been applied. TC3 has developed edits for both facility and professional claims. These claim edits are based on specific criteria that include: CPT codes, HCPCS codes, ICD-10 codes and place of service codes.

PHP has established expectations related to acceptable business practices for providers of health care services and their associates. These expectations have been communicated in the PHP Provider Manual.

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

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

How to Report Suspicious or Fraudulent Actions

Reporting to PHP

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

- Call the Sparrow Health System Compliance Hotline: 517.267.9990;

- » Send a letter to: Physicians Health Plan, PO Box 30377, Lansing, MI 48909-7877; or
- » Contact the PHP Compliance Department at 1.800.562.6197.

All reports can remain anonymous and confidential.

Reporting Medicaid Fraud to the State of Michigan

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

In Writing:
Office of Inspector General
PO Box 30062
Lansing MI 48909

Online Complaint Form:
Michigan.gov/Fraud

By Phone:
1.855.643.7283 (855 MI-FRAUD)

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

2016 HMO Member Responsibilities

Statement of Member Rights and Responsibilities, which include:

Member 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 use PHP's complaint/appeal procedure to resolve problems without fear of being penalized or retaliated against 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.

Member Responsibilities

As a covered person, you are expected to:

1. Select or be assigned a Primary Care Physician from PHP's list of network providers and notify PHP when you have made a change.
2. Be aware that all hospitalizations must be authorized in advance by PHP 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, that arises suddenly and requires immediate care and treatment (generally within 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 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 and your PHP provider agree on.
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.

Medical Record Documentation Reminders

Documentation of services is an important aspect of medical care. Claims submitted to Physicians Health Plan (PHP) must support the level of service billed and accurately documented in the medical record. In addition, time-based codes must include the time spent performing the services. Common errors found in medical record documentation are:

Diagnosis Coding

The diagnosis code does not identify the reason services were provided. PHP recommends that all diagnoses discussed or found at a specific visit be billed along with the corresponding CPT code. If a provider is ruling-out a condition, that condition is not the appropriate billing diagnosis. Until the condition can be determined by the provider, the symptom is the appropriate billing diagnosis. To ensure proper claim processing, each diagnosis code billed must be coded to the highest specificity.

History of Present Illness (HPI)

According to Centers for Medicare and Medicaid Services (CMS), only the provider can perform and document the HPI portion of the patient's history. Ancillary staff can document other parts of the history but not the HPI. It is not acceptable to have ancillary staff document the HPI and then the provider later document that they reviewed it.

The following questions/answers were taken from the CMS WPS Insurance Corporation provider's guide for Michigan Physicians:

Who can perform the History of Present Illness (HPI) portion of the patient's history?

» The history portion refers to the subjective information obtained by the Physician or ancillary staff. Although ancillary staff can perform the other parts of the history, that staff cannot perform the HPI. Only the Physician can perform the HPI.

If the Nurse takes the HPI, can the Physician then state, "HPI as above by the Nurse" or just "HPI as above in the documentation"?

» No. The Physician billing the service must document the HPI.

PHP routinely audits medical records to ensure compliance with all guidelines.

Please refer to your current CPT Manual, ICD-10-CM Manual and/or Centers for Medicare & Medicaid Services (CMS) 1995 and 1997 Documentation Guidelines on Evaluation and Management Services for any questions regarding documentation.

Regardless of the practitioner's specialty, PHP expects that all claims submitted for reimbursement will be billed with the appropriate CPT/and or HCPCS code representing the level of service provided and is accurately documented in the medical records. Failure to follow these practices could result in a reduction of claims payment.

Update For Behavioral Health Providers

Previously, PHP's claim system was configured to require prior authorization for CPT code 90837 (Psychotherapy, 60 minutes with Patient and/or family member). This configuration has been updated to no longer require prior authorization or notification. Benefit plan language will be modified as plans renew with PHP. You can find an updated notification table on PHP's website at phpmichigan.com, under the provider tab.

General Training 101

Are you interested in learning more about PHP? Your Provider Relations Coordinator Team is offering training sessions in 2016. Learning opportunities include review of provider manual, auditing, checking eligibility and benefits, claim status, authorizations, and much more. Attendees may include management, Physicians, and all office staff. Training will take place at PHP. A light meal will be provided during the presentation.

Please email your RSVP or questions to:

PHPProviderRelations@PHPMM.org

Available 2016 training dates:

July 28	Morning sessions | 8:30-10 a.m.
April 28 and Oct. 27	Afternoon sessions | noon to 1:30 p.m.

2016 PCP Incentive Program

Physicians Health Plan (PHP) implemented the new 2016 Triple Aim Incentive Program (TAIP) effective January 1, 2016. This program was created to make a difference in the health of our community, to assist our providers in identification of the members who need specific services and reward them for ensuring the care is received. PHP selected measures that relate to preventive care that are part of the Healthcare Effectiveness Data and Information Set (HEDIS) measures.

The measures included in the program for 2016 are:

- Well-Child visits during the first 15 months of life
- Well-Child visits 2 to 6 years old
- Adolescent Well-Care Visits
- Weight Assessment and Counseling for Nutritional and Physical Activity
- Chlamydia Screening in Women
- Human Papillomavirus Vaccine for Female Adolescents (HPV)
- Extended Office Hours

Primary Care Physicians (PCPs) who are currently contracted with PHP are eligible to collect a bonus reward for services rendered to PHP members. A detailed report is sent out to providers outlining which members are in need of services that are part of the program. In conjunction with the TAIP report, the providers are sent a membership roster. The membership roster is an important tool in ensuring providers get the credit and reward dollars associated with providing the needed care to the member. If the member is not listed on your roster, credit will not be rewarded to you.

Claims forms need to have current CPT and ICD-10 codes to be compliant with the TAIP program. If you have any questions about the program you may contact a Provider Relations Coordinator. They will be happy to answer any questions or schedule a training for your office.

Enhanced Clinical Editing in 2016

Physicians Health Plan (PHP) follows nationally recognized coding standards and guidelines, and applies a two-tiered approach to claims editing. First, PHP's fully integrated claims processing software, Facets, is configured to handle numerous automated claims processing editing functions including, but not limited to, clinical edits, procedure limits, duplication of service edits, and coordination of benefit indicators.

Secondly, PHP is contracted with TC3, which is a vendor specialized in providing overpayment claims reviews and loss control technologies for insurance carriers. TC3 performs post-adjudication, pre-payment review of claims to determine additional edits.

- » Enhanced clinical editing is a focus for PHP in 2016. The goal is to employ industry standard edits whenever possible, to applicable products and benefits. Examples of the sources of these edits include the rules, regulations, and recommendations from the following sources, among others:
- » American Medical Association (AMA)
- » Centers for Medicare and Medicaid (CMS)
- » Current Procedural Terminology (CPT)
- » Healthcare Common Procedure Coding System (HCPCS)
- » Local Coverage Determinations (LCDs)
- » Medically Unlikely Edits (MUE)
- » National Correct Coding Initiative (NCCI) and Correct Coding Initiatives (CCI)

Additionally, PHP has begun auditing 2015 claims data and will be adjusting claims. The focus of these reviews includes the following:

- » Previously missed duplicate claims
- » Non-valid National Drug Codes (NDC) for the date of service billed
- » Medical or pharmacy claims paid out for non-eligible members
- » Payments paid as primary when coverage was secondary to other insurances
- » Excessive units for DMEPOS or pharmacy items
- » Rental DME items billed beyond 10 months or beyond authorization timelines when required
- » Emergency room revenue codes billed on the same day as outpatient lab services
- » Emergency room revenue codes billed within 72 hours of an inpatient admission
- » Excessive or exclusive billing of one level of emergency and management services by a single provider

As these audits occur, if PHP finds any non-standard, high-dollar editing results for a provider, the provider will be notified in advance of adjustments.

Advance Directive Standard

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

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

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

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

Advance Care Directives Can Reduce:

- Personal worry
- Futile, costly, specialized interventions
- Overall health care costs

For Questions call:

PHP Compliance Department: 800.562.6197

Or visit:

MDHHS Patient Advocate Form (DCH-3916: Michigan.gov/MDHHS/ Michigan's Advance Directive Registry: MIPeaceofMind.org/

3 Types of Advance Directives

1. A durable power of attorney for health care allows the Patient to name a "Patient Advocate" to act for the Patient and carry out their wishes.
2. A living will allows the Patient to state their wishes in writing, but does not name a Patient advocate.
3. A do-not-resuscitate (DNR) declaration allows a Patient to express their wishes in writing that if their breathing and heartbeat cease, they do not want anyone to resuscitate them.

2 Laws

Michigan Dignified Death Act

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

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

1 Patient

Federal Patient Self-Determination Act

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

You Asked, We Listened

The Notification/Prior Authorization Table has been updated to a much easier to read and user friendly version. Please see the charts within this publication or visit **www.phpmichigan.com** for the most recent version of the Notification/Prior Authorization Table to download and print.

PHP Notification/Prior Authorization/Prior Approval Table-All Products Effective January 1, 2016			
		Notification Requirement	
SERVICES / ITEMS / PROCEDURES/MEDICATION		Within 1 business day	Prior to Service
Acute admissions that are urgent or emergent (including direct admissions) except maternity admissions that fall within federal timelines (see below for exception)		√	
Acute maternity admissions that exceed federal mandated LOS (48 hours after vaginal delivery & 96 hours after cesarean section delivery)		√	
Acute pre-operative admission days			√
Acute psychiatric/substance abuse admissions that are urgent or emergent (facility notification)		√	
Acute rehabilitation admission			√
Acute scheduled admissions		√	
Acute scheduled psychiatric or substance abuse admissions (facility notification)			√
Autism Spectrum Disorders treatment			√
Bariatric surgery			√
Behavioral Health Services- certain outpatient services (ECT, Neuro/cognitive/psychological testing, health and behavioral assessment, outpatient/ambulatory detoxification, etc.)			√
Behavioral Health Services- intermediate (day treatment, partial hospitalization, residential treatment)			√
Dental anesthesia: pediatric/adult			√
Dental services-accidental			√
Durable medical equipment: Implantable devices, e.g. insulin and infusion pumps, bone stimulators; power wheelchairs and/or mobility devices; automatic external defibrillators; chest wall oscillation vest			√
Endoscopy and intestinal imaging (capsule only)			√
Facet Injections: diagnostic injections > 3 dates of service per calendar year & all neurolysis procedures			√
Gamma knife procedures			√
Genetic testing			√
Home care visits			√
Hospice services			√
Hyperbaric oxygen therapy			√
Infertility medications			√
Long term acute care admission			√
Neuropsychiatric testing			√
Non-urgent ambulance requests			√
Outpatient home infusion services			√
Outpatient speech therapy			√
Outpatient rehab therapy (PT/OT/Cardiac/ Pulmonary)			√
Procedures that under some conditions may be considered cosmetic: Abdominoplasty, Breast Reduction, Procedures for Gynecomastia, Breast Reconstruction, Gender Reassignment, Jaw Surgeries, Photodynamic Therapy & Special Dermatologic Procedures, Sclerotherapy, Vein Surgery, including stripping and ligation, Eyelid Repair (blepharoplasty, brow ptosis, blepharoptosis), Rhinoplasty, Keloid Scar Revision.			√
Procedures requiring prior authorization- Joint replacements, back and neck procedures: 22558, 22858, 22612, 22614, 22630, 22632; 27125, 27130, 27132, 27134, 27137, 27445, 27446, 27447, 27486, 27487, 63005, 63012, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63047, 63048, 63056, 63057, 63075, 63076, 63185, 63190, 63191, 63200, 63252, 63267, 63272, 63277, 63282, 63287, 63290.			√
Surgical Treatment of Femoroacetabular Impingement (FAI)			√
Private duty nursing			√
Prosthetic devices over $1000			√
Psychodiagnostic testing			√
Sleep studies done out of network			√
Skilled nursing facility, subacute nursing & rehabilitation services			√
Spinal cord stimulation & sacral nerve stimulation			√
Temporomandibular Joint Dysfunction/Syndrome Treatment			√
Transplant services including screening and evaluation (If benefit: includes travel and lodging)			√
Unproven/investigational services including emerging technology/category III codes			√
Low-dose computed tomography (CT) for lung cancer screening			√
Uvulopalatopharyngoplasty (UPPP)			√
Weight management services including evaluation, management, surgery & post-surgical procedures			√
Code	**Drug Name**		
C9023	# testosterone undecanoate, 1 mg (Andriol)		√
C9025	# ramucirumab, 5 mg (Cyramza)		√
C9026	# vedolizumab, 1 mg (Entyvio)		√
C9135	# antihemophilic factor, recombinant Factor IX, Alprolix, per 10 IU		√
C9293	# glucarpidase (Voraxaze)		√
C9445	# C-1 esterase inhibitor (Reconest)		√
C9448	# netupitant (Akynzeo)		√
C9449	# blinatumomab (Blincyto)		√
C9450	# fluocinolone acetonide (Iluvien)		√
C9451	# peramivir (Rabivab)		√
C9452	# ceftolozane and taxobactam (Zerbaxa)		√
90378	# palivizumab (Synagis)		√
90620	# meningococcal group B vaccine (Bexsero)		√
90621	# meningococcal group B vaccine (Trumenba)		√
90625	# cholera vaccine (Dukoral-ShanChol)		√
J0129	# abatacept (Orencia)		√
J0135	# adalimumab (Humira)		√
J0178	# aflibercept (Eylea)		√
J0180	# agalsidease beta (Fabrazyme)		√
J0202	# alemtuzumab (Campath)		√
J0205	# alglucerase (Ceredase)		√
J0220	# alglucosidase alfa (Myozyme)		√
J0221	# alpha alglucosidease alfa (Lumizyme)		√
J0256	# alpha 1 proteinase inhibitor - human, (Aralast, Aralast NP, Prolastin, Prolastin-C, Zemaira)		√
J0257	# alpha 1 Antitrypsin-AAT (Glassia)		√
J0365	# aprotinin (Trasylol)		√
J0401	# aripiprazole (Abilify)		√
J0485	# belatacept (Nulojix)		√
J0490	# belimumab (Benlysta)		√
J0585-J0588	# Botox injections		√
J0596	# C-1 esterase inhibitor (Ruconest)		√
J0597	# C-1 esterase inhibitor (Berinert)		√
J0598	# C-1 esterase inhibitor (Cinryze)		√
J0638	# canakimab (Ilaris)		√

PHP Notification/Prior Authorization/Prior Approval Table-All Products Effective January 1, 2016

		Notification Requirement	
J0695	# ceftolozane and tazobactam (Kyocera)		√
J0712	# ceftaroline fosamil (Teflaro)		√
J0714	# ceftazidime and avibactam (Avycaz)		√
J0716	# centruroides immune f(ab) (Anascorp)		√
J0717-J0718	# certolizumab pegol (Cimzia)		√
J0775	# collagenase, clostridium histolyticum (Xiaflex)		√
J0795	# corticorelin ovine triflutate (Acthrel)		√
J0800	# corticotropin (Acthar)		√
J0875	# dalbavancin (Dalvance)		√
J0881-J0882	# darbepoetin alfa (Aranesp)		√
J0885	# epoetin alfa (Epogen, Procrit)		√
J0887	# epoetin beta (for ESRD on dialysis)		√
J0888	# epoetin beta (for non-ESRD use)		√
J0897	# denosumab (Prolia-Exgeva)		√
J1290	# ecallantide (Kalbitor)		√
J1300	# eculizumab (Soliris)		√
J1322	# elosulfase alfa (Vimizim)		√
J1325	# epoprostenol (Flolan)		√
J1438	# etanercept (Enbrel)		√
J1440-J1442	# filgrastim (G-CSF), (Neupogen)		√
J1458	# galsulfase (Naglazyme)		√
J1459	# immune globulin (Privigen)		√
J1556-J1557	# Immune globulin		√
J1559	# immune Globulin (Hizentra)		√
J1561	# Immune globulin		√
J1566	# immune globulin		√
J1568-J1569	# immune globulin		√
J1575	# immune globulin/hyaluronidase (HyQvia)		√
J1602	# Golimumab (Simponi) IV		√
J1640	# panhematin (Hemin)		√
J1650	# enoxoprin (Lovenox)		√
J1675	# histrelin acetate		√
J1740	# ibandronate sodium (Boniva)		√
J1743	# idursulfase (Elaprase)		√
J1744	# icatibant (Firazyr)		√
J1745	# infliximab (Remicade)		√
J1785-J1786	# imiglucerase (Cerezyme)		√
J1833	# isavuconazonium (Cresemba)		√
J1826	# interferon Beta-1A (Avonex)		√
J1830	# Interferon Beta-1B (Betaseron)		√
J1931	# laronidase (Aldurazyme)		√
J2170	# mecasermin (Increlex)		√
J2212	# methylnaltrexone (Relistor)		√
J2260	# milrinone lactate (Primacor)		√
J2323	# natalizumab (Tysabri)		√
J2353-J2354	# octreotide (Sandostatin)		√
J2357	# omalizumab (Xolair)		√
J2358	# olanzapine (Zyprexa Relprevv)		√
J2407	# oritavancin (Orbactiv)		√
J2426	# paliperidone Palmitate ER (Invega)		√
J2502	# pasireotide (Signifor LAR)		√
J2504	# pegademase bovine (Adagen)		√
J2505	# pegfilgrastim (Neulasta)		√
J2507	# pegloticase (Krystexxa)		√
J2562	# plerixafor (Mozobil)		√
J2724	# protein c concentrate (Ceprotin)		√
J2793	# rilonacept (Arcalyst)		√
J2796	# romiplostim (Nplate)		√
J2860	# siltuximab (Sylvant)		√
J2940	# somatrem (Protropin)		√
J2941	# somatropin (all growth hormones)		√
J3060	# taliglucerace alfa (Elelyso)		√
J3090	# tedizolid phosphate (Sivextro)		√
J3095	# televancin (Vibativ)		√
J3110	# teriparatide (Forteo)		√
J3262	# tocilizumab, (Actemra)		√
J3285	# treprostinil (Remodulin)		√
J3357	# ustekinumab (Stelara)		√
J3380	# vedolizumab (Entyvio)		√
J3489	# zoledronic acid (Zometa/Reclast)		√
J3490	# Unclassified drugs is a list of drugs without a specific HCPCs or CPT code assigned to it-PA is required for all of the following medications (the list is subject to change) : Corifact/Factor XIII, glucarpidase (Voraxaze) testosterone undecanoate (Andriol), Irecombinant factor IX (Ixinity), paliperidone palmitate ER (Invega Trinza), dinutuximab (Unituxin)		√
J3590	# Unclassified biologics		√
J7178	# human fibrinogen concentrate (RiaStap)		√
J7180-J7201	# factor products		√
J7205	# factor VIII Fc fusion protein		√
J7308	# aminolevulinic acid HCl (Levulan Kerastick)		√
J7309	# methyl aminolevulinate (MAL), (Metvixia)		√
J7311	# fluocinolone acetonide (Retisert)		√
J7312	# dexamethasone (Ozurdex)		√
J7313	# fluocinolone acetonide (Iluvien)		√

PHP Notification/Prior Authorization/Prior Approval Table-All Products Effective January 1, 2016			
		Notification Requirement	
J7316	# ocriplasmin (Jetrea)		√
J7336	# Capsaicin patch		√
J7340	# carbidopa 5 mg/levodopa 20 mg enteral suspension (Duopa)		√
J7503 & J7508	# tacrolimus (Prograf)		√
J7512	# prednisone, immediate release or delayed release, oral, 1 mg		√
J7527	# everolimus (Zortress)		√
J7686	# treprostinil (Tyvaso)		√
J7699	# NOC drugs, inhalation solution administered through DME		√
J7799	# NOC drugs, other than inhalation drugs, administered through DME		√
J7999	# Compounded drug, not otherwise classified		√
J8498	# antiemetic drug, rectal/suppository, not otherwise specified		√
J8499	# prescription drug, oral, non chemotherapeutic, NOS		√
J8562	# fludarabine phosphate (Oforta)		√
J8565	# gefitinib (Iressa)		√
J8655	# netupitant/palonosetron (Akynzeo)		√
J8700	# temozolomide (Temodar)		√
J9002	# doxorubicin hydrochloride liposomal doxil (Lipodox)		√
J9019	# asparaginase (Erwinaze)		√
J9027	# clofarabine (Clolar)		√
J9032	# belinostat (Beleodaq)		√
J9033	# bendamustine hydrochloride (Treanda)		√
J9035	# bevacizumab (Avastin)		√
J9039	# blinatumomab (Blincyto)		√
J9041	# bortezomib (Velcade)		√
J9042	# brentuximab vedotin (Adcetris)		√
J9043	# cabazitaxel (Jevtana)		√
J9047	# carfilzomib (Kyprolis)		√
J9155	# degarelix (Firmagon)		√
J9160	# denileukin diftitox (Ontak)		√
J9171	# docetaxel (Taxotere)		√
J9179	# eribulin (Halaven)		√
J9185	# fludarabine phosphate (Fludara)		√
J9225	# histrelin implant (Vantas)		√
J9226	# histrelin implant (Supprelin LA)		√
J9228	# Ipilimumab (Yervoy)		√
J9262	# omacetaxine mepesuccinate (Synribo)		√
J9268	# pentostatin (Nipent)		√
J9271	# pembrolizumab (Keytruda)		√
J9299	# nivolumab (Opdivo)		√
J9301	# obinutuzumab (Gazyva)		√
J9302	# ofatumumab (Arzerra)		√
J9306	# pertuzumab (Perjeta)		√
J9307	# pralatrexate(Folotyn)		√
J9308	# ramucirumab (Cyramza)		√
J9310	# rituximab (Rituxan)		√
J9315	# romidepsin (Istodax)		√
J9328	# temozolomide (Temodar)		√
J9351	# topotecan (Hycamtin)		√
J9354	# ado-trastuzumab emtansine (Kadcyla)		√
J9355	# trastuzumab (Herceptin)		√
J9371	# vincristine sulfate liposome (Marqibo)		√
J9400	# ziv-aflibercept (Zaltrap)		√
J9999	# Unclassified biologics		√
Q2050	# doxorubicin hydrochloride liposomal doxil (Lipodox)		√
Q3026	# Interferon Beta-1A (Rebif)		√
Q4081	# epoetin alfa (Epogen, Procrit)		√
Q4096	# antihemophilic factor (Alphanate)		√
Q9050	# sulfur hexafluoride lipid microspheres (Lumason)		√
Q9972	# epoetin beta (for ESRD on dialysis)		√
Q9973	# epoetin beta (for non-ESRD use)		√
	# Compounded drugs: All		√

PHP Notification/Prior Authorization/Prior Approval Table shows all possible services and medications that may require prior approval/authorization. It depends on the member's specific plan as to which of these services or medications do require prior approval/authorization.

Not otherwise classified, unspecified, unlisted, miscellaneous CPT or HCPCS services- services will be reviewed prior to claim payment and may be denied as: criteria not met, cosmetic, investigational, experimental, unproven, or not medically necessary services.

Services requiring prior authorization must be reviewed in advance of the service even if PHP is a secondary payor.

PHP Notification/Prior Authorization/Prior Approval Table does not define benefit coverage. Benefit coverage is determined by the Member's COC or SPD. This means that there may be services and medications listed in this document that are not covered under a particular member's COC or SPD. This list is subject to change. For questions about a Member's benefit and coverage please contact the PHP Customer Service Department at 1.800.832.9186

Non-emergent/urgent requests for benefit review are to be submitted at least 14 days in advance of the service or as soon as the service is determined to be appropriate by the practitioner. Urgent requests are requests for care or treatment for which a routine application of time periods for making the determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function or in the opinion of a practitioner would subject the member to severe pain that cannot be adequately managed without the care or treatment that is included in the request.

Medications that are reviewed and processed by the Pharmacy Department.

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

A New Approach to Getting Resolution

PHP would like to introduce a team approach to getting your questions and issues resolved immediately. PHP has many teams available to assist our provider network, starting first with our Customer Service Department at 517.364.8500 or 1.800.832.9186. Customer Service can resolve your questions pertaining to claims, eligibility, benefits, and much more. Customer Service is available Monday through Friday, 8:30 a.m. to 5:30 p.m.

PHPs Provider Relations Team, Bethany Dumond and Rachel Fields, will be conducting trainings, visiting offices and working with the PHP teams to resolve your issues. Bethany and Rachel will be working as a Team to accomplish these tasks and will work with Customer Service to resolve issues. In recent years, providers were assigned a Provider Relations Coordinator to contact specifically with issues. PHP wants to ensure you have direct contact to a person at PHP at the time you need it – not when your Provider Relations Coordinator is in the office. PHP's Customer Service Representatives are able to answer the majority of your calls and concerns. If they are not able to assist you, PHP has created a central email address to get to your Provider Relations Team for assistance. This mailbox is monitored daily and issues will be directed to the correct team for resolution.

For training and education needs contact:

Bethany Dumond 517.364.8323 or Rachel Fields 517.364.8316

To contact your Provider Relations Coordinator Team via email: PHPProviderRelations@phpmm.org

For eligibility issues, claims status, benefits or claims processing questions call Customer Service at 517.364.8500 or 1.800.832.9186

Doctors' Day Thank You

Physicians Health Plan wants to thank you for all that you do, whether that's working in an office, or an operating room, at two in the afternoon or two in the morning. Thank you for your compassion, support, knowledge, understanding and, most of all, the time you spend with each and every member explaining and planning the next stages in their treatment plan. You share moments with our member's families on a daily basis that will be remembered for a lifetime. PHP wants to make sure you are aware that you are appreciated every day. So we hope you had a wonderful Doctors' Day and that you'll take a moment to remember you are needed, appreciated, and valued.

A health plan
that works for you.

517.364.8484 PHPMichigan.com