Provider Connection

SECOND QUARTER 2016

In this issue

Physicians Health Plan

A health plan that works for you.

PHP's Annual Commercial HMO Surveys

Adult Member Satisfaction Survey Results and Rankings

Each year we participate in the CAHPS 5.0H survey, which measures many aspects of member satisfaction. The objective of the study is to capture accurate and complete information about consumer-reported experiences with healthcare. Specifically, the survey aims to measure how well PHP and other plans are meeting their members' expectations and goals. Through this, PHP is able to determine which areas of service have the greatest effect on members' overall satisfaction and identify areas where there is an opportunity for improvement. CAHPS survey questions are focused on the health plan services in addition to the care Patients receive from their doctors.

PHP's 2015 Commercial HMO Adult member satisfaction survey scores showed improvements in percentile rankings in the areas of Claims (75th) and Customer Service (95th), while Getting Needed Care and Rating of the Health Plan remained consistent. Areas that decreased in percentile ranking include, Getting Care Quickly, How Well Doctors Communicate, Rating of Healthcare, Rating of Personal Doctor, and Rating of Specialist.

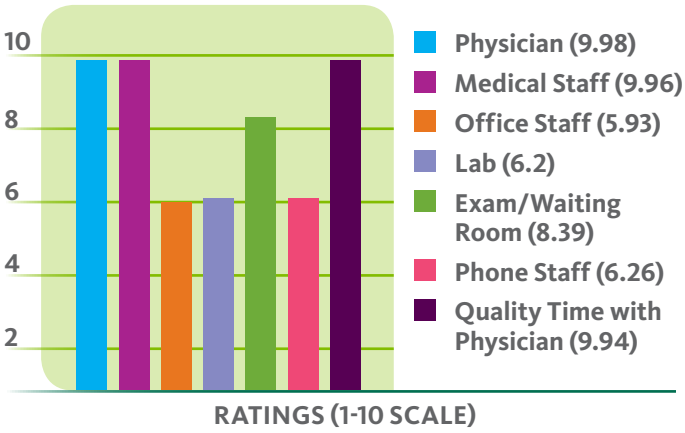
PHP's 2015 Commercial HMO Adult CAHPS 5.0H survey results are below:

MEASURE	2015		2014	
	Rate	Percentile	Rate	Percentile
Claims Processing	91.27%	75th	89.01%	50th
Customer Service	93.75%	95th	91.13%	75th
Getting Care Quickly	87.63%	50th	89.32%	75th
Getting Needed Care	91.05%	75th	91.51%	75th
How Well Doctors Communicate	97.09%	75th	97.65%	90th
Rating of Health Care	80.07%	50th	86.25%	90th
Rating of Health Plan	75.85%	90th	79.51%	90th
Rating of Personal Doctor	84.56%	25th	89.18%	75th
Rating of Specialist Seen Most Often	82.01%	25th	86.16%	50th

After seeing a decline in certain areas, PHP has assigned focus groups to research how to help our members with their healthcare needs.

Patients Rate their Physician and Office Staff

Improving the CAHPS survey results in 2016 for Rating of Personal Doctor and Specialist is a PHP 2016 strategic goal. In an effort to learn more about the reasons for these scores, PHP conducted a member/Patient survey to identify what items are considered when rating their personal doctor and specialist. PHP's survey results revealed that factors beyond direct Patient care—such as the member's or Patient's overall experience—go into their decision of rating their doctor or specialist. The results identified how Patients are treated by office staff as having the largest impact on their overall rating. We asked survey respondents what rating they gave their current medical office on a scale of 1-10. The rates given are reflected in the table below.



PHP found that the top factors important to members related to office staff includes:

1. Effective communication skills
2. Provides a warm greeting or welcome
3. Uses appropriate facial expressions and tone of voice
4. Personable
5. Knowledgeable
6. Helpful and willing to go the extra mile
7. Demonstrates teamwork
8. Offers direct eye contact
9. Is well organized
10. Maintains HIPAA compliance

PHP found that the top factors important to members related to their Physician include:

1. Effective communication skills
2. Personable, friendly, able to build a rapport
3. Sensitive to Patient's opinion
4. Uses EMR when appropriate and effective (not charting during visit)
5. Knowledgeable
6. Has appointment availability
7. Spends quality time with Patient
8. Offers direct eye contact
9. Uses physical touch/interaction
10. Is non-judgmental

Physician and medical staff both rated high, with a 9.96-9.98, with office and phone staff rating lower at 5.93-6.26. Conclusions based on the ratings and the top factors important to members reveal that overall satisfaction with medical care includes both Physician and staff providing a complete and personable experience from phone call to Patient care to check out.

PHP would like to partner with our provider network to identify ways PHP can support you in providing a complete and satisfactory Patient care experience. Contact your Provider Relations team if you would like to schedule a time to discuss in more detail.

Provider Satisfaction Survey Results

Results of the 2015 Provider Satisfaction Survey are in. Rates for overall satisfaction with Physicians Health Plan (PHP) scored 74.3 percent and respondents who say they would recommend Physicians Health Plan to other Physician practices came in at 92.2 percent.

Surveying provider satisfaction annually allows Physicians Health Plan to gauge its network providers' satisfaction with services performed by the Plan. The survey is administered externally by SPH Analytics, ensuring a confidential mechanism by which providers report on their experiences with PHP.

Surveys were sent to 1300 network Primary Care Physicians (PCPs), Specialists and Behavioral Health providers in an eight county service area. Respondents were asked to rate Physicians Health Plan compared to other health plans they work with on a five-point scale: from completely satisfied to completely dissatisfied.

The survey results reveal strengths as well as areas for improvement. PHP wants to build on the strengths and focus our efforts on the areas for improvement, including:

- More frequent visits from Provider Relations Coordinators
- Improved claims processing turnaround times
- Improved authorization review response times
- Improved timeliness of communications

PHP began implementing changes in 2016 to improve provider satisfaction, including:

- Instituting a Provider Relations Team approach
- Starting Provider Relations team visits (this will be ongoing throughout the year)
- Revising select prior authorization forms to improve communication with prescribers and increase awareness of PHP decision-making processes
- Revising the Authorization/Notification grid for easier use
- Improving the process to obtain a quicker turn-around time related to authorization notification
- Establishing quarterly Provider Education meetings
- Updating the Provider Newsletter for easier use and more effective communication
- Implementing more electronic options/capabilities including 27X transactions for eligibility and claims status
- Implementing Electronic Funds Transfers (EFT) for quicker payment to our providers

PHP's next Provider Satisfaction Survey will be administered during the third quarter of 2016. If you have any suggestions on process improvements you do not have to wait until the next provider survey - you can e-mail us today at PHPProviderRelations@phpmm.org. We are striving for a completely satisfied result - a score of 5 is how we want you to feel about PHP - so let us know what you believe we can do now to improve. Your feedback is appreciated.

Award-winning Customer Service

PHP's Customer Service Department is here to help! Our Customer Service Department answers questions from providers, members, and employers, over the telephone, through emails/faxes and in person. Our telephone hours are Monday-Friday, 8:30 a.m. to 5:30 p.m. You can always visit us in person at our office on Michigan Avenue, from 8 a.m. to 5 p.m., Monday-Friday.

Customer Service Specialists receive extensive training on topics including enrollment and eligibility, claim processing, and authorizations for medical services and prescriptions. Customer Service has a thorough quality monitoring program to ensure that the information we provide our callers is accurate. We record all of the incoming calls to Customer Service and we audit all of the outgoing written work. We use this information for regular performance feedback and to identify areas for additional training.

We are proud of our reputation for consistently providing outstanding Customer Service. In fact, our attention to detail and responsiveness result in consistently high satisfaction scores in both our member and provider surveys.

You Spoke – We Listened!

PHP received feedback from providers and members that the time between submitting a request for an Authorization for Medical Services until the decision notification is received can result in a delay of care.

In 2015, the PHP Utilization Management Team launched a plan to decrease the turn-around time on authorization requests for medical services by 10 percent. Through a series of process improvements and staff focus, the team was able to reduce the turnaround time by more than 30 percent by the end of 2015 and continues to make improvements well into 2016!

Claim Submission Requirements and Changes

As the industry changes, and the focus of data integrity and quality has become a focus for many within the healthcare industry, you will notice in the upcoming months that PHP will be communicating slight modifications to claims submission requirements. Many of these modifications are consistent with the Center for Medicare and Medicaid Services (CMS) guidelines in addition to specific requirements outlined for UB04 or 1500 claim form submissions. To maintain accuracy and meet the required data submission guidelines of the Federal Government, PHP will implement the following:

- **Invalid codes:** Claims submitted with an invalid, incomplete, or missing diagnosis or procedure code will be returned with a cover letter for appropriate correction.
- **Interim/Series Billing:** When submitting interim or series billing please remember the following guidelines:
  - Use the accurate type of bill as required for each month's services with the accurate billing requirement for the initial, continuous, and discharge claim. See below:

    Initial Claim – xx2 type of bill

    Continuing Claims – xx3 type of bill

    Final/Discharge Claim – xx4 type of bill

    Final/Discharge Claims for Home Health – xx9 type of bill

  - PHP will reject claims if they are not submitted in the appropriate order. If you are experiencing one of these rejections, remember that an xx2 (first claim) must be on file and billed before any additional continuing claims will be processed. This may require submitting an adjustment claim to get the xx2 on file before any continuing, final, or discharge bill types can be processed.

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

HEDIS Corner

What is HEDIS?

- Healthcare Effectiveness Data and Information Set is a tool used by employers and members to compare health plan performance across plans and against benchmarks.
- Standards and measures for HEDIS are developed by the NCQA (National Committee for Quality Assurance) and are the same for all insurers.

Why are scores important?

- Performance scores provide comparative data that is used to focus our quality improvement efforts.
- Increasing performance scores result in better quality outcomes for our members.

How is this done?

- Medical records are requested and reviewed for services rendered for the measure being reviewed.
- Administrative data is collected though claims.

HEDIS measure in focus - CCS- Cervical Cancer Screening

This measure looks at female members 21-64 years of age who were screened for cervical cancer. Either of the following criteria satisfies this measure:

- 21-64 years of age and at least one cervical cytology test performed every three years
- 30-64 years of age and at least one cervical cytology/human papillomavirus (HPV) co-testing performed every five years

HPV's ordered due to a positive PAP do not count for this measure.

Medical record guidelines

- Date the cervical cytology and/or HPV test was performed and the result or finding
- Evidence of hysterectomy with no residual cervix
- Documentation of "complete," "total," or "radical" abdominal or vaginal hysterectomy - include the year the surgical procedure was performed
- Documentation of "hysterectomy" in conjunction with a vaginal pap smear
- Documented diagnosis of cervical agenesis
- Documentation of hysterectomy in combination with documentation that the Patient no longer needs pap testing/cervical cancer screening

Documentation of hysterectomy alone is not sufficient evidence that the cervix was removed.

Approved codes for (CCS) measure

DEFINITION	CODE	CODE SYSTEM
Absence of Cervix	51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58951, 58953, 58954, 58956, 59135	CPT
Absence of Cervix	Q51.5, Z90.710, Z90.712	ICD10CM
Absence of Cervix	0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ	ICD10PCS
Cervical Cytology	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175	CPT
Cervical Cytology	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	HCPCS
Cervical Cytology	0923	UBREV
HPV Tests	87620, 87621, 87622, 87624, 87625	CPT

Electronic Funds Transfer

Have you signed up for Electronic Funds Transfer (EFT) yet? On March 7, 2016, Electronic Funds Transfer (EFT) became available through a partnership with PNC Bank. Receiving electronic payments is fast and easy.

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

Contact your Provider Relations Team at 517.364.8323 or 517.364.8316 to get started today.

Mid-Level Providers

Physicians Health Plan (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 Specialist (CNS)
- Certified Nurse-Midwife (CNM)

Top 10 Clinical Edits

PHP uses clinical edits in the processing and payment of all providers' medical claims. Clinical edits focus on correct coding methodologies and accurate adjudication of claims.

The top reasons for clinical edit denials:

- Labs not eligible for separate professional payment
- Status B code (Professional Claims - the procedure code billed is packaged into the primary procedure)
- NCCI/CPT bundles procedure into another procedure on same date of service
- Status N code (Facility Claims - the procedure code billed is packaged into the primary procedure)
- Medically Unlikely Edits (MUE) - units for procedure exceeded
- New Patient code not eligible for reimbursement
- No response to medical record request

The top reasons claims are stopped for additional investigation:

- Providers not submitting requested medical records to TC3
- Services were not supported in the medical record documentation that was submitted and reviewed
- Excessive units
- Start and stop times not documented
- Repeatedly billing for services included in the primary procedure
- Services are investigational, experimental, or unproven
- Physician orders not signed or dates of service submitted are not supported in documentation
- No documentation of drug wastage

PHP clinical edits are processed with an explanation code defining the reason for the denial. 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.

When billing PHP, please make sure to review general industry billing standards prior to submitting your claim, including but not limited to, the American Medical Association's (AMA) CPT Manual, Centers for Medicare and Medicaid Services (CMS), and National Correct Coding Initiative for Medicare Services (NCCI). Claims submitted in accordance with appropriate coding and clinical edit rules are more likely to process without delay!

Overpayment Processing

If you realize Physicians Health Plan (PHP) has made an overpayment, you must report this with a claim adjustment form and a corrected claim as needed. Claim adjustment forms can be found on PHP's website at PHPMichigan.com.

Refund checks should not be submitted to resolve an overpayment. PHP will initiate the adjustment/take back on a future Explanation of Payment (EOP). Example below:

Amount Billed	Allowed	Financial Allowance	Prov. Adjust	Patient Ineligible	Deductible	Copay/ Co-Ins	Other Ins	Net Paid
120.00	100.00	0.00	20.00	0.00	0.00	0.00	0.00	100.00

Interest Amount:	0.00
Refund Requested:	0.00
Auto-Recovered Amount:	-85.06
Prior Overpayment Balance:	0.00
Check Amount:	14.94

Claim Number/ Ref. Number	Member Name	Patient Acct. #	Recovery Type	Adjusted Date	Original Amount Paid	Original Overpay	Previously Recovered	Recovered This Check	Remaining Balance	Original Date Paid	Original Check Number
16000E000XXX	John Smith	1234567	B	12/14/2015	85.06	85.06	0.00	85.06	0.00	5/29/2015	654321

In certain situations, PHP may determine that a refund check is the only way to process an overpayment, such as a change in a tax identification number, doctor no longer practicing, or discontinuation of a product, such as PHP's Medicaid Product. In these situations, if money cannot be recovered automatically because there are no accounts available to recover money from, an overpayment recovery amount will be indicated as a remaining balance. It is important to pay attention to the Prior Overpayment Balance, or Remaining Balance noted in the example below, as it may be possible we would request a refund check be sent to PHP for that amount.

Paid to:	Michigan State Hospital	**Prior Overpayment Balance:**	$575.00
Tax Number:	123456789	**Auto-Recovered this Check:**	$250.00
Reference Number:	201611221023456	**Current Overpayment Balance:**	$325.00
Check Amount Number:	123456	**Year to Date Financial Allowance:**	$0.00
Check Amount:	$250.00		

Overpayment Recovery Detail (adjustment - Retractions could be applied to the net payment)

Claim Number/ Ref. Number	Member Name	Patient Acct. #	Recovery Type	Adjusted Date	Original Amount Paid	Original Overpay	Previously Recovered	Recovered This Check	Remaining Balance	Original Date Paid	Original Check Number
16000E000XXX	John Smith	1234567	B	12/14/2015	700.00	700.00	125.00	250.00	325.00	5/29/2015	654321

If a balance is unable to be recouped by PHP within three months of the Explanation Of Payment (EOP) mail date, the account will then be sent to a recovery agency on behalf of PHP. You may then receive letters and/or phone calls in regard to the overpayment collection process.

If you have questions on your EOP or the recovery amount process please contact Customer Service at 517.364.8500 or email the Provider Relations Team at PHPProviderRelations@phpmm.org.

Physicians Health Plan Credentialing Reminders

Our Credentialing Team Members are here to ensure that all provider data is accurate and up to date. Has your office moved? Did your remittance address or Tax ID change? Have you welcomed new providers or said goodbye to others? These are all examples of demographic changes that our Credentialing Department needs to be notified of to ensure that your practice is receiving payments to the appropriate tax ID and address, receiving correspondence sent by PHP, and you are listed correctly in the provider directory. Please keep us updated with professional liability cover sheets, current CAQH applications, license renewals, board certifications and reverifications and any other demographic changes. Please send any updated information, questions or concerns to PHP.Credentialing@phpmm.org or fax it to PHP Network Services at 517.364.8412.

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 a review of our provider manual, auditing, checking eligibility and benefits, claim status, authorizations, and much more. Attendees may include management, Physicians, and all office staff. Training takes place at PHP and a light meal is provided during the presentation.

Please email your RSVP or questions to: PHPProviderRelations@PHPMM.org

Upcoming 2016 training dates:

- **July 28 I 8:30-10 a.m.**
- **Oct. 27 I Noon – 1:30 p.m.**

PHP Community Health Fest

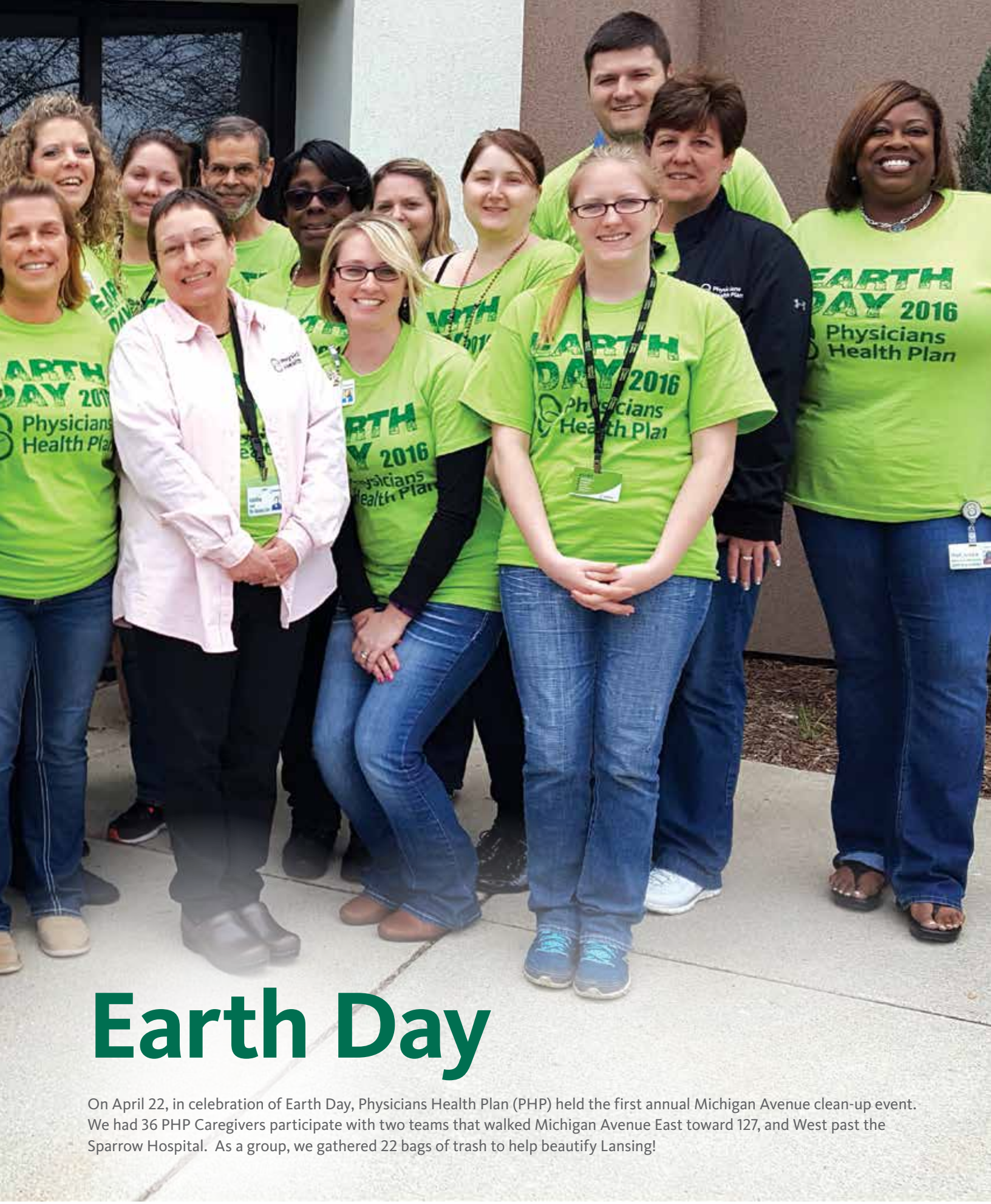
PHP Community Health Fest is an opportunity for members and providers to experience healthy foods, learn proper nutrition, get ideas and tips around diabetes prevention, and speak to personal trainers about exercise and keeping active, just to name a few.

PHP Community Health Fest will be held on Saturday, Nov. 5, 2016, from 10 a.m. to 2 p.m. at the Sparrow Michigan Athletic Club, 2900 Hannah Boulevard, East Lansing.

We are very excited to announce we will have on-site demonstrations based around nutrition and exercise, tastes from local restaurants, chair massages, health screenings, and a variety of health service vendors.

All attendees receive a free one week membership to the MAC and will be entered into a drawing to win a Fitbit activity tracker or a three month membership to the MAC.


EARTH DAY 2016
Physicians Health Plan



Earth Day

On April 22, in celebration of Earth Day, Physicians Health Plan (PHP) held the first annual Michigan Avenue clean-up event. We had 36 PHP Caregivers participate with two teams that walked Michigan Avenue East toward 127, and West past the Sparrow Hospital. As a group, we gathered 22 bags of trash to help beautify Lansing!

Physicians Health Plan

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

June Focus: Men's Health Month

When it comes to men and healthcare, the numbers don't lie: compared with women, men are 24 percent less likely to visit their doctors in any given year and 22 percent less likely to get their cholesterol checked. They're also less willing to be screened for cancer, despite the fact that their cancer mortality rates are higher.

June is national Men's Health Month, giving much needed attention to preventable health problems and encouraging early detection and treatment for men and boys.

There is no replacement for an annual physical performed by a qualified Physician or Dentist, but there are several self-examinations that can easily be performed at home to help detect disease or illness early, leading to better treatment outcomes for your Patients.

Self-exams to share with your Patients:

- Testicular Cancer check
- Breast Cancer check
- Oral Health/Gum Disease check
- Heart Rate check
- Skin Cancer check
- Belly Fat check
- Blood Pressure check

Use office visits to remind them of these routine self-exams that can help save their life.

July Focus: The sun is out. Are your Patients protected?

Summer is finally here bringing with it bright sunny days. July is appropriately designated UV Safety Awareness Month – a time to raise awareness on the harmful effects of overexposure and educate Patients, friends, and family on how to enjoy the outdoors with peace of mind.

The sun emits radiation known as UV-A and UV-B rays - both of which can damage your eyes and skin:

- UV-B rays have short wavelengths that reach the outer layer of your skin
- UV-A rays have longer wavelengths and can penetrate the middle layer of your skin

By learning the risks associated with too much sun exposure and taking the right precautions, our members can protect themselves and prevent future damage. It's also important to remember that dangerous sun exposure is not limited to sunny days!

Unprotected sun exposure can:

- Cause vision problems and damage eyes
- Suppress the immune system
- Lead to premature aging of the skin
- Cause skin cancer

Protect against harmful UV Rays by:

- Covering up
- Seeking out shade
- Wearing UV protective sunglasses
- Choosing the right sunscreen
- And applying the right amount of it!

By taking proper precautions, our members, your Patients, can be active and enjoy outdoor activities all year round.