2024 Provider Manual

Table of Contents

PROVIDER MANUAL

About Physicians Health Plan

Physicians Health Plan (PHP) welcomes you as a network provider.

More than 40 years ago, PHP was founded by leading physicians to ensure the people of Michigan would receive exceptional care. Today, PHP is owned by two of Michigan's top health systems, University of Michigan Health, and Covenant HealthCare, and our network of physicians, hospitals, and other professionals who deliver a full continuum of care continues to grow.

We strive to improve the health status of our members by facilitating access to quality, compassionate, and cost-effective healthcare services through organized health delivery systems.
We recognize the unique needs of the diverse communities we serve and aim to be a premier health financing organization, known for its ability to improve the health status of its members and for its service, quality, innovative, and cost-effective financing solutions for employers, individuals, purchasers, and governmental agencies.

We Will Do This By:

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

Our network providers play a key role as we pursue our commitment to improve the health and well-being of the individuals we serve. This manual is designed to provide information you need to know when treating a member in your office or facility. It contains information regarding PHP products, medical resource management, quality improvement programs, billing and claim procedures, ID cards, and eligibility verification. The procedures and descriptions of health benefit plans outlined in this manual are intended to cover most contracting situations you and your office staff will encounter.

The manual should not be used for determining coverage for a specific procedure. To verify more specific benefit information, please refer to the PHP website, located at PHPMichigan.com, the MyPHP provider portal, or you may also call PHP Customer Service. This manual is reviewed periodically and may be changed by PHP at 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 that 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.

- Commercial HMO/Exclusive Products, meaning all commercial HMO products offered by Physicians Health Plan
- Preferred Provider Organization (PPO) Products
- Third-party administrator (TPA) products

Service Areas

PHP Commercial	Michigan Care	Covenant Select
• Bay County • Clinton County • Eaton County • Gratiot County (group only) • Hillsdale County (large group only) • Huron (effective Jan. 1, 2024) • Ingham County • Ionia County • Isabella County • Jackson County (partial, large group only, full as of Jan. 1, 2024) • Lenawee County (partial, large group only) • Livingston County (partial) • Montcalm County • Saginaw County • Sanilac (effective Jan. 1, 2024) • Shiawassee County • Tuscola County • Washtenaw County	• Washtenaw County • Livingston County • Jackson County (partial) • Lenawee County (partial) • Monroe County (partial) • Oakland County (partial) • Wayne County (partial)	• Bay County • Saginaw County • Tuscola County

Product Overview- Plan Definitions

This section contains information about current PHP products. This manual is general in nature; therefore, there may be sections that do not apply. If you have any questions about PHP products, please contact PHP Provider Relations at the telephone number indicated on the page.

PHP Medicare Advantage

The rules and policies described in this Provider Manual do not apply to PHP Medicare plans, including Sparrow Advantage (HMO-POS), Covenant Advantage (HMO-POS), University of Michigan Health Advantage (HMO-POS), and PHP Medicare Advantage (PPO). For information on PHP Medicare plans including the PHP Medicare Advantage Provider Manual, please log into the MyPHP Provider Portal at PHPMichigan.com/MyPHP, then select “PHP Medicare Portal” in the Office Management drop down menu.

Commercial Products

HMO/Exclusive

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

High Deductible Health Plan (HDHP)

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

Self-Funded

The PHP Self-Funded product offers groups the same benefits available under all the PHP products. It allows the employer to choose the coverage and assume the financial risk for providing benefits to its employees. Rather than obtaining medical coverage from PHP, an employer elects to fund the risk directly.

PPO

PHP offers various Point of Service (POS) products allowing members to utilize both in-network and out-of-network providers while still receiving the benefits of great coverage for health services.

Marketplace Products

HMO/Exclusive Network Plans

Our HMO/Exclusive Network Plans for individuals offer a variety of plan options to meet the unique needs of our members.

Department Services

Customer Service

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

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

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

Medical Resource Management

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

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

- Case Management
- Disease Management
- Utilization Management

Case Management Program

Case Management is one component of a strategic approach to improve our members' overall health status. Case Management services are provided to members using evidence-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 Case Management Services with focused strategies related to Transitions of Care, Transplants, and Behavioral Health. The Case Management program allows members to have one single point of contact with a Case Manager who can

help facilitate and coordinate care while addressing multiple conditions and needs. Members have the right to decline participation (opt-out) in any case management program.

Common reasons to contact our Case Management Program:

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

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

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

Disease Management (DM)

The DM Program is focused on improving the quality of life for individuals with chronic conditions by preventing or minimizing the effects of diseases through integrated care. DM Programs are designed to improve the health of persons with chronic conditions and reduce associated costs from avoidable complications by identifying and treating chronic conditions quickly and more effectively. Disease Management services may differ based on TPA products. Please check the benefits and service area for coverage.

Disease Management members are identified by relevant claims data. PHP addresses eight areas of focus:

- Asthma
- Diabetes
- Diabetes Prevention
- Prenatal Education
- Tobacco Cessation
- Emergency Room Utilization
- Hypertension
- Chronic Pain

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

- Knowledge of selected chronic diseases, e.g., asthma, diabetes
- Information to assist members with making healthcare choices
- Education on improving self-management of chronic illnesses
- Information to guide members in ways to avoid complications of chronic illnesses
- Guidance toward the importance of establishing a Primary Care Physician (PCP)
- Resources needed to improve health, e.g., tobacco cessation program

- Education about covered benefits related to chronic disease(s)
- Education on community programs

Disease Management Programs

Asthma Education

Asthma education is available to members of all ages with asthma and includes information, educational materials, and Case Management.
What is available for PHP members:

- Asthma special equipment: Members can obtain nebulizers, spacers, and peak flow meters.
- Asthma education materials: Members may be 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.
- Case Management Services may be provided by a PHP Case Manager. The PHP Case Manager works with the member to assess areas of education, equipment, transportation, and psychosocial needs.
- Managing Asthma Through Case Management in Homes (MATCH) Program enrollment is available to all members with a diagnosis of persistent asthma. The referral connects members to a Certified Asthma Educator who will provide evidence-based education and interventions. The visits include assessment of asthma triggers, medication management, evaluation of exacerbations, and connection with resources to create an asthma-friendly home.

Key Resources for physicians and health care providers:

- The program is supported by guidelines for the diagnosis and management of asthma, established by the National Heart Lung and Blood Institute. For more information visit: NHLBI.NIH.gov/Health-Pro/Guidelines/Current/Asthma-Guidelines
- The program is supported by the PHP Clinical Practice Guidelines for Asthma, developed by the Michigan Quality Improvement Consortium (MQIC) and based on the 2023 General Principles for the Diagnosis and Management of Asthma Guidelines.
- The National Asthma Education and Prevention Program (NAEPP) - For more information visit: NHLBI.NIH.gov/About/Org/NAEPP
- The American Lung Association - For more information visit: Lung.org

Physician and Provider Expectations

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

Diabetes Education

Diabetes education may be 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.
What is available for 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.
- A Case Manager may be provided by Case Management Services. The Case Manager works with the member to assess areas of education, equipment, transportation, and psychosocial needs.
- Monitoring: All members with a diagnosis of diabetes are monitored for HbA1c testing and for annual dilated eye exams with reminders mailed to members.
- Physicians and health care providers can request and receive individual member medication/pharmacy usage profiles. At any time, members with diabetes may be referred to the PHP Case Management program by calling 517.364.8560 or 1.866.203.0618.
- Periodically, PHP will host Diabetes PATH (Personal Action Toward Health) workshops, which are offered free of charge to PHP members. Notification of upcoming workshops will occur on the PHP website: PHPMichigan.com/Providers

Key Features for Physicians and Health Care Providers:

- The program is supported by the PHP Clinical Practice Guidelines for Diabetes. The guideline was developed by the Michigan Quality Improvement Consortium (MQIC) and based on the 2022 Management of Type 2 Diabetes Mellitus Clinical practice recommendations for the treatment of diabetes American Diabetes Association: Professional.Diabetes.org
- National Institute of Diabetes and Digestive and Kidney Diseases. For more information visit: NIDDK.NIH.gov
- Michigan Department of Health and Human Services Diabetes, Prediabetes and Chronic Kidney Disease. For more information visit: MDHHS - Diabetes

Prenatal Education

The Prenatal Education program is provided to members who are pregnant.
What is Available to PHP members:

- Prenatal Class: Members may attend prenatal classes through Expectant Parent Organization. All prenatal classes are provided free of charge to PHP members. Visit Home | Expectant Parents Organization (epobaby.org) for more information.

Key Features for Physicians and Health Care Providers:

The program is supported by the PHP Clinical Practice Guidelines for Routine Prenatal and Postnatal Care. The guideline was developed by the Michigan Quality Improvement Consortium (MQIC) and based on 2022Routine Prenatal and Postnatal Care

Physician and provider expectations if you are treating a PHP member that is pregnant:

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

Tobacco Cessation

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

Emergency Room Utilization

PHP monitors members' use of the emergency room. Educational outreach may be provided when a member reaches an identified threshold. PHP encourages members to establish a relationship with a Primary Care Provider.

Hypertension Education

PHP o members have access to nutrition-based hypertension prevention and management education through virtual seminars provided by a Registered Dietician. Call 517.364.8433 or email PHPCaseManagement@phpmm.org for more information.

Chronic Pain

Education and case management services are available to members with chronic pain.

Periodically, PHP will host Chronic Pain PATH (Personal Action Toward Health) workshops, which are offered free of charge to PHP members. Notification of upcoming workshops will occur on the provider section of the PHP website.

A case manager may be provided to members with chronic pain. The case manager works with the members to assess areas of education, equipment, transportation, and psychosocial needs.

Utilization Management (UM) Department

The Utilization Management (UM) Department supports the health care delivery services provided by physicians, hospitals, behavioral health practitioners, home care agencies, and others as appropriate. UM is a key component of PHP's strategic approach to the design and management

of healthcare. UM has highly structured and clinically sound processes that facilitate access to healthcare resources and seek to improve member's overall health status.

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

PHP has written utilization management decision-making criteria that are objective and based on medical evidence. This process is based on the following:

- Appropriate physicians/practitioners involved in developing, adopting, and reviewing criteria.
- Annually reviewed and updated utilization management criteria and the procedures for applying them.
- Criteria used in making decisions are available through the Utilization Management Department for physicians/practitioners and Health Care providers upon request.

Contact the Utilization Management Department for the following:

- To provide notification for certain procedures and services
- To request prior authorization for services that are located on the Notification/ Authorization Table
- To obtain clinical decision-making criteria
- To ask questions about the utilization management process for notification or approval of care
- To schedule a peer-to-peer conversation with the Medical Director. This process only applies to non-approval benefit determinations made by the Medical Director. This process does not apply to contractual denials.

Access to Utilization Management:

PHP Medical Resource Management staff will identify themselves by name, title, and organization name when they initiate or return calls regarding utilization management. MRM provides access to staff for members and practitioners/providers who seek information about the utilization management process and the authorization of care, including:

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

Decision Making Criteria

PHP applies objective and evidence-based criteria, taking individual circumstances, and the local health delivery system into account when determining the medical appropriateness of health care services. PHP's decision-making is based only on the appropriateness of care, type of service, and the 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. This process involves appropriate physicians/practitioners in developing, adopting, and reviewing criteria. PHP annually reviews and updates utilization management criteria and the procedures for applying them.

Treating physicians can discuss medically necessary adverse determinations with the Medical Director in a peer-to-peer Review.

Pharmacy Management Program

Overview

The management of outpatient prescription medications is an integral part of the Pharmacy Program to improve the health and well-being of members. Physician/practitioner and member involvement is critical to the success of the Pharmacy Program. Please follow these guidelines when prescribing medication to a member. Additional information about the management of outpatient prescription medications can be found in the Prescription Drug List. To obtain a paper copy of the PDL, contact Customer Service at the telephone number listed on the "How to Contact Us" page. Pharmacy-related questions 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 possible, utilize e-prescribing. The online billing system will instantly alert you to whether the medication requires prior approval, the member's cost share, if the pharmacy is in-network, and any medication-medication, medication-age, or medication-gender incompatibilities.
- The standard prescription drug benefit allows up to a 31-consecutive-day supply of medication per prescription co-payment. Quantity limitations are based on FDA-approved dosing recommendations and package size and plan benefit limitations. Some select medications are subject to different quantity limits.
- If appropriate, recommend mail service to members for longer-term therapies once the 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 or the Prescription Drug List depending on the type of drug being prescribed. The authorization form is available on our website Pharmacy Services page.

Pharmacy Networks

- PHP offers a national retail pharmacy network that 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.
- Specialty Pharmacies are available for injectable medications. Forms and additional information are available our website Pharmacy Services page under "Pharmacy Specialty, Infusion Referral, and Mail-Order Forms."

Lock-In-Program

The Lock-In Program is a pharmacy service designed to "lock-in" or restrict members to one pharmacy provider. This service may be requested in writing by a member's healthcare provider or case manager. Members are restricted to a specific pharmacy in order for the member's healthcare providers to better monitor medications filled through PHP and reduce unnecessary or inappropriate utilization. This program is intended to prevent members from obtaining excessive quantities of prescribed drugs through multiple visits to prescribers and pharmacies.

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

Quality Management (QM)

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

Quality Program

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

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

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

To request information on PHP's quality goals and progress please call the Quality Management Department at the number listed on the "How to Contact Us" page.

Quality Improvement Suggestions

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

Requirements and Rights of Participation

Credentialing and Re-Credentialing

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 Re-credentialing Plan (Credentialing Plan). A copy of the Credentialing Plan is located on PHP's website PHPMichigan.com/Providers/Credentialing, or a copy may be requested by contacting Network Services at the number listed on the "How to Contact Us" page. PHP credentials all physicians/practitioners/facilities that are listed in PHP's provider directory. PHP credentials Medical Doctors, Doctors of Osteopathy, Certified Nurse Midwives, Podiatrists, Oral Surgeons, Optometrists, Chiropractors, Behavioral Health Providers, Nurse Practitioners, Physician Assistants, Lactation Consultants, Acupuncturists, 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 re-credentialing decisions based solely on an applicant's race, ethnical/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the physician/practitioner or facility specializes.

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

Applicants have the right to be informed of the status of their application, to correct erroneous information, and to review the 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 re-credentialing, PHP will verify that physicians/practitioners and facilities continue to satisfy the administrative and professional standards as described in the Credentialing Plan. The re-credentialing application is forwarded to the Committee for review and recommendation in accordance with the Credentialing Plan.

In addition to the information on the re-credentialing 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 insurance
- Adverse action reported to the National Practitioner Data Bank (NPDB)

Participating physicians/practitioners in the re-credentialing process will be re-credentialed 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 business or administrative related decision, it will compile pertinent information and refer the matter to the Committee. Alternatively, if the Committee directly receives information, which it believes, in its sole discretion, suggests that discipline or termination may be appropriate, the Committee may ask PHP staff to investigate the matter.

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

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

PHP, in its sole discretion, may administratively terminate the participation of any network physician/practitioner/provider without referring the matter to the Committee. Reasons for administrative terminations include, but are not limited to:

- Failure to comply with the administrative requirements of the Credentialing Plan
- Failure to adhere to the terms of the written participation agreement
- Change in the organizational structure following a merger or acquisition or change in the products offered by PHP
- Change in PHP's need for a physician/practitioner/provider given a reduction in the size of membership

Physician/Practitioner Credentialing Appeals

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

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

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

Physician/Practitioner Corrective Action

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

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

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

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

Requesting a Leave of Absence

PHP allows participating physicians/practitioners 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

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. Effective Jan. 1, 2023, PHP is updating the Locum Tenens arrangement requirements. To align with industry standards, PHP will not require a Locum Tenens provider to be credentialed if covering for a provider for less than 60 days. Locum Tenens provider claims must be submitted with the Q6 modifier when covering for a provider within those 60 days. Provider covering greater than 60 days will require plan credentialing.

Network Education and Integrity Program (NEIP)

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

NEIP Program Definitions

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

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

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

Suspension: Temporary loss of participation in PHN

Termination: Permanent loss of participation status in PHN

NEIP Description

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

- Non-compliance with authorization/notification process, which includes rendering non-covered services, with or without retroactive authorization requests (more than three (3) in one quarter or six (6) in one year)
- Referral patterns to out-of-network providers, including redirects and those without prior notification (more than three (3) in one quarter or six (6) in one year). At the time of notification, if the physician/practitioner is aware that a member is self-referred to an out-of-network provider, they will not be held responsible if they notify PHP in writing of each such occurrence and do not initiate a retroactive authorization
- Non-formulary use (2.0 standard deviations higher than peers over a six (6) month period)
- Physician profile data indicative of significant cost and/or over-utilization of services compared to peers (2.0 standard deviation over/under peers)
- Quality issues or repeated quality issues deemed significant by the PHP Quality Committee (more than three (3) in one (1) quarter or six (6) in one year)

- Deviation from PHP billing standards as defined in CPT coding and this manual (more than three (3) in one quarter or six (6) in one (1) year)
- Exceeding member or provider complaint thresholds deemed significant by the Credentialing and Peer Review Committee
- Non-compliance with other protocols as outlined in the PHN Participation Agreement and this manual (more than three (3) in one (1) quarter or six (6) in one year)

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

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

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

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

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

- Termination of eligibility for incentive plans or programs of PHP (i.e., Primary Care Incentive Management Program, special Fee Schedule incentives)
- Ceasing to assign new members (if PCP) or to refer members to a network provider for specialty care
- Automatic forfeiture of 5% of the financial allowance per occurrence of non-compliance

Responsibilities of Health Care Professionals

Provider Protocols and Requirements

- Refer members only to other participating providers unless health services are not available through a participating provider and are authorized by PHP
- Be bound by PHP's Provider Manual and Credentialing Plan as modified from time to time by PHP
- Obtain prior authorization for certain health services as defined by PHP
- Follow approved industry standard billing procedures
- Provider shall comply with the following requirements when admitting members to a hospital:

    - Provider has obtained prior authorization from PHP, as appropriate
    - Notify PHP, as appropriate, by telephone at least five (5) days prior to a scheduled admission
    - Notify PHP, as appropriate, immediately if provider admits a member to a hospital for an emergency
    - If the provider rendering 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 as applicable:
    - Provider may elect to perform all, or part of the laboratory services listed in "PHP's Office Laboratory List" within this Provider Manual. Laboratory services not listed in PHP's office laboratory list, or laboratory services not performed by provider must be performed by an in-network laboratory, and as outlined in the participation agreement. If applicable, provider shall be reimbursed only for those laboratory services listed in PHP's office laboratory list and performed, in whole or in part, for a member being treated directly by provider.
- Provider shall comply with PHP's Policies and Procedures as outlined in this Provider Manual

Practitioner/Provider Changes

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

- Tax ID number
- Telephone number
- Billing address
- Office address
- Office hours
- Open/closed status regarding new members
- After hours availability
- Physicians/practitioners joining or leaving your practice
- Any direction you would like PHP to offer to members assigned to primary care physicians leaving your practice

The "Provider Information Update Form" may be used to notify us of demographic/practice information changes. The "New Provider Request Form" should be used to add providers to an existing group or practice. **Failure to advise us of changes may result in delayed or incorrect claims processing.**

Primary Physician/Practitioner Role

Members select a primary care physician/practitioner (PCP) who is responsible for providing and coordinating their care with other physicians. Unless state mandates indicate otherwise, PCP's are defined as:

- Internists

- Family Physicians
- General Physicians
- Pediatricians
- Some Obstetrics/Gynecology Physicians
- Some Nurse Practitioners
- Some Physician Assistants
- Other Physician specialist as appropriate

Primary Physician/Practitioner Coverage

The primary care physician/practitioner ensures continuity and coordination of care for members and is required to provide 24-hour practice coverage, seven days a week. When the primary care physician/practitioner is unavailable to provide care for the member, they 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, they must agree to adhere to PHP administrative procedures as set forth in the provider participation agreement and this manual.

To locate a PHP physician/practitioner to act as a covering physician, review the provider directory online at www.phpmichigan.com or contact the Customer Service Department to determine the participation status of any physician. Refer to the "How to Contact Us" page for the telephone number.

Services Primary Physicians/Practitioners are expected to Perform or Provide

Primary physicians/practitioners are expected to perform, at a minimum, 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 their patient's care in an acute care facility/hospital, nursing home, and at home.

- Properly coordinate referrals with network specialists
- Provide preventive care and physical examinations, as appropriate, including breast exams and routine gynecological care with pap smear and pelvic exam

- Provide 24-hour, seven (7) days per week telephone access and on-call coverage including on-call arrangements with network physicians/practitioners as needed
- Supervise Physician Assistants (PA) and advanced Nurse Practitioners (NP) in accordance with state licensing and regulatory requirements
- Follow up and coordinate care with specialists, ensuring that the consultation notes are filed in the member's chart, proper actions are taken, and follow-up care is provided
- Work collaboratively with PHP Utilization staff, Case Management staff, and Medical Directors
- Conduct laboratory services in a Clinical Laboratory Information Act (CLIA) certified office laboratory
    - Laboratory work not performed in the office must be sent to a network laboratory

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 physician /practitioner whom the primary care physician has designated to treat PHP members.

Eligibility Status

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

Physician/Practitioner and Healthcare Provider Expectations

Physicians, hospitals, and other health care providers are expected to perform the following functions applicable to their areas of expertise:

- When initiating care, the physician/practitioner must remain accountable for the patient's care in an acute care facility/hospital, nursing home, and at home
- Properly coordinate referrals to other physicians/practitioners and health care providers; Refer to the Referral/Notification and Prior Authorization table for more information
- Provide 24-hour, seven (7) days per week telephone access and on-call coverage including on-call arrangements with network physicians as needed

- Supervise advanced practice providers in accordance with state licensing and regulatory requirements
- Follow up and coordinate care with physicians/practitioners, ensuring that the consultation notes are filed in the member's chart, proper actions are taken, and follow-up care is provided
- Work collaboratively with PHP Utilization staff, Case Management staff, and Medical Directors
- Conduct laboratory services in a Clinical Laboratory Information Act (CLIA) certified office laboratory
    - **Laboratory work not performed in the office must be sent to an in-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.

*Michigan Care members require a referral for all non-Michigan Medicine specialty care services outside of their PCP's care.

*Covenant Select members require a referral for all Non-Covenant Medical Group and Covenant HealthCare Partners specialty care services outside of their PCP's care.

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. If an ancillary provider provides consultative services, they must send the PCP a written consultation report within seven (7) days of the member evaluation, including:

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

- In addition, the ancillary provider must update the PCP at least monthly until the ancillary service is discontinued.

Acute and Urgent Care Providers

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

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

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:

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

Transition of Care

If your network participation is terminating for any reason, we require that you assist in the transition of care for our members. This may involve providing service(s) for a reasonable time to enable the member to transition care to another physician/practitioner. If you or our member needs assistance with transition, call Customer Service at the telephone number listed on the "How to Contact Us" page.

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

Transition of Care Coverage

PHP may provide transition of care coverage to a newly enrolled member. If a newly enrolled member's coverage becomes effective under the care of an out-of-network physician, PHP may grant the transition of the member's care to facilitate a smooth transition for the member to a network physician. The transition of care coverage for a member may allow for a limited interval of continued care with the out-of-network physician or practitioner at a network level of benefits. This is determined when an immediate transfer of care from one physician or practitioner to another could result in medical harm to the member. Physicians or practitioners should not encourage members to request transition of care coverage for reasons of convenience or only to continue an established physician relationship. For any questions on how to initiate the transition of care process, please contact PHP's Customer Service Department at the number listed on the member's ID card or the number listed on the "How to Contact Us" page.

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 to find specific policies and procedures related to a behavioral health service, refer to the number or website listed on the "How to Contact Us" page.

Additionally, a physician/practitioner may directly refer to an in-network provider. The provider directory should be referenced for a listing of in-network behavioral health practitioners.

Reporting Communicable Disease

Michigan physicians/practitioners are required to report patients with the following conditions to the patient's local Health Department. Report the unusual occurrence, outbreak or epidemic of any disease or condition, including healthcare-associated infections. 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.

How to Report

In general, health care providers should seek consultation regarding communicable disease prevention and control services through their local health department. To download the Physician and Laboratory Disease Reporting lists and directory of Michigan Health Departments, visit:
Communicable Disease Reporting in Michigan
STATE OF MICHIGAN COMMUNICABLE DISEASE AFTER HOURS CONTACT PH: 517-335-9030
Communicable Disease Division Ph: 517-335-8165 Fax: 517-335-8263
Immunization Division Ph: 517-335-8159 Fax: 517-335-9855
Bureau of Laboratories Ph: 517-335-8063 Fax: 517-335-9631

Referrals, Notification/Prior Authorization

When a referral is needed, it is important to confirm that the referral is to an in-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 PHPMichigan.com.

Referrals

PHP does not require a referral from the PCP if the member is seeking services from an in-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 an in-network specialist requires a referral from the treating physician/practitioner, PHP will provide support for the referral and education to the member regarding the appropriate referral process. Although referrals for in-network specialists are not always 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.

Michigan Care and Covenant Select Referrals

Michigan Care members require a referral for all Non-Michigan Medicine and Michigan Medicine Provider Specialty Care Service outside of their PCP's care. Referrals must be submitted prior to the service. A referral can be requested by logging into your MyPHP Provider Portal and clicking "Submit a New Request" on the home page, or the EZ Authorization/Referrals link in the Office Management drop down, or by calling PHP Medical Resource Management at 866.203.0618.

Covenant Select members require a referral for all Non-Covenant Medical Group and Covenant HealthCare Partners specialty care services outside of their PCP. Referrals must be submitted prior to the service. A referral can be requested by logging into your MyPHP Provider Portal and clicking "Submit a New Request" on the home page, or the EZ Authorization/Referrals link in the Office Management drop down, or by calling PHP Medical Resource Management at 866.203.0618.

Notification/Prior 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.

Network providers are expected to work collaboratively with PHP. PHP requires network providers to be responsive to phone calls and requests for clinical information, clinical literature, and chart notes. 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).

Prior authorization can be requested by logging into your MyPHP Provider Portal and clicking "Submit a New Request" on the home page, or the EZ Authorization/Referrals link in the Office Management drop down, or by calling PHP Medical Resource Management at 866.203.0618.

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

- ***Non-notification*** –PHP does not receive a request for a service that requires notification
- ***Late notification*** –PHP does not receive a request for service by the time frame outlined in the Notification/Authorization Table

Eligibility/Enrollment of Members

Members are assigned a member ID with a randomly assigned member ID number. Member ID cards will contain the PHP servicing company's logos; PHP, PHP Insurance Company, PHP Service Company, Covenant Select, and Michigan Care. PHP Service Company cards will typically contain the logo of the employer group or covered entity. Samples of Member ID Cards are located within the Provider Manual for your reference.

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

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

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

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

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

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

Medical Records

Network providers should maintain a 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's 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 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. This applies to paper and electronic records. Providers should have a written policy and an established process to maintain record confidentiality.

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 to preserve the confidentiality of all members' information and records in accordance with applicable statutes and regulations. PHP adheres to such policies and procedures at all times.

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 (PHP) 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 that an advance directive has been executed. A copy must be maintained in a prominent part of the adult patient's medical record.

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

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

Advance 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:

Michigan Office of Retirement Services Power of Attorney and Advance Directive Resources

Standards for Medical Record Documentation

The medical record entries must provide a complete and accurate reflection of the procedures/services provided and support the coding and claim data submitted for reimbursement. Incomplete records and lack of response to medical records requests may result in denials or reduced reimbursement. Please note that the "burden of proof" lies with the provider submitting claims for reimbursement. Often providers elect to house their records at locations other than the office or facility where the service is provided. The billing provider is responsible for obtaining necessary supporting records from other group locations, providers within the group, or data warehouses as needed. PHP requires that network providers maintain medical records in compliance with generally accepted CMS Documentation Guidelines and PHP policies, including but 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

Legibility & General Guidelines

- Entries must be legible and support billed charges

- 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, including family involvement in treatment plan or group therapy
- 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
- Treatment goals must be specific, measurable, and realistic. Must include a time frame for goal attainment. Progress or lack of progress towards treatment goals, the rationale for the estimated length of the 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 a treatment episode
    - Summary of the treatment goals achieved or reasons that goals were not achieved
    - Specific follow-up activities/aftercare plan

Evaluation & Management Services

- Documentation of personal, family, social histories, and social determinants of health that impact current medical decision making
- Tobacco habits, alcohol use, and substance abuse (prescribed or over the counter)
- A clear narrative of current condition, dates of onset, diagnosis, treatment plan, changes to the treatment plan, patient progress, and status of conditions
- Medication allergies and adverse reactions
- Past medical history, including serious illnesses, injuries, and operations
- Medication orders and administration records should include details such as the name of the medication, dosage, duration, route of infusion, name/credentials of administrator, amount dispensed, and dispensing instructions
- Immunization record
- For PCPs with adult patients, copy of advance directive for member or notation that member does not want an advance directive. If advanced directive exists, if must be filed in a prominent part of the medical record
- History and comprehensive physical examination (including subjective and objective findings)
- Lab and other studies ordered as appropriate
- Patient education and counseling
- Coordination of care with other providers
- Forms or templates may be used to gather the documentation to support the service; however, documentation carried forward should be noted as reviewed and how it pertains to the current visit

Time-Based Services

- For time-based services, start and stop time and/or total time in session must be clearly documented depending on the type of service
- If E/M levels are selected based on time, a qualifying statement must be included to support medical appropriateness and necessity. A statement of total time alone will not meet the standards of a qualifying statement of time. An example of a valid qualifying statement of time would be: A total of 65 minutes was spent on this encounter reviewing records from Dr. A. regarding neurological findings, discussed compliance with current medications and side effects of increased tiredness. Counseled the patient on medication options and ordered additional lab work.

Proof of Delivery

- Proof of delivery must be documented, including deliveries directly to the patient, picked-up, or shipped.
    - Proof of delivery includes a sufficiently detailed description of the item(s) being delivered, the dated signature of the member, and a clearly identifiable delivery method.
    - The date of service on the claim must match the date on the proof of delivery.
    - Proof of delivery for items shipped using a delivery service such as FedEx or USPS with a tracking number must include an invoice with item descriptions and a matching tracking number. The tracking number alone will be considered insufficient proof of delivery.

Requisitions & Orders

- A variety of services require orders to be performed, including but not limited to labs, x-rays, CAT scans, EKGs, DME items, medications, etc.

Amendments

- Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to PHP containing amendments, corrections, or addenda must:
    - Clearly and permanently identify any amendment, correction, or delayed entry as such
    - Clearly indicate the date and author of any amendment, correction, or delayed entry
    - Clearly identify all original content without deletion, and
    - Completed in a timely manner, no greater than two weeks from date of service.
- 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.

Signatures

- Signature requirements may vary based on services. PHP signature requirements align with CMS guidelines, Medicare Benefit Policy Manual, Chapter 15, Section 80.6.1, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4, and MLN Matters® Article SE1419 unless otherwise indicated in a PHP Reimbursement Policy.

Submission of Records & Timelines

- If a letter is received requesting medical records, documentation must be submitted within the timelines outlined in the request letter.
- All documentation requested should be submitted together.
- Do not submit documentation as a new claim. Submission of additional claims may result in duplicate denials and a delay in reimbursement.
- Review the explanation of the denial code on your explanation of payment and Medical Record Submission form to determine where the documentation should be submitted.
- If a claim or portion of a claim is denied due to lack of or incomplete documentation, please refer to your contract for timely filing limitations to meet clean claim requirements.
- If documentation is submitted after timely filing and/or appeal time limits, the denial will stand, and no further review will occur.
- Minimum necessary guidelines should be followed. Only send records that pertain to the date of service and encounter under review.

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

The admitting physician or the member's personal physician must report emergency admissions to the Medical Resource Management Department on the same or next business day.

Emergency Care

Members are instructed to contact their PCP's office or after-hours emergency number prior to seeking medical services except for emergency care. If the PCP determines that another physician/practitioner should examine the member, they 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.

Requests for Services with Out-of-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 an out-of-network provider can be submitted to the Medical Resource Management Department with the pertinent clinical information. The request will be clinically evaluated, and a determination will be communicated. (Applicable to HMO, PPO, Self-Funded and HDHP products). Please refer to the Out of Network Request Form.

Michigan Care and Covenant Select will require prior authorization and review. A request for an out-of-network provider can be submitted through the EZ Authorization/Referrals on the MyPHP Provider Portal or other PHP notification tools/resources.

Out-of-Area Transfers

Network providers are required to assist PHP in facilitating the transfer of a member from an out-of-network physician, facility, or other health care provider to an in-network physician, facility, or other health care provider if the transfer is determined medically acceptable by all involved health care providers.

Benefit or Claim Appeals Processes

Provider Appeal Process Related to Benefit or Claim Denial

A provider appeal is a written or verbal request by a provider or facility to change an adverse determination decision made by PHP regarding a specific member's benefit or complete or partial claim denial. PHP has one level of appeal. Providers are asked to complete an Appeal Form and submit all pertinent information related to the initial request.

Things to remember when submitting an appeal request:

- Fill out the provider appeal form completely and accurately.
- Submit the appeal request within 180 calendar days of the adverse benefit decision letter or the date of the initial claim denial.
    - Note: Appeal requests submitted after the 180-day time limit will be denied, and a letter will be mailed with an explanation.
- If the appeal is on behalf of the member for a medical necessity denial, the appeal must be submitted within 180 calendar days of the adverse decision letter.
- Include all pertinent clinical information and/or coding source rationale relevant to the appeal. This documentation may include medical records such as office notes, surgical notes, radiology, or lab reports, coding source rationale, or any other pertinent information dependent on the type of adverse determination received. All information is to be accurate and supported in the records. If in doubt, include it.
- Include a contact person and direct phone number/email so PHP can contact you if there are any questions.

Adverse Determinations may be the result of:

- Member's Certificate of Coverage (COC) benefit language, Summary Plan Description (SPD), Plan Document, exclusions, or benefit limitations.

- Denial for not obtaining prior authorization or prior notification for a service.
- Lack of or incomplete clinical information to support the request at the time the determination was made. If the information is submitted to PHP, it will be considered a new request and processed as a new request. The provider and member will receive a final determination notification following the timelines for benefit decisions.
- If an appeal request is received for a medical necessity denial, the member appeal process is engaged.

Note: Information about the Member Appeal process is available at www.phpmichigan.com/members/Complaint-and-Grievance-Procedures.

An explanation of the appeal process is included in the adverse determination letter. The member also receives a copy of the adverse determination letter and has 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.

Claim denials may be the result of:

- Bundled services
- MUE edits
- Improper payments
- Duplicate service(s)
- New patient code edits
- Incorrect/missing modifier

PHP will typically respond to a provider appeal in writing within 45 calendar days of receipt of the written appeal. However, the timeframe may be extended depending on the nature of the appeal issue. For life-threatening, or urgent services, or if the member is in the middle of treatment, an urgent or expedited appeal may be initiated by the member or provider. Please call PHP's Customer Service Department to request an urgent or expedited appeal. PHP will respond to the urgent or expedited appeal within 72 hours. 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 the provider a letter notifying you that the member has initiated an appeal. In this situation, the member's appeal outcome would be the provider's appeal outcome. We will send you a letter with the result of the member appeal. If you have a question about an Adverse Determination, please call PHP's Customer Service Department for assistance at the number listed on the "How to Contact Us" page.

Peer-to-Peer Discussions

Prior to initiating the appeal process, the treating provider(s) can discuss medically necessary Adverse Determinations with the Medical Director or Pharmacist making the decision. A peer-to-peer discussion with the Medical Director or Pharmacist does not constitute an appeal and is an optional step in the process that ***cannot*** occur after the provider appeal is submitted.

To schedule a telephonic or in-person peer-to-peer discussion, call the Medical Resource Management or Pharmacy Departments at the numbers listed on the "How to Contact Us" page. If the peer-to-peer discussion does not result in a certification decision, the provider may request an appeal of the Adverse Determination. Providers should use the Provider Appeal Form located on our website and submit any pertinent documentation to support the appeal.

Appeals may be mailed, emailed or faxed to:

Physicians Health Plan
ATTN: APPEALS
PO BOX 30377 LANSING MI 48909-7877

Email: PHPProviderAppeals@phpmm.org
(P): 517.364.8500 or 800.832.9186
(F): 517.364.8517 MONDAY-FRIDAY, 8 A.M. to 5 P.M., EST

Appeals are date-stamped when received during business hours. If received after business hours, your appeal will be date-stamped the following business day. Determination notification will be sent within 45 calendar days of the date stamp.

To provide a better understanding of the member rights under the member appeal process related to benefit or claim denial, the following explains the rights made available to members.
I. The member has a right to:

(a) Request a hearing

(b) Request assistance in filing a grievance or appeal and their requirements and timeframes for filing

(c) The availability of assistance in filing

(d) Request language or TTY services

(d) Toll-free numbers to file oral grievances and appeals

(e) Request continuation of benefits during an appeal; if the Plan's action is upheld in an appeal, the member may be liable for the cost of any continued benefit

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 the Centers for Medicare Services (CMS). Network providers are reimbursed in accordance with their signed Participation Agreement with the Health Plan. Billing information submitted is used for reimbursement related to health care services rendered, network reporting, identification of members for disease management, as well as for preventive care and incentive programs.

State and Federally Supplied Vaccines

PHP does not reimburse for vaccine(s) obtained at no cost to the provider through state or federal programs. Modifier SL is used to identify vaccines obtained at no cost to the provider. If billed to PHP, reimbursement will be $0.

When billing for vaccines obtained at no cost to the provider, services must be reported as follows to ensure proper claims adjudication:

- Report appropriate vaccination procedure code(s) with modifier SL
- Report appropriate administration code(s)
- All vaccines administered during an encounter must be reported on the same claim

Ambulance Protocols

1. The base rate billed must reflect the level of service rendered rather than the vehicle used.
2. Supplies and waiting time are included in the base rate reimbursement and not reimbursed separately.
3. When treatment is rendered, and no other care or transport is necessary, the provider may bill the base rate procedure code for the level of service performed but not for mileage.
4. In situations when an Advanced Life Support (ALS) vehicle intercepts with a Basic Life Support (BLS) vehicle, and the member is transferred to the ALS vehicle, only the provider who delivers the member to the hospital may bill for the base rate and mileage.
5. Round-trip transportation of members from one hospital to another for diagnostic and therapeutic services is not reimbursable.

Advanced Practice Providers and Mid-Level Practitioners

PHP follows industry standards for the reimbursement of mid-level providers. Mid-level providers are reimbursed at a reduced amount of the standard PHN fee max . PHP recognizes the following healthcare professionals as Advanced Practice Providers (APP) and Mid-Level Practitioners (MLP).

- Certified Clinical Nurse Specialist (CNS)
- Psychiatric and mental health (PMH) nurse clinical specialist

- Nurse Practitioner (NP)
- Physician Assistant (PA)

"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 qualifying supervisor personally performs the initial service, determines the Plan of Care, and remains actively involved in the course of treatment. Subsequent services provided by the Mid-Level must be related to the established Plan of Care. Services provided by the Mid-Level practitioner that qualify for "incident to billing" as defined should be billed under the Supervising Physician's NPI.

If there is a change in the care plan, the service would no longer meet the requirement for "incident to," and the patient must be re-evaluated by the qualifying supervisor, and services should be billed under the qualifying supervisor NPI number.

Who can supervise care?

The following clinicians are allowed to bill "incident to" services under their NPI as the supervising physician within the appropriate scope of their licensure:

- MD, DO
- Fully Licensed Psychologist
- Licensed Clinical Social Workers (LCSW)
- Occupational Therapist, Physical Therapist, Speech Therapist

Signature Requirements

The supervising physician is not required to co-sign the patient's record. However, the supervising physician must remain actively involved in treatment, and documentation must support review and involvement in the patient's care oversight.
For example, a 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) and Nurse Practitioners (NP):

- PHP does credential NPs and PAs. Any NP/PA credentialed by PHP must bill their services under their own provider NPI. Non-credentialed NPs and PAs must meet "incident to" billing guidelines in an office and outpatient setting. The services rendered may be rendered by an NP/PA and considered reimbursable if the following requirements are met:
- Qualifying "incident to" services must be provided by a PA/NP whom the MD/DO directly supervises and who represents a direct financial expense to the MD/DO's practice. ("W-2," leased employee, or an independent contractor).

- For new patients, the MD/DO must personally review history, examine the patient, establish a care plan, and make medical decisions regarding the patient's treatment and drug protocols.
- A PA must be licensed to render the services.
- An NP must have a master's degree in nursing.
- An NP must be a registered professional nurse and authorized by the state in which their services are furnished to practice as a nurse practitioner in accordance with state law.
- An 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 nurse practitioners.

Limited Licensed Behavioral Health Providers (LLBHP)

- Mental Health mid-level providers are required to meet "incident to" billing guidelines in an office and outpatient setting when billing under the supervising physician.
- The services may be rendered by a Limited Licensed Professional Counselor (LLPC), Limited Licensed Master Social Worker (LLMSW), Temporary Limited Licensed Psychologist (TLLP), and Limited Licensed Marriage & Family Therapist (LLMFT) and billed by the supervising Psychiatrist (MD, DO), Fully Licensed Psychologist, or Licensed Clinical Social Workers (LCSW) with the appropriate modifier to identify the level of the rendering provider.
- For new patients, the supervising physician must personally review history, examine the patient, and make medical decisions regarding the patient's treatment and drug protocols.

Failure to comply with the above "Incident to" guidelines may result in financial adjustments.

Multiple Procedure Reductions

If you are performing multiple procedures, bill the regular charge for each 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 global CPT procedures' professional and technical components 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. PHP follows CMS guidelines regarding code eligibility for reporting PC/TC components and the percent paid. Hospitals are exempt from reporting modifier TC. It is assumed that the hospital is billing for the technical component portion of any onsite service.

Preventive Medicine Services

Preventive Medicine Services should be reported using the appropriate preventive medicine CPT code with a Preventive Medicine diagnosis (ICD-10) code. A Preventive Medicine CPT code and an Evaluation and Management (E/M) CPT code may be submitted for the same member on the same service date. Unless documentation supports a significantly identifiable procedure, payment will only be allowed for a Preventive Medicine CPT code or an E/M CPT code. Billing should reflect the appropriate modifier. Preventative services are only eligible for reimbursement when rendered by an in-network practitioner. Additional information is available in the Preventative Services Benefit Coverage Policy (BCP-45).

Telehealth Services

Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in their health care profession in the state where the patient is located. Not all services are eligible for payment when performed via telehealth. Please refer to Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS®) to identify eligible telehealth codes. Codes eligible for telehealth are indicated by a star (★) symbol in the CPT® and HCPCS® coding manuals and are reviewed annually. Please review Physicians Health Plan's Benefit Coverage Policies and Reimbursement Policies for additional information regarding coverage limitations on the provider portal. A patient must be informed of and consent to any services performed and billed as telehealth.

Modifier 95

- Telehealth service performed via Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications system
- Required as an indication that the service was performed as a telemedicine encounter

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

Place of Service 02

Effective January 1, 2017, thru December 31, 2021, all telehealth services

Effective January 1, 2022, Telehealth Provided Other than in Patient's Home

- The patient is not located in their home when receiving health or health-related services through telecommunication technology.

Place of Service 10

Effective January 1, 2022, Telehealth Provided in the Patient's Home

- The patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health-related services through telecommunication technology.

When a patient receives Telemedicine services in a facility, bill with the appropriate place of service (e.g., 21,22) and modifier 95

When a patient receives Telemedicine services in a non-facility setting, bill with place of service code 02 or 10 (depending on the location of the member) and modifier 95.

Documentation

The documentation standards are the same for telehealth services as for any other face-to-face encounter. This includes documentation of components such as history, review of systems, consult notes, counseling, care plan, and any other documentation that supports medical decision-making and medical necessity. The documentation should also note that the services were performed via telehealth, the location of the patient, and the patient's consent to the telehealth encounter.

Information Security and Liability

Network providers providing telehealth services shall comply with all relevant laws, regulations, and codes for technology and information security, as well as those required by HIPAA's Security Rule and the HITECH Act. Network providers shall also obtain adequate cyber liability insurance, which covers the provision of telehealth services.

Additional information is available in the Telemedicine Services Payment and Reimbursement Policy (PRP-15) and the Telemedicine Services Benefit Coverage Policy (BCP-50).

Submitting a Claim

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

All claims, including adjusted claims, must be received within 6 months 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 6 months 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's responsibility on the Explanation of Payment or Explanation of Benefits.

Unless otherwise directed by PHP, all claims must be submitted using the 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's ID number, customary charges for the health services rendered to a member during a single instance of service, the provider's Federal Tax ID number, and/or other identifiers as outlined below.

Acceptable Claim Forms

Claims may be submitted in one of the following formats:

- Electronic Claim Submission
- UB-04
- CMS1500

Electronic Claims

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

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

EDI Validation

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

Claims submitted with non-HIPAA-compliant data will be rejected and returned to the provider for correction. It is important to submit valid member ID's as well as billing identification information, such as NPI, 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 and complete all fields required by HIPAA regulations. Some fields include:

- Patient name, address, and date of birth
- Subscriber name and address (if different than patient)
- Patient's PHP policy/member number
- Other insurance information

- The name, signature, USPS Standards rendering address, USPS Standards billing address, including 9-digit zip code, and telephone number of the Physician/practitioner/Provider/Facility performing the service
- The tax ID and NPI number of the Physician/practitioner/Provider/Facility performing the service
- Appropriate diagnostic codes (ICD-10)
- Appropriate procedure/service codes
- Current CPT/HCPC code with appropriate modifiers
- Current 4-digit revenue codes, if applicable
- Number of units rendered
- Referring Physicians name
- Dates of Service – day, month, and year the service was provided
- Place of Service
- National Drug Code (NDC) for prescription drug therapy, description and dosage
- Identification if service is a job-related injury or accident

Prompt Payment and Clean Claim Requirements

Claims received by PHP will be processed in accordance with prompt payment legislation (Public Act 28 of 2004). This means that PHP is required to pay a simple interest of 12% annum on all "clean claims" that are not paid within 45 days of receipt.

Public Act 28 defines clean claims as claims that:

1. Identify the health professional or health facility that provided the service to verify, if necessary, affiliation status, including provider's NPI(s) and tax identification numbers
2. Identify the member and health plan subscriber
3. List the dates and places of service
4. Claim must be billed for covered health services for eligible members
5. Substantiate the medical necessity and appropriateness of the service provided, when necessary
6. Contain prior authorization or notification information, when necessary
7. Identify the services rendered using a generally accepted system of procedure and diagnosis codes
8. Include additional documentation based on services rendered as required by the Health Plan

Incomplete/Missing Supporting Documentation (medical records, itemized statements, etc.)

A claim requiring supporting documentation (medical records, itemized statements) is considered not a clean claim until supporting documentation is received. Claim or claim lines will be denied with an explanation code indicating the information needed to be considered for payment on the provider's explanation of payment (EOP). Providers have six months or as otherwise specified in the provider's participation agreement to submit the requested documentation from the date of service. For the claim to be reconsidered, the provider must:

1. Return the requested supporting documentation to PHP or the address indicated on the Medical Records Submission Form.

2. Ensure that PHP receives the requested supporting documentation within six months of the service date or as otherwise specified in the provider's participation agreement.

A member may not be billed for services for which a claim submission has been returned to the provider for supporting documentation.

Where to Send Claims

Refer to the "Where to Send Claims" page for the appropriate address information for claims submissions.

Claim Status

You may check the status of a claim by accessing our online Provider Portal via the PHP website, electronic claim status 276/277 electronic transactions, or by contacting Customer Service at the number listed on the "How to Contact Us" page. Customer Service will status up to 5 claims per call. If you have more than 5 claims to status, you can fax your request to our Customer Service Department at 517.364.8411.

Claim Adjustments

It may become necessary to adjust a claim(s) to reflect the correct payment determination. To request an adjustment of a claim previously allowed by PHP, use the Claim Adjustment Request Form. Claim adjustment form and corrected/adjusted claims must be mailed to the address listed on the Claim Adjustment Request form. We require that requests for adjustment(s) be submitted within the timeframe identified in the Participation Agreement, or within six months 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 must be submitted within six months from the date on the primary carriers' Explanation of Payment (EOP).

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

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

Overpayments

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

If a manual check is required or needed to resolve the overpayment, please submit the refund check to:

Physicians Health Plan
Attn: Provider Refund
PO Box 30377
Lansing, MI 48909-7877

Medical Coordination of Benefits

Medical Coordination of Benefits (COB) is the procedure used to pay health care expenses when a member is covered by more than one insurer or plan that provides health care benefits. PHP applies certain rules to decide which carrier pays first (primary). The objective is to make sure the combined payments of all carriers are no more than the allowable expense.

Identification of the Primary Payor and Claim Submission

Prior to submitting a claim, it is important to determine if any other Payor has primary responsibility for payment of a claim. The identification of the primary Payor prior to claim submission will improve the efficiency and accuracy of the claim payment process. The "Primary Plan" means a plan whose benefits for a member's health care coverage must be determined without taking the existence of any other plan into consideration.

If it is determined that another Payor is primary, that Payor should be billed prior to billing PHP. After receipt of payment, submit an electronic claim to PHP including the primary carrier payment information located in the 2320 and 2330 loops of the electronic claim transaction. PHP also accepts paper claims which must include the following:

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

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

How Primary and Secondary Benefits are Determined

- The plan having no COB provision or non-duplication coverage exclusion is always primary.
- When a member is covered by two plans, the plan covering them as a subscriber rather than the plan covering them as a dependent is primary.
- Coverage for dependent children of parents who are not divorced or separated is determined as follows when the child is covered by both parents' plans:
    - The plan of the parent whose month and date of birth fall earlier in the year is primary for the child.
    - If both parents have the same month and date of birth, the plan that has covered the child for a longer period of time is primary for the child.

- Coverage for dependent children of separated or divorced parents when the child is covered by both parents' plans is determined as follows:
    - The plan of the parent who is required by court decree to provide health care coverage to a dependent child is the primary plan in all instances.
    - The plan of the "natural" parent who has custody applies next.
    - The plan of the stepparent, where the "natural" parent has custody, applies next.
    - The plan of the "natural" parent who does not have custody applies next.
    - The plan of the stepparent, where the "natural" parent is without custody, applies next.
    - The plan that covers a member as a subscriber who is neither laid off nor retired is primary over a plan that 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 covers the person for a longer period is primary.
    - If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

Medicare as the Primary or Secondary Payor

Individuals can become eligible for Medicare because of age or disability. Persons aged 65 and over who are entitled to monthly Social Security benefits are automatically eligible for Medicare. Medicare is primary for members 65 years and older if they or their spouse are not actively employed. Medicare is the primary payor for persons under age 65 when the person is covered by Medicare because of a disability (other than End Stage Renal Disease), their 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 to 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 to PHP's allowable. 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 that was covered by both Plans.

When the primary carrier does not make any payment (i.e., applies everything to member liability or denies the claim), PHP will pay the claim as though we are the only payor and process the claim according to the claim allowability and member's benefit, applying deductibles, copayments, and co-insurance as applicable. Providers should follow all rules of the primary carrier, including but not limited to authorization requirements, for secondary payment to be considered.

Subrogation

Subrogation is a process through which PHP has the legal right to recover benefits paid when the member's injury or illness is determined to be the 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-10 accident codes assists in the identification of these situations. Subrogation does not change the procedure for processing claims. We process the claim and pay for covered services at established fees. Subrogation activities take place after claims have been processed for payment.

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

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

Billable Copayments and Services

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

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

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

Deductible and Coinsurance Plans

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

Copayment/Coinsurance Waiver

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

Non-Covered Services Billable to Members

Services that are billable to members will be identified in the "Patient Ineligible" field of the Explanation of Payment (EOP). For any questions related to non-covered services, contact the Customer Service Department at the number listed on the "How to Contact Us" page.

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

Non-Covered Services Not Billable to Members

By entering into a Participation Agreement with Physicians Health Network (PHN), you have agreed to accept payment directly from PHP. Payment from PHP constitutes payment in full for the covered services you render to members. Some services may be considered ineligible for coverage as part of the claims adjudication processes established by PHP. Services include but are not limited to administrative facility fees, clinical edits, clinic fees, lab handling services, amounts over contracted rates, failure to obtain prior authorization, stand-by services, venipunctures, routine surgical supplies, services, including prescriptions, provided or written for Family members, amounts denied due to failure to comply with the terms of the Participation Agreement or Provider Manual. In addition, services considered integral to a routine evaluation and management service are not billable to members. For example, patient assessments or screenings performed to determine a patient's need to be seen by a dentist are considered integral to the Medical Decision-Making component of an E/M service. Integral services are not eligible for separate reimbursement. 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 patient admissions, medical records, or other similar expenses to be covered. These are not related to the treatment of an illness or injury and are not billable to members.

Clinical Edits

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. PHP's Clinical Edits aims 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.

Clinic Fees

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

Contracted Amounts

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

Facility-Based Private Duty Nursing

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

Non-Notification Processing

If the 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.

Services Provided for Family Members

PHP does not cover services, including prescriptions, performed or written 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 the same legal residence as the Member. This includes any service the provider performs for him or herself.

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.

Unlisted Codes

An unlisted code may be reported when a service or procedure does not have a more specific Current Procedural Terminology (CPT) code. Plan coverage of unlisted codes depends on the services rendered as documented. When submitting a claim with an unlisted code, please include

documentation of the procedure with the claim, a narrative as to why the unlisted code was selected, and any comparable code(s) to prevent claim denial for records. If a service that will be reported with an unlisted code could be considered investigational, experimental, or a service not covered per the member benefits and a prior authorization is not obtained, the service will be denied as such. If there is a more appropriate code(s) for the service documented, the unlisted code will be denied as an incorrect procedure code. A corrected claim with the appropriate coding may be submitted within timely filing limits. Please see PHP's Unlisted CPT-HCPCS Codes Payment Reimbursement Policy (PRP-03) for additional information.

Venipuncture

PHP reimburses providers for venipuncture when the same provider or provider group has performed an Evaluation and Management (E/M) service on the same day for the same member. However, 36415 and 36416 may be denied as bundled under multiple lab codes and/or other procedures.

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

Clinical Editing

Clinical Editing analyzes professional, and facility claims for reimbursement, ensuring clinical data's accuracy and completeness, including potential coding errors and rule infractions based on codes submitted on the same or different claims. Clinical Edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. PHP may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid for through CMS but are covered by the plan to support covered benefits available through one of the Plan's products. Clinical Editing rules are effective based on the date of service, and services will be denied payment when the edit is applied. As a normal business practice, Claims Editing software is updated quarterly to incorporate the most recent coding principles based on Medicare guidelines, specialty society guidelines, the National Correct Coding Initiative, and changes to AMA's CPT manual.

The purpose of PHP's clinical edits is to prevent improper payments. Clinical edits are applied to **all** claims submitted by facilities and professionals, both in-network and out-of-network, for all PHP Medical Plans, including self-funded and fully funded. PHP's Clinical Edits include bundling rules, Medically Unlikely Edits (MUEs), and other automated logic used during adjudication.

Services that result in clinical editing may be denied. 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.

Source rationale for clinical edits:

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

NCCI

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

There are two NCCI edit tables: “Column 1/Column 2 (Component/Comprehensive)” and “Mutually Exclusive Edit Table.” Each edit has a column 1 and 2 CPT/HCPCS code. The column 2 code services are included in the column 1 code service. All edits are included in the “Column 1/Column 2 Correct Coding Edit Table” except those that are based on the “Mutually Exclusive” criteria, in which case the edits are included in the “Mutually Exclusive Edit Table.”

NCCI Modifier Indicators

Each edit also contains a column that indicates when a modifier may override the edit. Modifiers that may override an NCCI edit:

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

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

Coding Based on Standards of Medical/Surgical Practice

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

- Cleansing, shaving, and prepping the skin
- Insertion of intravenous access for medication administration
- Insertion of urinary catheter
- Local, topical, or regional anesthesia is administered by the physician performing the procedure
- Surgical approach including identification of anatomical landmarks, incision, evaluation of the surgical field, debridement of traumatized tissue, lysis of adhesions, and isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles, including stimulation for identification or monitoring
- Insertion and removal of drains, suction devices, and pumps into the same site
- Surgical closure and dressings
- Preoperative, intraoperative, and postoperative documentation, including photographs, drawings, dictation, or transcription as necessary to document the services provided
- Surgical supplies, except for specific situations where the plan's policies permit separate payment

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

Per industry standards, supply items consistently used with each surgical procedure are considered integral to the procedure. These items are considered not separately reimbursable (NSR). The NSR items are considered included in the general cost of the room where services are being rendered or in the reimbursement for associated surgical or primary procedures, including but not limited to;

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

HCPCS/CPT Procedure Code Definition:

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

- A "partial" procedure is not separately reportable with a "complete" or "total" procedure
- A "with" procedure is not separately reportable with a "without" procedure CPT "Separate Procedure" definition

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

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

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

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

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

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

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

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

Procedure to Diagnosis Edit: This edit encompasses all billed professional claims and occurs when the procedure billed is unexpected based on the diagnosis billed. For example, a claim billed with diagnosis code 424.0 (Mitral Valve Disorders) and procedure code 43500 (gastrotomy; with exploration or foreign body removal). This procedure would be identified as unexpected for the diagnosis and would be denied.

Medically Unlikely Edits (MUEs)

On January 1, 2007, CMS incorporated Medically Unlikely Edits (MUEs) into the NCCI program. An MUE for HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same member on the same date of service. For example, there is only one unit allowed for an appendectomy. PHP may define the maximum number of services per day billed for covered services with a CMS MUE of 0. These quantity limits are based on clinical benchmarks and criteria (e.g., nature of service, anatomy). Clinical edits will be applied during claims processing. An appeal may be submitted for reconsideration with medical records for CPT/HCPCs code with an MUE Adjudication Indicator (MAI) of 3 may be appealed with medical records for consideration of medical necessity. Appeal documentation must support services reported, correct coding, and medical necessity.

Billing Multiple Lines

Payment may be denied or delayed when the same procedure code is billed on multiple lines instead of one line with multiple units. Before submitting a claim, please review claim lines and units for accuracy to ensure timely and accurate reimbursement. The following are examples for billing a pathology exam on three breast biopsy specimens:

Correct way: One line with CPT 88305 and 3 units

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

If the claim includes three lines with one unit for each line, the additional lines appear to be duplicated, causing the additional lines to be denied.

Duplicate Claim or Claim Line in History

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

Add-on Codes

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

Basic Validation Edits

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

Coverage Edits

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

Multiple Procedure Reduction (MPR)

Each CPT® code is assigned a relative value unit (RVUs) and calculated as a stand-alone procedure. However, when two services are performed during the same encounter, there are duplicated elements in the reimbursement of the additional procedure. This includes pre-procedure and post-procedure work as well as components integral to the standard surgical service. Reimbursement at 100% for the subsequent procedure(s) would represent reimbursement for duplicative components of the primary procedure. Therefore, when multiple procedures are performed on the same day by the same physician or other healthcare professionals, a reduction in reimbursement for the subsequent procedure(s) is applied. This practice is consistent with longstanding Centers for Medicare & Medicaid Services (CMS) policy and industry standards to prevent duplicate reimbursement for portions of physician work and practice expenses that are incurred only once when the same physician provides two or more procedures on the same date of service.

The procedures reviewed for MPR reductions are modifier -51 eligible in consideration of service categories (e.g., radiology, endoscopic). The service with the highest RVU will be priced at 100% of the contracted fee max amount. All subsequent surgical procedures performed on the same date of service are allowed at 50% of their respective fee max amounts. If the impacted claim line is reported with reimbursement-based modifiers such as an assistant surgeon, the appropriate additional reduction will be applied. Additional information can be found in the PHP Payment and Reimbursement Policy, Bilateral and Multiple Procedures (PRP-16).

Global Surgical Package

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

- Codes with "YYY" are codes for which the Plan will determine the global period. Components of the global surgical package considered part of a global surgical procedure are as follows:
    - Preoperative visits
    - Intra-operative services
    - Complications following surgery that do not require a return trip to the operating room
    - Postoperative visits
    - Postoperative pain management is done by the surgeon
    - Supplies
- Modifiers for physicians furnishing less than the full global package are as follows:
    - Modifier 54 surgical care only
    - Modifier 55 postoperative management only
    - Modifier 56 preoperative care only

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

Evaluation and Management (E/M) Services

Visits by the same physician on the same day as minor surgery or endoscopy are included in the payment for the procedure unless a significant, separately identifiable service is also performed, identified by modifier 25. In general, more than one E/M service on the same day by the same physician or physicians in the same group practice who are in the same specialty is not reimbursable.

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

Please refer to the Medicare Claims Processing Manual, Chapter 12, and the NCCI Guidelines for additional guidance on E/M billing requirements. CMS Manuals are available online at https://www.cms.gov/medicare/regulations-guidance/manuals.

Return Trips to the Operating Room During the Postoperative Period

When treatment for complications requires a return trip to the operating room, Physicians must bill the CPT code that describes the procedure(s) performed during the return trip. CPT modifier 78 is reported for these return trips. A new postoperative period does not start; only the intraoperative portion is paid. Modifier 58 was established to facilitate the billing of staged or related surgical procedures.

Procedures Done During the Postoperative Period of the First Procedure

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

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

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

Unrelated Procedures or Visits during the Postoperative Period

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

Status Code Indicators

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

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

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

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

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

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

Anesthesia/CRNA

Anesthesia services are reimbursed using the calculation of (time + base x conversion factor*). Please note that some anesthesia services are reimbursed on a fee-for-service basis.*

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

Robotic Surgery

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

Assistant at Surgery Services

The indicators for Assistant at Surgery Services are found in the Medicare Physician Fee Schedule Data Base (MPFSDB). These indicators are defined below and apply to the surgery for which the indicator is assigned.

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

- 1 – Team Surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report
- 2 – Team Surgeons permitted; pay by report

If a procedure reported with a co-surgeon or team surgeon modifier is denied, an appeal may be submitted for review with supporting documentation. The appeal must include documentation for **BOTH** surgeons to support modifier application. For a complete list of status indicators and their descriptions, access the MPFSDB and National Physician Fee Schedule Relative Value File on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched

New Patient Visits

The plan follows the AMA and CMS guidelines which describe a new patient as one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. The new patient visit will be denied if a new patient code is submitted within three years of previous physician service. Urgent Care and Telehealth groups that may have providers of different specialties treating patients for emergent services may not bill new patient visits for different specialists. The specialty of these groups is emergent care, not specialty-specific (pediatric, internist, primary, OBGYN) and the patient is not selecting the provider by specialty other than emergent care needs.

Operating Microscope

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

Pulse Oximetry

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

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

Legal and Regulatory References

- National Correct Coding Initiative (NCCI)
- Outpatient Code Editor
- Medicare Claims Processing Manual, Chapter 12
- National Physician Fee Schedule Relative Value File
- American Medical Association (AMA)
- Current Procedural Terminology (CPT)
- CPT Assistant
- CPT Changes
- 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
- Medicare NCCI Procedure to Procedure (PTP) Edits
- Medicare NCCI Medically Unlikely Events (MUE) Edits
- National Coverage Determinations (NCDs)
- HHS-Office of Inspector General
- Federal Register
- Publications
- Fraud Prevention & Detection
- National Library of Medicine – National Institute of Health (NLM-NIH)
- Specialty Society websites and publications, including, but not limited to:
    - American College of Obstetricians and Gynecologists (ACOG)
    - American Academy of Orthopedic Surgeons (AAOS)
    - American College of Radiology (ACR)
    - American College of Surgeons (ACOS)
    - American Hospital Association (AHA)
- Health Insurance Portability and Accountability Act (HIPAA) Code Sets

Fraud and Abuse

Billing Integrity Program

PHP is committed to detecting, mitigating, and preventing fraud, waste, and abuse. This is executed through the PHP Billing Integrity Program (BIP), which is managed by PHP's Compliance Department. The purpose is to prevent Fraud, Waste, and Abuse as well as detect billing errors and investigate Fraud when it is detected. The primary objective of BIP is to ensure that providers bill accurately and documentation supports the medical necessity of the service(s) and level of service(s) billed.

Claims Audit/Medical Record Review Process

PHP completes claims audit/medical record reviews on both a pre-payment and post-payment basis.

- Pre-payment audits are completed prior to claim adjudication and payment. Providers will receive written notification of the request for records from PHP and/or PHP's audit firm. The provider should submit all necessary documentation, as requested, in the letter within thirty (30) days or as specified in the letter. The documentation should be returned to the address referenced in the letter.
- Post-payment audits will include claims processed six months to one year before the audit/review date to identify billing trends and outliers. However, based on the findings, this time frame may be expanded as needed. Providers will receive written notification of a request for records from either PHP and/or an audit firm if warranted. The provider should submit all necessary documentation, such as Patients' medical records, as requested within fourteen (14) days or as specified in the letter to ensure a successful and timely audit. On occasion, an on-site audit may be requested. The Provider will receive an initial letter of notification and a follow-up call from a representative from PHP to schedule the on-site review.

PHP will not pay administrative fees for any audit unless specified in your provider agreement.

PHP will send a written notification to the provider explaining the post-payment audit results. Providers will not be notified via letter of pre-payment review results. However, any audit findings will be provided in your Explanation of Payment (EOP).

PHP has the right to recover payments from providers that participate with the health plan if such payments made are erroneous pursuant to an audit and/or medical record review conducted under the BIP and per the provider's participation agreement. Recovered payments may be recouped for up to two years before the request for records or date of discovery unless otherwise specified in your provider agreement.

Excessive Charge Monitoring and Auditing

Excessively charging for services is considered Fraud and Abuse. Audits may be performed on a pre-payment or post-payment basis. If an audit determines the services were billed in excess of usual, customary, and reasonable charging per unit, the final allowable amount may be reduced. The types of services that are monitored for reasonable payment are:

- Services billed above the usual, customary, and reasonable (UCR) charges represent a base amount that is considered the standard or common charge for a defined medical service performed in a particular geographic region. When a service isn't assigned a fee schedule rate and priced as a percent of charge, the UCR may be used to determine the final allowable amount for a service.

- Claims for drugs to identify potential billing errors and excessive charging. Documentation may be requested to determine if each claim is billed with the appropriate number of units and charges within UCR per unit pricing. PHP considers drug charges in excess of 130% of Average Wholesale Pricing (AWP) as possible abuse. The National UCR database Red Book is utilized to determine the UCR for AWP.

- Claims for surgical services for potential billing errors and abusive charging. PHP considers surgical services billed in excess of the 90th percentile of UCR by area zip code as possible abuse. National UCR database Context 4 is utilized to determine the UCR for surgical services.

- Claims for supplies and implantable devices for potential billing errors and abusive charging. PHP considers supplies and devices billed in excess of UCR plus 15% to be possible abuse. Pricing is differentiated by the region the provider is billing from to accommodate geographical pricing variations when applicable. National UCR database ImplantDX is utilized to determine the UCR for supplies and implantable devices.

Repayment Rule

Under the Patient Protection and Affordable Care Act, providers are required to report and repay overpayments within 60 days after the overpayment is identified.

An overpayment that is retained by the provider after the deadline to report/return an overpayment is an obligation under the federal False Claims Act (FCA), meaning that knowingly failing to report and return overpayment as required may subject the provider to liabilities and penalties under the FCA.

Payment Adjustments

PHP's Cost Containment department is responsible for identifying recovery opportunities by analyzing data to identify billing irregularities and trends to pursue claims payment recoveries. Activities include, but are not limited to:

- Incorrect payment- duplicate, overpayments, or payment to the wrong provider
- Trends of inappropriate use of coding
- Inappropriate modifier usage
- Negative balance accounts with no recent claim activity
- Higher level of service when a lower level of service is warranted

Overpayments due to duplicate payments and payments to the wrong provider, or for billing fraud or similar reasons, PHP may pursue recovery for as long as the law allows. For overpayments due to reasons such as identification of other carrier liability, code editing issues, or pricing errors, PHP will generally pursue recovery for no more than two years from the date of payment or as otherwise specified in the provider's agreement.

For all incorrect payments, PHP will adjust the claim and process a systematic takeback on future claims. This applied to incorrect payments that involve:

- Duplicate payments
- Adjustments to fee schedules or contracted fees
- Claims processing errors
- Payments to the wrong provider
- Identification of other primary insurance
- Audit findings
- Services determined not to be a covered benefit
- Services paid at the wrong benefit level
- Services not authorized

Explanation of Payment - EOP

The Explanation of Payment (EOP) is the name of the report that 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 a detailed listing of the EOP:

1. **CHECKSTOCK NAME:** The health plan, specialty company or product DBA (Doing Business As) check stock name
2. **CHECKSTOCK LOGO:** This is the logo for the health plan or self-funded group. The same logo displays on the laser checks
3. **PLAN ID TEXT:** Additional health plan informational message
4. **PROVIDER/ALT PAYEE:** The mailing name and address for the physician or health care provider or alternate payee
5. **SUMMARY PAYMENT INFORMATION:**
    a. **Paid To:** The name of the physician or health care provider payee
    b. **Tax #:** Physician or health care provider's Federal Tax Identification Number
    c. **Payment Date:** The date the check was issued
    d. **Reference #:** Reference number is used internally for report problem resolution. It identifies the site, schedule, and system cycle number for the report
    e. **Check #:** The number of the check that was generated

f. **Check Amount:** The total amount of the check
g. **Prior overpayment balance:** Amount previously overpaid
h. **Auto-Recovered this Check:** The total amount recovered or adjusted from the total check
i. **Current Overpayment Balance:** Amount in current the EOP report reflecting an overpayment
j. **Year to Date Financial Allowance:** Physician or health care provider year–to–date total financial allowance withheld from all claims for the reported Payor

6. **PATIENT NAME:** The name of the covered persons receiving services
7. **PATIENT ID#:** The 11-digit number for the covered person receiving services
8. **ACCOUNT NO:** The covered person's account number assigned by the physician or health care provider
9. **PROVIDER NAME:** The name of the physician or health care provider who performed the services
10. **PROVIDER #:** Twelve–digit number identifying the physician or health care provider
11. **NPI NO:** Physician or health care provider's National Provider Identification number
12. **PRODUCT: Medical Plan**
13. **CLAIM #: The** number assigned to the claim. (An original claim will end in "00", any adjusted claim will end in "01, 02, etc.)
14. **DIAGNOSIS CODE:** The ICD9 or ICD 10 diagnosis code indicated by the physician or health care provider
15. **DATE OF SERVICE**: the date the service was performed
16. **PROC:** The code identifying the procedure/service provided
17. **REV**: The revenue code (for the facility) identifying the service performed
18. **U:** The number of units for each claim line
19. **AMOUNT BILLED:** The total amount claimed for the procedure performed
20. **ALLOWED:** The amount allowed for payment in accordance with the Fee Schedule or Provider Agreement
21. **FINANCIAL ALLOWANCE:** The column may be blank, or it may indicate the financial allowance or withhold based on the Contractual Agreement
22. **PROV ADJUST:** Services that are not covered and are the physician or health care provider's responsibility
23. **REMARK CODES:** Reason codes that define any claim adjustments, disallows, or denials (Code descriptions can be found on the page at the end of the EOP)
24. **PATIENT INELIGIBLE:** Services that are not covered and are the covered person's responsibility
25. **DEDUCTIBLE:** Amount of deductible specified under the member's contract (It is the member's responsibility)
26. **COPAY/CO-INS:** Amount that the member is required to pay for services (Copayments will be a flat dollar copayment and co-insurance will be a percentage)
27. **OTHER INS**: Amount paid by another Carrier
28. **NET PAID:** Net amount paid to the physician or health care provider for services after all deductions have been taken
29. **INTEREST AMOUNT**: The amount of interest paid for the specific claim
30. **REFUND REQUESTED: The amount of refunds requested**
31. **AUTO-RECOVERED AMOUNT**: The amount recovered or adjusted from the claim
32. **PAYMENT TO PROVIDER:** The total net payment made to the provider for that claim

33. **TOTALS FOR PROVIDER:** Summary totals for each provider with claims reflected on the EOP
34. **EXPLANATION OF PAYMENT TOTALS**: Summary totals for all claims reflected on the EOP and check
35. **REMARK EXPLANATIONS:** The listing of remark codes and definitions identifying reasons for Provider adjustments of ineligible member charges
36. **ADJUSTMENTS**: Claims being adjusted or recovered will be reflected within the contents of the EOP report as identified above. The amounts being removed will be reflected with a (-) minus reflecting the amount removed from that account. Each column that reflected previous dollars processed will be identified as a subtracted number with the corresponding remarks code for an explanation of the adjustment

Electronic Fund Transfer – EFT

With Electronic Fund Transfer (EFT) you can receive your payments electronically through a partnership with Zelis® Payments. Zelis ePayments offers secure ePayment options and a no-fee ACH delivery of claims payments. Delivery of the 835 Electronic Remittance Advice (ERA) files to your clearinghouse is available directly through the ePayment Center.

To register for Zelis ePayment you will need:

- 9-digit Federal Tax Identification Number (TIN)
- Practice's corporate name and principal information
- Bank account routing transit number (RTN) or ABA Routing Number

How to register for Zelis ePayment Center:

1. To register for Zelis ePayment: Visit PhysiciansHealthPlan.epayment.center
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a Zelis customer service representative and a link will be sent to your email once confirmed.
4. Follow the link to complete your registration and set up your account
5. Log into the Zelis ePayment Center portal
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click "Submit"

Upon completion of the registration process, your bank account will undergo a pre-notification process to validate the account prior to commencing the EFT delivery. This process may take up to six business days to complete.

Additional enrollment instructions and a detailed question and answer guide are available for download at PhysiciansHealthPlan.ePayment.Center. For additional assistance, you can call 855.774.4392 or email help@epayment.center.

Defined Terms

Adverse Determination: Denial of a healthcare service, procedure, or treatment based on the member's Certificate of Coverage (COC), Summary Plan Description (SPD), or Plan Document using approved medical criteria of PHP policies

Benefit Contract: A benefit plan that includes health care coverage, is sponsored, issued or administered by Payor, contains the terms and conditions of a member's coverage

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

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

Convenient Care/Urgent Care: Setting for treatment of non-life-threatening conditions

Coordination of Benefits (COB): Coordination of Benefits is the procedure used to pay health care expenses when a member is covered by more than one insurer or plan which provides health care benefits

Coinsurance: Percentage dollar amount the member is responsible for per their Benefit Contract

Copayment: Flat dollar amount member is responsible for per their Benefit Contract

Dependent: An individual who is properly covered under a member Benefit Contract

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

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

Health Services: The Health Care services and supplies covered by the member's Benefit Contract

HIPAA: Health Insurance Portability and Accountability Act

HMO: Health Maintenance Organization. HMO is a type of health plan that requires members to restrict services to the doctors, hospitals, and other medical providers that are in the HMO network

IPA: An Independent Physician Association is a business entity organized and owned by a network of independent physician practices for the purpose of reducing overhead or pursuing business ventures such as contracts with employers, accountable care organizations (ACO), and or managed care organizations (MCOs).

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: This program was 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

PHO: Physician Hospital Organizations are organizations formed by a contractual relationship between a hospital and certain physicians or attending medical staff

Physician Health Network (PHN): The PHP network of providers

PPO: Preferred-Provider Organization is defined as a type of managed care health insurance plan that provides maximum benefits if you visit an in-network physician or provider, but still provides some coverage for out-of-network providers.

Primary Payor: Entity that would pay member's claim first in COB situations

Provider Portal: Enhanced online tool available to verify member eligibility, view claims information, and submit medical authorization inquiries and requests

Secondary Payor: Entity that would pay member's claim after the primary Payor has paid in COB situations

Synchronous Communication: The transmission of data that is time-dependent and the recipient would need to be available at the time of transmission. For example, a telephone call or video conference

Telehealth: Provision of healthcare services provided to a patient that is in a different physical location than the healthcare professional rendering services via telecommunication technology within state and federal law. Telemedicine services are inclusive of telehealth services

Telemedicine: Virtual health visits to perform remote diagnosis and treatment of a patient by means of telecommunications technology

TPA: Third-Party Administrator is a company that provides operational services such as claims processing and employee benefits management under contract to another company

PHP Commercial Forms, Notification/Authorization Table, and PDL's

The following PHP Commercial forms and resources are available online at www.phpmichigan.com/Providers/General-Forms-and-Information.
Attention Medicare Providers: The forms listed below are for PHP Commercial use only.

Appeals

Provider Appeal Form: Appeal an adverse determination or claim denial
Authorized Appeal Representative: Authorization to represent a member during the appeal process

Case Management

Case Management Referral Form: Refer a member to PHP Case Management

Claims

Claim Adjustment Request Form: Submit additional information for a processed claim
Medical Records Submission Form: Submit requested medical records, itemization, implant logs, invoices

Credentialing

HAAP Ancillary Provider Application: Non-Hospital Facilities applying for network participation
Hospital Application: Hospitals applying for network participation
New Provider Request Form – Fillable: Practitioners and Groups applying for network participation
New Provider Request Form - Excel Spread Sheet: Practitioners and Groups applying for network participation
Provider Information Update Form: Update or change practitioner, group, or facility information

Out-of-Network

Out-of-Network Authorization Request Form: Fax request prior authorization for out-of-network services

Pharmacy Specialty, Infusion Referral, and Mail-Order Forms

CVS/Caremark Mail-Order Form: Mail prescription orders to CVS Caremark Mail Service Pharmacy or e-Prescribe mail order prescription directly to CVS Caremark
CVS/Caremark Specialty Pharmacy - Medication Order Form: Fax referrals for Specialty Pharmacy Services to CVS Caremark or e-Prescribe specialty prescriptions directly to CVS Caremark
Coram (CVS) Home Infusion Referral Form: Fax referrals for Home Infusion Therapy to Coram (CVS specialty infusion services)
Soleo Home Infusion Referral Form: Access Soleo Health Specialty Pharmacy & Home Infusion Therapy referral forms
KabaFusion Infusion Referral Form: Access KabaFusion Pharmacy referral forms
Metro Infectious Disease Consultants Infusion Referral Form: Access Metro Infectious Disease Consultants Infusion referral forms

Prescription Drug Lists

Pharmacy benefit coverage is determined by the Member's COC, SPD, or Plan Document.

2024 Prescription Drug List - Includes Tier 3 and Tier 4

2023 Prescription Drug List - Includes Tier 3 and Tier 4

2024 Prescription Drug List - Tier 6

2023 Prescription Drug List - Tier 6

Prior Authorization Forms

Medical benefit coverage is determined by the Member's COC, SPD, or Plan Document.

PHP Notification/Prior Approval Table: Medications and services that require clinical review prior to obtaining the service

ABA Therapy Request Form: Fax request Applied Behavior Analysis (ABA) Therapy*

Bariatric Surgery Request Form: Fax request for bariatric surgery*

DME Authorization Request Form: Fax request for DME*

Home Health Care Request Form: Fax requests for Home Health Care*

Medication Authorization Form: Fax request for Medications requiring prior authorization

Outpatient Rehab Therapy Request Form: Fax requests for outpatient rehabilitation*

Prior Authorization Request Form for Services: Fax requests for prior authorization of services for in-network and out-of-network providers

Transplant Prior Approval Form: Fax request for prior authorization of Transplant services

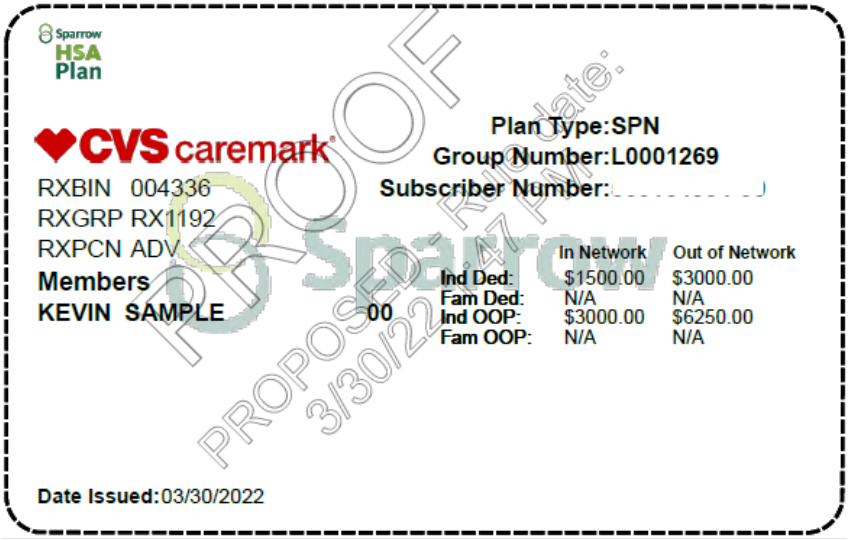
**These services can be requested online by accessing the EZ Auth/Referral Tool in the MyPHP Provider Portal.*

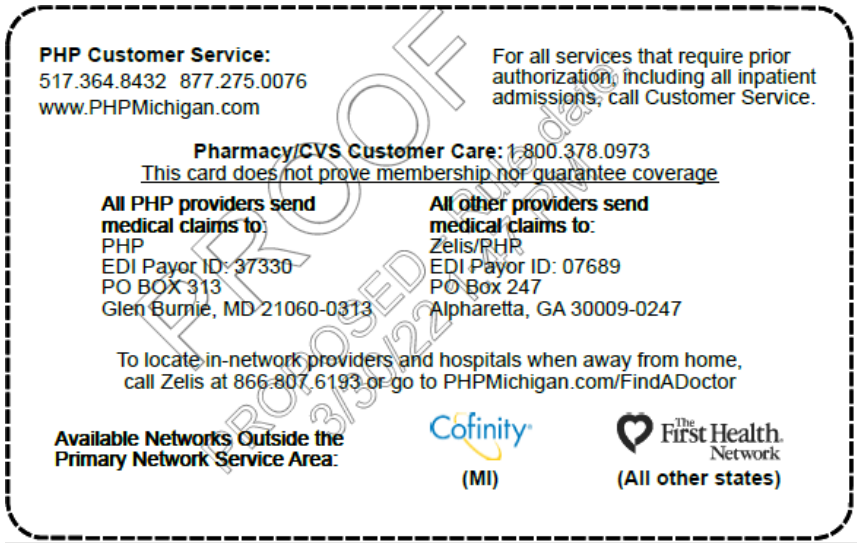
Provider Updates

Billing Company Information Questionnaire: Authorize PHP to speak to a 3rd party billing company

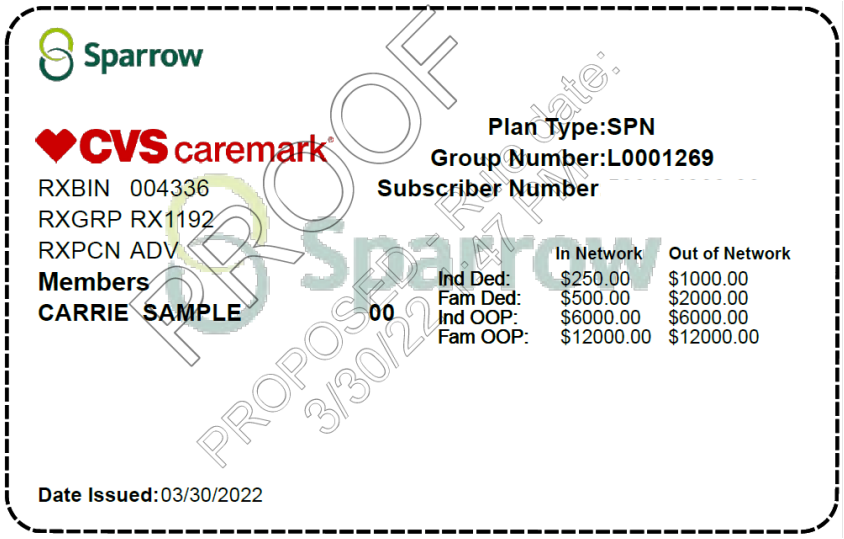
Member ID Card Examples

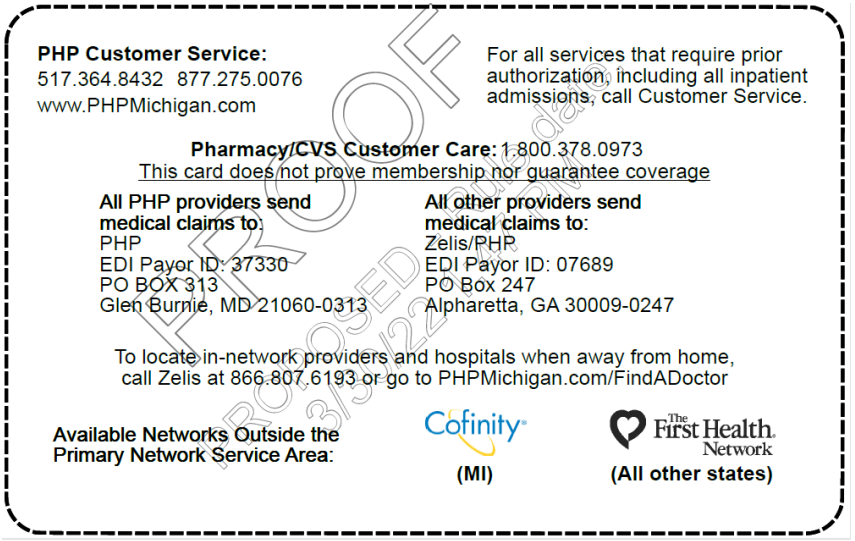
Sparrow Employee (HSA)



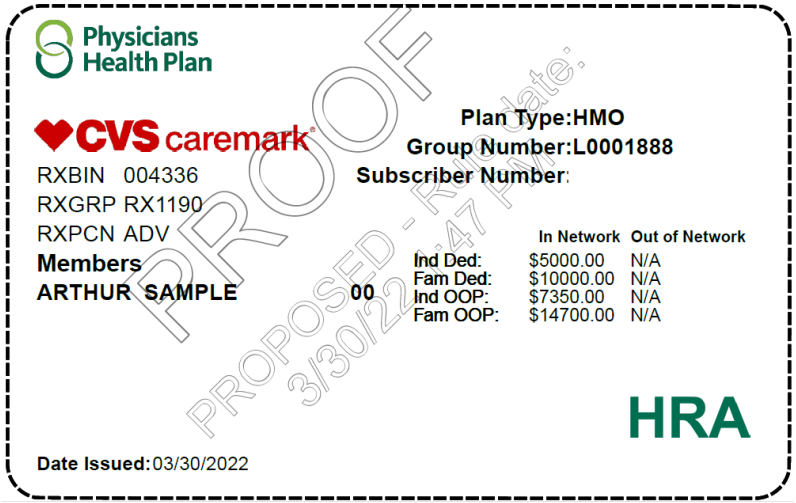


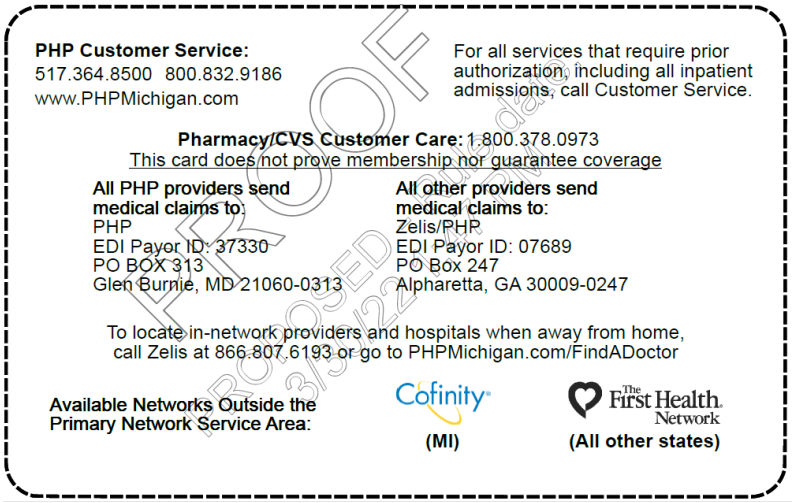
Sparrow Employee (No HSA)



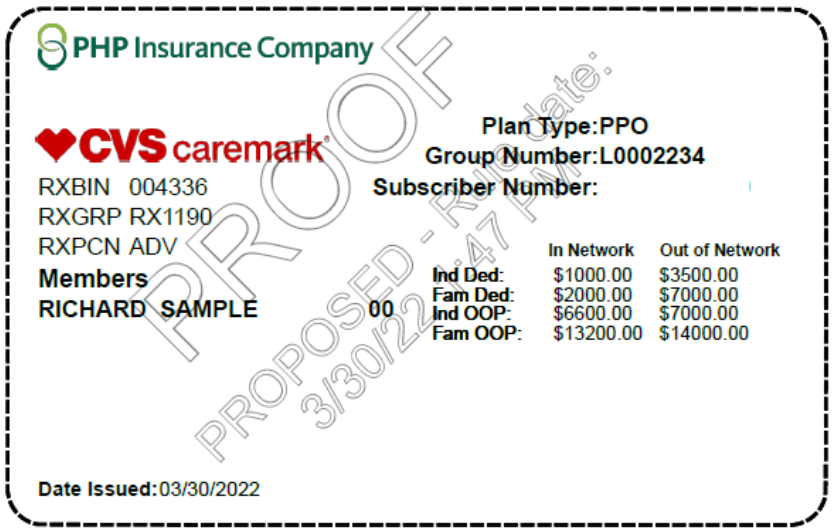


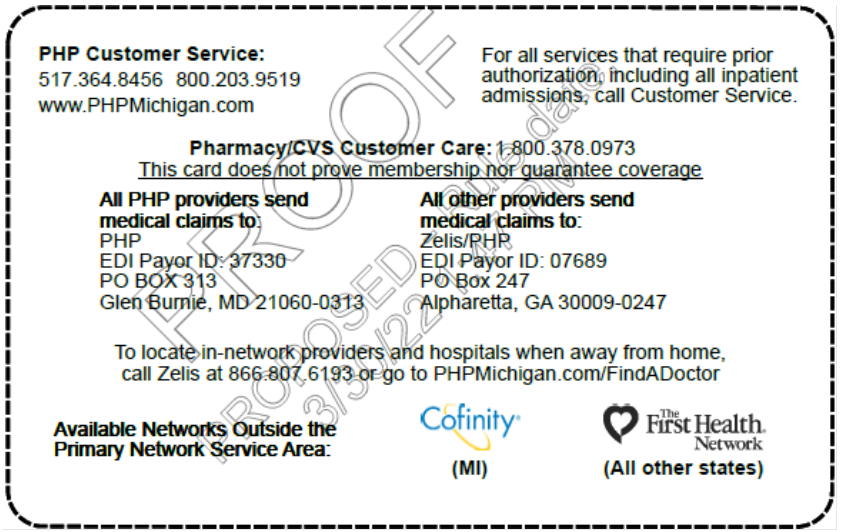
Physicians Health Plan (PHP HMO with HRA)



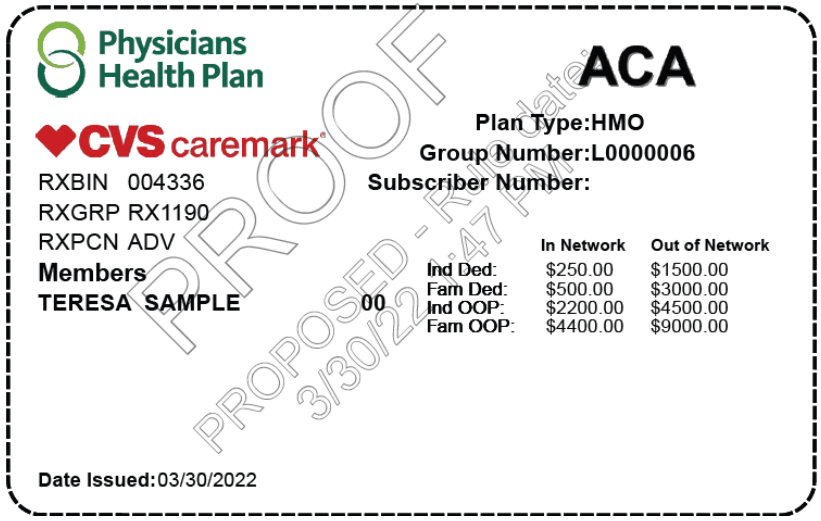


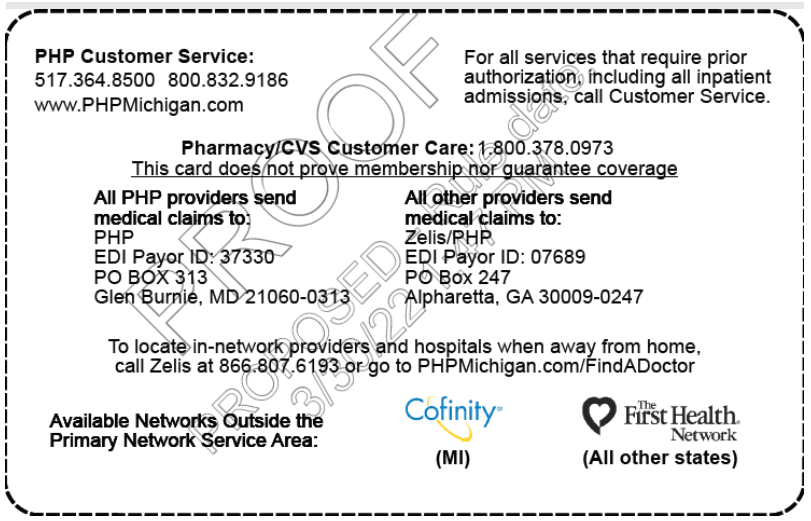
PHP Insurance Company (PPO)

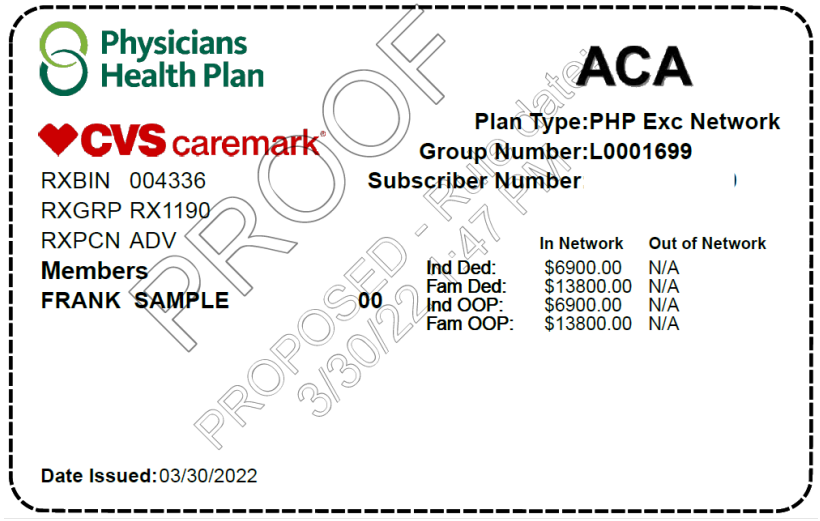




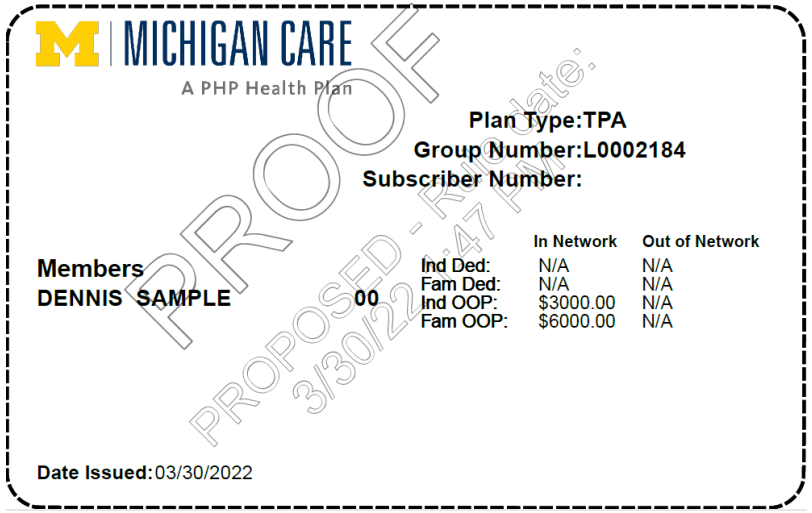
Sparrow PHP Marketplace







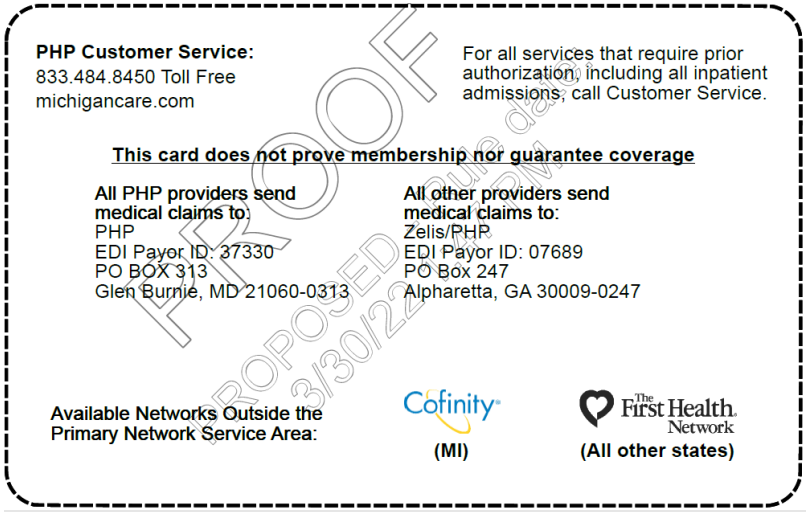
Michigan Care


MICHIGAN CARE
A PHP Health Plan

Plan Type:TPA
Group Number:L0002184
Subscriber Number:

		In Network	Out of Network
Members			
DENNIS SAMPLE	00		
	Ind Ded:	N/A	N/A
	Fam Ded:	N/A	N/A
	Ind OOP:	$3000.00	N/A
	Fam OOP:	$6000.00	N/A

Date Issued:03/30/2022


PHP Customer Service:
833.484.8450 Toll Free
michigancare.com

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

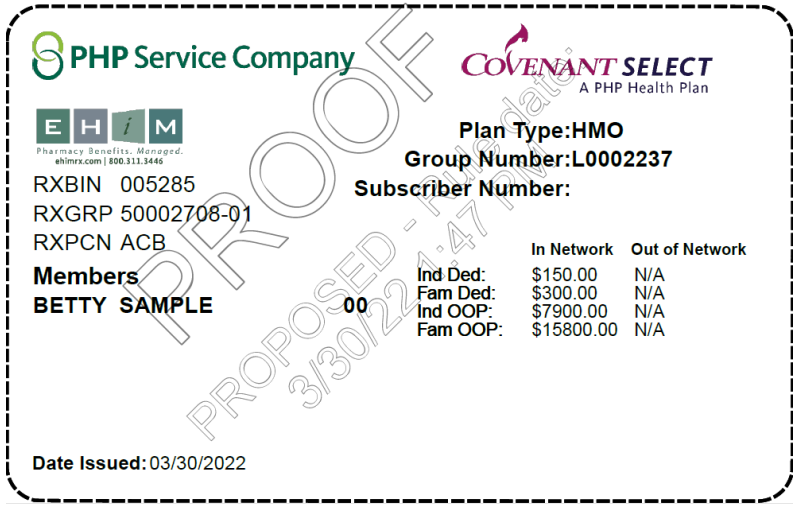
This card does not prove membership nor guarantee coverage

All PHP providers send medical claims to:
PHP
EDI Payor ID: 37330
PO BOX 313
Glen Burnie, MD 21060-0313

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

Available Networks Outside the Primary Network Service Area:
Cofinity (MI)
The First Health Network (All other states)

Covenant Select

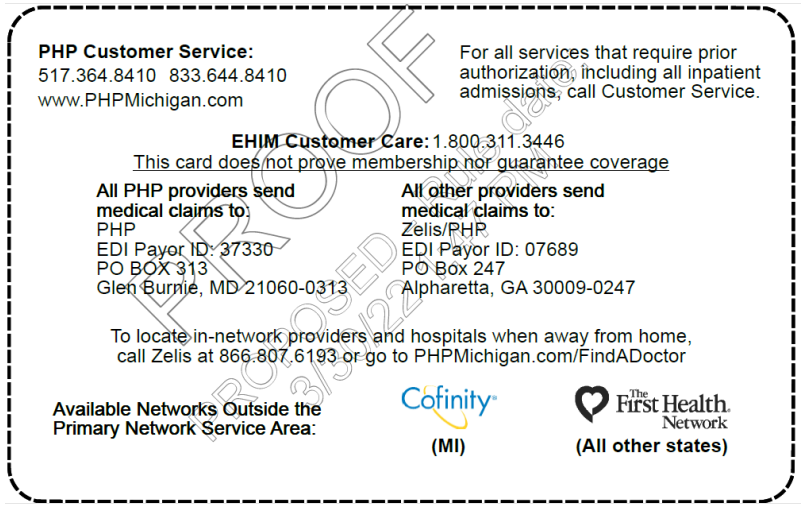

PHP Service Company
COVENANT SELECT
A PHP Health Plan
EHIM Pharmacy Benefits. Managed. ehimrx.com | 800.311.3446

RXBIN 005285
RXGRP 50002708-01
RXPCN ACB

Plan Type:HMO
Group Number:L0002237
Subscriber Number:

		In Network	Out of Network
Members			
BETTY SAMPLE	00		
	Ind Ded:	$150.00	N/A
	Fam Ded:	$300.00	N/A
	Ind OOP:	$7900.00	N/A
	Fam OOP:	$15800.00	N/A

Date Issued:03/30/2022


PHP Customer Service:
517.364.8410 833.644.8410
www.PHPMichigan.com

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

EHIM Customer Care:1.800.311.3446
This card does not prove membership nor guarantee coverage

All PHP providers send medical claims to:
PHP
EDI Payor ID: 37330
PO BOX 313
Glen Burnie, MD 21060-0313

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

To locate in-network providers and hospitals when away from home, call Zelis at 866.807.6193 or go to PHPMichigan.com/FindADoctor

Available Networks Outside the Primary Network Service Area:
Cofinity (MI)
The First Health Network (All other states)

Laboratory Test Lists

Physicians Health Plan (PHP) reimburses physicians for certain laboratory tests performed in their office or urgent care facility.

All member benefit and coverage rules apply. Clinical edits such as bundling, MUE's, or other automated logic may also apply.

Office/Urgent Care Laboratory Test List

Physicians may perform the following laboratory tests in their office or urgent care facility unless otherwise negotiated per their contract.

CPT CODE	DESCRIPTOR
80050	General health panel
80196	Salicylate
81000	Urinalysis, by dip stick or tablet reagent, with microscopy
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, without microscopy, non-automated
81003	Urinalysis, without microscopy, automated
81005	Urinalysis, qualitative or semi quantitative, except immunoassays
81007	Urinalysis, bacteriuria screen, except by culture or dipstick
81015	Urinalysis, microscopic only
81020	Urinalysis, two or three glass test
81025	Urine pregnancy test, by visual color comparison methods
82044	Albumin; urine, microalbumin, semi quantitative
82270	Blood; occult, by peroxidase activity, feces
82272	Blood; occult, by peroxidase activity, feces, 1-3 determinations
82274	Blood Occult Fecal HGB 1-3 determinations
82565	Creatinine; blood
82670	Estradiol
82947	Glucose; quantitative
82948	Glucose, blood reagent strip
82962	Glucose, blood by glucose monitoring device(s)
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
83036	Hemoglobin; glycosylated
83861	Microfluid analysis, tear osmolarity
83872	Mucin, synovial fluid (Ropes test)
83986	Molecular diagnostics, nucleic acid probe, each
84132	Potassium; serum
84144	Progesterone
84146	Prolactin
84702	Gonadotropin; chorionic (hCG); quantitative

CPT CODE	DESCRIPTOR
84703	Gonadotropin, chorionic (hCG); qualitative (urine pregnancy test)
85007	Blood count, blood smear, microscopic examination with manual differential WBC count
85013	Hematocrit, spun
85014	Hematocrit, other than spun
85018	Hemoglobin
85025	Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85027	Hemogram and platelet count, automated
85048	White blood cell (WBC)
85651	Sedimentation rate, erythrocyte; non-automated
85652	Sedimentation rate, erythrocyte; automated
86140	C-Reactive Protein
86308	Heterophile antibodies; screening
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
87426	Reports infectious agent antigen detection by immunoassay technique of SARS-CoV and SARS-CoV-2
87430	Streptococcus, group A (Infectious agent antigen detection by enzyme immunoassay technique)
87502	Influenza, 1st 2 types (Infectious agent detection by DNA/RNA)
87634	RSV (Infectious agent detection by DNA/RNA, amplified probe technique)
87651	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique
87804	Influenza
87807	RSV
87880	Streptococcus, group A (Infectious agent detection by immunoassay with direct optical observation)
89260	Sperm ISOL Complex Prep Insemination/DX Semen Analysis
89261	Sperm isolation; complex prep (e.g., 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

CPT CODE	DESCRIPTOR

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:

CPT CODE	DESCRIPTOR
88304	Level III-Surgical pathology, gross and microscopic exam
88305	Level IV-Surgical pathology, gross and microscopic exam
88312	Special stains; Group I for microorganisms, each
88313	Special stains; Group II, all other, except immunocytochemistry and immunoperoxidase stains, each

Rheumatology Laboratory Test List

In addition to the office laboratory test list, rheumatologists may perform these laboratory tests in their office.

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

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

Member Rights and Responsibilities

PHP Commercial Membership Rights

Enrollment with Physicians Health Plan (PHP) entitles members to the right to:

1. Receive information about your rights and responsibilities as a member in terms you can understand
2. Have access to culturally and linguistically appropriate language interpretation services free of charge
3. Always be treated with respect and recognition of your dignity and right to privacy
4. Expect privacy of your personal health information (PHI)
5. Choose and change a primary care physician (PCP) from a list of network physicians or practitioners
6. Information on all treatment options that you may have in terms you can understand so that you can give informed consent before treatment begins
7. Refuse treatment to the extent permitted by law and be informed of the consequences of your refusal
8. Openly discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage
9. Participate with providers in making decisions involving your healthcare
10. Voice concerns or complaints about your healthcare by contacting PHP Customer Service or submitting a formal, written grievance through PHP's appeals process.
11. Be given information about PHP, its services, and the healthcare providers in its network, including their qualifications
12. Make suggestions regarding PHP's member rights and responsibilities policies
13. Receive covered benefits consistent with your plan summary and state and federal regulations

…and Responsibilities

PHP members have the responsibility to:

1. Select or be assigned a primary care physician from PHP's list of network healthcare providers if required by your plan and notify PHP when you have made a change
2. Be aware that all hospitalizations must be approved in advance by PHP, except in emergencies or for urgently needed health services
3. Use emergency department services only for treatment of a serious or life-threatening medical condition
4. Always present your PHP ID card to healthcare providers each time you receive health services, never let another person use it, report its loss or theft to PHP, and destroy any old cards
5. Be considerate and courteous to PHP associates, your providers, their staff, and other patients
6. Notify PHP of any changes in address, eligible family members, marital status, or if you acquire other health care coverage
7. Provide complete and accurate information (to the extent possible) that PHP and healthcare providers need to provide care
8. Understand your health problems and develop treatment goals you agree on with your healthcare provider
9. Follow the plans and instructions for care that you agree on with your healthcare provider
10. Understand what services have cost shares to you and to pay them directly to the health care provider who gives you care
11. Read your PHP member materials and become familiar with your provider network
12. Follow your health plan benefits and PHP policies and procedures.
13. Report suspected healthcare fraud or wrongdoing to PHP, by contacting PHP Customer Service.

External Regulations & Standards

National Committee for Quality Assurance (NCQA)

Physicians Health Plan (PHP) is NCQA Accredited for its HMO/POS and Marketplace product lines. NCQA is a private, nonprofit organization dedicated to improving health care quality. PHP was rated 4 out of 5 stars in NCQA's commercial Health Plan Ratings 2023. During the accreditation process, PHP was measured against rigorous standards in the areas of:

- Quality Management and Improvement
- Population Health Management
- Network Management
- Credentialing and Recredentialing
- Utilization Management
- Member Rights and Responsibilities
- Member Connections

For more information visit NCQA website @ [www.NCQA.org.](http://www.NCQA.org)

Physicians Health Plan (PHP) is NCQA Accredited for its
Commercial HMO/POS and Health Insurance Marketplace Products.

Michigan Regulatory Agencies

The Department of Insurance and Financial Services (DIFS) ensures that PHP follows state laws that regulate all Michigan HMOs such as prompt claims payment and appeal processes.

Measuring Health Plan Quality and Effectiveness

HEDIS

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

- Childhood Immunization
- Adolescent Immunization
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Controlling High Blood Pressure
- Persistence of Beta Blocker Treatment After a Heart Attack
- Comprehensive Diabetes Care
- Follow-up after Hospitalization for Mental Health Illness
- Antidepressant Medication Management
- Adult Access to Preventative/ Ambulatory Health Services
- Prenatal and Postpartum Care
- Antibiotic Utilization
- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well-Care Visits

PHP obtains data for HEDIS in two ways, administrative services, and medical record review. Administrative services are based on claims submitted to PHP, and medical record review is based on medical record abstraction. Although most data ~~are~~ is collected through administrative services, there will be times when medical record review is necessary to obtain more accurate data. If this occurs, PHP will contact your office with a request for member medical records selected for the review. Your assistance in this process is appreciated.

Wellness and Prevention Mailings

PHP may send wellness and preventive screening reminders to members reminding them of needed well visits or wellness screenings or tests. These mailings may differ based on the type of product plan. Reminder mailings are sent when PHP does not have a record of a recommended preventative service. Mailings may include:

Breast Cancer Screening Reminder

Breast Cancer screening for women ages 50-74

Cervical cancer screening for women ages 21-64

Colorectal Screening

Colorectal cancer screening for members ages 45 and over

Well-Care Visits

Well-care visits for members ages 3-21 years of age

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

PHP is required to survey our membership annually. We send the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to eligible members beginning in February and ending in May every year. The CAHPS survey measures members' perceptions of their health plan and health care. It includes questions relating to the following areas:

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

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

How to Contact Us

How to Contact Us

P.O. Box 30377 Lansing, MI 48909-7877 517.364.8400 PHPMichigan.com

Department	Contact Purpose	Contact Number	Email Address
Customer Service	» Verify a covered person's eligibility, benefits or to check claim status to report suspected member fraud » Obtain claims mailing address » Claims and EDI questions » Request a copy of our Preferred Drug List	517.364.8500 800.832.9186 (toll-free) 517.364.8411 (fax)	
Medical Resource Management	» Notification of procedures and services outlined in the Notification/Authorization Table » Request benefit determinations and clinical information » Obtain clinical decision-making criteria » Behavioral Health and/or Substance Abuse Services, for information on Behavorial Health and/or Substance Abuse Services including Prior Authorizations, Case Management, Discharge Planning and referral assistance	517.364.8560 800.203.0618 (toll-free) 517.364.8409 (fax)	
Network Services	» Credentialing » Provider Data - report changes in practice demographic information » Provider/Practitioner education » MyPHP Provider Portal	517.364.8312 800.562.6197 (toll-free) 517.364.8412 (fax)	**Credentialing** PHP.Credentialing@phpmm.org **Data** PHPProviderUpdates@phpmm.org **Provider Relations Team** PHPProviderRelations@phpmm.org
Compliance	» Report suspected Provider/Practitioner Fraud and Abuse	866.PHPCOMP (866.747.2667)	
Quality Management	» Quality Improvement Programs » HEDIS » NCQA » CAHPS » Marketplace Quality Rating System (QRS)	517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org
Pharmacy Services	» Request drug coverage » Fax medication prior authorization forms » Medication Therapy Management Program	517.364.8545 877.205.2300 (toll-free) 517.364.8413 (fax)	**Pharmacy** Pharmacy@phpmm.org

Change Healthcare	» When medical records are requested	**Mail To:** Change Healthcare Attn: Pre-Pay 1849 West Drake Drive STE 101A Tempe, AZ 85283 952.224.8650 949.234.7603 (fax)	
Physicans Health Plan (PHP) Commercial Plans	» Send Claims	Physicians Health Plan **In-Network:** PO Box 313 Glen Burnie, MD 21060-0313 **Non-Network:** PO Box 247 Alpharetta, GA 30009-0247 Electronic Claims **In Network:** Payer ID: 37330 **Non-Network:** Payer ID: 07689	
	» Send Refunds	Physicians Health Plan Attn: Provider Refund PO Box 30377 Lansing, MI 48909-7877	
	» Approved Clearinghouses	Change Healthcare Trizetto Provider Solutions (TTPS) Zelis – Out of network Provider Only	
PHP Medicare Plans	» Send Claims	Physicians Health Plan PO Box 7119 Troy, MI 48007 PHP MA Payer ID: 83276	
	» Send Refunds	Physicians Health Plan PO Box 7119 Troy, MI 48007	
	» Approved Clearinghouses	Change Healthcare	

Forms The links below will take you to the Forms landing page at **PHPMichigan.com**:

Claims Adjustment Request Form

Claim Inquiry Form

Provider Information Update Form

New Provider Request Form

Out-of-Network Authorization Request Form