



# Physicians Health Plan

## PROVIDER MANUAL

---

## INTRODUCTION

Physicians Health Plan (PHP) welcomes you as a Network physician/practitioner or health care provider (Network Provider).

PHP began in 1980, when Sparrow Health System and a group of visionary physicians began mid-Michigan's first broad-based Independent Practice Association (IPA) model Health Maintenance Organization (HMO). An IPA is made up of a network of local physicians, hospitals and other professionals who deliver a full continuum of care. PHP's first products were introduced to the market in 1982. PHP's Network of Providers, known as the Physicians Health Network (PHN), provides healthcare services to members in various PHP products. The Network Program Description is applicable to the following HMO products:

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

Service Area	
PHP Commercial	
<ul style="list-style-type: none"><li>• Clinton County</li><li>• Eaton County</li><li>• Gratiot County</li><li>• Hillsdale County</li><li>• Ingham County</li><li>• Ionia County</li><li>• Isabella County</li><li>• Jackson County</li><li>• Lenawee County (partial)</li><li>• Montcalm County</li><li>• Saginaw County (partial)</li><li>• Shiawassee County</li><li>• Washtenaw County (partial)</li></ul>	

### **Our Mission**

To improve the health status of our members by facilitating access to quality, compassionate, accessible, and cost-effective health services through organized health delivery systems.

### **Our Vision**

To be the premier health financing organization, known for its ability to improve the health status of its members and for its service, quality, innovative and cost-effective financing solutions for employers, individuals, purchasers and governmental agencies.

### **Our Values**

To improve the health status of our members by providing quality, compassionate, accessible, cost-effective health services through an organized health delivery and financing system.

### **Why We Serve**

To improve the health status of our members by providing quality, compassionate, accessible, cost-effective health services through an organized health delivery and financing system.

Our Network Providers play a key role as we pursue our commitment to 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 and quality improvement programs, billing and claim procedures, ID cards, and eligibility verification. To the extent that any provision in your participation agreement differs from the requirement(s) described in this manual, the provisions of your participation agreement shall take precedence. The procedures and descriptions of health benefit plans outlined in this manual are intended to cover most contracting situations you and your office staff will encounter.

The manual should not be used for determining coverage in any particular case. Coverage may be determined by contacting the Customer Service Department at the number listed on the [“How to Contact Us”](#) page. While we have tried to make this manual complete, it is not intended to include every administrative policy or procedure.

This manual is reviewed periodically and may be changed by PHP in its sole discretion. This manual replaces manuals previously issued to your office or organization by PHP.

**Please note:** If you are a Network Provider who participates with certain PHP products through an IPA, hospital, medical group, PHO, or other organization which has contracted with Physicians Health Network (PHN), please look to that contracting organization for policies and procedures specific to those products that may take precedence over those outlined in this manual.

## Product Overview- Plan Definitions

This section contains information about current PHP products. This manual is general in nature; therefore, there may be sections that do not apply. If you have any questions about PHP products, please call Network Services at the telephone number indicated on the [“How to Contact Us”](#) page.

### Commercial Products

#### HMO

The HMO product provides coverage for a comprehensive list of 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 physician/practitioner that will coordinate the member's care. Members are required to seek services with a Network provider.

#### PHP Plus – Select Plus

The Plus product provides coverage for a comprehensive list of health care services, including preventive health services, such as health maintenance exams, immunizations and well-child check-ups when seeking services from Network Providers. It also gives members the opportunity to seek services outside the Network. The PHP Plus product has a deductible that applies for services provided outside the PHP network of providers.

#### High Deductible Health Plan (HDHP)

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

#### Self Funded

The PHP Self Funded product offers groups the same benefits available under all the PHP products. It allows the employer to choose the coverage and assume the financial risk for providing benefits to its employees. Rather than obtaining medical coverage from PHP, an employer elects to fund the risk directly. PHP acts as a third party administrator for the Self Funded product. This product is administered through the PHP Service Company.

#### PPO

PHP Insurance Company, administrated by PHP, offers various products, such as PHP Essentials and PHP Basics. The PPO product is a point of service product allowing members to utilize both Network and non-network providers while still receiving the benefits of great coverage for health services

## Marketplace Products

### Exclusive Network Plans - Sparrow PHP Silver Select Exclusive and Sparrow PHP Gold Select Exclusive

Our Exclusive Network Plans work with a broad HMO (Health Maintenance Organization). Members can receive health care from any provider within the exclusive network, once they have chosen a primary care physician (PCP). This coverage is only offered if the member resides in the counties of Clinton, Eaton, or Ingham County.

### Traditional Network Plans –

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

**Sparrow PHP Platinum Select**

**Sparrow PHP Gold Premier**

**Sparrow PHP Silver Premier**

**Sparrow PHP Silver**

**Sparrow PHP Bronze Premier**

**Sparrow PHP Bronze**

**Sparrow PHP Healthy**

## Department Services

### Customer Service

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

- Verify a covered person's eligibility
- Confirm a member's PCP assignment
- Confirm member benefits
- Verify provider participation status
- Check the status of a claim
- Update member Coordination of Benefits
- Arrange member transportation for Sparrow PHP members only

### Medical Resource Management

The Medical Resource Management (MRM) Department consists of three main components Utilization Management, Case Management and Disease Management. The goal of our MRM Department is to provide

our members with a focused and specialized support system which is designed to help facilitate and coordinate requested health care services.

Common reasons to contact our MRM Department:

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

## **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 evidenced based best practices and quality outcomes that contribute to the optimal health, function, safety and satisfaction of our members. Within the Case Management Program, PHP provides both Complex and General Case Management, with focused strategies related to Transitions of Care, Children with Special Health Care Needs(CSHCS), Transplants, Behavioral Health and potential misuse of health benefits e.g., Beneficiary Monitoring Program(BMP). With the exception of the BMP, members have the right to decline participation (opt-out) with any case management services. The Case Management program allows members to have one single point of contact with a case manager who can help facilitate and coordinate care while addressing multiple conditions and needs.

## **Complex Case Management (CCM)**

The CCM program includes coordination of services for identified high-risk members whose condition(s) or needs are described as persistent, substantially disabling or life threatening, and who require treatment and interventions across a variety of domains of care, such as medical, social, and/or behavioral health. The conditions often require treatment from multiple providers of care and sites of service

Referrals for CCM are identified by the following criteria:

- Use of software to combine medical, behavior health, and pharmacy claims creating current and prospective risk scores
- Data supplied by PCP, practitioners, PHP utilization nurse or case managers, hospital case managers/discharge planners, data from members or member's caregivers who are identified and approved for CCM program based on:
  - Greater than four chronic co-morbidities
  - New diagnosis or disability e.g., head injury, spinal cord trauma, Type 1 diabetes
  - Severe, persistent disability and/or special needs, e.g., congenital anomalies, cerebral palsy, etc.

If a member does not meet criteria for CCM program and unmet needs exist, the member is provided case management through the General Case Management (GCM) program and/or Disease Management program (DM).

## General Case Management (GCM)

General Case Management addresses unmet health care needs of members that do not meet the criteria for Complex Case Management. The GCM program provides members with a team to contact within the health plan who can help facilitate and coordinate care while addressing multiple conditions and needs.

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

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

## Disease Management (DM)

Disease Management is focused on improving quality of life for individuals with chronic conditions by preventing or minimizing the effects of diseases through integrated care. PHP disease management programs are designed to improve the health of persons with chronic conditions and reduce associated costs from avoidable complications by identifying and treating chronic conditions more quickly and more effectively.

## Utilization Management Program

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

Contact Utilization Management Department for the following:

- To provide notification for certain procedure and services
- To request prior authorization for services that are located on the Notification Table
- To obtain clinical decision-making criteria
- To ask questions about the UM process for notification or approval of care
- To schedule a Peer to Peer conversation with the Medical Director after a non approval of medical necessity benefit determination
- To discuss with nurse reviewer or other appropriate clinician when a requested service is not approved

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

## Access to Medical Resource Management Staff

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

- Availability of staff for calls during normal business hours (Monday through Friday 8:00 a.m.–5:00 p.m.) unless otherwise agreed upon at: 517.364.8560 or toll free: 866.203.0618
- 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 Customer Service at 800.832.9186 or 517.364.8500 and/or Sparrow PHP Customer Service at 800.661.8299 or 517.364.8540

## Decision Making Criteria

PHP applies objective and evidence-based criteria, taking individual circumstances and the local health delivery system into account when determining the medical appropriateness of health care services. PHP's decision making is based only on appropriateness of care and service and existence of coverage. PHP does not specifically reward practitioners or other individuals for issuing denials of coverage or service. Financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization.

PHP:

- Has written utilization management decision-making criteria that is objective and based on medical evidence
- Involves appropriate physicians/practitioners in developing, adopting and reviewing criteria
- Annually reviews and updates utilization management criteria and the procedures for applying them.

Criteria used making decisions is available through the Utilization Management Department, for physicians/practitioners and health care providers upon request. Treating physicians can discuss medically necessary adverse determinations with the Medical Director in a Peer to Peer Review. If a requested service is not approved, physicians/practitioners and health care providers have the opportunity to discuss the case with the nurse reviewer or other appropriate clinician/s.

## Network Services

The Network Services Department is available to assist providers with network related issues including contracting, credentialing, provider review and provider relations services, such as:

- Status of credentialing application or process
- Reporting changes in your practice, such as office hours, office address or phone number, hospital staff privileges
- Notification of a change in your federal tax identification number
- Notification of a change in your payment address
- Notification of a name change
- To request provider education or in office orientations
- To learn about online verification services, such as member eligibility, claims status and more
- Research and resolution of complex payment/processing issues
- Clarification on contractual obligations
- Other network related issues



## Quality Management

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

## Quality Improvement Program

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

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

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

To request a copy of the QIP, information on PHP's quality goals and progress towards meeting those goals, please call the Customer Service Department at the number listed on the ["How to Contact Us"](#) page.

## Quality Improvement Suggestions

PHP supports continuous quality improvement and is continually looking for ways to improve services. PHP welcomes your ideas. Please submit your ideas to the Quality Management Department, Attention, and Quality Improvement Team at the address listed on the ["How to Contact Us"](#) page.

## Standard of Care Guidelines

Guidelines for clinical care are a fundamental component of managed health care quality improvement standards. PHP supports and follows the Michigan Quality Improvement Consortium (MQIC) guidelines which are based on national sources. PHP Standard of Care Guidelines is available at [www.phpmichigan.com](http://www.phpmichigan.com). If you would like to obtain a paper copy of the guidelines, please contact the Quality Management Department at the number located on the ["How to Contact Us"](#) page. A listing of all the PHP standard of care guidelines are listed in the Standard of Care Guidelines.

# Requirements and Rights of Participation

## Credentialing and Recredentialing

PHP's goal is to maintain and deliver to its members a quality network of physicians/practitioners and health care providers. Participation in the Network requires submission, review and acceptance of physician/practitioner and facility credentials as outlined in the PHP Credentialing and Recredentialing Plan (Credentialing Plan). A copy of the Credentialing Plan is located on PHP's website [www.phpmichigan.com](http://www.phpmichigan.com) or a copy may be requested by contacting Network Services at the number listed on the "[How to Contact Us](#)" page. PHP does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnical/national identity, gender, age, sexual orientation or the types of procedures or patients in which the physician/practitioner or facility specializes.

PHP will ask for credentialing information with your application for initial network participation. Network facilities and physicians/practitioners are re-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 or Michigan Association of Health Plans (MAHP) applications. The credentialing staff determines compliance with the administrative criteria of the Credentialing Plan when evaluating applications. It is important that physicians/ practitioners sign, date and return this information to the address indicated in the credentialing packet. The initial credentialing application is forwarded to the Committee for review and recommendation in accordance with the Credentialing Plan.

Applicants have the right to be informed of the status of their application, to correct erroneous information, and to review information submitted in support of their application. Requests may be made in writing or by calling PHP at the number listed on the "[How to Contact Us](#)" page. PHP will respond to a request within two (2) business days. PHP is not required to allow an applicant to review personal or professional references or other information that is peer review protected or is otherwise prohibited from disclosure by law.

At the time of recredentialing, PHP will verify that physicians/practitioners and facilities continue to satisfy the administrative and professional standards as described in the Credentialing Plan. The recredentialing application is forwarded to the Committee for review and recommendation in accordance with the Credentialing Plan.

In addition to the information on the recredentialing application, the Committee review may include, but is not limited to the following:

- Member complaints
- Results of quality reviews
- Compliance with PHP policies and protocols
- Member satisfaction surveys, where applicable
- Medical record reviews, where applicable
- Clinical efficacy, efficiency and appropriateness
- Medical outcomes
- Results of office and facility site visits, where applicable
- Appropriate limits for malpractice and general liability insurance

Participating physicians/practitioners in the recredentialing process will be considered to be recredentialed unless otherwise notified.

### **Physician/Practitioner Disciplinary Action, Restriction, Suspension, or Termination**

If PHP receives information that appears to warrant the restriction, suspension, or termination of a physician/practitioner for reasons relating to the physician/practitioner's professional competence or conduct, or a business or administrative related decision, it will compile pertinent information and refer the matter to the Committee. Alternatively, if the Committee directly receives information, which it believes, in its sole discretion, suggests that discipline or termination may be appropriate; the Committee may ask PHP staff to investigate the matter.

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

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

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

- (1) a failure to comply with the administrative requirements of the Credentialing Plan;
- (2) failure to adhere to the terms of the written participation agreement;
- (3) a change in the organizational structure following a merger or acquisition or change in the products offered by PHP; and
- (4) a change in PHP's need for a physician/practitioner/provider given a reduction in the size of membership.

### **Physician/Practitioner Credentialing Appeals**

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

- (1) states the specific criteria that the Committee considered in making its decision;
- (2) the proposed effective date of the disciplinary action or termination;
- (3) a summary of the basis for the Committee's decision; and
- (4) the physician/practitioner's option to request, in writing, a hearing on the action, the time limit within which to request such a hearing and a general description of the appeals process.

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

### **Physician/Practitioner Corrective Action**

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

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

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

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

## **Responsibilities of Health Care Professionals**

### **Network Provider Status Changes**

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

- The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntary or involuntary, of the Network Providers license by any state licensing agency;
- The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntary or involuntary, of Network Provider medical staff membership or clinical privileges at any hospital or other health care institution;
- The cancellation, termination, restriction, probation, limitation, or other curtailment, whether voluntary or involuntary, of Network Provider status as a provider in any managed care organization, network, or preferred provider organization;
- The cancellation or restriction of Network Provider professional liability insurance coverage;

- The revocation, suspension, or voluntary relinquishment of any registration at the state, federal, or district level, which allows Network Provider to prescribe any medications;
- Any adverse determination by a peer review organization concerning Network Provider quality of care;
- The commencement of any formal investigation or the filing of any charges by the Department of Health and Human Services or any law enforcement agency or health care regulatory agency of the United States or any state;
- The filing of any lawsuit or the assertion of any claim against the Network Provider alleging professional liability;
- Any change in Network Provider Office of Inspector General sanction status or Government Services Administration (GSA) department status; or
- Any change in Network Provider ability to provide Covered Services to PHP Covered Persons.

### **Practitioner/Provider Changes**

Network Provider must notify PHP in writing and in advance of any demographic or status changes within the practice/facility. This includes:

- Telephone number
- Tax ID 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 “[Demographic/Practice Information Update Form](#)” may be used to notify us of demographic/practice information changes.

Failure to advise us of changes may result in delayed or incorrect claims processing.

### **Primary Physician/Practitioner Role**

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

- Internists
- Family Physicians
- General Physicians
- Pediatricians
- Some Obstetrics/Gynecology Physicians
- Some Nurse Practitioners
- Other Physician Specialist as appropriate

## Primary Physician/Practitioner Coverage

The primary care physician/practitioner ensures continuity and coordination of care for members and is required to provide 24-hour practice coverage, seven days a week. When the primary physician/practitioner is unavailable to provide care for the member, he or she must arrange for another network primary physician to cover and provide appropriate care/services. **A hospital emergency room is not an acceptable substitute for a covering physician/practitioner.**

The covering physician/practitioner should be a Network PHP physician/practitioner, and where applicable, part of the primary physician's/ practitioner's medical or specialty group. The covering physician/practitioner must comply with PHP protocols and accept PHP's payment schedules. When the covering physician/practitioner is not in the PHP Network, he or she must agree to adhere to PHP administrative procedures as set forth in the provider participation agreement and this manual.

To locate a PHP physician/practitioner to act as a covering physician, review the provider directory, the online provider listing at [www.phpmichigan.com](http://www.phpmichigan.com) or contact Network Services to determine the participation status of any physician. Refer to the "[How to Contact Us](#)" page for the Network Services telephone number.

## Services Primary Physicians/Practitioners are expected to Perform or Provide

Primary physicians/practitioners are expected to perform, at a minimum, all of the following functions applicable to their areas of expertise:

Conduct office visits during regular office hours for the evaluation and management of common areas of medicine. Member education may be delegated to appropriately trained staff under the primary physician's/practitioner supervision.

- When initiating care, the primary physician/practitioner must remain accountable for his or her patient's care in an acute care facility/hospital, nursing home, and at home.
- Properly coordinate referrals to specialists.
- Provide preventive care and physical examinations, as appropriate, including breast exams and routine gynecological care with pap smear and pelvic exam.
- Provide 24-hour, seven days per week telephone access and on-call coverage including on-call arrangements with Network physicians/practitioners as needed.
- Supervise physician assistants and advanced nurse practitioners in accordance with State licensing and regulatory requirements.
- Follow up and coordinate care with specialists, ensuring that the consultation notes are filed in the member's chart, proper actions are taken, and follow-up care is provided.
- Work collaboratively with PHP Care Coordinators and Medical Directors.
- Conduct laboratory services in a Clinical Laboratory Information Act (CLIA) certified office laboratory. Laboratory work not performed in the office must be sent to a Network laboratory.

**24 Hour Access-** Network primary care physicians/practitioners (PCP) must have appropriate methods for directing a member to seek medical care when the primary physician/practitioner is not available. The primary care physician/practitioner must arrange for the assistance to members in emergency situations 24 hours per day, 7 days per week. When the office is closed, the primary care physician/practitioner has either a well-informed answering service or a detailed answering machine message that provides instruction for access to after-hour coverage and emergency care. PCPs will need to include instruction for access to



emergency care and how to contact the primary care physician/practitioner, or another Network provider/practitioner whom the primary care physician has designated to treat PHP members.

**Eligibility-** It is the responsibility of the Network Provider to verify eligibility at the time of service. We encourage the use of electronic eligibility verification. You may check member eligibility by accessing our online tool, HealthWeb® via the PHP website, using electronic transactions 270/271 through your clearinghouse or clearinghouse portal or by contacting Customer Service at the number listed on the "[How to Contact Us](#)" page.

For questions on how to initiate electronic eligibility, contact the number listed on the "How "page. Electronic eligibility verification is easy and will provide your office with information about eligibility. For telephone eligibility inquiries, call the telephone number listed on the ID card. Examples of ID Cards are located on page 42. Refer to section, "Eligibility/Enrollment of Members" for additional information related to member eligibility and verification procedures.

### **Provider/Practitioner and Healthcare Provider Expectations**

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

- When initiating care, the physician/practitioner must remain accountable for the patient's care in an acute care facility/hospital, nursing home, and at home.
- Properly coordinate referrals to other physicians/practitioners and health care providers. [Refer to the Referral/Notification and Prior Authorization](#) table for more information.
- Provide 24-hour, seven days per week telephone access and on-call coverage including on-call arrangements with Network physicians as needed.
- Supervise physician assistants and advanced nurse practitioners in accordance with state licensing and regulatory requirements.
- Follow up and coordinate care with physicians and practitioners, ensuring that the consultation notes are filed in the member's chart, proper actions are taken, and follow-up care is provided.
- Work collaboratively with PHP Care Coordinators and Medical Directors.
- Conduct laboratory services in a Clinical Laboratory Information Act (CLIA) certified office laboratory. Laboratory work not performed in the office must be sent to a Network laboratory.

### **Specialty Care Physicians/Practitioners (SCPs)**

The PCP must coordinate a member's medical care, however, PHP members may self-refer when seeking treatment from a Network specialist practitioner. The SCP may then refer directly to another Network Provider without obtaining a referral from the PCP. The SCP should keep the PCP informed of their member's treatment. There are also specific care/services that require prior notification and compliance with specific timeframes. Refer to the [Referral/Notification and Prior Authorization table](#).

For continuity and coordination of care, it is recommended that the consulting SCP provide the PCP with a written consultation report within seven days, including:

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

All communication between the PCP and the SCP should be expedited for urgent/emergent situations when indicated.

### **Ancillary Providers**

Ancillary providers include; but are not limited to, urgent care, home care, and skilled nursing facilities. Ancillary providers must send the PCP a written consultation report within seven days of the member evaluation, including:

- Diagnosis
- Consultation findings
- Treatment plan
- Responses to specific questions
- In addition, the ancillary provider must update the PCP at least monthly until the ancillary service is discontinued.

### **Acute and Urgent Care Providers**

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

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

### **Medical Records**

Network Providers should maintain a single, permanent medical record for each member and protect records against loss, destruction, tampering or unauthorized use. Medical records should be available at the time of each patient visit. Medical records should be maintained in accordance with State and Federal regulations. PHP has the right to request medical records and to receive those records in a timely manner. PHP requires records be received within fourteen (14) days from the date of the request or as otherwise specified in the participation agreement.

### **Confidentiality of Records**

All members' medical records must be maintained in a secure, locked area that is not accessible to the general public. The office should have a written policy and an established process to maintain record confidentiality at all times.

Additional security measures should be established to protect medical records consistent with the Administration Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or any similar Federal or State statutes and regulations.



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

### **Standards for Medical Record Documentation**

PHP requires that Network Providers maintain medical records in compliance with generally accepted CMS 95 and 97 Documentation Guidelines and should include, but are not limited to, the following established medical record keeping standards:

#### ***Member demographic information***

- Member name and/or identification number on every page
- Gender
- Age or date of birth
- Address
- Marital status
- Occupational history
- Home and work phone numbers
- Name and telephone number of emergency contact

#### ***General documentation guidelines***

- All entries are dated and signed by the creator/provider/author within three business days
- Entries are legible
- Problem list documents significant illnesses and medical conditions with dates of onset and resolution for patients seen three or more times
- Medication allergies and adverse reactions are prominently noted. If no known allergies or adverse reactions, this is noted
- Past medical history is easily identified and includes serious illnesses, injuries and operations, this expectation is for Members seen three or more times (for anyone 18 years or younger, past history relates to prenatal care, birth, operations and childhood illnesses)
- Medication record includes name of medication, dosage, amount dispensed and dispensing instructions
- Immunization record is present
- Documentation of family or social histories is present
- Tobacco habits, alcohol use and substance abuse (prescribed or over the counter) are documented
- For PCP's with adult patients, copy of advance directive for member is included or documentation that the member does not want advance directives
- History and comprehensive physical examination (including subjective and objective findings) for members with two or more visits
- Unresolved problems from previous visit(s) addressed in subsequent visits
- Diagnosis and treatment plans consistent with findings
- Presence of growth charts, developmental assessment and measurement of head circumference for all pediatric patients
- Lab and other studies ordered as appropriate
- Patient education and counseling
- Documentation of coordinator of care with other providers to establish coordination of care

- Consultation, lab, imaging and special studies are initialed by the PCP to indicate review. Consultation and abnormal studies include reason for referral, follow-up plans and documentation of communication from consultant
- Documentation regarding the follow-up visit and plan of care, patient's progress, response to and changes in treatment and revision of diagnosis.
- Records include documentation of in-patient and outpatient hospitalizations, services provided by emergency rooms, skilled nursing facilities, surgical-centers or home health facilities.
- History of Present Illness (HPI) must be documented by the provider of record not ancillary staff and/or the patient
- The CPT and ICD-9/ICD-10 codes reported on the approved billing claim form should be supported by the documentation in the record.
- The date of service, either start or stop time or total time in session(for time based services), the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS), Revenue (REV) code billed, notation of the sessions attendees, the rendering clinician's name, professional degree, license, and relevant identification number as applicable.
- For time based services only, either a start and stop time or a total time in session must be clearly documented.
- Clear and uniform amendments to records: any error is to be lined through so the original content is still readable, then dated and initialed by the person making the change. Electronic Health Records (EHR) must provide a reliable means to clearly identify the original content, the modified content, the date and signature of each modification of the record.
- A medical History and complete psychiatric history including previous treatment dates, clinician or facility identification, therapeutic, interventions and responses, sources of clinical data, and relevant family information must be documented.
- For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic)
- Continue to list medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition.
- Documentation must support member (and when indicated family) involved in treatment planning
- Treatment goals must be specific, measurable, and realistic. Must include a time frame for goal attainment. Progress or lack of progress towards treatment goals, rational for estimated length of treatment episode, updates to the treatment plan whenever goals are achieved or new problems are identified. If a member is not progressing towards specific goals, the treatment plan should be re-evaluated to address the lack of progress and modify goals and interventions as needed.
- A discharge summary is completed at the end of the treatment episodes that includes the following elements:
  - Reason for treatment episode
  - Summary of the treatment goals that were achieved or reasons that goals were not achieved
  - Specific follow up activities/aftercare plan

The medical record must be complete. It must contain sufficient information to identify the patient, indicate the chief complaint, document any relevant history and pertinent health risks, physical examination findings, support the diagnosis, justify the treatment and document the treatment plan.

## Appointment Access and Office Wait Time

PHP expects that physicians/practitioners will see a member within the necessary time to ensure appropriate care and outcomes given the clinical situation at hand. PHP access standards are as follows:

<b><i>Purpose for visit</i></b>	<b><i>Member should be seen</i></b>
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.

## 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 a non-network physician, PHP may grant the transition of the member's care to facilitate a smooth transition for the member to a Network physician. Transition of care coverage may allow a limited interval of continued care with the non-network physician or practitioners at a Network level of benefits when it is determined that an immediate transfer of care from one physician or practitioner to another could result in medical harm to the member. Physicians or practitioners should not encourage members to request transition of care coverage for reasons of convenience or only to continue an established physician relationship. For any questions on how to initiate the transition of care process, please contact Customer Services at the number listed on the member's ID card or the number listed on the [“How to Contact Us”](#) page.

## Reporting Communicable Disease

Michigan health care providers are required to report patients with specific conditions to the patients' local health department. Lab confirmed and clinical diagnoses are reportable in the time intervals as indicated on the Reporting Communicable Disease section located within the Provider Manual.

## Eligibility/Enrollment of Members

All members are assigned a member ID card. Member ID numbers are randomly assigned. PHP cards will contain the PHP, PHP Insurance Company, PHP Service Company and Sparrow PHP logos. PHP Service Company cards will typically contain the logo of the employer group or covered entity. Samples of member ID cards are located within the Provider Manual for your reference.

Members should present their ID cards at every visit. In the event a member is unable to provide their ID card at the time of services, you may verify eligibility by accessing our online tool, HealthWeb® via the PHP website, using electronic transactions 270/271 through your clearinghouse or clearinghouse portal or by contacting Customer Service at the number listed on the "[How to Contact Us](#)" page.

We recommend making a copy of the member's ID card at each visit to be sure you have the most current information available.

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

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

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

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

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

## Lock-In-Program

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

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

Any services not provided by the designated physician/practitioner must have been referred by the primary physician/practitioner or must be a valid emergency to be reimbursed. Any prescriptions not prescribed by the member’s primary physician/practitioner and provided by the designated pharmacy must have been provided as a result of a documented emergency. A member wishing to change his or her designated primary physician must first obtain the authorization of PHP’s case management coordinator.

## Referral, Notification/Prior Authorization

When a referral is needed, it is important to confirm that the referral is to a PHP Network Provider. If the Network status of a physician or practitioner is unknown, contact the PHP Customer Service Department at the number listed on the "[How to Contact Us](#)" page or visit the PHP online provider directory at our website [www.phpmichigan.com](http://www.phpmichigan.com).

### Referrals

PHP does not require a referral from the PCP if the member is seeking services from a Network Provider. It is important to note that even though a referral may not be required, occasionally specialists will ask the PCP for a referral before setting up an appointment. If Network specialists require a referral from the treating Network physician/practitioner, PHP will provide support for the referral and education to the member regarding the appropriate referral process.

Although referrals for Network specialists are not required, certain procedures may require notification. PHP will assign an authorization/reference number for services that require prior notification. Refer to the [Notification/Authorization Table](#) to determine what services require prior notification/authorization.

The notification/authorization process begins with communication initiated by the physician/practitioner treating or scheduling specific procedures and/or services. Notifications allow PHP to facilitate access to needed care and support a positive outcome for members. PHP depends on physicians/practitioners and facilities for notification of the services listed on the notification table. Please refer to the [Notification/ Authorization Table](#) to

determine what services require prior notification/authorization. The presence or absence of a procedure, service or item on the notification table does not mean the procedure, service or item is eligible for coverage. The member's benefit plan will determine covered procedures, services, or items.

**Notification/Authorizations requirements for PHP products may be different. Please refer to the appropriate product on the [Notification/Authorization Table](#) for the notification requirements specific to the members benefit product.**

Network Providers are expected to work collaboratively with PHP. PHP requires Network Providers to be responsive to phone calls and requests for clinical information. This includes, but is not limited to; responding to telephone calls from PHP staff and providing information as requested in a timely manner (see the [Notification/Authorization Table](#)).

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

- Non-notification – when a request for a service that requires notification is not received by PHP.
- Late notification – when notification of a service that requires notification is received late (beyond the time frame outlined in the [Notification/Authorization Table](#)).

## General Guidelines

### Admission Services

Members should generally be admitted on the day of surgery, unless the member's medical condition requires otherwise. Laboratory work and routine pre-surgical procedures should be completed, whenever feasible, prior to admission or on the day of surgery. Refer to the [Notification/Prior Authorization Table](#) for more information.

### Emergency Admission

Admission of a member to a hospital on an emergency basis should be reported by the hospital, the admitting physician, or the personal physician to the Medical Resource Management Department on the same or next business day.

### Emergency Care

Members are instructed to contact their PCP office or after-hours emergency number prior to seeking medical services except for emergency care. If the PCP determines that the member should be examined by a physician/practitioner, he or she should use professional discretion in directing the member to the physician/practitioner's office, a Network urgent care facility, or as medically necessary, to the nearest emergency facility. If, under the circumstances, a member cannot contact their PCP before seeking medical attention for an emergency, the member should go to the nearest emergency facility.

The definition of an emergency medical condition is: a serious medical condition or symptom resulting from injury, sickness or mental illness that arises suddenly and, in the judgment of a reasonably prudent person would without immediate medical attention, result in serious jeopardy to the individual's health or to a pregnancy in the

case of a pregnant woman, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. This includes relief of acute pain to avoid extended or permanent physical impairment or loss of life.

### **Request for Services with Non-Network Physicians/Practitioners/Providers**

Referrals to physicians, practitioners or other health care providers that are not in the PHP network will require prior notification and review. A request for a non-network provider can be submitted to the Medical Resource Management Department with the pertinent clinical information. The request will be evaluated clinically and a determination will be communicated. (Applicable to HMO, PPO, Sparrow PHP, Self-Funded and HDHP products) Please refer to the [Out of Network Request Form](#).

### **Out-of-Area Transfers**

Network providers are required to assist PHP in facilitating the transfer of members from non-network physicians and health care providers to Network physicians, hospitals and other health care providers if the transfer is determined medically acceptable by all involved health care providers.

## **Process for Benefit or Claim Denials**

### **Physician/Practitioner/Provider Appeal Process related to benefit or claim denial**

A provider appeal is a written request, by a physician/practitioner/provider to change a decision made by PHP about a specific member. The decision may be about a member's medical or pharmacy benefit or a specific request to change a complete or partial claim denial. These types of decisions are referred to as Adverse Determinations. Appeals must be submitted no later than 90 days from the date of the initial claim denial or adverse benefit determination.

There are several types of Adverse Determinations that may be appealed. Adverse Determinations may be the result of:

- A member's Certificate of Coverage benefit language, exclusions, or benefit limitations
- Lack of or incomplete clinical information to support the request at the time the determination was made.
- Lack of medical necessity based on current medical or pharmacy policy
- A claims processing denial

An explanation of the provider appeal process is included in the letter to the member when services are not approved. Members have the right to discuss the decision with a reviewer by calling the Medical Resource Management Department at the number listed on the ["How to Contact Us"](#) page.

Treating physicians can discuss medically necessary adverse determinations with the Medical Director by calling the Medical Resource Management Department to schedule a telephone conference at the number listed on the ["How to Contact Us"](#) page. Discussion with a reviewer or the Medical Director does not constitute an appeal.

If a physician/practitioner or provider disagrees with the decision, they may request an appeal of the Adverse Determination by submitting the request in writing. It is important to include additional information that would support the reason for the appeal. PHP will respond to the provider appeal in writing within 30 calendar days of receipt of the written appeal.

For services that are urgent, life threatening, or if the member is in the middle of treatment, an urgent or expedited appeal may be initiated by the member or provider. Please call our Customer Service Department to request an urgent or expedited appeal. PHP will respond to the urgent or expedited appeal within 3 calendar days.

If both a member and provider initiate an appeal at the same time for the same benefit or issue, PHP will combine information from the provider appeal with the member appeal process. We will send you a letter notifying you that the member has initiated an appeal. In this situation, the outcome of the member appeal would be the outcome of the provider appeal. We will send you a letter with the result of the member appeal.

If you have a question about an Adverse Determination, please call Customer Service for assistance at the number listed on the [“How to Contact Us”](#) page.

If you would like to submit a provider appeal, submit your request in writing and include any pertinent documentation to support your appeal. You may submit a letter or use the Provider Appeal Form located on our website. You may mail or fax the appeal to:

Physicians Health Plan

ATTN: Customer Service, Provider Appeals

PO Box 30377 Lansing, MI 48909

(P): 517.364.8500 or 800.832.9186

(F): 517.364.8411

To provide a better understanding of the member rights under the member appeal process related to benefit or claim denial, the following explains those rights as made available to members at time of or during their enrollment.

- I. The member has a right to:
  - (a) A State Fair Hearing and information for how to obtain a hearing, and representation rules at a hearing.
  - (b) How to file a grievance and appeal and their requirements and timeframes for filing.
  - (c) Availability of assistance in filing
  - (d) Toll-free numbers to file oral grievances and appeals.
  - (e) Right to request continuation of benefits during an appeal or State Fair Hearing filing and, if the Plans action is upheld in a hearing, the member may be liable for the cost of any continued benefit.



# Pharmacy Management Program

## Overview

The management of outpatient prescription medications is an integral part of the Medical Resource Management program to improve the health and well-being of members. Physician/practitioner and member involvement is critical to the success of the pharmacy program. Please follow these guidelines when prescribing medication to a member. Additional information about the management of outpatient prescription medications can be found in the [Preferred Drug List](#). Questions regarding Pharmacy should be directed to our Pharmacy Department at the number listed on the [“How to Contact Us”](#) page.

## Guidelines

- When prescribing medication refer to the Prescription Drug List (PDL).
- Prescribe generic medication whenever therapeutic equivalent medications are available and appropriate.
- Inform the Member that an equivalent generic medication may be substituted for the brand-name medication.
- When phoning a prescription medication to a pharmacy, verify it is a Network pharmacy.
- Accept a call from the Network pharmacy notifying you of a possible problem with the prescribed medication. The pharmacy's on-line billing system alerts them to potential medication-medication, medication-age, or medication-gender incompatibility. This is an important service offered to Network physicians/practitioners and Members.
- The standard prescription drug benefit allows up to 31-consecutive-day supply of medication per prescription co-payment. Maximum quantity limits are supported on-line. Some select medications are subject to different quantity limits.
- Recommend mail service to member, if appropriate, for longer-term therapies once member has been stabilized on the medication. Mail service allows up to a 90-consecutive-day supply of medication per prescription co-payment. The prescription must be written for a 90 day supply.
- Certain services require prior notification/authorization. Please refer to the [Notification/ Authorization Table](#).

Copies of the PDL are distributed annually and updates are communicated when applicable. You can access the PDL from the PHP website at [www.phpmichigan.com](http://www.phpmichigan.com) or to obtain a paper copy of the PDL, contact Customer Service at the telephone number listed on the [“How to Contact Us”](#) page.

## Pharmacy Networks

- PHP offers a National Retail Pharmacy Network which is contracted to provide services to Members. The network contains approximately 60,000 retail pharmacies.
- A Mail Service vendor is also available for Members.
- To obtain a list of the Network pharmacies, contact Customer Services at the number listed on the [“How to Contact Us”](#) page.
- A Specialty Pharmacy is available for injectable medications.

## Behavioral Health Services

Behavioral Health Services are managed directly by PHP for all Behavioral Health Services. To request behavioral health services for your patient, or for specific policies and procedures related to the behavioral health management company, refer to the number or website listed on the "[How to Contact Us](#)" page.

Members may contact a behavioral health provider for behavioral health and substance abuse services directly with a referral from the behavioral health management company. Additionally, a physician/practitioner may directly refer to a Network Provider. The provider directory should be referenced for the listing of current, affiliated PHP behavioral health practitioners.

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

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

## Reimbursement for Health Care Services

### Reimbursement Methodologies

PHP follows reimbursement methods in accordance with the American Medical Association (AMA) CPT (Current Procedural Terminology) guidelines and Centers for Medicare/Medicaid Services ([CMS](#)). Network Providers are reimbursed in accordance with their signed participation agreement with the Health Plan. Sparrow PHP follows [MDCH](#) reimbursement methodology and payment rates regardless of participation status.

Billing information submitted is used for reimbursement related to health care services rendered, network reporting, identification of members for disease management, as well as for preventive care and incentive programs.

### Audits

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

### Mid-Level Providers

PHP follows Industry Standards for the reimbursement of Mid-Level Providers. Mid-Level Providers are reimbursed at 85 percent of the standard physician fee schedule. PHP recognizes the following healthcare professionals as Mid-Level Providers, Physician Extenders, or Non-Physician Practitioners (NPPs):

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

- Certified Nurse Specialists (CNS)
- Certified Nurse-Midwife (CNM)

### **Multiple Procedure Reductions**

If you are performing multiple procedures, bill your full normal charge for each individual procedure. Unless your participation agreement states otherwise, when multiple procedures are billed on the same date of service, reimbursement for the primary procedure reflects 100% of the contracted rate and reimbursement for the secondary and subsequent procedures procedure reflects 50%. Any amounts determined to be over the PHP allowable are not billable to the member.

### **Professional and Technical Component Payment**

PHP covers the professional and technical components of global CPT procedures based on professional and technical percentage splits. The appropriate -26 modifier (professional component) and/or -TC modifier (technical component) should be used as applicable for the service rendered.

### **Preventive Medicine Services**

Preventive medicine services should be reported using the appropriate preventive medicine CPT code with a preventive medicine diagnosis (ICD-9-CM) code. A preventive medicine CPT code and an Evaluation and Management (E/M) CPT code may both be submitted for the same member on the same date of service. Payment will only be allowed for either a preventive medicine CPT code *or* an E/M CPT code, unless documentation supports a significantly and separately identifiable procedure. Billing should reflect the appropriate modifier.

## **Submitting a Claim**

PHP accepts both paper and electronic claims. All claims need to be submitted in accordance with the guidelines as specified in your participation agreement or as outlined in this Manual.

### **Acceptable Claim Forms**

Claims may be submitted in one of the following formats:

- Electronic Claim Submission
- UB-04
- CMS1500

### **Electronic Claims**

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

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

## EDI Validation

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

Claims submitted with invalid data by the clearinghouse to PHP will be reviewed by a claims analyst for verification of data to be selected. It is important to submit valid member IDs as well as billing identification IDs, such as NPI and tax identification numbers and 9-digit zip codes. This will ensure appropriate member and provider selection processing.

## Completing the Claim Forms

When billing for services, providers should bill with normal charges, complete all fields and include the following information on the form:

- Patient name, address and date of birth
- Subscriber name and address (if different than patient)
- Patient's PHP policy/member number Other insurance information
- The name, signature, rendering address, billing address, including 9 digit zip code, and telephone number of the physician/practitioner/provider/facility performing the service
- All address information should be submitted using the exact information provided to PHP and in accordance with the United States Postal Service Address Standards.
- The tax ID and NPI number of the physician/practitioner/provider/facility performing the service
- Appropriate diagnostic codes, (ICD-9-CM)
- 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 job related injury or accident

## Provider Address on Claim

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

## Clean Claim

The following conditions must be met for a CMS1500 or UB04 form to be considered a clean claim. A clean claim must contain all of the following information:

1. It must identify the health professional or health facility that provided the service to verify, if necessary, affiliation status and includes any identifying numbers.
2. It must sufficiently identify the patient and health plan subscriber.
3. It must list the dates and places of service.
4. It must be a claim for a covered service for an eligible individual.
5. If necessary, it must substantiate the medical necessity and appropriateness of the service provided.
6. If prior authorization is required for certain patient services, it must contain information sufficient to establish that prior authorization was obtained.
7. It must identify the service rendered using a generally accepted system of procedure service coding.
8. It must include additional documentation based on services rendered as reasonably required by the health plan.

## Incomplete/Missing Claim Information

Claims missing required information cannot be processed. The Network Provider submitting claims without the required information will be notified that the claim cannot be processed. A member may not be billed for services for which a claim submission has been returned to the Network Provider for lack of information.

## Where to Send Claims

Refer to the "[Where to Send Claims](#)" page for the appropriate address information for claims submissions.

## Timely Claim Submissions

Claims need to be submitted within the timeframe specified in your participation agreement, within 365 days from the date that services are rendered or the date of discharge, or as required by law. When PHP is not the primary carrier, claims need to be submitted within 365 days from the date on the primary carriers' Explanation of Payment (EOP). If claims are not submitted within that timeframe, a financial penalty may be applied, including non-payment of the claim. The Network Provider is responsible for submitting the claim to the payer identified on the member's ID card. The member may not be balance billed unless it is indicated as a member responsibility on the Explanation of Payment or Explanation of Benefits.

## Claim Status

You may check the status of a claim by accessing our online tool, HealthWeb® via the PHP website, using electronic transactions 276/277 through your clearinghouse or clearinghouse portal or by contacting Customer Service at the number listed on the "[How to Contact Us](#)" page. Customer Service will status up to 5 claims per call.

## Claim Adjustments

It may become necessary to adjust a claim(s) to reflect the correct payment determination. To request an adjustment of a claim previously processed by PHP, use the [Claim Adjustment Request](#) form. We require that requests for adjustment(s) be submitted within the timeframe identified in the participation agreement, within 365 days from the date that services are rendered or the date of discharge, or as required by law.

## Overpayments

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

## Coordination of Benefits

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

### Identification of the Primary Payor and Claim Submission

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 persons’ health care coverage must be determined without taking the existence of any other plan into consideration.

If it is determined that another Payor is primary, that Payor should be billed prior to billing PHP. After receipt of payment, submit a hard copy claim including the following information:

- the original billed charges
- the amount received from the primary plan
- a copy of the other plan’s Explanation of Benefits (EOB) or Explanation of Payment (EOP) statement

If a condition is related to the patient’s employment or is the result of an automobile accident, workers’ compensation or no fault auto insurance may apply.

### How Primary and Secondary Benefits are Determined

- The plan having no COB provision or non-duplication coverage exclusion is always primary.
- When a member is covered by two plans, the plan covering him or her as a subscriber rather than the plan covering him or her as a dependent is primary.
- Coverage for dependent children of parents who are not divorced or separated is determined as follows when the child is covered by both parents’ plans:
  - The plan of the parent whose month and date of birth fall earlier in the year is primary for the child.
  - If both parents have the same month and date of birth, the plan that has covered the parent for a longer period of time is primary for the child.
- Coverage for dependent children of separated or divorced parents when the child is covered by both parents’ plans is determined as follows:
  - The plan of the parent who is required by court decree to provide health care coverage to a dependent child is the primary plan in all instances.
  - The plan of the “natural” parent who has custody applies next.
  - The plan of the stepparent where the “natural” parent has custody applies next.
  - The plan of the “natural” parent who does not have custody applies next.
  - The plan of the stepparent where the “natural” parent 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 which covers that member as a retired or laid off subscriber. This rule also applies when the member is a dependent under both plans, but not when the member is a subscriber under one plan and a dependent under the other. Refer back to the employer for determination.
- If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period is primary.
- If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.
- Medicaid is always the Payor of last resort.

### **Medicare as the Primary or Secondary Payor**

Individuals can become eligible for Medicare because of age or disability. Persons aged 65 and over who are entitled to monthly Social Security benefits are automatically eligible for Medicare.

Medicare is primary for members 65 years and older if they or their spouse are not actively employed. Medicare is the primary Payor for persons under age 65 when the person is covered by Medicare because of a disability (other than End Stage Renal Disease) and the group health plan sponsor employs less than 100 employees and the person is not actively performing services for the employer. Medicare becomes the primary Payor for persons with End Stage Renal Disease, after the 30-month coordination period following the earlier of:

1. the month in which the person begins a regular course of renal dialysis, or
2. the first day of the month in which the person became entitled for Medicare, if they received a kidney transplant without first beginning dialysis. Prior to August 1, 1997, the coordination period (the period of time the group health plan is primary) was 18 months; for persons who reached the 18-month coordination threshold on or before July 31, 1997, the 18-month coordination period will continue to apply; for all other persons, the 30-month coordination period will apply. This applies regardless of the size of the employer group.

Medicare is the secondary Payor for Medicare enrollees who:

- (1) are active employees and
- (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group.

Medicare rules change periodically and the most recent rules will apply, regardless of whether the rules are specifically described in this manual.

### **Secondary Reimbursement**

If PHP is the secondary carrier, PHP will calculate benefits' using the primary carrier's allowable. This allowable will either be the primary carrier's reasonable and customary allowance, Medicare allowable or the PHP contracted rate. The sum of the primary carrier's payment and the PHP payment will never exceed this allowable expense. Network Providers may not bill the member for any outstanding balance above the allowable expense which was covered by both plans.



When the primary carrier does not make any payment (i.e., applies everything to member liability), PHP will pay the claim as though we are the only Payor and process the claim according to the member's benefit applying deductibles, copayments and co-insurance as applicable.

### **Subrogation**

Subrogation is a process through which PHP has the legal right to recover benefits paid when the member's injury or illness is determined to be a liability of a third party. Many subrogation cases result from injuries incurred in an automobile accident or injuries that constitute a workers' compensation claim. Correct coding of claims using the ICD-9-CM accident codes assists in identification of these situations.

Subrogation does not change the procedure for processing claims. We process the claim and pay for covered services at established fees. Subrogation activities take place after claims have been processed for payment.

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

A copayment, co-insurance or deductible is a specific percentage or dollar amount to be paid by the member for covered services under their benefit plan. Copayment amounts may be different among benefit plans and services. Copayments can be verified on the member's ID card, electronically using our online eligibility system or by contacting Customer Service at the number listed on the "[How to Contact Us](#)" page.

### **Billable Copayments and Services**

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

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

Copayments, coinsurance, deductibles and any other charges that can be billed to members will be indicated in the "Patient Ineligible" field on the on the Explanation of Payment.

### **Deductible and Coinsurance Plans**

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

### **Copayment/Coinsurance Waiver**

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



## Urgent Care Centers

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

## Fast Track Services

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

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

## Non-Covered Services Billable to Members

It may be applicable to bill a member for non-covered services. Billable services to members will be identified in the “Patient Ineligible” field of the Explanation of Payment (EOP). For any questions related to non-covered services contact the Customer Services Department at the number listed on the “[How to Contact Us](#)” page.

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

## 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. These services will be listed in the “Prov Adjust” field of the Explanation of Payment (EOP) and are not billable to members. Services include, but are not limited to:

### Administrative Facility Admission Fees

PHP does not consider administrative fees associated with admissions of patient, medical records or other similar fees to be covered expenses. These are not directly related to the treatment of an illness or injury and are not billable to members.

## Clinical Edits

PHP uses clinical edits in the processing and payment of all medical claims. All providers’ medical claims for payment are subject to PHP clinical edits. Clinical edits focus upon correct coding methodologies and accurate adjudication of claims. PHP’s clinical edits follow general industry standards as defined by the American Medical Association’s (AMA) CPT Manual, Centers for Medicare and Medicaid Services (CMS), Michigan Department of Community Health (MDCH) and National Correct Coding Initiative for Medicare Services (NCCI) and other sources as applicable. PHP’s clinical edit include: bundling rules, Medically

Unlikely Edits (MUE's) and other automated logic used during the adjudication process. Any services denied due to PHP's clinical edits such as bundling, clinical daily maximums or other payment logic may **not** be billed to the member. The purpose of PHP's clinical edits is to prevent improper payments when incorrect code combinations are billed or prevent payment for an inappropriate number/quantity for the same service on a single day. PHP's clinical edits are applied to **both** professional and facility claims. Below is a list of resources used when PHP selects clinical edits:

#### **American Medical Association (AMA)**

Current Procedural Terminology (CPT)

CPT Assistant

CPT Changes

[AMA Website](#)

#### **Centers for Medicare & Medicaid Services (CMS)**

Healthcare Common Procedure Coding System (HCPCS)

Local Coverage Determinations (LCDs)

Online Manual System

National Physician Fee Schedule

National Correct Coding Initiative (CCI) Policy Manual

[National Correct Coding Initiative \(NCCI\)](#)

[Medically Unlikely Events \(MUE\) Edits](#)

National Coverage Determinations (NCDs)

Transmittals

[CMS Website](#)

#### **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 Orthopaedic Surgeons (AAOS)

American College of Radiology (ACR)

American College of Surgeons (ACOS)

American Hospital Association (AHA)

**Washington Publishing Company (wpc-ed)**

Health Insurance Portability and Accountability Act (HIPAA) Code Sets

## Clinic Fees

PHP does **not** cover any clinic facility fees for commercial members including those billed under revenue codes 510-529. Reimbursement for facility fees associated with office services is included in the physician professional fee and is **not** paid separately. Clinic fees **are** reimbursable under the Sparrow PHP Product.

## Contracted Amounts

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

## Facility Based Private Duty Nursing

PHP does not cover inpatient private duty nursing. Private duty nursing rendered in a hospital or skilled nursing facility is considered included in the room and board payment and are not billable to the member.

## Lab Handling

PHP does not cover laboratory handling charges separately. Lab handling is considered included in the primary evaluation and management service or a routine part of office overhead and are not billable to the member.

## Non-Notification Processing

If Network Provider fails to notify the Medical Resource Management Department of services being provided to a member that requires notification/prior authorization, payment for those services will be denied, and cannot be billed to the member. Members are responsible only for their copayment, deductible or co-insurance and may not be billed for the remainder of the charge.

## Standby Services

PHP does not generally cover standby services. The standby physician is reimbursed for those face-to-face services directly rendered to the member.

## Venipuncture

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

## Services provided for family members

PHP does not cover services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child, or performed by a provider with your same legal residence. This includes any service the provider performs on him or herself.

## Fraud and Abuse

### Billing Integrity Program

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

### Identification of Fraud and Abuse

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

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

Abuse refers to incidents or practices that are inconsistent, with accepted, sound business, fiscal or medical administrative practices. Abuse may, either directly or indirectly, result in unnecessary cost to the health plan, improper payment, or payment for services that fail to meet professional standards of care or that are medically necessary. Examples include ordering more tests than are medically indicated, a member's overuse of the emergency room, or members letting their friends and family use their PHP cards.

PHP wants to be notified of any fraud or abuse that your office may suspect, even if you are not sure that it is fraud or abuse. PHP can help to investigate to determine if any action is warranted. You can notify PHP confidentially about your fraud or abuse uncertainties in several different ways:

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

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

## Explanation of Payment- EOP

The Explanation of Payment (EOP) is the name of the report which gives physicians/practitioners and health care providers a detailed listing of the services that have been processed by PHP. One EOP will be issued for each Tax ID and billing address. The providers will be listed alphabetically, with totals following the end of each providers claims processing detail. A complete EOP total will be listed at the end of the report indicating the total amounts for all categories along with the Remarks Explanations for any disallows or ineligible charges. The EOP report should be used to accurately reflect payment or claims processing adjustments for accounts receivable reconciliations. Below is detailed listing of the EOP:

## Defined Terms

### **Adverse Determination**

Denial of a healthcare service, procedure or treatment based on the member's Certificate of Coverage (COC) using approved medical criteria of PHP policies.

### **Benefit Contract**

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

### **Case Management**

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

### **Clean Claim**

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

### **Coordination of Benefits (COB)**

Coordination of Benefits is the procedure used to pay health care expenses when a person is covered by more than one insurer or plan which provides health care benefits.

### **Co-Insurance**

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

### **Copayment**

Flat dollar amount member is responsible for per their Benefit Contract.

### **Dependent**

An individual who is properly covered under a member Benefit Contract.

### **Emergency Services**

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

### **Fast Track**

Urgent care setting with non-life threatening conditions

### **Health Services**

The health care services and supplies covered by the Member's Benefit Contract.

### **HealthWeb®**

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

**HIPAA**

Health Insurance Portability and Accountability Act

**Network**

Collectively, all physicians/practitioners and health care providers that have a written participation agreement in effect with PHN, directly or through another entity, to provide Health Services to selected groups of members.

**Network Education and Integrity Program**

Program created to monitor Network Providers who have documented quality issues or who have consistently not followed PHP policies and procedures. The program's intention is to promote quality, ensure compliance with policy and provide guidelines for sanctions.

**Network Provider**

A physician/practitioner or health care provider that has a written participation agreement in effect with PHN, directly or through another entity, to provide Health Services to selected groups of members.

**Payor**

An entity or person authorized by PHN to access one or more networks developed by PHN and that has the financial responsibility for payment of Health Services covered by a Benefit Contract.

**PCP**

The primary care physician/practitioner is responsible for providing and coordinating the care of members.

**PDL**

Prescription Drug List identifying the drug formulary allowed for members.

**Physician Health Network (PHN)**

The PHP Network of Providers.

**Primary Payor**

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

**Secondary Payor**

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

## How to contact us

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

Department	Contact Purpose	Contact Number	Email address
<b>Medical Resource Management</b>	<ul style="list-style-type: none"> <li>Notification of procedures and services outlined in the Notification/Authorization Table</li> <li>To request benefit determinations and clinical information</li> <li>To obtain clinical decision-making criteria</li> <li>Behavioral Health/ Substance Abuse Services, For information on mental health and/or substance abuse services including prior authorizations, case management, discharge planning and referral assistance</li> </ul>	517.364.8560 866.203.0618 (toll free) 517.364.8409 (fax)	
<b>Network Services</b>	<ul style="list-style-type: none"> <li>Credentialing - report changes in practice demographic information</li> <li>Coding</li> <li>Provider/Practitioner education</li> <li>To report suspected Provider/Practitioner fraud and abuse</li> <li>EDI claims questions</li> <li>Initiate electronic claims submission</li> </ul>	517.364.8312 800.562.6197 (toll free) 517.364.8412 (fax)	Credentialing <a href="mailto:PHP.Credentialing@phpmm.org">PHP.Credentialing@phpmm.org</a> Provider Relations Team <a href="mailto:PHPProviderrelations@phpmm.org">PHPProviderrelations@phpmm.org</a>
<b>Quality Management</b>	<ul style="list-style-type: none"> <li>Quality Improvement programs</li> <li>HEDIS</li> <li>CAHPS</li> <li>URAC</li> </ul>	517.364.8466 877.803.2551 (toll free) 517.364.8408 (fax)	Quality <a href="mailto:PHPQualityDepartment@phpmm.org">PHPQualityDepartment@phpmm.org</a>
<b>Pharmacy Services</b>	<ul style="list-style-type: none"> <li>Request a copy of our Preferred Drug List</li> <li>Request drug coverage</li> <li>Fax medication prior authorization forms</li> <li>Medication Therapy Management</li> </ul>	517.364.8545 877.205.2300 (toll free) 517.364.8413 (fax)	Pharmacy <a href="mailto:pharmacy@phpmm.org">pharmacy@phpmm.org</a>
<b>Change HealthCare (TC3)</b>	<ul style="list-style-type: none"> <li>When medical records are requested</li> </ul>	Mail to: Change HealthCare 5720 Smetana Drive, Suite 400 Minnetonka MN 55343 <ul style="list-style-type: none"> <li>Fax: 952.949.3713 or 949.943.8843</li> </ul>	

## Where to Send Claims

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

	PHYSICIANS HEALTH PLAN (PHP)	PHP SERVICE COMPANY (TPA)	PHP INSURANCE COMPANY (PPO)
WHERE TO SEND CLAIMS	<b>Physicians Health Plan (PHP)</b> <b>In Network:</b> PO Box 853936 Richardson, TX 75085-3936  <b>Non-Network:</b> PO Box 247 Alpharetta, GA 30009-0247  <b>Electronic Claims</b> In Network: Payer ID: 37330 Non-Network: Payer ID: 07689	<b>PHP Service Company</b> <b>In Network:</b> PO Box 853936 Richardson, TX 75085-3936  <b>Non-Network:</b> PO Box 247 Alpharetta, GA 30009-0247  <b>Electronic Claims</b> In Network: Payer ID: 37330 Non-Network: Payer ID: 07689	<b>PHP Insurance Company</b> <b>In Network:</b> PO Box 853936 Richardson, TX 75085-3936  <b>Non-Network:</b> PO Box 247 Alpharetta, GA 30009-0247  <b>Electronic Claims</b> In Network: Payer ID: 37330 Non-Network: Payer ID: 07689
APPROVED CLEARING HOUSES FOR ALL PRODUCTS	AllScripts (PayerPath) Availity (THIN) Capario (MedAvant, ProxyMed) RelayHealth OPTUMInsight Trizetto Provider Solutions (TTPS) Global Care- <b>For Out of Network Providers Only</b>		

## Forms

Clicking on the links below will take you directly to the form.

- [Claims Adjustment Request Form](#)
- [Claim Inquiry Form](#)
- [Demographic Change Form](#)
- [OON Request Form](#)
- [In Network Prior Authorization Form](#)
- [Provider Appeal Form](#)
- [HealthWeb User Request Form](#)
- [Out Patient Rehabilitation Prior Authorization Form](#)



## PHP Notification/Authorization Table and PDL's

You can now click on the links below to access PHP's notification/authorization table and also access the most current up to date Prescription Drug Lists.

### [PHP Notification/Authorization Table Link](#)



Clicking on the link above will take you directly to the Notification Table on our website.





### [PHP Commercial Prescription Drug List \(PDL\) Link](#)

Clicking on the link above will take you directly to the most current and up to date PDL's on our website.

## Member ID card Examples

### PHYSICIANS HEALTH PLAN (PHP HMO)

 	Rx Bin#: 610014 Rx Grp: PHPRX	Plan Type: <b>PLUS</b> Group Number: <b>L0001102</b> Subscriber Number: <b>100000070</b>
Name(s): <b>MEMBER, SAMPLE S</b> <b>00</b>		

<b>Important Consumer Information</b> For information, go to: <a href="http://www.phpmichigan.com">www.phpmichigan.com</a> Customer Service: <b>800-832-9186</b> <b>517-364-8456</b>	<b>Important Provider Information</b> For information, go to: <a href="http://www.phpmichigan.com">www.phpmichigan.com</a> Customer Service: <b>800-832-9186</b> Notify PHP of Emergency Admits: <b>866-203-0618</b>		
<i>This card does not prove membership nor guarantee coverage</i>			
<b>All PHP and PCN providers send Medical Claims to:</b> Electronic Payor ID: 37330 PHP PO Box 853936 Richardson, TX 75086-3936	<b>All other providers send Medical Claims to:</b> GlobalCare, Inc. / PHP EDI Payor ID: 07689 PO Box 247 Alpharetta, GA 30009-0247		
To locate In-Network Providers & Hospitals or to speak with a Registered Nurse when away from home, call GlobalCare at (866) 807-6193 or go to <a href="http://www.phpmichigan.com">www.phpmichigan.com</a>			
<b>Available Networks Outside the Primary Network Service Area:</b>			
 (in MI)	 (All other states)	 (complementary)	 Physicians Choice Network
<b>Date Issued: 01/28/2015</b>			

## PHP INSURANCE COMPANY (PPO)



Rx Bin#: 610014  
Rx Grp: PHPRX

Plan Type: **PPO**  
Group Number: **L0001573**  
Subscriber Number: **100000100**

Name(s):  
**MEMBER, SAMPLE S 00**

### Important Consumer Information

For information, go to: [www.phpmichigan.com](http://www.phpmichigan.com)  
Customer Service: **800-203-9519**  
**517-364-8456**

Notify PHP of  
Emergency Admits: **866-203-0618**

This card does not prove membership nor guarantee coverage.

### All PHP and PCN Providers

#### send Medical claims to:

Electronic Payor ID: 37330  
PHP PO BOX 853936  
Richardson, TX 75085-3936

### Authorization Required

For inpatient stay, Transplant services &  
Dental services related to an accident.  
call 866-203-0618 for authorization.

### All other providers send Medical Claims to:

GlobalCare, Inc. / PHP  
Electronic Payor ID: 07689  
PO Box 247  
Alpharetta, GA 30009-0247

To locate in-Network Providers & Hospitals or to speak with a Registered Nurse when  
away from home, call GlobalCare at (866) 807-6193 or go to [www.phpmichigan.com](http://www.phpmichigan.com)

### Available Networks Outside the Primary Network Service Area:



Date Issued: 01/30/2015

## Sparrow PHP Marketplace – (defined plans listed)

Sparrow PHP Gold Select Exclusive  
Exclusive

Sparrow PHP Platinum Select

Sparrow Silver Premier

Sparrow PHP Bronze Premier



Sparrow PHP Healthy

Sparrow PHP Silver Select

Sparrow PHP Gold Premier

Sparrow PHP Silver

Sparrow PHP Bronze

	<b>Marketplace-Exclusive-HMO</b>
	
Rx Bin#: 610014	Plan Type: Gold Exclusive
Rx Grp: PHPRX	Group Number: L0001699
	Subscriber Number: 100000080
Name(s):	
MEMBER, SAMPLE S	00


For important information, consumers and providers contact:  
[www.phpmichigan.com](http://www.phpmichigan.com)

(517)364-8567 (866)539-3342

This card does not prove membership nor guarantee coverage.

<b>All PHP and PCN providers send Medical Claims to:</b> Electronic Payor ID: 37330 PHP PO Box 853936 Richardson, TX 75086-3936	<b>All other providers send Medical Claims to:</b> GlobalCare, Inc. / PHP EDI Payor ID: 07689 PO Box 247 Alpharetta, GA 30009-0247
--	--

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

  
(in MI)

Date Issued: 01/28/2015

# Laboratory Tests List

## Office/Urgent Care Laboratory Test List

Physicians performing laboratory tests in their office or urgent care facility, and as otherwise required by their participation agreement, will be reimbursed for the following:

<b><u>CPT CODE</u></b>	<b><u>DESCRIPTOR</u></b>
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 semiquantitative, except immunoassays
81007	Urinalysis, bacteriuria screen, except by culture or dipstick
81015	Urinalysis, qualitative or semiquantitative, except immunoassays
81020	Urinalysis, two or three glass test
81025	Urine pregnancy test, by visual color comparison methods
82044	Albumin; urine, microalbumin, semiquantitative
82270	Blood; occult, by peroxidase activity, feces
82272	Blood; occult, by peroxidase activity, feces, 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
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
86317	Immunoassay for infectious agent antibody, quantitative
86329	Immunodiffusion; not elsewhere specified
86403	Particle agglutination, antibody
86406	Particle agglutination, titer, each antibody
86580	Skin test; tuberculosis, intradermal
87081	Culture, presumptive, pathogenic organisms, screening only
87205	Smear, primary source, with interpretation
87210	Wet mount for infectious agents
87220	Tissue examination by KOH slide
87430	Streptococcus, group A (Infectious agent antigen detection by enzyme immunoassay technique)
87880	Streptococcus, group A (Infectious agent detection by immunoassay with direct optical observation)
89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis
89300	Semen Analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen Analysis; motility and count (not including Huhner test)
89320	Semen Analysis; complete
89325	Sperm antibodies
89330	Sperm evaluation; cervical mucus penetration test; with or without spinnbarkeit test
89353	Thawing of cryopreserved; sperm/semen, each aliquot

### **Dermatology Laboratory Test List**

In addition to the office test list, dermatologists may perform these laboratory tests in their office and will be reimbursed for the following; provided the terms of their participation agreement are followed:

<b><u>CPT CODE</u></b>	<b><u>DESCRIPTOR</u></b>
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 and will be reimbursed for the following; provided the terms of their participation agreement are followed:

<b><u>CPT CODE</u></b>	<b><u>DESCRIPTOR</u></b>
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 PHP entitles you to:*

Enrollment with PHP entitles you to:

1. Be given information about your rights and responsibilities as a member.
2. Be treated at all times with respect and recognition of your dignity and right to privacy.
3. Choice of and ability to change a primary care physician (PCP) from a list of network physicians or practitioners.
4. Information on the nature and consequence of appropriate or medically necessary treatment options that may be involved in your health care, regardless of cost or benefit coverage in terms you can reasonably be expected to understand and so that you can give informed consent prior to initiation of any procedure and/or treatment.
5. The opportunity to participate in decisions involving your health care, including, making decisions to accept or refuse medical or surgical treatment and to be given information on the consequences of refusing or not complying with treatment.
6. Voice complaints or appeals about PHP or the care provided and/or use PHP's complaint/appeal procedure to resolve problems without fear of being penalized or retaliated against and/or without fear of loss of coverage.
7. Be given information about PHP, its services, and the physicians and practitioners who provide health services, including the qualifications of network providers.
8. Make suggestions regarding PHP's member rights and responsibilities policies.

### ...and Responsibilities

As a covered person, you are expected to:

1. Select or be assigned a Primary Care Physician from PHP's list of network providers and notify PHP when you have made a change.
2. Be aware that all hospitalizations must be authorized in advance by PHP and arranged by your PCP or network specialist, except in emergencies or for urgently needed health services.
3. Use emergency room services only for treatment of a serious medical condition resulting from injury, sickness or mental illness, which arises suddenly and requires immediate care and treatment (generally within twenty-four [24] hours of onset) to avoid jeopardy to your life or health.
4. Always carry your PHP ID card, present it to the provider each time you receive health services, never permit its use by another person, report its loss or theft to us and destroy any old cards.
5. Notify the health plan of any changes in address, eligible family members and marital status, or if you acquire other health insurance coverage.
6. Provide complete and accurate information (to the extent possible) that PHP and practitioners/providers need in order to provide care.

7. Participate in understanding your health problems and developing treatment goals you agree on with your PHP provider.
8. Follow the plans and instructions for care that you agree on with your PHP provider.
9. Understand what services have deductibles, coinsurance and/or copays, and pay them directly to the network physician, practitioner or provider who gives you care.
10. Read your PHP certificate of coverage and other PHP member materials and become familiar with and follow health plan benefits, policies and procedures.
11. Report health care fraud or wrongdoing to PHP.
  1. Notify the health plan of any changes in address, eligible family members and marital status, or if you acquire other health insurance coverage.
  2. Provide complete and accurate information (to the extent possible) that PHP and practitioners/providers need in order to provide care.
  3. Participate in understanding your health problems and developing treatment goals you agree on with your PHP provider.
  4. Follow the plans and instructions for care that you agree on with your PHP provider.
  5. Understand what services have deductibles, coinsurance and/or copays, and pay them directly to the network physician, practitioner or provider who gives you care.
  6. Read your PHP certificate of coverage and other PHP member materials and become familiar with and follow health plan benefits, policies and procedures.
  7. Report health care fraud or wrongdoing to PHP.



# Reporting Communicable Disease

Michigan physicians/practitioners are required to report patients with the following conditions to the patient's local health department. Lab-confirmed and clinical diagnoses are reportable in the time intervals specified. This reporting allows for appropriate public health follow-up for the patients and assists in identifying outbreaks not always evident to a sole provider.

## IMMEDIATELY

Any unusual occurrence, outbreak, or epidemic of any disease, condition, and/or nosocomial infection.

## WITHIN 24 HOURS

Any unusual occurrence, outbreak, or epidemic of any disease, condition, and/or nosocomial infection.

AIDS	H. influenza (meningitis of epiglottitis)	Plague
Anthrax	Hepatitis B in pregnant woman	Poliomyelitis
Botulism	Lymphogranuloma venereum	Syphilis
Chancroid	Measles	tuberculosis
Diphtheria	Meningococcal disease (meningitis or meningococemia)	Viral hemorrhagic fevers
Gonorrhea	Pertussis	Yellow fever
Granuloma inguinal		

## WITHIN THREE (3) WORKING DAYS

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

**WITHIN ONE WEEK**

Chicken pox (aggregate numbers)

HIV infection

Influenza (aggregate numbers)

**How to Report** - Call, mail or fax your local health department. Provide patient demographics, diagnosis and onset date

County	Health Department	City	Phone	Fax
Clinton	Mid-Michigan DHD	St. Johns	989.224.2195	989.224.4300
Eaton	Eaton DHD	Charlotte	517.543.2430/7110	517.543.7737
Gratiot	Mid-Michigan DHD	Ithaca	989.875.3681	989.875.3747
Ingham	Ingham County	Lansing	517.887.4311	517.887.4310
Ionia	Ionia County	Ionia	616.527.5341	616.527.5361
Isabella	Central Michigan DHD	Mt. Pleasant	989.773.5921	989.773.4319
Montcalm	Mid-Michigan DHD	Stanton	989.831.5237	989.831.5522

## Network Education and Integrity Program (NEIP)

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

### NEIP Program Definitions

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

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

- Facilities: may result in non-payment or reduction in payment of the per diem amount or contracted payment amount for each hospital day, service, and/or procedure for which the facility is non-compliant.
- Physicians/practitioners: may result in a Monetary Adjustment equal to the amount of the non-covered services or product or the difference between the amount paid by PHP and the PHP fee schedule as determined by PHP.

Suspension: Temporary loss of participation in PHN.

Termination: Permanent loss of participation status in PHN.

### NEIP Description

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

- Non-compliance with authorization/notification process, which includes rendering non covered services, with or without retroactive authorization requests (more than three in one quarter or six in one year)
- Referral patterns to non-Network Providers, including redirects and those without prior notification (more than three in one quarter or six in one year). At the time of notification, if the physician/practitioner is aware that a member(s) self referred to a non-Network Provider, he/she will not be held responsible if he/she notifies PHP in writing of each such occurrence and does not initiate a retroactive authorization.
- Non-formulary use (2.0 standard deviations higher than peers over a six month period)
- Physician profile data indicative of significant cost and/or over utilization of services compared to peers (2.0 standard deviation over/under peers)
- Quality issues or repeated quality issues deemed significant by the PHP Quality Improvement/Medical Resource Management Committee (more than three in one quarter or six in one year)
- Deviation from PHP billing standards as defined in CPT coding and this manual (more than three in one quarter or six in one year)
- Exceeding member or provider complaint thresholds deemed significant by the Credentialing and Peer Review Committee
- Non-compliance with other protocols as outlined in the PHN participation agreement and this manual (more than three in one quarter or six in one year)

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

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

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

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

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

- Termination of eligibility for incentive plans or programs of PHP (i.e., Physician Incentive Plan, special fee schedule incentives).
- Ceasing to assign new members (if PCP) or to refer members to Network Provider for specialty care
- Automatic forfeiture of 5% of the financial allowance per occurrence of non-compliance

## External Regulations & Standards

URAC



The URAC has awarded Physicians Health Plan accreditation for both its Commercial HMO/POS combined product lines and Medicaid product line.

URAC evaluates how well a health plan manages all parts of its delivery system -- physicians, hospitals, other providers and administrative services -- in order to continuously improve health care for its members.

During the accreditation process, PHP was measured against rigorous standards in the areas of:

- Customer service and addressing member concerns
- Providing high credentialing standards of providers
- Responding to member and practitioner issues
- Listening to and addressing feedback of new members

For more information visit [urac.org](http://urac.org)

## Michigan Regulatory Agencies

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

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

## Measuring Effectiveness

### HEDIS

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

- Childhood Immunization
- Adolescent Immunization
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Controlling High Blood Pressure
- Beta Blocker Treatment
- Comprehensive Diabetes Care
- Medications for People with Asthma
- Follow-up after Mental Health Illness
- Antidepressant Medication
- Adult Access to Preventative/Ambulatory Care
- Children Access to Primary Care Practitioners
- Prenatal and Postpartum Care
- Adolescent Well-Care
- Well-Child Visits First 15 Months of Life
- Well-Child Visit Third, Fourth, Fifth and Sixth Years of Life

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

## CAHPS

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

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

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

## Disease Management Programs

### AsthmaWatch Program

The AsthmaWatch Program is provided to members of all ages with asthma and includes information, educational materials, and case management.

#### Program Enrollment

PHP members with a diagnosis of asthma are automatically enrolled in the AsthmaWatch program based on claims for services and medication. At any time, members with asthma may be referred to the AsthmaWatch program by calling 517.364.8466 or 877.803.2551.

#### How the AsthmaWatch Program Works with PHP Members:

- Asthma Special Equipment: Members can obtain nebulizers, spacers, and peak flow meters
- Asthma Education Materials: Members are mailed educational materials to help them learn about and manage their asthma. Materials include information to address prevention and lifestyle issues such as: Triggers, Exercise, etc. Information is also available on the PHP website regarding the AsthmaWatch program at [www.phpmichigan.com](http://www.phpmichigan.com)
- Case Management Services may be provided by a Case Manager. The case manager works with the member to assess areas of education, equipment, transportation, and psychosocial needs.

#### Key Features for Physicians and Health Care Providers:

The program is supported by guidelines for the diagnosis and management of asthma National Heart Lung and Blood Institute. [www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines](http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines)

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

American Lung Association [www.lung.org](http://www.lung.org)

#### Physicians and Health Care Providers:

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

#### Physicians receive:

- Letter notification of members being case managed by a RN

#### Physician and Provider Expectations

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

### **Living with Diabetes Program**

The Living with Diabetes Program is provided to PHP members of all ages with diabetes. The program offers information for members to promote awareness and self-management of diabetes for blood glucose control, educational materials, and case management.

#### Program Enrollment

PHP members with diabetes are automatically enrolled in the Living with Diabetes program based on claims for services. At any time, members with diabetes may be referred to the Living with Diabetes program by calling 517.364.8466 or 877.803.2551.

#### How the Living With Diabetes Program Works with PHP Members:

- Diabetes Education Classes: Members are encouraged to attend a diabetes education class provided by an approved certified diabetes educator with a referral from their physician
- Diabetes Special Equipment: Members can obtain a glucose meter, test strips, needles, lancets and syringes
- Diabetes Education Materials: Members are mailed educational materials to help them manage their diabetes. Materials include information to address prevention and lifestyle issues. Information is also available on the PHP website regarding the Living With Diabetes program at [www.phpmichigan.com](http://www.phpmichigan.com)
- Case Management Services may be provided by a Case Manager. The case manager works with the member to assess areas of education, equipment, transportation, and psychosocial needs.
- Monitoring: All members in the Living With Diabetes program are monitored for HbA1c testing, and for annual dilated eye exams with reminders mailed to members.

#### Key Features for Physicians and Health Care Providers:

The program is supported by guidelines for Management of Diabetes Mellitus.

- The guideline was developed by the Michigan Quality Improvement Consortium (MQIC) and based on the 2014 American Diabetes Association Clinical Practice Recommendations.
- Clinical practice recommendations for the treatment of diabetes American Diabetes Association [http://professional.diabetes.org/CPR\\_search.aspx](http://professional.diabetes.org/CPR_search.aspx)

- National Institute of Diabetes and Digestive and Kidney Diseases  
[www.niddk.nih.gov/Pages/default.aspx](http://www.niddk.nih.gov/Pages/default.aspx)
- American Diabetes Association [www.diabetes.org](http://www.diabetes.org)
- Michigan Department of Health and Human Services Diabetes, Prediabetes and Chronic Kidney Disease [http://michigan.gov/mdch/0,1607,7-132-2940\\_2955\\_2980---,00.html](http://michigan.gov/mdch/0,1607,7-132-2940_2955_2980---,00.html)

#### Physicians and Health Care Providers:

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

#### Physicians receive:

- Letter notification of members being cased managed by RN

#### Physician and Health Care Provider Expectations

If treating a PHP member with diabetes, each member should have a (n):

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

## **Healthy Mom Healthy Baby**

The Healthy Mom Healthy Baby Program is provided to members who are pregnant. The program includes information and educational materials for all known expectant mothers. Postpartum follow-up is provided to ensure mother receives postpartum care and family has established a "medical home".

#### Program Enrollment

PHP pregnant members are enrolled in the Healthy *Mom* Healthy *Baby* program by calling PHP and requesting to be enrolled into the Healthy *Mom* Healthy *Baby* program. You may refer your pregnant patient to the Healthy *Mom* Healthy *Baby* program at any time by calling 517.364.8466 or 877.803.2551.

#### How the Healthy Mom Healthy Baby Program Works with Your Patients

- Prenatal Vitamins: Members can obtain a 90-day supply of prenatal vitamins for a one-month co-pay with a special authorization
- Pregnancy Education Material: Educational materials are sent to members. The materials are designed to answer specific questions about health and pregnancy, and encourage the establishment of a "medical home" for prenatal and postpartum care. Information is also available on the PHP website regarding the Healthy *Mom* Healthy *Baby* program at [www.phpmichigan.com](http://www.phpmichigan.com)
- Members are provided postpartum education regarding the importance of the 6 week follow-up visit, intervals for well child visits, importance of immunizations, and lead screening on or before the age of 2 years. Six-week Incentive Form: A form is mailed to your patient who has recently delivered. If the



member completes her postpartum visit between 21 and 56 days following delivery she is eligible to receive a \$25.00 gift card.

- Prenatal Class: Members may attend prenatal classes free of charge through Expectant Parent Organization.

### Key Features for Physicians and Health Care Providers

The program is supported by the PHP Clinical Practice Guidelines for Routine Prenatal and Postnatal Care. The PHP guideline was developed by the Michigan Quality Improvement Consortium (MQIC) and based on Routine Prenatal Care, and Institute for Clinical Systems Improvement July 2012.

### Physician and Health Care Providers:

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

### Physician and Provider Expectations

If you are treating a PHP member that is pregnant:

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

## **Wellness Mailings**

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

### **Lead Screening**

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

### **Missed Well Child Visits**

PHP encourages members ages 3–6 to see their PCP for a yearly well child visit. Well child services should be reported using the appropriate preventive medicine CPT codes with a preventive medicine ICD-9 diagnosis code.

### **Missed Adolescent Exams**

PHP encourages members ages 12–21 to see their PCP for a yearly adolescent health examination. Well adolescent services should be reported using the appropriate preventive medicine CPT codes with a preventive medicine ICD-9 diagnosis code.

### **Missed Adult Preventive Exams**

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

### **Cervical Cancer Screening Reminder**

Cervical cancer screening reminders target women ages 21-64 with no record of a cervical cancer screening within the past 36 months.

### **Breast Cancer Screening Reminder**

Breast Cancer screening reminders target women ages 52-74 with no record of a mammogram within the past 24 months.

### **Colorectal Screening**

Colorectal cancer screening reminders are sent to members age 50 and over.

## **Prevention Mailings**

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

### **15 Month Proactive Childhood Immunization**

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

- DTP
- Hepatitis B
- Hib
- Polio
- Prevnar
- MMR
- Varicella

### **Well Child Visit 3, 5, 8, & 11 Month Reminders**

Well child visit reminders target Medicaid children 3, 5, 8, & 11 months old to encourage them to make an appointment for their well child visit within the next month.

## Standards of Care Guidelines

PHP Standards of Care Guidelines assist by providing evidence-based recommendations in order for you to be able to focus on your patients care. If you would like to obtain a paper copy of the PHP Standards of Care Guidelines, please contact the Quality Management Department at the number located on the “[How to Contact Us](#)” page. Below are links of the PHP Standards of Care Guidelines based on Michigan Quality Improvement Consortium (MQIC). PHP will also strongly encourage our providers to utilize the Michigan Childhood Immunization Registry as outline in the MQIC guidelines. For more information on MQIC, you can visit their website at [mqic.org](http://mqic.org)

- [Diagnosis of Attention-Deficit/Hyperactivity Disorder \(ADHD\) for children and Adolescents Guideline](#)
- [Treatment of Attention-Deficit/Hyperactivity Disorder \(ADHD\) for Children and Adolescents Guideline](#)
- [Adolescent and Young Adult Health Risk Behavior Assessment Guideline](#)
- [Advance Care Planning Guideline](#)
- [General Principles for the Diagnosis and Management of Asthma Guideline](#)
- [Management of Acute Low Back Pain in Adults](#)
- [Management of Uncomplicated Acute Bronchitis in Adults Guideline](#)
- [Primary Care Diagnosis and Management of Adults with Depression Guideline](#)
- [Management of Diabetes Mellitus Guideline](#)
- [Adults with Systolic Heart Failure Guideline](#)
- [Screening and Management of Hypercholesterolemia Guideline](#)
- [Medical Management of Adults with Hypertension Guideline](#)
- [Diagnosis and Management of Adults with Chronic Kidney Disease Guideline](#)
- [In Office Use of Sedation](#)
- [Medical Management of Adults with Osteoarthritis Guideline](#)
- [Management and Prevention of Osteoporosis Guideline](#)
- [Prevention and Identification of Childhood Overweight and Obesity Guideline](#)
- [Treatment of Childhood Overweight and Obesity Guideline](#)
- [Management of Overweight and Obesity in the Adult Guideline](#)
- [Acute Pharyngitis in Children 2 - 18 Years Old Guideline](#)
- [Routine Prenatal and Postnatal Care Guideline](#)
- [Prevention of Pregnancy in Adolescents 12-17 Years Guideline](#)
- [Prevention of Unintended Pregnancy in Adults 18 Years and Older Guideline](#)
- [Routine Preventive Services for Infants and Children \(Birth - 24 Months\) Guideline](#)
- [Routine Preventive Services for Children and Adolescents \(Ages 2 - 21\) Guideline](#)
- [Adult Preventive Services Guideline \(18-49\)](#)
- [Adult Preventive Services Guideline \(Age>50\)](#)
- [Screening, Diagnosis, and Referral for Substance Use Disorders Guideline](#)
- [Tobacco Control Guideline](#)
- [Outpatient Management of Uncomplicated Deep Venous Thrombosis Guideline](#)