PriorityHealth

Physician and Practice News Digest

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Billing & Payment

Fee schedule changes effective Jan. 1

(September 2013) Priority Health's mission is to be the nation's leader in innovative health solutions, making health care obtainable for all. We're committed to providing affordable and excellent health care to individuals and employers through an ever-expanding array of products and services. To accomplish this, we conduct a review of the fee schedules annually.

We continually evaluate national and regional data to develop fee schedules that balance the needs of providers with those of employers and members who bear the burden of these costs.

Fee schedules are only one of the many tools we use to keep health care affordable. Other tools include, but are not limited to:

- Proper utilization
- Improved technology
- Continual pharmaceutical reviews
- Cost-sharing products by which members assume more of the costs for services they access

Payments to health care providers remain equitable

Our adjustments to fee schedules typically result in raising some fees while lowering others. We strive to have proper balance between primary care and specialty care as well as among specialists themselves. Our goal is to reimburse all providers at a fair market value.

We're committed to working with you in partnership within our communities to achieve best-practice levels of health care by optimizing outcomes, eliminating avoidable costs and ensuring the best health care experience for your Priority Health patients.

Request a new fee schedule online at *priorityhealth.com/provider/manual*. In the "Billing & Payment" section you will find a link to "Fee Schedules." In the message section of the online form, indicate that it is the 2014 fee schedule you are requesting. Note that login is required to access the Fee Schedule Request Form.

Medicaid fee schedule update

(Aug. 26, 2013) The State of Michigan's final rule for a primary care rate increase for Medicaid payment at 100% of Medicare was originally published in Dec. 2012. In a May update, we reported that before this increase can be implemented, a review and approval by the Centers for Medicare and Medicaid Services (CMS) is required. As we go to press, the State of Michigan is still awaiting CMS approval on the increase for Medicaid payments. When approved, the 100%-of-Medicare payout will be retroactive to Jan. 1, 2013.

To ensure that you'll receive accurate payments for care provided to Medicaid patients, make sure that your primary specialty designation is correct in the Community Health Automated Medicaid Processing System (CHAMPS). The State of Michigan provides this information to Priority Health, which we use for determining appropriate payment.

Coding change for psychiatric medication management visits

(Aug. 6, 2013) Changes in federal laws, as well as coding and billing requirements that became effective January 2013, are impacting patients whose coverage has a 20-visit cap on behavioral health outpatient benefits. Generally, this cap is included in plans offered by small businesses.

Med. management visits now apply to 20-visit cap

Many patients have language in their pre-2013 coverage documents indicating that psychiatric medication management visits will be covered and will not impact the 20-visit cap. This is no longer the case.

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Billing & Payment

The new 2013 coding and billing requirements:

- Visits that were previously considered "medication management" are now being processed as full office visits.
- Patients are now billed full office visit copayments for these visits.
- Each visit counts toward the 20 allowed outpatient visits per year.

Coverage documents are being adjusted

As we move forward under new regulatory requirements, we're adjusting coverage documents to provide accurate information to our members. We apologize for the confusion and difficulty that this change has caused your patients.

Pharmacy

Pharmacy benefit coverage varies among members

(Aug. 13, 2013) Priority Health offers many pharmacy benefit choices, including employer-sponsored (commercial), Medicaid and Medicare. Pharmacy benefits among Priority Health commercial members vary based upon the coverage purchased by the employer. Employer-sponsored plans have many different options for coverage and copayment levels, and the level of copayment affects the total cost of health care coverage for which the employer is responsible. Some purchasers elect not to cover prescriptions in their benefit plans.

Patient copayments

- **Flat** — With a flat copayment, the member pays the same fixed dollar amount or percentage for the copayment independent of whether the prescription is for a brand-name or generic product.
- **Two-tier** — With this level the member pays a lower copayment if the prescription is filled with a generic medication and a more expensive one for a branded product. Members with two-tier coverage have access to non-preferred products if their condition warrants their use and is medically necessary.
- **Three-tier** — This is similar to a two-tier copayment for the two lower copayment levels. The third tier is for non-preferred products. The non-preferred agents on the third tier will always require payment of the third-tier copayment.
- **Specialty** — Specialty pharmacy drugs, including those administered in the physician's office or infusion center, are classified as preferred specialty (fourth tier) or non-preferred specialty (fifth tier). Preferred specialty drugs typically have a lower copayment than non-preferred specialty.
- **Medicaid** — Priority Health Medicaid members are covered under a formulary that is similar to the standard, closed formulary, although the State of Michigan may require some coverage that is not part of the standard commercial benefit. Priority Health Medicare members typically have a four-tier copayment, though some Medicare plans provided by an employer may choose to have a two-tier copayment.

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Pharmacy

Generic drug substitutions

(Aug. 9, 2013) Priority Health has a generic substitution policy that mandates coverage of generics when an A-rated or equivalent generic is available.

Members may have to pay the difference

Currently, if a member or physician requests the brand-name product, the member may have to pay the difference in cost between the brand and generic drug, plus their copayment. This is known as the "member pay difference" (MPD).

Dispense-as-written prescriptions

DAW prescriptions can be prescribed and filled. Brand-name medications with authorized generics available are not eligible for DAW authorization. Authorized generics are prescription drugs produced by the brand pharmaceutical company and marketed under a private label, at generic prices.

Exceptions to the policy

Authorizations for the MPD override may be given for the following exceptions:

- Members on Coumadin® (no authorization required, automatic brand copayment)
- Patients who are color-blind and require a specific brand for identification purposes
- Patients with a documented allergy to an inactive component of the generic product
- Epilepsy meds: Patients currently stabilized on brand medications for epilepsy may have their physicians request continuation on the brand with no MPD. However, brand copayment still applies. Members starting on epilepsy therapy, or those taking anti-epileptic medications for indications other than epilepsy, will be required to pay MPD if a brand is chosen.

Birth control methods coverage varies

(Aug. 14, 2013) Coverage of birth control methods depends on the type of plan.

Employer-sponsored plans

- **Employers may offer "grandfathered" plans**, which are not required to meet all the requirements of health care reform. Employers offering grandfathered plans decide whether birth control methods are covered or not. When they are covered, the member must pay the copayment. Some employers have decided to cover birth control for a medical diagnosis only, while others have chosen not to cover it at all.
- **If the plan is not grandfathered**, the employer must cover women's preventive health care services, including coverage for oral, injectable, topical and vaginal birth control. Only generics are covered at no cost to the member.
- **For non-grandfathered plans**, birth control methods like the female condom, diaphragm and emergency contraceptives are also covered under the pharmacy benefit.

Medicare and Medicaid

Most birth control methods are covered for Medicare and Medicaid plans at the applicable copayment.

Prescription quantity and pharmacy limitations

(Aug. 14, 2013) Priority Health sets limits on how much of a supply of a drug our members can have filled at one time, and where they can go to get certain types of prescriptions.

31-day supply is the standard

Priority Health limits prescription coverage to a maximum 31-day supply per prescription.

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Pharmacy

Mail order saves most patients money on 90-day supplies

Our mail service pharmacy, Express Scripts, may provide Priority Health patients with up to a 90-day supply of medication for just one, two or two and a half copayments, depending on their plan. Shipping is free. Medicare members will pay three copayments.

Express Scripts will dispense the prescription exactly as you write it. If you write for a 30-day supply, they'll dispense a 30-day supply. So it's important to write for a 90-day supply of medication when your patient requests a prescription that will be filled by a mail order pharmacy.

How to send prescriptions to Express Scripts

- Electronic prescribing dedicated fax number: 866.825.6605. Remember to set up Express Scripts as the mail service pharmacy for Priority Health members.
- Fax: 800.875.6356 (physician use only)
- Phone: 800.553.3750 (physician use only)

90-day retail pharmacies program

Many of the pharmacies in our network participate in our "90 day at retail" program, allowing members to fill a 90-day supply at a local retail pharmacy for three copayments. These pharmacies are designated as 90-day pharmacies in the *Find a Doctor* tool. Medicaid members are not eligible for 90-day fills.

Specialty drugs

Most specialty drugs must be obtained from a network specialty pharmacy for commercial members. Priority Health may also use specific prior authorization criteria for some prescriptions, as well as quantity limits based upon clinical data or cost-effectiveness. Some drugs also require step therapy.

Drug formulary updates

(July, 29, 2013) The Pharmacy and Therapeutics Committee meets every other month to review the Priority Health formularies. Learn more at *priorityhealth.com/provide*r > keyword = **approved drug list**

Coverage of erectile dysfunction drugs

(Aug. 14, 2013) Drugs to treat erectile dysfunction are covered only if the employer has selected a rider that provides coverage for these drugs. If selected by the employer, the appropriate prescription copayment will apply. Medicaid and Medicare plans do not cover erectile dysfunction drugs although certain employer-sponsored Medicare plans choose to add coverage.

If you have questions about pharmacy benefits, please contact the pharmacy call center at 800.466.6642.

Drug authorizations after hours

(Aug. 9, 2013) When a member presents a prescription for an urgent drug that requires prior authorization after Priority Health has closed, pharmacies are encouraged to provide the patient with a starter supply of the drug. Priority Health covers up to seven days of medication to ensure that the member does not go without therapy while waiting for prior authorization. Pharmacies are encouraged to reach out to provider offices the next business day to notify the office that prior authorization is needed.

Adverse drug event? Call MedWatch

(July 23, 2013) If a patient experiences an adverse drug event, product problems or product use errors, we encourage you to report it to MedWatch by:

- Calling 1.800.FDA.1088; or
- Submitting the MedWatch 3500 form by fax or mail; or
- Going online to the FDA web page at *fda.gov/medwatch*

Performance Programs

Bone density tests

(July 11, 2013) We're calling our female Medicare members who've suffered a fracture within the past year and haven't had a bone density test or filled a related bone-strengthening prescription within six months of the fracture. We want to encourage them to schedule a bone mineral density test.

The due date for the DXA scan is given to us by Medicare and is based on the last claim submitted using the fracture code. The due date isn't always 6 months from the actual fracture date; if the member was in a rehab facility after the fracture, the due date would be the discharge date from the facility.

There will always be a due date for every member on the list. Sometimes patients are concerned about paying their office visit copayment. If you don't need to see the patient, or if their upcoming visit at your office is after the due date, you can refer them to testing without an office visit.

BMD page added to the Provider Manual

See CPT and diagnosis codes online on the *Bone mineral density test billing page.*

PCP Incentive Program incentives for 2013

Earn an incentive when you ensure that female patients 67 years of age and older with a fracture in 2013 have either of the following within six months of the fracture, but no later than December 31, 2013:

- Bone mineral density test
- Prescription for a drug to treat or prevent osteoporosis

Learn more at *priorityhealth.com/provider* > keyword = **provider manual**

Plans & Benefits

Our MIChild service area expands

(Aug. 21, 2013) As of Sept. 1, 2013, Blue Cross/Blue Shield of Michigan is no longer offered as a plan choice for new/renewing MIChild enrollees in counties with adequate plan choice (minimum two MIChild plans per county). Current enrollees were notified that they needed to switch insurance carriers effective 10/1.

Priority Health adds new MIChild counties

Priority Health is now approved for service area expansion in 11 out of 13 new counties, bringing the total to 19 counties in which we are contracted to offer MIChild. Our MIChild service area now includes providers in Allegan, Antrim, Barry, Charlevoix, Grand Traverse, Ionia, Kent, Lake, Leelanau, Mason, Mecosta, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego and Ottawa counties.

Interested in participating?

If you are not currently a Medicaid or MIChild provider, contact your provider account representative (PAR) to request a contract. When you are logged in to your *priorityhealth.com* account, your PAR's name appears in your *Find a Doctor* tool listing details.

Responsibilities & Standards

Quality assurance programs information online

(August 2013) We like to remind you annually of the plan information and programs available to you on our website. The listings below highlight these areas and direct you to more information available online.

Quality improvement program

For summary information regarding Priority Health's Quality Improvement Program performance results, go to *priorityhealth.com/provider* > keyword = **accreditation**

For more information: Visit the *Quality Improvement Program* section of the Provider Manual.

To review complete copies of our Quality Improvement Evaluation, Quality Improvement Program Description and Quality Improvement Work Plan, contact Bob VanEck at 616.464.8204 or bob.vaneck@priorityhealth.com.

Disease and case management services

Priority Health's free health management programs for asthma, diabetes, cardiovascular disease, pregnancy and tobacco cessation are designed to assist your practice. The programs help to educate patients about their health conditions, risk factors, adherence to evidence-based treatment and developing a personal action plan. For more information on ways to use our services and to see how we work with patients, visit the Clinical Resources section of our website.

Clinical practice guidelines

Clinical practice guidelines, including preventive health care, are available to support evidence-based care for children and adults. Additional practice management tools and patient education are also listed with each guideline. You can access them in the Clinical Resources section of our website. Print copies are available upon request through the Provider Helpline at 800.942.4765.

Utilization management decisions and InterQual criteria

To learn more, visit the Performance Programs section of the Provider Manual and select *Utilization Management.* If you have questions about utilization management decisions, would like copies of the medical criteria used to make decisions or would like to discuss the decision-making process, call the Health Management department at 800.942.4765.

Medical utilization criteria

The following physicians are available on staff to review and answer questions about utilization decisions:

John Fox, MD
Associate VP, Medical Affairs
616.464.8454
john.fox@priorityhealth.com

Jay LaBine, MD
Chief Medical Officer
616.464.8971
jay.labine@priorityhealth.com

Pharmacy utilization criteria

The following pharmacists are available on staff to review and answer any questions about pharmacy-related utilization decisions:

Jim Mezwicki, R.Ph.
616.464.8617
jim.mezwicki@priorityhealth.com

Erica Clark, Pharm.D.
616.464.8690
erica.clark@priorityhealth.com

For behavioral health criteria, go to the Authorizations section of the Provider Manual and click *Behavioral Health.* In addition, your agency or facility may also ask questions about behavioral health-related utilization decisions or request a copy of the Behavioral Health department's *Standards and Criteria for Utilization Management* by contacting our Behavioral Health case managers at 800.673.8073, from 8:30 a.m. to 5:00 p.m. Monday through Friday. A case manager will assist you with your questions or refer you to a board-certified psychiatrist.

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Responsibilities & Standards

Priority Health makes every effort to make utilization decisions that are fair and consistent in order to serve the best interests of the member. That is why we:

- Will make utilization decisions based only on appropriateness of care and service, as well as existence of coverage.
- Will not compensate practitioners or other individuals conducting utilization review for denial of coverage or service.
- Will not offer financial incentives or rewards for utilization decision makers to encourage denial of coverage or service.
- Will decide on coverage of new technology after comprehensive research and review by the chief medical officer and physician committees.

Medical policies

Visit *priorityhealth.com/provider/manual* and select "Medical policies." You can obtain a copy of the criteria used in making a specific determination upon request. In addition, a Priority Health medical director is available to discuss by telephone decisions based on medical necessity. Please contact the Health Management department for a copy of specific criteria, to discuss the Utilization Management process or a decision, or to discuss a case with the medical director. You can reach the Health Management staff through the Provider Helpline, 800.942.4765.

Member rights and responsibilities

Rights and responsibilities can be found online in the member handbooks at *priorityhealth.com/member.* Select "Handbooks."

Office management and standards

We're here to help your office operate as effectively as possible. The "Provider responsibilities and standards" section of our online provider manual has information on everything from medical record documentation and confidentiality requirements to data exchange to provider status information. You'll find it all at *priorityhealth.com/provider/manual.*

Practice or provider information changes

(Aug. 9, 2013) Please let us know about changes or updates to your practice or individual providers' information via our Provider Demographic Change form. This document allows you to communicate a variety of changes to us. Some changes require advance notification (as indicated on the form). To ensure accurate and timely claims processing, it is important that we know when a new physician joins or leaves your practice, as well as any tax ID, address, phone or fax number changes. These forms should no longer be returned to your PAR. Instead, fax your completed form to our Provider Information Management team at 616.975.8857 or email to ph-providerinfomgmt-demographics@priorityhealth.com.

Language help for patients is required

(Aug. 22, 2013) One of the requirements listed in the Provider Manual for treating Priority Health patients is to provide an interpreter for patients who don't speak English. This makes sense — if they don't understand your questions or instructions, your services will be of limited value.

For patients with limited English proficiency, you must offer interpretation services at no cost to patients.

This requirement applies to any entity receiving federal financial assistance (including Medicaid and Medicare reimbursement). Contact the Provider Helpline at 800.942.4765 if you need help finding a translator. Go to the "Provider office responsibilities" page online to see the complete list of provider responsibilities.

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Responsibilities & Standards

Revised patient discharge procedure

(July 17, 2013) In May, we released revisions to the patient discharge policy and procedure. Providers expressed concerns about the process for submitting requests as well as the review phase within Priority Health. We responded to this feedback with revisions to the discharge procedure that will improve the administrative process.

Updated patient discharge process

Changes include:

- Practices may submit the discharge form without supporting documentation.
- Practices may inform patients of discharge when submitting the form to Priority Health.
- All complete forms will be processed as approved.
- Priority Health will conduct audits to verify that practices are following discharge criteria and documentation requirements.

Practices must still collect all supporting documentation for the discharge in the medical record. Please review the patient discharge section of the Provider Manual for policy and procedure details. Contact your provider account representative with questions.

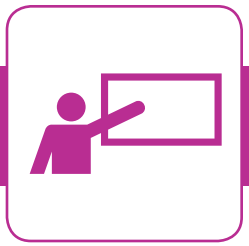
PCP reassignment process

Use this process to let us know when a member has notified you that he or she is seeing another provider as a PCP. This process remains as it was updated in May.

Review the clinical practice guidelines

(Aug. 2, 2013) Clinical practice guidelines are developed in collaboration with area physicians based upon standards established by national organizations. Each guideline addresses a specific condition, diagnosis, therapeutic intervention, patient education/follow-up or issue related to continuity and coordination of care. Guidelines are available for treating alcohol/substance use and depression as well as managing chronic diseases such as asthma, diabetes and osteoporosis. Review the clinical practice guidelines in the Provider Manual.

Training Opportunities



Fall Provider Collaborative

Shared accountability:
Engaging patients and changing behaviors

Discuss how shared accountability is critical to population health and how we all — physicians, patients, employers and health plans — must work together to engage patients and change behaviors.

When & Where
Wed., Oct. 23, 2013 from 7:30 a.m. to 11:15 a.m.
Frederik Meijer Gardens & Sculpture Park

Who should attend?
Physicians, physician organization administration, healthcare leaders

Learn more at *priorityhealth.com/provider* > keyword = **provider collaborative**

Health reform and providers

(July 10, 2013) When it comes to health reform, we understand that providers wear many hats. Most importantly, you care for your patients. Many of you are also employers with staff members who rely on you for information about health reform. In addition, you play the role of health care educator.

Our three-part webinar series, led by Priority Health Director of Health Reform Marti Lolli, is now available to you in our online provider center.

- Health reform and providers: Your role as employers
- Health reform and providers: Your role as providers
- Health reform and providers: Your role as patient educators

Learn more at *priorityhealth.com/provider* > keyword = **health care reform**

Guidelines and Principles of ICD-10-CM for Coders

(June 27, 2013) Mark your calendars: Registration is open for the two-day ICD-10-CM workshop for coders in Grand Rapids.

- March 5 and 6, 2014
- Priority Health Conference Center, 3111 Leonard St., Grand Rapids, MI
- Presented by Judy B. Breuker, CPC, CPMA
- Cost is $500 (early registration discount will be available) including all materials and lunch
- Approved for AAPC and AHIMA CEUs
- More information is available at *judybreuker.com*

Priority Health Academy is back!

Two Priority Health Academies (PHA) will be held in November.

Grand Rapids PHA on Monday, Nov. 18
Calvin College, Prince Conference Center
8:00 a.m. – 3:00 p.m.
Sessions will include morning and afternoon coding workshops with Judy B. Breuker, CPC, CPMA. Other sessions include 2014 Incentives for PCPs, LEAN Training, Medicare Updates, Medicaid Expansion and Human Resources. Our keynote speaker, Marti Lolli, director, Health Care Reform will discuss the Affordable Care Act.

Traverse City PHA on Wednesday, Nov. 20
Traverse City Golf Club
9 a.m. – 3:30 p.m.
Sessions include a coding workshop with Judy B. Breuker, CPC, CPMA and a session on the Affordable Care Act, among others.

Complete details and registration information for both locations will be available soon. Mark your calendars and watch your email and our Recent News at *priorityhealth.com* for updates.

Priority Health News

National Depression Screening Day is October 10

(Aug. 2, 2013) National Depression Screening Day® is held during Mental Illness Awareness Week each October. It's designed to call attention to the illness of depression on a national level, educate the public about its symptoms and effective treatments, offer individuals the opportunity to be screened for depression and connect those in need of treatment to the mental health care system.

Patients can now compare price, quality and patient reviews

Our Healthcare Blue Book* tool shows Priority Health members the "Fair Price" calculated by Healthcare Blue Book for more than 200 common procedures, including surgery, labs and imaging tests when they log in to their accounts. They'll also be able to see quality ratings for doctors and hospitals from Healthgrades®.

In a world with eBay, Trip Advisor and Angie's List, it's common for consumers to compare quality and price details for a car, resort or plumber. Health care service shopping can be as straightforward as many other online shopping experiences. The Healthcare Blue Book tool from Priority Health makes health care comparison shopping easier by identifying fair prices of more than 200 common procedures, including surgery, labs and imaging tests. And since price and quality are both important factors, consumers can also review quality rankings and consumer reviews of hospitals and physicians through Healthgrades®, an independent website used by more than 225 million consumers.

"We can't continue to ask individuals to take on more responsibility for health care costs without giving them the resources they need to manage those dollars," said Michael P. Freed, president and CEO for Priority Health.

"Priority Health is in a unique position to pull back the curtain on health care costs and provide our customers with the information they need to make informed health care decisions." Healthcare Blue Book uses Priority Health contracted fees to determine a "fair price" for health care services. The easy-to-understand results provide members with a traffic light visual to help them identify price ranges for facilities in each of Michigan's geographic regions. Costs are assessed, by market, on a scale: at or below fair price (indicated by green), slightly above fair price (yellow) or among the most expensive (red).

Priority Health members can log in to their accounts on *priorityhealth.com* to access the Healthcare Blue Book tool from Priority Health.

*Not available for Medicare or Medicaid members.

Learn more at *priorityhealth.com/provide*r > keyword = **Healthcare Blue Book**

October is Breast Cancer Awareness Month

Prevention steps for women and families at high risk

(September 26, 2013) Approximately 7,000 Michigan women are diagnosed with breast cancer each year. Of those, approximately 1,500 are under age 50.[1] October's National Breast Cancer Awareness Month marks an annual campaign to increase awareness and discuss risks of breast cancer as well as appropriate steps to detection and prevention.

This time of year, it is especially important to identify women at high risk, such as those with a family history of breast cancer, and to provide information about screening and prevention. Women at high risk for hereditary breast and ovarian cancer based on their family history should be

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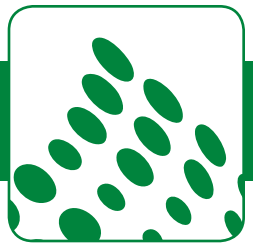

referred for cancer genetic services[2,3,4], which is a covered benefit for Priority Health members (please refer to Genetic Counseling, Testing and Screening Medical Policy #91540). Women at high risk can also benefit from earlier and more frequent screening, chemoprevention and prophylactic surgeries.[3]

Approximately one in 10 (10.4%) Michigan women have a significant family history of breast or ovarian cancer, and an estimated 90% of Michigan women with a significant family history of breast and/or ovarian cancer have not received genetic counseling and risk assessment services.[5] However, because breast cancer is common in the general population, many women with a family history are not at increased risk. Therefore, it is important to ask the questions below of women with a family history of cancer. These questions relate to first-degree relatives (parent, sibling, or child) as well as second-degree relatives (half-sibling, aunt/uncle, grandparent, niece/nephew, or grandchild) and should be asked with regard to both maternal and paternal history, as these genes can be inherited from either side of the family.

Questions for women with a family history of cancer

- Is there a breast cancer diagnosed before the age of 50?
- Is there ovarian cancer diagnosed at any age?
- Are there breast and ovarian cancer in the same person?
- Are there bilateral or multiple primary breast cancers in the same person?
- What is the family's ancestry? Is there Ashkenazi Jewish ancestry with any breast and/or ovarian cancer?
- Is there a history of male breast cancer in the family?
- Is there a known BRCA1 or BRCA2 mutation in the family?
- Was any breast cancer diagnosed prior to age 60 with triple negative pathology (ER-, PR-, Her2-)?

Women with a significant personal or family history of young breast cancer diagnosis (50 or under), ovarian cancer or male breast cancer should be referral to a trained health care provider for genetic risk assessment and genetic counseling to discuss appropriate indications for genetic testing. Several clinical tools have been created to aid in the identification of women appropriate for cancer genetic services based on their breast and ovarian cancer family history. For an electronic tool, consider the Breast Cancer Referral Genetics Screening Tool (B-RST) at *breastcancergenescreen.org/* or for a handheld tool, view the MDCH Cancer Family History Guide at *migrc.org/Providers/CancerFamilyHistoryGuide.html.* To order a copy of the Cancer Family History Guide, contact the MDCH Cancer Genomics Program at 1-866-852-1247 or genetics@michigan.gov.

1. Michigan Resident Cancer Incidence File. Updated with cases processed through December 28, 2012. Division for Vital Records & Health Statistics, Michigan Department of Community Health.

2. U.S. Preventive Services Task Force: Genetic risk assessment and BRCA mutation testing for breast and ovarian cancer susceptibility: recommendation statement. Ann Intern Med 2005; 143: 355–361.

3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Genetic/Familial Risk Assessment: Breast and Ovarian V.3.2013. © National Comprehensive Cancer Network, Inc., 2013. All rights reserved. Accessed July 1, 2013. To view the most recent and complete version of the guideline, go online to www.nccn.org. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, NCCN GUIDELINES® and all other NCCN content are trademarks owned by the National Comprehensive Cancer Network, Inc.

4. American College of Surgeons Commission on Cancer 2012 Patient Care Standards accessed June 2012 from http://www.facs.org/cancer/coc/cocprogramstandards2012.pdf.

5. Mange S, Fussman C, Anderson B, Duquette D. Breast and Ovarian Cancer Genetic Counseling Among Michigan Women. Lansing, MI: Michigan Department of Community Health, Lifecourse Epidemiology and Genomics Division, Surveillance and Program Evaluation Section, Chronic Disease Epidemiology Unit, June 2013.

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Priority Health News

Provider news changes

Maybe you've noticed some changes in how we are bringing you the news from Priority Health these days.

Getting you your news faster

All news articles are immediately added to the Physician and Practice News area at *priorityhealth.com*, instead of saving them for inclusion in a bi-monthly issue of the newsletter.

Highlighting "Recent news"

Each time we add a news article or make a change to the Provider Manual, we add a headline to the "Recent news" area to alert you. "Recent news" shows up in three places:

- Your logged-out home page
- Your logged-in home page
- The main provider news page

Now you can search by category and topic

Are you interested only in certain kinds of news items? Each news item is now tagged with a category, such as "Authorizations" or "Billing and Payment." It can also have several "topic" tags, like "Medicare" or "Preventive health."

Click any news tag and all articles that share the same tag will appear in a list. For example, clicking the "Medicare" tag on a news item will bring up all other items related to Medicare from the last few months of news. To see all the category and topic tags, scroll all the way down the left-hand column of any news item.

In case you miss a news item or two

We know you don't have time to check the news every time you visit *priorityhealth.com*. We'll be collecting the news items into a digest like this and sending it out to physician practices. We plan to send the digest out quarterly — spring, summer, fall and winter.

PriorityHealth

1231 East Beltline Ave. NE
Grand Rapids, MI 49525

Physician and Practice News Digest

Questions?

Contact your provider account representative (PAR) with questions related to information in this newsletter. Need to find your PAR? When you are logged in to your ***priorityhealth.com*** account, your PAR's name appears in your *Find a Doctor* tool listing details.

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