PriorityHealth

Physician and practice news digest

Fall 2014

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Billing & payment

Email address change for claims and payment questions

(07-15-2014) You can now use our general email address for all inquiries regarding claims questions or requests for claim appeals. It is *provider.services@priorityhealth.com*.

We recently integrated our claim review service teams and no longer use separate email addresses for facilities, ancillary groups and practitioners.

Claims/payment faxes

When faxing information related to claims or appeals use the fax number: 616.975.8856.

Look for separate contraceptive-only ID cards

(06-20-2014) We're required by Health Care Reform laws to offer contraceptive and sterilization coverage for all female members ages 10 to 65, even if their employers are religious organizations who choose not to cover these services. Some members have two ID cards, each with a distinct contract and group number: one for their medical coverage and one for contraceptive and sterilization coverage.

The number of dual card-carrying members may increase throughout the year as contracts renew.

Use the Member Inquiry tool to verify contraceptive contract number

You can verify this coverage by logging in to *priorityhealth.com/provider* and opening the Member Inquiry tool. Go to the member detail page and scroll down to see if there is a second employer section that says "Employer Group: Women's Contraceptive."

- Use the member's contract number from their Priority Health ID card that says "Group ID: 991100 Women's Contraceptive" anytime you're billing preventive contraceptive or sterilization services not covered by the member's medical plan.
- Use the member's contract number from their Priority Health ID card with the group ID that lists their employer for any services covered by their medical plan.

Submit claims with the appropriate contract number

We continue to remind dual card-carrying members to present the appropriate card at the time of service, but we ask for your help on the front end to check with patients and to use the correct contract number when submitting claims.

Understanding your Medicaid uplift payment

(07-01-2014) You may have recently received an uplift payment for the balance owed for services you provided to Medicaid patients in 2013. You received the check as part of the Affordable Care Act and Medicaid expansion—ACA legislation that was designed to increase access for Medicaid patients by reimbursing providers at the Medicare rate.

We will distribute to you quarterly a pass-through payment from the State of Michigan. The state is focused on providing you the maximum reimbursement possible but reconciliation of this payment with your patient encounter data has been and will continue to be challenging.

We appreciate your patience and partnership. We want to work with you to provide meaningful information about your patient encounters including giving you options to sort the data we provide with the uplift payments. If you have questions or concerns, contact your Provider Account Representative.

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Billing & payment

Medical records required for modifier 59

(05-30-2014) Due to inaccurate or inappropriate use of the modifier when submitted for certain code pairs, we now require the submission of medical records with initial claims for select CPT codes when reported with modifier 59.

Although modifier 59 may be appended to a claim line on first submission, this does not guarantee reimbursement of these services. Documentation must support a distinct procedural service.

Reasons for this requirement

CPT guidelines indicate that modifier 59 (distinct procedural service) should be utilized only when documentation supports a different session, different procedure/surgery, different surgical site, separate injury, separate incision or excision, or separate lesion for services that are otherwise considered bundled. The use of this modifier has been identified by the Office of Inspector General (OIG) as a commonly misused modifier. Inaccurate or inappropriate use of this modifier can generate overpayments, incorrect coding and increased member cost sharing.

See the list of CPT codes

We have updated the billing information for modifier 59 in the Provider Manual with this requirement, including a list of the codes that will require submission of medical records. Go to *priorityhealth.com/provider*. Search keywords: **Modifier 59**

EFT and ERA now accepted electronically only

(05-02-2014) We no longer accept requests for EFT or ERAs via paper or fax. All new requests and changes to previously submitted requests must be completed electronically.

In January, we created two electronic forms that allow you to 1) request to be set up for electronic funds transfer (EFT) to receive claims payments, and 2) to receive remittance advices (ERAs) electronically. You just complete them online and click to submit them.

Find forms and instructions at *priorityhealth.com/provider*. Search keywords: **Electronic funds transfer**

Billing for labs/screenings under Medicare

(05-01-2014) We're finding that some lab claims for Medicare patients are being denied, not because they shouldn't be covered, but because they're not submitted with the codes that are covered by Medicare. This is causing unnecessary member appeals.

That's why we've expanded the information in our Provider Manual about this topic. We want to help you understand how to order and bill routine, preventive and diagnostic lab tests and screenings for your Medicare patients. You'll find clarification at *priorityhealth.com/provider*. Search keywords: **Medicare lab tests**

Billing & payment

Spiral CT screenings for lung cancer covered at a reduced rate

(06-02-2014) As of Aug. 1, 2014, spiral computed tomography (CT) scanning is a covered service for annual screening for lung cancer in high-risk patients.

- Covered by HMO, POS, PPO, MyPriority℠ and Priority Health Choice (Healthy Michigan Plan and Medicaid) plans
- Not a covered benefit for Medicare, as services are determined by the Centers for Medicare and Medicaid Services (CMS)

Reminder: This and other high-tech radiology services require prior authorization through AIM.

Billing information for preventive spiral CT scans

Note that, although spiral CT scanning is a covered service when the criteria are met, it will not be considered a preventive benefit until Jan. 1, 2015.

When performed as preventive, this service should be billed with CPT code 71250 and modifier 33. Payment will be at 60% of fee schedule. Member liability applies.

The use of the CPT code with modifier 33 is temporary until a permanent code is established.

Eligibility criteria

High-risk patients include those who meet all of the following criteria:

- No signs or symptoms suggestive of underlying cancer
- Age is equal to or greater than 55 and less than or equal to 80
- At least a 30-pack/year history of cigarette smoking
- If patient is a former smoker, his/her quit date is within the past 15 years

This information has been added to the Provider Manual at *priorityhealth.com/provider*. Search keywords: **Spiral CT scans**

Corrected claim submission changes for Oct. 1

(08-26-2014) To comply with contract language regarding claim submissions, effective Oct. 1, 2014, we will no longer accept requests for reprocessing claims by email, reports or Excel files.

If a claim was denied or paid incorrectly as the result of the way the claim was originally billed (i.e. billing error, improper billing), you must submit a corrected or voided claim. Find complete information on how to submit a corrected claim in the Provider Manual.

Pharmacy

Reminder: Pharmacy benefit coverage varies among members

(07-01-2014) Priority Health offers many pharmacy benefit choices including employer-sponsored (commercial), Medicaid and Medicare. Pharmacy benefits among 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.
- **Medicare** — Priority Health Medicare Advantage members typically have a four-tier copayment, though some Medicare plans provided by an employer may choose to have a two-tier copayment.

Zetia formulary change effective July 1

(06-27-2014) New treatment suggestions for patients with hypercholesterolemia have been made by the ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, the successor to ATP-III.

One of the larger changes addresses add-on therapies beyond standard statin therapy. The new guidelines found no existing data to show that adding a non-statin drug to a high-intensity statin therapy provides incremental ASCVD risk reduction.

Our goal is to minimize patient exposure to medications that do not provide a mortality benefit and help reduce the cost burden on both patients and the health care system. Therefore, we have made the following changes to our formulary effective July 1, 2014.

Zetia add-on therapy has moved to non-preferred brand status for commercial members

Formulary	Zetia, prior tier	Tier as of July 1, 2014
Employer-sponsored and individual (Commercial)	Preferred brand	Non-preferred brand
Medicare	Preferred brand	Preferred brand*
Medicaid	Excluded	Excluded

**Zetia will move to non-preferred brand status Jan. 1, 2015.*

Members taking Zetia who have been affected by a copayment change have received letters from us. They were encouraged to discuss their treatment with you.

continued >

Pharmacy

Evaluation of other add-on therapies suggested

We strongly encourage you to evaluate the use of other add-on therapies such as niacin and fibric acid in current and new hypercholesterolemia patients. Members on these products also received letters encouraging them to discuss with you the risks and benefits of continuing treatment.

Contact your Provider Account Representative to receive a list of your patients impacted by this formulary change.

Reminder: Medicare formulary exception process

(07-01-2014) For drugs that are not on our Medicare formulary or that require utilization management (e.g. prior authorization, step therapy, quantity limits), you can request an exception to coverage if the covered alternatives won't work or have not worked as well for the member.

All Medicare prior authorization forms ask you to supply supporting evidence/documentation when requesting an exception. When evidence/documentation is provided, we will use this information in determining if the request is medically necessary. If the evidence/documentation is not received, requests will not be approved.

Find medication prior authorization forms at *priorityhealth.com/provider*. Search keywords: **Prior auth forms**

Reminder: Formulary updates

(06-05-2014) The Pharmacy and Therapeutics Committee meets every other month to review the Priority Health formularies. Our pharmaceutical management procedures are reviewed annually. Both are available online in the "drug auths" section of the Provider Manual.

How to get a copy of our formulary

The updates are available at *priorityhealth.com/provider*. Search keywords: **Printable drug list**

Reminder: Drug auths after hours

(07-01-2014) 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 assure 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.

Reminder: Adverse drug event? Contact MedWatch

(05-01-2014) If a patient experiences an adverse drug event, product problems or product use errors, we encourage you to report it to MedWatch by:

- Calling 800.FDA.1088 (800.332.1088), or
- Using the MedWatch Online Voluntary Reporting Form at *www.fda.gov/safety/medwatch*

Questions about utilization management decisions and processes?

Call the Pharmacy department at 800.466.6642. Physician and pharmacist reviewers are available to help you.

Plans & benefits

Clarification on Healthy Michigan Plan HRA reimbursement

(08-12-2014) When individuals first sign up for the Healthy Michigan Plan, they are covered under Medicaid fee-for-service. During that time the State will not reimburse primary care providers for submitting the members' HRAs.

How to request reimbursement for the HRA

Always wait until the patient is assigned to you as a Priority Health Healthy Michigan Plan member before submitting the HRA to us.

If you complete the HRA for patients before they're assigned to Priority Health, hold on to the HRA until the patient's effective date, which you can find using the Member Inquiry tool. We can't hold the HRA for later processing.

Once a patient is a Priority Health member:

1. HRAs completed during the member's fee-for-service coverage period must be faxed to us within 30 days of the member's effective date with Priority Health
2. Fax us the HRA completed at the initial visit
3. Bill us for 99420
4. Use the date you are transmitting the HRA and claim to us, NOT the date of service, on both the HRA and the claim. Then we will reimburse you for the HRA.

Further details

Per direction from the State of Michigan, PCPs must use the date of submission of the Health Risk Assessment form as the date of service when billing code 99420.

Providers should periodically check the Community Health Automated Medicaid Processing System (CHAMPS) for health plan enrollment information. Effective dates with Priority Health can be found by logging in to the Member Inquiry tool.

Questions?

See more details in the Provider Manual or contact your Provider Account Representative (PAR) with questions.

Changes to the Preventive Health Care Guidelines

(08-08-2014) Our commercial group and individual health plans cover preventive services as outlined by the Affordable Care Act and recommended by the U.S. Preventive Services Task Force, Centers for Disease Control and Prevention and Health Resources and Services Administration. By following these guidelines, we're making sure the care we recommend and cover as preventive is safe and effective according to the latest medical research.

Changes to our Preventive Health Care Guidelines may now take place throughout the year

You can always find them as web pages and printable PDFs at *priorityhealth.com/preventive*. Also see our online Provider Manual for coding and billing help for preventive services.

CBC removed from our guidelines Jan. 1, 2015

Complete blood count (CBC) will no longer be covered as a preventive service.

Added to our guidelines:

Service	Recommendation	Effective date
Hepatitis C screening	Adults at high risk and a one-time screening for adults born between 1945 and 1965	**July 1, 2014** New to our guidelines
Vitamin D supplement	For adults age 65 and older who have an increased risk of falls	**July 1, 2015** New to our guidelines
BRCA risk assessment and genetic counseling/ testing	Risk assessments for women with a family history of breast, ovarian, tubal or peritoneal cancer. Women who test positive should receive genetic counseling and, if indicated after counseling, BRCA testing.	**Sept. 1, 2014** Risk assessment and testing are new to our guidelines

Plans & benefits

Service	Recommendation	Effective date
Breast cancer prevention medication	Risk-reducing medicines for women with an increased risk of breast cancer	**Sept. 1, 2014** New to our guidelines
Lung cancer screening	Annual screening (including CT) for adults ages 55 to 80 who smoke or quit smoking within the past 15 years	**Jan. 1, 2015** New to our guidelines

Welcome Henry Ford Health System

(06-27-2014) We're pleased to partner with Henry Ford to broaden access to high quality health care in metro Detroit. As of Aug. 1, members with HMO, PPO, POS and Medicare coverage can seek health care services with all 2,000 Henry Ford Health System providers, hospitals, health centers, urgent care facilities and outpatient clinics.

Learn more about Henry Ford at *henryford.com*.

Medicare home care evaluations must be face-to-face in 2015

(07-31-2014) Beginning in 2015, Medicare Advantage Organizations must ensure that their members are certified for home health care services by a face-to-face evaluation.

The Centers for Medicare and Medicaid Services (CMS) announced this requirement in its call letter for policy changes effective Jan. 1, 2015.

Priority Health follows CMS rules for certification of home health care. Beginning Jan. 1, 2015, our members must have evidence in the home care agency's records that they received this evaluation. All applicable Medicare rules concerning face-to-face evaluations apply.

For more information see MLN Matters SE 1038 and CMS Home Health Care FAQs at *cms.gov*.

New Michigan QIO as of August 1

(07-30-2014) The Centers for Medicare and Medicaid Services (CMS) has announced that, effective Aug. 1, 2014, the new Quality Improvement Organization (QIO) for the State of Michigan is:
KEPRO
5201 W. Kennedy Blvd, Suite 900
Tampa, FL 33609
Toll Free: 1.855.408.8557
Fax: 1.844.834.7130

The Notice of Medicare Non-Coverage (NOMNC) reflecting this change in QIO will soon be posted at *priorityhealth.com/provider/forms*.

Performance programs

2014 Physician Quality Award recipients

(07-17-2014) We recognize our Quality Award recipients for providing exceptional patient care, and for their contribution to making health care more accessible and more affordable in their communities. We applaud the physicians, health care professionals and practice staff for their commitment to improving the health and lives of our members. See the list of this year's recipients at *priorityhealth.com/provider*. Search keywords: **Quality awards**

Responsibilities & standards

CAQH online applications mandatory as of June 1

(05-01-2014) As of June 1, 2014, all providers seeking initial credentialing or participating in recredentialing with Priority Health must be registered with the Council for Affordable Quality Healthcare (CAQH).

CAQH is an online provider data-collection service. Using Universal Provider Data (UPD), the CAQH application streamlines provider data collection by using a standard electronic form that meets the needs of nearly every health plan, hospital or health care organization. UPD enables physicians and other health care professionals in all 50 states and the District of Columbia to enter information free-of-charge into a secure central database, then authorize health care organizations to access that information. UPD eliminates redundant paperwork and reduces administrative burden.

If you're not yet registered, go to *https://upd.caqh.org/oas/*. Or, call CAQH at 888.599.1771.

Learn more about the Priority Health credentialing and recredentialing process in our online Provider Manual.

Reminder: Behavioral health standards for utilization, medical necessity and level of care determinations

Behavioral health utilization decision process reviewed

In order to serve the best interests of our members, we make utilization decisions that are fair and consistent by:

- Basing utilization decisions only on appropriateness of care and service as well as existence of coverage
- Not compensating or rewarding practitioners or other reviewers for denial of coverage or service
- Not offering financial incentives for utilization decision-makers to encourage denial of coverage or service
- Deciding on coverage of new technology after comprehensive research and careful review by our board-certified psychiatrists
- Providing information about the utilization management process and the authorization of care

If you have a question regarding general or specific utilization management decisions or processes, contact the Behavioral Health department at 800.673.8043. Complete details are available in the Behavioral Health section of the Provider Manual under Authorizations > Behavioral Health.

Medical necessity and level of care determination criteria reviewed

The Behavioral Health Medical Necessity Criteria and Level of Care Standards are reviewed annually by the Priority Health Medical Affairs Committee. This is a multidisciplinary group of mental health and substance abuse disorder treatment providers. The Behavioral Health Medical Necessity Criteria and Standards were last reviewed in August 2014. Request a copy or get answers to specific questions about behavioral health utilization by contacting the Behavioral Health department at 800.673.8043 or 616.464.8500.

Reminder: Behavioral health staff available 24/7 for emergencies

Call us at 616.464.8500 or 800.673.8043. Our business hours are Monday – Thursday, 8 a.m. - 5:30 p.m., Friday 8 a.m. - 5 p.m. After hours, choose option #1 when prompted and your call will be routed to our emergency answering service.

Clinical resources

National Depression Screening Day (NDSD) is October 7

(07-01-2014) 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.

Reminder: Review the clinical practice guidelines

(05-01-2014) Clinical practice guidelines are developed in collaboration with area physicians based on standards established by national organizations. Each guideline addresses a specific condition, diagnosis, therapeutic intervention, patient education/follow-up, continuity and coordination of care.

Go to *priorityhealth.com/provider/clinical-resources* to find guidelines for:

- ADHD
- Advance care planning
- Alcohol and substance use
- Asthma
- Back and neck pain
- Cardiovascular conditions
- Chlamydia
- Depression
- Developmental screenings
- Diabetes
- Influenza
- Lead poisoning
- Maternity
- Obesity
- Osteoporosis
- Pain management
- Sleep apnea
- Tobacco use

Training opportunities

Priority Health Academy

The Priority Health Academy is a convenient, affordable opportunity for network practice staff members to enhance their skills in a variety of subjects. Three dates/locations are available and all include lunch. Judy B. Breuker, CPC, CPMA, will present a coding update session at all three locations.

Register early as space is limited. Additional course information and the registration form are available at *priorityhealth.com/provider*. Search keywords: **Priority Health Academy**

Southfield	**Wednesday, Oct. 29** 9 a.m. – 3:40 p.m.	Hilton Garden Inn
Grand Rapids	**Monday, Nov. 10** 8 a.m. – 4 p.m.	Calvin College Prince Conference Center
Traverse City	**Wednesday, Nov. 12** 9 a.m. – 4:30 p.m.	Traverse City Golf & Country Club

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1231 East Beltline Ave. NE
Grand Rapids, MI 49525

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**Registration verification process takes up to five business days.*