PriorityHealth

Physician and practice news digest

Spring 2014

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Billing & payment

EFT and ERA setup available through electronic forms

(Jan. 7, 2014) Previously, requesting electronic funds transfer (EFT) or electronic remittance advices (ERAs) required you to fill out and return to us two separate forms. For EFT, you also had to attach a voided check. We have simplified the process by creating electronic forms you can fill out and submit online.

You must log in before you click form links

Log in to your provider account at *priorityhealth.com*. If you're not logged in, you will be asked to log in, but then you'll be sent to your main account page and you'll have to go back to the provider forms page and click the link to the form again. Links exist to:

- Direct deposit and electronic funds transfer (EFT) form
- Electronic remittance advice registration form

For more details

Place your cursor over any field on the forms to get additional information on how to complete them. See more information in the Provider Manual under:

- Electronic funds transfer setup page
- EDI setup page

Care management billing and coverage updates

(Dec. 30, 2013) Priority Health reimburses practices for care management plan-of-care G-codes and telephone visits. Coverage is offered to all members in fully-funded HMO, POS and PPO plans.

$0 member liability

To align with the goals and objectives of the Michigan Primary Care Transformation (MiPCT) demonstration and to improve access to care management services, care management G-codes and telephone visit CPT codes will be reimbursed without member liability.

Special claims process

The codes listed below process and pay as $0 on your Remittance Advice and the reflect code is CO96, "no compensation allowed for this service – reporting only." Every 60 days, Priority Health batches a payment for the full allowed amount of each practice's billed G-code and telephone visit CPT codes. These payments are sent to the practice's claims remittance advice address.

Codes covered include: G9001, G9002, G9007, G9008, 98966, 98967 and 98968.

Now applicable for QHP telephone visit billing

Qualified health professional telephone visit codes can be billed and are payable as of Jan. 1, 2014.

HRA overpayment recovery to be automated

(Jan. 16, 2014) Effective Feb. 3, 2014, Priority Health began to auto-recover health reimbursement arrangement (HRA) overpayments when possible. This reduces the need for you to send refund checks, saving both time and processing costs.

In some cases, we will not be able to auto-recover an HRA overpayment, such as when we have no further claim payment on the employer group or line of business from which the overpayment was made. When that happens, you'll need to send us a refund check. Check your monthly overpayment statements for updated information.

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Billing & payment

New clinical edits tool for Medicare DME claims

(Jan. 29, 2014) We're excited to introduce to DME providers a tool that shows you how clinical edits will be applied to Priority Health Medicare claims before you submit them. It also explains how edits have been applied to your processed Medicare claims. The OPTUMInsight™ (formerly Ingenix®) tool, known as iCES, became available on Feb. 24.

Find out how Medicare DME claims will adjudicate

The "what if" component of iCES, called Edits Checker, will show how your Medicare DME claims will pay. Just enter your billing and diagnosis code options. You'll be able to click on references to learn how and why the edits apply. To use the tool, log in to *priorityhealth.com/provider* and click the "edits checker" link in the list of provider tools on your home page.

The claims processing tool speeds payment

The claims processing component of the edits checker tool reduces Priority Health processing turnaround time for faster claims payment with automatic adjudication rates.

- Transparency is improved because the tool displays clearly defined editing rules and sources
- Streamlined clinical edit definitions follow NGS MAC using LCDs
- Faster clinical edit review is available right in the tool

On your view of any processed Medicare claim, you'll find a "see edits" link on the claim screen. Click the link to find how the edits checker tool applied clinical edits to a claim and sites sources for the editing rules.

New requirements for therapy modifiers

(Dec. 18, 2013) Effective for dates of service on or after Jan. 1, 2014, as required by the Patient Protection and Affordable Care Act (PPACA), providers are required to bill all therapy codes with modifiers consistent with Medicare rules.

This applies to all products for providers who bill using a CMS 1500 form. Learn more in the Provider Manual under:

- GN, GO, and GP therapy code billing
- Physical therapy billing

Urgent care billing update

Effective immediately, services obtained in an urgent care setting must be billed as follows:

Hospital based urgent care

UB: Rev Code 456 or 516 (whichever is appropriate) with corresponding E&M code*

1500: POS 22 with corresponding E&M code

**member liability will be applied, if applicable*

Independent urgent care

1500: POS 20 with corresponding E&M*

**member liability will be applied, if applicable*

Questions about billing and payment?

Email the Provider Payment Solutions Center at *provider.services@priorityhealth.com.* Go to *priorityhealth.com/provider/manual* or call the Provider Helpline at 800.942.4765, option 2.

Pharmacy

Changes to Medicare Part B vs. Part D coverage determinations

(Jan. 24, 2014) Per recent CMS guidance, we are changing our process for notifications for Medicare Part B vs. Part D medication coverage determinations.

Currently, when a medication is determined to be covered under the member's Part B benefit and, therefore, is not a Part D drug, we send the member an approval letter. However, this approval letter does not explain that the drug is being covered under the member's Part B (medical) benefit, which can cause confusion.

New notification format as of March 1, 2014

We have revised our process to issue a "Notice of Denial of Medicare Prescription Drug Coverage." This notice, required by CMS, explains that:

- The drug is being denied for coverage under Medicare Part D
- It is covered under the Medicare Part B benefit

Essentially, we will be making both Part B and Part D coverage determinations simultaneously and communicating those decisions in one notice.

Reminder: Formulary updates

(Jan. 30, 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

Our commercial, Medicaid and Medicare formularies are available through our website at *priorityhealth.com/provider*. Search keywords: **printable drug list**

Last year we updated the formulary quick reference guide that summarizes our coverage of drugs used to treat common conditions. To print a copy, visit *priorityhealth.com/provider*. Search keywords: **affordable prescription guide**

Reminder: Reduce medication waste

(Jan. 15, 2014) In an effort to lessen the likelihood of waste associated with prescriptions, we encourage you to be judicious in the quantity prescribed for new medications. While our benefit allows for up to a 90-day supply for commercial and Medicare members, consider writing for less when prescribing a new medication. Why? Sometimes patients may experience an adverse reaction or side effect with a new medication and will discontinue it before a 90-day prescription is fully used. Or the medication may require a dosage titration prior to 90 days. Also, members save money by paying one copayment, instead of two or three copayments, for what could end up being wasted medication.

Go green!

Reducing medication waste helps the environment, as medications that are not disposed of properly can pollute. For more information on proper medication disposal, visit *fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186188.htm*.

Questions about pharmacy utilization management decisions and processes? Call the Pharmacy department at 800.466.6642. Physician and pharmacist reviewers are available to assist you.

Plans & benefits

New benefit in 2014: Medicare phone and web visits

(Dec. 24, 2013) As of Jan. 1, 2014, Priority Health Medicare Advantage plans cover a new supplemental benefit called Web and Telephone-Based Technologies. The Centers for Medicare and Medicaid Services (CMS) approved Priority Health Medicare to offer this supplemental benefit for diagnosing and treating conditions online or via the telephone.

CMS already covers this benefit for use in rural health professional shortage areas (HPSA) and counties not classified as a metropolitan statistical area (MSA). With the approval of this supplemental benefit, Priority Health Medicare is able to offer telehealth services not just in rural areas but in all parts of our service area. This expands the ability of providers to reach members who may be confined to their homes, especially the frail and elderly.

Plans affected

This benefit applies to members of all four Priority Health Medicare Advantage plans:

- **Priority**Medicare Value℠ (HMO-POS)
- **Priority**Medicare℠ (HMO-POS)
- **Priority**Medicare Merit℠ (PPO)
- **Priority**Medicare Select℠ (PPO)

Details and codes

For details, see phone and e-visit billing under Medicare in the Provider Manual.

Getting questions about "narrow networks"?

(Jan. 27, 2014) As we settle into 2014, health care reform questions continue. You may be getting inquiries from patients, and potential patients, about whether or not they will still be able to see you.

What are narrow networks?

This is one topic that has gotten a lot of local and national press coverage. It refers to plans that restrict the facilities and providers members can use when they need care. Priority Health does not have narrow network plans. Help your patients understand their plan options by reminding them that not all plans or carriers are created equal.

Signs to look for to identify a narrow network

If patients are buying new coverage they should be sure to read the fine print. Some of the plans with the lowest monthly premiums have a lot of restrictions that people won't expect if they're used to employer-provided health coverage.

- The low-cost plans may come with very limited networks that restrict access to only a few hospitals and medical groups.
- Often, those same plans require a referral to see a specialist.
- Many have prior authorization requirements on more services than is typical.
- Some of the new PPO plans do not cover basic services such as urgent care, physician office visits and specialist visits when the plan member goes to out-of-network providers. There is simply not an option to pay out-of-network rates.

Priority Health still offers direct access to robust networks

A broad choice of doctors and hospitals participate with our networks. Member benefits include:

- Individual plans that use the same network of providers as those on our commercial/employer-sponsored plans
- No referrals required to see a specialist
- True PPO plans in which members can go to any health care provider for covered services. They'll just pay more when going out of their network.

More health reform and coverage information for individuals

If your patients have questions about how to purchase health insurance, direct them to *priorityhealth.com*. Keywords: **get covered**

Plans & benefits

Health care reform resources available

(Nov. 7, 2013) When it comes to health care reform, we know you wear many hats. As a trusted health resource, you get questions from your patients. You may also be an employer or a staff member with personal questions on what health care reform means to you.

We continue to develop tools to help prepare you, your practice and your patients for changes ahead. Visit "health care reform for providers" in the news & education area of *priorityhealth.com/provider*, for:

- Health reform and providers webinar series
- Consumer advocate toolkit with a webcast and printable patient education pieces
- White papers on health reform issues such as *Transforming your business: The effects of health care reform on providers*

Reminder: Check the preventive health care guidelines

(Feb. 3, 2014) Each year, before releasing our annual update to our Preventive Health Care Guidelines, Priority Health reviews current evidence and guideline statements on effective preventive health care. This year, we also must consider the requirements of the Affordable Care Act. For 2014, only minor changes were made.

You can always find the guidelines on *priorityhealth.com/provider*. Search keywords:

- Commercial and individual plan preventive health care guidelines
- Medicare preventive health care guidelines
- Prenatal and maternity care guidelines

Preventive care billing codes are available at *priorityhealth.com/provider*. Search keywords: **preventive service codes**.

CMS ruling on coverage of Medicare skilled care

(Jan. 20, 2014) Medicare coverage of skilled care offered by a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), home health (HH) or other outpatient (OPT) facility has been clarified by revised language in the Medicare Managed Benefits Manual. Priority Health follows the CMS determination regarding a beneficiary's need for skilled care.

MLN Matters bulletin MM8458 states, as an overview:

> In accordance with the Jimmo v. Sebelius Settlement Agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant program manuals used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

For additional information on what language changed in the Managed Care Manual, go to *cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf*

continued >

Plans & benefits

Autism benefits coverage changes for 2014

(Jan. 24, 2014) Based upon providers' observations, questions and feedback, and further direction from state and federal legislative bodies, Priority Health has made changes to our coverage of services for the treatment of autism spectrum disorders.

Benefit available as plans renew in 2014

This new benefit will be available to members beginning with their plan renewal. For example, if a member's plan does not renew until July, the new autism benefit will not be available for that member until July 1, 2014. It won't be available to some groups with grandfathered plans or those that are keeping their 2013 plan through 2014.

What has changed?

- **Day limits**: Instead of a cap on the dollar amount, services will be managed through a maximum number of allowed days, 135 days per contract year for 2014. There is no limit on the number or type of services that can take place on a given date of service.
- **New habilitative services benefit category**: The new benefit for the treatment of autism disorders will be considered a habilitative services benefit. It won't count against the traditional behavioral health benefits of counseling, psychiatry, etc. The habilitative services benefit will include applied behavioral analysis (ABA), speech therapy, occupational therapy and physical therapy when billed with an approved autism spectrum disorder diagnosis. All four of these service types will count toward the day limit.

What remains the same?

- Treatment services are only available to members with an approved autism spectrum disorder diagnosis through the age of 18.
- Coverage is included in all commercial plans and the My**Priority**SM individual plans.
- Self-funded plans are exempt from the state mandate, but riders can be elected for the coverage of services to treat autism.
- Priority Health Choice (Medicaid) members under the age of 5 should be directed to their pediatrician, primary care physician or the Community Mental Health authority for their county of residence. Medicaid members from age 5 to 18 should be directed to the appropriate staff at their school district.
- A child or adolescent receiving ABA services must be re-tested every three years using approved tools and methodology to insure proper diagnosis and treatment recommendations.

Prior authorization requirements will not change

We have added a new page to the Provider Manual to document autism treatment requirements. Go to *priorityhealth.com/provider/manual/auths/autism*.

- Prior authorization is required for applied behavioral analysis (ABA) therapy and psychotherapy when treating a child diagnosed with an autism spectrum disorder.
- Prior authorization is not required for speech therapy, occupational therapy or physical therapy when billed with an autism spectrum disorder diagnosis.

Provider credentialing and oversight

Contracted providers must still complete a supplemental application process to be approved to treat members diagnosed with an autism spectrum disorder. If you have not gone through this approval process, any claims you submit will be delayed or denied for payment. State legislation still requires that ABA treatment be overseen by a board-certified behavioral analyst (BCBA).

For more information see the Priority Health medical policy 91579 at *priorityhealth.com/provider/manual/auths/~/media/documents/medical-policies/91579.pdf*

Responsibilities & standards

HEDIS chart reviews coming in March

(Jan. 14, 2014) Our annual HEDIS® (Healthcare Effectiveness Data and Information Set) member chart reviews will start in March. The purpose of HEDIS is to allow employers and the general public to compare health plans and understand the value of their health care. Member charts will be randomly selected to be audited for compliance.

What the review entails

If one of your patients is selected, Priority Health will be looking for specific information in your patient's chart for one of 13 HEDIS measures such as childhood immunizations, preventive cancer screenings, chronic disease management or medication monitoring. The level of detail needed in your patient's chart differs with each measure. Some measures, such as preventive cancer screenings and immunizations, require a simple yes or no answer to the question "was this completed?" Others, such as long-term medication monitoring, require more extensive medical record review. To be able to appropriately review this information, we may need to see the patient's chart for multiple years.

Review permitted under HIPAA rules

The HIPAA Privacy Rule permits a provider to disclose protected health information to a health plan for the quality-related health care operations of the health plan, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. HEDIS review is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rules [45 CFR 164.501 and 506(c) (4)]. Thus, a provider may disclose protected health information to a health plan for the plan's HEDIS purposes.

Thank you for your help and flexibility over the next few months as we contact your office to schedule chart reviews. If you have questions about HEDIS, contact Chelsea Selbig at 616.464.4146.

Behavioral health/PCP coordination of care survey results available

(Feb. 4, 2014) Each year, we survey PCPs and behavioral health specialists to promote coordination of care and support quality improvement.

Compared to 2012:

Although behavioral health practitioners report greater direct collaboration with a client's primary care physician to coordinate treatment, information exchanged typically occurs only at the initial evaluation and at discharge. The most frequent information shared is treatment plan and goals, and summaries of care.

- Direct collaboration with a client's primary care physician to coordinate a client's treatment plan increased from 87% to 89%.
- Information exchanged upon initial evaluation and upon client discharge increased from 37% to 60%.
- However, greater gaps exist in direct communication during the actual treatment phase or when the treatment plan is updated. This exchange of information declined from 63% to 42%.

Mailing and faxing remain the primary method of communication between medical and behavioral health providers, as only 53% have shared electronic medical systems to view each other's notes. This is up from 24% in 2012.

Reminder: HIPAA regulations allow for coordination of care

We encourage you to make coordination of care a routine part of your treatment plan for all treatments, including behavioral health. The behavioral health coordination of care form is in the provider forms section at *priorityhealth.com/provider*. If you prefer, you may create your own equivalent coordination of care form or letter.

HEDIS is a registered trademark of the National Committee on Quality Assurance.

Responsibilities & standards

HIPAA Code of Federal Regulations, Section 45 CFR 164.506, allows for the sharing of protected health information for the coordination of care between providers. If you have questions about coordination of care, contact our Behavioral Health department at 800.673.8043.

Reminder: Quality assurance programs information online

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*. Search 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 *robert.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 and adherence to evidence-based treatment, and assist them with 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 *priorityhealth.com/provider*.

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 *priorityhealth.com/provider*. Print copies are available upon request through the Provider Helpline at 800.942.4765, option 2.

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, option 4.

Medical utilization criteria

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

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

John Fox, M.D.
Associate VP, Medical Affairs
616.464.8454
john.fox@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 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

continued >

Responsibilities & standards

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.

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. 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 health management staff through the Provider Helpline at 800.942.4765, option 4.

Member rights and responsibilities

Rights and responsibilities can be found online in the member handbooks at *priorityhealth.com/member*. Search keyword: **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 and provider status information. You'll find it all at *priorityhealth.com/provider/manual*.

Inform patients of their right to formulate advance directives

Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. We ask that you inform your patients of their right to formulate advance directives and document in a prominent place in the medical record if a patient has executed an advance directive. For more information, patients can go to *priorityhealth.com* and search keywords: **advance directives**.

Need help accessing our online tools?

Need a provider account? No problem. Just go to *priorityhealth.com/provider* and select register now. Questions? Contact the Provider Helpline at 800.942.4765, option 2.

Authorizations

New post-acute-care rehabilitation management system

(Jan. 13, 2014) Priority Health has implemented a new clinical quality initiative for our members. We've partnered with a company called naviHealth™ to enhance the quality of post-acute-care (PAC) services.

NaviHealth offers an evidence-based decision support tool called LiveSafe™. Care managers enter a patient's functional, cognitive and clinical information, as provided by acute care facility staff, into the LiveSafe™ tool. The tool then provides a recommendation not only for the most appropriate type of post-acute-care setting for that particular patient, but also detailed information about the rehabilitation therapy intensity and expected length of stay that will help that patient regain their functional status. This recommendation helps the patient and their family plan a smooth, efficient, seamless and well-planned care transition from hospital to rehabilitation facility to home.

Benefits to patients

- Data-driven information will help patients and their families understand what to expect at discharge and throughout the rehabilitation period.
- The focus is on what is best for the patient, and the holistic management of patient care through discharge planners, rehabilitation therapists, social workers and Priority Health care managers.

Benefits to care providers

- No extra paperwork
- Determination of the optimal discharge setting earlier in the hospital stay
- Easier management of patient/family expectations
- Lower hospital admission rates
- Benchmarking of post-acute provider performance identifies the highest quality providers in your area

Changes to genetic counseling requirements

(Jan. 21, 2014) Since June 2013, we have noticed a significant increase in both the number of genetic tests being ordered and the number of laboratories performing such testing. In several situations testing was not appropriate, or the wrong test was ordered and completed, so we could not cover the cost of the test. This leads to significant out-of-pocket costs for members.

Going forward, we will carefully evaluate laboratories to ensure the best possible results for both members and providers. As our partner, you can help. By ensuring that your patients get the genetic counseling services covered by their Priority Health plans prior to testing, you can ensure the most appropriate evaluation of the member's clinical situation and help your patients make informed decisions.

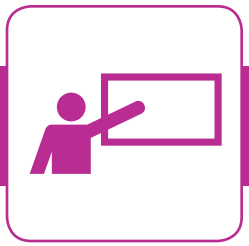
Our genetics testing policy

- Please review with your staff our genetics counseling, testing and screening policy at *priorityhealth.com*. Search keywords: **genetics testing medical policy**
- Appendix A on page 26 of that policy has a list of tests that require genetic counseling either before or at the same visit as the collection of the DNA sample. We will not approve payment for these tests otherwise.
- We offer a list of approved genetic counselors/counseling centers for plan members at *priorityhealth.com*. Search keywords: **genetic counseling centers**

"Informed consent" per Michigan law

Michigan law requires specific written informed consent for genetic testing, the components of which are covered by the counseling process. Learn more at *legislature.mi.gov*.

Training opportunities



View a webcast on Medicaid expansion

(Jan. 22, 2014) We've put together a webcast covering:

- The Affordable Care Act and the Healthy Michigan plan
- The impact of Medicaid expansion on primary care
- The Priority Health difference

Watch *Priority Health Choice: Thrive in a changing world* at *priorityhealth.com/blogs/posts/provider/2014-jan/webinar-on-medicaid*

Also in our video library

Tools at *priorityhealth.com/provider/news-and-education/video-library* include:

- Three webcasts on health reform covering your role as an employer, health care provider and patient educator.
- Video demos of our online provider tools, usually three minutes or less. Get an overview of member inquiry, claims inquiry and more.

Online CME program available on hereditary breast and ovarian cancer risk evaluation

(Feb. 3, 2014) This case-based CME activity will improve your ability to identify, evaluate and manage patients at risk for hereditary breast and ovarian cancer.

- Access the program at *nchpeg.org/hboc/*
- Program includes case studies and links to helpful hereditary breast and ovarian cancer risk assessment tools and resources.
- Earn up to two Category 1 CME credits free. CME is administered through Michigan State University.

Developed by collaborators from the Michigan Department of Community Health, Georgia and Oregon Departments of Health, National Coalition of Health Professional Education in Genetics (now Jackson Labs), and the Division of Cancer Prevention and Control at the Centers for Disease Control and Prevention.

Workshop: The Guidelines and Principles of ICD-10-CM

(Nov. 18, 2013) Register early as seating is limited.

- Tuesday, May 20, 2014
- Calvin College's Prince Conference Center, Grand Rapids, MI
- Presented by Judy B. Breuker, CPC, CPMA
- This program has the prior approval of AAPC for 6.5 continuing education hours.
- Download the workshop brochure and registration information at *priorityhealth.com/blogs/posts/provider/2013-nov/icd-10-workshop*

Clinical resources

MQIC mobile apps now available

(Jan. 13, 2014) Many of the evidence-based clinical practice guidelines published by the Michigan Quality Improvement Consortium (MQIC) are available in the Clinical Resources section of *priorityhealth.com/provider*.

Now, MQIC is offering providers easy access to its clinical practice guidelines and other useful provider tools from smartphones and tablets.

Download the free MQIC app

(available in both the Apple store and on Google Play)

1. Search for MQIC
2. Download to your phone or tablet
3. Launch the app and select "sync"

The app will notify you if a guideline has been updated, prompting you to sync the app again. Download the instruction sheet at *priorityhealth.com*. Search keyword: **MQIC mobile app**

About MQIC

For more information on MQIC committees and guidelines, go to *mqic.org*.

USPSTF reaffirms cancer screening recommendations

(Feb. 10, 2014) The United States Preventive Services Task Force (USPSTF) recently reaffirmed that primary care providers should screen women with a family history of breast, ovarian, fallopian tube or peritoneal cancer to identify those potentially at increased risk for a BRCA mutation.

The group recommends that women with a significant family history receive genetic counseling, and, if indicated, they be offered genetic testing. They recommend against routine genetic counseling and testing for women whose family history is not indicative of increased risk.

Recommendations for providers:

- Obtain breast, ovarian, fallopian tube and peritoneal cancer family history on all women
- Use an available screening tool
  - Five tools were evaluated by USTPSF including one available at *breastcancergenescreen.org*
  - The Gail Model was not included because it does not assess a woman's chance of having a BRCA1/2 mutation
- Offer all adults at increased risk a referral for genetic counseling. Referral indications include:
  - Breast cancer diagnosed under age 50
  - Ovarian cancer
  - Male breast cancer
  - Known familial BRCA1/2 mutation
- Priority Health requires counseling by a board certified/eligible genetics provider before collecting a sample for BRCA testing. For a list of board certified genetics providers in Michigan, visit *migrc.org/Library/MCGA/MCGADirectory.html* or contact Karen Lewis at *karen.lewis@priorityhealth.com*.

Moyer V.A. on behalf of the U.S. Preventive Task Force (2013). Risk assessment, genetic counseling, and genetic testing for BRCA-related cancer in women: U.S.P.S.T.F. recommendation statement. Annals of Internal Medicine online first, December 24, 2013.

Nelson H.D., Huffman L.H. Fu R., Harris E.L.; U.S. Preventive Services Task Force (2005). Genetic risk assessment and BRCA mutation testing for breast and ovarian cancer susceptibility: systematic evidence review for the U.S.P.S.T.F. Annals of Internal Medicine, 143:362-79.

Clinical resources

National Alcohol Screening Day® (NASD) is April 10, 2014

(Feb. 10, 2014) National Alcohol Screening Day (NASD) is an outreach, education and screening program that raises awareness about alcohol misuse and refers individuals with alcohol problems for further evaluation. We encourage providers to use standardized alcohol abuse screening tools for the assessment and evaluation of patients.

For more information about standardized alcohol abuse screening tools, go to *samhsa.gov*.

Performance programs

2014 PCP Incentive Program information available

(Jan. 2, 2014) We reward prevention, improved clinical outcomes and the delivery of cost-effective care. Log in to the "incentive programs" page in the Provider Manual to find our 2014 incentive program manual, measures chart and more.

Prospective incentive payments have ended

(Jan. 16, 2014) Effective Dec. 31, 2013, the prospective primary care provider incentive program (PCP IP) monthly payments for provider practices who have received payments directly from Priority Health have ended. All incentive payments due for the 2013 program will be paid in the final PCP IP settlement in April 2014.

Questions about performance programs should be directed to your provider account representative (PAR). 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.

PriorityHealth

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Physician and practice news digest

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