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Billing & payment

Grace period for ACA Marketplace subsidized members

(April 2, 2014) The Affordable Care Act requires that we share with providers the plan status of ACA Marketplace members who are receiving a subsidy (Advanced Premium Tax Credit, or APTC).

Coverage during the 3-month "grace period"
The total "grace period" for non-payment of premiums is three months. The ACA requires plans to pay claims for the first month of the premium grace period.

At this time, our response is to respect member/patient privacy. Providers, both participating and non-participating with Priority Health, will be able to identify members in the grace period:

• Proactively through EDI 270/271 eligibility checks, which are available in as little as three seconds; and which now include the paid-through date

• Retroactively on the Remittance Advice

NPI must match rendering provider name

(Feb. 12, 2014) When billing a claim, the rendering provider name on the claim must match the Type 1 NPI for that provider. Claims billed with a physician name that does not match the NPI will be closed and will not process in our system. Closed claims require rebilling.

To learn more, go to *priorityhealth.com* and search keywords: **EDI setup**

Clinical edit code combinations realigned May 1

(Feb. 20, 2014) Effective May 1, 2014, Priority Health realigned our clinical edits for the CPT and HCPCS code combinations below with the current version of CMS National Correct Coding Initiatives (NCCI). In short, column 2 codes reported on the same date as column 1 codes are considered bundled unless significant, separately identifiable services are performed.

Column 1 code
90460-90461, 90471-90474, 94010, 94060-94070, 94640

Column 2 code (edited code)
99201-99205, 99212-99215

If documentation supports a significant, separately identifiable service, the appropriate modifier can be appended (when applicable per NCCI guidelines) to the edited code.

Medical records must be submitted with any request for reconsideration, or if a modifier is added, once services have been denied as unbundled due to this clinical edit.
See criteria and guidelines at *CMS.gov.*

Billing & payment

2-Midnight Rule for Medicare inpatient admissions

(April 23, 2014) On Aug. 2, 2013, the Centers for Medicare and Medicaid Services (CMS) issued a final rule, CMS-1599-F, sometimes referred to as the "2-Midnight Rule." It updates 2014 Medicare payment policies and rates under the Inpatient Prospective System (PPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS), effective Oct. 1, 2014.

However, Priority Health is a Medicare Advantage Organization (MAO), falling under Part C Medicare rules. As such, we are allowed to create our own billing and payment procedures. We've updated the online Provider Manual with information about how we will apply our utilization management rules in implementing the 2-Midnight Rule.

Read more at *priorityhealth.com*. Search keywords: **2 midnight rule.**

Weekly oncology service billing under Medicare

(Feb. 11, 2014) Because billing rules for our Medicare Advantage plan patients differ from rules under Original Medicare, we've added information about billing for weekly oncology services to *priorityhealth.com/provider/manual*. Search keywords: **weekly oncology service**

Topics include:
• Member copayments and out-of-pocket limits

• Billing codes

• Billing fractions of a week

• Billing the technical component

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 at *priorityhealth.com/member* as web pages and printable PDFs. Search keywords:
• **Preventive health care guidelines**

• **Medicare preventive services**

• **Prenatal and pregnancy health care**

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

Questions about billing and payment?
Email *provider.services@priorityhealth.com*. Go to *priorityhealth.com/provider/manual* or call the Provider Helpline at 800.942.4765, option 2.

Reminder: MTM program coordinates patient prescriptions

(Feb. 15, 2014) In 2011, Priority Health began a partnership with community and physician office-based pharmacists to administer a Medication Therapy Management (MTM) program to:

- Ensure Medicare members get the best results from their medications

- Help Medicare members control their out-of-pocket costs

Because many Medicare members have multiple doctors prescribing drugs, the MTM program is designed to complement physicians' work by coordinating all prescriptions. The latest clinical information is used by MTM pharmacists when reviewing patients' medication therapy, such as updates to the Beers criteria for high-risk medications and revised monographs for old and new medications. MTM pharmacists also listen to patients' concerns about their medications and may offer recommendations to physicians and patients to help achieve their goals of therapy. As always, physicians make the final decisions about changes in drug therapy.

Pharmacists provide the following services as part of the MTM program:

Comprehensive medication review. The pharmacist will meet with your patients face-to-face to review all of their medications, including OTCs, herbals and supplements. This will help identify any drug-related problems including duplications, drug interactions, missing therapy, dose titration, and under- and over-utilization.

Drug information. When starting a new medication, the pharmacist will:
- Talk to your patient about its purpose and correct use

- Follow-up to make sure the drug is working right and the patient isn't experiencing drug-related adverse effects

Targeted intervention. This service identifies members using brand-name medications when generic options are available. It also identifies medication-related quality interventions that support PIP and HEDIS, such as beta-blocker post-MI and appropriate asthma medication use.

Medication adherence assessment. Patients who are taking their chronic medications less than 80% of the time are identified for an assessment of barriers and targeted interventions to improve adherence. The pharmacist will follow the patient's medication refill patterns for improvement.

MTM Pharmacist interaction

Your Priority Health Medicare members may receive an interactive **Comprehensive Medication Review** (CMR) any time during the year.

- The MTM pharmacist may reach out to you to clarify your patient's medical history prior to a review or information received from your patient during the review, such as why and how they are supposed to use their medications.

- After a CMR, the MTM pharmacist may contact you with questions or recommendations about your patient's medications, or your patient may call you to discuss suggestions they received from the MTM pharmacist.

Targeted Medication Reviews (TMRs) occur throughout the year to identify specific or potential medication-related problems. You may be contacted by the MTM pharmacist if a TMR identifies a potential medication-related problem for your patient. TMRs are driven by prescription and medical claims received by Priority Health, run through a clinical "engine" and provided to the MTM pharmacist as a potential medication related problem or gap.

Other communications may be sent to you periodically throughout the year. These communications are intended to help resolve other potential medication-related problems or identify other opportunities to optimize your patient's medication use.

Pharmacy

Priority Health Medicare members will receive a printed standardized summary, Form CMS-10396, as a reference about their CMR. This summary will include a cover letter, medication action plan and personal medication list. Your patients are encouraged to share these documents with you and other health care providers at regular visits and request updates as needed. If you'd like to see examples of these forms, ask your provider account representative.

Referring patients to MTM Services
If you have a Medicare member who would benefit from meeting with an MTM pharmacist, you may refer them by:
- Visiting *priorityhealth.com* and searching keywords: **medication therapy management**. A list of participating MTM pharmacies is available.
- Calling the Priority Health pharmacy department at 800.466.6642
- Working with their Priority Health case manager, if applicable

The MTM program and incentive program performance
MTM pharmacists, partnering with physicians and other providers, can positively impact physician incentive program performance on the following quality and efficiency measures:
- Diabetes care: Controlled HbA1c less than 7.0%
- Diabetes care: Controlled HbA1c less than 8.0%
- Diabetes care: Controlled HbA1c less than or equal to 9.0%
- Diabetes care: Cholesterol medication therapy
- Diabetes care: Monitoring for nephropathy
- Diabetes care: Controlled blood pressure
- Diabetes care: Hypertension medication therapy
- Optimal diabetes care
- Hypertension: Controlled blood pressure
- Cardiovascular care: Cholesterol medication therapy
- Asthma care management
- Annual lab monitoring for patients on persistent medications
- Generic prescriptions filled: Selected therapeutic classes

Reminder: Formulary updates
(March 28, 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 at *priorityhealth.com.* Go to the approved drug list and click "get printable drug list."

Last year we updated the HMO/PPO/POS 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: Mail order prescriptions
(April 1, 2014) Priority Health members have the option of obtaining their prescriptions from Express Scripts. The mail service pharmacy 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.

Sending prescriptions to Express Scripts
- Electronic prescribing: Express Scripts has a dedicated e-prescribing fax number: 866.825.6605. Use this number for e-prescribing transactions. 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)

Reminder: Process for urgent pharmacy prior authorization requests

(April 1, 2014) Priority Health Pharmacy has defined and abides by timelines for responding to drug prior authorization requests. These timelines ensure all members receive appropriate, timely pharmaceutical care based on sound evidence and individual needs.

Requesting urgent pharmacy authorizations

Clearly mark requests sent by fax as "urgent." Or, call the Pharmacy Department at 800.466.6642 to notify us that a request requires urgent review.

Defining "urgent"

A prior authorization request is considered urgent when:
- A delay in response could seriously jeopardize the life or health of a member or the ability of the member to regain maximum function, or

- A physician with knowledge of the member's medical condition believes that a delay would subject the member to severe pain that cannot be adequately managed

Our commitment is 24 hours or less

When a request is urgent, we will complete it as soon as possible taking into account the medical exigencies, but no later than 24 hours following receipt of the request.

Requesting non-urgent pharmacy authorizations

These requests will be completed within a reasonable period of time, usually 48-72 hours.

We will complete your requests no later than:
- 15 calendar days following the receipt of the request for commercial and Medicare Part B authorizations

- 72 hours following the receipt of the request for Medicare Part D authorizations

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.

Performance programs

2014 PCP Incentive Program revisions announced

(April 17, 2014) We've made changes to some PCP Incentive Program measures in accordance with the current clinical guidelines from the Joint National Committee 8, the American College of Cardiology and the American Heart Association.

Revised measures

• Diabetes care: Cholesterol medication therapy

• Diabetes care: Controlled blood pressure

• Diabetes care: Hypertension medication therapy

• Optimal diabetes care

• Hypertension: Controlled blood pressure

• Cardiovascular care: Cholesterol medication therapy

• CG CAHPS

When logged in, you can download revised PDFs of the manual and measures grid at *priorityhealth.com/provider.* Search keywords: **PCP Incentive Program**

Partners in Performance 2014 Triple Aim grantees announced

(April 11, 2014) Priority Health offered grants to network participants who were interested in a new approach to earning incentive dollars, while at the same time advancing the elements of the Triple Aim. Grants were intended to support new and creative initiatives that would improve the patient experience, improve health outcomes, reduce costs or any combination thereof. A total of 10 applications were received.

We congratulate three awardees for demonstrating the grant's intent of innovative approaches in support of the Triple Aim.

Holland PHO

• Focus: Chronic disease management

• Collaboration with Hope College to train and deploy community health coaches

We Are For Children and WMPN

• Focus: Behavioral health

• Structured program and care coordination with community partners for adolescent depression screening

Metro Health

• Focus: Chronic disease management

• Community partnership to improve asthma outcomes

Performance programs

PCP Incentive Program report reduction

(March 12, 2014) Effective with March reporting, some PCP Incentive Program (IP) reports have been eliminated to better align with the current PCP IP. If you receive monthly reports electronically, these will no longer be included in your report set.

Report	Reason
Generic prescription reports	No longer part of the incentive program
e-Prescribing reports	No longer part of the incentive program
Inpatient days/1,000	No longer part of the incentive program
Measure reports at the physician level	Payment at the practice level only. Physician level reports can be obtained by sorting the 11C report or #70 supplemental data report.
High-tech radiology reports	No longer part of the incentive program
Key indicator by specialist	Specialists are no longer included in incentive measures

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.

Plans & benefits

Healthy Michigan Plan

(March 20, 2014) - The Healthy Michigan Plan, formerly known as Medicaid expansion, began enrolling members prior to the April 1 effective date. We've added some basic information to our Provider Manual explaining what we know about how the Healthy Michigan Plan works.

Highlights

Participation: If you are contracted with us to provide services to Medicaid members, that contract includes the Healthy Michigan Plan.

ID cards: We are not allowed to say "Healthy Michigan Plan" on ID cards, so these patients will carry cards reading "Priority Health Choice HMI."

Copayments: You don't collect copayments at time of service for Healthy Michigan Plan members. We collect the copayments later.

Benefits: The benefits will be slightly different from traditional Medicaid. For example, the Healthy Michigan Plan covers habilitative services.

Initial visit requirement: Members should have an initial visit with their PCP within 150 days of their effective date.

Health Risk Assessment forms: PCPs must sign a state-standardized Health Risk Assessment for these members and forward it to Priority Health.

Healthy Michigan Plan incentives added

(March 31, 2014) Participating primary care providers, both physician and mid-level, can earn a $25 incentive for completing a Healthy Michigan Plan Health Risk Assessment (HRA) form and faxing it to us.

Double the incentive you earn

Good news! PCPs who are open to new Medicaid members will earn an extra $25, for a total of $50 per completed HRA form. This second incentive will be paid quarterly.

Get complete details and a link to the state-issued HRA form at *priorityhealth.com/forms*.

Medicaid and MIChild plan names removed from ID cards

(March 19, 2014) Effective immediately, the State of Michigan has asked us to remove the names Medicaid and MIChild from our member ID cards. This change will be made as members renew. You will still see the old names on ID cards issued prior to March 18, 2014. This change does not affect benefits.

Plan names shown on our member ID cards

• Medicaid = **Priority Health Choice MDC**

• MIChild = **Priority Health Choice MIC**

Healthy Michigan Plan

As we roll out our Healthy Michigan Plan, member ID cards will show Priority Health Choice HMI.

Questions?

Contact our Provider Helpline at 800.942.4765, option 2.

Affordable Care Act now covers BRCA genetic testing for those at risk for hereditary breast and ovarian cancer

(May 9, 2014) Approximately 1 in 10 Michigan women have a significant family history of breast and/or ovarian cancer (HBOC) but less than 10 percent has received genetic counseling/testing services[1].

In 2013, the United States Preventive Services Task Force recommended counseling and testing for women with a significant family history of HBOC[2]. As a result, appropriate BRCA testing for high risk individuals is now a covered benefit through Priority Health when done in conjunction with genetic counseling.

Determine if your patient is at risk
Ask about family history
- Include information on first- and second-degree relatives on both sides of the family since HBOC can be passed down from the mother or father.

- Collect ages of onset and ethnicity. Early onset (<50) and Ashkenazi Jewish ethnicity are independent risk factors for HBOC.

Use a screening tool
- Several are quick to administer including one available at *breastcancergenescreen.org*.

- If a screening tool indicates increased risk, refer the patient to a board-certified genetics provider. The Michigan directory of providers is available at *migrc.org/Library/MCGA/MCGADirectory.html*.

If risk is determined
- Michigan law requires ordering providers to obtain written informed consent prior to pre-symptomatic or predictive genetic testing.

- Priority Health members must have genetic counseling by a genetic counselor before testing can occur for certain conditions including BRCA. Counseling can occur at the same visit as the sample(s) for testing are collected with appropriate documentation as defined above. Genetic counseling must be performed by a board certified genetic counselor that is independent of the laboratory performing the requested testing.

Review our genetics testing policy at *priorityhealth.com*. Search keywords: **policy 91540**

[1] 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.

[2] 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.

New User Admin tool for providers

(March 25, 2014) This tool allows network practices and facilities to identify a provider user administrator. This person has the responsibility of verifying and authenticating the users associated with their practice or facility that should be allowed access to patient information.

Purpose of the User Admin tool

• **User administration** - This tool allows provider user administrators to remove users within their network and to control their facility's accessibility to *priorityhealth.com/provider*

• **Patient security** - The tool was created, and the process put in place, to ensure the security of patient information

• **User attestation** - We require that you regularly perform a user attestation process, reviewing and verifying your list of active users in order to maintain the integrity of the user database and to ensure the provider center is accessible to appropriate users only.

Get access to the tool through your Provider Account Representative

If they don't hear from you first, Priority Health Provider Account Representatives (PARs) will be contacting physician organizations and practices network-wide to identify user administrators before August 2014. If your organization already utilizes another payer's tool to manage online account users and/or if you have a person in place that handles web user administration, let your PAR know.

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.

Reminder: Review your demographic info in Find a Doctor

(Feb. 10, 2014) We get many emails from members unhappy with the information in our Find a Doctor tool. They're telling us things like:

• "The phone number you show is disconnected."

• "This doctor doesn't accept Medicare."

• "They moved their office three blocks away."

Once or twice a year, would you check your listing in our Find a Doctor tool? If you find outdated information, let us know using the Provider Change Form at *priorityhealth.com/provider/forms*.

Do we have your photo?

When we perform user testing on our website, we find that the physician photos are consistently rated "very valuable." So if your listing doesn't include a photo, please email a black and white or color one to your Physician Account Representative and he or she will get it loaded in Find a Doctor.

Learn more about photo guidelines for Find a Doctor at *priorityhealth.com/provider*.
Search keywords: **Add your photo**

Surgery prior authorization changes effective March 24

(March 13, 2014) As of March 24, prior authorizations are no longer required for:

• Lumbar fusion

• Lumbar laminectomy

• Knee arthroscopy

All other Spine Centers of Excellence (SCOE) program processes remain in effect.

This adjustment is due to the ongoing effectiveness of our SCOE program as well as changes in medical practices.

We will, however, continue to monitor the utilization of these three procedures. We may opt to reinstitute a modified prior authorization approach in the future, potentially incorporating member education and shared decision making.

You'll find additional information on lumbar fusion, lumbar laminectomy and knee arthroscopy at *priorityhealth.com.* Search keywords: **auth list**

Medical policy changes

(March 11 and March 24, 2014) The Priority Health Medical Affairs Committee reviewed and changed several medical policies on Feb. 12, 2014. To see summaries of the changes, visit *priorityhealth.com/provider/manual/auths/medical-policies*.

Clarified/increases in benefits

• Balloon Sinus Ostial Dilation, 91596

• Gastroparesis Testing and Treatment, 91572

• Markers for Digestive Disorders, 91583

• Surgical Treatment of Obesity, 91595

Other changes

• Colorectal Cancer Screening 91547: Wireless Capsule Endoscopy added as not covered for general screening effective March 4, 2014

• Obstructive Sleep Apnea & Upper Airway Resistance Syndrome 91333: Changes and additional criteria effective April 14, 2014

• Total Hip Resurfacing 91530: Retired effective Jan. 23, 2014

The following policies have minor changes and additions for clarification or an increase in benefit for members.

• Pharmacogenomics Testing, 91570

• Stimulation Therapy and Devices, 91468

• Tumor Markers, 91562

Questions?

Contact the Provider Helpline at 800.942.4765, option 2.
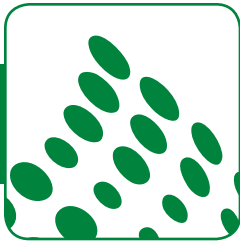
Practice staff and clinician access to Healthcare Blue Book!

(March 25, 2014) In 2013, we introduced Healthcare Blue Book, an online transparency tool that helps members live informed, healthier lives. Your patients have begun comparison shopping for approximately 200 "shoppable" medical services — from X-rays and lab tests to non-urgent surgeries and procedures.

Now practice staff and clinicians have access to Healthcare Blue Book from your logged-in provider account. So, you'll have informed answers when your Priority Health patients ask about cost of care and quality of services.

Learn more about how to use Healthcare Blue Book
Go to *priorityhealth.com/provider/news-and-education* to find:

• Webcasts:

- Engaging patients through transparency: Healthcare Blue Book access for PCP and Specialist offices (6 min.)

- Healthcare Blue Book "How-To" (3 min.)

• Printable Healthcare Blue Book 1-page "How-To" chart

• Links to member tools

Reminder: SSNs are unavailable in Provider Helpline

(March 5, 2014) In the interest of both privacy and accuracy (since a Social Security number can be associated with more than one contract), we're asking our provider partners to use our member contract ID on calls to the Provider Helpline or when looking up a member on our website.

Training opportunities

Save the date:
Priority Health Academy

We're starting to plan our fall Priority Health Academies.
Complete details are forthcoming, but mark your calendars:

East Michigan	Wed., Oct. 29	Southfield
West Michigan	Mon., Nov. 10	Grand Rapids
Northern Michigan	Wed., Nov. 12	Traverse City

We'd like to know if you plan to join us. Please let us know by taking our survey. You'll find it at *priorityhealth.com/academy.*

Questions?
Contact the Provider Helpline at 800.942.4765, option 2.

PriorityHealth

1231 East Beltline Ave. NE
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Physician and practice news digest

Reduce office clutter.

If you haven't already done so, go to *priorityhealth.com* and click "create account."

Register and provide us with your email address in order to stay informed electronically.*

Registration verification process takes up to 5 business days.