PriorityHealth

Physician and practice news digest

Winter 2014

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COMING SOON

2015 Virtual Office Advisory schedule

VOA forums are offered several times a year to connect you with Priority Health experts and help your practice maximize its effectiveness with the network. Look for the next series of VOA forums in spring 2015.

Check the news section of *priorityhealth.com/provider* for updates.

Billing and payment

Clarification on Healthy Michigan Plan HRA reimbursement

(08-11-2014) 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 (see the L letter you should have received from them), 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 on the HRA and reimbursement in the Provider Manual, and contact your Provider Account Representative (PAR) with questions.

Provider Payment Solutions Center fax and email addresses deactivated

(10-01-2014) The Priority Health Provider Payment Solutions Center was reorganized and as of Oct. 1, 2014, several fax numbers and email addresses were removed from service. Please update your records accordingly to ensure we receive your emails and faxes.

Email addresses no longer in use

Emails about provider payments and claims formerly sent to ppsc.prac, ppsc.fac, etc. @priorityhealth.com should now be sent to *provider.services@priorityhealth.com*.

Faxes no longer in use

Fax numbers 616.975.8852, 616.975.8853 and 616.942.7992 have been de-activated.

- Fax documents related to claims payment and administrative appeals to 616.975.8856.
- Fax medical and clinical edit appeal documents to the number listed on the appropriate form.

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Billing and payment

Medicare rates increase for skilled nursing facilities

(09-24-2014) The Centers for Medicare and Medicaid Services (CMS) announced a final rule in a fact sheet dated July 31 that Medicare rates for skilled nursing facilities (SNF) will increase 2% for fiscal year 2015. SNF providers contracted with Priority Health Medicare will see this annual adjustment in their composite per diem rate for dates of service on and after Oct. 1, 2014.

If you have questions call the Provider Helpline at 800.942.4765, option 2 or visit *cms.gov*.

HIPPS-related claims hold removed

(09-14-2014) We learned in July that CMS amended the Claim Frequency Type codes that are accepted for HIPPS billing.

Providers this affects include participating and non-participating providers who bill for skilled nursing, home health care and acute rehabilitation services. HIPPS codes are required on each billed claim.

Please re-bill us for HIPPS-related claims now

If you previously billed us claims and received denials due to the claim frequency type code, please re-bill those dates of service as soon as possible. We apologize. Because they were an upfront edit denial, our system does not have a record of them.

Updates include the addition of:

Loop ID: 2300
Reference: CLM05-3
Name: Claim Frequency Type Code

Codes:

1: Original claim submission
2: Interim - First claim
3: Interim - Continuing claim
4: Interim - Last claim
7: Replacement
8: Deletion
9: Final claim for Home Health PPS episode

Corrected claim submission changes as of Oct. 1

(08-26-2014) To comply with contract language regarding claim submission, as of Oct. 1, 2014, we 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 under Corrections.

Reminder: Using the clinical edits tools for Medicare DME claims

(10-27-2014) The Edits Checker tool, powered by CES, shows DME providers 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 CES has been in use throughout 2014.

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Billing and payment

Find out how Medicare DME claims will adjudicate, in advance

The "what if" component of CES, called Edits Checker, will show how your Medicare DME claims will pay. To use it, log in and click the Edits Checker link in the list of provider tools on your home page. Enter your billing and diagnosis code options. You can click on references to learn how and why the edits apply.

Missing modifiers will cause claims to deny

Remember to submit services with the appropriate, required modifiers as outlined by NGS policies. Services submitted without the required modifiers will be denied.

Example: If the LCD policy indicates a KX is required for coverage, this modifier is required on the claim or this service will be denied for lacking a modifier needed for claim processing.

NU and RR modifiers:

As a Medicare Advantage plan, we also require NU and RR modifiers to be appended as primary modifiers (in addition to NGS-required modifiers listed secondary to these). Review our Clinical edits page in the online provider manual for an outline of codes that may or may not require the NU and RR modifiers. For example, with B codes the NU or RR modifiers are not required but for E codes NU and RR can be used as they will identify if the item is a purchased item (NU) or a rental item (RR).

The claims processing tool speeds payment

Once you send in a claim, the claims processing component of the CES tool cuts 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 Medicare claim already processed, you'll find a "See edits" link on the claim screen. Clicking it will show you how the CES tool applied clinical edits to the claim, with sources for the editing rules.

Questions?

Email us at ***provider.services@priorityhealth.com*** or call the Provider Helpline at 800.942.4765, option 2.

Pharmacy

Hepatitis C treatment changes coming

(10-06-2014) The treatment landscape for hepatitis C is changing, and we'd like to make you aware of our timeline and approach for covering new therapies.

New treatments approved in October

On Oct. 10, 2014, the FDA approved Gilead Sciences' new oral combination therapy sofosbuvir/ledipasvir. AbbVie's oral therapies paritaprevir, ombitasvir and dasabuvir are also expected to receive FDA approval this year.

Changes to the Priority Health formularies will occur in 2015

We anticipate reviewing these new hepatitis C drugs at the January 2015 Pharmacy and Therapeutics (P&T) Committee meeting. The committee will evaluate the efficacy, safety, tolerability and cost of new and existing therapies, and determine coverage for the commercial and Medicare formularies. The decisions made at the January 2015 P&T Committee meeting will be effective March 1, 2015.

Changes to the Medicaid formulary

We're waiting for the State of Michigan's P&T Committee to review and make a coverage decision before these drugs are covered on the Priority Health Medicaid formulary.

Follow current prior authorization process until further notice

Today, Sovaldi- and Olysio-containing treatment regimens are covered for commercial and Medicare members with prior authorization. We ask that you reserve requests for coverage of new hepatitis C drugs until we have completed our review and finalized coverage and authorization requirements. For patients with an urgent need for treatment prior to January's review of new therapies, currently available therapies will continue to be covered when prior authorization criteria are met.

Generic breast cancer prevention drugs covered as of Sept. 1

(09-08-2014) As of Sept. 1, 2014, Priority Health HMO, EPO, POS, PPO and My**Priority**SM medical plan members are eligible to receive generic breast cancer prevention drugs at the preventive services benefit level. Tamoxifen and raloxifene (generic for Evista) have no copayment, coinsurance or deductible when members fill their prescription at an in-network pharmacy.

We've made this change as part of the Affordable Care Act. Medicaid, Healthy Michigan Plan, MIChild and Medicare plan members are not eligible for this benefit.

How to prescribe these drugs

In order for your patient to receive a prescription at no cost, call the Priority Health pharmacy line at 800.466.6642 to confirm your patient meets the eligibility requirements.

We've contacted our members

We mailed a letter to members who meet the requirements. The letter asks them to:

- Contact their doctor and ask the doctor to call Priority Health and confirm their eligibility OR
- Contact Priority Health Customer Service and we'll call their doctor for them.

Patient eligibility requirements

To be eligible to receive these drugs at the preventive services benefit level, members must:

1. Be female
2. Be 35 or older
3. Take the drug to prevent breast cancer
4. Have never had breast cancer
5. Have not taken the drug for more than five years
6. Have a non-grandfathered health plan (Priority Health will verify this requirement)

continued >

Pharmacy

Reminder: Step therapy required for select drug categories

(09-01-2014) Within the Priority Health commercial formulary some drug categories require step therapy, or the therapeutic trial of an alternative drug or drugs, before authorization is granted for the originally-requested medication.

The following drug classes require step therapy:

Celebrex

Celebrex requires documented trial with two of the following NSAIDs:

- Meloxicam (Mobic)
- Diclofenac (Voltaren)
- Nabumetone (Relafen)
- Etodolac (Lodine)

Prior authorization is available for members who are at high risk for a GI bleed.

Antidepressants

Brand-name antidepressants require documented trial with at least one generic antidepressant first.

Antipsychotics

Brand-name antipsychotics require a documented trial with at least one generic atypical antipsychotic.

Triptans

Brand-name triptans for treatment of migraines require a documented trial with at least one generic triptan.

Reminder: Answers to questions about pharmacy benefits

(09-01-2014) Pharmacy benefits among Priority Health members can vary based on the coverage purchased. Here are answers to some frequently asked questions about Priority Health pharmacy benefits:

Q: Who determines the copayment the patient pays?

Priority Health offers employers many different options for pharmacy coverage. The employer or purchaser analyzes the options and makes the decision. The level of copayment affects the total cost of health care coverage for which the employer is responsible. Pharmacy coverage is an essential health benefit for all small group plans but large employers (those with 50 or more employees) can elect not to cover prescriptions.

Q: What are flat, two-tier and three-tier copayments? Or specialty drug copayments?

A flat copayment is when the patient pays the same fixed dollar amount for the copayment independent of whether the prescription is for a brand-name or generic product.

The two-tier copayment is when the patient pays the lower copayment if the prescription is filled with a generic medication or a more expensive one if it is for a branded product. Patients with two-tier coverage have access to non-preferred products if their condition warrants their use and is medically necessary.

A three-tier copayment 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. Some members will pay more for specialty pharmacy drugs, including those administered in the physician's office or infusion center. Specialty drugs 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.

continued >

Pharmacy

Q: Why can one patient have a different copayment from another patient?

Priority Health offers many pharmacy benefit choices: employer-sponsored (commercial), Medicaid and Medicare. Employer-sponsored plans have many different options for coverage and copayment. 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.

Q: Do you cover birth control pills or drugs for erectile dysfunction?

Due to the Affordable Care Act, contraceptives for women are a covered benefit for non-grandfathered health plans. Contraceptive coverage can be excluded by religious employers. Drugs to treat erectile dysfunction are only covered if the employer has selected a rider that provides coverage for these drugs. If either of these options is selected by the employer, the appropriate copayment will apply to the prescription. Medicaid and Medicare plans cover contraceptives but do not cover drugs for erectile dysfunction. Certain employer-sponsored Medicare plans choose to add coverage for erectile dysfunction drugs.

Q: How has the Affordable Care Act impacted pharmacy benefits?

In addition to the changes for contraceptive coverage noted above, coverage for several medications have been classified as preventive. These drugs are covered at 100% to members in a non-grandfathered health plan. Covered drugs include tobacco cessation medications, breast cancer preventive medication and low-dose aspirin to prevent heart disease in adults. For a complete list of these medications, review the Priority Health Preventive Health Care Guidelines.

Q: What other limits apply to the pharmacy benefit?

Priority Health limits coverage to a maximum 31-day supply per prescription. Mail order prescriptions may provide up to a 90-day supply of medication for either one, two, or two and a half copayments. And many of the pharmacies in our network participate in our “90 day at retail” program, allowing members to fill a 90-day supply for three copayments at a local, retail pharmacy. Medicaid members are not eligible for 90-day fills. 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 on clinical data or cost-effectiveness. Some drugs also require step therapy.

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

Reminder: Generic drug substitutions

(09-01-2014) 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.

continued >

Pharmacy

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.

Reminder: Availability of physician and pharmacist reviewers

(10-30-2014) Questions or concerns regarding our utilization management decisions can be referred to your Provider Account Representative or the pharmacy department at 800.466.6642. We may use physician and pharmacist reviewers to assist you.

Reminder: Formulary updates

(09-29-2014) 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**.

Authorizations

Medical policies revised

(09-08-2014) The following policies were revised and approved at recent Medical Affairs Committee meetings. For details and to read the revised policies see the "Recent and upcoming policy changes list" page in the Provider Manual under "Medical policies."

Revised policy effective Feb. 1, 2015

- Cardioverter Defibrillators - 91410

Revised policy effective Jan. 1, 2015

- Autism Spectrum Disorders - 91579

Revised policy effective Dec. 25, 2014

- Renal Artery Stenosis - 91561

Revised policies effective Dec. 1, 2014

- Telemedicine - 91604
- Biofeedback - 91002

continued >

Authorizations

- Clinical Trials - 91606
- Clinical Trials for Cancer Care - 91448
- Experimental/Investigational/Unproven Care/Benefit Exceptions - 91117
- Intraoperative Radiation Therapy - 91556
- Surgical Treatment of Obesity - 91595
- Varicose Vein Treatment – 91326
- Ventricular Assist Devices - 91509

Revised policy effective Oct. 15, 2014

- Obstructive Sleep Apnea - 91333

Revised policy effective Oct. 8, 2014:

- Stem Cell or Bone Marrow Transplantation - 91066

Revised policies effective Sept. 8, 2014:

- Chemosensitivity Assays - 91566
- Neuropsychological/Psychological Testing - 91537
- Psychological Evaluation and Management of Non-Mental Health Disorders - 91546

Reminder: Behavioral health standards

Behavioral health utilization decision process reviewed

(08-27-2014) 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, then 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

Plans and benefits

Healthy Michigan Plan "key" to completing the HRA form available

(08-21-2014) The Healthy Michigan Plan HRA form must be complete and correct before being faxed to us. In the Medicaid/Healthy Michigan Plan section of our online provider manual you'll find a "key" to print and share with your staff. This tip sheet will help you complete the HRA with all necessary information. Incomplete/incorrect forms will be faxed back to you. If you have questions contact your Provider Account Representative. Search keywords: **Healthy Michigan Plan key**

More patients to receive in-home health assessments

(09-10-2014) We're expanding our use of in-home health assessments beyond Medicare plan members to include members of our individual and small group health plans.

The assessments are free to members. The data we collect from the assessments is used to improve care management programs and to capture risk scores of our members.

How we're communicating with our members' providers

Primary care providers are the central part of a patient's medical home. We want to strengthen that relationship.

That's why:

- These in-home assessments will not affect the member's coverage or care from providers.
- Patients with any health concerns identified during the in-home assessment will be directed to contact their PCP for guidance.

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
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

Responsibilities and standards

Notify patients of Healthy Michigan Plan copays

(12-01-2014) The Michigan Medicaid Program recently sent Informational letter L 14-52, dated Oct. 28, 2014, to all providers. The purpose of the letter is to notify you that you must provide Healthy Michigan Plan members information on potential copays at the point of service.

- Every provider is required to provide this notice
- Every visit
- Every service - office visits, X-rays, labs, prescription pickup, etc.

As a reminder, copays are not collected at the time of service.

Use the official form

To fulfill this requirement, CMS requires that Healthy Michigan Plan members receive from you at time of service a copy of the copay notification form found at *michigan.gov*. Print these forms to distribute to your Healthy Michigan Plan members at each visit.

Questions?

Direct your questions regarding this letter to 800.292.2550 or *providersupport@michigan.gov*.

Review the provider responsibilities and standards

(09-01-2014) We're here to help your office operate as effectively as possible. The online Provider Manual section called "Provider responsibilities and standards" has information on everything from setting up your online account to office accessibility requirements to how to change status.

Please review this information annually:

- General office setup and standards
  - Responsibilities of office and staff
  - Compliance with fraud and abuse prevention
  - Requirements for treating Medicare patients
  - Accessibility and availability standards (location, hours)
  - Changes to contact information, staff or online accounts
  - Requesting and using NPI numbers
  - Accessing and using online Provider Center accounts
- Confidentiality
- Contracting
- Credentialing, enrollment and re-credentialing
- Data exchange
  - HL7
  - 5010 electronic data interchange
  - Electronic fund transfers
  - Performance data
- Provider-patient relationship
  - Treating yourself and your family
  - Discharging patients
  - PCP reassignments
  - Extension of care
- Provider status
  - Locum tenens
  - Opening or closing to new members
  - Moving a practice and mass transfer of members
  - Closing a practice and mass transfer of members
  - Sanction and suspension
- Record keeping
- Site visit review standards

Search keywords: **Provider responsibilities and standards**

continued >

Responsibilities and standards

Reminder: Handling patient complaints

(09-01-2014) A key component of patient satisfaction is the establishment of a trusting relationship between the patient and the provider. Sometimes patient/provider relationships can become strained. Dealing with patient/provider issues in a constructive and professional manner is the best way to maintain positive relationships.

Priority Health wants to make sure that you are informed about the concerns patients express. If a member makes a formal complaint against you or your staff, we will contact you to give you the opportunity to respond to the complaint. If you have questions about this process please contact your Provider Account Representative.

Reminder: Reporting fraud and abuse

(09-01-2014) Fraud and abuse costs companies billions of dollars each year, pushing health care prices up nationally. To help keep costs down, Priority Health has a special team that checks for fraud and abuse, and we depend on you to report fraud and abuse to us when you see it. Search keywords: **Report fraud and abuse**

Performance programs

2015 PCP Incentive Program information available

(11-07-2014) In 2015, we'll continue to reward prevention, improved clinical outcomes and the delivery of cost-effective care through our PCP Incentive Program. Go to the PCP IP page in the online Provider Manual to find our updated incentive program manual draft, measures chart and more. Print copies will be available around the first of the year. Contact your Provider Account Representative with questions.

Clinical resources

Free classes for patients at risk for developing diabetes

(09-09-2014) Improve the health of your patients by encouraging them to attend a nationally recognized diabetes prevention program. Taught by a certified lifestyle coach, the class arms patients with tools to recognize and overcome barriers to being healthy. The class is free to members and their spouses.

Benefits include:

- Losing 7% of starting body weight
- Learning healthy eating habits
- Finding ways to increase physical activity to 150 minutes a week
- Reducing medication use

Eligibility

- Patients with a body mass index (BMI) greater than 24
- Pre-diabetes diagnosis
- At-risk for developing diabetes

New sessions will start in January 2015 in Grand Rapids and Jackson. Learn more about the free Diabetes Prevention Program offered by Priority Health and the National Kidney Foundation. Search keywords: **Diabetes prevention programs**

Priority Health news

New digital magazine promotes health and wellness

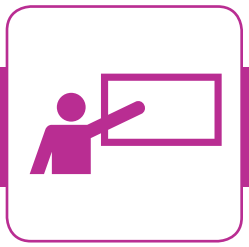
Priority Health is proud to launch ThinkHealth, a first-to-market digital magazine that features content from providers and Priority Health experts as well as other thought leaders and third-party organizations across the health insurance, health care technology and fitness industries.

ThinkHealth provides thought-provoking, educational content to aid Michigan consumers in their health and wellness decisions. It features personal stories from individuals looking to improve their health and inspire others. Readers will also find information on fitness events across Michigan.

Access the magazine at *thinkhealth.priorityhealth.com*. Consider sharing the stories with patients who will benefit from a healthy dose of useful information.

Search keyword: **ThinkHealth**

Training opportunities



March 2015 coding workshop scheduled

Grasping the Guidelines of ICD-10-CM

Understanding the Official Guidelines for Coding and Reporting is essential for correct coding. Here is an affordable opportunity to increase your ICD-10-CM coding confidence.

Tuesday, March 24, 2015

Priority Health Conference Center
3111 East Leonard St., Grand Rapids, MI

Presented by: Judy B. Breuker, CPC, CPMA, CCS-P, CDIP, CHC, CHCA, CEMC, AHIMA Approved ICD-10-CM/PCS Trainer

Schedule:

- Continental breakfast and registration: 8 a.m.
- Education session 8:30 a.m. – 4:15 p.m.
- Light lunch included

Registration:

- See *judybreuker.com* for details or to register.
- Registration is limited to 60.
- Registration fee: $69.
- Attendees will be sent a link two weeks prior to the class to download the 2015 ICD-10-CM Official Guidelines for Coding and Reporting.

Continuing education credits:

This program has the prior approval of AHIMA for 6.5 CEUs and AAPC for 6.5 continuing education hours. Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.

Priority Health Academy was a success

We're glad many of you were able to take part in the fall Priority Health Academy offered in Southfield, Grand Rapids and Traverse City. Nearly 300 network attendees from across the state were able to join us at the regional events.

PriorityHealth

1231 East Beltline Ave. NE
Grand Rapids, MI 49525

Physician and practice news digest

Go paperless

If you haven't already done so, go to *priorityhealth.com* and click "create account." Register and provide us with your email address to stay informed electronically.*

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