PriorityHealth

Physician and practice news digest

Summer 2015

Billing and payment

Pharmacy

Register your online account at *priorityhealth.com* for full access to patient tools and incentive program information.Visit *priorityhealth.com/provider* to read this digest online.

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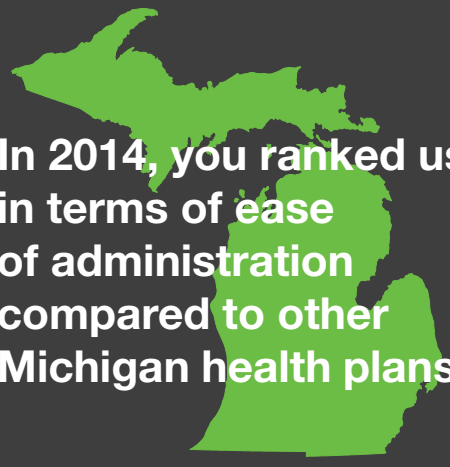
HOW WOULD YOU LIKE TO RECEIVE INFORMATION?

We value your partnership.



In 2014, you ranked us #1 in terms of ease of administration compared to other Michigan health plans.

Our goal is to continue to serve you at the highest level. We'd like to know how you would prefer to receive information like the content in this newsletter—in printed format or electronically?

Please complete a short survey so we can best serve your needs.

priorityhealth.com/newsdigestsurvey

Billing and payment

Provider Level I and Level II appeal forms changed

(02-09-2015) Level I and Level II appeal forms were modified in February to help clarify the appeals process and help you determine which department will handle your request. See the changes in the Provider Manual under Billing and payment > Reviews and appeals.

Clarification on submitting claims over 12 months old

(05-01-2015)

For commercial group or individual plan member claims:

Priority Health will not accept claims submitted for payment more than 12 months from the date of service.

For Medicare or Medicaid/Healthy Michigan Plan member claims:

Claims submitted to Priority Health with dates of service 12 months old or greater are not eligible for payment and will be denied. We will accept a claim submitted more than 12 months from the date of service if the claim includes charges credited (charges removed from the originally processed claim) and is submitted as a corrected or void claim.

To submit corrected claims:

- Claims must be billed as a corrected or void claim to bypass the timely filing limit without an automatic rejection.
- To bill a UB-04 hospital claim as a bill type xx7 or xx8, enter the bill type in box 4.
- To bill a HCFA 1500 physician or clinic claim, enter the bill type as a 7 or 8 in box 22, and enter a comment in box 19 noting the credit.

Virtual bronchoscopy navigation no longer separately payable

(04-09-2015) As new technologies become standards of care, we review the way these services are paid. That's why virtual bronchoscopy navigation (procedure code 31627) is no longer separately payable for commercial and Medicaid members. You may continue to bill this procedure code to report the procedure, but it will not be paid as a separate service.

For Medicare, this procedure is still payable as a separate professional fee.

Pharmacy

Reminder: Formulary updates

(02-02-2015) The Pharmacy and Therapeutics Committee meets every other month to review the Priority Health formulary. 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.

Questions about utilization management decisions and processes?

Physician and pharmacist reviewers are available to help you. Call the Priority Health pharmacy department at 800.466.6642.

Reminder: Prescription quantity and pharmacy limitations

(04-01-2015) Priority Health sets limits on how much of a supply of a drug our members can have filled at a time, and where they can go to get certain types of prescriptions.

31-day supply is the standard

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

Mail order saves most patients money on 90-day supplies

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

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

How to send prescriptions to Express Scripts

- **Electronic prescribing dedicated fax number**: 800.211.1456
  Remember to set up Express Scripts as the mail service pharmacy for Priority Health members. Electronic prescribing (E-Scribe) is set up through the prescriber's computer system through a central service called SureScripts. Prescribers having issues with electronic prescribing can email Express Scripts at *eprescribingsupport@express-scripts.com* for assistance.
- **Fax**: 800.837.0959 (physician use only)
- **Phone**: 888.327.9791 (1-888-EASYRX1) (physician use only)
  Option 2: To connect to a live person to verbally call in a prescription
  Option 3: To obtain an ESI fax form to be faxed in with the prescription(s). The form will have a direct fax number on it.

90-day retail pharmacies program

Many of the pharmacies in our network participate in our "90 day at retail" program, allowing members to fill a 90-day supply at a local retail pharmacy for three copayments. These pharmacies are designated as 90-day pharmacies in the Find a Doctor tool.

Medicaid members are not eligible for 90 day fills.

Specialty drugs

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

Authorizations

Medical policies added, updated

(02-26-2015) The following updates and changes were approved at recent Medical Affairs Committee meetings.

Changes retroactive to Jan. 1, 2015

Rehabilitative and Habilitative Medicine Services: This policy was updated due to a change in the state law related to physical therapy services without a physician referral. This change is retroactive to Jan. 1, 2015.

NEW Multi-Marker Tumor Panels: There is coverage of multi-marker tumor panels using next generation sequencing in the diagnosis and treatment of cancer when specific criteria are met. Requests for prior authorization should be submitted using the Next Generation Sequencing PA form.

Updated policies as of:

April 8, 2015

- Retired: Fluocinolone Implant - 91511

March 9, 2015

- Spine Procedures - 91581
- Stimulation Therapy and Devices - 91468
- Surgical Treatment of Obesity - 91595

Feb. 26, 2015

- Apnea Monitors
- Cardiovascular Risk Markers
- Chemosensitivity Assays
- Colorectal Cancer Screening
- Cosmetic and Reconstructive Surgery Procedures
- CT Scanning for Lung Cancer Screening
- Gastroparesis Testing and Treatment
- Genetics: Counseling, Testing, Screen
- Home Dialysis
- Intraperitoneal Hyperthermic Chemotherapy
- Obstructive Sleep Apnea
- Parenteral Nutrition Therapy
- Pharmacogenomic Testing
- Tumor Markers

A summary of the changes to each policy above is posted on the Medical policy updates and changes page of the Provider Manual.

No authorization is required when…

(04-22-2015) "Does this require an authorization?" No need to call us for the answer—you can check the Authorization reference list page in the Provider Manual. It has the most up-to-date information on what procedures and services require prior authorization.

- Find the service or procedure in alphabetical order
- See which plans do or don't require prior authorization
- For more coding and coverage details, click the link to the medical policy PDF
- If there's a specific authorization form for a procedure or service, you'll find a link to it there

Reminder: Behavioral health accepts authorization requests by fax

The Behavioral Health department requests that providers send faxed requests for the following:

- To complete concurrent reviews
- To submit discharge information
- To submit supplemental clinical information, if needed
- To request initial authorization for inpatient treatment

If you have questions or concerns about the appropriateness of an admission or medical necessity criteria, contact the Behavioral Health department at 800.942.4765.

continued >

Authorizations

Response turnaround times

Faxes are typically not processed during the lunch hour. The requesting facility will receive a response fax within 24 business hours. Listed below are department time frame goals for processing faxed requests:

- Information faxed prior to 11 a.m.
  Response the same business day
- Information faxed after 2 p.m.
  Response by 11 a.m. the next business day
- Information faxed after 4 p.m.
  Response by 2 p.m. the next business day

Emergent assistance

Please phone in emergent behavioral health questions. We have clinical staff on call 24 hours a day.

An emergent assessment faxed in at any time, by an agency or provider other than the receiving facility or by the receiving facility, will be processed in our normal fax response timeframes listed here.

Questions?

For more information on our fax process, see "faxing auth requests and assessments" in the Provider Manual.

If you have concerns regarding coverage or criteria, call us at 616.464.8500 or 800.673.8043. Behavioral Health department business hours are 8 a.m. to 5 p.m., Monday through Friday. After hours, choose option 1 when prompted and your call will be routed to our answering service.

Performance programs

Care management code added to PCP Incentive Program manual

(02-20-2015) In February, we updated pages 37 and 50 of the online provider manual with the new Medicare code 99490 released by CMS. It replaced the former code Gxxx1.

Download a revised 2015 PCP Incentive Program Manual in the Provider Manual > Performance programs > PCP Incentive Program.

Questions?

Contact your Provider Account Representative.

Plans and benefits

Update to physical therapy medical policy

(02-10-2015) A state law took effect Jan. 1, 2015, allowing anyone to seek physical therapy services without a physician referral for up to 21 days or 10 visits, whichever comes first. While the law states that health insurers are not required to cover physical therapy services without physician referral, Priority Health will provide coverage for patients to access physical therapy services as allowed by the law for commercial products. This creates parity with chiropractic access.

This state requirement does not affect members of our Medicare Advantage products. Physician referral is not required under Medicare law.

Medicaid patients are the exception

Medicaid patients still require referral for physical therapy, as mandated by the state.

Read the updated policy

Medical Policy 91318 has been updated retroactive to Jan. 1, 2015. Read the policy in the provider manual at *priorityhealth.com*. **Search keywords: rehabilitative and habilitative medicine.**

Changes to the Preventive Health Care Guidelines

(05-01-2015) We cover preventive services as outlined by the Affordable Care Act and recommended by the U.S. Preventive Services Task Force (USPSTF), 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.

Hepatitis B screening and cavity prevention covered

As of May 1, our Preventive Health Care Guidelines were updated to include:

- Screening for Hepatitis B for high-risk individuals
- Cavity prevention in children up to age 5

These recommendations are issued by the USPSTF.

Patients covered

These services are now covered at 100% for members of non-grandfathered commercial group and individual plans, and for Medicaid and Healthy Michigan Plan members.

Cavity prevention in children up to age 5

This refers to the application of a fluoride varnish to the primary teeth of children up to age 5, performed in a pediatrician or PCP office. It is not a dental benefit. Research shows that all young children can benefit from this treatment and it is most helpful for children without a fluoridated water supply.

Hepatitis B screening

This service was previously covered for pregnant women. Now this screening is available for all adults and adolescents at high-risk for this infection. For more information visit *uspreventiveservicestaskforce.org.*

Responsibilities and standards

Risk adjustment information added to provider manual

(04-20-2015) The method that the Centers for Medicare and Medicaid Services (CMS) uses to adjust payments to health plans depends on accurately capturing claim diagnosis codes. By risk adjusting plan payments, CMS can make accurate payments to health plans for enrollees with differences in expected medical costs.

Chart reviews help everyone

This scrutiny of medical records is a compliance measure to ensure our payments from CMS are based upon reliable and accurate records from the physicians and facilities. Chart reviews are important since, in addition to payment inequities, undocumented, inaccurate or missed diagnoses can lead to members not receiving the quality of care they need to lead healthy lives.

Learn more about why Medicare risk adjustment matters at *priorityhealth.com*. **Search keywords: Risk adjustment.**

New all-payer claims database (APCD) extracts

(04-03-2015) Priority Health has adopted a new all-payer claims data (APCD) format for our claims data extracts. The extracts provide ACNs, PHOs, POs and medical groups with member eligibility, paid medical claims and paid prescription claims data. The new format replaces the external sharing of information with providers (ESIP) and physician hospital organization (PHO) data extracts.

We want to provide you with a user-friendly source for the most complete and accurate data in an external, accepted format. We're leading the way in Michigan by switching to the APCD format developed by the APCD Council. Twelve states have already implemented statewide all-payer claims databases based on this model.

Learn more about APCD extracts and how we're making the switch easy in the Provider Manual under the responsibilities and standards section. You must be logged in to view the page.

Behavioral health/PCP coordination survey results

(05-01-2015) In 2014, we surveyed PCPs and behavioral health specialists to promote coordination of care and support quality improvement. The survey results below indicate that some improvement occurred over the past year but there is still a gap regarding exchange of information and care coordination. We encourage you to make coordination of care a routine part of your treatment plan for all treatments including behavioral health. HIPAA Code of Federal Regulations, Section 45 CFR 164.506, allows for the sharing of protected health information to enable such coordination of care.

Key questions	2013	2014
BH reported having an E.H.R. where medical and behavioral health can view each other's notes	48%	35%
PCP reported having an E.H.R. where medical and behavioral health can view each other's notes	Not asked	17%
Highest reported method for sharing of information (reported by both PCP and BH) is by fax	37%	59%
BH reported always or most of the time providing clinical information to the PCP	42%	46%
PCP reported always or most of the time receiving clinical information from the patient's BH provider	48%	33%
BH reported providing clinical information upon initial assessment and whenever treatment plan changed	25%	31%
PCP reported providing health information to the BH clinician at some point during medical treatment	Not asked	26%

Other findings

- 20% of PCPs report never receiving important behavioral health clinical information on their patients
- 20% of PCPs report never providing medical information to a BH clinician at any point during treatment

Responsibilities and standards

- 28% of BH clinicians reported only sending clinical information once, with no ongoing exchange regarding treatment
- Fax is the primary method for the exchange of information
- Fewer phone conversations to coordinate care were reported by BH and PCPs in 2014, compared to 2013
- PCPs and BH clinicians report the importance of collaboration, but indicate the following barriers
  - Time constraints
  - Lack of integrated systems of care, including shared E.H.R.s
  - Securing releases of information

Recommendations

Research shows that integration of primary care and behavioral health improves health outcomes. We recommend that you periodically survey your patients about their perceptions of how well they feel you are doing in coordinating their care across the medical and behavioral health spectrum. We also recommend that you examine and update your protocols associated with the exchange of information so your work flow promotes the exchange of information and integrated treatment plans.

Member experience with behavioral health

(05-01-2015) Each year we survey a sampling of members who received mental health treatment during the calendar year. Key performance indicators (KPIs) of satisfaction are based on NCQA's Access and Member Satisfaction Standards. In 2014, 396 members responded to our survey. Our goal is to achieve 90% in each KPI. Below, 2014 results are compared to 2013. Some questions are not comparable due to required changes to the survey reflecting updated NCQA access standards.

Key performance indicators	2013	2014
Member seen for urgent mental health counseling within 48 hours (always/usually)	Not comparable	68%
Member seen for ER (non life threatening) mental health counseling within 6 hours (always/usually)	Not comparable	70%
Member seen for routine appointment for mental health needs as soon as wanted (always/usually)	83%	85%
Days waited for routine appointment for mental health needs (within 10 days)	70%	80%
Days waited for medication management appointment (within 10 days)	Not asked	69%
Counseling is responsive to member's language, race, religious, ethnic or cultural needs (yes)	33%	90%
Helped by the mental health counseling received (a lot, somewhat)	84%	85%
Overall rating of mental health counseling (8,9,10 combined 0=worse and 10=best)	74%	75%

All indicators improved over the prior year, and the 90% goal was met in one category.

Results indicate strong performances in:

- Getting routine mental health appointments when desired
- Receiving culturally competent counseling
- Counseling/treatment was helpful

Improvement is needed in access to care:

- Member seen within 48 hours for urgent treatment
- Member seen within 6 hours for emergency non-life threatening treatment
- Member seen within 10 days of requesting a medication management appointment.

Only 75% of respondents rated their counseling/treatment as an 8, 9 or 10 (with 10 being the best). This falls short of our 90% goal.

Recommendations

We encourage you to examine your own access standards for meeting NCQA national standards for urgent and emergent care, and medication management visits. In addition, please periodically survey your own clients for their overall rating of the treatment they are receiving for continued improvement of the overall member experience.

If you have questions about coordination of care, contact our Behavioral Health department at 800.673.8043.

Training opportunities

Free ICD-10 webinar series available

(02-26-2015) As payers, Priority Health, Humana, Blue Cross Blue Shield of Michigan, United HealthCare and Health Alliance Plan (HAP) are working together to help physicians and other health care providers in the transition to ICD-10. Our goal is to show that the transition doesn't have to be overly costly or burdensome.

Webinars offered on Thursdays at noon

In March, our ICD-10 Payers Collaboration began offering a series of free hour-long webinars by specialty on Thursdays at noon Eastern Time.

Each webinar offers:

- An examination of how diagnosis codes common to your specialties are affected by ICD-10
- Transition checklists to help minimize disruption in the move to ICD-10
- Free ICD-10 testing options to help assess coding proficiency
- Demonstration that the payers you work with are prepared to handle ICD-10-coded claims and encounters on Oct. 1, 2015

CME credits are not offered for these webinars. See the complete schedule and register at *priorityhealth.com/provider*. **Search keywords: ICD-10 webinars.**

Virtual Office Advisory Forum June 17

(01-15-2015) These lunch hour sessions provide you with an opportunity to hear from Priority Health experts about network updates, new programs, educational opportunities and more.

Join us June 17 from Noon to 1 p.m.

Watch for an email invitation with a registration link soon. If you don't receive emails from us and would like to stay informed electronically, go to *priorityhealth.com* and click "Register." The account verification process takes up to five business days.

Save the Date: Priority Health Academy

(05-10-2015) Mark your calendars for convenient, affordable education and training on subjects including billing and coding, telemedicine, care management, the 2016 PCP incentive program and more. The Academy will be held in three cities, and more information will be coming soon.

- Grand Rapids Oct. 21
- Traverse City Oct. 28
- Southfield Nov. 3

Priority Health news

Beginning July 1, members can earn financial rewards by being engaged health care consumers

With the debut of a program called **Priority**Rewards, Priority Health is leading Michigan with an innovative solution that rewards members for choosing to receive care at high-quality, lower-cost facilities. Beginning July 1, 2015, Priority Health will offer a financial reward to all commercial members who use the Cost Estimator transparency tool available at *priorityhealth.com* to choose a lower-cost option for select health care services.

As patients face higher out-of-pocket costs, Priority Health has published the prices of more than 300 health care procedures—including X-rays, MRIs, lab tests and surgeries—to help members save money and plan for health care expenses. Now, when a member uses the tool and has a procedure performed at a facility with pricing at or below the fair market rate, the member will receive a Visa® reward card in the mail. **Priority**Rewards will be available to all commercially-insured members, but not to members in government programs. Not all procedures in Cost Estimator are rewardable.

This initiative is a significant step in Priority Health's drive to reduce health care costs through transparency and member engagement. As providers, you can help by encouraging your patients to get engaged in their care and by performing procedures at the best-priced facilities.

Learn more about our cost and quality transparency tools at *priorityhealth.com/provider/news-and-education/transparency.*

PriorityHealth

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