PriorityHealth

# Physician and practice news digest

**Spring 2016**

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DIGITAL ACCESS!

## Our news digest is going digital.

Our goal is to continue to serve you to the highest level and communicate with you in the way that you prefer. Via surveys last year, 75% of providers polled told us they prefer to receive information in digital format — and we've listened. So, we will be phasing out this printed newsletter later this year.

See inside (pg. 19) to be sure you're set for electronic delivery in the future.

**SPOTLIGHT:**

# PROVIDERS RANK PRIORITY HEALTH #1 IN MICHIGAN

## 2015 Provider experience survey results

The results are in. In September we surveyed physicians, practice managers, nurses and other staff from primary care, specialty and ancillary sites plan-wide.

We are thrilled to report that once again **we ranked #1** in ease of administration between practices and health plans. You also told us:

- You are using our website to get the information you need.
  - 95% use our online tools
  - Nearly 50% use our online provider manual
- Authorization requests are the #1 thing you would like us to make available online. Nearly 1 in 2 of respondents expressed interest in this. We hear you and are working on a solution.
- About 15% of PCP sites are currently offering telemedicine services and 31% are considering offering these services.

We learned a lot from your feedback, thank you! For an infographic with more result details go to *priorityhealth.com/provider*. **Search keywords: 2016 provider experience survey.**

# Billing and payment

## New Medicare EOC exclusion forms available

(01-15-2016) Priority Health has created more than 100 forms, one per exclusion in the Medicare Advantage plans' Evidence of Coverage (EOC), stating that the item or service is excluded from coverage in the EOC.

These forms can be used by providers to document that they have informed their Priority Health Medicare Advantage patients that an item or service is excluded from coverage in the EOC, and that the member will therefore be 100% responsible for the cost of the item or service.

For more details on billing for items/services excluded in the EOC, go to the Provider Manual > Billing and payment > Medicare non-coverage billing. Find the EOC exclusion forms listed on a new page under Provider forms: Medicare EOC exclusion forms.

## Medicaid fee schedule: New update policy

(01-14-2016 ) Effective Apr. 1, 2016, Priority Health will post the Medicaid Priority Health Choice fee schedule on the website annually or quarterly based on the first publication of that fee schedule (as noted below) by the State of Michigan.

The current published fee schedule will be posted in the Provider Manual and will be used to adjudicate claims until the next published fee schedule is posted.

Priority Health is moving to an annual or quarterly schedule based on the service type, in alignment with other payers. However, if the Michigan Department of Health and Human Services (MDHHS) posts a specific bulletin instructing the health plan that an update has occurred, we will make updates outside of the annual/quarterly updates.

**Services updated annually**

These services will be updated annually upon original publication:

- Ambulance
- Chiropractic
- Hearing Aid Dealers (HAD) Databases
- Hearing Services Databases
- Local Health Dept.
- Maternal Infant Health
- MH/SA Children's Waiver Services Database
- MH/SA Serious Emotional Disturbance (SED)
- PCP Incentive
- Telemedicine
- Therapies (Outpatient)
- Vision

**Services updated quarterly**

These services will be updated quarterly upon original publication:

- Ambulatory Surgery Centers (ASC)
- Clinical Lab
- Durable Medical Equipment (DME)
- Drugs and Biologicals
- Family Planning
- OPPS Wrap Around Code List — A2, A5 and A7 only
- Practitioner and Medical Clinic

## Faxed original or corrected claims no longer accepted

(01-05-2016) Effective Jan. 1, 2016, Priority Health will no longer accept original claims or corrected claims via fax.

***continued >***

# Billing and payment

Instead claims must be received electronically (preferred method), or by mailing a hard copy to:

Priority Health Claims
P.O. Box 232
Grand Rapids, MI 49501

Claims received via fax will be returned unprocessed.

Go to our claim submission instructions or to the Provider Manual > Billing & Payment section to see more detailed how to bill and corrected claims instructions.

Questions? Email *provider.services@priorityhealth.com* or call the Provider Helpline at 800.942.4765.

## Commercial claim timely filing limit updated

(01-04-2016) As of Jan. 1, 2016, providers have 90 days from the date of the original commercial claim denial (if beyond the one year date of service) to resolve payment discrepancies including submitting corrected claims. If follow-up is not completed within 90 days:

- Any request will deny for filing limit without appeal rights.
- Corrected or augmented information received after that date will be automatically denied as the provider's responsibility.
- Negligence by the provider's staff does not justify an exception to this policy.

### When the 90-day limit does not apply

This 90-day limit does not include upfront rejected claims or other insurance adjustment EOBs. Also, denials related to authorizations/medical necessity or coding/clinical edits still follow the filing limit rules.

### Commercial plan claim billing examples

Billed within timely filing limit, denial after filing limit:

- Date of service 09/24/2014
- Claim received date 09/23/2015
- Claim denied date 10/12/2015
- Provider has 90 days from 10/12/2015 to resolve
- Corrected claim received date 11/01/2015
- Claim will process since it was received within 90 days from the original denial date of 10/12/2015

Billed within timely filing limit but not re-billed within 90 days:

- Date of service 09/24/2014
- Claim received date 09/23/2015
- Claim denied date 10/12/2015
- Provider has 90 days from 10/12/2015 to resolve
- Corrected claim received 01/11/2016
- Claim will deny for one year timely filing. Provider does not have filing limit appeal rights.

Billed within timely filing limit, more than one denial:

- Date of service 09/24/2014
- Claim received date 11/10/2014
- Claim denied date 01/12/2015 (within filing limit)
- Corrected claim received date 10/01/2015 (after one-year filing limit)
- Second claim denied date 11/01/2015
- Claim will deny for one-year timely filing
- The additional 90 days does not apply, based upon the original denial date of 01/12/2015

If the claim denies within the filing limit and the provider corrects it, but then gets a different denial: Since it's a new/different denial, provider would have the option to submit within the 90 days after filing limit.

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# Billing and payment

**For more information**
View the timely filing rules in their entirety in the Provider Manual > Billing and Payment > How to bill > Claim deadlines.

## 2016 fee schedule changes effective Jan. 1 now online

(12-01-2015) Priority Health conducts a review of fee schedules annually. We continually evaluate national and regional data to develop fee schedules that balance the needs of providers with those of employers and members who bear the burden of these costs.

This aligns with the Priority Health mission to be the nation's leader in innovative health solutions, making health care obtainable for all. We're committed to providing affordable and excellent health care to individuals and employers through an ever-expanding array of products and services.

Our adjustments to fee schedules typically result in raising some fees while lowering others. We strive for balance between primary care and specialty care as well as among specialists themselves. Our goal is to reimburse all providers at a fair market value.

**Fee schedules now available online**
Priority Health is now posting fee schedules online. Participating providers who are logged in to their provider accounts on this website can access fee schedules by going to the Provider Manual > Billing and payment section > Fee schedules page.

## TC modifier accepted on outpatient radiology and lab services

(11-16-2015) In 2016, Priority Health will accept the TC modifier from facilities choosing to report the technical component for services where the professional component is performed by another entity. This modifier should be placed in the next available modifier field, and should not supplant existing modifier hierarchy direction.

This change is due to CMS requirements associated with Commercial Individual and Small Group On-Exchange and Off-Exchange ACA plan data submissions for Reinsurance and Risk Adjustment reimbursement. Their Edge Server software strictly views un-modified codes as Global, causing rejections for duplicate services. See the Provider Manual for additional information on use of the TC and 26 modifiers.

## APR-DRG Medicaid inpatient reimbursement

(11-11-2015) As of Oct. 1, 2015, the State of Michigan Department of Health and Human Services requires all inpatient facility claims to be paid using the new APR-DRG payment methodology. This applies to all Michigan Medicaid, Healthy Michigan Plan and MIChild beneficiary inpatient cases.

- Priority Health Choice, Inc. now reimburses all inpatient facility claims with discharge dates of 10/1/2015 forward per APR-DRG payment methodology rather than MS-DRG payment methodology.
- Regardless of which DRG is submitted, the claim will be adjudicated per APR-DRG computation; if the old DRG methodology is billed, it will pay to the new DRG methodology.
- Facilities that render Long Term Acute Care services are advised that the State of Michigan will continue to reimburse for those services.

**For more information**
See the Michigan Department of Health and Human Services Medical Services Administration Bulletin MSA 15-30, Inpatient Hospital Reimbursement System Reform.

# Pharmacy

## Medicare Part D prescribers must be enrolled in Medicare

(01-18-2016) Effective June 1, 2016, the Centers for Medicare and Medicaid Services will require all physicians and other eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare and in an approved status, or have a valid opt-out affidavit on file in order for their prescriptions to be covered under Part D in accordance with Medicare rules found in 42 CFR § 423.120(c) (6).

Prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Medicare administrative contractor as soon as possible to avoid confusion or delay in prescriptions being filled after June 1, 2016. For additional information, visit the Part D Prescriber Enrollment page at *cms.gov*.

## Home BP monitors covered as pharmacy benefit as of Dec. 1

(11-10-2015) For more than five years, Priority Health has covered home blood pressure monitors as a durable medical equipment (DME) benefit for nearly 70,000 members managing hypertension. As of Dec. 1, we've expanded this coverage as a pharmacy benefit of our individual and group commercial plans. Now these plan members have easier access to the monitors they need to support their efforts to control hypertension.

- **A hand-written or faxed prescription is required** (due to EMR limitations) for all home blood pressure monitors.
- **Omron brand** monitors are the only brand that will be covered as they have been clinically validated in literature.
- Pharmacies and members alike have been educated about this expanded benefit.

Questions? Call the Pharmacy Call Center at 800.466.6642.

## Jan. 2016 formulary updates

(01-29-2016) Our commercial and Medicare Advantage formularies are updated up to six times a year. The Pharmacy and Therapeutics Committee met in January 2016 to review the Priority Health commercial formulary, which applies to both group and individual HMO, POS and PPO plans, and our Medicare Advantage formulary. We also update our pharmacy policies and procedures annually.

### Medicaid formulary no longer included in these updates

As of January 2016, the Medicaid formulary will be updated quarterly based on recommendations from the State's work group.

### Medicare formulary changes await CMS approval

Changes to the Priority Health Medicare Part D formulary will not take effect until Priority Health receives CMS approval. For drugs covered by Medicare Part B, prescribers must follow WPS-Medicare local coverage determinations.

### See a listing of the changes

Updates to all our formularies have been made in the online Approved Drug List tool. To see a list of the January 2016 changes, go to the Provider Manual under Authorizations > Drugs > Formulary Updates.

### 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.

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# Pharmacy

## Reminder: Reduce medication waste

(01-15-2015) In an effort to lessen the likelihood of waste associated with prescriptions, we encourage you to be judicious in the quantity of medication 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 because medications that aren't disposed of properly can pollute. For more information on proper medication disposal, visit *fda.gov* and search "medication disposal."

## Reminder: MTM program coordinates patient prescriptions

(02-10-2016) Because many Medicare members have multiple doctors prescribing drugs, we offer a free Medication Therapy Management (MTM) program to all Priority Health Medicare members. The MTM program is designed to complement doctors' work by using specially trained network pharmacists to:

- Coordinate all prescriptions
- Ensure Medicare members are getting the best results from their medications
- Help Medicare members control their out-of-pocket costs

MTM pharmacists work at many pharmacies that your patients use. Most chain pharmacies participate, including Walgreens, Meijer, Spartan Stores, Rite Aid, CVS, Wal-Mart, and many independent pharmacies.

### Services included

We partner with OutcomesMTM® to administer this program. MTM services offered include:

**Comprehensive medication reviews (CMRs).** The pharmacist meets with your patient to review all of their medications, including OTCs, herbals and supplements. This will help identify any drug-related problems such as duplications, drug interactions, missing therapy, dose titration, and under- and over-utilization, etc.

**Drug information.** When starting a new medication, the pharmacist will:

- Talk to your patients 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 medication reviews (TMRs).** 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. This service identifies:

- Members using brand-name medications when generic options are available
- Medication-related quality interventions that support our incentive program, HEDIS, and Medicare 5-star measures, such as appropriate use of blood pressure medication in patients with diabetes and hypertension and medication adherence to diabetes, hypertension and hyperlipidemia drugs.

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# Pharmacy

### When an MTM pharmacist might contact you

Reviews can occur any time during the year. We encourage you to work with MTM pharmacists to ensure appropriate medication use for your patients.

After a member receives an interactive comprehensive medication review (CMR), the MTM pharmacist may call or fax 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.
- To ask questions or make recommendations about your patient's medications

You may be contacted by an MTM pharmacist if a targeted medication review (TMR) identifies a potential medication-related problem for your patient. We do our best to connect your patients with their local pharmacist but if that pharmacist isn't available to provide MTM services in a timely manner, your patient may be contacted by one of our partners. In this case, you may hear from a Cardinal Health pharmacist, who has provided your patient MTM services by phone.

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

### What members receive

Priority Health Medicare members receive a printed standardized summary of their CMR, Form CMS-10396, including a cover letter, medication action plan and personal medication list. We encourage your patients to share these documents with you and other health care providers at regular visits and to 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:

- Calling the Priority Health pharmacy department at 800.466.6642
- Working with their Priority Health case manager, if applicable

### The MTM program and PIP performance

MTM pharmacists, partnering with physicians and other providers, can positively impact Physician Incentive Program (PIP) 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: Monitoring for nephropathy
- Diabetes care: Controlled blood pressure
- Optimal diabetes care
- Hypertension: Controlled blood pressure

## Reminder: Step therapy required for select drug categories

(10-15-2015) 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)

*continued >*

- 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 migraine require a documented trial with at least one generic triptan.

## Reminder: Generic drug substitutions

(10-15-2015) 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 copay. 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.

### Exceptions to the policy

Authorizations for the MPD override may be given for the following exceptions:

- Members on Coumadin® (no authorization required, automatic brand copay)
- 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 copay 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: Prescription quantity and pharmacy limitations

(01-15-2015) 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.

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# 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 (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.

# Clinical resources

## Resources for diabetes prevention and management

(11-04-2015) We offer clinical practice guidelines and patient education materials in our Clinical resources section online to help you improve the quality of care and education for your diabetes patients.

### Diabetes prevention program

Your patients can improve their health and quality of life by enrolling in one of our certified Diabetes Prevention Programs. The programs are led by a certified lifestyle coach and have been a proven way to reduce the risk of developing type 2 diabetes by as much as 58%. Priority Health partners with leading health organizations to provide our members with access to the National Diabetes Prevention Program for free when they meet established criteria. Programs begin throughout the year in locations across the state. Find locations at *priorityhealth.com/prevent-diabetes*.

### PCP Incentive program

We remain focused on patient-centered care that optimizes health, ensures the best care experience and eliminates avoidable costs. Learn more about measures for optimal diabetes care included in our PCP Incentive Program at *priorityhealth.com/providers*. **Search keywords: Performance programs**.

# Responsibilities and standards

## CMS provider directory requirements for 2016

(01-04-2016) The Centers for Medicare & Medicaid Services (CMS) has issued new requirements for 2016 regarding online provider directories. The requirements are designed to ensure that members have information about and access to contracted providers that are accepting new patients.

### CMS is requiring:

- Health plans must have regular, ongoing communications/ contacts (at least quarterly) with providers in order to verify their availability and acceptance of new patients.
- Contracted providers must inform the plan of any changes that affect availability including street address, phone number and office hours.

This new requirement does not supersede, but is complementary to, existing language in your contract stating that you agree to provide 60 days written notice when closing to new members.

### Resources to help you stay compliant

As of January, PCPs who have a Priority Health login and access to Filemart now receive two additional reports designed to help you meet this requirement.

- PIP_007 Open/Closed report
- PIP_099 Demographics report

Both reports will be delivered monthly with other reports. We ask that you review these once a month and submit updates as needed. It is required that you complete this review at least quarterly to avoid compliance penalties.

### Notifying us of changes to your availability

Updates to your Open/Closed status, to inform us of another location, or to make other demographic information changes can be made on the reports, via the provider change form, or by using another pre-approved method. Email your updates to *PH-PELC@priorityhealth.com* or fax them to 616.975.8857.

### PCP practices required to have a Filemart login as of January 31

All PCPs needed a Priority Health Filemart login by Jan. 31, 2016, in order to receive these reports. If you need help requesting an online account, view our four minute video on the process. It usually takes two business days for us to verify your access.

### Questions?

If you have questions about this new requirement, how to create a login, or how to ensure your compliance and avoid penalties, contact Pam Gilbert at 616.464.8585.

## Behavioral Health/PCP coordination of care survey results

(02-01-2016) In 2015, Priority Health surveyed PCPs and behavioral health specialists to learn about how care is coordinated between the two disciplines. Research shows that integration of primary care and behavioral health care improves health outcomes.

The survey results below show some improvement over the past year. However, there is still a gap regarding exchange of information and care coordination.

| KEY QUESTIONS | 2013 | 2014 | 2015 |
|---|---|---|---|
| BH reported having an EHR, where medical and behavioral health can view each other's notes | 48% | 35% | 44% |
| PCP reported having an EHR, where medical and behavioral health can view each other's notes | Not asked | 17% | 19% |
| BH reported always or most of the time providing clinical information to the PCP | 42% | 46% | 43% |
| PCP reported always or most of the time receiving clinical information from the patient's BH provider | 48% | 33% | 23% |
| BH reported providing clinical information upon initial assessment and whenever treatment plan changed | 25% | 31% | 38% |
| PCP reported providing health information to the BH clinician at some point during medical treatment | Not asked | 26% | 32% |

***continued >***

# Responsibilities and standards

### Other findings

PCPs and BH clinicians report the importance of collaboration, but indicate the following barriers:

- Time constraints
- Lack of integrated systems of care, including shared EHRs
- Members willing to sign, or other barriers to securing, releases of information

### Recommendations

Research shows that integrating primary and behavioral health care improves health outcomes. We recommend that you periodically survey your clients/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 to ensure that your work flow promotes the exchange of information and integrated treatment plans.

## Behavioral health patients' satisfaction survey results

(02-01-2016) Each year we survey a statistically valid sample of members who received mental health treatment during the calendar year. Key Performance Indicators (KPIs) of satisfaction are based on NCQA Access and Member Satisfaction standards.

Our goal is to achieve 90% in each KPI. Below, 2015 results are compared to 2014. Unfortunately, Priority Health members experienced less access to timely behavioral health services in 2015. Overall satisfaction with mental health services is slightly improved, but within the individual categories there is work to be done.

| KEY PERFORMANCE INDICATORS (KPI) | 2014 | 2015 |
|---|---|---|
| Member seen for urgent mental health counseling within 48 hours (always/usually) | 68% | 53% |
| Member seen for ER (non-life-threatening) mental health counseling within 6 hours (always/usually) | 70% | 61% |
| Member seen for routine appointment for mental health needs as soon as wanted (always/usually) | 85% | 80% |
| Days waited for routine appointment for mental health needs (within 10 days) | 80% | 72% |
| Days waited for medication management appointment (within 10 days) | 69% | 63% |
| Counseling is responsive to member's language, race, religious, ethnic or cultural needs (yes) | 90% | 83% |
| Overall satisfaction with mental health services (completely satisfied and somewhat satisfied) | 81% | 83% |

### Recommendations

We ask you to examine your own access standards with a goal of meeting NCQA national standards for:

- Urgent and emergent care
- Routine visits
- Medication management visits

In addition, please periodically survey your own clients/patients for their overall rating of the treatment they receive. Only by seeing the experience we offer through patients' eyes can we continue to improve overall member satisfaction. If you have questions, contact our Behavioral Health department at 800.673.8043.

## Reminder: Inform Medicare patients of their right to create advance directives

(01-29-2015) 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 that conversation in a prominent place in the medical record. If

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# Responsibilities and standards

they have executed an advance directive, this should also be documented. See details at *priorityhealth.com*. **Search keywords: Advance directives**

## 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: Review the clinical practice guidelines

(01-15-2015) Clinical practice guidelines, including preventive health care, support evidence-based care for children and adults. These are available in the Clinical resources section of *priorityhealth.com*, along with practice management and patient education tools. Request printed copies through the Provider Helpline at 800.942.4765.

On *priorityhealth.com*, you'll find guidelines for:

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

## Reminder: Performance program information online

(01-15-2015) We remind you annually of the performance program information available to you at *priorityhealth.com*. The listings below highlight these areas and direct you to more details.

### Quality Improvement Program

For summary information regarding the Priority Health Quality Improvement Program performance and key quality results, go to About us > Company profile > 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 Tamara Hibbitts at 616.464.8925 or *tamara.hibbitts@priorityhealth.com*.

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# Responsibilities and standards

### Disease and care management services

Our health management programs for asthma, diabetes, cardiovascular disease, pregnancy and tobacco cessation are designed to assist your practice. These free programs help to educate patients about their health conditions, risk factors, adherence to evidence-based treatment and 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*.

### Utilization management decisions, InterQual criteria and medical policies

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:

- Base utilization decisions only on appropriateness of care and service, as well as existence of coverage
- Will not reward practitioners or other individuals for issuing denials of coverage
- Will not offer financial incentives for utilization decision makers that would encourage denial of coverage or service
- Decide on coverage of new technology after comprehensive research and review by the chief medical officer and physician committees

To learn more, visit the Utilization management section of the Provider Manual. If you have questions about utilization management decisions, would like copies of the medical criteria/policies used to make decisions or would like to discuss the decision-making process, call the Health Management department at 800.942.4765.

### Medical utilization criteria

Physicians are available to review and answer questions about utilization decisions during business hours. Call 616.464.8432.

### Pharmacy utilization criteria

Pharmacists are available to review and answer questions about pharmacy-related utilization decisions by calling 800.466.6642.

### Behavioral health medical necessity criteria

Find them in the Authorizations section of the Provider Manual under 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 case managers at 800.673.8043, from 8:30 a.m. to 5 p.m. Monday through Friday. A care manager will assist you with your questions or refer you to a board-certified psychiatrist.

## Reminder: Review the provider responsibilities and standards

(01-15-2015) 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 (locum tenens, closing your practice, etc.).

Please review this information annually:

- General office setup and standards
- Confidentiality
- Contracting
- Credentialing, enrollment and recredentialing
- Data exchange
- Medical record keeping
- Medical record documentation
- Provider patient relationship
- Provider status
- Site visit review standards

***continued >***

# Responsibilities and standards

## Reminder: Patient rights and responsibilities

(01-15-2015) Patient rights and responsibilities can be found online in the Member Handbook section of *priorityhealth.com/member*. Choose Handbook in the top navigation bar.

## Reminder: Reporting fraud and abuse

(01-15-2015) Fraud and abuse cost 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 potential fraud and abuse, and we depend on you to report potential fraud and abuse to us when you see it. Get complete details at *priorityhealth.com*. **Search keywords: Fraud and abuse**

## Reminder: Behavioral health accepts authorization requests by fax

(01-15-2016) 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, please contact the Behavioral Health Department.

### 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 our 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

### Emergency 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 above.

### 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. – 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

## 2016 PCP Incentive Program information now available

(12-16-2015) Go to the PCP Incentives Program (PCP IP) page in the Provider Manual to download the 2016 incentive program manual, measures chart and quick reference guide. Here, you'll also find tips and tools for submitting data online to simplify your reporting process. Contact your provider account representative with questions. They can help you meet your program objectives.

## New program helps providers improve quality, prepare for value-based care

(01-19-2016) Michigan providers have an opportunity to improve quality with the Great Lakes Practice Transformation Network (GLPTN).

The GLPTN is funded by the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services to assist providers with quality compliance, transitioning to value-based care, and engaging patients as health care consumers. There is no cost for providers to participate.

With the assistance of Altarum Institute, the facilitators of the GLPTN in Michigan, the GLPTN will provide:

- In-office support delivered by a dedicated Quality Improvement Advisor.
- Alignment of quality improvement initiatives with existing reporting programs (PQRS, PGIP, PCMH, HEDIS, etc.).
- Support for participation in PQRS and the value-based modifier program.
- Assistance setting up billable care coordination services leveraging new Medicare billing codes.
- Technical assistance for workflow evaluation, improving office and clinical efficiencies, and optimizing EHR use for data driven quality improvement.
- Collaboration on practice-identified improvement priorities as well as targeted clinical quality improvement areas (including diabetes management, depression screenings, etc.).
- An opportunity to utilize PTN participation for 20 free CME and 20-25 free MOC Part IV credits.

### Eligible providers

Eligible providers include primary and specialty care physicians, nurse practitioners, physician assistants, and their respective ambulatory practices.

Providers are not eligible to participate if they currently participate in the Medicare Shared Savings Program (MSSP), Pioneer Accountable Care Organizations (ACO), or the Michigan Primary Care Transformation (MiPCT) project.

### Contact and enrollment

For more information or for provider enrollment, email *glptn-mi@altarum.org* or visit *mceita.org/?GLPTN*.

## Physical therapists around the state earn rewards for patient-centered care

(01-08-2016) Results are in for our third evaluation period of the Physical Therapy (PT) Incentive Program. The program ran from Apr. 1 through Sept. 30, 2015. Financial rewards totaling more than $48,000 were presented to 29 clinic locations throughout the state recognizing providers and their staff members for providing excellent patient-centered care, bringing the total paid for the entire year to just under $95,000.

Learn more about the PT Incentive Program in the Provider Manual and view the list of recent recipients at *priorityhealth.com/provider/news-and-education/pt-incentives*.

# Authorizations

## Pending/retired/updated medical policy list

(12-22-2015) From time to time, we make changes to our medical policies. This list shows the policies that are new or have recently been changed. All policy changes are posted to our website so you can review the changes before they go into effect. Find summaries of the recent and upcoming changes at *priorityhealth.com/provider/manual/auths/medical-policies/policy-changes*. Or use the search box on our website to search for a policy by name or policy number.

**Effective Jan. 1, 2016:**

- Gender Reassignment Surgery for Medicare Members — 91612
- Transcranial Magnetic Stimulation for Depression — 91563
- NEW Autism Spectrum Disorders — 91563

**Effective Dec. 21, 2015:**

- Blood Pressure Monitors & Ambulatory Blood Pressure Monitoring — 91503
- Clinical Trials — 91606
- Clinical Trials for Cancer Care — 91448
- Experimental/Investigational/Unproven Care/Benefit Exceptions — 91117
- Varicose Vein Treatment: Endovenous Laser Therapy, Endoluminal Radiofrequency Ablation and Sclerotherapy — 91326

**Effective Dec. 1, 2015:**

- Computerized Tomographic Angiography Coronary Arteries (CCTA) — 91614
- Breast Related Procedures — 91545
- Skin Conditions — 91456

# Plans and benefits

## Medicaid changes effective Jan. 1

(01-22-2016) Effective Jan.1, 2016, Priority Health has a new contract with the State to offer Medicaid coverage. Our service area has changed. The north and southeast regions are no longer assigned to Priority Health; however the southwest (Kalamazoo) region has been added.

The new contract took effect Jan. 1, 2016, and will last for 5 years with a possible three one-year extensions for a total length of up to 8 years. In addition, the MIChild plan is being combined with the Medicaid product, which will necessitate changes to our website and our forms.

**Southeast and north regions exiting our service area**

In November, members from both regions were mailed communications from Priority Health and from the Michigan Department of Health and Human Services (MDHHS) regarding their plan change. Members in the southeast (region 9, within Hillsdale and Jackson counties) were moved to Aetna Better Health Care of Michigan, Inc. as of Jan.1, 2016.

In the north, region 2, Priority Health has exited Grand Traverse, Leelanau, Manistee and Missaukee counties. Affected members had the option of selecting a new plan as of January 1.

*continued >*

# Plans and benefits

The provider team will continue to hold one-on-one meetings with key providers in impacted areas to explain the changes. Priority Health sent a letter to providers in the southeast (region 9) notifying them of the change in Medicaid assignment and that our members will automatically be enrolled in the Aetna Better Health of Michigan.

A letter has also been sent to providers in the affected northern counties notifying them of the change.

**Counties added to the southwest service area**

Under our 2016 contract with Medicaid, we are adding the following counties:

- Branch
- Berrien
- Calhoun
- Cass
- Ionia
- Kalamazoo
- Lake
- Oceana
- St. Joseph

New members will be added to Priority Health by their choosing, by auto-assignment, or choosing Priority Health in lieu of the plan they were auto-assigned. Additional work is underway to increase our provider network in this region.

**MIChild plan combined with Medicaid**

As of Jan. 1, MIChild beneficiaries will no longer have MIChild ID cards. They will have Medicaid coverage and Medicaid ID cards. The core MIChild benefits will not be changing, so this should be a seamless merger to our members. The MIChild name will be removed from pages, forms and tools on this website, and MIChild information will be merged with Medicaid pages.

## Reminder: Check the Preventive Health Care Guidelines

(02-03-2016) 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.

You can always find the guidelines at *priorityhealth.com* as web pages and printable PDFs.

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

Preventive care billing codes are available in the Provider Manual under Billing and payment > Services > Preventive care. If you have questions, contact your provider account representative or call the Provider Helpline at 800.942.4765.

## Supplemental Medicare home health benefits added

(12-14-2015) Priority Health has added two new supplemental home health benefits for Medicare Part C (Medicare Advantage) plan members effective Jan. 1, 2016: In-home safety assessments and in-home post-discharge medication reconciliation.

These benefits are not covered by traditional Medicare, but rather CMS has allowed Priority Health to administer these benefits as a supplemental component of medical necessity. Learn more in the Provider Manual > Billing and payment > Procedures & services > Home visits, Medicare.

# Priority Health news

## Priority Health names new president

(12-07-2015) On Dec. 7, 2015, Richard C. Breon, President and CEO of Spectrum Health, the parent company of Priority Health, announced that Joan Budden was selected as President and CEO of Priority Health. Budden accepted the position having served as Chief Marketing Officer for Priority Health since 2009. Budden assumed her new responsibilities in January.

## Two improvements to provider center

(02-24-2016) We've made two improvements to help you get more quick, accurate information online when you're logged in to your Priority Health provider account.

**Claim denial reason details**

For the 45 most common claim denial reasons, we've added new details and clear next steps, if applicable. You'll find these additional details at the bottom of remittance advices, which are available in the Claims Inquiry tool by clicking on a specific claim.

**Clearer plan names (including narrow and tiered)**

We've also added a more descriptive plan name in the Member Inquiry tool. Previously, the plan listed may have said, for example, "Medicare." Now, the full plan name is provided, such as "Medicare Value."

Spectrum Health Partners members will show their plan as "Narrow Network" followed by the product (ex. HMO). West MI Partners members will show "Tiered Network" followed by the plan type (ex. HMO, SF POS). The hospital network on Member Inquiry matches the primary affiliation of the member's PCP.

In most cases, these names match what is found on the member ID cards and will help you better understand the plan and benefits available to your patients.

See more at *priorityhealth.com/blogs/posts/provider/2016-feb/2-improvements.*

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