PriorityHealth

Physician and practice news digest

Summer 2016

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. So, this will be our last printed newsletter.

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SPOTLIGHT:

Go green. Register to get your electronic news digest.

The majority of readers want to receive information in a digital format. It's more convenient, more current and frankly, better for the environment. So, this will be our last printed newsletter.

You can look forward to a new approach for getting your news: on your phone, tablet or computer. You'll still be able to find the resources you need at your fingertips and in real-time. If you wish, the newsletter will be available for you to print from our website. In the meantime, make sure you're signed up to receive news electronically.

Be sure you're on our list. Go to *priorityhealth.com/newsdigest*

Billing and payment

Billable code sheet for expanded services now available

(04-15-2016) The patient-centered medical home model is transforming the delivery of personal, cost-effective health care. Care managers are an integral part of the value-added care team along with pharmacists, behavioral health providers and social workers. We recognize the value of these additional services and reimburse for many of them across multiple plan types.

Expanded services coding references available

As you expand the services you deliver in your practice, use the Provider Manual to find detailed coding and billing guidance on these services:

- Outpatient behavioral health
- Advance care planning
- Care management
- Tobacco cessation
- Telephone services, virtual visits and hosted visits
- Telemonitoring
- Medication therapy management

To understand what expanded services you can bill us and what your patient's cost share will be go to *priorityhealth.com/provider*. **Search keywords: Contracted billable codes**

Date change to Modifier 25 medical notes requirement

(03-28-2016) We have delayed implementation of the modifier 25 medical notes requirement, so it did not begin April 1. We'll release additional details as they become available.

Per CMS National Correct Coding Initiative, Chapter 11: If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

For additional resources, see the Provider Manual > Billing and payment > Code modifiers > Modifier 25.

Substance abuse Screening, Brief Intervention and Request for Treatment (SBIRT) education now covered

(02-24-2016) Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive public health approach for the early intervention of at-risk substance abusers. As of Jan. 1, Priority Health covers this proven approach in primary care settings.

continued >

Billing and payment

Learn more about SBIRT in the Provider Manual

Go to the Provider Manual > Billing and payment > Procedures & services > Substance abuse screening to learn more about this approach, including resources from national partners. With early intervention, you can help substance abusers receive the treatment they need before more severe consequences occur.

Prevent upfront rejects with up-to-date information

(02-24-2016) When billing for physician services, the physician name associated with their NPI must match exactly with NPPES. When the name of the rendering physician and/or supervising physician does not match on their NPI and NPPES, the claim will reject up front. The rejection will appear on the service receipt. If you need to update information, do so at *nppes.cms.hhs.gov/NPPES*.

Rendering physician not linked to physician group

Claims for rendering physicians not linked to the physician group in our system will be rejected up front. The physician will see this information on their service receipt.

Add a provider to your group by completing and submitting the appropriate change form, both available at *priorityhealth.com/provider/forms:*

- Provider Change Form
- Non-Participating Provider Change Form

Billing questions? Contact us at 800.942.4765 or *provider.services@priorityhealth.com.*

PO modifier required for Medicare and Medicaid claims

(02-02-2016) As of Jan. 1, 2016, the PO modifier is required to report each outpatient service furnished at an off-campus provider-based department (PBD) for Medicare and Medicaid claims. The PO modifier is still optional for commercial group and individual claims.

A CMS OPPS Final Rule released April 2015 determined that reporting the PO modifier was voluntary in 2015, but beginning in 2016 it would be required.

See more details and links to CMS and other resources defining “off-campus provider-based departments” on the PO modifier page the Provider Manual.

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 as 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 & payment > Services > Preventive care.

Questions? Contact the Provider Helpline at 800.942.4765.

Pharmacy

MDHHS releases common drug formulary for Medicaid

(02-04-2016) The Michigan Department of Health and Human Services (MDHHS) has released a 2016 Medicaid common drug formulary.

According to MDHHS:

- The Common Formulary is part of the recent comprehensive health plan contract and streamlines coverage for beneficiaries and providers. Prior to this, each health plan had their own different formulary by which drugs were covered for beneficiaries. By aligning coverage across the state, MDHHS aims to reduce interruptions in a beneficiary's drug therapy should they have a change in health plan.
- Included in the Common Formulary are certain drug management tools such as prior authorization criteria and step therapies. Contracted health plans may be less restrictive, but not more restrictive, than the coverage parameters of the Common Formulary.
- The list of drugs covered under the Fee-for-Service benefit remain unchanged. To promote safe medication transitions and minimize the burden on prescribers and patients, all contracted health plans are required to follow the common set of policies and procedures on transition of care and grandfathering of drug therapy.

For general information about the common drug formulary, go to *michigan.gov.*

Reminder: Adverse Drug Event? Call MedWatch

(03-15-2015) If a patient experiences an adverse drug event, product problems or product use errors; we encourage you to report it to MedWatch by:

- Calling 800.FDA.1088 (800.332.1088); or
- Submitting the MedWatch 3500 form by fax or mail; or
- Using the MedWatch Online Voluntary Reporting Form at *fda.gov/medwatch*

Questions? Call the Pharmacy Call Center at 800.466.6642.

Reminder: Answers to questions about pharmacy benefits

(03-15-2015) 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 copay 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 copay 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 copays? Or specialty drug copays?
A flat copay is when the patient pays the same fixed dollar amount for the copay independent of whether the prescription is for a brand-name or generic product.

The two-tier copay is when the patient pays the lower copay 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 copay is similar to a two-tier copay for the two lower copay 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 copay.

continued >

Pharmacy

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 copay than non-preferred specialty.

Q: Why can one patient have a different copay than 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 copay. 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 copay, though some Medicare plans provided by an employer may choose to have a two-tier copay.

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

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

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

In addition to the changes for contraceptive coverage noted above, coverage for several medications has 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 copays. 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 copays 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: Drug auths after hours

(03-15-2015) When a member presents a prescription for an urgent drug that requires prior authorization after Priority Health has closed, pharmacies are encouraged to provide the patient with a starter supply of the drug. Priority Health covers up to seven days of medication to assure the member does not go without therapy while waiting for prior authorization. Pharmacies are encouraged to reach out to provider offices the next business day to notify the office that prior authorization is needed.

Reminder: Step therapy required for select drug categories

(03-15-2015) 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)
- Nabumetone (Relafen)
- Etodolac (Lodine)

Pharmacy

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: Availability of physician and pharmacist reviewers

(03-15-2015) Questions or concerns regarding our utilization management decisions can be referred to your Provider Performance Specialist or the pharmacy department at 800.466.6642. We may use physician and pharmacist reviewers to assist you.

Reminder: Medicare formulary exception process

(03-15-2015) For drugs that are not on our Medicare formulary or that require utilization management (e.g. prior authorization, step therapy, quantity limits), you can request an exception to coverage if the covered alternatives won't work or have not worked as well for the member.

All Medicare prior authorization forms ask you to supply supporting evidence/documentation when requesting an exception. When evidence/documentation is provided, we will use this information in determining if the request is medically necessary. If the evidence/documentation is not received, requests will not be approved.

Reminder: Generic drug substitutions policy

(03-15-2016) 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 (DAW) 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.

Authorizations

Medical policy updates

(04-15-2016) From time to time, we make changes to our medical policies. The following policies were revised and received approval at recent Medical Affairs Committee meetings. 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 May 1, 2016:

- Infusion Services and Equipment, 91414

Effective April 15, 2016:

- Cardiovascular Risk Markers, 91559
- Markers for Digestive Disorders, 91583
- Osteoarthritis of the Knee, 91571
- Pharmacogenomic Testing, 91570
- Platelet Rich Plasma/Platelet Rich Fibrin Matrix/Autologous Blood-Derived Products, 91553
- Surgical Treatment of Obesity, 91595
- Tumor Markers, 91562

Effective April 1, 2016:

- Computed Tomography Scanning for Lung Cancer Screening, 91600

March 22, 2016:

- Stimulation Therapy and Devices, 91468

March 18, 2016:

- Breast Related Procedures, 91545

March 1, 2016:

- Telemedicine, 91604

Medical policy change for Remicade and IVIG infusions

(02-29-2016) As of May 1, Priority Health members who receive a new prescription for Remicade or IVIG infusions, or who are new to Priority Health and currently receive these injectables, may receive infusions from any approved site of service. Approved sites of service are physician offices, in-home providers or infusion centers. These members will not be able to receive infusions from outpatient hospital settings.

Members affected

This change applies to members in fully and self-funded commercial plans who receive a new prescription for Remicade or IVIG.

This change does not apply to:

- Priority Health members currently receiving Remicade and IVIG infusions
- Pediatric members
- Members with a cancer diagnosis
- Medicare and Medicaid members

Our medical policy change aligns with the Triple Aim by providing low cost, high quality care with a great member experience. Members are able to choose a facility that is convenient for them from options that provide high quality, safe and affordable care.

More details

The updated medical policy that became effective May 1 is available for review on the Pending changes to Medical policies page in the Provider Manual.

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Authorizations

Fax communications for some prior auths ended May 1

(03-25-2015) As of May 1, we no longer send a fax communication to offices or facilities when:

- Authorization is requested for a service that does not require prior authorization
- An inpatient hospital stay is requested

Services that do not require prior authorization

We often get authorization requests for procedures that don't normally require one. Here are the top 10 services that, when performed in an outpatient setting by a participating Priority Health provider, don't require authorization:

- Colonoscopy
- Hernia repair
- Tonsillectomy
- Adenoidectomy
- Cystoscopy
- Lithotripsy
- D&C
- Myringotomy tubes
- Cholecystectomy

If you're providing one of these services, simply schedule and perform the procedure.

To look up other services and see if they require authorization, check the Provider Manual > Authorizations > Prior authorization reference list.

Authorization numbers available online

For inpatient hospital stays and other services that do require prior authorization, you can look up the authorization number using our Auth Inquiry tool. Simply log in to your provider account and click on the "Auth Inquiry" link in the left-hand list of tools.

Watch a 2-minute video showing how to use Auth Inquiry in our video library at *priorityhealth.com/provider.*

Preventive lung cancer CT screen coverage changes

(02-26-2016) As of April 1, 2016, Medicare members who meet the coverage criteria are covered for an annual CT scan to screen for lung cancer as a preventive benefit. This service is already covered as a preventive benefit for commercial group and individual members and for Medicaid and Healthy Michigan Plan members.

Shared decision making required for all members

For Medicare members, CMS requires "A counseling and shared decision making visit, including the use of one or more decision aids (e.g. Emmi, Option Aid), to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure." Shared decision making is a collaborative process where the provider helps the patient understand the decision, its consequences, and then helps them apply their values and preferences in order to make a decision.

We've updated our medical policy on CT scanning for lung cancer screening to require shared decision making for all members as of April 1, 2016.

- **Documentation:** The physician who orders the scan will have to confirm that a conversation took place and that a shared decision making tool was completed by the member.
- **AIM authorization:** The provider will be able to attest to providing shared decision making during the prior authorization process in our high-tech imaging authorization tool, AIM.

Authorizations

The option to use Emmi

Along with a documented counseling and shared decision making visit, physicians can meet the shared-decision-making requirement by using Emmi®. Emmi is an online interactive tool that helps patients understand procedures and surgeries and the benefits and risks. The tool is designed to reinforce the information a physician shares with their patient.

The Emmi program for lung cancer screenings is available at *my-emmi.com/SelfReg/PHLUNGCT* and the tool plus more information is available in the Provider Manual in the Authorizations > Patient engagement section.

Physicians can have patients view the program in the office, or they can provide their patient's name and email address then click the "View program" button. An email is then sent to the patient with a link to the program so they can complete it at a time that is convenient for them.

Performance programs

April updates to PCP Incentive Program

(04-21-2016) Several measures of the 2016 PCP Incentive Program (PCP IP) have been updated to reflect recently-released Medicare and Medicaid targets or to provide further clarification.

April 2016 measure updates

MEASURE	CHANGE/UPDATE	PAGE(S)
Pediatric obesity	Case definition	19
Hypertension medication therapy	All targets	28
Hypertension: Controlled blood pressure	All targets	30-31
Tobacco cessation	Case definition	33
Healthy Michigan Plan	Identified measure	34
Measure codes for adolescent immunizations	Code added to Tdap/Td	41

Updated PDFs are available

Go to the PCP Incentives Program section of the Provider Manual to download the revised PCP Incentive Program Manual and new versions of the measures chart and quick reference guide.

About the PCP Incentive Program

Since 1997 we've rewarded primary care providers for ensuring that their patients receive the best clinical care while balancing cost and patient experience, thus supporting our Triple Aim. Through the PCP Incentive Program, Priority Health has awarded more than $220 million to practices across Michigan over and above standard payment of services in support of excellent primary care. Program measures and incentives change from year to year. Priority Health sets high targets, with practices needing to meet or exceed the national 90th percentile in order to qualify for incentive awards.

Clinical resources

Flint water rashes reporting

(03-16-2016) In response to reports from multiple health care providers and members of the public, on Jan. 29, 2016, the Michigan Department of Health and Human Services (MDHHS) launched an investigation to characterize reported rashes possibly associated with Flint municipal water exposure. Health care providers can assist in this effort to better characterize rashes that have a possible association with Flint water exposure.

Reporting process

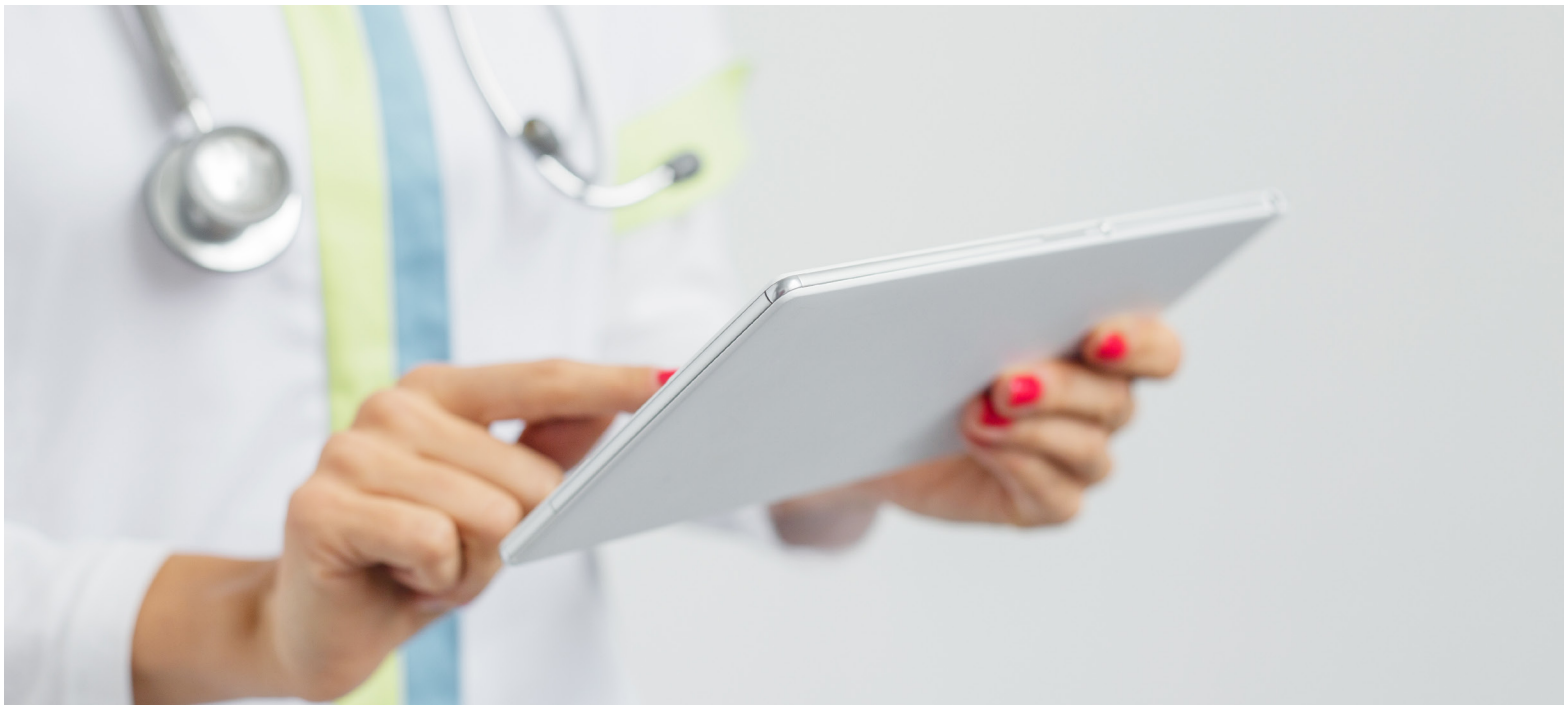
Individuals meeting the rash criteria below may be reported to MDHHS, where they will be interviewed and offered referrals for dermatology screening and EPA home water testing.

1. Rash is not reportable in the State of Michigan, so first ask individuals if they would be agreeable to follow-up contact by the MDHHS
2. If they agree, call MDHHS directly at 800.648.6942 to provide the patient's contact information

Criteria for reporting to MDHHS

- Patient's residence (or other significant exposure location) is supplied with Flint city water
- Current rash identifiable by exam, with onset on or after Oct. 16, 2015, OR existing rash with a period of obvious worsening on or after Oct. 16, 2015
- No alternative medical diagnosis that is clearly unrelated to water exposure

Get the most up-to-date information on the Flint water crisis at *michigan.gov/flintwater.*



Plans and benefits

More benefits now displayed in Member Inquiry tool

(03-23-2016) We've made some updates to the information available to you in the Member Inquiry tool.

Virtual visits copay added

The Medical benefits section of the Member Inquiry tool now displays the member's "virtual visit" benefit. You can now see if a member has a copay or coinsurance for telephone/video visits.

Clearer names for narrow and tiered networks

In February we shared that more descriptive plan names have been added 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 show their plan as "Narrow Network" followed by the product (ex. HMO).
- West MI Partners members show "Tiered Network" followed by the product type (ex. HMO, SF POS). Note that Member Inquiry is displaying benefits for these members at the higher Tier 2 copays/coinsurance/deductible level. Until further notice, please call 800.942.4765 to verify benefits. We apologize for the inconvenience.
- 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's ID card and will help you better understand the plan and benefits available to your patients.

Get rewarded when you help patients achieve their **Health**byChoice goals

(06-22-2016) The results are in. Our employer-sponsored incentives-based **Health**byChoice plans have successfully lowered employer costs and improved employee health.

A five-year study* concluded that **Health**byChoice members, when compared to similar members in non-wellness plans:

- Have a lower propensity for developing chronic diseases including atrial fibrillation, diabetes and lung disease.
- Saved employers up to 12% in claims costs or, on average, $60 per month. This reduction in health care costs helped save employers roughly $1.2 million over four years.
- Tend to make routine and preventive doctor visits. This offers you greater opportunities to nurture your doctor/patient relationships, creating an increased likelihood for high-quality care and lower cost.

How does the plan work? **Health**byChoice plans reward members for being, getting and staying healthy. Participants can qualify for lower out-of-pocket costs when they meet certain health criteria.

How can you help? Support your patients by completing their qualification form, and get rewarded in return.

- Network providers: Submit results online for a $30 reimbursement per form. Use the online qualification tool.
- Out-of-network providers: print and fax qualification forms to Priority Health. The forms can be found in the forms section of the provider site.

** Study compared 4,153 members enrolled in **Health**byChoice Incentives plans to 4,106 standard non-wellness plan members with continuous enrollment from January 2010 – December 2014*

Priority Health news

PCPs now highlighted in Cost Estimator

(04-25-2016) We listened to you, our valued partners, and your request for recognition within the Cost Estimator tool is now complete. We now highlight the primary care provider office as the first/best location to receive services, if available.

As of April 25, Priority Health Cost Estimator tool displays PCP office locations for select procedures and categories of services. For a PCP office to be added to the tool, the office must have billed for one of the searchable services within the last nine months. Practices are added or removed from the tool based on claim activity in any 9-month window.

Key enhancements:

- Our members see their PCP as the first choice for a service if the PCP performs it
- Providers are listed along with facilities where they perform the service; prior to this, the tool just showed facilities
- Members can now view more information about physicians — contact info, language, and specialty
- The default for sorting location results is distance (nearest to the member's ZIP code), it is no longer price
- There are green options in every geographic region, demonstrating good value for members who shop for these basic services

With these updates to Cost Estimator showcasing the PCP office as a great value location to receive care, this is the right time to engage in the cost conversation with your patients. We are committed to transparency in all aspects of the Triple Aim: Quality, Experience and Cost. Cost Estimator supports members engaging in managing the cost of their care.

PriorityHealth

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