PriorityHealth

Physician and practice news digest

Fall 2017

Spotlight: Our clinical appropriateness strategy

(p. 2)

Billing and payment

Reminder: Medicare Outpatient Observation Notice (MOON) form required (p. 4)

Medical code review fax number has been retired (p. 4)

Discontinued appeal forms no longer accepted (p. 4)

and more…

Pharmacy

Changes coming to opioid coverage (p. 6)

Topical corticosteroid formulary changes for commercial members (p. 6)

Formulary updates (p. 6)

and more…

Authorizations

Reminder: Requesting behavioral health authorizations (p. 8)

Prior authorization now required for insulin pumps (p. 8)

New updates and enhancements to Auth Request tool (p. 8)

and more…

Performance programs

PCP Incentive Program and CPC+ Program targets, measures updated (p. 10)

Physical Therapy Incentive Program recipients announced (p. 11)

Clinical resources

Some analyzers may give false blood lead level results (p. 11)

Plans and benefits

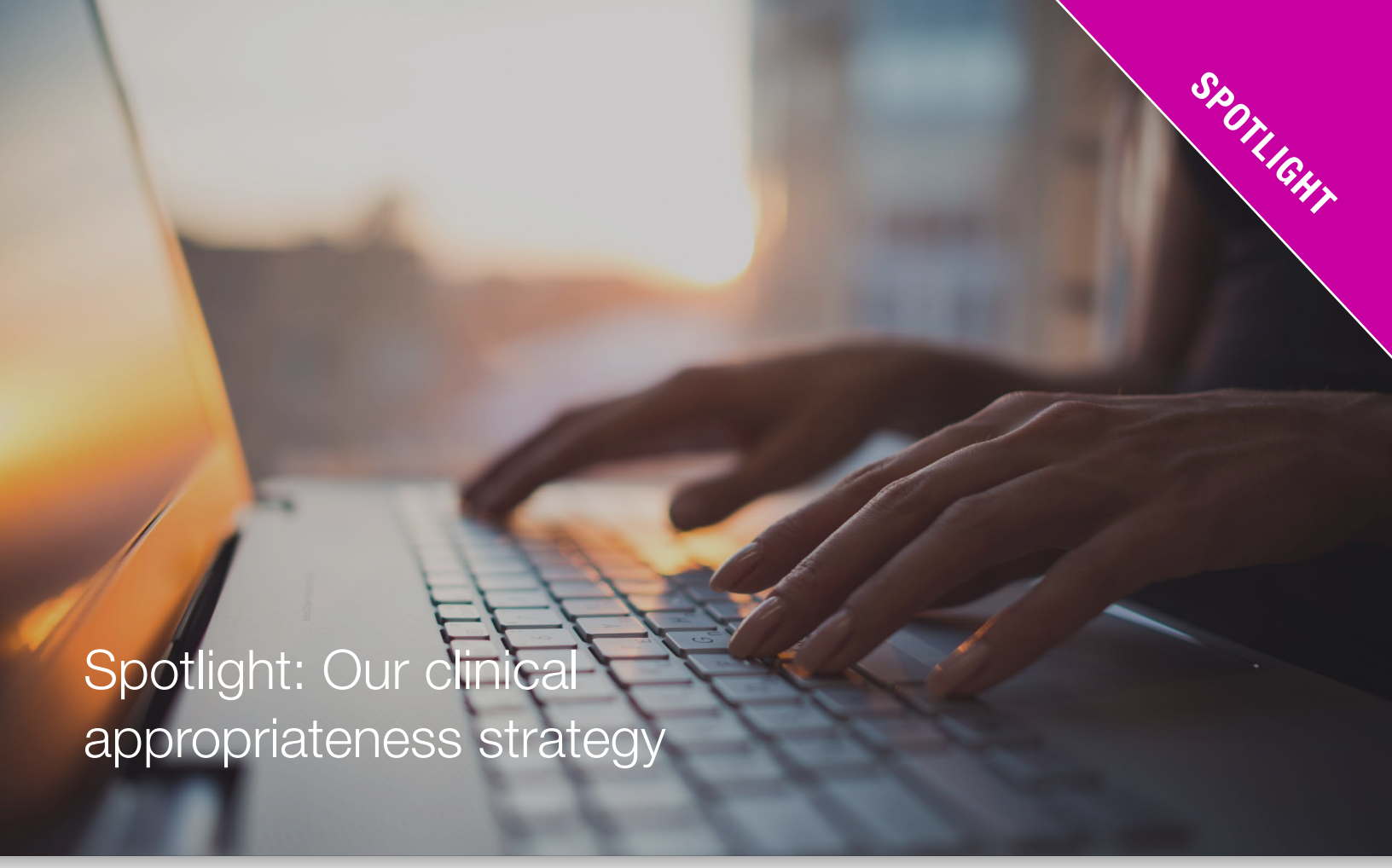
Shingles vaccine now payable for Medicaid members 50+ (p. 11)

Responsibilities and standards

Fraud, waste and abuse tip (p. 12)

Priority Health News

Newly designed provider site launched (p. 12)



SPOTLIGHT

Spotlight: Our clinical appropriateness strategy

One of our goals is to work more closely with you—our provider partners—to provide the right care at the right time to ensure those we care for have the best health outcomes. We want care to be supported by clinical evidence, and give patients access to shared decision making and support tools about their procedures. We're also committed to managing the total cost of care in order to keep it affordable and available to all. It's one of the reasons we've invested in new prior authorization tools like Clear Coverage™ and eviCore.

While we've worked hard to ensure a smooth adoption of eviCore, we apologize for the unnecessary frustration, delays and confusion this transition has created. We thank our network partners for working diligently with us to identify and correct technological issues and for allowing us into their practices to train, troubleshoot and observe. We want you to know that we've heard you, and are working with eviCore to identify solutions and address issues.

The following changes will ease your administrative burden while we continue to gather data to evaluate the operational effectiveness of eviCore.

Clinical criteria denials have been lifted through Dec. 31, 2017

All musculoskeletal and advanced imaging procedures that received denials for clinical criteria will be paid through the end of this calendar year.

- We'll continue to require a prior authorization as well as proper clinical documentation, but there will be no denials based on clinical criteria. Over the next few months, the data from these authorizations will be crucial in determining our next steps.
- We are retroactively paying claims for musculoskeletal and advanced imaging claims submitted for dates of service from Aug. 1, 2017 on. We've generated a list of claims denied for failure to meet eviCore's clinical criteria, and will be reviewing and reprocessing them.

continued>

- Authorizations for musculoskeletal procedures for Medicare Advantage members had been previously set up to auto-approve through Sept. 1, 2017. Auto-approval is being extended through Dec. 31, 2017 for these members to maintain consistency.

Peer to peer clinical reviews have been suspended from Aug. 22 through Dec. 31, 2017

Any previously scheduled peer to peer reviews can continue, but no new reviews need to be scheduled. If you receive a denied authorization pending peer to peer review before the end of the year, call us at 616.464.8432. Leave a message with the eviCore case number, a brief overview of the case and caller contact information, and we will reprocess the case. After review, we will manually overturn peer to peer based denials.

An educate and pay protocol has been implemented from Aug. 22 through Dec. 31, 2017

In place of the peer to peer review between now and Dec. 31, 2017, if an authorization request fails to meet eviCore's clinical criteria you will receive notification that clinical criteria has not been met, and you will be directed to available standards. The claim will still be paid as long as we've received the authorization.

These changes, along with increased training opportunities, are our initial steps in addressing network concerns for eviCore operationalization. Internally, we will continue to work with eviCore to resolve functional issues that contribute to the large administrative burden.

We want to hear from you. Please continue to call us at 616.464.8432 with concerns or improvement suggestions related to eviCore.

Reminder: Medicare Outpatient Observation Notice (MOON) form required

(07-19-2017) Effective March 8, 2017, Medicare Fee for Service and Medicare Advantage require that hospitals provide standardized written notice, the Medicare Outpatient Observation Notice (MOON), to any beneficiary who is receiving observation services as an outpatient for more than 24 hours. The MOON explains to beneficiaries that the services they are receiving are outpatient benefits, not inpatient, and therefore patient liabilities and benefits will be billed as such, which may be different than anticipated. The standard MOON form and its delivery are mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on Aug. 6, 2015.

Timeframe for notice delivery

Hospitals, including critical access hospitals, must deliver the notice to the patient no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged or admitted.

More information

Go to the Beneficiary Notices Initiative (BNI) page on CMS.gov to learn more. The MOON form and accompanying form instructions are available in "Downloads."

Medical code review fax number has been retired

(07-18-2017) In a continued effort to streamline our efforts, we've retired the separate Medical Code Review fax number of 616.975.8881 as of July 17, 2017. Fax your code review requests to 616.975.8856, the fax number for our Provider Resolution Operations hub.

Discontinued appeal forms no longer accepted

(06-26-2017) As of July 1, offices are required to use the current Level I and Level II appeal forms. We've discontinued faxing back educational reminders if you're using an old form. If your appeal is not on the correct form or the requirements are not met, your appeal will not be processed. Current forms are dated at the bottom: Level I (05/2017), and Level II (04/2017).

Check out additional information and resources in Review and Appeals if you have questions.

FQHC and RHC must bill Medicaid claims on UB forms

(06-16-2017) All Medicaid claims billed by Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC) and Tribal Health Centers (THC) must now be billed on a Uniform Billing (UB) claim form instead of a HCFA 1500 form.

Specifically, providers must bill:

- **Electronic claims** using the ASC X12N 837 5010 institutional format.
- **Paper claims** on the National Uniform Billing Code (NUBC) claim form.

This mandatory change from CMS is in effect for all Medicaid plans. Using the institutional format will align Medicaid with Medicare billing and allow for each clinic's respective encounter rate to be paid after successful adjudication for fee-for-service (FFS) claims. Currently, a provider must bill Medicare on the institutional format and then resubmit the claim to Medicaid on the professional format. This change will streamline the billing process.

For additional information, see the MDHHS bulletin.

System updates associated with CMS releases

(06-01-2017) When the Centers for Medicare and Medicaid Services (CMS) change or update their coverage policies or pricing, they allow health plans up to 30 days to reconfigure our systems in response. At times this will not align with the implementation of the changes for traditional Medicare or Medicaid.

continued>

Billing and payment

New or revised National and Local Coverage Determinations (NCDs and LCDs)

We update our systems with NCD and LCD changes within 30 days of the release date from CMS or local MAC carrier. Updates to NCDs/LCDs are not retrospectively applied to claims that have already processed in our system.

Pricing and payment updates

We implement pricing updates associated with changes to the Medicare and Medicaid payment systems within 30 days of release date from CMS. Payment system updates are not retrospectively applied to claims that have already processed in our system.

Clinical edits updates

(06-01-2017) In an effort to better align our clinical edits with Medicare and Medicaid, we implemented an update to our system on Aug. 1, 2017. These updates will better align our Medicaid plan with Michigan Medicaid guidelines. You may begin to see new edits associated with these changes. Use our Edits Checker tool to identify the rationale behind these updates.

Modifier 78 update

Also effective Aug. 1, 2017, services coded with modifier 78 began taking an intraoperative percentage reduction when billed in the global period for the original or related procedure. See Modifier 78 for more information.

New Provider Resolution Operations hub available

(05-01-2017) As of May 1, the provider reimbursement team has streamlined the post-payment email and appeal processes for providers. We've united the Provider Services, Code Review and Medical operations teams in a central intake hub called Provider Resolution Operations (PRO), reachable at *provider.services@priorityhealth.com* or 616.975.8856.

This allows for faster turn-around times for post-service inquiries. By aligning team members from each area, PRO can move email inquiries to the correct location the first time, reducing the volume of routing between departments. All post-payment inquiries will route PRO for processing.

What is changing?

Changes to the process as of May 1, 2017:

- **You'll use one email address and one fax number** to contact Code Review, Medical and Provider.
- Reimbursement: *provider.services@priorityhealth.com*, and fax number 616.975.8856.
- **Authorization for services that have not yet been rendered** should be requested online when possible, by using Auth Request (participating providers) or the fax forms (non-par providers). You can check the auth reference list in the Provider Manual to see if services require authorization.
- **All faxes** require a cover sheet. We will be providing a fax-back notification confirming receipt of your request and a unique inquiry number for tracking your fax.
- **All medical records** must be sent to us securely. Log in to your Priority Health account, click your Mailbox in the green menu bar and select "compose a message." For the "To" address, choose "medical record submission" from the drop-down list. Reference the inquiry number if you have one.
  - Emailed requests will be completed within 45 business days when received with necessary supporting documentation.
  - Once a decision is made, we will inform you of the outcome of the review by remittance advice within five business days of the decision.
- **Provider Level I and II appeal forms** have been simplified and updated to include the only fax number of 616.975.8856. An informal review must be completed prior to filing an appeal with the exception of clinical edit/correct coding denials, which should be completed on the appeal form. See Reviews and appeals for more details.

continued>

Changes coming to opioid coverage

(08-01-17) Opioid use and abuse is a hot topic in our state and with good reason. According to the Centers for Disease Control and Prevention, nearly 2,000 deaths in Michigan in 2015 were directly related to opioids—the seventh highest number in the nation.

To improve the health and lives of our members, Priority Health has developed an opioid management strategy to reduce opioid use and abuse. This strategy will change opioid drug coverage and ensure our members have access to assistance and treatment. Initiatives include:

- Improving behavioral health access to opioid dependence treatment
- Creating provider reporting to identify members who use excessive doses and/or multiple prescribers and pharmacies
- Limiting the number of opioid prescription fills and quantities members may fill
- Identifying high-risk opioid members and encouraging them to have naloxone on hand

Get your patients ready

As of Sept. 1, 2017 for our MyPriority (Individual) members:

- Short-acting opioids will be limited to 2 fills every 3 months with each fill limited to a 15-day supply.
- Long-acting opioids will continue to be limited to a 30-day supply per fill for all products, prior authorization will be required for MyPriority members.
- A dose limit that accumulates all opioids used by a member will be implemented; members will be limited to a maximum dose of 120 MEqD (morphine equivalent dose). An opioid dose calculator is available here.

We expect to apply these changes to group commercial and Medicaid members by Oct. 1 and Nov. 1, 2017, respectively. We don't plan to add the prior auth requirement for long-acting opioids to other plans.

For patients on long-term opioids, you may need to start working to reduce their MEqD ahead of this change. Additional resources are available on our website.

Topical corticosteroid formulary changes for commercial members, as of Aug. 1, 2017

(08-01-17) Commercial formularies for topical corticosteroid products have recently been revised to include step therapy requirements and benefit coverage changes. Details are found in this chart.

Please prescribe covered medications, when available, to save your patients out-of-pocket costs. Questions? Call the Pharmacy Call Center at 800.466.6642.

Formulary updates

(06-08-2017) The Priority Health Pharmaceutical and Therapeutics (P&T) Committee recently approved many updates to the Approved Drug List for all product lines, specifically reviewing drug classes of:

- Acne - Oral isotretinoins
- Antifungals
- Antihistimines
- Anti-inflammatories
- Antineoplastics
- Antiseborrheics
- Antivirals
- Immunosuppresive
- Keratolytic/antimitotic
- Psoriasis
- Rosacea
- Steroids, high, medium and low potency

Edits can be found in Formulary updates. Call the Pharmacy Call Center at 800.466.6642 if you have questions.

continued>

Pharmacy

ACA patient medication management visits

(05-05-2017) To ensure optimal disease management, we want to partner with you to motivate members with chronic health conditions to schedule a medication management visit annually.

What we're doing

We've identified members who've filled prescriptions related to a chronic condition in the last year yet may not have seen their PCP this year to have the diagnosis documented.

We're sending these members a letter asking them to schedule an appointment with their physician within the next 90 days and to bring a copy of that letter with them to that visit. This visit is important because it could affect our ability to continue sharing the cost of their prescription refills. Seeing these patients annually ensures they are engaging with you in the management of their condition.

What you can do

- **Remind** your Priority Health patients with Affordable Care Act (ACA) plans that they should complete a medication management visit with you yearly. You can identify these MyPriority℠ PPACA patients using Member Inquiry, Filemart file or their ID card. See our reference guide, Identifying ACA patients, for details.
- **Document each patient's diagnosis** with corresponding ICD-10 code and any supplemental data or notes from your conversation with them in their medical record.

Authorizations

Reminder: Requesting behavioral health authorizations

(07-19-2017) During business hours, Monday through Friday, 8 a.m. – 5 p.m., providers may phone or fax authorization requests to the Behavioral Health department for all services other than outpatient and intensive outpatient services.

- Phone: 800.673.8043
- Fax: 616.975.0249

Fax only requests

Fax us your outpatient and intensive outpatient service requests, including concurrent review and discharge information.

Emergency treatment authorizations

During business hours:

Monday through Friday, 8 a.m. – 5 p.m., you can call us. A clinician is available to help you with requests for emergency treatment for Priority Health commercial group, commercial individual and Medicare plan members.

After hours:

Our behavioral health team is available by phone 24/7 for emergencies. Fax us the Inpatient Authorization form. It will be processed in our normal time frames.

Prior authorization now required for insulin pumps

(07-07-2017) As of August 1, prior authorization is required for insulin pumps and continuous glucose monitors for commercial and Medicaid members. New insulin pump prescriptions will also require authorization.

With the authorization, we require your patient's latest A1c reading. This data will be used to help us track the performance of all insulin pumps.

Medtronic is our preferred insulin pump manufacturer for patients 17 and older; however, patients can use other pump brands if there are clinical or financial reasons or if the member prefers to use another brand.

Fast, easy and online authorizations

Requesting authorization is fast and easy with our online tool, Auth Request, which will take you to Clear Coverage™. Log in to your provider account on this website and click "Auth Request" in the Provider tools menu. Then follow the steps to submit your request. You'll also be able to access Clear Coverage training materials when you're logged in.

New updates and enhancements to Auth Request tool

(06-29-2017) Priority Health has partnered with eviCore healthcare to assist us with the prior authorization of certain high-cost, high-utilization procedures. As of June 19, 2017 eviCore replaced AIM for high-tech radiology authorizations. You can also request authorizations for musculoskeletal, spine and joint procedures such as arthroscopies, and for genetic testing.

You can request authorizations through eviCore by using the Auth Request tool in your provider tools menu. Auth Request will send you to either Clear Coverage or eviCore, depending on the procedure you're requesting.

Clear Coverage updates

Since the successful go-live of Clear Coverage, we've made a few enhancements and updates.

Spine or joint procedures

When you admit a patient and input an authorization through Clear Coverage for a spine or joint procedure, choose "EVICORE" as the unit option. This will allow you to bypass admission criteria and admit the patient.

Continued stay reviews

These are now required every four days for commercial group and individual plan patients, and every five days for Medicare and Medicaid patients. It previously was every two days. Continued stay reviews are to be submitted on the day they are due and NOT before, as this causes issues with submission of reviews.

continued>

Authorizations

Elective OB admissions

The requirements for these types of admissions have been adjusted to allow you to enter an admission without needing to step through InterQual Criteria.

Modification of admission dates

We've added the ability to modify admission dates for elective admissions. Simply click the "Modify Request" button to change the admission date.

To learn more about requesting authorizations with Clear Coverage or eviCore, visit the Provider Manual Authorizations page.

Documentation for pended Clear Coverage auths no longer accepted by fax

(06-14-2017) As of June 26, you must upload all additional information for pended prior authorizations through Clear Coverage if you requested the authorization through them. Priority Health is no longer accepting faxed-in documentation to attach to your prior authorization requests. Check out additional information and resources at Auth Request tool.

continued>

PCP Incentive Program and CPC+ Program targets, measures updated

(07-28-2017) The 2017 PCP Incentive Program and CPC+ Program supports your efforts to provide the best clinical care while balancing cost and patient experience, a structure that directly reflects the Triple Aim.

Edits to the programs as of July 2017

We want to make you aware of recent changes to measurements in both programs. Among the changes are:

- Measure targets and payout are now available for MTM and all-cause readmissions
- Payout methodology for care management was updated to reflect risk adjustment for CPC+ and the PCP Incentive program for Priority Health ACA individual members
- Additional depression codes were added

New and revised pages for the manuals

Please print and update your binder with the following new or revised pages:

PCP Incentive Program Manual: Pages 23, 32, 40, 41, 42, 44, 47, 48, 49, 53, 57, 82, 83

CPC+ Manual: Pages 22, 31, 38, 39, 40, 41, 42, 43, 46, 47, 48, 52, 56, 81, 82

Measures impacted

Colorectal cancer screening (PIP pg. 23) (CPC+ pg. 22): Changed the numerator section

Hypertension: Controlled blood pressure (PIP pg. 32) (CPC+ pg. 31): Changed case definition section

MTM (PIP pg. 39) (CPC+ pg. 38): Added measure targets and payment for HMO/POS, ASO/PPO, Medicare and Medicaid

Care management (PIP pg. 40-42) (CPC+ pg. 39-41):

- Revised/added to the identified measure section
- Added risk adjustment and payout for patients/members covered by Priority Health Affordable Care Act (ACA) individual products ("Payout" section)
- For CPC+ only - Added payout and risk adjustment information ("Payout" section)
- Added to the Notes section

PCMH (PIP pg. 43) (CPC+ pg. 42): Added to the Notes section

CG CAHPS® (PIP pg. 44) (CPC+ pg. 43): Added to the Notes section

All-cause readmissions (PIP pg. 47-48) (CPC+ pg. 46 -47): Added target, improvement and shared savings information

ED PCP treatable care (PIP pg. 49) (CPC+ pg. 48): Added HMO/POS and Medicaid, target, improvement and shared savings information

Code set

Well-child visits (PIP pg. 53) (CPC+ pg. 52): Removed the statement "3-6 years"

Pediatric and adult BMI (PIP pg. 57) (CPC+ pg. 56): Added additional adult BMI codes

Depression code set (PIP pg. 82-83) (CPC+ pg. 81–82): Added additional depression screening codes

Log in and go to the PCP Incentives Program (PCP IP) page in the Provider Manual to see the 2017 plan changes and download the new 2017 Manual and measures chart. Contact your provider performance specialist with questions. They can help you meet your program objectives.

continued>

Performance programs

Physical Therapy Incentive Program recipients announced

(07-28-2017) Results are in for our October 2016 through March 2017 Physical Therapy Incentive Program evaluation period. Financial rewards totaling nearly $50,000 were presented to 38 clinic locations throughout the state, bringing the total paid since the program began to more than $270,000.

The Physical Therapy Incentive Program recognizes providers and their staff members for providing excellent patient-centered care. Providers in the program use WebOutcomes, a third-party physical therapy outcome tool, to enter data about their Priority Health patients. This helpful tool tracks a provider's success by measuring the quality of their service. It generates online progress reports and dashboards that provide invaluable benchmarking information to evaluate and run their practices.

Learn more about the program.

Clinical resources

Some analyzers may give false blood lead level results

(06-05-2017) The US Food and Drug Administration (FDA) issued a safety warning about use of Magellan Diagnostics LeadCare® analyzers for venous blood samples because they might result in falsely low test results. FDA advises that these analyzers should no longer be used with venous blood samples. The safety alert does not apply to capillary blood lead test results collected by finger stick or heel stick.

When to re-test

As a result, the Centers for Disease Control and Prevention (CDC) recommends that health care providers re-test patients who are:

1. Younger than 6 years (72 months) of age at the time of the alert (May 17, 2017) and had a venous blood lead test result of less than 10 micrograms per deciliter (µg/dL) analyzed using a Magellan Diagnostics' LeadCare® analyzer at an onsite (e.g., health care facility) or at an offsite laboratory.
2. Currently pregnant or lactating women who had a venous blood lead test performed using a Magellan Diagnostics' LeadCare® analyzer.

See the full CDC Advisory that summarizes the FDA warning and CDC recommendations.

Plans and benefits

Shingles vaccine now payable for Medicaid members 50+

(06-05-2017) Michigan Department of Health and Human Services (MDHHS) has recommended to lower the age limit for the Herpes zoster, Zostavax® (shingles) vaccine, to age 50. Effective immediately, for Medicaid only, Priority Health will allow the vaccine to be billable for age 50 and older.

For commercial and Medicare, the shingles vaccine is still recommended for age 60 and older.

Responsibilities and standards

Fraud, waste and abuse tip

(08-07-2017) Be aware of marketing tactics from some DME suppliers resulting in potential fraud, waste or abuse. Examples include:

- Unsolicited orders for medical equipment or supplies, often with wording such as "We received a call from your patient Jane Doe who wants you to order…" and then lists multiple items on a pre-printed order for you to approve.
- Pre-completed medical necessity forms with instructions to just "Sign and date here."

There are steps you can take to protect your practice:

- Pay careful attention to orders that cross your desk asking for your signature.
- Before signing, ask your staff to provide the patient's medical record so that you can review before signing an order. You may also want to reach out to your patient to validate the request.
- Document in your patient's medical record the medical justification for any item of DME ordered for your patient.
- You should keep a record of the DME you've ordered for your patient.

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.

Priority Health news

Newly designed Provider Center launched

(05-22-2017) We just launched the newly designed Provider Center at *priorityhealth.com* with an updated landing page and customizable dashboard. It was designed to offer you a better, faster, more personalized experience and easier access to the content you use every day. Learn more.

PriorityHealth®
A healthier approach to health care®