PriorityHealth

Physician and practice news digest

Spring 2017

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SPOTLIGHT

Welcome

HEALTH CARE

Our network expanded statewide March 1

Spotlight: Welcome McLaren Health

(01-26-2017) As of March 1, members with HMO, PPO, POS and Medicare coverage can seek health care services with McLaren hospitals and physician hospital organizations statewide. This new agreement adds the McLaren hospitals located in Lansing, Bay City, Lapeer and Flint and nearly 1,000 physicians to the Priority Health network.

The agreement expands an existing relationship between Priority Health and McLaren established in October 2014 that added McLaren's Northern Michigan, Central Michigan, Karmanos, Oakland and Macomb hospitals to our network.

We're pleased to partner with McLaren to broaden access to high quality health care across the state of Michigan. Read the full press release and learn more about McLaren Health Care.

Billing and payment

Medicare Outpatient Observation Notice (MOON) form now required

(01-09-2017) As of March 8, Medicare Fee For Service and Medicare Advantage will 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.

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.

Priority Health will release additional information and education as it becomes available, including specific process change details. We've convened an internal team to formulate a comprehensive education plan for our providers.

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

Reminder: Non-participating labs are not covered for HMO plans

(02-02-2017) To help ensure our members are getting the highest quality, most affordable health care through our network partners, use labs that participate in the Priority Health network.

Non-participating labs are not covered for members with HMO plans without an approved authorization, even if the lab is performed on the same day as an office visit with a participating provider.

Members will be liable for the costs of out-of-network labs unless authorization is requested and approved in advance.

What should providers and facilities do?

Refer your patients to participating providers and facilities. A complete list of in-network providers, including labs, is available in our Find a Doctor tool. To request an authorization, follow these steps.

If a Priority Health member receives services at a non-participating provider or facility without prior approval, inform the member that they will have higher costs.

Improved corrected claims submission process

(11-21-2016) We've streamlined the corrected claims process. Now, not all denied claims require that you submit a corrected claim or medical records. However, when submitting corrected claims be sure to submit the entire claim not just the claim lines you are correcting.

Changes to corrected claims submissions

- No payment on the entire claim: make the changes and submit a new original claim.
- Some or all lines paid: make the changes and submit a corrected or voided claim.
- Add modifier 25 or 59 to a denied line: submit a corrected claim and include medical records. You can send medical records with a paper claim or through the Priority Health Secure Mailbox.

See more in the Provider Manual corrected claims page.

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Billing and payment

National Drug Code validation began November 15

(11-14-2016) As of Nov. 15, 2016, Priority Health began authenticating the National Drug Codes (NDC) submitted for professional and facility claims only for Medicaid.

We will validate that:

- There is an NDC present
- It's necessary
- It's the correct code for your claim

We won't require a NDC code if the status indicator is N for these Medicaid claims.

To learn more about how to bill or for claim reimbursements, see NDC numbers in the Provider Manual.

DRG weights updated effective October 1

(11-03-2016) DRG weights were updated effective Oct. 1, 2016. Payment amounts automatically change where appropriate. Download our HMO/POS/PPO and Medicare standard fee schedules for more information (you must be logged in to your provider account to see the fee schedules page).

Pharmacy

Specialty pharmacy switched to Accredo as of Jan. 1

(12-12-2016) As of Jan. 1, 2017, certain specialty medications for Priority Health commercial and Medicaid members are covered in full when ordered through Accredo®, our Express Scripts specialty pharmacy program.*

With Accredo®, your patients will receive safe, prompt mail delivery of their medication and supplies to help manage their condition and they will save money paying only their plan's copayment.

Accredo® mailed a letter to your current specialty pharmacy patients to notify them of this coverage change. Your patients may ask you for a new prescription or request that you contact Express Scripts directly to make the switch. Call them at 800.987.4904 Monday through Friday, 8 a.m. – 8 p.m. EST.

We need your help in letting your patients know that their portion of their cost will be more, even the full cost of the medication, if they choose to use pharmacies other than Accredo®.

**This applies to self-administered pharmacy benefit drugs and not drugs covered by medical benefits and administered in a hospital setting.*

Formulary updates

(12-07-2016) The Priority Health Pharmaceutical and Therapeutics (P&T) Committee recently approved several updates to the approved drug list for all product lines. Edits can be found in the Provider Manual.

Questions?

Call the Pharmacy Call Center at 800.466.6642.

Authorizations

Now available: Request authorizations online with Clear Coverage

(12-05-2016) We've transitioned to the Clear Coverage™ prior authorization tool.

Clear Coverage lets you request authorizations online and receive immediate responses, including automatic approvals for some procedures, making the approval process quicker and easier.

We expect up to 60% of prior authorizations to approve automatically and anticipate faster approvals for those that need additional review. You can make requests and check the status of authorizations 24/7 using the new tool.

Log in and use Clear Coverage for your prior auth requests.

Clear Coverage is available for all Priority Health product lines including commercial group and individual plans, Medicare and Medicaid.

Start using this convenient tool today for all of the services you already request authorizations for, like procedures; durable medical equipment (DME); home care; as well as physical, occupational and speech therapy. Starting March 13, these services can only be requested through Clear Coverage for in-network providers.

Urgent/emergent inpatient authorizations are scheduled to move to the tool later in the first quarter of 2017. The processes for high-tech radiology, behavioral health and drug authorizations are not changing.

Get training guides, a demo video and FAQs online.

Medical policy updates

(01-17-2016) The following policy updates received approval at recent Medical Affairs Committee meetings. For summaries of the changes and links to the updated policies, go to the Policy changes page.

Effective Jan. 1, 2017

- **Gastroesophageal Reflux Disease (GERD) and Barrett's Esophagus** – 91483
- **Gender Reassignment Surgery** – 91612

Effective Jan. 15, 2017

- **Autism Spectrum Disorders** – 91615
- **Stimulation Therapy and Devices** – 91468

Effective Feb. 1, 2017

- **End Stage Renal Disease (ESRD): Renal Dialysis** – 91526
- **Orthotics Support Devices** – 91339

Existing medical policy criteria transitioned to InterQual Feb. 1, 2017

For some services, Priority Health has replaced our custom medical policy criteria with InterQual® criteria. InterQual Criteria are evidence–based clinical decision support criteria used across the health care industry. The following medical policies have been updated to reflect the use of InterQual criteria.

- **Breast related procedures** – 91545
- **Cardioverter defibrillators** – 91410
- **Cranial helmets** – 91504
- **Electrophysiology testing and catheter ablation for cardiac arrhythmias** – 91314
- **Gastroparesis testing and treatment** – 91572
- **Hearing augmentation** – 91544
- **Obstructive sleep apnea** – 91333

continued>

Authorizations

- **Orthognathic surgery** – 91273
- **Sexual dysfunction and impotence** – 91160
- **Spine procedures** – 91581
- **Stimulation therapy and devices** – 91468
- **Transcatheter heart valve procedures** – 91597

Need to change an authorization?

(12-05-2016) You can update an existing prior authorization by email or fax.

To make date changes, a written request via fax is not necessary.

1. Log in to your Priority Health provider account, and then go to your Mailbox to compose a message.
2. Choose Medical Auth Update for the "To" address.
3. In the body of the message, include the member name and ID number as well as the authorization number. Then let us know about the date change.

We'll reply to your email to tell you the change is completed.

To change a doctor, facility, procedure or diagnosis, fax us a new or updated prior authorization form. See a list of authorization forms. Learn more about requesting authorizations in the Provider Manual.

New prior auths, Emmi requirements

(12-01-2016) As of Feb. 1, 2017, prior authorizations are required for:

- Pediatric tonsillectomies
- Radical prostatectomies
- Initiation of maintenance renal dialysis and non-emergent placement of dialysis access

These prior authorizations will also have an Emmi® pre-surgical decision support tool recommended for members.

As a provider, you simply have to request an authorization before performing the service. Authorization requests will be submitted automatically through our new authorization tool, Clear Coverage®, which launched Jan. 20, 2017. Clear Coverage® replaces our current manual process offering fast, easy requests with transparent medical necessity criteria. Our website will include more information and training opportunities for the tool soon.

Once the authorization is received, Priority Health will send the member an Emmi® video electronically. The video can be viewed online or via smart phone. It is designed to help patients and their caregivers understand the procedure, the associated risks and complications, and what they can do before and after to optimize their outcome.

To familiarize yourself with Emmi®, preview a module that may apply to your patients at *tryemmi.com* using the password PRIORITYHLTH.

Search keywords: ESRD, tonsillectomy or **prostatectomy** to review the programs.

Our goal is to ensure that all patients are getting the right care at the right time, are optimized for good outcomes and are fully informed about the service they're receiving.

Benchmarking against national plans as well as listening to and collaborating with our network partners has led Priority Health to create a focus on specialty care. We have added prior authorization for select specialty procedures with significant variation and overutilization compared to national standards. This way we are taking steps to engage specialists to become more active participants in transforming the care model.

Additionally our new prior authorization requirements will improve patient care and outcomes by identifying patients that may need additional care for an optimized surgical experience, at the lowest costs possible, with reduced variation and minimized complications.

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Authorizations

Authorization required for observation stays over 48 hours

(11-30-2016) As of February 1, new observation stays exceeding 48 hours require prior authorization.

If authorization is not requested and approved, payment will deny and providers will be liable for costs after the first 48 hours. This applies to adult and pediatric stays, including behavioral health, for commercial products only.

This change is a new step in our current process.

- **Patients in their first 48 hours of observation:** No change if they are going home or moving to inpatient status.
- **Patients moving to inpatient:** We continue to require clinical or medical review for inpatient stays.
- **NEW: Patients who will stay in observation longer than 48 hours:** You must request authorization using Clear Coverage®. When you access the tool, you'll be able to see who is nearing the 48-hour mark and needs authorization.

Request prior authorizations and learn more about observation billing in our provider manual.

Autism medical policy criteria transitioning to InterQual

(11-21-2016) As of Jan. 15, 2017, our autism medical policy began using InterQual® Criteria instead of custom criteria developed by Priority Health. This means our medical necessity criteria will align with nationally recognized decision support criteria. This change applies to group and individual commercial plans only. It does not apply to Medicare or Medicaid plans.

View the revised policy in our Provider Manual.

What are InterQual Criteria? InterQual Criteria are evidence-based clinical decision support criteria developed by McKesson and used across the health care industry. They allow providers to use a standardized approach to assess each patient's unique situation and recommend the most appropriate care.

Advanced Imaging Management has new appeals fax line

(02-22-2017) Effective immediately, please use 888.583.1005 for quickest response when faxing an imaging request appeal to Advanced Imaging Management (AIM).

Clinical resources

HPV vaccine updates

(12-23-2016) Earlier this year the Centers for Disease Control and Advisory Committee on Immunization Practices (ACIP) released changes to the Human Papillomavirus (HPV) vaccine recommendations:

- HPV vaccine recommendations now include males through age 26. The recommendation specifically describes vaccinating men aged 22 – 26 who have compromised immune systems, are gay, bisexual, or who have intercourse with other men. Effective immediately, Priority Health will cover HPV vaccines for both women and men through age 26.
- ACIP also voted to recommend patients ages 11 – 12 receive two doses of the nine-valent HPV vaccine (HPV9; Gardasil 9) at least 146 days apart, rather than the previously recommended three doses at least 6 months apart, to protect against cancers caused by HPV infections. Teens and young adults who start the series later, at ages 15 – 26, will continue to need three doses of HPV vaccine. Our 2017 physician incentive program methodology for the HPV measure has been reviewed and changed to align with this new recommendation.

Updates to the 2017 PCP Incentive Program Manual

(01-17-2017) The 2017 PCP Incentive Program supports your efforts to provide the best clinical care while balancing cost and patient experience, a structure that directly reflects the Triple Aim.

This year's program features a redesign of care management measures to focus on longitudinal care, new measures to support care transformation, and differentiation between products to improve results for unique patient populations. We've made additional changes since posting the manual December 1.

Edits to the manual as of Jan. 12, 2017 are located on pages: 11, 13, 16, 20, 23, 35, 37 – 82.

- Comprehensive Primary Care Plus (CPC+) – Added additional language (pg. 11)
- Cervical cancer screening – Edits to age criteria (pg.13)
- Adolescent immunization – Edits to identified measure (pg.16)
- Chlamydia screening – Edits to exclusionary criteria (pg. 20)
- Colorectal cancer screening - Edits to numerator and provider data input (pg. 23)
- Depression (pg. 35)
  - Added to case definition
  - Added to exclusionary criteria
  - Added and removed information from numerator
- Depression flowchart – new page (pg. 37)
- Senior care education – Updated webcast and attestation information (pg. 38)
- Medical Therapy Management (MTM) – Edits to denominator (pg. 39)
- Healthy Michigan Plan – Replaced retired CPT 99420 with 96160 in identified measure, method of measurement, provider data input and payout sections (pg. 45-46)
- All-cause readmissions
  - Edited case definition (pg. 47)
  - Edited minimum membership (pg. 48)
- FIT-DNA (Cologuard) – Added 81528 to the measure code set (pg. 58)

2017 plan changes

- Care management measure focuses on longitudinal care
- Differentiation between products to improve results for all patient population segments
- Support for care transformation with new measures: All-cause readmissions
- Medicare 5-star optimal measure
- Medication Therapy Management (MTM)
- Recorded BMI (pediatric and adult)

Additional measures retired and revised for 2017

- Adolescent immunization – added combo 2, Meningococcal, Tdap and HPV
- Care management – revised criteria and payout
- Chlamydia screening – removed commercial product line
- Depression screening and follow-up – revised criteria
- Diabetes care: Hypertension medication therapy – retired
- Expanded colorectal cancer screening to include CT colonography and FIT-DNA (Cologuard)
- Expanded emergency department (ED) PCP treatable care to include Medicaid
- Expanded senior care education to include proper coding for risk adjustment
- Optimal diabetes care – removed Medicare
- Patient-centered medical home (PCMH) recognition – removed commercial and Medicare
- Pediatric obesity – retired
- Tobacco cessation counseling – retired

Download the most recent 2017 manual and measures chart by logging in to the PCP Incentives Program (PCP IP) page in the Provider Manual.

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Performance programs

Physical therapists in Michigan earn financial rewards for providing patient-centered care

(12-05-2016) Results are in for the most recent evaluation period of the Physical Therapy (PT) incentive program which ran April 1 through Sept. 30, 2016. Financial rewards totaling nearly $50,000 were presented to 32 clinic locations for providing patient–centered service.

These clinics ranked the highest among participating providers when measured in:

- Completion of care
- Patient satisfaction
- Attaining the minimum clinically importance difference (MCID)
- Pain scale improvement
- Completion of goals

Providers in the program use WebOutcomes, a third party physical therapy outcome tool, to enter data on their Priority Health patients. This helpful tool tracks a participant's success by measuring the quality of their service.

It generates online progress reports and dashboards that provide invaluable benchmarking information with which participants can evaluate and run their practices.

The PT incentive program has already proven successful for the patients of these 32 providers. Going forward, our goal is that every participating Physical Therapist be recognized for providing the very best in patient services.

Learn more about the PT Incentive Program.

Healthy Michigan plan HRA code update

(01-16-2017) The Healthy Michigan Plan: HRA completion and open access E&M code 99420 which is billed to indicate the initial visit and the HRA form was completed by the PCP (physician or mid-level) was retired Dec. 31, 2016.

Code 99420 was replaced by 96160. Learn more about the Healthy Michigan Plan.

Plans and benefits

Reminder: Balance billing prohibited for Medicare-Medicaid eligibles

(11-18-2016) You may not balance bill for services and supplies furnished to Qualified Medicare Beneficiaries (QMBs).

For QMBs, Medicaid is responsible for:

- Deductibles
- Coinsurance
- Copayment amounts for Medicare Part A and B covered services

For more information see MLN Matters SE1128.

Note: QMBs are sometimes called "dual eligibles." They are entitled to Medicare Part A, eligible for Medicare Part B, have income below 100% of the Federal Poverty Level, and have been determined to be eligible for QMB status by the State Medicaid Office.

Responsibilities and standards

HEDIS medical record data collection has begun

(01-27-2017) Annual medical record data collection for the Healthcare Effectiveness Data and Information Set (HEDIS®) began in February and will end in early May. During the HEDIS record collection period, Priority Health collects a large volume of records as proof a specific set of clinical services were provided.

Beginning in 2015, Priority Health began contracting with Optum Health as our software vendor to collect physical records. This year we are adding Arro Health to contact providers on our behalf. Not all providers will receive requests for medical records due to the unique randomized sample of members that is pulled each year.

If you have any questions or concerns, contact *chelsea.selbig@priorityhealth.com*.

Behavioral health member satisfaction survey results

(01-10-2017) Each year we survey a statistically valid sample of members who received mental health treatment during the calendar year in order to assess member satisfaction with access to care. Access questions in the survey are based on NCQA Access standards. Our goal is to achieve 90% in each access measure.

The survey results below indicate Priority Health members experienced greater access to urgent counseling and routine counseling appointments over the past year. However, members experienced less access to emergent non-life threatening and medication management appointments.

These results are predictable based upon a shortage of psychiatrists, but still of concern due to safety risks. Increasingly tele-psychiatry is being offered to fill the gap created by fewer psychiatrists and remedy access concerns.

We recommend the following to improve access:

- Examine your practice's access standards with a goal of meeting national benchmarks for routine, urgent, emergent and medication therapy appointments.
- Periodically survey your clients for their view of access to behavioral health care and to determine if their needs are being met in current scheduling protocols.
- Consider implementing tele-psychiatry where lower access to emergent care and medication therapy appointments place clients at risk.

2016 survey results

Measure	Goal	2015	2016	Change from 2015 – 2016
Non-life-threatening emergency counseling within 6 hours *(% always/usually)*	85%	61%	56%	↓
Urgent counseling within 48 hours *(% always/usually)*	85%	53%	69%	↑
First routine counseling appointment within 10 business days *(% yes)*	85%	72%	73%	↑
Follow-up routine counseling appointment within 30 business days *(% yes)*	85%	Not asked	95%	N/A
Medication Management Therapy (MTM) appointment within 10 business days	85%	63%	61%	↓

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Behavioral health/PCP coordination of care survey results

(01-10-2017) Each year we survey primary care providers (PCPs) and behavioral health providers to assess how care is coordinated between the two disciplines. Research shows that integration improves health outcomes. Unfortunately, the survey results below indicate that less collaboration is occurring between providers when compared to results from a year ago.

Barriers to collaboration include:

- Lack of time to collaborate despite believing that collaboration is very important
- No patient-signed release approving two-way communication
- Limited ways to communicate across two health systems with fax and postal mail outside of the workflow due to electronic health records
- Lack of electronic means to view each other's clinical notes

Advanced medical homes (AMHs) or a model of care in which behavioral health and primary care are fully integrated and exist at one point of service is considered the best solution to optimizing coordination of care and producing more positive health outcomes.

We recommend the following to improve coordination:

- 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.
- Examine and update your protocols to ensure that your work flow promotes the exchange of information and integrated treatment plans.

2016 survey results

Measure	2015*	2016*	Change from 2015 – 2016
Behavior health provider results			
BH provider reported that their attempts to collaborate with the PCP were always/most of the time successful	69%	76%	↑
BH reported having an EHR where medical and behavioral health can view each other's notes	44%	31%	↓
BH reported always/most of the time providing client clinical information to the PCP	43%	39%	↓
BH reported providing clinical information upon initial assessment and whenever treatment plan changed	38%	31%	↓
BH provider reported that when they received clinical information from the PCP, it was always/most of the time sufficient (clear, accurate, relevant)	Not asked	75%	N/A
Primary care provider results			
PCP reported an EHR that allows medical and behavioral health practitioners to view each other's notes	19%	18%	↓
PCP reported always/most of the time providing health information regarding a patient to BH provider	32%	26%	↓
PCP reported always/most of the time receiving relevant clinical information from BH provider	24%	24%	N/A
PCP reported that when they received clinical information from the BH provider it was always/usually sufficient (clear, accurate, relevant)	49%	48%	↓

**2015: 120 responses (30% return rate)*
2016: 245 responses (35% return rate)

continued>

Reminder: Reporting potential fraud and abuse

(01-16-2017) Fraud, waste 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, waste and abuse to us when you see it.

Reminder: Medicare annual training requirements

(11-08-2016) Any provider who is contracted with Priority Health Medicare products is considered to be a first tier, downstream or related entity (FDR) of Priority Health. Providers, their staff, including volunteers and temporary employees, and all downstream contractors, are subject to federal laws related to the Medicare program as well as CMS rules.

FDR training requirements include:

- Ensuring that all applicable employees receive compliance training within 90 days of initial hire and annually thereafter.
- An annual training session for all providers offering services to Medicare plan members on how to recognize and prevent fraud, waste and abuse (FWA).

FDRs can complete the general compliance and/or FWA training modules on the CMS Medicare Learning Network website.

- Medicare Parts C & D General Compliance Training
- Medicare Parts C & D Fraud, Waste and Abuse Training*
- Once an individual completes the training, the system will generate a certificate of completion.

*Deeming exemption: Provider FDRs who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are deemed to have met the FWA training and education requirements. The deeming exception for FWA training does not apply to the general compliance training and education requirement. Therefore, even if the provider FDR is deemed for FWA training and education, the requirement for general compliance training and education must be fulfilled.

All FDRs are prohibited from employing or contracting with persons or entities that have been excluded from doing business with the Federal Government. Upon hiring or contracting and monthly thereafter, FDRs are required to verify their employees (including temporary and voluntary) against the DHHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the General Services Administration (GSA) Excluded Parties List System (EPLS).

Note: GSA has incorporated EPLS within the System for Awards Management (SAM). Monthly screening is essential to prevent inappropriate payment to providers, pharmacies, and other entities that have been added to exclusions lists since the last time the list was checked. FDRs should be prepared to produce evidence that their employees and any other entities with whom they contract have been timely checked against the exclusion list.