

Physician and practice news digest

Summer 2017



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Spotlight: New auth process for ortho surgeries, genetic testing and advanced imaging

Beginning June 19, our Auth Request tool will take providers to either Clear Coverage™ or to eviCore healthcare, depending on the type of auth you're requesting. eviCore is already working with thousands of Michigan providers on authorization services but they will be taking on new services for Priority Health members.

Services authorized by eviCore

eviCore follows evidence-based guidelines that are clear and they have medical directors that are specialty-specific to engage in meaningful peer-to-peer discussion. You'll work directly with eviCore to request prior authorization for the following services:

- All musculoskeletal procedures, such as surgeries or arthroscopies for hips, knees and shoulders
- Spinal procedures including open, percutaneous and endoscopic interventions
- Genetic testing
- Advanced diagnostic imaging (authorizations will move from AIM to eviCore)

For services that require authorization, providers are liable for the cost if the service is performed without authorization.

How to request eviCore authorizations

We'll be adding information about accessing eviCore authorizations to the Provider Manual. You'll have multiple ways to request authorizations:

- Online: Log in to your Priority Health provider account and click Auth Request in the provider tools menu
- Phone: Call eviCore direct at 844.303.8456
- Fax radiology/spine/joint auth requests: 800.540.2406; fax lab requests: 844.545.9213

Eligible plans

Authorization for the services listed above will be required by all Priority Health plans.

More information mailed

eviCore mailed a letter and training webinar invitation to providers who have billed for the codes that will require authorization through eviCore. You can also visit evicore.com/healthplan/priorityhealth to find webinar training dates, clinical guidelines, FAQs and a list of CPT codes that require authorization.

Our goal is to work more closely with you to optimize health outcomes while providing evidence-based, value-driven care. The evidence is clear that focusing on appropriate care impacts all aspects of the Triple Aim: quality care and outcomes, satisfaction and improved cost.



Billing and payment

April 1 Medicaid fee schedule delayed

(04-17-2017) The state of Michigan releases updated practitioner fee schedules for Medicaid each quarter. Unfortunately the state has not released the fee schedule intended to be effective April 1, 2017. At this time we will continue to process Medicaid claims based on the most recently released fee schedule.

Once the quarterly fee schedule is received, it takes approximately two weeks to load and apply the new fees.

Providers can:

- Choose to hold any claims with dates of service on or after April 1, 2017 and send them to Priority Health once the new fee schedule is applied.
- Send in claims with dates of service on or after April 1 to process at first-quarter rates. We will not reprocess these claims with the new rates.

We will post to the [Provider News and Education website](#) when we have additional information or a timeline for when the new fee schedule will be applied.

Physician fee schedule changes July 1, 2017 for patients with ACA health plans

(04-14-2017) The individual market created by the Affordable Care Act (ACA) continues to pose significant challenges for health plans here in Michigan and nationally. The ACA exchange population has been much sicker and more costly than anyone anticipated and we continue to see individuals abuse the system and purchase coverage for urgent issues and then drop coverage after receiving services. These challenges add complexity to an already volatile health care industry where pharmacy costs continue to escalate at unsustainable rates while our population grows older and increasingly unhealthy. This is forcing everyone to make difficult decisions in order to be able to continue to serve this market.

In an effort to address these unsustainable costs, we have to adjust provider pricing so we can continue to offer ACA plans beyond 2019. Click here to see the [new fee schedule](#).

Need help identifying your patients with ACA health plans?

See our [provider reference guide](#) on how to identify Priority Health members in your practice.

Questions?

If you have questions about this fee schedule change contact your Provider Performance Specialist (PPS). Find their [contact information](#) by selecting Contact us at priorityhealth.com/provider or by calling the Provider Helpline at 800.942.4765.

Effective July 1, FQHC, RHC and THC must bill claims on UB forms

(04-14-2017) Effective July 1, 2017, all Medicaid claims billed by Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC) and Tribal Health Centers (THC) must be billed on a Uniform Billing (UB) claim form instead of a HCFA 1500 form. Specifically, these providers must bill electronic claims using the ASC X12N 837 5010 institutional format and file paper claims on the National Uniform Billing Code (NUBC) claim form.

This change is [mandatory from CMS](#) and 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.



DME Medicare billing edit change was effective April 1

(03-29-2017) As of April 1, 2017, Durable Medical Equipment (DME) services that exceed the Medically Unlikely Edits (MUE) will deny all units for a claim line(s). The MUE clinical edit associated with DME claim will align with the Centers for Medicare and Medicaid (CMS) criteria defined by MUE adjudication indicator.

Previously, if a provider billed multiple units on single or multiple lines of a claim form and the total units exceeded what was medically likely to have occurred on that date, the MUE limit might be partially paid up to the allowed units depending on how the provider billed.

As of April 1, 2017, if the total units for a code exceeds MUE, then all units will be denied in lieu of a partial payment. Specific information about the MUE adjudication indicator edit criteria can be found in the [CMS notice](#).

Out-of-network claims processing changes effective February 1

(03-28-2017) Effective Feb. 1, 2017, the out of network (OON) claims process changed for:

- Group PriorityPOS members
- Group PriorityPPO members
- Individual POS members

OON claims are now processed by Data iSight, a tool that uses industry trends and area-specific data to determine the fair cost or usual and customary charge for an out of network service. Essentially, all claims for OON providers will now route at a leased network rate or be priced as usual and customary by Data iSight.

This will change what Priority Health reimburses for OON services and therefore may change the out of pocket amounts some members pay. OON providers accept Priority Health payment as payment in full but can bill the member the difference. Members are always encouraged to choose an in-network provider which can be done via the [Find a Doctor tool](#) in MyHealth.

Edits Checker User Guide now available

(03-17-2017) The Edits Checker tool lets any provider enter professional or facility claim data to view clinical edits and the associated rationale that may be applicable to a claim scenario. It'll show any local coverage determinations, national coverage determinations, correct coding initiative errors and more.

Edits Checker shows up in your provider tools list, on the left of your logged-in Priority Health provider account landing page.

We've created a handy [Edits Checker User Guide](#) for you.

Basic instructions for using Edits Checker:

Use the same field formats you would use on a paper/electronic claim:

- Do not use decimals or periods within the diagnosis codes
- Capitalize alpha characters for modifiers, and procedure and diagnosis codes
- Format date fields as MM/DD/YYYY
- Separate multiple modifiers and/or diagnosis codes for a claim line with a comma only, no spaces
- Fill in as many fields as possible for the most accurate analysis. Leaving any fields blank may result in inaccurate results

Claim analysis results:

- **Line ID** – Indicates whether the clinical edit flag status applies to the entire claim (as indicated by "CLAIM") or to a particular claim line (as indicated by the claim line ID)
- **Flag description** – Short description of the clinical edit
- **Flag status** – Indicates how the claim/line will process
- **Deny** – indicates a clinical edit is applicable to the claim/line and will result in a denial



Billing and payment

- **Review** – indicates a clinical edit is applicable to the claim/line and will require manual review (e.g. unlisted codes)
- **Profile** – indicates a clinical edit is applicable for tracking purposes; will not result in a claim/line denial or manual review
- **Clean line** – indicates a clinical edit is not applicable to the claim/line
- **Disclosure** – Rationale or source for the clinical edit

Disclaimer explanation

A claim scenario processing as clean in Edits Checker does not guarantee payment. A clean result in Edits Checker simply indicates that clinical edits will not apply to the claim scenario that has been entered in Edits Checker. Any changes in the claim scenario may result in different results. A claim submitted to Priority Health will process and pay/deny depending on several variables (product, benefits, contractual agreements, etc.).

Inpatient admissions policy change

(03-10-2017) Effective June 1, 2017, Priority Health instituted an inpatient admissions policy change. We now apply InterQual® hospital admissions criteria at 24 hours for patients. This will apply to all our products and aligns with our current policy for Medicaid and Medicare members.

InterQual® ISD criteria are clinically based on best practice, clinical data and medical literature. They are updated continually and released annually. Decisions made using this criteria are based on each patient's clinical status and rely on patient-specific clinical indicators, service requirements and discharge/transfer readiness.

Facilities must notify us around 24 hours following hospital admission, once the patient's clinical status has been assessed, treated and reassessed, to determine admission bed status. This period of assessment allows adequate time to verify if the patient's condition has stabilized and to determine if they are an inpatient admission or will remain in observation.

Priority Health care managers are available to support the assessment of admission (bed type) appropriateness and to assist with discharge planning once the patient has been stabilized and is ready for transition to the next most appropriate level of care. For more information contact the care management team at 800.998.1037.

Change to Medicaid fee schedule for behavioral health

(03-10-2017) Effective May 1, 2017, there was a change in reimbursement to appropriately align the Medicaid plan's reimbursement for behavioral health services to the Medicaid practitioner published fee schedule.

For more information, reference the [practitioner fee schedule](#) on the MDHHS website.

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

(02-22-2017) 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, 2016 Priority Health began covering this proven approach in primary care settings. In the past year, we have seen an increase in SBIRT services being billed but would like to encourage providers to continue to utilize these services. With early intervention, you can help substance abusers receive the treatment they need before more severe consequences occur.

Learn more about SBIRT in the [provider manual](#).



Billing and payment

Modifiers 59, XE, XS, XP and XU medical record requirement changes

(02-08-2017) As of April 1, 2017, the list of codes changed which require medical records be submitted when billing modifiers 59, XE, XS, XP and XU on professional claims.

These modifiers identify distinct services that are typically considered inclusive to another service. A health care provider may need to use an X {ESPU} modifier or modifier 59 to indicate that a procedure or service was distinct or independent from other services performed on the same day.

This commonly means a different location, different anatomical site and/or a different session.

See the Provider Manual page on [Modifiers XE/XS/XP/XU](#) or [Modifier 59](#) for details on when to use modifier 59 vs. the X {ESPU} modifiers. These pages have the updated list of code changes as well.

Code changes effective April 1, 2017

Each year the claims team does a comprehensive analysis of code changes. The following codes now need medical records when used with initial professional claims. Codes listed in bold were added as of April 1, and codes in *[bracketed italic]* removed.

- **Cardiovascular system:** 36215-36218, 36901, 36902, 38220
- **Digestive system:** 44005, 45378, 45380, 45381, 49000, 49010, 49320
- **Integumentary system:** 11055-11057, 19120, 19125, 19260, *[19290, 19291, 19295]*, 19301, 19303, 19307, 19316, 19318, 19325, 19328, 19330, 19340, 19357, 19361, 19370, 19371, 19380
- **Medicine:** 92960, 93975, 93976, 96160, 96161, 97760, 99173

- **Musculoskeletal system:** *[20600, 20604-20606, 20610, 20650]*, 20670, 20680, *[22214]*, 22224, *[22425]*, 22505, *[22520, 22521-22524]*, 22551, 22552, 22554, 22585, 22600, 22610, 22612, 22614, 22630, 22633, 22634, 22800, 22802-22804, 22830, 22842, 22845, 22846, 22848, 22850-22852, 22855, 22867, 22868, 23430, 23700, 24300, 25259, 26340, 27570, 27860, 28110, 28230, 28232, 28270, 28272, 28310, 28135, 28725, 29805-29807, 29819-29825, 29870, 29884
- **Nervous and ENT systems:** 63005, 63012, 63030, 63035, 63042, 63045-63048, 63055-63057, 63075, 63076, 63081, 63082, 67105, 69210, 69990
- **Radiology:** *[76942]*
- **Urinary/reproductive systems:** 52000, 52310, 57100, 57268, 58555, 58660

L1 Modifier deleted as of January 1

(02-06-2017) As of Jan. 1, 2017, CMS discontinued the L1 Modifier. Medicare, Medicaid and commercial claims containing this modifier now deny up front.

CMS originally implemented modifier L1 in 2014 to allow for separate payment of laboratory tests when laboratory tests were the only services on the claim or when the laboratory tests were unrelated to the other services on the claim. In 2016, CMS implemented status indicator Q4, which allows for automatic separate payment for laboratory tests when these are the only services on the claim without the use of the L1 modifier. For 2017, [CMS has discontinued the L1 modifier](#).

Please resubmit any claims sent in with dates of service after January 1 that contained this modifier.



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 have identified members who have filled prescriptions related to a chronic condition in the last year yet may not have seen their PCP this year and had 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. See our [provider reference guide](#) on how to identify Priority Health members in your practice.
- Document each patient's diagnosis with the corresponding ICD-10 code and any supplemental data or notes from your conversation with them in their medical record.

July 1 changes to testosterone meds coverage

(05-02-2017) Starting July 1, 2017, Priority Health is no longer covering the following testosterone prescriptions for commercial and individual plans:

- AndroDerm®
- AndroGel®
- Axiron®
- Fortesta®
- Testim®

Covered alternatives

- Testosterone injection
- Testosterone 1% gel pump
- Testosterone 25mg/2.5gm gel
- Testosterone 50mg/5gm gel

We're notifying patients

We are sending a letter to commercial group and individual plan patients who had a prescription of Androderm, Fortesta, Testim, Axiron and Androgel filled in 2017. It encourages them to discuss alternative medications with their provider. If an alternative covered medication is not feasible, providers should contact Priority Health for a possible prior approval or possible formulary exception.

Formulary updates

(02-09-2017) 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](#), or for questions, call the Pharmacy Call Center at 800.466.6642.



Authorizations

Auths not accepted by fax as of June 1

(05-01-2017) Facilities: Clear Coverage™ online authorizations are now mandatory for urgent and emergent inpatient requests, including:

- Admission
- Conversion/status change
- Continuing stay
- Discharge
- Birth

How to request authorizations online

1. Log in to your account.
2. Select “Auth Request” from the provider tools menu.
3. Select the “Hospital use only: Inpatient admissions” option.

Fax process continues for some auth types

Behavioral health, skilled nursing, long-term acute care, hospice and inpatient rehab will continue to use our fax process for authorizations.

Training in Auth Request/Clear Coverage

Training is recommended for anyone who works on utilization management requests including staff working in utilization management/review intake, administrative utilization review support staff admissions departments and utilization discharge planners.

[Get self-paced training materials](#), including a recorded training webinar and an FAQ (login required).

Medical policy updates

(04-11-2017) The following policy updates received approval at a recent Medical Affairs Committee meeting. For a full list of all the medical policy changes over the past two years, go to the [Policy changes](#) page.

Effective March 1, 2017

- [Genetics: Counseling, test, screening](#) – 91540

Effective April 1, 2017

- [Infusion services & equipment](#) – 91414

Effective April 10, 2017

- [Allergy testing](#) – 91037
- [Drug testing](#) – 91611
- [Oral surgery and dental extractions](#) – 91542

Effective May 1, 2017

- [Lumbar fusion](#) – 91590
- [Spine procedures](#) – 91581

Effective May 12, 2017

- [Medical management of obesity](#) – 91594
- [Osteoarthritis of the knee](#) – 91571
- [Surgical treatment of obesity](#) – 91595

Reminder: Advance Beneficiary Notices banned under Medicare Advantage rules

(02-15-2017) Provider organizations should be aware that since May 2014 an Advanced Beneficiary Notice of Non-Coverage (ABN) is not a valid form of denial notification for Medicare Advantage plan members. ABNs, sometimes referred to as “waivers,” are used in the Original Medicare program. However, you can’t use them for patients enrolled in Priority Health Medicare plans as the Centers for Medicare and Medicaid Services (CMS) prohibits use of ABNs or ABN-like forms.

If you’re a provider who has elected to participate in the Medicare program, you need to understand which services are covered by Original Medicare and which are not. Priority Health Medicare plans are required to cover everything that Original Medicare covers and in some instances may provide coverage that is more generous or otherwise goes beyond what is covered under original Medicare.

If you’re a Priority Health Medicare contracted provider, you are also expected to understand what is covered under Priority Health Medicare.



Authorizations

CMS mandates that providers who are contracted with a Medicare Advantage plan, such as Priority Health, are not permitted to hold a Medicare Advantage member financially responsible for payment of a service not covered under the member's Medicare Advantage plan unless that member has received a pre-service organization determination (PSOD) notice of denial from Priority Health before such services are rendered.

PSODs can be initiated by you as the provider or by the member in order to determine if the requested/ordered service is covered prior to a member receiving it or prior to scheduling a service such as a lab test, diagnostic test, or procedure.

If the member does not have a PSOD notice of denial from Priority Health on file, you must hold the member harmless for the non-covered services and cannot charge the member any amount beyond the normal cost-sharing amounts (i.e., copayments, coinsurance and/or deductibles).

When a service is never covered under original Medicare or is listed as a clear exclusion in the member's Evidence of Coverage (EOC) or other similar plan document, a pre-service organization determination is not required in order for you to hold the member financially liable for such non-covered services.

Please note, services or supplies that are not medically necessary or are otherwise determined to be not covered based on clinical criteria do not constitute "clear exclusions" under the member's plan. The member is not likely to be able to determine on the face of the EOC that such services will not be covered.

Remember, unless a service or supply is never covered under Original Medicare, you will only be able to hold a Priority Health Medicare member financially responsible for a non-covered service if the member has received a PSOD denial from Priority Health and decides to proceed with the service knowing they will be financially liable.

Learn more about Medicare non-coverage and the pre-service organization determination process in the Provider Manual [Medicare non-coverage](#).

Request urgent/emergent inpatient authorizations online with Clear Coverage

(02-10-2017) In March, we transitioned requests for urgent/emergent inpatient admissions to our new online authorization tool, Clear Coverage(TM). Clear Coverage gives you 24/7 access to request and update the status of inpatient admissions quickly and conveniently online. As of June 1, urgent/emergent inpatient admissions can only be requested through Clear Coverage.

Who can use Clear Coverage?

Clear Coverage is available for all Priority Health products, including:

- Commercial group
- Individual plans
- Medicare
- Medicaid

Clear Coverage is already available for scheduled procedures, services and DME. [Learn more about requesting scheduled services](#).

Clear Coverage training

[Get a sneak peek](#) of how to request an urgent/emergent admission in Clear Coverage (log-in required).

Update to Makena prior authorization criteria

(02-07-2017) In November, the Pharmacy and Therapeutics (P&T) Committee approved moving Makena to the non-preferred specialty tier and adding a step requirement for the generic hydroxyprogesterone caproate to Makena's prior authorization criteria. This went into effect on Dec. 1, 2016 for commercial, individual and Medicaid members.

The multi-dose vial formulations of hydroxyprogesterone caproate and Makena have identical active and inactive ingredients. Both products are clinically equivalent and expected to perform the same when used to reduce the risk of preterm birth in a woman with a singleton pregnancy who has a history of singleton preterm birth.

The new step therapy requirement is built within the [prior authorization](#) form for Makena.



Performance programs

Physical therapists can earn financial rewards for patient-centered care

(03-03-2017) Physical therapists are invited to participate in our industry-recognized, pay-for-performance incentive program. Designed to reward quality providers, the program helps reduce the cost of health care. Since 2014, we have awarded more than \$220,000 to independently-contracted physical therapy clinics.

Participation is easy and free

To participate, complete the online [PT incentive program participation form](#).

Once registered, you'll enter data into WebOutcomes, a third-party physical therapy outcome tool, for patients who are Priority Health members. It takes just a couple of minutes per patient.

Get reports and earn rewards

We evaluate and reward the top-performing participants based upon quality standards twice a year. Plus, additional reports are available to you to help you validate your results to referring providers.

More details

For more information about how to participate, how to set up your WebOutcomes account and program timelines, go to [PT Incentive Program](#).



Plans and benefits

Healthy Michigan Plan HRA process change

(04-25-2017) Effective immediately, Priority Health will not require the member results section of the Healthy Michigan Plan Health Risk Assessment (HRA) to be populated in order for the HRA to be considered "complete." This change is to align with the Michigan Department of Health and Human Services (MDHHS) policy.

Now, if a provider does not populate the member results section (including lab values) on a member's HRA form, Priority Health will no longer fax the form back for completion.

PCP Incentive Program reporting

For members with missing HRA member results, the PIP_012 reports will still show as "partial" completed.

- No fax-back date listed: Member results are missing on the HRA but no action is needed.
- Fax-back date listed: We need additional information.

Learn more about the Healthy Michigan Plan and the HRA on the [MDHHS website](#).

Healthy Michigan Medicaid co-pay amounts changed April 1

(04-12-2017) Effective April 1, 2017, the Michigan Department of Health and Human Services (MDHHS) changed co-pays for Healthy Michigan plan members. The process for collecting co-pays or verifying benefits has not changed, only the dollar amount of co-pays based on a member's federal poverty level (FPL) has. To clarify, the health plan will still collect co-pays, as usual. Providers are still encouraged to educate members on their co-pays at the time of service, and should make the [co-pay amounts](#) available for member viewing.

Providers are currently directed to check beneficiary eligibility using the Community Health Automated Medicaid Processing System (CHAMPS) at the time of every service. As of April 1, 2017, the eligibility response within CHAMPS will provide the tiered co-pay amounts applicable to the beneficiary.

For additional information about the Medicaid Healthy Michigan plan, navigate to the [MDHHS page on Healthy Michigan](#).



Responsibilities and standards

Fraud, waste and abuse prevention tip

(05-01-2017) Medical necessity for procedures or tests must be individualized and documented in the member's medical record and included in the treatment plan of care. Orders for "custom profiles", "standing orders" or to "conduct additional testing as needed" are not sufficiently detailed and would not support medical necessity.

For example:

- Pulse ox was ordered for an eye irritation, no medical necessity documented to support the need for this procedure

- Ordering a complete drug testing panel vs. only ordering each drug or drug class that is supported in the patient's medical record based on the patient's medical history or current clinical presentation.

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

Cost Estimator adds procedures, user enhancements

(02-28-2017) The Priority Health Cost Estimator tool will be seeing a variety of enhancements this year. The first of which is the addition of new procedures and user enhancements that went live February 27.

Cost Estimator lets Priority Health members look up cost information for surgeries and services. The procedures added in this enhancement represent the top 100 most frequently billed CPT codes that make up approximately 40 unique procedures, such as: office visits, behavioral health, physical therapy, allergy, dialysis, chiropractic and vision.

Enhanced functionality for users

- Showing procedures that can be either preventive or diagnostic, and informing the member that if preventive the out-of-pocket costs may be lower
- Secondary sorting following the default sorting by distance

More to come

Additional enhancements are scheduled to launch throughout 2017, including the addition of Rx prices.