PriorityHealth

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Keeping quality at the forefront

By Richard Vienne, DO, VP, Medical and Clinical Operations

As we look forward to transitioning into a new year, one thing will remain the same – our commitment to offering our members, your patients, the best affordable care possible. We accomplish this by partnering with you to drive quality success in offering the right care, at the right time, in the right place and at the right cost.

As a health plan, we're measured by our quality performance and **we're happy to share that our Medicare HMO-POS contract received its first 5-star rating, the "excellent" standard for quality and performance**. Thank you for all the work you do that contributes to our star ratings. When we receive higher ratings, we're able to offer richer benefits to remove cost and access barriers for your patients when delivering care.

Let's continue working together to close gaps in care and improve the well-being of our community as we enter another year.

Below are some quality metrics we need your continual support in.

Controlling blood pressure

- Patients with hypertension should be seen on a regular basis and have their blood pressure taken at every visit – preferably twice as best practice.

Diabetic retinal eye exam

- Encourage your patients with diabetes to get their Diabetic Retinal Exam. These exams are a crucial monitoring aspect of diabetes that can help prevent deterioration of vision or potential blindness.
- **Referrals aren't required for this screening**.

Immunizations

- Immunization rates are dropping across Michigan every year. It's critical to educate parents on the importance of routine childhood immunizations.

Lead screenings

- We're always tracking lead screening performance to ensure these services are taking place. Over the last three years, we've seen a decline in lead screenings that are completed before a child's 2nd birthday.

Thank you for the care you provide our members with to help them reach their health goals.

Best wishes,
Richard Vienne, DO

Billing & coding tips

Below, we've compiled resources, tips and tricks for the six billing-related topics we've received the most calls about in the past few months:

1. **Setting up electronic claim/RA file sharing**

   Visit our Provider Manual's EDI setup page to learn about:

   - Electronic data interchange (EDI) setup
   - Transaction types available for EDI
   - Real-time transaction exceptions

2. **Download your remittance advice files from Filemart within 90 days**

   After 90 days, requests for archived remittance advice files won't be accepted

   - Save the files to your internal servers within 90 days
   - Share the files with third-party billing companies as needed
   - Maintain the files for the federally mandated 5-7 years

3. **Resources for prism**

   Visit our Provider Manual's prism resources page to learn about:

   - How to register for prism or create an account
   - Managing your group or facility
   - Managing claims and appeals
   - How to enroll a provider, make changes and track status
   - Using our digital navigation assistant
   - How to submit questions using prism's General Requests feature

4. **Contact us about a specific claim**

   Follow the process below to send us a message about a specific claim:

   1. Log into your prism account
   2. Open the **Claims** menu and click **Medical Claims**
   3. Type the claim number in the box that says **Specific Claim Search**, then click **Search**
   4. Click the **Claim ID** to open the Claim Details page
   5. Click **Contact us about this Claim**
   6. Follow the listed prompts to submit your inquiry

   Don't use **General Requests** to submit an inquiry about an existing claim. We'll close any inquiry submitted incorrectly and notify the sender to resubmit correctly.

5. **When to submit a corrected UB04 claim or a new UB04 claim**

   - **Submit a correct claim** if there's any type of payment on the claim, member liability was processed on the claim or if you're appending a modifier not submitted on your original claim
   - **Submit a new claim** if the entire claim was denied or if no payment was made on the original claim

6. **90-day grace period:**

   When we make or recover payments near or after our filing limit, you have 90 days from the date on the Explanation of Benefits (EOB) to submit the claim to us. Payment corrections from another health plan require the claim and EOB to be submitted to us.

   Submitting takeback EOB information doesn't require an appeal. If you're within the 90-day grace period, open the claim in question in prism, click **Contact Us about this Claim** and use the **Other Related Claims Questions** drop down option, attaching relevant documentation before submitting. This ensures your inquiry will reach the right department for faster review.

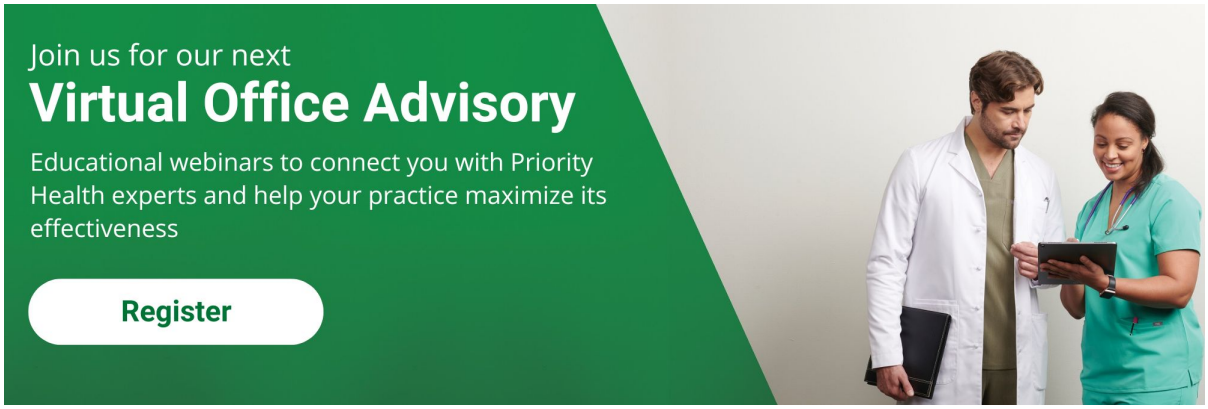
   Helpful tips:

   - Attach the EOB to the claim so we can verify the claim was submitted to us within 90 days.
   - If you don't follow-up within 90 days, we'll deny requests without appeal rights.
   - We'll deny revised information received after the 90 days to provider liability.
   - Denials related to authorizations/medical necessity or coding/clinical edits still follow the filing limit rules.
   - We won't make exceptions to this policy for overlooking a claim or response deadline.

Medicare & Medicaid quality news

Together, we can continue to close your patients' gaps in care. From preventative screenings to managing chronic conditions, we're here to support you. Get information on our latest Medicare & Medicaid quality information, provider tools and member benefits.

DOWNLOAD THE GUIDE



Value-based incentive programs

We appreciate your partnership as we work to provide the right care, at the right time, in the right place and at the right cost. We're continually evolving our incentive programs to help us achieve these goals and to recognize the hard work you do to keep our members healthy.

Below you'll find key incentive program updates and deadlines for the fourth quarter of 2022.

PCP Incentive Program (PIP)

A whole new PIP
We've redesigned and rebuilt our PCP Incentive Program (PIP) from top to bottom for 2023, ushering in opportunities to earn incentive payments more frequently throughout the year. Starting in January, you'll:

- Engage more deeply in specific measures
- Get more targeted data
- Receive incentive payments both quarterly and at year-end

Review our Preliminary 2023 PIP Manual for details on the new program's three components: Push Measures, Quality Index Score and Transformation Measures.

GET THE PRELIMINARY 2023 PIP MANUAL

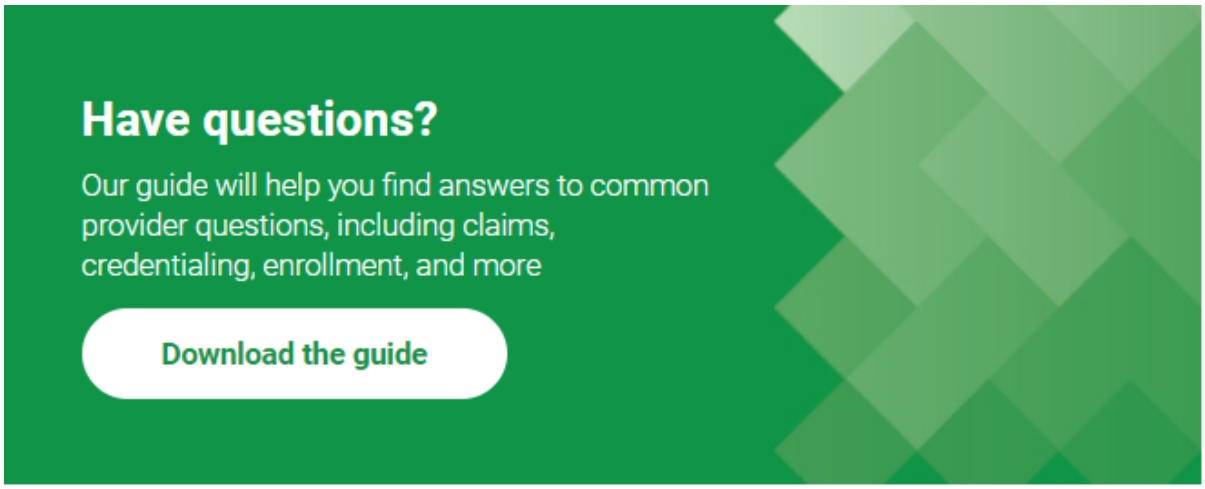
Behavioral Health Collaborative Care (BHCC) meeting
Attend our next BHCC meeting:

- **When:** November 30 at noon
- **Where:** Virtual (registration link below)

REGISTER ONLINE

Heads up: BHCC attestations due December 16

If you're participating in our BHCC measure, mark your calendars for December 16. Your BHCC attestations will be due on that date. Our team will send details and the attestation template on November 1.



Latest news

See the latest news posted to our website from July to October:

AUTHORIZATION NEWS

- GuidingCare tips: InterQual Smartsheets and messages
- Prior authorization is now required for IMRT services
- New prior authorization requirements for bariatric surgery coming Oct. 31

BILLING & PAYMENT

- New clinical edits for facility claims went into effect Sept. 15, 2022
- Legacy THC providers must wrap up claims, appeals by Dec. 31, 2022
- New clinical edit: Principal or first-listed diagnosis codes went into effect Oct. 1, 2022
- New clinical edit went into effect Oct. 15, 2022
- Reminder: Save remittance advice files within 90 days
- "Unspecified Codes" clinical edit went into effect Oct. 11, 2022
- Check out our newly updated Medicaid billing webpage

INCENTIVE PROGRAMS

- Aligning APCD data with our value-based programs has never been easier
- Check out our 2022 Quality Award winners

PHARMACY

- New dose rounding policy

PLANS & BENEFITS

- September is suicide prevention awareness month
- PriorityWell Choice benefits launching Dec. 1, 2022 for commercial large groups; Health Choice retiring by 2024
- Reminder: Cigna members traveling through Michigan are covered in our PPO network

PRIORITY HEALTH NEWS

- Watch out for telemedicine fraud
- Join us for our PriorityPROs Connect virtual event

PriorityMom™

The **Priority**MOM pilot program has been active for our commercial, Medicaid and individual group lines of business (LOB) for over a year and has already produced promising engagement statistics:

60% +
of the emails about the program are being opened

93% +
of moms who completed the exit survey would recommend the program

Satisfaction rating
4.3/5 stars

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