Priority Health

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In this issue

Message from the medical director

Two new chronic pain care management codes now covered to bundle key services for our Medicare and commercial members

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Chronic pain patients have medical complexities that drive higher utilization and costs of care compared to the average patient.
To help our members with chronic pain get the care and relief they need, we're covering care management (CM) codes G3002 and G3003 for our group commercial, individual and Medicare plans, including D-SNP.

See our FAQ for codes G3002 and G3003.

Why is this important?
These new codes enable members with chronic pain to more easily work with their providers to develop and implement care management plans. Covering the codes can also improve payment accuracy and drive down the cost of care for these services through bundling rather than billing a' la carte.

What provider types can bill these codes?
Any provider able to bill Priority Health who is helping a member manage their chronic pain can bill these codes.

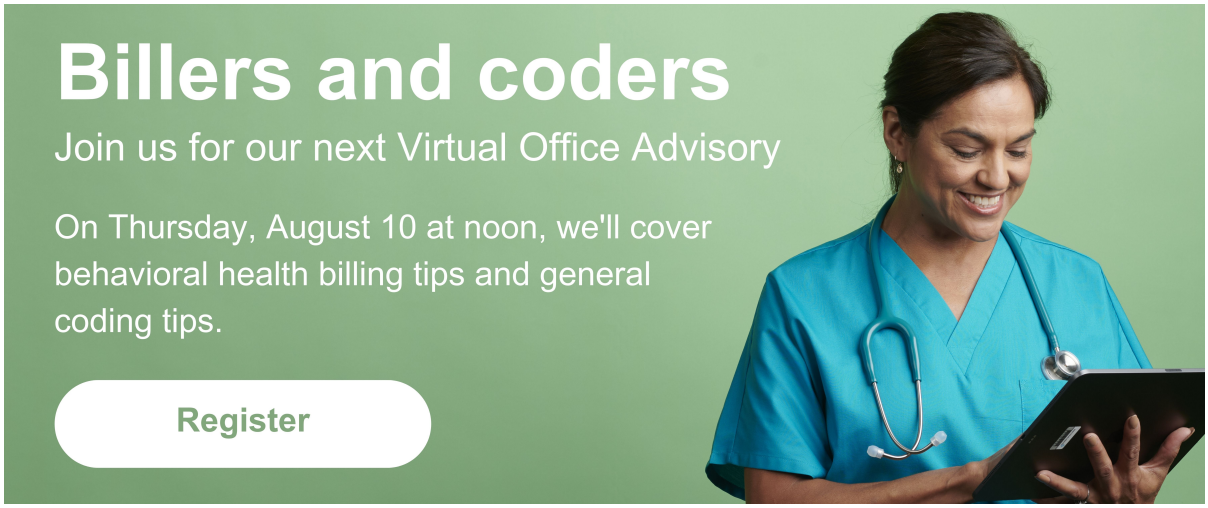
What do these codes cover?
G3002 can be billed monthly for chronic pain management and treatment including but not limited to diagnosis, assessment and monitoring, medication management, pain and health literacy counseling, and ongoing communication and care coordination between practitioners giving care. See our recent news item for a complete list and more details about the CM codes.

- *Requires initial visit at least 30 minutes in length provided by a physician or other health care professional able bill Priority Health, per calendar month.*

G3003 can be billed for each additional 15 minutes of chronic pain management and treatment by a physician or health care professional able to bill Priority Health, per calendar month.

- *List separately in addition to code for G3002. When using G3003, 15 minutes must be met or exceeded.*

We appreciate the work you do to help our members, your patients, with chronic pain be their healthiest.



Using your questions from the past quarter, our Provider Resolutions and Medical Code Review teams put together this list of tips to **save you time and energy** with your claims, appeals and more.

#1. Find front-end rejection details in prism, and resubmit corrected claims

You can quickly and easily find any front-end rejections that may have applied to your claim in prism.

1. Log into your **prism** account.
2. Open the **Claims** tab and click **Medical Claims**.
3. Under the **Search Front-End Rejected Claims** section, click to select or type in the **Start Date** using the M/D/YYYY format. Enter the same date for the **End Date**, then click **Search**.

This will return all front-end rejected claims for a provider with that date of service – including a column detailing the "Rejected Reason." With the front-end rejection information at hand, you can correct and resubmit your claim for payment.

We don't process appeals for front-end rejections.

#2. Submit one inquiry for multiple claims with the same issue

Do you have one issue affecting more than 10 members' claims?

1. **Use the "Contact us about this claim" tool in prism to send us an inquiry** for one of the impacted claims, noting in your message what the issue is and that it's happening to multiple members' claims.

2. **We'll investigate and contact you if we need more examples.** There's no need to submit an inquiry for each claim if one issue is affecting more than 10 claims.
3. **If an issue is affecting fewer than 10 members' claims, or it is a different issue for each member,** send us an inquiry using the **"Contact us about this claim"** tool for each individual claim.

#3. Audit your third-party appeal companies

Don't lose your one appeal right! We often get appeals from third-party companies that are incomplete. We encourage you to review or audit any third-party appeal company you may work with that's submitting on your behalf.

Providers have one post-claim appeal right with us, and every appeal submission we receive is treated as an official appeal.

See our "What makes a good appeal" document for tips on what to include with your post-claim appeals.

#4. Ensure services not covered, but chosen by the member, don't become provider liability

Pre-service organization determinations (PSODs) are requests used to determine whether an item or service will be covered for a Medicare member. The PSOD process is like the Traditional Medicare Advanced Beneficiary Notice (ABN) process, protecting all parties involved – the member, provider and Priority Health.

- **When the requested service is covered,** we'll provide the required confirmation.
- **When it's not covered,** we'll send the Notice of Denial of Medicare Coverage (CMS-10003) to the provider and member. This notice lets the member know they'll be liable for the cost if they pursue the service.

What to do if the member decides to pursue a non-covered service

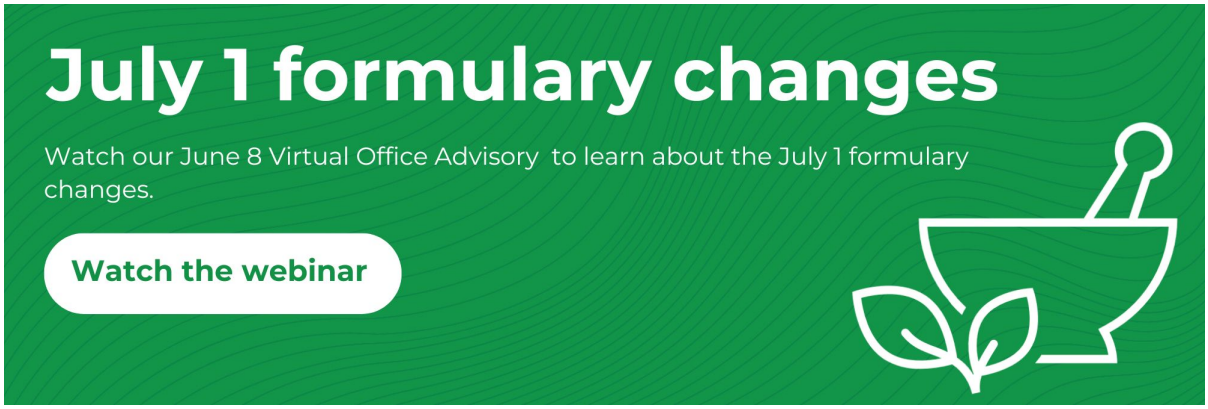
1. **Bill with modifier GA** if the Medicare member decides to move forward with the service knowing coverage has been denied. This will make sure the balance goes to member liability rather than provider liability.
2. **The member, their representative or their provider have the right to request a PSOD.** Find out how in our Provider Manual.

#5. Use prism's claim inquiry feature to ask questions about clinical edits

We frequently see incorrect submissions of provider questions related to clinical edits. To ensure a timely follow up from the appropriate team, follow this process for submitting a clinical edit question:

1. Log into your **prism** account.
2. Click **Claims** and then **Medical claims**.
3. Search for the claim in question. Click the **Claim ID**.
4. On the Claims Detail page, click **Contact Us About This Claim**.
5. Choose **Clinical Edits** from the dropdown menu.
6. Attach documentation, enter your message, and click **Send**.

See our Get Your Questions Answered document for more information on how to submit your inquiries to the appropriate Priority Health teams.



Medicare & Medicaid quality

Together, we can close your patients' gaps in care. From preventative screenings to managing chronic conditions, we're here to support you.

Get our latest Medicare & Medicaid quality newsletter to find tips to increase your 2023 PIP payment for the Kidney Health Evaluation for Patients with Diabetes measure, member benefits and more.

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 second quarter of 2023.

2023 PCP Incentive Program (PIP)

Patient Profile & PIP_070 will retire after the 2023 program year
Beginning with the 2024 program year, *Patient Profile* and *PIP_070 – Supplemental Data Worksheet* won't be accepted data sources for gap closure. ACNs may continue using the following standard data sources:

- MIHIN APS
- Direct data feed (HL7 / APS)
- Claims including CPT II codes
- Medical record submission (exclusionary data)

We'll continue accepting supplemental data for 2023 dates of service entered using the Patient Profile and PIP_070 – Supplemental Data Worksheet through Jan. 31, 2024 – allowing ACNs to close out the 2023 program year.

Video: PIP reporting breakdown

Did you miss our training where we reviewed the four most-used PIP reports? Watch the recording to learn about the purpose and content of each report, as well as how to use them together and separately.

WATCH THE RECORDING

Provider Roster Application (PRA)

We're excited to share that Accountable Care Networks (ACNs) can now batch upload group and subgroup data into the Provider Roster Application (PRA).

ACNs can now quickly import their desired group / subgroup settings via Excel file to see them reflected in applicable Filemart reports. Get details and instructions in our recently updated PRA Manual.

GET THE MANUAL

Login required

Important dates

Mark your calendars for this quarter's important dates:

- **August 1-15** – PRA attestation
- **September 1-15** – PRA attestation
- **Late September** – 3rd focus measure pre-payment
- **October 1-16** – PRA attestation

Close your Medicare patients' gaps in care and earn

You're likely to see more of your Medicare patients calling to schedule their Annual Wellness Visits (AWVs) and Comprehensive Physical Exams (CPEs). We recently reached out to our members who hadn't had these visits yet this year to encourage them to make an appointment to see you.

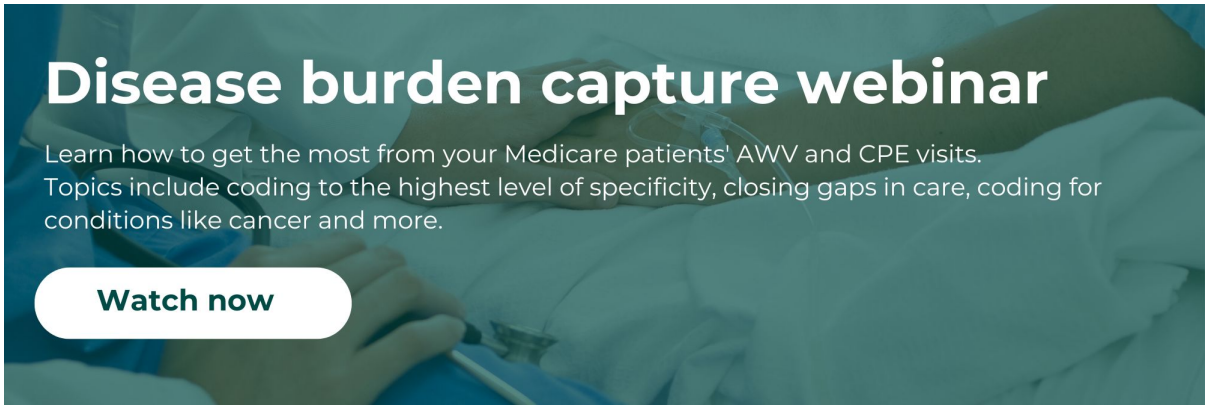
These AWVs and CPEs, both free to our Medicare members, offer a great opportunity to:

- Close your Medicare patients' gaps in care
- Increase your PCP Incentive Program (PIP) payments

How these visits impact PIP
At each AWV and CPE, you'll check several boxes that impact your practice's PIP performance. To help increase your potential 2023 PIP earnings:

- Be sure to **code each visit to the highest level of specificity**, providing an ICD-10-CM code carried to the maximum number

of digits for the code being used.
- **Submit supplemental data by Jan. 31, 2024**



Latest news

See the latest news posted to our website from April to June:

AUTHORIZATIONS

- Our transition to 2023 InterQual
- Two Midnight Rule: Our UM practices remain unchanged
- CPT code 99222 no longer used for authorizations

BILLING & PAYMENT

- Webinar on disease burden capture is now available on demand
- We're fixing incorrectly denied claims for Cigna members
- Claim form 1500 street address reminder
- Submitting surprise billing appeals as an out-of-network provider

PHARMACY

- FDA withdrawal of approval for Oxandrin® and generic oxandrolone tablets
- Recall of multiple drugs manufactured by Akorn Pharmaceuticals

PLANS & BENEFITS

- Priority Health Medicare Health Fair on Aug. 24
- July clinical edits
- Include disputed codes with your claim appeals

PRIORITY HEALTH

- Schedule your Medicare patients AWVs and CPEs today
- Q2 physician and practice news digests
- Post-PHE coverage changes for your patients and virtual billing updates

RESPONSIBILITIES & RESPONSIBILITIES

- Be sure to keep your practice name updated in our Find a Doctor tool
- Reminder: you must refer members to in-network providers, including labs
- Reminder to complete D-SNP Model of Care training
- Enhancing our payment integrity program
- May 2023 medical policy updates
- Medicaid redetermination

TRAINING OPPORTUNITIES

- Join us for our next Virtual Office Advisory (VOA) on August 10