PriorityHealth

Physician and practice news digest

Winter 2015

Billing and payment

Two new point-of-service hospital codes for inpatient hospital billing (p. 4)

Pharmacy

Home blood pressure monitors covered as pharmacy benefit beginning Dec. 1 (p. 4)

Reminder: Formulary updates (p. 4)

Reminder: Step therapy required for select drug categories (p. 5)

and more…

Authorizations

Advance Beneficiary Notices discontinued for non-covered Medicare Advantage services (p. 6)

AIM requires member ID numbers on all orders (p. 7)

Pending/retired/updated medical policy list (p. 7)

Performance programs

2016 Incentive program (p. 8)

2015 Quality Award recipients announced (p. 8)

Plans and benefits

Medicaid copays removed Oct. 1 (p. 9)

2016 preventive health care guidelines changes (p. 9)

and more…

Responsibilities and standards

Reminder: Reporting potential fraud and abuse (p. 10)

Clinical resources

Free diabetes prevention classes for members (p. 10)

Register your online account at *priorityhealth.com* for full access to patient tools and incentive program information. Visit *priorityhealth.com/provider* to read this digest online.

SPOTLIGHT ON:

New plan options for 2016

As a non-profit health plan, we've worked for 30 years to keep health care affordable while improving the health and lives of our Michigan neighbors. We're committed to offering product options to individuals no matter where they are in life — and in 2016, we'll offer new plan types to meet growing consumer demand.

Spectrum Health Partners

For 2016, we're introducing plans with a narrow network available only to residents of Kent County. These plans, called Spectrum Health Partners, give consumers the option to receive some of the lowest monthly premiums while receiving high quality care from one of the nation's top 15 hospital systems.

West MI Partners

We're also launching a tiered network for employer groups that provides member access to all of the providers in Priority Health's network. West Michigan partners, our tiered network, gives members access to high quality providers at a lower cost to the member. Members will have financial incentives to stay within the tier 1 network.

Learn more about these networks at *priorityhealth.com/provider/manual/plans/networks.*

New holistic and exercise reward benefits

We've partnered with American Specialty Health (ASH) to deliver holistic care benefits in 2016 to members in select individual and small group plans.

Acupuncture and medical massage

We're proud to be the first carrier in Michigan to partner with ASH to offer acupuncture and massage when medically necessary. We're the only plan available to Michigan individual consumers that combines traditional benefits and holistic care features.

ExerciseRewards

We are also partnering with ASH to offer ExerciseRewards™, a program that allows members to receive discounts at local gyms and to earn cash rewards for being active. We ask that you encourage your patients in these plans to keep fit by tracking their fitness and maximizing their $120 annual reward.

Check out all of our plan offerings at *priorityhealth.com/plans.*

Billing and payment

Two new point-of-service codes for inpatient hospital services

(10-06-2015) The Centers for Medicare and Medicaid Services (CMS) will have two Place of Service (POS) codes for outpatient hospital services effective Jan. 1, 2016. CMS has changed the definition of POS 22 and added a new POS 19.

- POS 19 - Off-Campus Outpatient Hospital
- POS 22 - On-Campus Outpatient Hospital

Priority Health will implement this change Jan. 1, 2016 per CMS guidelines.

For additional information, visit *wpsmedicare.com*.

Pharmacy

Home blood pressure monitors covered as pharmacy benefit beginning Dec. 1

(11-10-2015) For over five years Priority Health has covered home blood pressure monitors as a Durable Medical Equipment (DME) benefit for nearly 70,000 members managing hypertension. Beginning Dec. 1, 2015 we're expanding this coverage as a pharmacy benefit. Now our commercial members have easier access to the monitors they need to support their efforts to control hypertension.

A hand-written or faxed prescription is required (due to EMR limitations) for all home blood pressure monitors. Omron brand monitors are the only brand that will be covered as they have been clinically validated in literature. Both pharmacies and members have been made aware of this expanded benefit.

For questions, call the Pharmacy call center at 800.466.6642.

Reminder: Formulary updates

(10-15-2015) The Pharmacy and Therapeutics Committee meets every other month to review the Priority Health formulary. Our pharmaceutical management procedures are reviewed annually. Both are available online in the "drug auths" section of the Provider Manual.

How to get a copy of our formulary

The updates are available at *priorityhealth.com/provider*.
Search keywords: Printable drug list

Questions about utilization management decisions and processes?

Physician and pharmacist reviewers are available to help you. Call the Priority Health pharmacy department at 800.466.6642.

continued >

Pharmacy

Reminder: Step therapy required for select drug categories

(10-15-2015) Within the Priority Health commercial formulary some drug categories require step therapy, or the therapeutic trial of an alternative drug or drugs before authorization is granted for the originally requested medication.

The following drug classes require step therapy:

Celebrex
Celebrex requires documented trial with two of the following NSAIDs:

- Meloxicam (Mobic)
- Diclofenac (Voltaren)
- Nabumetone (Relafen)
- Etodolac (Lodine)

Prior authorization is available for members who are at high risk for a GI bleed.

Antidepressants
Brand-name antidepressants require documented trial with at least one generic antidepressant first.

Antipsychotics
Brand-name antipsychotics require a documented trial with at least one generic atypical antipsychotic.

Triptans
Brand-name triptans for treatment of migraine require a documented trial with at least one generic triptan.

Reminder: Availability of physician and pharmacist reviewers

(10-15-2015) Questions or concerns regarding our utilization management decisions can be referred to your Provider Account Representative or the pharmacy department at 800.466.6642. We may use physician and pharmacist reviewers to assist you.

Reminder: Generic drug substitutions

(10-15-2015) Priority Health has a generic substitution policy that mandates coverage of generics when an A-rated or equivalent generic is available.

Members may have to pay the difference

Currently, if a member or physician requests the brand-name product, the member may have to pay the difference in cost between the brand and generic drug plus their copay. This is known as the "member pay difference" (MPD).

Dispense-as-written (DAW) prescriptions

DAW prescriptions can be prescribed and filled. Brand-name medications with authorized generics available are not eligible for DAW authorization. Authorized generics are prescription drugs produced by the brand pharmaceutical company and marketed under a private label at generic prices.

Exceptions to the policy

Authorizations for the MPD override may be given for the following exceptions:

- Members on Coumadin® (no authorization required, automatic brand copay)
- Patients who are color-blind and require a specific brand for identification purposes
- Patients with a documented allergy to an inactive component of the generic product
- Epilepsy meds: Patients currently stabilized on brand medications for epilepsy may have their physicians request continuation on the brand with no MPD, however, brand copay still applies. Members starting on epilepsy therapy, or those taking anti-epileptic medications for indications other than epilepsy, will be required to pay MPD if a brand is chosen.

Authorizations

Advance Beneficiary Notices discontinued for non-covered Medicare Advantage services

(10-12-2015) As of Dec. 7, there is a new process for providers who have Priority Health Medicare Advantage members seeking services that may not be covered. Providers who do not follow the new process are responsible for any costs associated with the denied claim and cannot bill members for any portion of a denied claim.

Due to guidance issued by The Centers for Medicare and Medicaid Services (CMS), providers may no longer use an Advance Beneficiary Notice or similar waiver for members of Medicare Advantage plans.

Instead, providers must request a pre-service organization determination from Priority Health. That determination will generate a Notice of Denial of Medicare Coverage (or Payment). Request an organization determination if:

- The provider is not sure if the service is covered or
- The exclusion in the member's Evidence of Coverage (EOC) is not clear

EOCs are available online. Click your patient's plan to see their specific EOC.

Checking for coverage

If you're not sure a service is covered, we recommend using a medical necessity software checker. If the checker says the service denies, check the member's EOC to identify if there is a "clear exclusion." If it is not a clear exclusion, request an organization determination from Priority Health. If you don't have a medical necessity checker, log in to use the Priority Health Edits Checker tool and enter the claim. If a service may be denied, request an organization determination.

How to bill members for non-covered services

The member must:

- Receive a Notice of Denial of Medical Coverage (CMS-10003) from Priority Health (sent after the pre-service organization determination is requested by the provider)

or

- If there is a "clear exclusion in the member's EOC you may provide the service but Priority Health requires the provider to inform the member of the "clear" exclusion and document that in their record.

and

- Elect to receive the non-covered service by signing an optional form that acknowledges they understand they're liable for any costs (members cannot sign an ABN form, and the form must be kept in the patient's record)

Requesting a pre-service organization determination

To request an organization determination if a service is not covered, complete the Medical Prior Authorization form and fax it to 888.647.6152. Decisions will be made within 14 calendar days. Urgent decisions require proof of medical necessity; these decisions will be made within 72 hours. Members and providers will receive written notification of the decision.

Questions?

Contact the Provider Helpline at 800.942.4765 or view the organizaton determination webpage at *priorityhealth.com/provider/manual/billing-and-payment/medicare-noncoverage*.

Authorizations

AIM requires member ID numbers on all orders

(10-19-2015) As of Oct. 24, when you use the AIM ProviderPortal℠ you are required to enter your patients' health plan member ID number when initiating a new order or checking on the status of a previous order.

In addition, you will be prompted to enter either:

- Patient first and last name or
- Patient date of birth

Priority Health member ID numbers can be found on the member's ID card, or online through the Member Inquiry tool in our online Provider Center. This change is part of AIM's security enhancement improvements and will provide greater protection of your patients' private health information.

Questions?
If you have any questions about this change or entering your online order, contact the AIM Provider Portal Support Team at 800.252.2021.

Pending/retired/updated medical policy list

(09-30-2015) From time to time, we make changes to our medical policies. This list shows the policies that are new or have recently been changed. All policy changes are posted to our website so you can review the changes before they go into effect.

Find summaries of the recent and upcoming changes at *priorityhealth.com/provider/manual/auths/medical-policies/policy-changes*. Or use the search box on our website to search for a policy by name or policy number.

Effective Jan. 1, 2016

- NEW Gender Reassignment Surgery for Medicare Members - 91612

Effective Oct. 1, 2015

- Bone Density Studies - 91494
- Carotid and Intracranial Artery Stenting - 91495
- Cranial Helmets - 91504
- Drug-Eluting Stents for Ischemic Heart Disease - 91580
- Fetal Surgery - 91120
- Hearing Augmentation - 91544
- High-Intensity Focused Ultrasound - 91601
- Lumbar Fusion - 91580
- Menorrhagia Treatment - 91575
- Monochromatic Phototherapy (anodyne therapy/mire therapy/low level light therapy) - 91486
- Neuropsychological and Psychological Testing - 91537
- Orthotics/Support Devices - 91339
- Panniculectomy/Abdminoplasty - 91444
- Platelet Rich Plasma/Platelet Rich Fibrin Matrix/Autologous Blood-Derived Product - 91553
- Radiosurgery - 91127
- Spine Centers of Excellence - 91531
- Stem Cell or Bone Marrow Transplantation - 91066
- Transplantation of Solid Organs - 91272
- NEW Urolift Prostatic Urethral Lift - 91613
- Uterine Fibroid Treatments - 91573

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Performance programs

2016 Incentive program

(11-05-2015) At Priority Health, we continue to reward prevention, improved clinical outcomes and the delivery of cost-effective care. The 2016 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 is highly aligned with 2015 and continues the focus on care management. It has one new tobacco cessation measure, one retired measure, and slight modifications to five existing measures.

Final versions of the manual and measures chart will be available at *priorityhealth.com/provider* by the end of 2015.
Search keywords: Performance programs

2015 Quality Award recipients announced

(08-04-2015) This year, 245 physicians and practices in our network were recognized with the Priority Health Quality Award. These practices achieved the highest overall scores for preventive care and chronic disease management while ensuring a good patient experience.

How recipients are selected

Recipients are selected after analyzing the results of the Priority Health Primary Care Provider Incentive Program, a program that tracks clinical quality measures against national standards and evidence-based medicine. We rewarded physicians with $22 million in 2015 based on their performance in 2014.

Key success measures

The program's success is clearly demonstrated by the number of practices earning the primary care medical home (PCMH) designation as well as participants' demonstrated success in chronic disease care. By collaborating with physicians, Priority Health has successfully helped health plan members avoid incidence of chronic disease complications for conditions such as congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, asthma and hypertension at rates better than state and national averages.

Learn more about the Quality Awards and see a list of the 2015 recipients at *priorityhealth.com*.
Search keywords: Quality awards

Plans and benefits

Medicaid copays removed Oct. 1

(09-01-2015) As of Oct. 1, Priority Health Choice, our traditional Medicaid plan, removed copays for all members who are over 21 years old. The new copays are $0. This is a global change that will affect all services. Primary care visits did not have copays and will continue to have none.

This change impacts all emergent, pharmaceutical, device and specialist services. The administrative decision is in response to a request for reconsideration from the Michigan Department of Health and Human Services (MDHHS).

The Provider Manual and Member Inquiry tool was updated to reflect this change as of October 1. Providers can check the Member Inquiry tool for up-to-date benefits information.

2016 preventive health care guidelines change

(08-07-2015) Our health plans cover preventive services as outlined by the Affordable Care Act and recommended by the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention and the Health Resources and Services Administration. By following these guidelines, we're making sure the care we recommend and cover as preventive is safe and effective according to the latest medical research.

Note that Medicare has separate guidelines for preventive services covered for Medicare Advantage patients. You can always find information on both our Guidelines and Medicare preventive care:

- At *priorityhealth.com/preventive*
- In the Members area of *priorityhealth.com* both as web pages and printable PDFs

Also see our online Provider Manual for coding and billing help for preventive services.

Digital breast tomosynthesis will be covered as of Jan. 1

Beginning Jan. 1, we will cover digital breast tomosynthesis (DBT) for breast cancer screening at 100% in response to the dense breast notification legislation recently passed in our state. However, this screening is available to all women who fall within the breast cancer screening guidelines. We encourage doctors who believe their patients would benefit from DBT to ensure they visit an imaging center that has the equipment to perform this service.

Coverage notes: Covered once every 2 years for women ages 50-74. Begin at age 30 for those at high risk or at your doctor's discretion.

Responsibilities and standards

Reminder: Reporting potential fraud and abuse

(10-15-2015) 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.

Get complete details at *priorityhealth.com*.
Search keywords: Fraud and abuse

Clinical resources

Free diabetes prevention classes for members

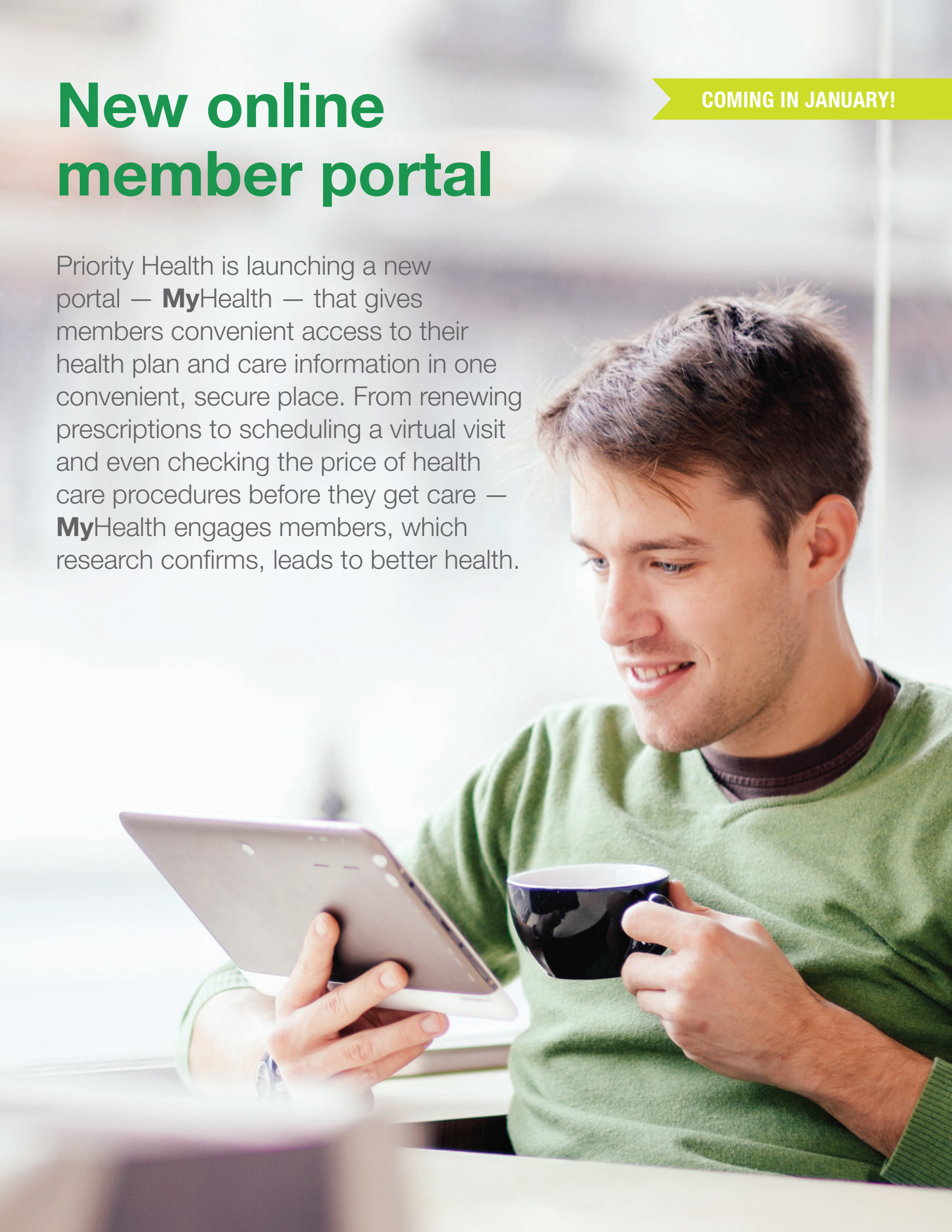
(09-02-2015) As part of our commitment to improve the health and lives of our members, Priority Health continues to offer the National Diabetes Prevention Program free to our members who are at-risk for developing type 2 diabetes. Through partnerships with various organizations in the communities we serve, we're offering the nationally recognized program proven to reduce the risk of developing type 2 diabetes by up to 58%, according to the Centers for Disease Control, by giving participants information and support to make healthy lifestyle changes.

2016 sessions will be offered in locations statewide
Help your patients be their healthiest by referring them to these classes. For more information on 2016 programs or registration, visit *priorityhealth.com/prevent-diabetes.*

New online member portal

COMING IN JANUARY!

Priority Health is launching a new portal — **My**Health — that gives members convenient access to their health plan and care information in one convenient, secure place. From renewing prescriptions to scheduling a virtual visit and even checking the price of health care procedures before they get care — **My**Health engages members, which research confirms, leads to better health.



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