Priority Health

Login

PriorityActions
FOR PROVIDERS

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Welcome to our biweekly PriorityActions for providers, where you'll receive important information to help you work with us and care for our members.

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You're receiving this email because you're a part of an Accountable Care Network (ACN) or Provider Organization (PO) with us. Please share relevant information with your provider groups and practices. Your Provider Strategy & Solutions Consultant remains your primary contact for support.

INCENTIVE PROGRAMS

Updated 2024 PIP Manual available

We recently updated our 2024 PCP Incentive Program (PIP) manual (login required).

To access the manual after logging into your account through the link provided, click **PCP Incentive Program** in the menu then click the **Get the 2024 PIP Manual** button. You can then bookmark the manual URL in your browser for quick access.

Here's a summary of the changes:

Administrative details (pg. 7)

Under the *ACN payment rules* section, we clarified that discrepancies with settlement payments must be brought to Priority Health's attention within two weeks of the ACN receiving settlement reporting.

Care management (pg. 15)

We expanded our definition of the staff who can provide care management services under the supervision of a PCP. This change aligns with industry standards and will make it easier for ACNs to meet the CM measure's requirements.

- Qualified Health Professional (QHP) definition and licensure requirements have been removed.
- Initial and continuing education requirements are still required for clinic staff on the care team who are providing care management services.

2024 DBM preliminary payments were mailed

Preliminary payments for the 2024 Disease Burden Management (DBM) Program went out in August. Settlements were issued via paper check and mailed to eligible ACNs.

Who received a preliminary payment?

As part of the DBM program's PCP Visits incentive, ACNs with providers who saw 70% or more of their attributed patients by May 31, 2024 earned a preliminary payment. See the DBM Program Manual for more information.

Interested in learning more about how to be successful in the DBM program?

Contact your Risk Adjustment Specialist or your Provider Strategies and Solutions Consultant to schedule a meeting.

Thank you for your ongoing partnership and dedication to providing our members, your patients, high quality care.

Updated 2024 HEDIS Provider Reference Guide available

We recently updated our 2024 HEDIS Provider Reference Guide (login required).

To access the manual, after logging into your prism account through the link provided, click **Quality Improvement**. You can then bookmark the manual URL in your browser for quick access.

Here's a summary of the changes.

Page 32: Glycemic Status Assessment for Patients with Diabetes (GSD) measure

- **Added clarification on how to interpret the rate for this measure:** We added a note stating that, because the rate for this measure is inverted, a lower rate reflects higher performance.
- **Updated numerator compliance:** The numerator compliance section was updated to state that glycemic status must be ≤9% to show evidence of control.
- **Corrected required exclusions:** The required exclusions section was corrected due to inaccurate information.

Page 39: Kidney Health Evaluation for Patients with Diabetes (KED)

- **Corrected test, service or procedure to close care opportunity:**The test, service or procedure to close care opportunity section was corrected due to inaccurate information.

Page 202: Colorectal Cancer Screening (COL-E)

- **Updated billing codes**

AUTHORIZATIONS

Reminder: Radiation oncology authorization program with EviCore launches September 15

Our radiation oncology authorizations program with EviCore, first announced in June, will launch on September 15. On that date, authorization requests initiated in **prism** for impacted codes performed in an outpatient setting will be automatically redirected to EviCore's provider portal to complete the request.

Be sure to check if you have treatments already scheduled that will now require authorization. Review the impacted code lists to see which services and procedures will be managed by EviCore on our members' behalf. **Bolded** codes are those that don't currently require authorization but will for dates of service on / after September 15.

Below is an FAQ to support your success:

How do you submit an authorization through EviCore?

Our provider portal, prism, will automatically redirect you to EviCore to complete authorization requests when appropriate – no separate login needed. Find step-by-step instructions in our provider training slides.

What if you've already submitted a request through GuidingCare?

If you've already submitted an authorization request to Priority Health through GuidingCare, there's no need to resubmit through EviCore. Your existing authorization request will be honored.

What if your patient is undergoing treatment when this authorization program goes live on September 15?

We'll honor all radiation oncology courses of treatment that are in progress as of EviCore's management, effective Sept. 15, 2024. Modifications to existing authorizations, such as date extensions, are managed through Priority Health. Contact Priority Health to determine if an authorization for the services underway is already on file.

What if there's a change in the approved treatment plan (such as adding IGRT or additional treatments)?

An authorization is only valid for the treatment plan requested. A new medical necessity determination is needed for any new or modified treatment plans. If you need to change the plan during the course of treatment, contact EviCore. It's strongly recommended to call EviCore as soon as it is known there is a change in treatment plan and prior to billing for the corresponding services.

Are provider trainings available?

Yes! EviCore has hosted three provider training webinars, with one remaining on September 17 at 1 p.m. ET. Registration is available online.

Where can you find additional information?

Below you can find links to additional information to help you and your providers be successful through this transition:

- Provider training webinar slides – including an overview of the program, how to submit requests and contact information in case you have questions
- Provider FAQs – answers common questions about EviCore
- Impacted procedure codes – lists the procedures that will be managed by EviCore when performed in an outpatient setting starting September 15

- Clinical guidelines – search for Priority Health to find applicable clinical guidelines. Before September 15, click the **Future tab** to access the guidelines.

BILLING AND PAYMENT

New and updated billing policies are available in our Provider Manual

In alignment with industry standards, we've posted several new billing policies to the Provider Manual.

Policies going into effect Nov. 11, 2024

The following policies and policy updates will go into effect on Nov. 11, 2024. Below are links and a high-level overview of each policy. Please see each policy for specific billing, coding and reimbursement details.

Advance care planning (ACP) billing policy
Modifier 33 is required for ACP to be considered a preventive service for all products. For Medicare plans, we're aligning with CMS to pay as preventive once per year when billed with an annual wellness visit (AWV). For commercial plans, we'll pay as preventive visit once per quarter. More frequent billings will still be considered, but cost share will apply. This is a new policy.

Advanced Practice Professionals (APP) billing policy
We're better aligning with CMS requirements for mid-level billing. Mid-level providers are paid differently when billing directly for versus "incident to" services (those billed under the NPI of a supervising physician). This is a new policy.

E/M services billed with treatment room revenue codes policy
In alignment with industry standard, we'll deny claims billed with treatment room revenue codes (760, 761 and 769) when billed with an E/M service. This is a new policy.

Lab and pathology billing policy
We'll require providers to append panel codes (87800 or 87801) when billing three or more infectious agent lab tests. Impacted lab tests include 87468-87799. This update is in alignment with CMS guidelines associated with the panel code verses individual code reporting. This is a policy revision.

Positive Airway Pressure (PAP) devices for treatment of sleep apnea billing policy
We're aligning to CMS standards for limits on supplies. This is a new policy.

Professional and technical components status indicator payment policy
We're aligning with CMS's professional and technical status indicator requirements. This is a new policy.

Wound care and debridement billing policy
We're aligning with CMS policy on the proper use of modifiers 59, XE, XP, XS, XU. These separate and distinct modifiers will only be appropriate when performed at a separate location – they'll no longer be appropriate when performed in a separate session. This is a policy revision.

Additional policy updates

Additionally, the following policies were recently posted to or updated in the billing / coding policies page in our Provider Manual. The new policies and revisions outline our **current** requirements for transparency. Please see the individual policies for details:

- Cardiology billing policy (Revision)
- Critical care billing policy (New)
- Diabetes education billing policy (Update)
- ECG interpretation billing policy (Revision)
- HIV prognosis and monitoring billing policy (New)
- Miscellaneous DME coding policy (Revision)
- MSK shoulder billing policy (New)
- Nutrition counseling, education and therapy (Update)
- Osteopathic manipulation treatment (OMT) billing policy (Revision)
- Prostate biopsy pathology billing policy (New)
- Psychiatry and psychology services coding policy (New)
- Radiology PC / TC multiple same-day billing policy (New)
- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) payment policy (New)
- Sepsis billing policy (New)
- Trauma team activation billing policy (Revision)
- Unbundling policy, inpatient and outpatient (Revision)

Changes coming for Medicaid claims submissions for select home health care services

The Centers for Medicare & Medicaid Services (CMS) will soon require states use an Electronic Visit Verification (EVV) system to validate claim submissions for select home health care services covered under Medicaid. The State of Michigan has selected the vendor HHAeXchange to manage these claims.

How will this impact providers?

Providers will be required to submit Medicaid claims for the following services/codes to HHAeXchange, rather than directly to Priority Health. **Note**: This change only impacts Medicaid claims. Medicare and commercial claims won't be affected.

Code	Service
G0151	Services performed by a qualified physical therapist in the home health or hospice setting
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting
G0156	Services of home health/hospice aide in home health or hospice settings
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting
G0300	Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting

When will this change go into effect?

Providers can begin submitting impacted claims to HHAeXchange beginning September 3. The EVV effective date, at which time claims will only be accepted if submitted directly to HHAeXchange, hasn't been determined by the state of Michigan.

How can providers prepare for this change?

We encourage home health care providers to complete onboarding through HHAeXchange to ensure an easy transition.

Learn more about onboarding through HHAeXchange.

What's EVV?

EVV confirms the following encounter information submitted through claims is complete and accurate:

- Date of visit
- Time of visit
- Location of visit
- Type of care or home health care service(s) provided
- Provider name
- Patient name

PLANS AND BENEFITS

Transportation assistance is moving to SafeRide for your Priority Health Medicaid patients

Starting September 8, all transportation assistance for your Priority Health Medicaid patients, including non-emergent medical transportation (NEMT), will be scheduled through SafeRide. SafeRide coordinates travel using ride-share options, like Uber or LYFT, and will dispatch NEMT providers for special assistance, like wheelchair services.

What's changing?

Currently, transportation assistance for Priority Health Medicaid patients is coordinated through Priority Health. On September 8, this will transition to SafeRide.

How do your Priority Health Medicaid patients schedule a ride through SafeRide?

To schedule a ride on or after September 8, eligible patients must call SafeRide at 833.944.0535. SafeRide is available 24 hours a day, 7 days a week. Calls for a ride must be made at least three business days before the patient's scheduled appointment.

Will this change how providers get authorization for food and lodging for their patients traveling long distances to appointments?

No. To get authorization for meals and lodging for your Priority Health Medicaid patients traveling over 50 miles for their appointments, continue to contact the designated provider line at 616.575.5770.

How are we communicating this to patients?

Your impacted patients were sent an email and/or a letter communicating this change and offering instructions on how to schedule with SafeRide.

Updates on seeing key provider information in Find a Doctor

Find a Doctor is used by you and your patients to access a variety of provider demographic information, but a recent change in functionality means that you'll need to do something slightly different to see:

- Whether a provider is accepting new patients
- What tier a provider is in for tiered networks

What's different?

Due to recent updates, you can no longer see whether a provider is accepting new patients and the tier information for health care plans when searching with "all plans" selected. However, this information is still available when you select a specific plan. See this one-pager for details.

Why the change?

Search results with "all plans" selected occasionally included inaccurate information. This change in functionality fixes that issue.

Still have other Find a Doctor questions?

Please see our Find a Doctor 101 one-pager for a guide to using the tool and seeing a patient's plan information.

Questions? Connect with your Provider Strategy & Solutions Consultant.

Access an archive of our PriorityActions for providers emails here.