Priority Health

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Physician & practice news digest

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Message from the Medical Director

Caring for our moms and babies

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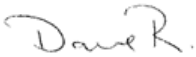
We're always striving to help your patients, our members, get the right care, at the right time. One way we do this is supporting maternal care, both before and after baby is born.

We're offering Priority Health Medicaid members new rewards to help them through their pregnancies and decrease the risks of low birth weight and long-term health complications in infants. Beginning May 1, they're eligible for more than $100 in gift cards: $20 for notifying us of their pregnancy in the first trimester, $50 for completing at least four visits with a doula, and $50 for seeing a provider between 7 and 84 days after delivery.

We also continue to offer our PriorityMOM™ and PriorityBABY™ programs to our commercial (group and individual) and Medicaid members.

- PriorityMOM™ supports expectant mothers during pregnancy with gifts and educational resources, all aimed to improve health outcomes for mom and baby.
- To expand on the success of that program, we created PriorityBABY™ to support children and their caregivers during a child's first two years with more gifts, incentives and educational resources.

I invite you to encourage our pregnant members to enroll in these programs. Thank you for your continued partnership as we strive to support our members through every stage of life.



Billing & coding tips

Using provider inquiries, issues and data from the past quarter, our teams put together this list of tips to save you time and energy with your claims and more.

#1. Submit all claim corrections with frequency code 7.

Effective June 2, 2025, all submitted claims requiring a correction – both facility and professional, regardless of any allowed / paid amount on the original claim – will require submission of a corrected claim with frequency code 7.

Amount allowed on original claim	Current process	Process effective June 2
$0 allowed	Submit a new claim	Submit a corrected claim with frequency code 7

Amount allowed on original claim	Current process	Process effective June 2
Partially or fully paid	Submit a corrected claim with frequency code 7	Submit a corrected claim with frequency code 7

After June 2, new claims submitted to correct an original claim with $0 allowed will be rejected with the direction to submit a corrected claim instead.

This change supports our alignment with the Centers for Medicare and Medicaid Services (CMS) regulations that state all rebills for $0 allowed claims are corrected claims and must be billed with frequency code 7.

#2. See in prism exactly why your claim denied.

It's important to us that you understand how your claims were processed and why. We recently improved the Claims section in prism, pulling all claim denial details and rationale into one place. There are no additional buttons to click or external resources to access.

We highly recommend you reference prism to understand claim denials, not the CARC/RARC denial codes that appear on your electronic remittance advice (ERA/835) files. These CARC/RARC denial codes are generic while the prism denial codes are specific to the denied code and include denial rationale.

To see how your claim processed and any denials that may have applied:

1. Log into your prism account.
2. Click Medical Claims under the Claims tab.
3. Search for the claim in question and click the Claim ID.
4. Scroll down to the Line Billed Detail and look for the Claim Line Explanation. There, you'll now see the denial code, details and rationale – all in one place.

In some cases, when the rationale is lengthy, you'll see a "see more" option to expand for further detail.

#3. Code to the highest degree of specificity.

Accurate diagnosis coding provides Priority Health with a snapshot of medical conditions affecting our member population. Once you identify and document the most accurate diagnosis, we can provide members with information on maintaining a healthier lifestyle.

To code diagnoses to the highest degree of specificity:

1. Use the most current ICD-10 codes and code books, which are updated annually.
2. Accurately document conditions that can be reported with combination ICD-10 codes.

3. Use the most specific diagnosis available when there are multiple forms of a given diagnosis.
4. Use the “history of” Z code on diagnosis codes for conditions the member no longer has.
5. Watch for certain diagnosis codes that can only be billed in the first-listed or primary diagnosis field, according to ICD.

GET MORE TIPS

#4. (Re)watch our recent billing webinar for more tips.

We recently hosted a webinar with important information and tips, including:

- Credentialing and enrollment tips: How to set up a new group, add a provider to an existing group and update provider information
- Clinical edits and misused modifiers: The most commonly seen clinical edits and misused modifiers and how to correct these issues and bill appropriately
- Behavioral health billing: Ensuring your staff is credentialed appropriately, getting authorizations when necessary, coding diagnoses to the highest specificity and more
- Ambulance billing: Tips and reminders for successful ambulance billing
- Including more than 12 diagnosis codes on a claim

WATCH THE WEBINAR

Medicare & Medicaid quality

Together, we can close care gaps for your patients, our members. From preventive screenings to managing chronic conditions, we’re here to

support you.

Get our latest Medicare & Medicaid quality newsletter to learn more about improving health outcomes with our medication adherence reports, coding to close care gaps in the Postpartum Care HEDIS measure, Social Determinants of Health (SDOH) screenings, improving well child visit scores in underperforming counties and more.

DOWNLOAD THE GUIDE

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 2025.

PCP Incentive Program (PIP)

2024 PIP settlement
Our 2024 PIP settlement will take place in June, as it has in previous years. As in 2023, for the 2024 performance year, settlement will take place at the Accountable Care Network (ACN) level. Please reach out to your ACN with any questions.

2024 Quality Awards
We'll once again award the top physicians in our network through the 2024 Quality Awards. These are awarded following settlement and will go to individual practitioners across the state exemplifying high quality care for our members. Stay tuned for additional details.

2025 Filemart reports
The first 2025 Filemart reports were released in March to ACNs. Please contact your ACN to receive reporting for your practice.

Disease Burden Management (DBM) program

2024 DBM settlement
Due to a system reporting error, 2024 DBM settlement and 2025 March DBM reports are delayed. Please reach out to your ACN with questions.

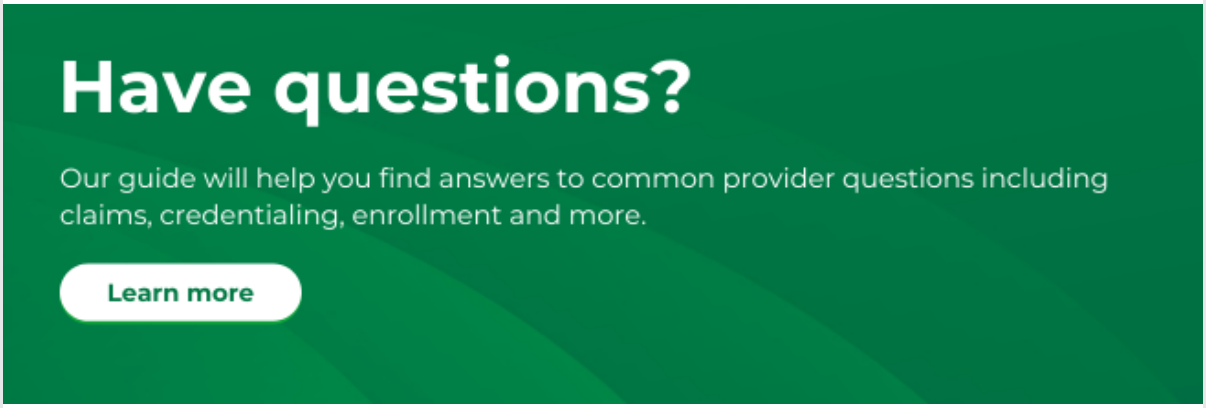
2025 DBM target lists
Your first DBM target lists for 2025 were sent in March. We recommend using these lists to identify and engage your higher risk patients to encourage them to get the care they need as soon as possible. Getting care earlier in the year allows you more time to accurately assess and treat your patients' chronic conditions and helps us provide necessary programs, resources and care management support.

How to report additional diagnoses on claims forms
Our April Billing & Coding provider webinar offers education on documenting your patients' chronic conditions when claims forms are limited to twelve diagnoses or fewer.

WATCH THE WEBINAR

We have new resources to support accurate disease burden capture

- Correctly coding and documenting cancer
- Documenting malignant neoplasms
- Information on the CMS-HCC V28 updates



Latest news

See the latest news posted to our Provider Manual from February 2025 to April 2025:

AUTHORIZATIONS

- Authorizations appeal update effective June 2
- Reminder: EviCore radiation oncology authorization program & resources
- We'll use 2025 InterQual criteria starting June 2
- Authorization requests for diagnostic imaging procedures 73700 and 73200 now auto approve
- New prior authorization requirement for cardiac procedures 92924 and C1605 effective Apr. 21, 2025
- New authorization requirement for renal denervation, effective Apr. 6, 2025

- Reminder: Call backs aren't available for missed peer-to-peers for inpatient cases
- Updated TurningPoint provider training guide now available

BILLING & PAYMENT

- New and updated billing policies now available (April)
- Update to corrected claims goes into effect June 2
- Reminder: Claim dispute (appeal) decisions are delivered via prism
- New and updated billing policies now available (March)
- We're reprocessing select doula telemedicine claims due to an error in the MDHHS fee schedule
- We're resolving some Medicaid claims rejecting incorrectly for missing or invalid date of death
- New and updated billing policies are now available (February)
- Seeing in prism why a claim denied is now easier than ever

INCENTIVE PROGRAMS

- Updated 2025 PCP Incentive Program (PIP) manual now available
- Updated 2025 PIP and DBM program manuals are now available

PHARMACY

- A reminder of our processes for submitting drug coverage authorization requests and appeals
- Coverage changes coming for Stelara, Yesintek and Selarsdi
- Changes in TREMFYA coverage coming Apr. 1, 2025
- Prior authorization changes coming for diabetic insulin supplies for Medicare members
- Medicaid formulary changes coming Feb. 1, 2025

PLANS & BENEFITS

- New member rewards supporting maternal care for your Priority Health Medicaid patients

REQUIREMENTS & RESPONSIBILITIES

- Reminder: You must complete our 15-minute, CMS-required D-SNP Model of Care training by Dec. 31
- We're collecting records for our Medicare retrospective chart review
- Provider re-enrollment for the Vaccines for Children program closes on April 1
- February 2025 medical policy updates
- 2025 D-SNP MOC training is now available
- Medicaid formulary changes coming Feb. 1, 2025
- NCQA's 2025 HEDIS audit is underway policy

PRIORITY HEALTH

- National Prescription Drug Take Back Day April 26
- Guidance on coding and submitting documentation for exclusion conditions in a virtual visit for the SUPD and SPC measures
- Get our 2025 member outreach calendar
- We're collecting medical records for our Medicare retrospective review

- Pontiac General Hospital is no longer part of the Priority Health network
- We're closing fax number 616.975.8856
- Get at-home colorectal cancer test kits for your eligible Priority Health patients
- Reminder of our CPAP & BiPAP rental guidelines

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