Priority Health

Login

PriorityActions
FOR PROVIDERS

Authorizations | Billing and payment | Priority Health

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

April 3, 2025
Issue #3.7

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 Network Management Specialist remains your primary contact for support.

AUTHORIZATIONS

We'll use 2025 InterQual criteria starting June 2

Beginning June 2, 2025, we'll use 2025 InterQual® criteria to make medical necessity determinations on prior authorization requests to ensure our members are getting the right care, at the right place and at the right time.

Why are we updating to 2025 InterQual?

InterQual is nationally recognized as an industry standard for evidence-based medicine criteria, ensuring appropriate care. These criteria are regularly updated to reflect the most recent evidence-based and clinical standards.

What authorization types are affected?

As a result of this transition, the following authorization types will be based on modifications to 2025 InterQual criteria, for all plan types:

- Level of care (LOC): Acute Adult*
- LOC: Acute Pediatric*

- LOC: Inpatient Rehabilitation
- LOC: Subacute/Skilled nursing facility
- LOC: Home Care Q&A
- LOC: Long-Term Acute Care
- CP: Durable Medical Equipment
- CP: Procedures
- Medicare: Post Acute & Durable Medical Equipment
- Medicare: Procedures
- Behavioral health (BH): Adult and Geriatric Psychiatry
- BH: Child and Adolescent Psychiatry
- BH: Substance Use Disorders
- BH: Services

*Several criteria set revisions based on best practices and available evidence

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Authorization appeal update effective June 2

Effective June 2, 2025, we won't review post-claim appeals for medical necessity when a denied authorization is on file for the following authorization types, for all lines of business:

- Outpatient, home health & DME
- Elective inpatient
- Behavioral health

Note: This change doesn't apply to inpatient acute / urgent / emergent or post-acute authorizations.

This applies when you've requested an authorization, received a denial for medical necessity and performed the service or procedure. Services / procedures performed with a denied authorization become provider liability. This change is in alignment with industry standards.

Use your authorization appeal rights appropriately

We encourage you to take advantage of the authorization appeal rights available to you as appropriate:

- Two pre-service appeals are available (Levels 1 and 2) if you've received a denial on an authorization request and haven't yet performed the service. Learn more.
- One post-service, post-claim medical necessity review is available if you performed the service but didn't yet request authorization.

In this case, you'd submit a claim and then follow our post-claim appeal process.

Reminder: EviCore radiation oncology authorization program & resources

As a reminder, our new radiation oncology authorizations program with EviCore launched on Sept. 15, 2024. To support you in getting your patients, our members, the care they need when they need it, EviCore offers a variety of provider resources and trainings:

Access EviCore's Priority Health resources hub

On EviCore's website, there's a Priority Health Resources page that includes code lists, FAQs, training materials and quick reference guides for each of the procedure / service types they manage on our behalf, including radiation oncology. To access these resources:

1. Visit the EviCore Priority Health Resources page.
2. Click the Solution Resources tab.
3. Select the appropriate procedure / service type.

Register for EviCore's virtual provider trainings

EviCore offers one-hour virtual training sessions on an ongoing basis, to help providers successfully use their authorization submission portal and navigate their online provider resources. To register for these trainings, providers should:

1. Enter evicore.webex.com in their web browser.
2. Select Webex Training from the drop-down menu in the top-left corner.
3. Click the Upcoming tab.
4. Click Register next to the session they'd like to attend.

Subscribe to EviCore's provider e-newsletter

EviCore's provider newsletter is sent out to subscribers with important updates and tips. To subscribe:

1. Go to EviCore.com.
2. Scroll down to the bottom of the homepage to the Stay Updated With Our Provider Newsletter heading.
3. Enter your email address and click Subscribe.

Contact EviCore

Providers can reach out to EviCore's Client and Provider Services directly for support with issues experienced during authorization submission, eligibility issues (member, rendering facility, ordering physician), to report EviCore system issues and more.

EviCore Client and Provider Services team can be reached at 800.646.0418 (option 4) or ClientServices@EviCore.com.

If an issue requires further escalation, contact your Priority Health Provider Network Management consultant for support.

BILLING AND PAYMENT

Update to corrected claims goes into effect June 2

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
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.

Reminder: Corrected claims must include the original claim ID

We require that corrected claims – submitted to either replace, correct or void an original claim that was partially or fully paid – include the original claim ID. As we shared in January, we'll soon begin front-end rejecting corrected claims (both facility and professional) that have an

invalid / incorrect original claim ID.

PRIORITY HEALTH

Complete the survey about our PriorityActions emails

We're collecting feedback about our bi-weekly PriorityActions emails.

Please complete this survey by Thursday, April 17. (Estimated time to complete is one to three minutes.)

Thank you for partnering with us as we strive to provide the information you need to work with us and care for our members.

Questions?

Connect with your Provider Network Management Specialist, Robert Everett Iii .

Access an archive of our PriorityActions for providers emails here.

1231 E. Beltline Ave. NE
Grand Rapids, MI 49525-7024