Priority Health

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Physician & practice news digest

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Message from the Medical Director

Caring for the caregivers; supporting you while you care for your patients.

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We talk often about improving patient care, but little is said about caring for the caregivers. According to the 2024 Medscape Physician Burnout and Depression Report, 49% of physicians say they feel burned out and 20% say they struggle with depression. We deeply value you and work hard to do our part to support you as you positively impact the lives of patients. Here's what this looks like in practice.

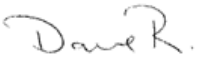
The right people. We believe in curating a team that can speak on behalf of the provider experience. Recently, we welcomed our new Chief Medical Officer, Dr. Elif Oker. Dr. Oker has experience with the payer and

provider side of health care, along with a passion for collaboration and connecting with our communities. We're confident her experience will drive our mission to improve health, instill humanity and inspire hope.

The right programs. 2024 has been a year of refining and implementing programs that help our members get the care they need when they need it and support you in your efforts to deliver high-quality care. With our newest authorization programs going live this September - cardiology and MSK surgical care with TurningPoint and radiation oncology with EviCore – we look forward to supporting you through enhanced peer-to-peer engagement and optimized patient outcomes.

The right mindset. We recognize the relationship between payers and providers is complex. We're committed to strengthening this relationship through open dialogue. Your input is truly valued and used to inform our policies and programs. Please continue sharing your experiences with us. We take feedback through our: Medical Affairs Committee meetings, Pharmacy and Therapeutics Committee meetings, Joint Operating Committee (JOC) meetings and Provider Network Leadership Forum (PNLF) meetings. You can also email me or our Vice President of Provider Strategy and Solutions, Heather Watkowski, directly. We want to hear from you.

As we move into the second half of 2024, we're committed to working alongside you to improve the health and lives of your patients, our members . Thank you for all you do.



Billing & Coding Tips

Using provider inquiries, issues and data 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 and more.

#1. Include a refund form with overpayment checks.

When sending a refund check to us for an overpayment, it's important that you also include a completed refund form. This completed form allows us to apply the refund to the correct claim overpayment.

When are refund checks necessary?
We'll send a letter requesting repayment in the following cases:

- **Professional providers:** $200+ overpayment
- **Facility providers:** $5,000+ overpayment

For overpayments less than the amounts listed above, we'll make the necessary corrections and adjustments on a future remittance advice
Where can you find the refund form?
Download a fillable and printable refund form or find it linked in our Provider Manual.

Get more information.

#2. Follow ICD-10 guidelines and code to the highest degree of specificity.

As a reminder, when billing for both professional and facility services, it's important to code to the highest level of specificity

At Priority Health, we use several coding and billing resources to align correct coding guidelines for accurate claims processing. This includes criteria defined by ICD-10 coding guidelines.

See our General Coding Policy, available on the Billing & coding policies page in our Provider Manual, for details.

#3. Submit one inquiry per claim issue.

When the same issue is affecting multiple claims, you should submit a claim review request for one of the impacted claims, indicating in your submission that the issue is impacting multiple claims. Ask your third-party billing companies (TPBs) to do the same.

Submitting multiple inquiries for the same issue can result in delayed and redundant responses.

#4. Sign up for electronic remittance advices.

If your group isn't already signed up for electronic remittance advices (ERAs), we highly recommend you do so. Note ERAs are separate from

electronic fund transfers (EFTs) and must be set up separately.

ERAs are stored in Filemart for 365 days before they're archived. Get more information in our Provider Manual.

Tip: Please also make sure your TPBs have appropriate access to your remittance advices. Your group's prism security administrator (pSA) can grant access.

#5. Use self-service tools in prism.

Our prism provider portal has several self-service tools you can use to get your questions answered:

- Claims tool: See detailed claim denial reasons (more specific than what's shared on the 835 file), access a member's entire date of service to identify claim submissions, access front-end rejected claims, contact our Provider Resolutions team for critical post-claim and post-payment issues
- Authorizations tool:Request an authorization, submit an inquiry on an authorization that was requested
- Member inquiry: See a member's eligibility and benefits
- General Requests tool: Submit inquiries to our team that aren't claim-specific (i.e., authorization changes, pended claims, upfront rejections, contracting, gaps in care / incentive programs, website tools). See all inquiries submitted by any team member with access to your provider group/facility.

Learn more about how to best work within prism.

#6. Bookmark our Billing & Coding Policies page.

There you'll find a growing series of medical claims payment policies detailing billing, coding and reimbursement guidelines.

These policies are intended to help you:

- Bill claims more accurately
- Reduce processing delays
- Avoid rebilling
- Reduce requests for additional information

Bookmark the page linked below to have quick access to current and upcoming policies.

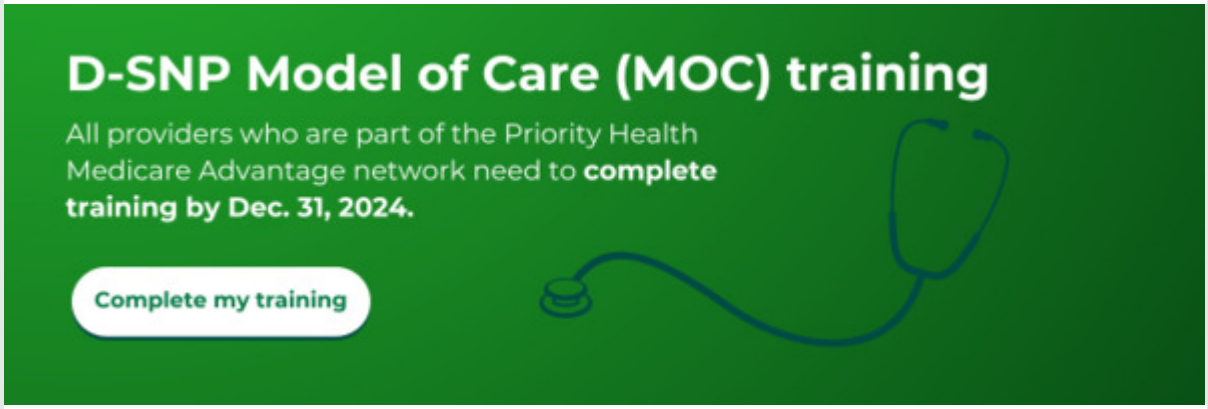
SEE THE POLICIES

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 learn about increasing your PIP incentive with at-home colorectal cancer test kits, closing care gaps for your patients with diabetes, 2024 medication adherence reports, the Vaccines for Children program 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 the latest incentive program updates.

PCP Incentive Program (PIP) updates.

2023 PIP settlement
Our 2023 PIP settlement took place in June at the Accountable Care Network (ACN) level. Please reach out to your ACN with any questions.

2025 PIP program webinar We recently held an informational webinar on our 2025 PIP program which highlighted the ways your practice can earn incentive dollars for the care you provide our members.

In addition to the program elements that will be carried over from 2024, this webinar session covered:

- Return to practice-level settlement, possible with practice-level data entered in our Provider Roster App (PRA) tool in 2024

- Care Management monthly PMPM payment, replacing focus measure pre-payments
- Preventive, chronic disease management and Medicare 5-Star measures maintained from 2024
- New disparity measures, addressing differences and/or gaps in the quality of health care across racial, ethnic and socio-economic groups

WATCH THE WEBINAR RECORDING

2024 Disease Burden Management (DBM) program

The DBM program preliminary payment incentive settlement

Our 2024 DBM program preliminary payment incentive settlement will go out in August. All providers that were able to see a minimum of 70% of their attributed patients before May 31, 2024 will receive this incentive. Payments will be distributed at the ACN level.

The new OIG toolkit can help you identify high-risk diagnosis codes and decrease improper Medicare Advantage payments

To ensure accurate patient documentation and proper reimbursement, the Office of the Inspector General (OIG) released a toolkit designed to help providers identify and evaluate high-risk diagnosis codes. This toolkit can help improve the accuracy of submitted diagnoses that are high risk for being miscoded.

GET THE OIG TOOLKIT

DBM program resources

- Watch our DBM program webinar on-demand now
- Get our 2024 DBM program manual (login required)get our DBM program one pager
- Watch our April VOA for education on how to document all your patients' chronic conditions when claims forms are limited to twelve diagnoses or fewer

Latest News

See the latest news posted to our website from February to April 2024:

AUTHORIZATIONS

- Portion of 2024 InterQual® criteria delayed
- Provider trainings for TurningPoint authorizations programs
- Outpatient peer-to-peer reviews to follow new policy
- Inpatient peer-to-peer policy update coming Sept. 4, 2024
- New radiation oncology authorizations program to launch this fall
- New MSK prior authorizations program will launch September 2024
- Ensure proper clinical documentation for authorizations
- Standard vs expedited authorization requests

BILLING & PAYMENT

- New billing policies posted to the Provider Manual
- Aligning commercial DME coding/billing guidelines with CMS effective Aug. 1, 2024
- Follow ICD-10 guidelines and code the highest degree of specificity
- Reprocessing incorrectly rejected Tdap vaccines
- Refund forms are required with overpayment checks
- New billing policies posted to the Provider Manual

INCENTIVE PROGRAM

- Updated 2024 HEDIS Provider Reference Guide available
- Updated 2024 PIP manual now available

PLANS & BENEFITS

- New features now available for Teladoc Health wellness tool

REQUIREMENTS & RESPONSIBILITIES

- Reminder: You must refer members to in-network providers, including labs
- May 2024 medical policy updates

- Mandatory annual pSA renewal process begins June 1s

PRIORITY HEALTH

- Prism inquiry turnaround times and when to reach out to our team
- Get our new Vaccines for Children Provider Toolkit
- Q2 physician and practice news digest

PHARMACY

- Resource to address GLP-1 shortages and support medication adherence
- SaveOnSP ended on May 31 for select commercial members
- Medical benefit coverage changes for Ontruzant and Kanjinti start August 1
- PriceMyMeds launching on April 25
- Formulary changes for commercial group and individual members coming July 1