Priority Health

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Physician & practice news digest

In This Issue

Message from the Medical Director

Boosting vaccination rates with affordable and accessible vaccines

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Flu season is nearing and COVID-19 cases are resurging in our communities, and we know that nobody feels this burden more than providers as you care for your patients. Our teams are working alongside you to encourage vaccination and help keep your patients, our members, healthy.

Free flu and COVID-19 shots

Under most Priority Health plans, flu and COVID-19 shots are free when members get them from an in-network provider or pharmacy. In addition, Priority Health Medicare members who get a flu shot before Dec. 31, 2024, may claim a $10 gift card of their choice.

Information and outreach

Throughout the year, we contact our members via phone calls, text messages, letters and emails to encourage them to stay current on their immunizations, remind them to schedule an appointment with their

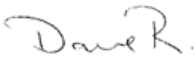
PCP and highlight the positive impacts of vaccines for themselves, their families and the community.

Transportation assistance

Many of our plans offer transportation assistance for eligible members, including Medicare, Medicaid and D-SNP. You can encourage your patients to reach out to us for more information.

If you'd like a refresher on combatting vaccine hesitancy in your patients or are interested in more information on the resources we offer members to help support vaccinations, check out our vaccine hesitancy Virtual Office Advisory (VOA) webinar module.

Thank you for your front-line work building confidence in vaccines that safeguard health and prevent disease. We value the work you do and will continue to partner with you to help keep our communities healthy this fall and beyond.



Billing & coding tips

Reminder: Informal claim reviews are required before appeals

It's important to us that we accurately process your claims, and you understand the way your claims are handled.

To support you through the claim dispute process and make sure your questions / concerns are addressed in a timely manner – and you're paid accurately and fairly for the care you've provided to our members – we're sharing a few reminders and tips for our claim review and appeal process.

Understand how your claim processed

In **prism**, you can see exactly how a claim processed and, if it was denied, why. To do this:

1. Log into your prism account.
2. Under the Claims menu, click **Medical Claims**.
3. Search for and click the **Claim ID** in question.
4. Scroll down to see line paid details, including any denial explanation. If a clinical edit applied to the claim, a **See Edits** button will appear, which takes you to an explanation of the edit(s).

If you're unable to find the information you need in prism, you can reach out to us for help. Learn how.

Follow our two-step claim dispute process

The claim dispute process includes two steps:

1. **Informal claim review** – This step, including a review decision from our team, is required before an appeal can be processed. You must wait 45 days after submitting a claim, to allow claim processing, before submitting a claim review asking us to reconsider our decision on a claim. This may include a comprehensive review, coding / clinical edit questions, third party liability, coordination of benefits and more.
2. **Claim appeal** – If you're unsatisfied with the outcome of the claim review, you can submit an appeal. Appeals can dispute payment issues, clinical edits and claim denials. Please note, you have one appeal right per claim. Any future claim corrections won't result in additional appeal rights.

Review tips & tricks

We recently updated our claim reviews and appeals tipsheet to include even more helpful information, including answers to common questions like:

- What's the difference between a claim review and appeal, and when can you use them?

- What makes a good appeal?
- What sort of documentation can you submit with an appeal?
- What about reviews for multiple claims?
- And more

Billing policies recently posted to our Provider Manual

We've posted several new billing policies that align with industry standards to the Provider Manual.

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.

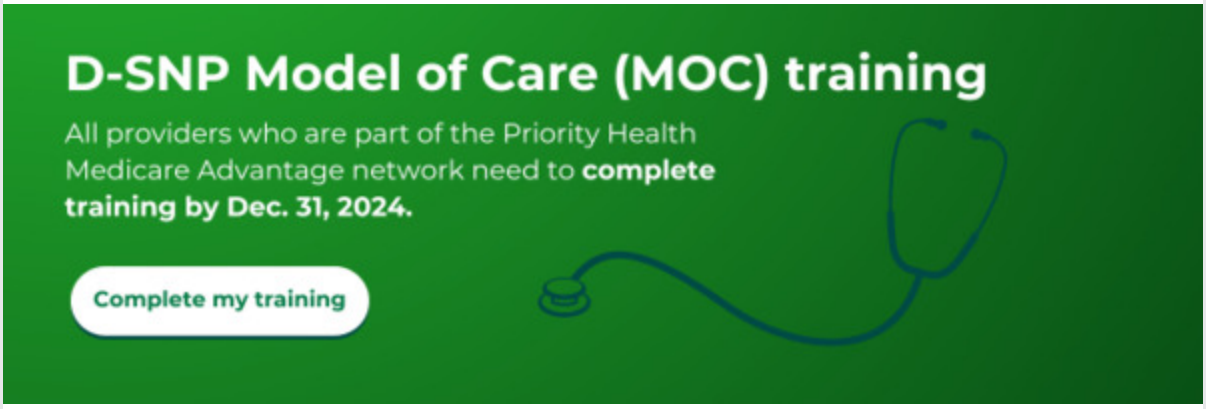
For more billing policies, visit our Provider Manual's billing policy page.

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 our quality HEDIS focus measures, reports that help you close care gaps, combatting vaccine hesitancy, resources for your Medicaid patients with HIV 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

Preliminary 2025 PIP manual now available

After months of planning, in collaboration with ACN leaders and network physicians, the Preliminary 2025 PCP Incentive Program Manual (login required) is now available. The final manual, including targets and payouts, will be released on or around Dec. 1, 2024.

See our recent news item for an overview of the program and changes.

Congratulations, 2023 Quality Award winners!

Our 2023 Quality Award winners were recently announced. From Detroit to Muskegon and Petoskey to St. Joseph, more than 380 practices throughout Michigan received an award for their performance in our 2023 PIP program.

Learn more about the Quality Awards and the 2023 recipients.

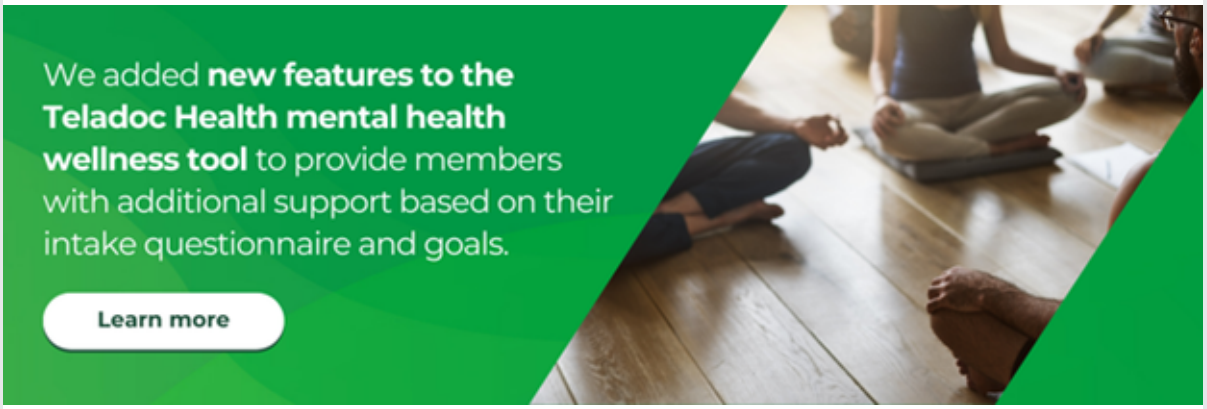
Disease Burden Management (DBM) program updates

End of year record requests are underway
Through the end of 2024, our Risk Adjustment team will contact select providers via fax and email to request medical records to validate encounter data and hierarchical condition categories (HCC) recapture scores for the Disease Burden Management (DBM) program. If you're contacted by our Risk Adjustment team, please follow the instructions in the communication you receive and **send all requested documentation via your preferred delivery method by Jan. 30, 2025**.

Register for the 2025 Disease Burden Management Program VOA.
Join us on October 29 for a webinar to learn more about the 2025 Disease Burden Management (DBM) program. This session will cover:

- Elements from the 2024 DBM program that will carry over into 2025
- What's changing in 2025, including two new program incentives
- How to be successful in risk adjustment and the 2025 DBM program

Can't make it?
All webinars are recorded and posted to our website within a week of the event, so you can watch at your convenience.



Latest news

See the latest news posted to our Provider Manual from July to October 2024:

AUTHORIZATIONS

- Reminder: CGM authorization timeframes by plan type
- Reminder: Radiation oncology authorization program launches September 15
- Peer-to-peer policy update delayed
- Our prism authorization request form has a new look
- TurningPoint launches for cardiac and MSK authorizations
- Procedure codes impacted by new auth programs
- Resources and trainings for TurningPoint authorization programs
- Finalizing 2024 InterQual criteria transition
- EviCore radiation oncology provider trainings

BILLING & PAYMENT

- New resource available: Understanding why a claim denied
- New or corrected claims requirement for retro authorizations
- Informal claim reviews required before appeals
- Submitting requested medical records for claims processing
- Void claims now appear on remittance advice with original claims
- Simplifying EFT setup
- Resolving claims denying incorrectly for no anatomical modifier
- New and updated billing policies now available
- Changes for Medicaid claims for select home health care services
- ER imaging claims reprocessing
- New coding policies posted to the Provider Manual
- IVF billing reminder
- Coding policies going into effect Sept. 23, 2024

CLINICAL RESOURCES

- Sharing resources for providers for Falls Prevention Awareness Week
- We've added exclusion criteria added to our SUPD provider tipsheet
- Introducing Carelon Health, a new name for Aspire Health
- RSV vaccine and monoclonal antibody coverage

INCENTIVE PROGRAMS

- Preliminary 2025 PIP Manual now available
- Provider news: End of year record requests are underway
- 2024 DBM preliminary payments were mailed
- Updated 2024 HEDIS Provider Reference Guide available
- Updated 2024 PIP manual now available

PLANS & BENEFITS

- Medicaid rebid doesn't impact Medicare
- Transportation assistance moving to SafeRide for Medicaid members
- Updates on seeing key provider information in Find a Doctor
- Medicaid rebid provider impacts
- Do your Medicare patients qualify for Extra Help?

REQUIREMENTS & RESPONSIBILITIES

- Complete our D-SNP Model of Care Training
- August 2024 medical policy updates
- pSA mandate, phase 1
- Reminder to complete our CMS-required D-SNP Model of Care training
- Unique NPI required for rehab groups to credential BH providers
- Mandatory pSA renewal reminder

PRIORITY HEALTH

- National Prescription Drug Take Back Day
- Provider news: New reports coming to help close osteoporosis care gaps

- Learn more about our fall Quality initiatives
- Get our new 2024 member outreach calendar
- Get our Q3 Physician and practice news digest and our Q3 Quality newsletter