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 Network Management specialist remains your primary contact for support.

PRIORITY HEALTH

Vaccine coverage effective Sept. 1, 2025, now available

In alignment with our commitment to maintaining and ensuring affordable access to vaccines, we recently updated our Provider Manual's vaccines section to reflect vaccine and administration coverage effective Sept. 1, 2025.

Note: we'll continue to cover the COVID-19 vaccine as preventive (without member cost share) for all members ages 6 months and older.

For a list of the changes made, see our recent news item.

BILLING AND PAYMENT

October 2025 billing policy updates

We publish billing policies to offer transparency and help you bill claims more accurately to reduce delays in processing claims, as well as avoid rebilling and additional requests for information.

The following billing policies were recently published to or updated in our Provider Manual – see details in our recent news item.

Policies with an * are effective Dec. 16, 2025. All others represent our current system set up and/or expectations for transparency. There are either no changes for you as the policy is already in effect, **or** the policy was recently shared with the network and we're implementing a clinical edit in alignment with the policy's language.

New billing policies

- Bisphosphonate drug therapy*
- Chelation therapy
- External breast protheses*
- Infectious disease panel testing*
- Influenza testing
- Patient lifts*
- Pressure reducing support items
- Somatosensory testing
- Suction pumps
- Therapeutic shoes
- Transcutaneous electrical joint stimulation devices*

Updated billing policies

- Facility billing*
- Fundus photography

We'll no longer be paying certain HCPCS codes per CMS guidelines

Several Home Health HCPCS codes were created by CMS to collect data on telehealth for Home Health, which some providers had previously billed for.

We'll no longer be paying these claims separate from the home health visit for any product, effective Dec. 16, 2025:

- G0320: Home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system.
- G0321: Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive

audio-only telecommunications system.
- G0322: The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (for example, remote patient monitoring).

Per the Medicare MLN regarding these codes: The amended plan of care requirements in 42 CFR 409.43(a) also state that these services can't substitute for a home visit ordered as part of the plan of care and can't be considered a home visit for the purposes of patient eligibility or payment, per section 1895(e)(1)(A) and (B) of the Social Security Act.

AUTHORIZATIONS

Varicose vein authorizations updates

We're sharing two updates regarding varicose vein procedure authorizations.

Commercial & Medicaid auto approvals

We began requiring prior authorization for certain varicose vein procedures for commercial and Medicaid plans on Jan. 1, 2025, with all requests pending for review.

As of Oct. 1, 2025, providers now receive auto approvals on these authorization requests when:

1. The requesting provider completes the InterQual® questions included in the authorization submission **and**
2. The member meets the applicable InterQual® criteria, confirming that services aren't being performed for cosmetic reasons

This change will expedite the authorization process for both providers and our utilization management team in many cases.

No authorization requirements for Medicare plans

We won't be implementing varicose vein prior authorization requirements in 2026 for Medicare plans, as we'd previously stated we would. The prior authorization requirements will remain solely for commercial and Medicaid plans.

PHARMACY

IXCHIQ and Ocaliva withdrawn from the market due to potential safety concerns

Effective immediately, IXCHIQ® and Ocaliva® have been withdrawn from the market by the U.S. Food and Drug Administration (FDA) due to potential safety concerns.

We're notifying members

Impacted members will receive letters in the mail informing them of the drug changes and encouraging them to discuss concerns or alternative treatment plans with their provider. These changes will only impact a total of 26 members. You can find more information on these drug changes below.

IXCHIQ®

What does it treat

IXCHIQ works to prevent chikungunya virus in individuals 18 years and older who are at an increased risk of exposure.

Reason for withdrawal

The FDA suspended the biologics license for IXCHIQ due to serious safety concerns, including reports of chikungunya-like illness and hospitalizations following vaccination.

Ocaliva®

What does it treat

Ocaliva is used to treat biliary cholangitis, a rare liver condition caused by bile build-up.

Reason for withdrawal

Ocaliva is being voluntarily withdrawn from the market by the manufacturer, Intercept Pharmaceuticals, at the request of the FDA due to concerns of potential liver damage.

You'll receive a list of impacted members from your Provider Network Management (PNM) Specialist.

REQUIREMENTS AND RESPONSIBILITIES

Reminder: You must complete our 15-minute, CMS-required D-SNP Model of Care training by Dec. 31

Providers play an integral role in the care teams that support our dual-eligible special needs (D-SNP) members. **That's why the Centers for Medicare and Medicaid Services (CMS) requires us to make sure providers who are contracted with us to see PriorityMedicare patients are trained on our Model of Care (MOC) every year.**

Our Model of Care is a quality improvement tool that ensures the unique needs of our D-SNP members are met and describes the processes and systems we use to coordinate their care.

Who needs to complete Model of Care training?

- All providers who are part of the Priority Health Medicare Advantage network. **(All providers contracted with this network must complete the MOC training, regardless of whether they participate in Medicaid.)**
- Out-of-network providers who see at least five D-SNP members

This includes specialists, ancillary providers and anyone part of an ICT (interdisciplinary care team) for a D-SNP member. This is a CMS requirement.

How to complete training

Option #1: Bulk attestations
You can group our D-SNP MOC training with existing, required training (like compliance training) so you can submit attestation for providers at the same time. If you choose this option, you'll need to:

1. Distribute training to your providers using this link.
2. To attest to training, fill out the roster template with providers who've received training. **Only the Priority Health MOC roster Excel sheet provided will be accepted to report your completion.**
3. Send attestation rosters to DSNPtraining@priorityhealth.com. Please direct any questions to your Provider Network Management specialist, as this inbox is not monitored for questions.

When an attestation is submitted, one of two automated messages will be sent:

- A confirmation email stating the roster was successfully processed.
- An email stating the roster wasn't processed and the reason(s) why.

Option #2: Virtual training (only takes 15 minutes)
Training is available as an on-demand webinar if you want to complete this training individually. It only takes 15 minutes to complete. Provider registration for the on-demand webinar counts as attestation, which means no additional documentation is required.

Be sure to submit the correct provider NPI.
Ensure the correct provider NPI number is included when submitting the provider roster or registering for the online training. **If the NPI is incorrect, the provider's status will be marked "incomplete" in our system.** To correct an "incomplete" status due to an incorrect NPI, resubmit the provider roster or re-register for the online training with the correct NPI.

Training needs to be completed and attested to by December 31, 2025.
Late submissions will not be accepted.

Questions?

Connect with your Provider Network Management specialist, Andrew Turner Jr .

Access an archive of our PriorityActions for providers emails here.

Priority Health

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