Priority Health

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PriorityActions
FOR PROVIDERS

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

Feb. 6, 2025
Issue #3.3

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 Strategy & Solutions Consultant remains your primary contact for support.

AUTHORIZATIONS

New authorization requirement for renal denervation, effective Apr. 6, 2025

Effective Apr. 6, 2025, we'll require prior authorization for the following procedures for Medicare cases:

- 0338T: Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral
- 0339T: Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient

measurements, flush aortogram and diagnostic renal angiography when performed; bilateral

As previously shared, we'll also require prior authorization for these procedures for commercial cases starting Feb. 1, 2025.

Background

These procedures were previously considered not medically necessary under the scope of our medical policy #91636 – Category III Current Procedure Terminology (CPT) Codes as temporary codes for emerging technologies considered to be experimental or investigational.

These codes are now covered for Medicare, effective Oct. 1, 2024, and will be covered for commercial effective Feb. 1, 2025. New medical policy *#91644 – Renal Denervation for Resistant Hypertension* (to be posted to our Provider Manual on Feb. 1) will include commercial criteria. (Note: These procedures remain not covered for Medicaid.)

Requesting authorization

Authorization requests for 0338T and 0339T will be submitted through GuidingCare, accessed through prism's authorizations request tool (login required).

Reminder: Call backs aren't available for missed peer-to-peers for inpatient cases

We're sharing a reminder that call backs to our medical director team aren't available for missed peer-to-peer (P2P) calls for inpatient cases.

While we'd previously allowed call backs, this practice resulted in afterhours communication with our medical director team and, in some instances, calls about cases that didn't yet have a P2P scheduled. Because this practice was unsustainable, in early 2023, we removed the call-back function for inpatient cases. (Note: Call backs are allowed for missed P2Ps for outpatient cases, due to lower volume and more latitude for rescheduling than with inpatient cases.)

Should you miss a scheduled P2P call for an inpatient case, you have the option to either:

#1. File a medical necessity appeal

This option is outlined in our P2P policy and is the most appropriate next step in most cases. We offer Level 1 and Level 2 medical necessity appeals – find instructions in our Provider Manual, for Medicare cases and non-Medicare cases.

#2. Discuss at your next P2P (for back-to-back appointments only)

In some cases, you may have multiple P2P appointments scheduled back-to-back – for example, at 11:15 a.m., 11:30 a.m. and 11:45 a.m.

- **If you miss the first P2P call** at 11:15 a.m., our medical director team will leave a message stating, "I will be calling you back at 11:30 a.m. for our next scheduled P2P. If time allows, we can discuss the 11:15 a.m. P2P. Thank you.", and call back at 11:30 a.m.
- **If time allows** during the 11:30 a.m. appointment, you may discuss the missed P2P case at that time. If there isn't enough time or if the subsequent call is missed, a medical necessity appeal is the next available step.
- **If you miss two back-to-back P2P calls**, all remaining P2P calls during the scheduled block of time (i.e., 3rd / 4th calls etc.) are forfeit – our medical director team won't call at the remaining scheduled times.

BILLING AND PAYMENT

Seeing why a claim denied is now easier than ever in prism

It's important to us that you understand how your claims were processed and why, and that you can find out easily. We know this information has been difficult to piece together from disparate resources in the past. That's why we're happy to share that we recently improved the Claims section in **prism**, pulling all claim denial details and rationale into one place. No additional buttons to click or external resources to access.

We hope this update will:

- **Support you** in understanding how a claim processed, quickly and easily
- **Reduce** the number of inquiries to our teams you need to submit and manage
- **Help you** determine any next steps (i.e., submitting corrected claims or disputing a claim denial) more quickly

Reference prism for denial details instead of ERA/835 files

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.

See how your claims processed, in prism

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.

INCENTIVE PROGRAMS

Updated 2025 PIP & DBM manuals are available

Updated manuals for the 2025 PCP Incentive Program (PIP) and 2025 Disease Burden Management (DBM) program are now available. Access them in our Provider Incentives webpage (login required).

Below is a summary of the updates made:

2025 PIP Manual updates

Care Management measure
The Care Management measure claims information on page 20 has been updated to include lines of business by code as well as the following billable codes:

- **G0511**: Care coordination services and payment for RHCs and FQHCs only
- **G0512**: Psychiatric Collaboration Care Model for FQHCs
- **G0556**: Care Management – one chronic condition
- **G0557**: Care Management – multiple chronic conditions

- G0558: Care Management – multiple chronic conditions & Qualified Medicare Beneficiary

These five codes were recently added to the commercial fee schedule effective Jan. 1, 2025, will serve to identify members that have received care management services and will count toward the 2% target. Additional billing and payment information for these codes is available in our Provider Manual.

We also clarified the language on page 20 about telephone service / telephone-only codes. It now reads: "While many CM codes may be delivered by telephone service (see our Care Management billing policy for details), only one telephone-only code (including 98966, 98967, 98968) will count toward the required incentive touchpoints."

Disparity of Care measures

The example for the Disparity of Care Measures on page 17 has been updated to replace the Diabetic Eye Exam example with Controlling High Blood Pressure. Note: The example doesn't encompass all measures included in Disparity of Care, which are listed in full on page 16 of the manual.

2025 DBM Manual updates

The Billing Requirements section on page 17 of the PCP Visit Incentive has been updated to include the below approved CPT code for DBM visits, which was left out in error.

- CPT code 99386

Rationale for excluding ASO / PPO from 2025 PIP Transformation of Care measures

For our 2025 PCP Incentive Program (PIP), ASO / PPO membership was excluded from Transformation of Care measures – including Care Management, Behavioral Health Collaborative Care (BHCC) and Health Information Exchange (HIE) Participation with MiHIN.

As indicated in the 2025 PIP Manual, the PIP program's settlement payments won't exceed the program's budget for each line of business. ASO / PPO funding for PIP is based on a percentage of paid claims, making the exact budget vary year-over-year.

Historically, due to this budget constraint, ASO / PPO awards have been

indexed down (paying less than 100% on the dollar) when provider performance exceeded the dollars collected from our self-funded employers. We'd calculate the overall performance for all PIP participants, then index down to align with our budget.

Below are our indexing rates from 2018-2023:

- **2018**: $0.82
- **2019**: $0.66
- **2020**: $0.50
- **2021**: $0.56
- **2022**: $0.69
- **2023**: $0.58

By excluding ASO / PPO from the 2025 PIP Transformation of Care Measures, we removed the need to index based on performance. ASO / PPO membership remains included in the Preventive Health and Chronic Disease Management measures.

TRAINING OPPORTUNITIES

Register now for our February 20 product tips & reminders webinar

Join us for a product tips & reminders webinar to learn about:

- Finding Priority Health product information
- Servicing HMA members with Priority Health's TPA product
- Seeing Cigna members in Michigan through Priority Health's Strategic Alliance
- Understanding HIDE SNP, a new integrated plan replacing D-SNP
- Reviewing Medicare benefits, including Galleri, Carallel and Extra Help

REGISTER NOW

Can't join us?

All webinars are recorded and posted to our website within a week of the event, so you can watch at your convenience.

REQUIREMENTS AND RESPONSIBILITIES

2025 D-SNP MOC training is now available

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.

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 Dec. 31, 2025. *Late submissions will not be accepted.*

We're allowing more time for audit appeals, effective Jan. 1, 2025

Effective Jan. 1, 2025, we've increased the window of time you have to appeal adverse audit results and technical denials from 30 days to 60 days. This applies to all audit types for all vendors.

We're in the process of updating the audit findings letters providers receive. **Some audit letters may still state 30 days; however, we'll honor the 60-day window in all cases** as will our vendors.

Background: audits & technical denials

When a paid claim is identified for audit and requires medical record review, you'll receive three written requests to submit medical records. These letters include a list of the requested medical records along with instructions and a deadline for submission.

If you don't respond with the requested medical records by the deadline, we deny the paid claim to provider liability and take back the paid funds. This is a technical denial.

How to appeal audit results & technical denials

You have the right to appeal both adverse audit results and technical denials. The appeals process varies by audit type (i.e., facility vs DRG) – see our Provider Manual for instructions.

PRIORITY HEALTH

Get at-home colorectal cancer test kits for your eligible Priority Health patients

Our 2025 campaign to close care gaps with Exact Science's at-home Cologuard® test kits is now open for ACNs. This campaign is opt-in only and supports gap closure in the Colorectal Cancer Screening (COL-E) HEDIS measure for your Priority Health patients.

New this year: This campaign is now open to all eligible Priority Health patients across all lines of business.

Patients who return their test kits to Exact Sciences by Dec. 31, 2025 will count toward your 2025 PCP Incentive Program (PIP) incentive.

How long will the campaign run?

ACNs can opt into this program any time throughout the year, however if you'd like your patients' CRC screening gap closures to count toward your 2025 PIP incentive, you must send your target list to us before Aug. 1, 2025. Introductory letters will be mailed to your targeted patients once this list is received. If you're planning to participate, please let us know as early as possible to allow patients optimal time to complete test kits and close care gaps in the COL-E measure.

Note: March is Colorectal Cancer Awareness Month, offering providers the opportunity to further highlight the importance of colorectal cancer screenings and encourage their patients' participation in the Exact Sciences campaign.

How does the campaign work?

For a full breakdown of this campaign, including the patient outreach process and how results are distributed, check out our Exact Sciences provider FAQ document.

How do I get started?

To participate in this campaign, contact your Provider Strategy and Solutions Consultant.

Get our winter Physician and practice news digest and our Medicare/Medicaid Quality

newsletter

Our winter 2025 Physician and practice news digest and our Medicare/Medicaid Quality newsletter are here.

These newsletters are sent to our ACN contacts and all providers with a prism account who have opted in to receive our communications. They include our latest news and updates and share information and ideas to help our providers work with us and provide the best care for our members.

Did you miss last quarter's newsletters?

You can find newsletters from 2024 and earlier in our Provider news archive.

Questions?

Connect with your Provider
Strategy & Solutions Consultant, Robert Everett Iii .

Access an archive of our PriorityActions for providers emails here.