Premier Health Group

From the Desk of the Chief Medical Officer

Welcome to the December 2017 edition of our Provider Brief. We value the opportunity to share news, update you regarding ongoing initiatives, and provide the information you need to help you better serve patients and the community.

This month, read about the Quality Reward Program for Primary Care Physicians. Find information about pharmacy services and learn more about the screening options for Colorectal Cancer that satisfies the Healthcare Effectiveness Data and Information Set (HEDIS) measure.

As always, if you have any questions or would like to speak to our Chief Medical Officer or our local Medical Director, please call **(937) 499-7441**.

We look forward to our continued work together.

Yours in health,

Jerry Clark, MD, FACP
President and Chief Medical Officer
Premier Health Group

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Network Operations

Directory Updates

CMS routinely audits Medicare Advantage (MA) online provider directories. CMS issues compliance notices to health plans if it determines the plan's provider directory is inaccurate.

A person who enrolls in a health insurance plan relies on these online directories to access care. When the information is incorrect, it can create a barrier to members getting the healthcare they need.

Premier Health Plan's provider directories must be updated every 30 calendar days, or the Health Plan can be sanctioned by CMS. Practices **must** provide accurate office location, phone number(s) and hours of operation data to PHG. It's important to notify us when this information changes. Please communicate all provider changes (i.e. new providers, terminations, office changes, accepting new patients/not accepting new patients, etc.) to the PHG team using the Provider/Change of Address/Deletion Form. This form is a fillable PDF file, which means you can type the needed information directly into the form on our website. Please email the completed form to PHG@PremierHealth.com or fax to (937) 641-7377.

Medical Pay Policies

Throughout the year, we update our Medicare Advantage and Commercial Policies and Procedures. Go here to view the most recent policies and procedures:

- Commercial policies and procedures
- Medicare policies and procedures

Contact Numbers

Please reference the table below for contact information.

Department	Purpose	Contact Number
Provider Services	Eligibility, claims inquiries and appeals information	(855) 514-3678
Medical Management	Prior authorization	(855) 869-7140
Provider OnLine	Technical concerns	(855) 222-1043
Pharmacy Services	Pharmacy information	(855) 266-0713
Medicare Member Services	Member inquiries	(855) 572- 2161
Commercial Member Services	Member inquiries	(855) 572- 2159
Provider Relations	Provider questions	(937) 499-7441

As always, you can reach out to our Chief Medical Officer or our local Medical Director at **(937) 499-7441**.

2018 Primary Care Provider Quality Reward Program

We understand the 2017 Risk Adjustment Factor (RAF) reward using CPT code 99429 was a challenge operationally. Therefore, we structured the 2018 incentives to be easier to manage, as providers are often asked to document for many patients. The

Annual Wellness Visit (AWV) quality reward is claim-based, so the provider may simply submit one of the 3G codes. We want to make the process for providers as smooth as possible so you may concentrate on patient care.

Quality Reward Program metrics:

Quality Metric	Amount of Reward	Eligible members	Description	Payment Frequency	Billing Codes
Annual Wellness Visit	$100 Per Member Per Year	Premier Medicare Advantage (MA)	Providers who perform an Annual Wellness Visit (AWV) on Premier MA members will receive a quality reward of $100, eligible once per member per year. Providers are encouraged to complete a patient assessment form (PAF) during the AWV. This is in addition to normal fee-for-service rates for this type visit.	Quarterly	G0402 G0438 G0439
Physician Coding/Risk Adjustment Training	$250 per physician, Nurse Practitioner (NP) or Physician Assistant (PA)	N/A	Physicians, NPs or PAs who attend a PHG-sponsored coding/risk adjustment training in-person or via a registered on-line webinar at least 1X per year (training will be offered quarterly) will receive a once-annual quality reward of $250. We hope to offer CME credits.	Yearly	n/a

If you have any questions, please contact us at **(937) 499-7441**.

Pharmacy Services

Beginning January 1, 2018 there will be some formulary changes that will apply to Premier Health Plan's commercial members – Premier Health Employee Plan and Premier Health Business Value Plan.

The following drugs will be removed from the formulary:

Drug Name	Alternative
FLUOCINONIDE 0.05	fluocinonide lotion and fluocinonide ointment.
HYDROCODONE-ACETAMINOPHEN 5-300 MG	hydrocodone/acetaminophen 5mg/325mg, hydrocodone/acetaminophen 7.5mg/325mg, and hydrocodone/acetaminophen 10mg/325mg.
NASONEX 50 MCG/ACT	fluticasone nasal spray, flunisolide nasal spray and Veramyst.
DYMISTA 137-50 MCG/ACT	fluticasone nasal spray, flunisolide nasal spray and Veramyst.
VICODIN ES 7.5-300 MG	hydrocodone/acetaminophen 5mg/325mg, hydrocodone/acetaminophen 7.5mg/325mg,

	and hydrocodone/acetaminophen 10mg/325mg.
HYDROCODONE-ACETAMINOPHEN 7.5-300 MG	hydrocodone/acetaminophen 5mg/325mg, hydrocodone/acetaminophen 7.5mg/325mg, and hydrocodone/acetaminophen 10mg/325mg.
QNASL 80 MCG/ACT	fluticasone nasal spray, flunisolide nasal spray and Veramyst.

The following non-preferred drugs will have a higher tier cost share. The alternative medications are preferred formulary medications:

Drug Name	**Alternative**
QVAR 80 MCG/ACT	Asmanex or Flovent HFA.
QVAR 40 MCG/ACT	Asmanex or Flovent HFA.
BYDUREON 2 MG	Trulicity and Victoza
XOPENEX HFA 45 MCG/ACT	Ventolin HFA
TUDORZA PRESSAIR 400 MCG/ACT	Incruse Ellipta or Spiriva.

Providers and Patients - Know your provider network

Kaiser Health News recently reported the federal government paid providers more to conduct urine drug tests in 2014 than was spent on the four most recommended cancer screenings combined. The article went on to point out that while much of this increased testing is driven by the heightened awareness of the chemical dependency problem that the USA is facing – including prescribed opioids – this, unfortunately, has led some providers of those services to take advantage of the situation by performing volumes of tests and expensive quantitative level testing that seems excessive. Unfortunately, the evidence based literature is lacking to give providers clear guidelines on drug testing and how to use them efficiently.

This is a good opportunity to remind our PHG providers of a few items. First, Primary Care Providers (PCP) should have Compact Care agreements with the specialists they use. Once the agreements are approved by both the PCPs and specialists, the agreements should specify how bidirectional communication should occur, how responsibilities of care and how care coordination are defined, etc. Secondly, it's both PCPs and Specialists' responsibility to be aware of and seek information regarding the **total cost of care** for their mutual patients – including ancillary costs – such as labs.

Finally, it is critical when making referrals for your patients, including labs and x-rays, to consider whether those referrals are within the provider network of the patients' health insurer. If not in-network, these 'blind' referrals (to which the patients may not have insight until after the fact) may lead to unexpected and significant cost to the patient, as well as increase the total cost of care for those patients.

As a reminder, Compunet Clinical Labs and Quest are the sole in-network laboratory providers for PHG. Compunet has committed to PHG to be available to our providers to answer questions about the vast array of reference lab tests available. Further, if a provider has a need for a medically necessary test not currently offered, Compunet will make arrangements with the appropriate reference lab and process the specimens for the provider. The provider should merely contact their Compunet lab representative to discuss.

Colorectal Cancer Screenings

Recently, there have been some quality of service issues arising from Colo-guard testing for our members. In the interest of helping you serve your patients, we wish to re-visit the subject of quality measures.

Care and performance assessment allows Premier Health Plan to continue its commitment to lead the region in high-quality, high-value care. Our focus on quality standards helps us remain a competitive choice for employers and a growing population of consumers, as well as meet requirements for our health plans. Our focus on quality and performance is part of what makes us a trusted provider of comprehensive care in our communities. The Healthcare Effectiveness Data and Information Set (HEDIS) helps us work toward that achievement.

HEDIS is a quality and performance assessment tool, required by the Centers for Medicare and Medicaid Services (CMS), which employs standardized measures set by the National Committee for Quality Assurance (NCQA). The review is conducted each January to May 15, and takes a retrospective look at care and services through claims, medical record reviews, and member surveys. The results guide us in developing quality initiatives, assessing performance, and building educational programs. Premier Health Plan is making new strides in quality performance and member care through their participation in the Healthcare Effectiveness Data and Information Set (HEDIS):

- **Benefits to members** - Our members thrive when we work toward and achieve excellence. The HEDIS initiative puts members in reach of preventive care and self-management, enhancing physician-patient relationships and resulting in quality outcomes.

- **Benefits to providers** - Premier Health Plan is committed to supporting the essential role physician practices play in promoting the health of our members. HEDIS measures help us identify ways to bolster quality of care and performance that not only improves member outcomes, but maximizes a practice's productivity and compensation. Premier Health Plan offers you the

tools you need to effectively manage your patient population and our quality reward programs reward your efforts in this regard.

One of the HEDIS assessments used is the Colorectal Cancer Screening measure. This measure is for patients 50 to 75 years of age who are members of a Medicare Advantage plan. It evaluates the percentage of members who had at least one appropriate screening for Colorectal Cancer based upon the below guidelines. Appropriate screening is an annual FOBT, annual FIT, FIT-DNA test (Cologuard®) once every 3 years, sigmoidoscopy in the last 5 years, or colonoscopy in the last 10 years.

How providers can help:

- Documentation (date and result) of one or more of these screenings that satisfy for the metric:
    - Colonoscopy during measurement year or 9 years prior to the measurement year;
    - Fecal Occult Blood Testing (FOBT) during measurement year;
    - Fecal Immunochemical Test (FIT) during measurement year;
    - FIT-DNA test (Cologuard®) during measurement year or 2 years prior to the measurement year;
    - Flexible Sigmoidoscopy during measurement year or 4 years prior to the measurement year
        - EXCLUSIONS from this measure by December 31st of the measurement year:
            - Members who have a history of colon cancer OR
            - Members who have had a total colectomy OR
            - Members who are under Hospice care

Currently the FIT-DNA test(Cologuard®) is covered by Premier Health Advantage plans (Medicare Plans).

Beginning in January 2018, the FIT-DNA test(Cologuard®) will be covered by all Premier Health Plan products that include:

Medicare Plans:

- Premier Health Advantage (HMO)
- Premier Health Advantage VIP (HMO and SNP)
- Premier Health Advantage Choice (HMO-POS)

Commercial Plans (Large Group):

- Premier Health Employee Plan
- Premier Health Business Value

Compliance Questions?

If you have compliance-related questions or concerns, you are encouraged to report them! If your issues or concerns were not or cannot be addressed through normal channels (i.e., Provider Services or Provider Relations), you are encouraged to contact Compliance anonymously by using the Compliance Hotline at **(888) 271-2688**, available 24 hours a day, 7 days a week.

Please see the Premier Health Code of Conduct at: http://www.premierhealthplan.org/About-Us/ for additional information about on our non-retaliation policy and about reporting compliance questions or concerns confidentially and in good faith.

Fraud, Waste and Abuse

Premier Health Plan is committed to building healthier communities in southwest Ohio. In one of our efforts to keep healthcare affordable, we seek to detect, correct and prevent fraud, waste and abuse. If you suspect fraud, waste or abuse please contact us at our toll-free number, **(855) 222-1046**.