Premier Health Group

From the Desk of the Chief Medical Officer

Welcome to our March 2018 edition of the 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 an important announcement regarding our Medicare Advantage Health Insurance plan. Learn about electronic prior authorization submissions, where to find our Quick Reference Guide and what information you can retrieve from the guide. Finally, read about our Quality Reward Program and CME credits that are offered.

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

IN THIS ISSUE

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. Form. This form is now 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 and Commercial Policies and Procedures. Click on the links below to view the most recent policies and procedures:

- Commercial policies and procedures
- Medicare policies and procedures

Earn a $250 Quality Reward and CME Credits

As part of the Quality Reward Program, you will receive a yearly quality reward of $250 if you complete the PHG sponsored coding and risk adjustment training. In addition, you will receive CME credits. The training will focus on defining Risk Adjustment and the importance of accurate documentation and coding.

The first training is scheduled for the below time. Please note there are two times to accommodate schedules. You will need to register for this training. Registration details will be announced in the April provider brief.

April 26, 2018
Premier Health Center
2nd Floor, Conference Room 2
7-9 a.m. OR 6-8 p.m.

Who should attend the training? Physicians, Nurse Practitioners, or Physician Assistants.

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**.

Medicare Advantage Health Insurance

As part of the implementation of Premier Health's 2020 strategic plan and the uncertainty in the current healthcare economic environment, Premier Health Plan and the Centers for Medicare & Medicaid Services (CMS) have mutually agreed to terminate their Medicare Advantage contract, effective April 1, 2018. Additionally, we have made the decision to exit the commercial large group insurance market, effective January 1, 2019, and will not be renewing any existing large group employer contracts. Premier Health has been and will remain committed to its mission of improving the health of the communities we serve.

We will continue that mission by ensuring that our Provider Services, Utilization Management/prior authorization and Claims Call Center teams remain intact and continue to be responsive throughout the transition process, which will extend beyond the dates we exit the Medicare Advantage and commercial large group markets. These teams are equipped to help ensure that you/your office receive timely resolution of your authorization requests, routine inquiries and outstanding claims issues. Additionally, you have our commitment that our provider portal and website will remain operational and will be updated timely throughout the transition process, as well.

The Centers for Medicare & Medicaid Services (CMS) is offering a Special Enrollment Period (SEP) for all affected members through May 31, 2018. All members enrolled in Premier Health Plan Medicare Advantage plans will be able to join another Medicare health plan or switch to Original Medicare during the SEP. Medicare Advantage members will receive a letter from the health plan with information about their SEP, their options and the next steps they need to take.

- We understand this may be confusing and we will do the best we can to give you the information you need.
- Premier Health has been and will remain committed to its mission of improving the health of the communities we serve.
- Rest assured, Premier Health Plan will ensure that your needs as a provider are met and addressed in a timely fashion until all run out operations are completed and addressed.

- Your patients enrolled in Premier Health Plan's Medicare Advantage plan can either join another Medicare health plan during a SEP or switch to Original Medicare. The SEP runs through May 31, 2018.
- **If your patients do not select a different Medicare health plan prior to April 1, 2018, they will be automatically enrolled in Original Medicare and in Silverscript, a Part D plan selected by CMS for their prescription drug coverage**.
- If your patients ask you for help in selecting a new plan:
  - You can tell them to call 1-800-Medicare or visit Medicare.gov for help in reviewing their health plan options;
  - They can also call the Ohio Senior Health Insurance Information Program (OSHIIP) at 1-800-686-1578 for assistance. Counselors are available to answer their questions, discuss their needs, and give them information about their options. All counseling is free. TTY users should call 711.
  - You can also share with your patients the **full list** of Medicare Advantage plans in which you participate as a network provider.
  - If you decide to assist your patient with this matter, **it is important you remain neutral**, assist your patient in an objective assessment of his or her needs, and review the potential options to meet those needs. You should try to help ensure your patient selects a plan that is in their best interest.
- You may notice an increase, starting April 1, 2018 and continuing through early June 2018, of individuals seeking care who do not yet have an insurance card. This is because when individuals enroll in a different Medicare Advantage plan or Original Medicare, their enrollment date is effective the month after they enroll (e.g., if they enroll in a new MA plan on March 5, 2018, their enrollment effective date with the new MA plan is April 1, 2018). If individuals enroll in a new plan mid-late month, they may not get their new insurance card by their effective enrollment date.

We sincerely apologize for any inconvenience this has caused you. If you need any assistance going forward, please do not hesitate to call Provider Inquiry at 1-855-514-3678.

Electronic Prior Authorizations Submissions

We are excited to announce that we are continuing to streamline processes to make workflows easier. No longer will paper faxes or phone be the only method for submitting Prior Authorization (PA) requests. You are now able to electronically submit PA requests.

By submitting the request electronically, you can:

- View the status of an authorization request at any time
- Edit an existing authorization request prior to decision

To submit a PA electronically, you need to have a Provider Portal account to access Identifi Practice. Identifi Practice is a web-based point of care decision support tool that enables you to submit PAs electronically. The web link to access Identifi is located on the homepage of the provider portal on the left-hand side.

Do you already have a Provider Portal account?

- If you answered **yes**, and want access to submitting PAs electronically, please send an email to PHG@PremierHealth.com with the following information:
  - User first name
  - User last name
  - Email address used to create the Provider Portal account
  - User name and phone number used for the Provider Portal account
  - NPI(s) you need access too
- If you answered **no**, then click here to register and create a user ID for the Provider Portal. Once you complete the registration process please allow two weeks before you receive your user ID to login to the portal. The portal can be accessed here. Once you receive your login information for the portal, you need to email PHG@PremierHealth.com requesting access to submit electronic PAs. Be sure to include the needed information outlined above, under the first bullet.

For all outpatient (non-emergent) CT, PET, MRI, MRA, Nuclear Stress and Echo Stress studies you will continue to use eviCore healthcare to request prior authorization. View the Premier Health Plan Implementation Resources website.

Quick Reference Guide

A reminder that the Quick Reference Guide is available online at https://www.premierhealthplan.org/Providers/Provider-Resources/Prior-Authorization-and-Pharmacy/. Find resources about prior authorization, Premier Health Plan implementation, and pharmacy. You can also download a formulary guide and prior authorization forms.

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, **1-855-222-1046**.