SecurityHealth Plan℠
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Provider News

FEBRUARY 2017

Reminder: decimal billing required on time-based therapy codes for BadgerCare Plus members

In accordance with Forward Health guidelines, Security Health Plan requires decimal billing on time-based codes for therapy received by BadgerCare Plus members.

Procedure codes for many occupational therapy (OT) and physical therapy (PT) services specify a unit of time. When an amount of time is specified, that amount of time equals one unit. For example, procedure code 97032 for PT and OT services indicates, "Each 15 minutes." This means that for this particular procedure code, one unit is equal to 15 minutes.

If you provide a patient with less than one unit of therapy, you must bill the units in decimals. For example, if you want to bill for 7.5 minutes of PT, you would bill .5 units (7.5/15 minutes).

Decimal billing is also appropriate for some speech therapy codes. Security Health Plan will review BadgerCare therapy claims for accurate billing on time-based codes.

For more information, please review the following Provider Handbook topics on the Forward Health Portal at **https://www.forwardhealth.wi.gov/WIPortal/Default.aspx**

1. Select "Online Handbooks" from the left-hand "Providers" menu.
2. Review License terms, click "I Accept" and then "Submit Agreement."
3. Click "Advanced Search," enter the below topic number you wish to review and click "Search."

    Topic 2751 Unit of Service

    Topic 2792 Physical Therapy Procedure Codes

    Topic 2793 Occupational Therapy Procedure Codes

    Topic 2794 Speech and Language Pathology Procedure Codes

Provider credentialing combined: Security Health Plan and Marshfield Clinic Health System

We are proud to announce our efforts to improve efficiency for both our providers and Security Health Plan: Security Health Plan's provider credentialing process has been combined with Marshfield Clinic Health System's credentialing process.

Please expect any future correspondence you receive regarding credentialing information to come from Marshfield Clinic Health System, rather than from Security Health Plan. Please call Marshfield Clinic Health System Manager of Credentialing and Privileging Julie Sinha with any questions: 715-221-7681.

Major depression: coding for care continuity

Patients come to you with a variety of health needs. In cases of depression, accurately coding the patient's condition can be nearly as challenging as determining the diagnosis. However, it's important to capture the diagnosis accurately for continuity of care and resource allocation based on risk.

The CMS V22 payment model for risk adjustment associates Major Depressive Disorder with a Hierarchical Condition Category (HCC) code, and the American Psychiatric Association's DSM 5 manual outlines diagnostic criteria. When the patient meets the below criteria, it is appropriate to code for Major Depressive Disorder:

Symptom	Frequency and duration
1. Depressed mood	Most of the day, nearly every day
2. Markedly diminished interest or pleasure in all, or almost all, activities	Most of the day, nearly every day
3. Significant weight loss when not dieting or weight gain; decrease or increase in appetite	Nearly every day
4. Insomnia or hypersomnia	Nearly every day
5. Psychomotor agitation or retardation	Nearly every day
6. Fatigue or loss of energy	Nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt	Nearly every day
8. Diminished ability to think or concentrate or indecisiveness	Nearly every day
9. Thoughts of death (not just fear of dying); suicidal ideation without a suicide attempt or a specific plan for committing suicide	Recurrent

A. The patient has at least five of the above symptoms in a two-week period and the symptoms are a change from prior functioning. ***(At least one of the symptoms must be #1 or #2.)***

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

The diagnostic code for Major Depressive Disorder is based on whether the patient has a **single** or **recurrent** episode. Consider the **attributes** below when documenting and selecting the most specific International Classification of Diseases, Tenth Revision, Clinical Modification (ICD 10) code:

A. **Episode frequency** – Is this a ***single*** or a ***recurrent*** episode? (There must be at least two months between separate episodes to be considered recurrent.)

B. **Severity** – Given a qualifying number of criteria symptoms, what is the severity (degree of functional disability) of those symptoms? (Refer to the DSM 5's levels of severity, below.)

- **Mild** – The patient has few symptoms in excess of those required to make the diagnosis; the intensity of the symptoms is distressing but manageable; and the patient has minor impairment in social/occupational functioning.
- **Moderate** – The number and intensity of symptoms (and/or functional impairment) are between those indicated for mild and severe.
- **Severe** – The number of symptoms is substantially in excess of those required to make the diagnosis; the intensity of the symptoms is seriously distressing and unmanageable; and the condition markedly interferes with the patient's social/occupational functioning.

C. **Association with psychotic symptoms**

D. **Remission** – Has the patient experienced a degree of remission?

- **Partial** – Symptoms of the patient's last major depressive episode are present but full diagnostic criteria are not met, or the patient experiences a period of less than two months without significant symptoms.
- **Full** – The patient has displayed no signs or symptoms of depression in the past two months.

When your documentation does not include any of the attributes listed in A-D above, it is appropriate to code "Depression Not Otherwise Specified (NOS)," "Depressive Disorder NOS" or "Major Depression NOS." These three diagnoses do not impact the risk factor scores of Medicare Advantage members.

From the pharmacy: Lower senior patients' overall risk

You're probably never more aware that all treatments have their trade-offs than when you're treating your senior patients. These patients tend to present with a host of interacting, complex health issues to manage. This often makes managing their medications a risk-benefit analysis, with patients' overall health as the goal.

Security Health Plan pharmacists share your goal; we'd like to offer our assistance with this particular challenge. We care about our members – your patients – as much as you do, which is why we're concerned that many of our Security Health Plan Medicare Advantage members are receiving high-risk medications.

High-risk medications are those identified by AGS Beers Criteria and by the Pharmacy Quality Alliance that tend to cause adverse drug events in older adults due to their pharmacologic properties and the physiologic changes of aging. Our members' prescription drug claims suggest skeletal muscle relaxants, indomethacin and digoxin (at doses higher than .125mg) are commonly prescribed medications on a list of drugs that should be used with caution in patients over age 65.

We're guided by both the Centers for Medicare and Medicaid Services (CMS) and the Healthcare Effectiveness Data and Information Set (HEDIS), which have quality measures focused on decreasing the use of high-risk medications in the elderly. The CMS measure is defined as the percentage of members receiving more than two prescription fills of a high-risk medication. For this measure, a lower percentage is better.

In the near future, Security Health Plan will share information with you regarding patients who may be receiving high-risk medications. Based on this information, please evaluate whether safer alternatives may be appropriate for your patients. The information supplied contains only recommendations and is not intended to be a substitution for your clinical judgement. We recognize providers see the "whole picture" when they assess and diagnose a patient, but we're always looking for ways to improve patient safety and health.

We're here to help whenever we can.

Please visit **http://onlinelibrary.wiley.com/doi/10.1111/jgs.13702/pdf** for a more complete listing of the 2015 AGS Beers Criteria of Potentially Inappropriate Medication Use in Older Adults.

Reminder: Stay current with 2017 prior authorization requirements

Security Health Plan requires prior authorization for certain medical services, care or equipment to ensure coverage and payment for those services. A number of requirements have been added for 2017 to make sure all care, services and treatments are medically necessary.

Providers can find specific prior authorization requirements on our website at **https://www.securityhealth.org/provider-manual/shared-content/utilization-management/prior-authorization**

You can also call our Provider Assistance Line at 1-800-548-1224.

Diabetic supplies: member coverage

When Security Health Plan members meet the clinical guidelines, they can receive coverage for their insulin pumps and Continuous Glucose Monitoring (CGM) devices from the below providers:

Neighborhood Diabetes
- Insulin Pumps
- CGMs

Tandem Diabetes
- Insulin Pumps

Byram Healthcare
- Insulin Pumps
- CGMs

Insulet Corporation
- Insulin Pumps

Aspirus
- Insulin Pumps

Note: All pumps, CGM devices and supplies require prior authorization. Providers can find specific prior authorization requirements on our website:

https://www.securityhealth.org/provider-manual/shared-content/utilization-management/prior-authorization

Provider appeals: adverse determination based on medical necessity

Security Health Plan uses nationally recognized criteria when making coverage determinations. When we deny coverage of a service or supply that is determined not medically necessary, not appropriate, or excluded because it is considered to be experimental or investigational, a provider may request an appeal.

You may appeal adverse determinations for prior authorization, pre-certification, referral authorization or hospital stays – in part or in total. When you appeal an adverse determination, you must support your request for reconsideration with additional information or written documentation from the medical record that was not previously reviewed by the Security Health Plan Medical Director. The Medical Director will consult with like-specialty physicians at his or her discretion.

Appeal timeframe

Appeals must be submitted within 60 calendar days from the date of the adverse determination and notification to provider of this determination. Appeals must be complete and contain all pertinent information. An appeal decision will be based only on the information submitted by the provider.

Security Health Plan will respond in writing within 45 calendar days from the receipt of the complete appeal. For BadgerCare Plus appeals, Security Health Plan will respond within 45 days from the date on the provider appeal form. An appeal is considered a complete appeal when Security Health Plan has received all requested information.

For formal appeal submission procedures, please visit: **https://www.securityhealth.org/provider-manual**, select *Claims Processing Policies and Procedures* and choose *Provider Appeal and Grievance Policy.*

Eligibility with ease: Verify patients' Medicare and Medicaid coverage with these tools

We're familiar with the struggles a provider may encounter when attempting to verify a member's eligibility for services – especially if that member has Medicare or Medicaid coverage.

Some patients carry outdated insurance cards (or no cards at all), while others struggle to distinguish between Medicare and Medicare Advantage Plans, or Medicaid and Medicaid Managed Care Plans. Not knowing a patient's coverage (and accompanying service requirements) can be costly for you and the patient.

We'd like to connect you with two resources that can help: the CMS and Forward Health portals.

Once you've created an account, you'll have a simpler process in place for verifying patients' Medicare and Medicaid eligibility and coverage. You'll be able to update your eligibility files with the correct payer and bill the appropriate parties.

***CMS portal:* https://marx.cms.hhs.gov**

***Forward Health portal, Medicaid*: https://www.forwardhealth.wi.gov/WIPortal/Default.aspx**

If you don't already have a Forward Health account, you'll need to contact your facility's system administrator to gain access. If no one at your facility has access, you can take the first set-up steps here:
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Account/PortalAccessRequest.aspx

As always, feel free to contact Security Health Plan's Customer Service Department at 1-800-548-1224 with questions pertaining to Medicare Advantage and Medicaid BadgerCare member benefits.

Help patients find you

- Has your practice relocated?
- Is your practice still accepting new patients?
- Has your facility changed its business name?
- Has your practice experienced staffing changes?

Help patients find you by keeping information about your practice current with Security Health Plan.

Security Health Plan's online provider directory is the primary provider search tool we offer our members. Members use the "Find a Doctor" tool to search for providers who can fill their specific care needs, whether they're looking for a primary care provider who sees children, a specialist with privileges at a specific hospital, or an affiliated nursing home near their aging parents.

To help patients find you, go to **www.securityhealth.org** and click on "Find a Doctor" at the top of the page. Whether you're a provider, a practice or a facility, please review the directory information for accuracy.

Be sure to contact us right away with any needed updates: You can report a change to Provider Relations staff at 715-221-9640, fax changes to us at 715-221-9699 or email us at **shpprd@securityhealth.org**.

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Provider *News*

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