SecurityHealth Plan℠

Promises kept, plain and simple.®

# Provider News

FALL 2015

## Discussing health issues with your patients

Security Health Plan members may be asked to complete surveys regarding conversations they have had with their provider that are mandated by the Centers for Medicare and Medicaid Services. The surveys ask our members if their providers have discussed specific healthcare concerns during their visits.

Responses to these questions have a dramatic impact on Security Health Plan's overall Medicare star rating. The star rating system generates additional plan revenue that is used for quality improvement activities and pay-for-performance contracting with our providers.

This is important to providers, because improved star ratings have a direct impact on provider reimbursement.

When visiting with your Security Health Plan Medicare patients, please be sure to discuss the following healthcare concerns at each visit:

- Falls
- Problems with balance or walking
- Improving physical activity and exercising regularly
- Urine leakage problems

## New mandatory generic policy for 2016

To manage costs and discourage the use of unnecessary, high-cost brand-name medication, Security Health Plan will change its 2016 pharmacy benefit to include an ancillary charge when a brand name drug is requested by the member where an FDA-approved generic equivalent is available. This applies to commercial, individual and family plans.

If a member requests the brand-name drug, they will be responsible for the copay and coinsurance that applies to the brand-name drug plus an ancillary charge. The ancillary charge is equal to the difference between the cost of the brand-name drug and the generic drug. The ancillary charge will not count toward the member's out-of-pocket maximum.

If a brand name drug is either legally required or medically necessary as deemed by the prescriber (and annotated on the prescription) the dispensing pharmacy can submit the claim as *"Physician writes dispense as written"* (DAW-1) or *"Substitution not allowed; brand mandated by law"* (DAW-7), then the brand name medication will be dispensed even if a generic is available, and the member will only be responsible for the co-pay and coinsurance that apply to the brand-name drug.

## Medical record documentation standards

Security Health Plan's medical record documentation standards can be found in the Credentialing Program Manual online at **www.securityhealth.org/credentialmanual**.

Scroll to the bottom of the webpage, under *Providers*, click on *Provider Manual*, and then *Credentialing Program Manual*.

# Security Health Plan moving away from Advocare name as we add new Medicare Advantage products

Security Health Plan is introducing two new Medicare Advantage products in 2016.

*Assurance Rx HMO-POS* lets members have their choice of providers with minimal additional costs. *Assurance Rx HMO-POS* is available exclusively in Columbia, Dane, Green, Iowa, Marquette, Richland and Sauk counties.

*Secure Saver,* a Medicare Medical Savings Account (MSA) will be available to Medicare beneficiaries with residence anywhere in Wisconsin.

Here's how *Secure Saver* will work:

- Each time a member visits their provider they will present their Secure Saver MSA member ID card.
- Providers should bill Security Health Plan.
- Members are responsible for payment of any bills until reaching the total annual deductible of $4,000; members can use their *Secure Saver MSA* debit card or check book to pay for qualified medical expenses. However, only Medicare-covered medical expenses will count towards the members' annual deductible.
- Once the member has reached the $4,000 annual deductible, *Security Health Plan* will reimburse up to 100% of Medicare fee-for-service approved rates.
- In choosing a *Medicare MSA Plan*, members are still in Medicare, will need to follow Original Medicare coverage and rules and will still have Medicare rights and protections.

As our portfolio of Medicare products expands, Security Health Plan has decided to move away from the Advocare name during the coming year. Other Medicare Advantage products for 2016 will be *Spirit HMO-POS, Spirit Rx HMO-POS, Essence HMO-POS, and Essence Rx HMO-POS.* You will see this name change reflected on your provider statements, member marketing materials and member ID cards.

However, the name change will not change provider reimbursement or contract terms, Prior Authorization or other Medicare requirements or your affiliation with Security Health Plan. Additional information on Security Health Plan's Medicare Advantage plans can be found on our website at **www.securityhealth.org/medicaredocuments**.

# 100-day Skilled Nursing Facility Benefit

It has come to our attention there is confusion regarding the 100-day skilled nursing benefit for Security Health Plan Medicare Advantage (Advocare) members.

Security Health Plan works with naviHealth to manage its SNF members to ensure they receive the right care at the right place of service for the right amount of time.

Medicare Advantage HMO members do have a 100-day SNF benefit. However, 100 days of coverage are not automatically provided. Each day of coverage is approved only when members have a skilled need, meet Medicare criteria and continue to make significant progress for the SNF coverage to continue up to a potential maximum of 100 days.

In the event you have a conversation with a Security Health Plan Medicare Advantage (Advocare) member about the skilled nursing facility benefit, please reiterate the 100-day benefit is not a guarantee of 100 days.

Please direct members to Security Health Plan Customer Service for specific questions about member benefits at 1-877-998-0998.

If you have any questions regarding this information please contact Dan Gell, Director of Health Services at 1-800-548-1224, extension 19677.

# Clarification on billing under the Medicaid EAPG system

Under the EAPG system, Wisconsin Medicaid reimburses hospital providers for outpatient hospital services based on the quantity and type of services they provide per date of service. To receive accurate and appropriate reimbursement under EAPG pricing logic, providers are required to submit all services completed on the same date of service on a single claim form. Failure to comply will result in claim rejections for any subsequent claim submissions.

For additional information, see topic #15258, titled "Billing under the EAPG system" in the Hospital, Outpatient Claim Submission ForwardHealth Provider Handbook.

# Sedative hypnotic coverage change

Zolpidem, eszopiclone and zaleplon are popular sedative-hypnotic sleep aids placed on the Beer's List by the Centers for Medicare and Medicaid Services (CMS). These products increase the risk of falls, hip fractures, and confusion when used in older patients. Safer alternatives exist, including non-pharmacologic attention to sleep hygiene or, if medications are necessary, OTC melatonin, the prescription melatonin agonist ramelteon, or prescription low-dose trazodone.

Sedative-hypnotics are recommended for short-term use in the FDA package labeling. Starting January 1, 2016, coverage for sedative hypnotic medications for Security Health Plan members with Part D will be limited to a 90-day supply in any 365-day period.

# We follow evidence-based clinical practice guidelines

Security Health Plan's has adopted evidence-based clinical practice guidelines that are used as the foundation of our disease management programs and clinical quality outcome measures. Clinical practice guidelines are available for the chronic conditions of diabetes, asthma, depression, ADHD, cardiovascular conditions, COPD and many other chronic conditions.

Health care guidelines are also available for preventive services for adults and for children and adolescents, as well as prenatal and postpartum care. These guidelines are reviewed and updated at least annually or more frequently as clinical practice recommendations change.

We recently reviewed and updated the guidelines. All guidelines may be accessed from our website at **www.securityhealth.org/guidelines**. From our home page, scroll to the bottom and click on *Provider Tools and Resources*. Find the paragraph, **Stay Current with Clinical Practice Guidelines,** and click on *Learn More*. You can request a paper copy of any of these healthcare guidelines by calling 1-800-548-1224.

# An update on prior authorizations

**Reminder:** A complete list of required prior authorizations can be found in the Care Management section of our Provider Manual at: **www.securityhealth.org/providermanual**.

### Chiropractors and high-end imaging

Effective January 1, 2016, chiropractors must seek prior authorization from eviCore (previously MedSolutions) for high-end imaging procedures.

### Effective February 1, 2016, radiation oncology services will require prior authorization

Security Health Plan will require prior authorization of radiation oncology services. We are working with eviCore (previously MedSolutions) to manage Security Health Plan radiation oncology service prior authorizations for our commercial, Medicaid and Medicare Advantage members.

Please visit **www.securityhealth.org/radiationservices** for additional information including a list of radiation oncology services that will require prior authorization.

### Answering your questions about Medicare Advantage coverage determination

If you need to submit a prior authorization for Medicare coverage determination, the form is available in the *Notice and Information* area of our website: **www.securityhealth.org/providernews**.You can find the form plus answers to common questions about Medicare Advantage.

### Answering your questions about prior authorizations for high-end imaging

eviCore (previously MedSolutions) does high-end imaging approvals for Security Health Plan. Please see our provider portal for the required CPT list and eviCore FAQs.

If you have received an approval for high-end imaging and during the procedure you have to upgrade the code, notification to eviCore is required within 3 days from the date of service.

### Medicaid members will need prior authorization for outpatient therapies beginning January 1, 2016

Based on requirements from Forward Health, Security Health Plan will reinstate prior authorization for outpatient therapies, including physical, speech and occupational therapies.

Providers will need to use the initial and concurrent prior authorization forms that are on our website.

Security Health Plan will use the Forward Health medical necessity criteria as stated in Forward Health Policy No. 2015-46.

### Outpatient therapy prior authorization will need appropriate coding

Outpatient therapy requests should include coding that appropriately matches the therapy treatment plan. If claims are submitted for modalities that were part of the treatment, but without prior authorization, these will be denied to provider as "provider contract requirement."

# Foot orthotics and shoe inserts

To align our coverage for durable medical equipment or supplies (DME) for our members with industry recognized standards, we have updated our medical criteria in our policies and certificates of coverage for those groups and members renewing January 1, 2016.

This change involves following DMERC criteria for foot orthotics and shoe inserts.

For these groups, foot orthotics and shoe inserts **received** after December 31, 2015, will have the new medical criteria applied. No **exceptions** will be made.

**Please note all items must be dispensed before January 1, 2016. If they are ordered but not received new criteria will be applicable.**

Other groups will have the new criteria applied as they renew in 2016.

## ICD-10 codes are now being used

The ICD-9 code sets used to report medical diagnoses and inpatient procedures have been replaced by ICD-10 codes **for any dates of service October 1, 2015, or after.** If any issues are identified with the new coding we will provide updates to our affiliated providers.

## HCC coding and morbid obesity

In 2014, morbid obesity was added as a diagnosis that supports a Hierarchical Condition Category code (HCC) in the Medicare Risk Adjustment model. Previously, ICD-9 CM Diagnosis Coding Guidelines indicated that a BMI of 40 (or greater) was required to support morbid obesity.

In the recently implemented ICD-10 CM Coding Guidelines, a specific BMI is not required to support the diagnosis of morbid obesity. However, diagnosis codes that indicate a BMI of 40.0 or greater also support the same HCC as morbid obesity, in the Medicare Risk Adjustment model. BMIs may be obtained and documented by clinicians other than the patient's provider.

The ICD-10 CM Coding Guidelines categorize morbid obesity further with the following additional details (when known):

- Morbid obesity due to excess calories
- Morbid obesity due to drugs (indicate specific medication if known)
- Morbid obesity is associated with alveolar hypoventilation

Include these details in your documentation related to a patient's morbid obesity, when the details are known.

Additional information about Risk Adjustment and HCC coding is available on the Security Health Plan website.

## Shared decision-making brochures

We know that shared decision-making is new to many members. So we have produced a brochure for your patients explaining what shared decision-making is and why it is required for some services.

If you would like copies of this brochure our Provider Relations team will be happy to supply them to you. To make a request for a supply of these brochures, call 1-715-221-9640.

## Make sure you update information for Provider Directory

The Centers for Medicare and Medicaid Services (CMS) now requires Medicare Advantage plans to regularly seek updated information for their online provider directory, including:

- Ability to accept new patients
- Street address
- Phone number
- Office hours
- Any other changes that affect availability to patients

Please contact Provider Relations and Contracting at 1-715-221-9640 with any modifications to the above items as soon as possible.

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# Provider News

## FEATURED INSIDE

- Discussing health issues with your patients
- Send us your updates!
- Clarification on billing under the Medicaid EAPG system
- Security Health Plan moving away from Advocare name, as we add new Medicare Advantage products
- Medical record documentation standards
- ICD-10 Updates
- 100-Day skilled nursing facility benefit
- Sedative hypnotic coverage change
- New mandatory generic policy for 2016
- Shared decision-making brochure
- An update on prior authorizations
- Foot orthotics and shoe inserts

**Provider News:** Security health Plan's Provider News is intended to keep providers in our network current with the latest developments in group and direct pay, Medicare, Medicaid and other managed care programs. You can view an electronic version of the newsletter at **www.securityhealth.org/providernews**. If there is a topic you would like addressed in Provider News, please contact Dave Mueller, editor, at 715-221-9817.