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Provider News

FALL 2016

Provider contract addendum outlines CMS dual-eligible requirements

Security Health Plan has a couple thousand dual-eligible members on its current plans. In addition, Security Health Plan is launching a Dual-eligible Special Needs Plan (D-SNP) in select counties, effective January 1, 2017. This new plan coordinates care for members that have both Security Health Plan Medicare Advantage and Wisconsin Medicaid.

Security Health Plan recently mailed a contract addendum to all practices to outline the Centers for Medicare and Medicaid Services (CMS) requirements for members eligible for D-SNP plans so providers can maintain compliance with CMS. The requirements apply to all dual-eligible members regardless of plan choice. Per provider contracts with Security Health Plan for its Medicare Advantage plans, providers already agree to comply with CMS requirements relating to Medicare Advantage plans. A quick summary of the information outlined in the addendum is noted below for your convenience. If you have additional questions, please contact your Security Health Plan Provider Relations Contract Manager directly or by calling 715.221.9640.

Dual-eligible

Federal law prohibits Medicare Advantage providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual-eligible program that exempts individuals from Medicare cost-sharing liability. Medicare Advantage plan members will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. The provider will either (a) accept Security Health Plan Medicare Advantage payment as payment in full, or (b) bill the appropriate state source.

Security Health Plan Medicare Advantage will provide for continuation of enrollee health care benefits —

(i) For all Medicare Advantage members, for the duration of the contract period for which CMS payments have been made; and

(ii) For Medicare Advantage members who are hospitalized on the date its contract with CMS terminates, or, in the event of an insolvency, through discharge.

Security Health Plan to remove shared decision-making requirements for most plan members

Over the last year Security Health Plan has utilized a shared decision-making tool in an effort to ensure members have all the information they need to be able to have a productive conversation with their providers about their options.

Security Health Plan talked with affiliated providers and found that providers have worked to incorporate the objectives of shared decision making into their practices. We commend our providers on embracing the shared decision making concept and working to ensure members are fully educated about treatment options prior to undergoing certain elective procedures.

Therefore, Security Health Plan has made the decision to stop requiring shared decision-making effective December 1, 2016, for all plan members **except for the State of Wisconsin employee group (ETF) as it is a contract requirement for this employee group.**

Feel free to contact Dan Gell, Director of Health Services, with questions or concerns at 1**-715-221-9677**.

Prior authorization updates for 2017

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

Examples of new prior authorizations for 2017 include:

- Genetic testing when received from any **in-network or out-of-network provider**
- For Medicare Advantage members, certain dialysis drugs covered under Part B when received out of network
    - Calcimimetics
    - Erythropoiesis stimulating agents
    - Injectable iron products
    - Levocarnitine
    - Phosphate binders
- For Medicare Advantage members when receiving out of network: high-end imaging tests, radiation therapy, outpatient rehabilitation, home health care, skilled nursing care and many other Part B drugs

This is a partial list of the new prior authorizations required of members and providers to obtain in order to ensure payment for services. Providers can find more information on 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**.

Plan to implement APR-DRG pricing for inpatient claims

Effective January 1, 2017, Security Health Plan will follow ForwardHealth's implementation of the APR-DRG (All Patient Refined Diagnosis Related Group) classification system to calculate pricing for inpatient hospital claims.

The APR-DRG system classifies patients into clinically meaningful groups that account for severity of illness and risk of mortality, thus pricing inpatient claims more appropriately. APR-DRG will replace the current pricing system, MS-DRG. This change will impact all inpatient hospital claims, inpatient crossover claims and encounters with dates of discharge or "to" dates of service on or after January 1, 2017. Additionally, Security Health Plan will require all providers to submit a DRG on their inpatient claims to ensure payment.

For additional information, please review this link: **https://www.forwardhealth.wi.gov/WIPortal/content/Provider/APRDRG/Home.htm.spage**

In association with the implementation of APR-DRG classification on January 1, 2017, when a woman gives birth, the hospital provider is required to submit separate claims for the hospital stay of the woman and the hospital stay of her newborn. In addition, the newborn's birth weight in grams must be recorded on any newborn's claim (age 0-28 days) using Value Code 54.

For additional information, please see the July 2016 ForwardHealth update titled "Policy Regarding Submission of Hospital Claims for Births."

Opioid program revised to ensure patient safety

Monitoring the utilization of opioids can ensure patients have access to safe, effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

Security Health Plan has revised our Opioid Management Program to include prospective alerts to pharmacies for high-dose opioid prescriptions and now requires clinical authorizations for morphine equivalent doses (MED) >240 mg. Authorizations will include attestation of checking the Wisconsin Prescription Drug Monitoring Database as well as a signed pain management agreement.

A retrospective review will be conducted each month to identify outlier members based upon: 5 or more opioid based medications claims and 3 or more prescribers and 3 or more pharmacies. Outlier members will be sent letters offering care management services and providers will also be notified of the event. Members who do not change behavior will be required to select a single pharmacy for prescription fulfillment of their opioid based medication prescriptions.

In addition, utilization reports and trend analysis will be implemented to measure outcomes of the program. This new program was implemented as of September 1, 2016.

Notice of 2017 formulary changes

In an effort to manage the cost of prescription medications, Security Health Plan has restructured its formulary. The updated formulary will be effective January 1, 2017.

These adjustments are being made for several reasons:

- Ensure our members receive the most appropriate, clinically safe and cost-effective therapies available
- Minimize premium, deductible and copayment/coinsurance increases for members, while still providing comprehensive and affordable benefits
- Control costs for employers
- Reduce waste in healthcare spending
- Shift costs back to pharmaceutical manufacturers

Some key things to know about the updated formulary:

- Security Health Plan has carefully reviewed all therapies listed in the formulary. As a result, some medications have moved to different copayment tiers.
- Depending on the tier change, members may experience higher out-of-pocket costs for some drugs while others may have lower out-of-pocket costs. Members who are likely to see higher copayments for their current medications will be notified in advance and provided with information about cost-effective preferred alternatives.
- In addition to the formulary update, we are implementing a 4-tier copayment structure for all commercial plans. For employers that currently have a 3-tier pharmacy benefit, the cost sharing for tier 3 and tier 4 prescriptions will be assessed the current tier 3 copayment.
- At the time of renewal, we will encourage employers to move toward a 4-tier benefit plan. The 4-tier copayment structure is more cost effective compared to the 3-tier copayment structure.
- Specialty medications and other high-cost prescriptions will be assessed the tier 4 cost-share. Specialty medications must be filled through our preferred specialty pharmacies. Our specialty pharmacies can help members take advantage of manufacturer copayment assistance programs that may reduce the cost of their medications.

All Security Health Plan employer groups and members are being notified of the formulary changes in October.

Security Health Plan recommends reviewing the formulary changes for 2017. Additional information, including the new list of covered prescriptions, can be found at **www.securityhealth.org/formulary**.

Drugs removed from the formulary or moved to higher tiers:

- OTC medications removed from formulary
  - Loratadine
  - Cetirizine
  - Fexofenadine
  - Folbic
  - Folgard
  - Ketotifen eye drops
- Opioid-based pain medications
  - Hydrocodone
  - Oxycodone
  - Codeine
- NSAID medications
  - Celecoxib
  - Fenoprofen

- Specialty medications:
  - Oral chemotherapy
  - Multiple sclerosis medications
  - Growth hormone
  - Hepatitis C medications
- Many generic topical corticosteroids (aclometasone, betamethasone dipropionate, clobetasol, desonide, desoximetasone, diflurasone)
- Combination ingredient products (amlodipine-atorvastatin, clindamycin-benzoyl peroxide, clotrimazole-betamethasone, erythromycin-benzoyl peroxide)
- Extended/delayed release formulations (Naproxen DR, verapamil ER)

Drugs added to the formulary or moved to lower tiers:

- Carbamazepine ER
- Ciprofloxacin ER
- Clarinex
- Desvenlafaxine ER
- Dimethylphenidate ER
- Fenofibrate micronized
- Guanfacine ER
- Lamotrigine (disintegrating form)
- Levetiracetam
- Polyethylene glycol powder
- Topiramate XR

Formulary changes for insulin

New prior authorization program for non-formulary brands

Security Health Plan changed the formulary on October 1, 2016, to make Novo Nordisk® insulin products preferred for members with prescription drug coverage. Additionally, a new insulin step therapy program has been implemented.*

All insulin manufactured by Novo Nordisk® (Novolin®, Novolog® and Levemir®) will continue to be the preferred brands and process at the member's tier 2 copay. Lantus® insulin will also remain as a preferred product.

Insulins manufactured by Eli Lilly and Company® and Sanofi® (Humulin®, Humalog®, and Apidra®) will become non-formulary products. These insulin products will reject at the pharmacy and require prior authorization paperwork from the prescriber.

Requests may be approved by Security Health Plan following an unsuccessful trial of a preferred insulin product or if other medical necessity is established. Approved requests will process at the higher, non-preferred, tier 3 copay.

Affected members have been notified of this change. They have been instructed to contact their insulin prescriber to discuss their choices and determine if a preferred brand is right for them.

If your patients have questions about their prescription drug benefits, please advise them to contact the number on their member ID card.

* These changes do not apply to members with Medicare Part D.

NCCI edits applied to commercial outpatient facility claims

Effective December 1, 2016 (claim receipt date), National Correct Coding Initiative (NCCI) bundling and day frequency edits will be applied to all commercial outpatient facility claims.

"The NCCI edits are applied to services submitted on a single claim, and on lines with the same date of service. NCCI edits address unacceptable code combinations based on coding rules, standards of medical practice, two services being mutually exclusive, or a variety of other reasons. In some cases, the edit is set to pay the higher-priced service, in other cases the lesser-priced service." – Integrated OCE (IOCE) CMS specifications

Please visit **https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/2016-Jul-Integrated-OCE-Specs.pdf** for more information.

Personalized Recovery Care can benefit plan members

Marshfield Clinic partnered with Contessa Health to operate a Personalized Recovery Care program for Security Health Plan members, which began September 1, 2016. Personalized Recovery Care provides the care needed to recover from a surgery or other procedure in a safe, comfortable and more cost-efficient setting than a traditional hospital setting. Rather than being admitted to a hospital for recovery, the patient may be admitted to a skilled nursing facility or the Comfort and Recovery Suites at Marshfield Clinic Health System, where care can be provided at the same high quality as in the hospital, but at a much lower cost.

Through this collaborative program, Security Health Plan members with certain conditions that would typically require inpatient hospitalization will have the option to receive hospital-level care in the comfort of the Comfort and Recovery Suites at a lower cost than traditional inpatient hospitalization. Members with these health conditions may be eligible for the Personalized Recovery Care program:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Deep vein thrombosis/Pulmonary embolism
- Urinary tract infections
- Cellulitis
- Pneumonia

How is high-quality care provided through this program?

Contessa Health professionals will identify Security Health Plan members who may qualify for the service, will talk with members about their condition, provide education about the Personalized Recovery Care program and determine the member's desire to participate in the program.

> ***For example:*** A member with congestive heart failure who requires I.V. diuretics and has no other complicating conditions would be identified by Contessa Health professionals for potential admission to the Personalized Recovery Care program. Contessa would talk with the member to provide education and get the member's agreement to receive hospital-level care at the Comfort and Recovery Suites. The member would receive continuous care from registered nurses and Marshfield Clinic hospitalists.

Security Health Plan members will be charged copays and deductibles associated with the specific services (doctor visits, facility-based services) they receive through the Personalized Recovery Care program.

Personalized Recovery Care is a ***convenient, safe*** and significantly ***more cost-effective*** way for Plan members to receive high-quality care for certain conditions.

Protein calorie malnutrition and HCC coding

Several nutritional abnormality diagnoses are associated with Hierarchical Condition Category (HCC) coding. ICD 10 coding related to protein calorie malnutrition includes the following diagnosis codes:

- E43 - Unspecified severe protein-calorie malnutrition
- E44.0 - Moderate protein-calorie malnutrition
- E44.1 - Mild Protein-calorie malnutrition
- E46 - Unspecified protein-calorie malnutrition

Security Health Plan's HCC auditors frequently note documentation of protein calorie malnutrition, along with patient history and clinical findings that support this diagnosis. In many of these cases, the provider is focused on the underlying condition that has contributed to the malnutrition and neglects to include the malnutrition diagnosis on the claim for service. However, protein calorie malnutrition (and any other diagnosis considered in the patient's care) should be added to the provider's claim whenever documentation indicates it is present.

Documentation to support a diagnosis of protein calorie malnutrition may include the patient's nutritional intake, weight loss, changes in muscle mass and subcutaneous fat, functional capacity, as well as laboratory findings. Documentation should indicate the severity of protein calorie malnutrition that correlates with the diagnosis code submitted on the claim for service.

Additional information about risk adjustment and HCC coding is available on the Security Health Plan Provider website at **https://www.securityhealth.org/provider-manual/shared-content/claims-processing-policies-and-procedures/risk-adjustment---hcc-coding**

Are you listed correctly in our provider directory?

- Did your practice move to a different address?
- Is your practice still accepting new patients?
- Has your facility changed its business name?

Security Health Plan's online provider directory is a tool members use to find a primary care provider who sees children, a specialist who has privileges at a specific hospital, or decide which affiliated nursing home is closest to mom and dad. Help our members find you as quickly as possible. Go to **www.securityhealth.org** and click on "Find a Doctor" at the top of the page. Whether you are a provider, a practice or a facility, please review the directory information to be sure everything listed is current and accurate.

Did you find a problem? Please contact us so we can correct it right away. You can reach our Provider Relations staff at **715-221-9640**, fax changes to us at 715-221-9699 or email us at **shpprd@securityhealth.org.**

Quitting tobacco:

E-cigarettes as smoking cessation aid up for debate among providers

Knowing what tobacco cessation medication to recommend to a hopeful and willing patient can be challenging. A provider is in a powerful position to offer advice and prescribe medication to send a patient down a life changing path.

Unfortunately, tobacco cessation advice is not an easy one-size-fits-all recommendation. According to a recent study conducted by researchers at Stanford University and the University of California in San Francisco and Berkeley, consumers are asking more and more about the safety of e-cigarettes as a smoking cessation aid. This same study is finding that the providers being asked generally have a "more positive attitude toward e-cigarettes." The study said 54 percent of providers included e-cigarettes as cessation aids, with or without reference to other cessation treatments.

The bottom line is that there are no e-cigarettes approved by FDA for therapeutic uses, and they are not a recommended cessation aid. E-cigarettes may contain ingredients that are known to be toxic, and there are also no known health effects of long-term use. The good news is that there are many FDA-approved treatments that are proven to be safe and effective, including Nicotine gum, nicotine skin patches, nicotine lozenges, nicotine oral inhaled products, nicotine nasal spray, Zyban and Chantix.

The decision to stop using tobacco is one of the most important decisions someone can make to improve their health, feel better and prevent early death. Security Health Plan encourages members to discuss with their health care provider any questions they have about quitting. We also have experienced health coaches ready to help support your patients during the quitting process through our telephonic Tobacco Free program. By simply calling Security Health Plan and asking to speak with a health coach, our members will have additional motivation and support to make their quitting experience a successful one.

Here are two sources for information on e-cigarettes and smoking cessation.

http://www.vapingpost.com/2016/09/07/smoking-cessation-clinician-providers-not-always-negative-toward-e-cigarette/

http://betobaccofree.hhs.gov/about-tobacco/Electronic-Cigarettes/

Discrimination is against the law

Security Health Plan of Wisconsin, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Security Health Plan of Wisconsin, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Security Health Plan of Wisconsin, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If your patient needs these services, contact Customer Service. If your patient believes that Security Health Plan of Wisconsin, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, your patient can file a grievance with:

Security Health Plan Member Advocate
1515 North Saint Joseph Avenue
Marshfield, WI 54449-8000
Phone: 715-221-9596 (TTY: 711)
Fax: 715-221-9449
Email: shp.quality.dept@securityhealth.org

Your patient can file a grievance in person or by mail, fax, or email. If your patient needs help filing a grievance, Security Health Plan's Member Advocate is available to help. Your patient can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
Phone: 1–800–368–1019 or 800–537–7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Limited English Proficiency Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY: 711).

Security Health Plan does not discriminate

The U.S. Office for Civil Rights (OCR) already prohibited discrimination on the basis of race, color, national origin, sex, age or disability. As of May 13, 2016, however, the definition of illegal discrimination has expanded: the final rule implementation of Section 1557, the nondiscrimination provision of the Affordable Care Act (ACA), made discrimination based on sex — including gender identity and sex stereotyping — illegal.

The Office for Civil Rights will uphold the new ruling in situations such as the following:

A transgender individual alleged that Aetna discriminated against him by denying him coverage for gender reassignment surgery and making inappropriate comments. Initially, Aetna told the complainant that this surgery was not covered under the terms of the complainant's health plan. However, during OCR's investigation, Aetna recognized that its original denial had inappropriately been based on an exclusion for cosmetic procedures. Aetna stated that requests for gender reassignment surgery are considered based on medical necessity and are covered under the complainant's plan in accordance with Aetna's policies. Aetna informed OCR that it will cover the complainant's gender reassignment surgery and is incorporating this surgery as a covered benefit in all of its group plans. In addition, Aetna is retraining its customer service representatives who respond to telephone calls to ensure that representatives respond to calls appropriately. (HHS.gov)

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The expanded discrimination definition will require significant changes of the Health Plan and its industry counterparts. But the modifications will be a team effort. Below are the major highlights of changes being made within the Health Plan to ensure compliance:

- **Certificates/Plan Documents/Marketing Revisions** - Any mention of specific gender benefit coverages must be removed. For example, "Over-the-counter contraceptives unless Food and Drug Administration-approved and prescribed for a woman by her health care provider," would be revised to, "Over-the-counter contraceptives unless Food and Drug Administration approved and prescribed by the health care provider."
- **Gender Reassignment Surgery** – While no longer excluded, these surgeries will require a prior authorization.
- **Operational Changes** – A review of auto claim edits due to gender will take place, along with revision of claim denial letters for denial based on medical necessity vs. sex (including pharmacy and appeals & grievance denials as well). The gender reassignment surgery policy will be activated and revisions to appropriate plan documents will include the required nondiscrimination/limited English proficiency notice.
- **Communication** – The changes will be communicated to members as well as to providers and third party business partners.

For additional information, including examples of discrimination and the requirements for communicating with Limited English Proficiency individuals, please check out this Section 1557 civil rights training PowerPoint provided by the U.S. Department of Health and Human Services, Office for Civil Rights: **http://www.hhs.gov/civil-rights/for-individuals/section-1557/trainingmaterials/index.html**

Hypertension control helps reduce cardiovascular disease

High blood pressure, or hypertension, has become known as the "silent killer." Hypertension increases the risk of heart disease and stroke, the leading causes of death in the United States. There is need for improvement, as medical costs related to high blood pressure total more than $46 billion annually. Reports also attribute a high death rate to high blood pressure. Approximately one in three U.S. adults have high blood pressure, but only about half of these people have it under control.

Security Health Plan uses the Healthcare Effectiveness Data and Information Set (HEDIS). The HEDIS measure CBP (Controlling High Blood Pressure) measures the percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year.

Two rates are reported:

1. Documented diagnosis of hypertension on or before June 30th of the measurement year.
2. The most recent blood pressure reading, which must occur after the date of the hypertension diagnosis and show adequate blood pressure control. Adequate control is based on the following criteria:
   - Members 18-59 years of age whose BP was <140/90 mmHg.
   - Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mmHg.
   - Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mmHg.

Unacceptable blood pressure readings are readings taken during an acute inpatient stay or an ED visit, those taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole), a blood pressure obtained the same day as a major diagnostic or surgical procedure, or a blood pressure reported by or taken by the member.

Members with evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to December 31, 2015 are excluded from this measure. Other exclusions include members who are pregnant within the measurement year and non-acute inpatient admission within the measurement year.

The following is included here as a reminder of best practices with hypertension:

Key Messages taken from the "Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure"

- In persons older than 50 years, systolic blood pressure greater than 140 mmHg is a much more important cardiovascular disease (CVD) risk factor than diastolic blood pressure.
- The risk of CVD beginning at 115/75 mmHg doubles with each increment of 20/10 mmHg: individuals who are normotensive at age 55 have a 90 percent lifetime risk for developing hypertension.
- Individuals with a systolic blood pressure of 120-139 mmHg or a diastolic blood pressure of 80-89 mmHg should be considered as prehypertensive and require health-promoting lifestyle modifications to prevent CVD.
- Thiazide-type diuretics should be used in drug treatment for most patients with uncomplicated hypertension, either alone or combined with drugs from other classes. Certain high-risk conditions are compelling indications for the initial use of other antihypertensive drug classes (angiotensin converting enzyme inhibitors, angiotensin receptor blockers, beta-blockers, calcium channel blockers).
- Most patients with hypertension will require two or more antihypertensive medications to achieve goal blood pressure (<140/90 mmHg, or <130/80 mmHg for patients with diabetes or chronic kidney disease).
- If blood pressure is >20/10 mmHg above goal blood pressure, consideration should be given to initiating therapy with two agents, one of which usually should be a thiazide-type diuretic.
- The most effective therapy prescribed by the most careful clinician will control hypertension only if patients are motivated. Motivation improves when patients have positive experiences with, and trust in, the clinician. Empathy builds trust and is a potent motivator.

Key Points taken from "JNC 8 Guidelines for the Management of Hypertension in Adults"

- In the general population, pharmacologic treatment should be initiated when blood pressure is 150/90 mmHg or higher in adults 60 years and older, or 140/90 mmHg or higher in adults younger than 60 years old.
- In patients with hypertension and diabetes, pharmacologic treatment would be initiated when blood pressure is 140/90 mmHg or higher, regardless of age.
- Initial antihypertensive treatment should include a thiazide diuretic, calcium channel blocker, ACE inhibitor, or ARB in the general nonblack population or a thiazide diuretic or calcium channel blocker in the general black population.,
- If the target blood pressure is not reached within one month after initiating therapy, the dosage of the initial medication should be increased, or a second medication should be added.

SecurityHealth Plan℠

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
www.securityhealth.org

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Provider News

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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.