SecurityHealth Plan℠
Promises kept, plain and simple.®

Provider News

Hot Topics

PLEASE SHARE WITH YOUR APPROPRIATE CLINIC PERSONNEL December 2015

Important: *To ensure that your questions are answered by the appropriate person, we have created new email addresses. Please use one of the following email addresses that best fit your questions:*

Benefit or Eligibility or General Inquiries: *shp.provider@securityhealth.org*
Claim Inquiries: *shp.provider.claim@securityhealth.org*
Subrogation/Workers Compensation: *shp.subrogation@securityhealth.org*
COB Inquiries: *shpcob@securityhealth.org*

Security Health Plan needs provider assistance to correctly code for cancer

The coding of cancer can be challenging for health care providers. Security Health Plan must follow the International Classification of Diseases – 10 CM (ICD-10) coding guidelines when submitting diagnoses to CMS; therefore it is important for providers to carefully consider the following definitions when submitting cancer diagnosis codes on claims. Providers frequently indicate that a patient needs to go years without disease recurrence before they consider the patient cured or to have a "history of" cancer, rather than active disease.

ICD-10 guidelines, which coders are required to follow, indicate that coders consider the following when diagnosing cancer:

- **"Active"** cancer – indicates a current, active diagnosis of cancer when the patient meets any of the following criteria:
  - Has evidence of current disease.
  - Is receiving treatment for cancer (includes surgery, chemotherapy, radiation or hormonal therapy). Monitoring for disease recurrence with diagnostic studies is not considered treatment.
  - Did not receive definitive treatment for their malignancy (personal choice or due to other circumstance).
- **"History of"** cancer – indicates the patient has successfully completed treatment for malignancy, has no current treatment for the condition, and no evidence of disease.
  - One exception to this logic relates to leukemia and lymphoma. Coding resources indicate that patients who are in remission are still considered to have active disease and codes should be assigned from the active category.

A recent audit of a sampling of Medicare Advantage members conducted by Security Health Plan revealed that 58 percent of the members who had been coded to have "active" cancer did not have provider documentation to support the diagnosis. These members should be coded as having a personal "history of" cancer.

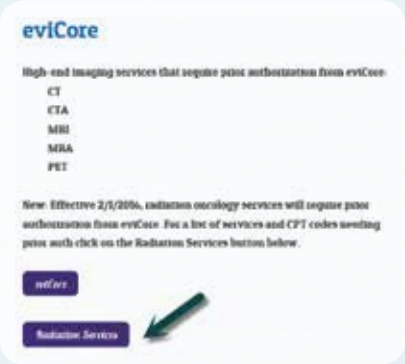
CMS holds health plans responsible for diagnoses that are submitted for risk adjustment. Security Health Plan is required to return the HCC coding revenue associated with the cancer diagnosis on these members to the Centers for Medicare and Medicaid Services (CMS). CMS provides the following cancer-related guidance to health plans when submitting supporting diagnostic documentation during a CMS Risk Adjustment Data Validation (RADV) audit:

> "Pay special attention to cancer diagnoses. Annotations indicating 'history of cancer,' without an indication of current cancer treatment, may not be sufficient documentation for validation. For example, if in an attempt to validate HCC 10 (Breast, Prostate, Colorectal and Other Cancers and Tumors) a Medicare Advantage organization submits a record that indicates a patient has a history of cancer that was last treated outside the data collection year, the HCC may not be validated."

Please consider this information when diagnosing cancer on your patients. Additional information about Risk Adjustment and HCC coding is available on the Security Health Plan website.

High-end imaging and radiation therapy prior authorization

Security Health Plan's Provider Portal provides fast and easy access to high-end imaging and radiation services prior authorization requirements and other information pertinent to your practice. Follow these instructions to find high-end imaging procedures and radiation services CPT codes that require prior authorization by Security Health Plan.



1. **Go to www.securityhealth.org/providermanual**
2. **Under "Group and Direct Pay" click on "Utilization Management"**
3. **Under "eviCore" click on "Radiation Services"**
4. **Here you will find a list of high-end imaging procedures and radiation CPT codes that require prior authorization**

If you have questions contact our Provider Relations staff by calling 715-221-9640.

An easy, fast way to check claim status

While our customer service representatives are always pleased to help you when you need help, providers have another, more efficient way to check on claim status. Use the steps below to send us a secure email to request the information you need:

Step 1: Go to **www.securityhealth.org/providers**, then scroll down and click on *Provider Tools and Resources*

Step 2: Scroll down and click on *Claims Inquiry*

Step 3: Copy and paste the information you need into the email

Step 4: Sending a secure email will be simpler and faster for you and for us

Important online information is a click away

You can find important information on services, standards and processes when you visit our Provider and Facility Manuals at **www.securityhealth.org/providermanual.**

- Clinic practice guidelines for chronic conditions (diabetes, asthma, depression, ADHD, cardiovascular conditions, COPD, nicotine dependence)
- Preventive service guidelines for patient care
- Descriptions of disease management and care management programs and how to refer patients
- Completing advance directives
- Obtaining a Quality Improvement program description and/or evaluation
- Site visit/medical record keeping standards
- Appointment access standards and availability of providers
- Medicare record documentation standards
- Utilization management: Obtaining a copy of the criteria used in making decisions, availability and how to contact medical director/pharmacist, how to contact the department, non-compensations statement, timeliness of decisions and hours of operation
- New technology, evaluation process and coverage decisions
- Pharmacy management procedures, formulary, exception process, prior authorization
- Statement of member rights and responsibilities; member complaints and appeals procedures

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**.

Hip/knee/back pain consults:
Remember to look at the authorization expiration date. If the member needs to continue seeing an orthopedic or neurosurgeon for his/her condition, a new prior authorization is required.

Physical therapy:
Effective January 1, 2016, Security Health Plan will not be requiring prior authorization for outpatient therapy visits for the BadgerCare plan.

You are reminded that for those plans that cover dry needling therapy services, prior authorization is required as well as appropriate coding. See the APTA position statement on what CPT code to use for these services.

High-end imaging/radiation oncology:
Effective **January 1, 2016**, the prior authorization (PA) requirement for high-end imaging (HEI) is **expanded** to require non-affiliated providers to obtain PA for HEI for Security Health Plan's commercial and BadgerCare plans. Non-affiliated providers are not required to obtain PA for HEI for Medicare Advantage plans.

Affiliated providers are still required to obtain PA for HEI for Security Health Plan's commercial, BadgerCare and Medicare Advantage plans.

Effective **February 1, 2016**, prior authorization for radiation oncology is required for all commercial and BadgerCare plans with affiliated and non-affiliated providers. Non-affiliated providers are not required to obtain PA for radiation oncology for Medicare Advantage plans.

Affiliated providers must also obtain prior authorization for radiation oncology for Medicare Advantage plans.

For inquiries regarding prior authorization requirements for Security Administrative Services, please utilize the contact information printed on the back of the member's ID card. Prior authorization requirements vary by each Security Administrative Services group.

Prior authorization of high-end imaging and radiation oncology services does not apply to Family Health Center members.

For more information refer to our Provider Manual located at www.securityhealth.org

Claims spanning 2 calendar years

As we near the transition to 2016, we would like to remind providers that outpatient, skilled nursing facility and NON-PPS inpatient (e.g. critical access hospital) services from different calendar years should be reported on separate claims. Claims spanning two calendar years will be denied with CARC 268.

For more information on this direction, please refer chapter 1, section 70.8.1 of the *Medicare Claims Processing Manual* at: **http://bit.ly/cmsguidance**

IMPORTANT NOTICE FOR DENTISTS AND ORAL SURGEONS

Coverage for services related to oral appliances for the treatment of obstructive sleep apnea

Effective January 1, 2016, Security Health Plan is updating how follow-up services for members with an oral appliance will be covered under member policies for our Commercial and Medicare Advantage plans including our new Medicare Medical Savings Account (MSA) plan.

Security Health Plan follows CMS standards of coverage for services relating to oral appliances for the treatment of obstructive sleep apnea. Per confirmation with CMS, coverage guidelines dictate that payment for all care associated with the oral appliance dispensed for obstructive sleep apnea is included in the reimbursement for the device. Specifically, "all care" is defined as the initial visit, fitting, adjustments, modifications, home sleep studies, and all other professional services. Claims for these professional services will be denied as not separately payable.

Effective for dates of service on and after January 1, 2016:

- Security Health Plan will deny all care prior to, the same day as, or within 90 days after delivery of the oral appliance, as ***provider*** responsibility.
- Security Health Plan will deny any follow-up services with a dentist or oral surgeon related to oral appliances that are greater than 90 days after the delivery of an oral appliance, as ***member*** responsibility.

CMS standards of coverage for services relating to oral appliances can be found in CMS Local Coverage Article A52512 (Oral Appliances for Obstructive Sleep Apnea) dated October 2015.

Security Health Plan formulary updates

Security Health Plan updates its interactive formulary to reflect both positive and negative changes prior to the 5th business day of each month. The Security Health Plan website also contains important information regarding covered medications, tier levels, prior authorization, quantity limits, generic substitution, and step-therapy.

Providers are encouraged to review the Security Health Plan website on a regular basis for the most recent updates. To learn more visit **www.securityhealth.org/prescriptiontools**.

Security Health Plan begins move away from Advocare brand name

Security Health Plan has begun to slowly retire the word Advocare when referring to our Medicare Advantage plans. This decision was made to prevent confusion as our Medicare Advantage service area continues to expand. Materials that have previously referred to Advocare will now refer to the term Medicare Advantage.

The name change will not change provider reimbursement or contract terms, prior authorization or other Medicare requirements, or your affiliation with Security Health Plan.

Prior authorizations for Security Administrative Services

Please visit the Security Health Plan Provider Portal to view important prior authorization updates regarding Security Administrative Services. The portal provides a list by Employer Group of services that will require pre-certification with Hines & Associates effective January 1, 2016.

Reminder, modifiers will be required on outpatient therapy claims effective 1/1/16

As communicated in the Spring 2015 Security Health Plan Provider News, in 2013 the Centers for Medicare and Medicaid Services (CMS) implemented a new claims-based data collection requirement for outpatient therapy services. As part of the change, CMS requires GP, GO and GN modifiers be reported on claims for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. To align with CMS's change, effective January 1, 2016, Security Health Plan will implement this requirement for all product lines (commercial, BadgerCare and Medicare Advantage), Security Administrative Services and Family Health Center, to allow for consistency in claims processing.

In line with CMS, all outpatient therapy codes billed must include modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- **GN** services delivered under an **outpatient speech-language pathology** plan of care
- **GO** services delivered under an **outpatient occupational therapy** plan of care
- **GP** services delivered under an **outpatient physical therapy** plan of care

Effective January 1, 2016, therapy claims billed without the appropriate therapy modifier (GP, GO, GN) will be denied for a missing modifier. Modifiers GN, GO and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. The modifiers should not be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services or nutrition therapy are not reported with therapy codes which require GN, GO and GP modifiers.

This instruction is applicable for all claims from physicians, non-physician practitioners (NPPs), PTPPs, OTPPs, SLPPs, CORFs, OPTs, hospitals, SNFs and any others billing for physical therapy, speech language pathology or occupational therapy services as noted on the applicable code list.

More information and the list of applicable therapy services is available at:
http://bit.ly/medicare-therapy

SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

You can save time and find answers to most of your questions on our website – ***www.securityhealth.org***. The Provider Portal features instructions and tutorials on *Eligibility and Benefits, Claim Status, Prior Authorization and Authorization Look-up*, and Checking Coverage – Schedule of Benefits. You'll find these tutorials on the *Announcements* page under *Provider Portal Education Materials*. If you need assistance navigating Security Health Online or need to talk with someone about a related matter, please call ***1-800-548-1224***.