SecurityHealth Plan℠
Promises kept, plain and simple.®

Provider News

Hot Topics

PLEASE SHARE WITH YOUR APPROPRIATE CLINIC PERSONNEL May 2016

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*

Physician and facility place of service must match or claims will be denied

Effective July 1, 2016, for all Security Health Plan products, when a member has both facility and professional charges, the place of service billed for the facility charges and professional charges must match or claims for **both** the facility **and** professional charges will be denied.

Example 1: A facility bills a patient as observation; the physician charges need to be billed as outpatient or both will deny.

Example 2: A patient is initially admitted to observation and during the stay, circumstances lead the patient to be inpatient; the facility and provider need to recognize this change and bill as inpatient or both claims will deny.

Note: All prior authorization/precertification requirements are still required as appropriate.

Providers must file BadgerCare post-service appeals within 60 days

Following guidance from the Wisconsin Department of Health Services, we are amending what was recently shared in the Spring 2016 Provider News. The new 365-day timeframe for post-service provider appeals will not apply to Security Health Plan's BadgerCare claims. Providers will continue to have 60 days from statement date to appeal any post-service BadgerCare claim denials.

Clarification regarding appeals (reconsiderations)

Effective for dates of service July 1, 2016, and after, for all Security Health Plan products **except SHP BadgerCare:**

To better align with industry standards, Security Health Plan will modify its timeline requirement for submitting appeals of post-service provider claim denials for all product lines except SHP BadgerCare. Appeals (reconsiderations) of post-service claim denials must be submitted within 365 days of the provider's statement date on which the charge was denied.

Please Note:

- No post-service appeals (reconsiderations) may be submitted until the claim has been received and denied in full or in part.
- The 60-day timeline for appeals of pre-service denials remains unchanged.
- The timeline for submitting appeals on behalf of members remains unchanged.

Colonoscopy preparation kits now covered

Effective May 20, 2016, bowel preparation kits prescribed prior to a cancer prevention colonoscopy screening are covered without any cost sharing to the Security Health Plan member. Preventive coverage has been mandated by the Affordable Care Act (ACA) and will be provided to all Security Health Plan commercial and exchange ACA members. All Food and Drug Administration approved kits with a prescription will be covered at $0 for these individuals ages 50 to 75.

SAS transitions to new claims platform

Security Administrative Services (SAS) members transitioned to a new claims platform effective April 1, 2016. Please note this platform is separate from the Security Health Plan platform. As a result of the transition, providers can no longer verify eligibility for SAS members online using the Security Health Plan provider portal. Eligibility verifications for SAS members should be directed to SAS customer service at **1-800-570-8760** or by email to **sascs@sastpa.com**.

New SAS Payer ID

Effective 4-1-16 claims submitted for SAS members should be using Payer ID #35202. Please note that claims for SAS members can no longer be submitted using Security Health Plan's Payer ID #39045.

As a result of the transition there has been a slight delay in claims processing for SAS members. We ask that you do not bill SAS members for any claims that are currently in an "insurance pending" status until you receive a remittance advice from SAS for the pended claim. We anticipate resuming normal levels of claims processing in the next few weeks and appreciate your cooperation during the transition period.

SAS provider portal active

The Security Administrative Services provider portal is up and running. Please contact SAS at **sascs@sastpa.com** to be set-up as a new user. Self-registration is not available at this time.

Follow NCQA guidance for rechecking blood pressure

During our annual HEDIS review of medical records required by NCQA, we found significant variations with guidelines regarding rechecking of blood pressure. NCQA recommends patients with a reading classified as hypertensive should be rechecked.

Recheck during office visit: If the blood pressure taken at the beginning of the exam is high, wait at least 5 minutes and recheck when the patient is more relaxed.

Recheck during follow-up visit: If the blood pressure taken during an annual exam is high, blood pressure should be checked at a follow-up visit during the same calendar year. A follow-up visit for blood pressure only can be scheduled.

Patients with hypertension should have an office visit at least annually.

The ICSI and NCQA recommendations for blood pressure are <140/90 for adults up to age 60, and <150/90 for age 60 and above.

For more information on blood pressure, we recommend this page from the American Heart Association: **http://hyper.ahajournals.org/**.

Risk adjustment coding requires greater detail

The Center for Medicare and Medicaid Services requires that ICD-10 coding guideline requirements are followed to support the diagnoses coded and submitted for risk adjustment.

ICD-10 coding guidelines are more specific than the ICD-9 coding guidelines that preceded them. This increase in specificity leads to a need for more details in documentation. The following details may impact specificity in coding and determine if a condition risk adjusts. This information should be documented when known:

- **Status of the condition:** Acute, chronic, acute on chronic, controlled, uncontrolled, mild, moderate, severe, stable, unstable, stage, type, etc.
- **Laterality/location:** Right or left, upper or lower, proximal/distal, systolic, diastolic, etc.
- **Cause & effect:** Create a link between conditions when one causes another. Use verbiage like "due to" or "secondary to," or similar to diabetic retinopathy, which makes it clear that one condition is causing the other.
- **Confirmed diagnosis:** Code the signs and symptoms of the patient's condition until you make a diagnosis. Avoid coding of probable, suspected or possible condition.

Providers should document and code all coexisting conditions the patient has that are applicable to the encounter with the patient. This includes conditions that are stable with treatment, being managed by another professional, or influence decision-making related to the current condition. For example, if a provider chooses a medication that is metabolized by the kidneys to treat an infection because the patient has liver impairment, it is appropriate to document and code the liver disease.

Coders are not allowed to interpret or make assumptions related to provider documentation and diagnostic studies. Provider documentation of the specific details of a patient's conditions and supporting studies is essential to support complete and accurate diagnosis coding. This specificity can impact whether a diagnosis is supportive of a HCC condition that can impact risk adjustment revenue.

Prior authorization needed for state-mandated Medicare Supplement skilled nursing stays

Providers are reminded that prior authorization is required for Security Health Plan members with Medicare Supplement policies when using the 30-day Wisconsin-mandated skilled nursing facility (SNF) benefit for non-Medicare covered stays.

For Medicare Supplement only, prior authorization requests and supporting documentation should be submitted to Security Health Plan by fax at **715-221-9980** or by calling **1-800-991-8109**.

NOTE: For Security Health Plan's commercial and Medicare Advantage members, naviHealth manages SNF admissions. Information should be submitted directly to naviHealth for those products.

New split-fill program will save money and reduce waste

Some individuals who take oral chemotherapy medications may experience severe side effects and need to discontinue taking their medication within the first few weeks of therapy. This often results in expensive medications wasted and creates a safety risk or potential environmental hazard.

Effective June 1, 2016, Security Health Plan is implementing a "split-fill" program for all commercial and health insurance marketplace members with a pharmacy benefit.

Details of the split-fill program:

- Members will be limited to receive up to a 15-day supply of medication during the first 12 weeks of therapy.
- The member's cost-sharing will be adjusted accordingly based upon benefit design. Example: The member will pay $10 for a 15-day supply if the standard copay is $20 for a 30-day supply.
- This program will only apply to members who have not had claims for a select list of medications within the past 3 months.
- Members who are able to tolerate therapy will be permitted to fill a standard 1-month supply of medication after this introductory period.

The following medications have been documented to be poorly tolerated by some individuals and are included in the new split-fill program:

Afinitor® (everolimus)	Tarceva® (erlotinib)
Bosulif® (bosutinib)	Targretin® (bexarotene)
Erivedge® (vismodegib)	tretinoin
Gleevec® (imatinib)	Stivarga® (regorafenib)
Sprycel® (dasatinib)	Votrient® (pazopanib)
Inlyta® (axitinib)	Xtandi® (enzalutamide)
Jakafi® (ruxolitinib)	Zelboraf® (vemurafenib)
Lysodren® (mitotane)	Zolinza® (vorinostat)
Nexavar® (sorafenib)	Zytiga® (abiraterone)
Sutent® (sunitinib)	

Attending provider NPI required for Medicare claims

Institutional providers are reminded that the attending provider national provider identifier (NPI) is a CMS requirement on claims for all services other than emergency transportation. The attending provider NPI must not be your facility or billing NPI; the name and NPI must be an individual provider.

See MLN Matters Number **MM7902** for further information.

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***.