Medicare Advantage benefits now include routine eyeglasses stipend

Beginning January 1, 2017, in addition to Medicare-covered vision benefits, most Security Health Plan Medicare Advantage plans provide a stipend for routine eyeglasses from a network provider. The stipend amount varies by plan and is listed below. The plan name is listed on members' ID card for easy identification.

- $175 stipend for eyeglasses for these Medicare Advantage HMO-POS plans:
   ○ Essence, Essence Rx, Spirit, Spirit Rx, Assurance Rx and Promise Rx
- $150 stipend for Surety Rx HMO-POS
- $275 stipend for Ally Rx D-SNP (Dual-eligible Special Needs Plan)
- No coverage for Secure Saver MSA (Medicare Medical Savings Account)

At this time, Security Health Plan does **not** allow patient paid claims from in-network providers. Because this is not a separate benefit but is combined with the Medicare Advantage member's medical insurance, providers **MUST** send a claim to Security Health Plan.

Providers may decide the best operation for their business, but here are a few options to consider:

1. Provider requires a minimum deposit to place the eyeglasses order from the member and sends a claim. Security Health Plan processes and sends payment according to the stipend amount available. If necessary, the provider bills the member for any additional balance.

2. Provider assumes the member has full stipend amount available based on their plan and collects the remaining portion at time of the eyeglasses order. The provider sends a claim, and Security Health Plan processes and sends payment according to the stipend amount available. If necessary, the provider bills any remaining portion to the member.

3. Provider charges the full amount to the member upon eyeglasses order and sends a claim for the full amount. Security Health Plan processes and sends payment according to the stipend amount available. The provider will then have to reimburse the member for any credit due.

For a good overview of each plan, you can find Customer Guides and other member materials at the following link: **https://www.securityhealth.org/insurance-resources/member-document-library/medicare-plan-documents**

Drug Utilization Review edits maintain safe, effective therapy

All pharmacy claims submitted for processing are subject to point of sale drug utilization review (DUR) checking to detect potential therapeutic problems. DUR alert messages are returned to the pharmacist when problems are discovered by this review. The purpose of DUR is not to replace professional judgment or individualized patient care in the delivery of health care services, but rather to enhance it with additional information.

Effective January 1, 2017 Security Health Plan has activated additional point of sale DUR edits for:

- Drug/Drug Interaction (severity 1)
- Therapeutic Duplication
- Morphine Equivalent Dosage (MED)

These edits will have minimal impact on providers, as pharmacy providers will be able to assess the appropriateness of therapy and override the edit by entering standard codes in their pharmacy claim system.

Please contact Security Health Plan Pharmacy Services at 1-877-873-5611, Monday through Friday from 8 a.m. to 5 p.m., if you have any questions regarding these new edits.

837/835 Enrollment Requests must come from providers

Security Health Plan will no longer accept 837/835 Enrollment Requests from clearinghouses. These forms should to be completed by providers and/or practice locations. When completing the form, ensure that you have completed all sections including the Clearing House Information section.

The 837/835 Enrollment Request can be found in the provider document library on Security Health Plan's website:

www.securityhealth.org/providers/provider-tools-and-resources/provider-document-library

Scroll down to "Claims" and the first selection is the 837/835 Enrollment Request. Click on the link to fill out and print the form. Fax the completed form to Security Health Plan Provider Relations at number **715-221-9699**.

If you have questions regarding the form or this process, please call Provider Relations at **715-221-9640**.

SNFs must use naviHealth-assigned RUG level for Medicare Advantage member claims

Notice for skilled nursing facilities:

Beginning with dates of service of March 1, 2017, the naviHealth-assigned RUG and HIPPS code 60 are required to be submitted on your claims for Medicare Advantage members. In the event you submit a different RUG than what was assigned by naviHealth, your claim will be denied. You may resubmit the claim with the assigned naviHealth RUG or submit a provider appeal.

There is a process for advocating for a different RUG level versus the naviHealth-assigned RUG level. Please reach out to your assigned naviHealth Care Coordinator to initiate this request.

Providers can help improve health outcomes survey results

Medicare's annual Health Outcomes Survey (HOS) measures how the care provided to members of Medicare Advantage Organizations (MAO) such as Security Health Plan affects their health outcomes.

The survey is sent to a sampling of MAO members in April through June. It asks members age 65 and older to report on the care and treatment they received from their health care providers.

The survey includes questions that address mental and physical health, physical and social functioning, pain, energy and quality of life. Members are surveyed to collect a baseline, then surveyed again 2 years later to measure the change in health over time.

How providers can help improve HOS results

Use your patient's annual wellness visit to discuss the following:

- Discuss balance problems, falls, difficulty walking and other risk factors for falls
  - Suggest the use of a cane or a walker
  - Check orthostatic blood pressures
  - Suggest an exercise or physical therapy program
  - Suggest a vision or hearing test
  - Perform bone density screening, especially for high risk patients

- Discuss the need for physical activity and ways to increase physical activity
  - Talk to your patient about the importance of exercise and physical activity
  - Discuss with the patient how to start, increase or maintain activity

- Discuss bladder control and potential treatments for bladder control issues that may arise as the patient ages
  - Ask your patient if bladder control is a problem
  - If so, ask if it interferes with sleep or daily activities
  - Talk to the patient about treatment options

- Discuss physical and mental health
  - Ask your patient about physical and mental health compared to 2 years ago
  - Discuss ways to improve status of both mental and physical health
  - Suggest your patient begin exercise programs or physical therapy if warranted

These topics can be discussed by the office or nursing staff while patients are waiting to be seen and can be addressed by the provider during the visit.

New payment reduction modifier for X-rays using film

A new payment reduction modifier became effective on January 1, 2017, for Medicare Advantage claims and will be effective March 15, 2017 for all other Security Health Plan products except for BadgerCare Plus. When billing for an X-ray using film, the claim must include modifier FX. A payment reduction of 20 percent will apply to the technical component (and the technical component of the global fee) for X-ray services furnished using film.

Note that the beneficiary is NOT liable for the FX modifier payment reduction.

For more information please contact your Provider Relations Contract Manager.

Check website for monthly formulary updates

Security Health Plan updates its interactive pharmacy 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**.

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?
- Are all of your listed providers still current with your practice?

Security Health Plan's online provider directory is a tool members use to choose a primary care provider who sees children, find 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 is current and accurate.

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

HCC diagnosis opportunities with COPD and other respiratory conditions

Chronic Obstructive Pulmonary Disease (COPD) is a progressive and often disabling condition associated with chronic airflow limitation. Emphysema and chronic bronchitis are the two most common types of lung disease categorized as COPD.

These conditions are risk adjustment eligible in the Medicare Risk Adjustment model. The HCC category associated with COPD is in the top five of Security Health Plan's missed HCC diagnosis opportunities.

Appropriate resource allocation for medical care and reimbursement from CMS is dependent upon proper and specific diagnostic reporting. A very important piece to this puzzle is that your documentation supports the ICD 10 diagnosis code you submit on the claim. If the diagnosis is not supported by documentation, it cannot be reported to CMS for risk adjustment. Here are documentation and coding considerations related to COPD:

1. What is the patient's condition?

   a. Bronchitis:

      - Acute or chronic

      - Simple, mucopurulent or mixed chronic bronchitis

      - Chronic tracheobronchitis

   b. Emphysema

      - Unilateral pulmonary, panlobular or centrilobular emphysema

      - Emphysematous bleb

      - Vesicular emphysema

      - Emphysema, unspecified

   c. COPD

      - Chronic obstructive pulmonary disease

      - Chronic obstructive pulmonary disease with acute lower respiratory infection

      - Chronic obstructive pulmonary disease with (acute) exacerbation

2. Is the patient on continuous oxygen? Does the patient have chronic respiratory failure? This is a separately identified HCC from the one associated with COPD.

3. What is the current status of the condition? Is it stable, worsening or improving?

4. How is the condition being managed? Medication, pulmonary rehabilitation, managed by pulmonary, etc.?

Keep this golden rule of HCC coding in mind when documenting and coding COPD and other conditions: **Do not code more specifically than your documentation supports. In other words, documentation must support the diagnosis reported.**

Information about HCC coding is available on our website: **www.securityhealth.org/provider-manual/ shared-content/claims-processing-policies-and-procedures/risk-adjustment---hcc-coding**

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