Security Health Plan℠
Promises kept, plain and simple.®

Provider News

PLEASE SHARE WITH YOUR APPROPRIATE CLINIC PERSONNEL July 30, 2015

Claim Questions: *For any claim questions, please contact the Provider Claims Line at* ***1-800-584-1224*** *or via email at:*

- ***Subrogation:*** *shp.subrogation@securityhealth.org*
- ***Workers Compensation:*** *shp.work.comp@securityhealth.org*
- ***COB Inquiries:*** *shpcob@securityhealth.org*
- ***CLAIMS Inquiries, Benefit, Eligibility, or General Inquiries:***
  - ***Commercial Claims:*** *shp.commercial.provider@securityhealth.org*
  - ***Medicaid/FHC Claims:*** *shpgovt.claimprocess@securityhealth.org*
  - ***Advocare Claims:*** *advocare.claim@securityhealth.org*
  - ***Security Administrative Services:*** *shp.tpa.provider@securityhealth.org*

Hines & Associates to provide managed care services for Security Administrative Services

Security Administrative Services, which administers employers' self-funded insurance plans, is contracting with Hines & Associates for managed care services – care management, disease management, utilization management, and precertification for inpatient and outpatient services.

For some employers who use Security Administrative Services for managing care, the transition will take place as employer's self-funded plans renew contracts with Security Administrative Services. Once a contract has been renewed, covered beneficiaries will receive new ID cards that directs providers to contact Hines & Associates for precertification.

Providers will continue to send claims to Security Administrative Services. Here's how the ID card will appear for converted groups administered by Security Administrative Services.

For Pre-certification contact
Hines & Associates at
1.800.483.5984
or
www.precertcare.com

Security Health Plan
Security Administrative Services
PO Box 8000
Marshfield WI 54449-8000

Providers, for prompt payment send claims to:
Security Administrative Services
PO Box 8000
Marshfield, WI 54449

Avoiding denials due to incorrect billing of repeat procedures for Badgercare claims

Providers can avoid denials and payment delays for services to their BadgerCare patients if they follow proper billing procedures.

When billing repeat procedures or services, the first instance of the procedure or service should not have a repeat procedure modifier. All other instances of the procedure or service performed on the same day on the same patient should be submitted on one line with the appropriate quantity and appropriate repeat procedure modifier.

Example of **INCORRECT** lab billing:

DOS	CPT/Modifier	Units
5/20/14	86147	1
5/20/14	86147-91	1
5/20/14	86147-91	1

Example of **CORRECT** lab billing:

DOS	CPT/Modifier	Units
5/20/14	86147	1
5/20/14	86147-91	2

When another insurance carrier is primary, Security Health Plan will need this information

Claims for members with an insurance primary to Security Health Plan must include the other insurance name, subscriber name and ID number listed on the member's other insurance ID card.

This information is very important when coordinating benefits for members with other insurance, and applies to both electronic and paper claims. When submitting an explanation of benefits (EOB) from the member's primary insurance, a copy of the original EOB or a printout from the provider's system is acceptable.

An EOB printout from the provider's system must include all pertinent information from the original primary EOB.

Electronic Funds Transfer payments available for Security Administrative Services

Providers who currently receive electronic funds transfer (EFT) payments from Security Health Plan will start receiving EFT payments for patients that have their health coverage administered by Security Administrative Services (SAS). We are in the process of implementing EFT payments on behalf of our self-funded groups administered by SAS.

With EFT, we'll deposit your payments directly into your bank account, making them available to you more quickly.

To sign-up for EFT simply go to the Provider Document Library at **www.securityhealth.org** and download the EFT enrollment form.

If you have questions about EFT payments from Security Administrative Services you can contact our Provider Relations and Contracting Department at **1-800-548-1224**.

Make sure Place of Service codes correctly match patient's hospital status

For Advocare and Medicaid products, professional services corresponding to an inpatient or outpatient hospital visit must be billed with the appropriate Place of Service (POS) code, inpatient 21 or outpatient 22.

In some cases, professional services are billed with an inpatient place of service, but the patient's hospital status has changed to outpatient, or the authorization for an inpatient stay is denied. All POS codes for professional services billed must match the patient's hospital status or the claims will be denied.

Providers can check a member's up-to-date claim status

Providers are concerned about providing services to members who may be in a grace period – knowing they are at risk for nonpayment if the member is soon to be disenrolled.

By going to the Security Health Plan Provider Portal, providers can get real time information on a member's status and find out if the member is in a grace period. If a member is in a grace period, this is displayed under the member's benefits and will identify if the member is in Premium Grace Period Month 1, 2 or 3. If a member's premium is paid in full for the month, the "Premium Grace Period" line will not display at all.

Insurance Carrier	Eligibility Dates
1. COMMERCIAL QUALIFIED HEALTH PLANS	01/01/14 - Curren

Benefits

Premium Grace Period - Month [2]
Below is an explanation of COMMERCIAL QUALIFIED HEALTH PLANS medical benefits from all pr
This does not include any pharmacy, mental health or AODA benefits.
Consult the online Provider Directory for affiliation information.

Dry needling is not a coverable service

For trigger point injections, dry needling is not a coverable service. Dry needling is considered experimental or investigational.

Provider appeals are required within 60 days of pre-service denial

As a reminder: The time frame for a provider to submit an appeal is within 60 days after an adverse determination (pre-service denial). You can find the appeal form in the Security Health Plan provider manual.

An appeal for a post-service claim denial must be received within 60 days of the claim denial.

Once an appeal determination has been upheld, the decision is final and binding and no further appeal rights are available, with the exception of members of certain groups covered by Security Administrative Service. For more information contact our Customer Service department **1-800-472-2363** to verify.

Some updates on prior authorization

Case numbers and prior authorization numbers differ

When Security Health Plan's Utilization Management staff set up case management, the provider is given a case reference number, indicating the case has been set up and no determination has yet been made. The prior authorization number is issued when the case determination has been approved.

Worker's compensation/liability cases

Prior authorization should be sought for worker's compensation/liability cases, to avoid denials in the event worker's compensation/liability coverage is denied or exhausted.

If a Security Health Plan member is being seen for an injury believed to be work-related and covered by worker's compensation, the services should be prior authorized at the same time the service is provided, to ensure coverage in the event the injury is not deemed worker's compensation-related.

Therapy services will include range of dates and number of visits

When obtaining prior authorization for therapy services Security Health Plan will issue a specified number of visits and a date range.

We will always authorize the number of visits and a date range for those visits. This allows for the authorized number of visits to be used during the established time frame. The visits approved do not carry over past the date range.

For example, Security Health Plan has approved 8 physical therapy visits between August 1 and August 31, but on August 30, the member has used only 6 visits. If the member needs the final two visits, the provider must notify Security Health Plan of the need to continue treatment beyond the end of the approved date range (August 30).

Security Health Plan does not retro-authorize services.

No prior authorization required for joint injections

While prior authorizations are required for orthopedic consults, no additional prior authorization is required if the provider will be doing injections into the joint. If at the time of appointment the physician finds the cause is different from the original diagnosis, a separate prior authorization is not required. Example: a member comes in with an approval for a hip pain consult, the provider does the evaluation and finds that back pain is the cause of the patient's discomfort - no prior authorization is required to add the back diagnosis. Prior authorization for future visits is required.

Notification is only required for acute injury and past surgical history on the same joint.

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***.