SecurityHealth Plan℠
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Provider News

SPRING 2016

Security Administrative Services moves to new claims processing system

On April 1, 2016, Security Administrative Services LLC (SAS) migrated to a new claims processing system which will require changes for electronic claim filing. SAS will have its own payer ID which is 35202. Your clearinghouse will need to be notified of this new SAS ID for claims submission.

SAS has contracts with the following clearinghouses to accept electronic claims.

- Emdeon
- SmartData Solutions
- Carevu

Security Health Plan will forward electronic claims to SAS until May 1, 2016. After this date providers will need to send claims to the new payer ID.

Please feel free to contact Eric Twerberg, SAS chief operations officer, with specific questions at **715-221-9575** or **twerberg.eric@sastpa.com**.

Attention:

On April 1, Security Administrative Services participants migrated from the QNXT platform to Luminx. The result is that eligibility appears as terminated on the current Security Health Plan portal. If checking for coverage of SAS participants, please go to http://sastpa.com/providers or email SASCS@sastpa.com.

Itemized statements must be accurate or claims will be denied

Security Health Plan requests itemized statements from facilities in the course of UB-04 claim reviews. We have observed a number of errors in itemized statements, such as:

- Supplies used during a surgery, but billed the day before or after the surgery date
- Duplicate billing of items or services that are provided daily, such as medication or oxygen
- Invalid ICD-10 procedure codes

For audit purposes, it is important the information in itemized statements is accurate and transparent. Effective June 1, 2016, incorrect billing on an itemized statement will cause your claim to be denied.

Improve your reimbursement: Talk to your Medicare patients about these topics

To ensure your practice receives the best possible reimbursement for a performance–based contract, providers need to discuss certain topics with their Medicare patients. Each year Security Health Plan members may be asked to complete surveys regarding conversations they've had with their providers. The surveys ask our members if their providers have discussed specific health care concerns during their visits. Discussion of these concerns is mandated by the Centers for Medicare and Medicaid Services (CMS).

Responses to these questions have a dramatic impact on Security Health Plan's overall Medicare star rating. The star rating system generates additional plan revenue that is used for quality improvement activities and pay-for-performance contracting with our providers. Improved star ratings have a direct impact on provider reimbursement.

When visiting with Security Health Plan Medicare patients, providers should be sure to discuss the following health care concerns at each visit:

- Falls
- Problems with balance or walking
- Improving physical activity and exercising regularly
- Urine leakage problems

Attestations ensure compliance with CMS requirements

CMS requires Medicare Advantage plans to ensure all of their contracted providers meet CMS requirements for First Tier Downstream and Related Entities (FDRs). Accordingly, Security Health Plan must collect annual attestations from contracted providers to verify compliance with CMS requirements.

To help meet this requirement, Security Health Plan implemented a process using a compliance software vendor, Compliance 360. Attestations for 2015 were emailed during the 4th quarter of 2015. If you did not receive an attestation for 2015 from Compliance 360, please check your junk email.

You should have received a follow-up email on February 26, 2016. Please understand that failure to provide your 2015 FDR attestation could subject you to an audit by Security Health Plan. Your attention to this matter is greatly appreciated.

Beginning in January 2016, Security Health Plan began distributing FDR attestations using providers' contract effective dates. Some of you may have already received a 2016 Attestation. We made this change to help us comply with the new CMS requirement that all new providers need to complete an attestation within 90 days of their contract effective date. To be consistent, we've taken the same approach to send attestations to existing contracts according to their contract effective date.

If you have not completed your 2015 attestation or are unable to find the email, please call Tiffany Faber at **715-221-9877** or Tammy Zenner at **715-221-9734** or email **shp.compliance.dept@securityhealth.org**.

Avoid probable, possible or suspected diagnoses

As a health care provider, you are regularly asked to piece together your patient's symptoms, health history and results of diagnostic studies to determine the patient's condition. Sometimes it takes a while to come to a diagnostic determination. While documenting the conditions in your differential diagnosis makes sense, adding unconfirmed diagnoses on your claim for service can be incorrect.

The International Classification of Diseases-10 coding guideline states the following:

> *"Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit."*

Based upon this guidance, it is correct to code your patient's signs and symptoms until you are able to confirm the condition they have. This is especially important when the condition is associated with a hierarchical condition category code (HCC). Submitting claims with a diagnosis that is not supported in documentation puts Security Health Plan (SHP) at risk of overpayment from the Centers for Medicare and Medicaid Services (CMS) for that member. Upon CMS audit, this could be costly, especially if CMS extrapolated the overpayment to the health plan's entire population with that condition. A good rule to keep in mind is to never select a diagnosis more descriptive than your documentation when submitting a claim for your service.

Additional information about Risk Adjustment and HCC coding is available on the Security Health Plan website.

Some orthopedic prior authorization requirements removed

Knee, hip and wrist pain consultations:

As of April 1, 2016, Security Health Plan is no longer requiring prior authorization for knee, hip or wrist pain consultations with an orthopedic or neurosurgeon. However, Security Health Plan must be notified when one of our members is scheduled for one of these consultations so that we can work through our shared decision-making process.

Changed or added services:

If Security Health Plan has given prior authorization for certain services and the provider then needs to change the course of or add to the services, the provider must notify Security Health Plan with additional information. If the provider fails to notify Security Health Plan of the changes and submit the claim, these services will be denied back to the provider and our members will be held harmless.

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**.

Chemical exfoliation no longer covered

Security Health Plan no longer covers chemical exfoliation, which is considered cosmetic. If providers have questions they should contact Dan Gell, Director of Utilization Management, **715-221-9677** or **gell.dan@securityhealth.org**.

Use appropriate ICD-10 codes for diabetic foot care

Security Health Plan has denied a number of provider claims for diabetic foot care. Our experience is that providers are using the correct CPT codes but may not have included all the appropriate ICD-10 codes. Refer to CMS local coverage determinations for routine foot care.

Orthotics approved only for specific conditions

Providers are reminded that claims for orthotics will be denied as not medically necessary unless they fit one of three specific circumstances:

- Gross deformity of the foot
- The orthotic is attached to a corrective shoe or brace
- Foot requires stabilization after surgery

Providers will have 365 days for appeals (reconsiderations) related to post-service provider claim denials:

Effective July 1, 2016, for all Security Health Plan products:

To better align with industry standards, Security Health Plan will modify its timeline requirement for submitting appeals of post-service provider claim denials.

- **Current policy:** Appeals of post-service claim denials have to be submitted within 180 days of the provider's statement on which the charge was denied.
- **Effective dates of service July 1, 2016, and after:** Appeals (reconsiderations) of post-service claim denials must be submitted within 365 days of the provider's statement on which the charge was denied.

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.

Consolidate late charges into one submitted claim

Effective July 1, 2016, Security Health Plan will require all late charges for UB claims to be consolidated into one claim for submission. Providers must submit a corrected claim for the stay with all charges consolidated into one claim. If late charges are received separately, they will be denied as a billing error.

Process changes for re-review of adverse determinations for Medicare Advantage members

Effective immediately: As clarified by CMS, Security Health Plan is changing its re-review process for adverse determinations for all Medicare Advantage members. "Adverse Determination" means a determination made by us that a health care service or supply request has been reviewed and, based upon the information provided, is not medically necessary or appropriate or is considered experimental or investigational. The new process is as follows:

1. After receipt and review of the clinical information provided to support services requested and/or rendered, Security Health Plan's first-level team determines it does not meet the clinical guidelines. Security Health Plan will contact and inform the person who submitted the request that the case does not meet the clinical guidelines at the first level, and that the case will be referred to a medical director for a secondary review.
2. Upon receipt of the above response from Security Health Plan, the provider or facility must either submit additional supporting information or call to request a re-review discussion with a Security Health Plan medical director within 24 hours of the original request. Security Health Plan will render a determination and notify the person who submitted the request of the determination. (Rev. 105, Issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)
3. If there is no submission for additional information or request for re-review within the 24 hours following initial submission of all the supporting documentation, the organization determination will be made. If an adverse determination is rendered, the provider/facility's recourse would be to follow the standard Medicare Advantage reconsideration (appeal) process for pre-service denials.

Providers should use Medicare Advantage occurrence codes

Use occurrence code 50 to report assessment dates:

Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF) and Swing Beds (SB) are required to utilize occurrence code 50 to report the date(s) of when the assessment was completed. This is not required for SNF HIPPS code AAAxx. If occurrence code 50 is not included on the claim, the claim will be denied for missing/incomplete/invalid occurrence code(s).

Use occurrence code 55 to report date of death:

Occurrence code 55 is required to report the date of death when the patient discharge status code is 20 (expired), 40 (expired at home), 41 (expired in a medical facility), or 42 (expired – place unknown). If occurrence code 55 is not included in these circumstances the claim will be denied for missing/incomplete/invalid occurrence code(s).

Rural health clinics should report HCPCS codes

Effective April 1, 2016, rural health clinics (RHCs), including RHCs exempt from electronic reporting under Section 424.32(d)(3), are required to report the appropriate HCPCS code for each service line along with the revenue code and other required billing codes. Payment for RHC services will continue to be made under the All-Inclusive Rate (AIR) system when all of the program requirements are met. There is no change to the AIR system and payment methodology, including the "carve out" methodology for coinsurance calculation, due to this reporting requirement.

Please refer to the following CMS notifications for claim submission guidelines:

MLN Matters® Number: MM9269 Revised:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9269.pdf

Required Billing Updates for Rural Health Clinics: Transmittal 1637/Change Request 9269:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1637OTN.pdf

Tips to submit error-free paper claims

Security Health Plan uses optical character recognition (OCR) software when processing paper claims. OCR software processes claim forms by reading text within fields on the claim form utilizing scanners to create an image. This software speeds paper claim processing if claim forms are completed correctly.

Tips for submitting error-free paper claim submission:

- Use only a CMS 1500 (02-12) red and white claim form
- Use black ink only
- Accurately align text within the individual fields on the claim form
- Do not highlight data on the claim form; this shows as black on the scanned image
- Do not staple, clip, or tape anything to the claim form
- All attachments should be one sided; do not print double sided
- If submitting an attachment intended for claim forms, please put a copy of the attachment behind each claim form
- Place all necessary documentation in the envelope behind the claim form on a 8 x 11 sheet of paper; do not submit additional notes on post-its or paper size smaller than 8x11

Check website for monthly formulary update

Security Health Plan updates its interactive formulary to reflect both positive and negative changes prior to the fifth 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**.

Medicare Advantage HMO members have two different cards

We told you in the Fall 2015 Provider News that Security Health Plan is moving away from the "Advocare" name for its Medicare Advantage HMO plans. All members who have new Medicare Advantage HMO plans or have switched to a different plan as of January 1, 2016, have an ID card that no longer includes the Advocare logo. All other Medicare Advantage HMO members still have an ID card with the Advocare logo.

We anticipate that by the end of 2016 we will have provided the new ID cards to all of our Medicare Advantage HMO members.

Medicare pilot focuses on accuracy of provider directories

Providers may receive calls from CMS

CMS guidelines require health plans to proactively conduct at least quarterly communications with contracted providers to ensure that required information in the plan's provider directory is accurate.

In line with this requirement, CMS is developing a provider network accuracy (PNA) pilot. We do not know whether Security Health Plan will be one of the plans selected for this pilot. The pilot will test the accuracy of the data by calling providers listed in selected health plans' provider directories to ensure the provider is still contracted with the plan and that provider information such as address and phone number is correct.

Security Health Plan will be notified if any errors are identified with instructions to correct the errors. After a minimum of 30 days, CMS will validate that corrections have been made.

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, 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 reach our Provider Relations staff at **715-221-9640**, fax changes to us at **715-221-9699** or email us at **shpprd@securityhealth.org**.

SecurityHealth Plan℠

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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.