Soundpath HEALTH

Provider Pulse

Provider News & Information

Welcome to the spring edition of the Provider Pulse.

Obtaining a Prior Authorization

Did you know that as PCPs, you're required to obtain prior authorization for certain services before they are covered by our plans? Visit our website at **http://bit.ly/SPHProviders** to download the most current list of prior authorizations.

Prior authorization does not guarantee coverage. Soundpath Health will review your prior authorization request and provide a coverage decision no later than 14 days after the requested authorization, and likely sooner based on medical urgency, as long as all reasonably necessary information is provided to Soundpath Health.

Soundpath Health believes that a partnership with a trusted physician is at the core of any healthcare journey. That's why our plans are built around a network of experienced medical professionals like you. Thank you for collaborating with us to provide excellent healthcare to our members.

How to Begin the Prior Authorization Process

There are 2 ways to obtain a prior authorization.

- by completing our prior authorization form and faxing it to (253) 682-4811 or 1 (866) 362-0627 or Please attach supporting medical records to substantiate medical necessity for requested service(s)

or

- by calling us at (253) 682-4813 or 1 (866) 352-7086

CERIS – Institutional Outlier Claim Review

Effective mid first quarter 2018, Soundpath Health has instituted a new claims review procedure to ensure claims accuracy. The new procedure entails reviewing all inpatient facility claims received on a paper UB04 or an electronic 837-I format that incur an outlier amount.

Claims that incur an Outlier amount are based on the charge amount and above the threshold per diagnosis related group (DRG). Soundpath Health has contracted with CorVel Healthcare Corporation's ("CorVel") CERIS division, to review hospital's itemized billing statements as well as any supporting medical documentation.
The review provided by CERIS identifies errors, duplicate charges, and non-separately payable routine services and supplies, including equipment. Only the itemized bill is needed, as this review does not include medical necessity, and the review does not affect the DRG portion of the payment.
In order to receive timely payment on claims, please provide any requested itemized billings within the time limits stated in the request. Payments could be reduced or delayed if this information is not provided.

CERIS Review Program FAQ's

1. **Who is CERIS?**
   a. *CERIS is an independent facility claim review service.*
2. **Why is CERIS reviewing facility provider's itemized bills?**
   a. *[**Plan]** has a fiduciary duty to review all claims for accuracy. The review provided by CERIS identifies errors, duplicate charges, and non-separately payable routine services and supplies, including equipment. Only the itemized bill is needed, as this review does not include medical necessity.*
3. **Are all DRG claims reviewable by CERIS?**
   a. *No only inpatient claims that reach an Outlier status.*
4. **Is CERIS reducing the DRG payment?**
   a. *No. The DRG is not affected by the Itemized Bill Review. Charges billed in error are removed and the claim is priced with the new allowable.*
5. **What should occur if a hospital appeals CERIS' review?**
   a. *Appeals, received in writing, should be forwarded to the **CERIS' Customer Service Department.** CERIS will review the original outcome ensuring the recommendations are correct and provide a complete appeal response to the client and/or hospital.*
6. **What should occur if I have questions related to the CERIS review?**
   a. *You can contact **CERIS' customer service at 800-546-2570** or send an email to the team at CustomerService@CERIS.com.*
7. **What should occur if the provider has any questions related to the CERIS review?**
   a. *Providers can be directed to contact **CERIS customer service at 800-546-2570.***

Claims / Payment Integrity

It's important to follow correct billing practices to ensure proper claims payment. Have you ever wondered when to use Modifier 50, or Modifier 25? Please visit our briefing online to learn more about the new procedures. http://bit.ly/SPHProvider.

- Also in April 2018 new claims processing procedures were put in place for the following issues:
  - Non – Covered Laboratory Services (CPT 80320 – 80377)
  - Anesthesia Services billed in an Electronic format (837-P)
  - Anesthesia Patient Status Modifiers (P1 – P6)
  - Professional Claims (CMS 1500 & EDI) and Admission Date Requirement on Certain Place of Services.
  - Inpatient Claims – Discharge Status and Occurrence Code 55
  - Same Day Transfers and Condition Code 40
  - Patient Reason for Visit Diagnosis Codes for Facility Providers
  - Manifestation Diagnosis Codes billed as a Principal Diagnosis Code on UB04.
- Reminder Articles
  - Timely Filing
  - Proper Submission of Corrected Claims
  - Hospice Claims Billing and Medicare Advantage.

Please visit our website at http://bit.ly/SPHProviders to review the correct billing practices to ensure proper claims procedures.

My Advocate®: Helping You Save Money

My Advocate®

Soundpath Health is proud to partner with My Advocate, which helps our members find government programs that provide financial aid. My Advocate staff have helped thousands of Medicare members apply for their state's Medicare Savings Program (MSP). Members who qualify for MSP can save money on their Part B premiums, the amount deducted every month from your Social Security check. Advocates assist eligible members with the application process. They also identify Medicare beneficiaries who may qualify for extra help with Part D prescription drug costs.

To learn more about MyAdvocate, visit www.SoundpathHealth.com or call Customer Service at 1-866-789-7747 (TTY: 711).

What's the Skinny on Obesity and BMI?

Obesity and BMI are important to Hierarchical Condition Category (HCC) and HEDIS data capture.

Physicians- Are you documenting in the medical record correctly?

Coders – Are you assigning ICD -10-CM codes correctly?

Let's explore the nuances of appropriate physician documentation and diagnosis coding for obesity and BMI. Please download our latest briefing at **http://bit.ly/SPHProviders** to learn more.

Do you need to update your office, provider or facility's information?

Let our Provider Service team help you by calling 866-789-7747 option 3.

Front: Aimee, Sam, Wendy (Lead)
Back: Rona, Hope, Norma, Rachele, Tina, Tahnya and Jamie

Are you registered to use our Provider Portal?

Visit our website at https://soundpathhealth.com/en/providers.aspx to sign up now.