

The Provider Connection



A Newsletter from Provider Network Operations

Medical Management 2019 "UM" Updates

**Please note the Medical Management portion of this newsletter contains corrections along with additional clarification of information published in our Q4 2018 Newsletter.*

Community Health Options Medical Management (MM) team participated in regional provider meetings this fall to provide an overview of impending 2019 Utilization Management requirements and to solicit provider feedback to enhance efficiencies. We actively listened to feedback and incorporated several of the proposed changes, and we continue to update and refine our program based on utilization patterns and provider feedback.

This update highlights information that providers have asked us to clarify and it also provides a high-level overview of 2019 Utilization Management changes.

General questions about this content can be directed to our Provider Network team at (207) 402-3347 who will consult or refer to our Medical Management team as needed.

Behavioral Health Care Program (BHCP) Updates

- **Crisis Evaluations** - Providers requested an extension for Crisis Evaluation Notification timeframe. Notification has been extended from 48 hours to ten (10) business days (BD).
- **Urine Drug Screening** - Prior Approval is processed by Health Options' Medical Management team. See below section (Urine Drug Screening) for details.

eviCore Updates

Based on providers' feedback, we have pulled some of the eviCore Notification/Prior Approval services back in house for processing by the Health Options' Maine-based Medical Management team. These services include:

- **Chiropractic Services**

- **Obstetrical Ultrasounds (OB US)**
- **Outpatient Physical, Speech and Occupational Therapy Services**

eviCore continues to review requests for the following services:

- **Advanced Imaging** - 3-D rendering, CT/CT Angiography/CT Colonography, MRA, MRI, Nuclear Medicine, PET, Pulmonary Perfusion and Ventilation Imaging
- **Cardiology Imaging** - Echocardiography, Diagnostic Heart Catheterization, Myocardial Perfusion Imaging (Nuclear Stress test), Stress Echocardiography
- **Durable Medical Equipment-** Osteogenesis Stimulator (**Spine only**)
- **Joint Surgery (Shoulder, Hip, Knee)** - Allograft, Arthroplasty, Arthroscopy, Arthrotomy, Autograft, Capsulorrhaphy, Ligamentous reconstruction
- **Pain Management** - Destruction by Neurolytic Agent, Electrothermal Annuloplasty, Injections & Indwelling catheter placement (Anesthetic or steroid, diagnostic or therapeutic agent, neurolytic substances, chemonucleolysis, percutaneous lysis of epidural adhesions)
- **Ultrasound (non-obstetrical)**

*Note: Elective procedures approved by eviCore are based on ambulatory settings. Approved services that require inpatient admissions **require Notification to Health Options** medical management team within 48 hours of the inpatient admission.*

Health Options Medical Management Clarification/Updates

Inpatient Admission

- Notification is required within 48 hours of any inpatient admission (elective/unscheduled).
- Health Options reviews medical necessity of the inpatient stay.

Laboratory Testing (general guidance regarding Prior Approval categories)

- Allergen Specific IGE/IGG
- Urine Drug Testing (see below Urine Drug Screening details)
- Genetic Testing
- Molecular Pathology Procedure
- Necropsy (Autopsy)
- Unlisted Lab Codes

Medication Prior Approval (through Medical Benefit when not dispensed by a pharmacy)

- 2019 Medication Quick Reference Guide now lists both BRAND and generic drug names.
- Prior Approval requirements for all CPT/HCPCS codes are available through our online authorization portal.
- Prior Approval is required for all unclassified codes and

submitted claims for medications with unclassified codes must include the National Drug Code (NDC) number.

- All medical benefit medication claim submissions are subject to claim review/edits.

Site of Care Program (voluntary transition to an alternative site for medication administration)

- Medications included in our voluntary *Site of Care* program are denoted with an (*) in our 2019 Medication Quick Reference Guide.
- 2019 Medication Prior Approval Form is required for all *Site of Care* medications.
- Approvals are based on units, frequency, and visits which is tailored to Member's condition.
- During the UM review process, Members may be offered the option to voluntarily transition to an alternate site of care.
- If Member consents to an alternate Site of Care, the provider will be contacted.
- Provider can opt for voluntary transition to an alternative Site of Care.

Observation Stays

- Health Options will perform Medical Necessity review for the entire duration of the Observation stay (must meet observation medical necessity criteria).
- Notification is required within 24 hours (or by noon on the first business day after the weekend) even if the patient is already discharged.
- An approved day of Observation Stay is based on the clinical presentation and is not necessarily for all services rendered during the stay.
- Consult Health Options Medical Management team if there is any question RE: medical necessity of proposed procedures during an Observation Stay.
- Submit all supporting clinical documentation as soon as feasible and within 10 business days of the Observation stay.
- Health Options will review the Observation claim to ensure submitted services are related to and appropriate for the observation stay.
 - Health Options will review submitted clinical information to support the claim.
 - If medical necessity is not met, claim line item may be denied. Facility/provider has reconsideration options and appeal rights.
- Examples of services that may not be appropriate for an Observation stay include but are not limited to:
 - Genetic Testing
 - Surgical Procedures
 - Unlisted Procedures
 - Diagnostic Imaging

Obstetrical Ultrasounds (OB US)

- Health Options now processes all Notification/Prior Approval requests for OB US.
- Up to four (4) OB US screening procedures from the designated OB US CPT code list will be approved for low risk pregnancies without medical necessity review (Notification is required, and Member must be eligible for services).
 - Additional OB US services require Prior Approval.
 - Exception: Up to four (4) OB US screening procedures from the designated code list can be repeated without medical necessity review (Notification required) when a Member is referred to another practice (generally for a higher level of care).
- Requests for a high-risk condition can be submitted for all anticipated OB US for the remainder of the pregnancy (subject to medical necessity review).
 - The authorization date range can be extended to the EDC (due date) upon request.
- All genetic testing requires Prior Approval.

Online Authorizations

- Providers are encouraged to submit authorization requests through our online authorization portal which is embedded within our Provider Portal.
- Providers can track the status of the authorization request to:
 - Confirm the authorization request has been received.
 - Obtain a reference number for tracking purposes.
 - Monitor the status of the authorization (it is being worked, approved, or denied).
 - Print authorization determinations.
- Providers can see CPT/HCPCS codes authorization requirements through the online portal. Once a code is entered in the applicable field, a flag will pop-up indicating the authorization rule for that specific code. Examples include but are not limited to the following:
 - No PA required (service does not require Prior Approval)
 - PA required by eviCore (provider needs to submit Prior Approval request to eviCore)
 - Non-covered (this service is excluded from coverage)

Note: To register for the provider portal, please email or call our Provider and Network Operations team: Phone: (207) 402-3347.

Reconsiderations and Peer-to-Peer Reviews (of adverse authorization determinations)

- Providers have two options for reconsideration for medical necessity denials.
 - Submit additional clinical information within 15 calendar days of the adverse decision date.
 - Request a peer-to-peer (P2P) review within 15 calendar days of the adverse decision.
 - A peer-to-peer can follow a written reconsideration review when it is submitted within 15 calendar

days of the adverse decision, but a written reconsideration cannot follow a P2P review.

- If the adverse decision is upheld during reconsideration or P2P, provider has Appeal rights.

Retrospective Authorization Reviews

- In 2018 we limited retrospective reviews to urgent cases/two business days (BD). In response to providers' feedback, we modified the submission time frame to allow up to 10 BD for submission of all new/updated outpatient requests.
- Post-service change to existing Observation Stay/Outpatient authorizations (CPT/HCPCS codes) are accepted up to 10 BD of DOS.

Claim Denial for no authorization on file

- Authorization service requests (new or updated) must be submitted within 10 business days (BD) of the date of service (DOS).
- If provider receives a claim denial with remark code <no authorization on file>, provider has two options:
 - Submit a claims reconsideration with an explanation of exceptional circumstances that prevented submission of an authorization within 10 BD of DOS.
 - Provider retains appeal rights if the claim reconsideration is upheld.
 - Submit a claims appeal providing an explanation of exceptional circumstances that prevented submission of an authorization within 10 BD of DOS.

Transportation (Ambulance Transports)

- Emergency ambulance transportation (911 response) does not require Prior Approval.
- Non-emergency ambulance transportation requires Prior Approval.
- Benefit coverage is limited to transport to the nearest medical facility licensed and equipped to manage the care.
- Fixed wing air ambulance transport always requires Prior Approval even for routine/urgent interfacility ambulance transports.
- Interfacility ground ambulance transports also requires notification by the sending facility within one business day of the transport.
- Clinical review must support the transport is medically necessary and it is to the nearest medical facility licensed and equipped to manage the care.
- Wheelchair vans, taxis and limos are non-covered services.

Unlisted Codes

- All unlisted codes, that are not otherwise specified as non-covered, require Prior Approval by Health Options Medical Management team.
- Medical Benefit Medication claims must include National Drug Code (NDC) when claim submission includes any unclassified

J-codes.

Urine Drug Screening (UDS)

- Health Options Medical Management team reviews UDS Prior Approval requests.
- All UDS tests performed by Out-of- Network labs require Prior Approval.
- UDS tests performed by In-network labs do not require Prior Approval except for alcohol biomarkers.
- Alcohol biomarker tests require Prior Approval when performed by In-network and Out-of-Network labs.
- UDS Benefit Limit (per year):
 - 20 Qualitative UDS
 - 20 Quantitative UDS
- Please consult Health Options Provider Directory for a current listing of In-Network labs.

Chiropractic and Osteopathic Manipulation Treatment Services

We are pleased to announce changes to our Medical Management policies related to Notification/Prior Approval requirements and benefit limits for Chiropractic (CHIRO) and Osteopathic Manipulation Treatment (OMT) services.

With the collaboration and consultation of the Maine Osteopathic Association (MOA), Maine Chiropractic Association (MCA), and individual providers, we have decided to remove Notification and Prior Approval requirements for specific CHIRO and OMT services. This does not impact any other Notification/Prior Approval requirements (e.g., advanced imaging authorization requirements).

Notification/Prior Approval is no longer required for 2019 CHIRO/OMT manipulation Services.

This will take effect immediately and will apply to 2019 CHIRO/OMT claims submitted for dates of service January 1, 2019 or later.

We are also modifying our annual benefit limits. Rather than having a combined CHIRO/OMT annual benefit limit per eligible Member, we will apply separate limits for CHIRO and OMT services as follows:

- **40 CHIRO visits/per eligible Member/per calendar year**
- **40 OMT visits/per eligible Member/per calendar year**

At Health Options, we aspire to continually strengthen our relationship with our providers by increasing communication and collaboration with all providers. We are committed to continuing our partnership and consultation with provider advisors from MOA and MCA who will assist Health Options' leaders in evaluating utilization patterns and clinical outcomes.

Eligibility Inquiry and Response 270/271 and Claim Status Inquiry and Response 276/277 Transactions Update

Community Health Options Connects with Change Healthcare's Hosted Real-Time platform to deliver Eligibility Inquiry and Response 270/271 and Claim Status Inquiry and Response 276/277 transactions.

Effective immediately, Community Health Options is pleased to announce the availability of Real-Time 270/271 and 276/277 transactions through our clearinghouse partner Change Healthcare. We hope you will take advantage of this new solution to validate member eligibility, benefits, and claims status both for batch or one-off transactions.

Please update your systems to take advantage of this new transaction capability. For assistance with submitting Real-Time transactions, please contact your Practice Management System Vendor or Change Healthcare Customer Support. You can visit www.changehealthcare.com to access Change Healthcare's Payer Dictionaries/Guidelines for more detailed descriptions, and/or technical Companion Guides.

Provider Survey

As in previous years, Health Options conducts a brief survey to gather feedback on our services to you and how we can improve the care given to our Members. Please help us serve you and our Members better by taking a few minutes to fill out this survey. We value the relationship we have with you and appreciate your input.

[Take the Survey](#)

Member Satisfaction Survey Results

Health Options conducted Member satisfaction surveys and learned the following relevant to providers. If there are steps that you believe could improve your interactions with Health Options or Member's understanding of the health care process, please let us know.

Composite Scores				
Question	Marketplace Members		Commercial Members	
	2018	2017	2018	2017
Rating of Personal Doctor	44th	56th	56th	63rd
Rating of Specialist	75th	75th	66th	63rd
Access to care	44th	96th	83rd	85th
Care Coordination	51st	95th		

Access to Care				
Question	Marketplace Members		Commercial Members	
	2018	2017	2018	2017
Access to Care Composite	44th	96th	83rd	85th
Getting care quickly percentile	59th	99th	87th	89th
Receiving care right away when needed	57th	96th	90th	90th
Received appointment for routine care as soon as needed	68th	99th	84th	89th
Ease of receiving care/tests/treatment	41st	92th	83rd	92nd
Received a specialist appointment as soon as needed	32nd	89th	79.2nd	83rd

Care Coordination				
Question	Marketplace Members		Commercial Members	
	2018	2017	2018	2017
Care Coordination Composite	51st	95th	82nd	83rd
Follow-up with test results	46th	93rd		
Dr. informed about specialist care	68th	85th		
Dr. discussed prescription medications	69th	79th	96th	97th
Obtained help from Dr to manage care	36th	80th	85th	86th

**The question between the 2 surveys did not align, therefore there are questions without results.*

Risk Adjustment and Data Collection

Risk Adjustment is a method to balance the cost of providing health insurance for individuals who have chronic medical conditions. Health plans who enroll a greater than average number of individuals with chronic health conditions will receive payments from plans that enroll lower risk populations. **Centers for Medicaid and Medicare Services (CMS)** requires medical records as proof of the risk adjustment data submitted by Health Options.

The Provider and Facility play an extremely important role in ensuring that the best documentation practices are established.

Documentation requirements include:

1. All documentation must be legible.
2. Patient's name and date of birth should appear on all pages of the record.
3. The documentation must be clear, concise, and specific about the patient's condition.
4. The documentation must show the condition was monitored, evaluated, assessed/addressed or treated (MEAT).
5. When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.

6. Provider's signature, credentials, and date must be legible.

Helpful Tools for Risk Adjustment, Coding and Documentation:

- [Risk Adjustment - Key Points for Providers](#)
- [Common Coding and Documentation - Key Points for Providers](#)

Health Options Online: A New Behavioral Health Telemedicine Tool for Our Members

Community Health Options is launching a new behavioral health service for its Members soon. In addition to traditional in-person health services, Members will now have access to Health Options Online, a telemedicine service that provides a convenient way for Members to quickly see a provider for an appointment with a psychiatrist or therapist. Health Options has partnered with American Well to provide this telemedicine technology to all its Members.

Health Options Members can access behavioral health psychiatry and counseling services through the HIPAA-compliant platform by way of a device with internet connection, like a smartphone or computer. Health Options Online has many benefits, such as improved access to psychiatrists and counselors and increased ability to quickly see a psychiatrist after discharge from the hospital. Member cost sharing for the new service is applied for all visits and depends on the Member's plan.

Health Options Online provides the following services for its Members:

- **Behavioral Health Psychiatry** – Psychiatrists will help Members manage and prescribe medications related to mental and behavioral health diagnoses.
- **Behavioral Health Counseling** – Qualified counselors and therapists provide counseling and therapy services.

Please note that Health Options Online does not provide mental and behavioral health crisis support or medical services outside behavioral health services. Members may access Health Options Online through their Member Portal.

If you are interested in providing behavioral health services for our Members through Health Options Online, please contact Provider Relations for more information at 207-402-3347.

Maine Community Health Options | (207) 402-3347 | provider@healthoptions.org | HealthOptions.org

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