Community Health Options Provider Connection Newsletter

Quarter 1, 2021

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IMPORTANT CONTACTS

Health Options Service Associates: 855-624-6463

Instamed: 866-945-7990 https://www.instamed.com/

Provider Relations: 207-402-3347 provider@healthoptions.org

Contracting Department: 207-402-3885 Contracting@healthoptions.org, bhnetwork@healthoptions.org

Have members of your team sign up for our quarterly newsletter:
Register @ www.healthoptions.org/providers/overview/
Or call or email Provider Relations

COVID-19

First, we want you to know how much everyone at Health Options appreciates your continued dedication to delivering healthcare services throughout these challenging times. We continue to keep our Members and Providers informed as we respond to the availability of COVID-19 vaccines in our region. To learn more about Member communications click www.healthoptions.org/members/covid-19-update/

Please note the following:

- Approved vaccine doses will be available at no out-of-pocket cost. Health Options will reimburse for the administration of approved COVID-19 vaccines in accordance with Federal and State mandates. We will cover the administration of COVID-19 vaccines at no out-of-pocket cost.
- We continue to support Provider partners as you address changes in office procedures and volume. These changes include:
    - Providing information to Members about expanded resources for no-cost testing through statewide "swab and send" sites.
    - Expanding the waiver of Member cost-sharing provisions to include medical costs for COVID-19 admissions at an in-network hospital (effective March 12, 2020 throughout the duration of the public health emergency).
    - Waiving cost-sharing for COVID-19 diagnostic testing (regardless of location) and associated fees, and reimbursing Providers at in-network rates for COVID-19-related hospital admissions.
    - Advising Members to contact their Provider's office for medical advice about their coronavirus symptoms or behavioral health issues, and to take advantage of telehealth
    - Click on the link to find more details on coding www.healthoptions.org/s/codingguidelines/
    - For more Provider information on our COVID-19 response click on https://www.healthoptions.org/providers/covid-19/

Risk Adjustment

As a Qualified Health Plan, Community Health Options participates in the federal Commercial Risk Adjustment Data Validation (RADV) process. This process strives to equalize the illness severity within the marketplace through accuracy of medical condition documentation for verification of Member chronic conditions.

Along with our participation under NCQA and HEDIS, Health Options engages with you in the Provider community to assess and review medical records for the purpose of maximizing care to our Members and complying with the Risk Adjustment program under the Affordable Care Act. The number of Risk Adjustment related medical record requests can be reduced through clear ICD-10 clinical coding documentation. Resources for clinical coding guidelines can be found here.

Health Options has also partnered with Inovalon, Inc. to deliver key prospective and retrospective interventions with members and Providers to ensure condition documentation accuracy and improve clinical outcomes and economic performance across the healthcare landscape.

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

How can you help?

Share documentation that is clear, concise, complete, and specific. It should use standard abbreviations only and the Provider's signature and credentials should be legible. All documentation should include the following:

- The patient's name, date of birth and date of service on the top of each page
- The reported diagnoses that are supported with medical records documentation
- Supporting materials that shows the evaluation, monitoring, or treatment of the condition documented

  Common Coding Errors
  - "History of" versus "Active Conditions"
  - "History of" means the patient no longer has the condition
  - Coding past conditions as active
  - Coding "history of" when condition is still active

ePASS through Inovalon

- The Electronic Patient Solution Suite or ePASS is an easy-to-use portal to attest to open, or potential open gaps-in-care for Health Options members
- A HIPAA compliant avenue for our Provider partners to assist us in closing gaps-in-care for patients while avoiding excessive medical record requests that aim to achieve the same goal
- For more information in ePASS please contact Provider Relations at the number or email noted on the cover page

Chronic Conditions

All chronic conditions are required to be assessed every year. Examples of terms that indicate evaluation and treatment:

- Stable on Medications
- Medication adjusted to improve condition
- Tests ordered, documentation of review and results entered in treatment plan

Coding Tips

- **Diabetes:** include whether it is Type 1, 2 or secondary; a condition controlled or uncontrolled; If second DM, document what the cause is
- **Cancer:** only code cancer as active if the patient is undergoing treatment
- **COPD & Asthma:** document current treatment, medications, response to treatment; and any related testing
- **Mental Health:** for major depression, clearly document the level of severity, and do not code as unspecified
- **Cardiology:** acute Myocardial Infarction (Heart Attack) status coding is up to 4 weeks post infarction, it then becomes "old MI"
- **CVA (acute diagnosis):** use this code at the time of initial onset or diagnosis

Provider Portal

Availity®

We are pleased to announce that Health Options will be transitioning our Provider portal from HealthX® to Availity. This change will deliver improved functionality offering a better user experience when accessing patient eligibility, claim status, and on-line authorizations. Health Options' planned transition to Availity will occur during the upcoming second quarter of 2021. We will provide more details on exact timing in the very near future.

You will need to be registered with Availity to access Health Options' Member information. Registration can be completed through the site immediately at www.availity.com. Once we have fully transitioned to Availity, you will need to select Community Health Options from the payer drop down menu when you are logged into the Availity website. Upon selecting Community Health Options, you will have access to your enrolled patients' information.

Medical Management

Adverse UM Decisions *NEW* Medical Policy

Clarifies Authorization Rules

https://www.healthoptions.org/media/2982/adverseumdecisions10072020.pdf

- Includes updated category – Administrative Denial

Administrative Denial

- Issued when plan requirements are not met
- Requests for services that are submitted outside of designated timeframes
- Eligible for appeal
- Not eligible for reconsiderations or peer-to-peer reviews

Prior Approval

Observation Stays

- Health Options reviews medical necessity of the entire stay
- Notification is **required** within 48 hours of Observation stay
  - **Required** even if patient is already discharged
  - Allowed up to noon on the first business day (BD) after the weekend
- Submit all clinical documentation within ten (10) BD of the first observation day
- Observation stays are subject to claim-edit review
- Observation stays are limited to 48 hours
  - Members must be admitted or discharged to appropriate level of care within 48 hours

Ambulance Transportation

- Emergency ambulance transports (911 responses) **do not require** prior approval (PA)

- All non-emergency (urgent and routine) ambulance transports **require** PA
- All fixed wing air ambulance transports **require** PA
  - Please contact Health Options for support in securing in-network air transport services
- The sending facility is **required** to notify Health Options when arranging inter-facility transport
  - Health Options knows the sending facility does not have complete authorization details (mileage etc.)
  - Notification initiates the medical necessity review using the clinical information supplied by the sending facility

Health Options then outreaches to the ambulance service to obtain transport details

Inpatient Admissions

- All inpatient stays (scheduled and unscheduled) **require** PA
- Notification is **required** within 48 hours of admission (or by noon on the first business day after the weekend)
- Delayed notification results in an administrative denial for days prior too late notification
- Even if an elective procedure is pre-approved, Notification is **required** within 48 hours and medical necessity review is **required** for the entire inpatient stay

Inpatient Review

- Health Options reviews each inpatient stay based on the clinical presentation which informs medical necessity review to facilitate claims payment
- Concurrent Review Extended Stay Requests:
  - A request for an extended stay concurrent review must be made within 24 hours of the authorization expiration date
  - Lack of timely request to extend the stay results in presumed discharge
- Discharge Planning:
  - Discharge evaluation commences upon admission
  - Please send regular clinical updates to include discharge planning considerations
  - Health Options' Clinical Specialists are available to assist with transitions of care
  - Please let us know if there are any anticipated discharge barriers
  - Please forward a copy of the signed discharge summary

Level of Care (LOC)

Health Options leverages MCG® evidenced-based care guidelines to assess LOC Medical Necessity
*It is the facility's responsibility to notify Health Options of change in LOC or proposed change in LOC

- Elective surgical procedures – ambulatory vs inpatient
- Observation stays
- Acute care inpatient admissions
- Recovery Care Facilities (e.g. acute rehabilitation/skilled nursing facility)
- Home health services
- Behavioral Health Care Admissions (e.g Partial Hospitalization Program (PHP), Intensive Outpatient Programs (IOP) and Residential Programs)

Health Options may customize the guidelines to meet the nuances of the local delivery system

If Health Options is unable to approve a request based on submitted clinical information, we will request additional information specifying what is needed for the requested level of care/bed type

Online Authorization Submission

Direct electronic exchange of prior authorization-related communications saves you time and effort. No need to fill out the paper prior authorization form, endure long wait times for a response or call Member Services to see if an authorization is needed or check a prior authorization status.

Advantages of online prior authorizations:

- The online authorization process is highly reliable and efficient
- All information is entered and confirmed electronically
- The data entry process lets you check whether a Prior Authorization is required for requested services
- Clinical guidelines are available for Providers to select appropriate criteria to align with clinical presentation
- Clinical documentation is easily attached electronically to support requested services
- After data entry and submission, the system provides an authorization summary including an authorization reference number
- Knowing authorization reference numbers lets you check the status of multiple prior authorization requests at any time instead of waiting for a determination letter or calling Member Services

The portal is a secure entry point that is accessible 24 hours a day, seven days a week. With a Provider portal account, in-network Providers can access and view prior authorization requests, Member eligibility, and claim details.

To access the portal, go to HealthOptions.org and select the "Sign in" option at the top right of the page and choose Provider Login On the next page, add your username and password if you are already a registered user. If you are not, simply follow the registration process to gain access or call 207-402-3347 for assistance. You will be required to have a paid claim number within the past 60 days and to verify your tax identification number (TIN) to create an account.

Medical Management Contacts

For Care Management referrals, please call Member Services:

(855) 624-6463 Monday-Friday, 8am-6pm

For Health Options Utilization Management questions, please utilize the portal
https://provider.healthoptions.org/

Pharmacy

Providers and Members may check the formulary for medication coverage on our website: https://www.healthoptions.org/members/medications/#drug-formulary. Providers may also contact Health Options to request follow up from an in-house pharmacist by outreaching to Member Services at (855) 624-6463 Monday-Friday, 8am-6pm

Prior Authorizations and other Medication Designations

Medications dispensed by pharmacies undergo Prior Approval (PA) through ESI.

- Medications requiring Prior Approval (PA), Step Therapy (ST), Quantity Limits (QL) are listed with designations on the Health Options Formulary
- ESI accepts PA requests through the following methods:
- Electronic Prior Authorization (ePA) through http://www.esrx.com/pa or https://www.covermymeds.com/ or Telephone (ESI PA Line): (800) 753-2851

Prior Approval Needed through Health Options

This list includes NEW medications that require Prior Approval submission to Health Options. We have listed current Brand names, but due to new drugs coming to the market on a regular basis, it may not be all-inclusive and may be subject to change.

BRAND NAME	Generic Name
BLENREP	Belantamab mafodotin-blmf
CERIANNA	Fluorestradiol f18
DOTATOC GA 68	Gallium ga-68
FETROJA	Cefiderocol
MONJUVI	Tafsitamab-cxix
NYVEPRIA	Pegfilgrastim-apgf
OCLUMO	Lumasiran
PHESGO	petuzuamab-trastuzumab, hyaluronidase
PROPEL	Memetasone furoate sinus implant
SPRAVATO	Esketamine intranasal
TECARTUS	Brexucabtagene autoleucel
SINUVA	Mometasone furoate sinus implant
SCENESSE	Afamelanotide implant
SEVENFACT	Factor via
UPLINZA	Inebilizumab-cdon
ZEPZELCA	lurbinectedin

Non-covered service

The following are considered a non-covered service under a Member's benefit plan

BRAND NAME	Generic Name
VILTEPSO	*viltolarsen*

As a reminder Unclassified drug/injection codes under "Not Otherwise Classified" or "Not Otherwise Specified (NOS)" (e.g., J3490, J3590, J8499, J8999, etc.) require prior approval and Providers must submit the National Drug Code (NDC) number to ensure claims properly adjudicate for reimbursement.

Credentialing

Items to keep in mind:

- CAQH® information through the CAQH portal is up to date
- This includes all your practice locations
- Practitioner location additions
- New locations require up-to-date and current COI (certificate of insurance)
- Any practitioner change request will also require a current COI
- Effective dates

Health Options' also requires that all of our network Providers be board certified in the specialty they are practicing in as required by the respective accrediting body.

Provider Resources

Claim & Eligibility Inquiries

Claim Service Associates

Health Options has a team trained specifically to assist with claims related questions/issues.

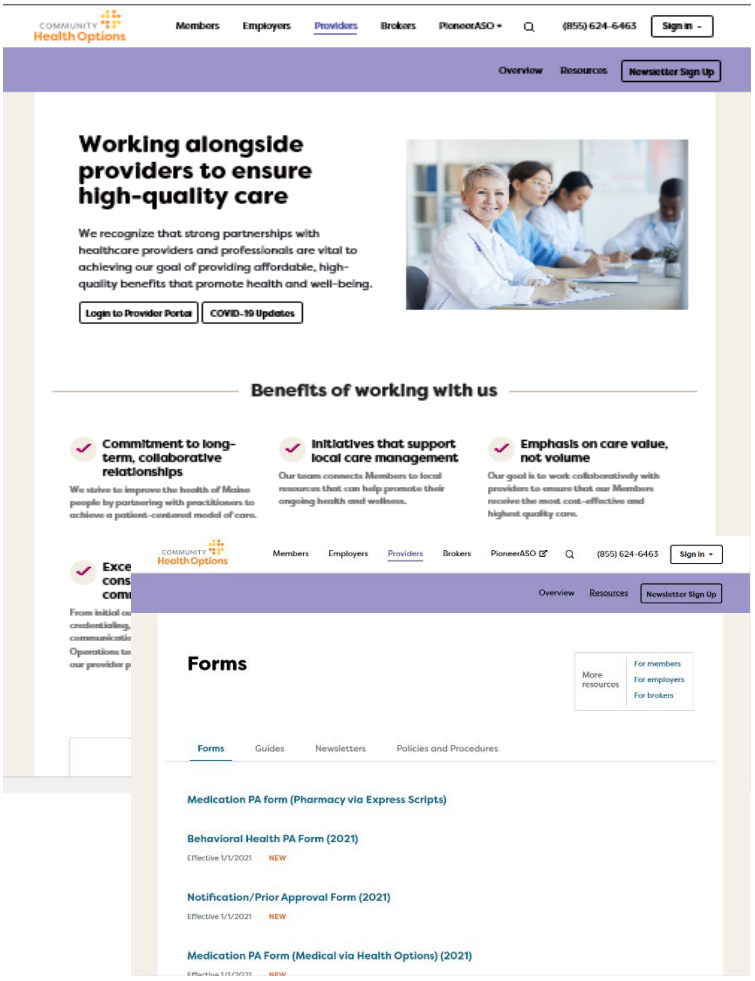
When you call **855-624-6463** and choose the Provider/claims option you can speak to a specially qualified Claims Service Associate (CSA), as available.

Provider Resources

The Provider portion of our Website includes:

- Policies & Procedures
- Resources
  - The Resources tab lands on the **Forms** section, but there are several other tabs on this page, such as the **Guides**, **Glossary**, **Videos**, archived **Newsletters**, and the **Policies and Procedures** tabs

Go to:
www.healthoptions.org/providers/overview/
for more information



Policies and Procedures (https://healthoptions.org/providers/resources/)

Itemized Bill Submission

https://healthoptions.org/media/3055/itemized-bill-submission-external-110920.pdf

- Health Options requires an itemized bill for each claim with a billed amount equal to and greater than $20,000
  - An itemized statement is defined as a listing of each service(s) or item(s) provided to the beneficiary. Statements that reflect a grouping of services or items (such as a revenue code) are not considered an itemized statement
- The itemized bill must include, but not limited to, for each line item detail:
  - charge code
  - description
  - date of service
  - quantity
  - amount that matches the billed claim form
- For your convenience, Health Options accepts itemized bills electronically using the following email address: **itemizedbill@healthoptions.org**

Required Anesthesia Modifiers	Definition	Reimbursement Percentage of Allowed Amount
AA	Anesthesia services performed personally by anesthesiologist	100%
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	100%
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA service: qualified nonphysician anesthetist with medical direction by a physician	50%
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist	50%
QZ	CRNA service: without medical direction by a physician	100%

Replacement Claim Billing

https://healthoptions.org/media/3054/replacement-claim-external-110920.pdf

Replacement (a.k.a. Corrected) Claims may be submitted electronically

- Frequency code “7” on professional claims
- Bill type code ending in “7” on institutional claims
- Must include the full 16-digit original claim number
- Must be for the same patient and the same claim type (professional or institutional)
- Timely filing limit is 120 days from the date of service or discharge date

*Late Charges and Interim Billing should not use the replacement claim process

Payment Integrity Audit

https://healthoptions.org/media/3252/payment-integrity-audit-policy_external-branded.pdf

The purpose of this policy is to identify, prevent and correct fraud, waste and abuse and to facilitate accurate claim payments through pre-payment and post-payment audit review processes that include medical review.

Health Options will analyze claims to determine provider compliance with Centers for Medicare & Medicaid Services (CMS) coding and billing rules, Health Options' policies, any in-place Contractual Agreement(s), and take appropriate corrective action when healthcare Providers are non-compliant. The goal is to "correct the behavior in need of change and prevent future inappropriate billing" (Medicare Program Integrity).

Health Options has the authority to review any claim at any time. Health Options will target error prevention efforts toward services and items that pose the greatest financial risk and that represent the best investment of resources.

Health Options or its designee may request medical documentation and/or full bill itemization to substantiate the treatment items, services, and supplies provided and billed by Health Care Providers, in the course of conducting reviews and audits.

Facility Revenue Code Requirements

https://www.healthoptions.org/media/3148/facility-revenue-code-requirements_external.pdf

In line with the National Uniform Billing Committee (NUBC) Community Health Options ("Health Options") requires facilities to report current and accurate CPT or HCPCS codes with all applicable Revenue Codes, as defined by the National Uniform Billing Committee (NUBC). Facilities are required to report CPT, HCPCS, and modifiers on outpatient facility claims at the highest level of specificity, when an appropriate code exists, that is supported by the medical record.