Community Health Options
Provider Connection

1st Half Yearly 2022 Newsletter

INSIDE THIS ISSUE

Risk Adjustment

As a Qualified Health Plan, 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 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.

Providers and facilities play an extremely important role in ensuring that the best documentation practices are established.

How can your office 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 which demonstrate 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

Submitting Documentation: through ePass e The Electronic Patient Solution Suite or ePASS is an easy-to-use HIPAA compliant 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 on ePASS please contact Provider Relations at the number or email noted on the cover page

Chronic Conditions

All chronic conditions are required to be evaluated and documented 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; DM with hyperglycemia (E11.65); 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

Medical Management

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.
Examples where LOC could change:

- 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.

Medical Management Contacts

For Care Management referrals, please call the Member Services team at (855) 624-6463, Monday through Friday, 8 a.m. to 6 p.m. For Health Options Utilization Management questions, please utilize the portal: https://provider.healthoptions.org/.

Pharmacy

Pharmacy Resources:

View the Health Option's formulary at : www.healthoptions.org/members/medications/.

Contact an in-house pharmacist by outreaching to the Member Services team at (855) 624-6463, Monday through Friday, 8 a.m. to 6 p.m.

Important Reminders:

- All medications dispensed by pharmacies undergo Prior Approval through ESI, Health Option's pharmacy benefit manager. Medications
- ESI accepts PA requests through the following methods:
    - Electronic Prior Authorization (ePA) through www.esrx.com/pa or www.covermymeds.com/ or
    - Telephone (ESI PA Line): (800) 753-2851
- Medications that require Prior Approval , are used in Step Therapy or have Quantity Limits (QL) are listed with designations on the Health Options Formulary.

Prior Approval Needed for Medications Covered Under the Medical Benefit

- Submit authorization requests via: Provider Portal (preferred) https://provider.healthoptions.org/ or Health Options (Medical Management): Fax: (877) 314-5693 Phone: (855) 542-0880

This list includes NEW changes to medications that require Prior Approval submission to Health Options under the medical benefit.

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
ADCETRIS	brentuximab
BYOOVIZ	ranibizumab-nuna
CAMCEVI	leuprolide
CYTOGAM	cytomegalovirus immune globulin intravenous human
FYARRO	sirolimus protein-bound particles
GALLIUM Ga-68 PSMA-11	gallium ga-68 psma-11
JEVTANA	cabazitaxel
KORSUVA	difelikefalin
ONCASPAR	pegaspargase
PYLARIFY	piflufolastat F 18
RYPLAZIM	plasminogen, human-tvmh
THROMBATE III	antithrombin
TIVDAK	tisotumab vedotin-tftv
VEKLURY	remdesivir
XIPERE	triamcinolone acetonide, suprachoroidal

Non-Covered Service

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

BRAND NAME	Generic Name
SUSVIMO	ranibizumab
TICOVAC	tick-borne encephalitis vaccine

No Prior Approval Required

The following medications no longer require Prior Approval submission to Health Options.

BRAND NAME	Generic Name
FETROJA	cefiderocol

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. As a reminder, providers must submit the National Drug Code (NDC) number to ensure claims properly adjudicate for reimbursement.

Credentialing

Items to keep in mind:

- Ensure CAQH® information through the CAQH portal is up to date; this includes the following:
  - All 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

*Providers are considered credentialed with Health Options on the date in which all of the information is submitted accurately and requires no follow-up. If additional information, outreach or updates is needed, the effective date will shift to the receipt of necessary information. Recredentialing is required every 36 months.

Provider Resources

Availity Provider Portal

Availity Our partnership with Availity is an efficient way to submit online Prior Approvals and to obtain real-time decisions on certain services. Please note, all known eligibility and claims issues have been resolved. Stay tuned as more features are added to the Availity portal. continue to add more features

If you have questions regarding online authorizations, please contact the Member Services team at (855) 624-6463 or visit the Health Option's website at www.healthoptions.org/providers/resources/. If you need access to additional NPI or tax id numbers in order to see claims or submit authorizations, please contact your organization's administrator. For any other questions please contact Availity directly at 1-800-Availity (1-800-282-4548)

Accessing Availity

Availity is a secure portal available 24 hours a day, seven days a week, with the rare exception for system maintenance. With a provider portal account, in-network providers can access and view Prior Approval requests, Member eligibility, and claim details.

To access the portal, go to www.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 Availity 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.

Online Authorization Submission

Direct electronic exchange of authorization-related communications saves you time and effort. No need to fill out the paper Prior Authorization form. Here are advantages of online **Prior Authorizations:**

- The process is highly reliable and efficient.
- All information is entered and confirmed electronically.
- Authorizations for requested services may be viewed.
- Clinical guidelines are displayed so providers can select the appropriate criteria to align with clinical presentation.
- Clinical documentation is easily attached electronically to support requested services.
- The system provides an authorization summary including an authorization reference number; and when real-time approval is available, the provider can look up the status for decisions that are pending internal review.
- 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

Payer Space on Availity Provider Portal

Be sure to visit our Payer Space section when in the provider portal under the News and Announcements tab to get up to date important communications, as well as access to new and updated forms, and Policies and Procedures.

Claims Submission

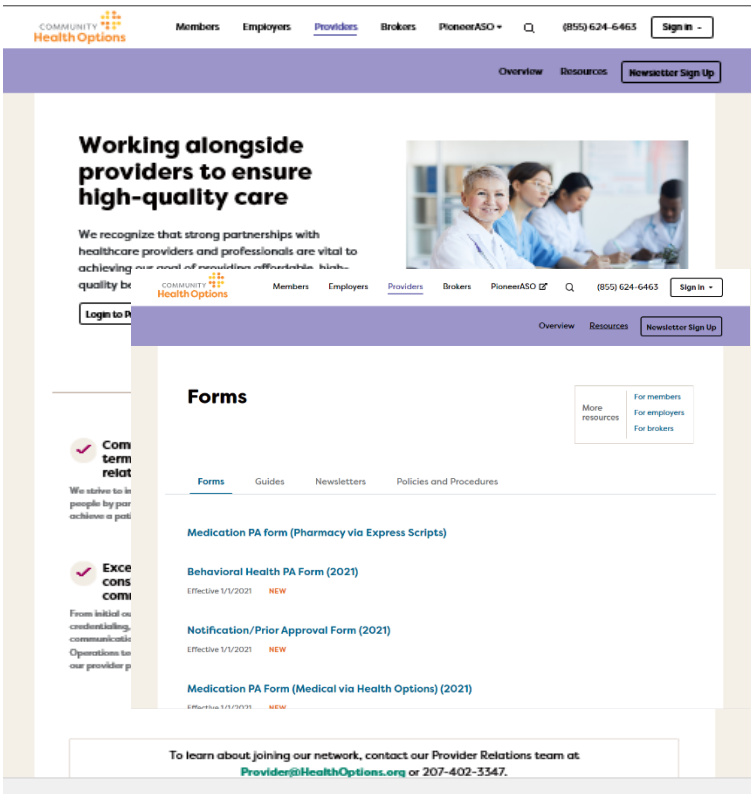
As a reminder the change to Availity has no impact on how you submit claims to Health Options as we are not currently compatible to have claims submitted through the provider portal. Please continue to submit electronic claims through your clearinghouse to our payer ID 45341.

Website

The Provider portion of our website includes:

- Important Information
- Covid-19 Updates
- Newsletter Sign Up
- Resources

  - The Resources tab opens to the Forms section, where you can find the most up to date forms. From here you can navigate to the various tabs, such as the Informational Guides, old and new Newsletters, or the Policies and Procedures tabs.



Visit www.healthoptions.org for more information.

Policies and Procedures

Coming Soon:

- Hearing Aid Billing Guidelines
- Treatment Room Reimbursement Policy

New and Updated Published Policies:

- **Routine Supplies, Services, and Medical Equipment Policy**

This policy will be fully implemented into the Health Option's claims systems to deny effective June 1, 2022. The policy is now updated to provide clarification on routine supplies, services, and equipment that are not eligible for separate reimbursement.

To read full the policy click HERE. Note the policy was last updated on 4/26/2021,

GENERAL UPDATES AND INFORMATION

Provider Tiering

We have had several calls regarding provider tiering and folks wanting to know how to become a Preferred Provider. Consideration is given to elements that include cost, quality, efficiency data and geographic location, in determining which providers are placed in the standard or preferred categories. Currently this information is used to tier certain *hospital services*, *primary care providers*, *urgent care facilities*, and *freestanding laboratory* and *imaging centers*. At this time, we are not assessing any other provider types. If you have a patient that has a tiered plan and they ask why you are not a preferred provider, you can just advise them that not all provider types are being considered at this time, we will be enhancing these plans over the next few years and adding different provider types as we go. There is reference to this on our website when you are in the provider search tool under disclosures. For any additional questions from the member or provider please contact the service center at 855-624-6463.

IMPORTANT CONTACTS

Health Options Services Team (855)624-6463

Instamed: (866)945-7990 www.instamed.com

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

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

*** Sign up for our Provider Newsletter: Register @** www.healthoptions.org/providers/overview/ Or call or email Provider Relations