Transition to New Operating Platform FAQ

This collection of frequently asked questions (FAQ) was developed to answer questions from participating providers regarding Community Health Options (Health Options) transition to its new operating platform. This document will be updated as additional questions are received.

Please email us at provider@healthoptions.org if you have further questions after reviewing the FAQ.

General

1) **What is the new operating platform?**
The term - new operating platform - is being used to describe the claims processing system managed and maintained by Health Options, which we will be using to coordinate core processing functions such as enrollment, claims, and premium billing.

2) **Why is Health Options changing platforms?**
As a not for profit health insurer domiciled in Maine, Health Options is committed to our mission of enhancing the health and wellness of our members, and the communities we serve. In support of our mission, we have taken a close look at our current tools, systems, and processes to identify opportunities to streamline and improve processing activities.

Moving our claims processing to the new platform will offer greater capabilities, increased flexibility in benefit design, and enhanced functionalities to improve the customer experience. In addition, it will enable us to gain efficiencies and lower our operating costs.

3) **When are these changes happening?**
The migration of Health Options membership to the new platform will be completed on 12/31/2017. Claims processing will cut over based on date of receipt, with claims received through end of business day 12/15 processed and run out on our existing platform with our Third Party Administrator, Cicerone Health, and claims received on 12/16 and going forward will be processed on the new platform by a combination of Health Options staff in Lewiston, as well as our new BPO partner, UST Global.

4) **If our claims are submitted through a clearinghouse/trading partner, how will the clearinghouse/trading partner handle this transition? What action does my office need to take?**
All providers should work directly with their clearinghouse/trading partner(s) to ensure a smooth transition to avoid claims submission issues.

Health Options will be transitioning its primary trading partner duties to McKesson, Relay

Health, which is now combined with Change Healthcare, and legacy Change Healthcare (Emdeon). Our clearing house Payer ID remains the same (45341) which you should continue to use for electronic claims submission.

5) **If we are registered for Electronic Funds Transfer (EFT), is there anything else our billing office has to do in order for this transition to go as smoothly as possible? Will EFT/ERA processes change?**
Yes, Health Options is changing its EFT processes from direct processing through our banking partner KeyBank, to utilizing InstaMed. EFT/ERA services will be offered to you through InstaMed at no cost, however if you do not already have an account with InstaMed, you **must** register with them to continue to receive electronic payments in 2018.

If you do not currently receive funds electronically from us, ERA/EFT is a convenient, paperless and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the TRN Reassociation Trace Number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions. Also, by signing up with InstaMed the additional benefits include:

- More convenient than receiving payments by check;
- Payments clear your account faster for improved control of your cash flow; and
- Eliminates paper checks and EOPs.

To receive Community Health Options payments as free ERA/EFT, register with InstaMed at www.instamed.com/eraeft.

Billing/Claims Submission

6) **How will this affect providers who submit paper claims?**
If you choose to submit paper claims (i.e., CMS-1500 for professional claims, UB-04 for facility claims), you must follow National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines when completing these forms. Submit your claims to the following addresses:

Community Health Options
P.O. Box 1121, Mail Stop 200
Lewiston, ME 04243

Note: We encourage you to submit claims electronically, as most providers do. Submitting claims electronically can result in increased accuracy of claims, better tracking ability, and greater office efficiency and productivity. In addition, you'll also benefit from error reporting, which allows you to easily correct claims before submission. You will experience fewer payer rejections and administrative concerns, resulting in faster claim payments.

7) **Will I need to bill differently because of the new platform?**
No. The date of receipt will determine the platform on which claims will be processed. Claims received on or before 12/15 will be processed on the current platform, and claims received 12/16 and going forward will be processed on the new platform. Claim corrections, or claim retro adjustments for 2017 dates of service, received or enacted after 12/15 will be managed and processed on the new platform.

Please also note that effective 1/1/2018, Health Options has instituted a new provider based billing policy that requires professional services delivered in a non-institutional setting to be billed on a CMS-1500 form. Claims for professional services not conforming to these standards will be rejected back to the provider, and are not reimbursable. For more information about Health Options Provider Based Billing Policy, contact Provider Relations at 207-402-3347, or email us at provider@healthoptions.org.

8) **Will there be changes to member ID cards?**
No, there are no material changes to Health Options member ID cards post platform migration, or for 2018 member plans.

Post Migration

9) **How will the transition affect my transactions (e.g., authorizations, claims or eligibility inquiry)?**
You will still have access to member eligibility status, as well as the ability to self-service claims inquiries by accessing our Provider Portal. If you have not signed up to use the Provider Portal please visit https://www.healthoptions.org/health-care-professionals, and click on [Provider Login] at the top right of the page. This will take you to our portal where you can either login, or register and create a new account. Remittances will continue to be available through the Provider Portal, and prospectively via InstaMed should you choose to subscribe to that free service. Should you need assistance with either claims inquiry, member eligibility status, or payment remittances, you can also contact our Member Services department at (855) 624-6463.

Health options will be loading 90 days (4th quarter 2017) of historical authorizations into the new platform to ease the transition.** Authorizations older than 90 days automatically expire, and you will need to renew any authorization request where an encounter or admission has not occurred during this time frame.

**eviCore
For reminder, Health Options has engaged eviCore to manage prior authorization and utilization management processes for certain advanced imaging, and cardiology procedures, as well as certain musculoskeletal conditions beginning 1/1/2018. For more information about our program with eviCore, or which procedures you should direct to eviCore when seeking

prior authorization, visit our website at https://www.healthoptions.org/health-care-professionals/professional-document-and-forms.

To request Prior Approval from eviCore (starting 12/22/2017 for dates of service 1/1/2018 or later), log onto www.evicore.com/pages/ProviderLogin.aspx **-or-** Call eviCore at (855) 316-2673.

10) How will the transition affect claim processing?

There should be relative stability with regard to processing as we transition to the new platform, however please note that Heath Options has chosen to implement Mckesson's ClaimXten clinical editing software effective 1/1/2018 to audit provider billing, and professional services correct coding standards. After having used Optum's similar services for the past four plan years the differences in clinical editing should be minimal, but in the event that you have any questions or concerns our Provider Relations, and Claim Operations departments are ready to assist you.