Provider Newsletter
Fall 2019 edition

Products and Programs

All provider payments transitioning to electronic delivery
Health Options will be transitioning delivery of all provider payments to electronic methods in the fourth quarter of 2019. Providers or facilities that are currently receiving payment by EFT will not experience any change in payment delivery. Providers or facilities that receive payment by paper checks will transition to virtual card payments, or may choose to sign up for faster payments via EFT by visiting: https://register.instamed.com/eraeft

Regional provider meetings scheduled in October
You are cordially invited to attend an upcoming Health Options annual regional provider meeting for discussions on prior authorization, policy updates/changes, and much more. Meeting dates and locations are:

October 22nd at the MPX office, 2301 Congress Street, Portland;
October 23rd at the Senator Inn, 284 Western Avenue, Augusta; and
October 24th at the Bangor Inn & Suites, 713 Hogan Road, Bangor.

Each session runs from 11:00 am to 3:00 pm, and lunch will be provided. Space is limited and registration is required. Click here to register.

Administrative Updates

(Policies and forms described in this section are online: https://healthoptions.org/providers/resources)

Reminder: Claims submission pathways and requirements
Electronic submission of claims is preferred and will provide the fastest and most accurate claims processing experience. Our Payer ID is 45341. We also accept paper claim submissions in accordance with our Paper Claims Submission Standards policy, found on our website (using the link above) in the Policies and Procedures section.

Replacement (a.k.a. corrected) claims
Health Options accepts replacement electronic and paper claims. Requirements are detailed in our Replacement Claim Billing policy, found on our website (using the link above) in the Policies and Procedures section. The correct original claim number (16 digits) must be included on replacement claims for accurate processing to occur. Please be mindful of the timeliness requirements for both original and replacement claim submission (120 days from date of service).

Claim reconsiderations
Providers can request reconsideration of a payment decision on previously processed claims while still retaining the right to file a future appeal, either by contacting our Member Service Department at 855-624-6463 or by completing and returning the most recent version of the Health Options Claim Reconsideration Form. Reconsideration requests are considered timely when received within 90 calendar days from the date of the Explanation of Payment. The most recent version of the form is on our website (using the link above), located in the Forms section.

New addresses for submitting appeals and reconsiderations
Effective immediately, please use our new email, fax and mail addresses for submitting appeals and reconsiderations.

For appeals:	For reconsiderations:
Mail Stop 800 Community Health Options PO Box 1121 Lewiston, ME 04243 appeals@healthoptions.org Fax: 877-314-5693	Mail Stop 800 Community Health Options PO Box 1121 Lewiston, ME 04243 reconsiderations@healthoptions.org Fax: 877-314-5693

Please use the most recent version of our claim reconsideration or appeal forms. Newly updated appeals and reconsideration forms with comprehensive instructions for their use can be found on our website (using the link above) in the Forms section. Questions can be directed to Health Options Member Services at 855-624-6463.

Guidelines and Policies

Supplemental claim editing rules effective October 1, 2019
Community Health Options utilizes claim editing rules when processing claims for services provided to our Members. As we previously advised, additional claim edits will be in place for all Health Options plans and products starting with date of service October 1, 2019. Descriptions of the supplemental claim editing rules are found by following this link to the Outpatient and Professional Services Reimbursement Policy on our website.

Quality Updates

Upcoming provider and Member outreach
To improve future compliance with our CMS-mandated Health Effectiveness Data and Information Set (HEDIS) requirements, Health Options will send supplemental data requests to providers to validate compliance with following measures:

- Avoidance of antibiotics for bronchitis/URI
- Appropriate testing for pharyngitis to confirm need for prescriptive antibiotics
- Avoidance of imaging for initial 28 days of low back pain
- Timely follow-up for Members newly prescribed ADHD medications

Health Options will also be communicating directly with Members to inform them about gaps in diabetic care and children's wellness visits.

HEDIS Measures can be accessed here and guidance on antibiotic avoidance is available from Choosing Wisely .

Completion of gap closure forms for Health Options' 2019 Risk Adjustment Program
Health Options routinely reviews records to identify Members with high-risk conditions and that appear to have gaps in care. We actively outreach to identified Members and will promote the need to schedule a well visit with their PCP by the close of 2019. Members may obtain scheduling assistance from our Medical Management team and from our partner, Indegene.

Gap Closure forms are sent to the Member's PCP of record. If you receive one or more of these forms, please encourage the indicated patient(s) to schedule the needed appointment.

After the visit we ask that you complete the Gap Closure form, making sure to document any chronic conditions, and return it as indicated. If you have any questions regarding Risk Adjustment, please contact Deidre DeRoche, Manager, Government Programs at dderoche@healthoptions.org.

Support Services Available from Health Options
Health Options' Medical Management team offers a wide array of services to support Members' overall health that include:

- Complex Case Management for Members experiencing catastrophic diagnoses or extensive use of healthcare resources
- Care Management programs for Members facing metastatic cancers, transplants, and pediatric intensive care unit admissions

Other areas of healthcare that support services are available include (but are not limited to): Transitions of Care, Behavioral Health, Substance Use, Cancer Care, Maternity, Disease Management, and Point of Service. Members can request services and providers can refer Members by contacting Health Options Member Services, Monday – Friday, 8am – 6pm, at 855-624-6463.

Utilization Management Questions Answered
Answers to questions about utilization management, prior authorization requirements, and clinical criteria are available from Health Options' Utilization Management team, Monday – Friday, 8am-5pm, at 855-542-0880.

Annual Affirmative Statement
Medical Management staff involved in the prior authorization process must annually sign the following Non-Inducement/Affirmative Statement:

"Health Options' prior authorization determinations are based on the medical necessity of care utilizing evidenced-based guidelines and existence of benefits based on Member's health plan. Health Options does not pay or give incentives to our employees or contracted Providers to improperly deny or withhold benefits."

Legislation

Legislative Update
The Maine legislature recently passed four bills, effective September 19, 2019, that pertain to health insurance plans and carriers. These regulations do not require any action by providers but may impact Health Options' processes, payment, and benefits. We will keep you informed of any changes we make as a result of the new legislation.

Links to the legislation are provided below.

An Act To Ensure Protection of Patients in Medical Reviews by Health Insurance Carriers

An Act Regarding Responsibility for the Duplicative or Incorrect Payment of Health Insurance Claims

An Act To Prevent Discrimination in Public and Private Insurance Coverage for Pregnant Women in Maine

An Act Regarding the Process for Obtaining Prior Authorization for Health Insurance Purposes