Community Health Options Provider Connection Newsletter

Quarter 3, 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@chealthoptions.org

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

Policies and Procedures

Please see all Policies (new and updated) on our website in the **Policies and Procedure** section here:

https://healthoptions.org/providers/resources/

Professional Services Policy (Revised under new name)

All professional services must be billed on a CMS-1500 claim form (electronic 837P), utilizing CPT®/HCPCS® codes to appropriately identify the rendered services. Professional services include those provided by, but not limited to, hospital-based physicians, radiologists, hospitalists, emergency room physicians, anesthesiologists, Certified Registered Nurse Anesthetists (CRNA), clinical psychologists, independent practitioners, physical therapists, occupational therapists, and speech therapists.

Note: *This policy replaces the previously published Provider Based Billing policy that was effective 1/1/2018.*

Clinic Charges Policy (Revised under new name)

Community Health Option (Health Options) will not allow clinic services rendered to covered members by qualified healthcare professionals at any clinic owned, operated, or controlled by a healthcare facility/system when billed on a UB-04. Revenue codes 0510-0529 (Clinic and Freestanding Clinic) will be denied as provider responsibility. Participating providers and facilities may not balance-bill the patient.

All clinic services provided in an outpatient clinic setting are required to be billed on a CMS-1500 claim form or electronic equivalent. Professional claims will be reimbursed according to the contracted professional fee schedule.

Note: *The guidelines in this policy were included in the previously published Provider Based Billing policy that was effective 1/1/2018. The Provider Based Billing policy was rewritten under the title Professional Services. This policy was created to provide additional clarification specific to Clinic Charges.*

Modifier Reference Guide (New Policy)

Health Options adheres to the billing/coding guidelines defined by American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) for appropriate use of modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered.

Level I CPT Modifiers: Commonly known as CPT Modifiers and consists of two numeric digits and are updated annually by AMA.

Level II HCPCS Modifiers: Commonly known as HCPCS Modifiers and consists of two digits (Alpha / Alphanumeric characters) in the sequence AA through VP. These modifiers are annually updated by CMS.

Payment Integrity Audit Policy (Updated Policy)

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 has updated the policy to include Ambulatory Surgical Centers (ASC) Covered Surgical Procedures list as required by Federal Regulation (Source:47 FR 34094, Aug. 5, 1982) and maintained by CMS. Social Security Law: Title 42 Section 416.1 (2) Section 1833(i)(1)(A) of the Act requires the Secretary to specify the surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgical center. Services not on the covered surgical procedure list will not be reimbursed.

Routine Services, Supplies & Equipment Policy (Updated Policy)

For claims that are reimbursed at a percent of charge, only charges for covered services are eligible for reimbursement. Items identified in this policy are charges not eligible for reimbursement. Except for the applicable copayment, Health Care providers may not bill Members for routine supplies, services, and medical equipment because their costs are packaged into the payment for the procedure/facility charge with which they are used.

Health Options has updated the policy by expanding on the routine supplies list, redefined capital equipment, and added other disallowed charges.

Provider Portal

Launch of Availity

As a reminder, Community Health Options has **transitioned our provider portal from HealthX to Availity. This was effective on Monday, June 28**. This change is designed to deliver improved functionality, which will offer a better user experience when accessing patient eligibility, claim status, and on-line authorizations. You will notice upon our transition to Availity that you are required to choose a location ID from a list when you submit or search for authorizations. This requirement is just for a couple weeks until we transition to phase two of our launch. **Please note, the change to Availity will have no impact on how you submit Health Options' claims. You should continue to submit electronic claims for Health Options through your clearinghouse to our Payer ID 45341.**

To register or learn more about Availity, you can follow the link https://www.availity.com/provider-portal-registration Registration is required to access Health Options' Member information. This can be completed through the site immediately. After registering, you will need to select Community Health Options from the payer drop-down menu. Upon selecting Community Health Options, you will have access to your enrolled patients' information. If you experience technical issues with registration, log on, or navigation of the Availity site, please contact **Availity Client Services at 800-282-4548** between the hours of 8:00 a.m. and 8:00 p.m. eastern, Monday through Friday. If you have any questions or need more information, please contact us at provider@healthoptions.org

Medical Management

Early Adoption of Low Dose CT scans for Lung Cancer

In support of broader and earlier screening for lung cancer, Community Health Options has **made two important changes to its benefits** related to low dose CT scans.

1. Health Options has incorporated the recently announced criteria set by the United States Preventive Services Task Force throughout the company's fully insured benefits structure effective **July 1, 2021.** While adherence to these criteria is required by January 1, 2023, **Health Options decided that earlier implementation was vital to the interests of its Membership**. Visit the United States Preventive Services Task Force (USPT) recommendations for more information https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening.
2. In keeping with Health Options' emphasis on prevention, we are also **removing prior authorization requirements** for the screening service, also effective **July 1, 2021**.

Colorectal Cancer Screening Benefit Change Effective July 1, 2021

Recently the USPST put forth suggested changes to the colorectal cancer screening recommendations. Formerly the recommendation was adults aged 50 years and older were to receive screening. This recommendation has changed to 45 years of age or older. Health options will incorporate this change in our preventive benefits effective July of 2021. For more information visit

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.

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

Script Saver Program

Our Script Saver program, led by in-house pharmacists, provides personal outreach to Members to assist them with reducing prescription medication costs. Using an analysis of claims data, we advise Members on strategies such as switching from retail to mail order fulfillment, suggesting alternative dosage forms, steering Members with Chronic Conditions to our Chronic Illness Support Program (CISP) if it is covered by their plan, or suggesting preferred products on the formulary. This program has led to out-of-pocket savings of $98,000 for our Members in 2020 and is on track for even greater savings for Members in 2021.

Provider Resources

Impact of the American Rescue Plan Act on Consumers

Starting April 1, 2021, consumers enrolling in Marketplace coverage through HealthCare.gov have been able to take advantage of increased tax credits to reduce premiums. CMS is also extending access to a 30-day Special Enrollment Period on Healthcare.gov until **August 15, 2021**. Additionally, beginning in early July on HealthCare.gov, consumers who have received or have been determined eligible to receive unemployment compensation for any week during 2021 may be able to get another increase in savings when enrolling in new Marketplace coverage or updating their existing Marketplace application and enrollment. To read the full **HHS press release**, visit: https://www.hhs.gov/about/news/2021/03/23/2021-special-enrollment-period-access-extended-to-august-15-on-healthcare-gov-for-marketplace-coverage.html

Community Health Options' New Logo and Branding

You may recall that last summer Community Health Options kicked off a new look with an updated logo and color palette. Branding assets continue to be available so that you can update the Health Options' brand on your own website or materials. This will ensure it matches Members' ID cards and will help Members quickly identify that you are a participating provider. Please contact Provider Relations at Provider@healthoptions.org for assistance in updating the logo.

General Health Options Updates

Interoperability

Interoperability will offer the ability for data to be shared and used among doctors, laboratories, hospitals, pharmacies and the consumer/patient. The goal of sharing healthcare data within the health service industry is to create a more effective and efficient means to provide quality care by enabling quicker and more informed decisions. Opening these channels of information is a federal requirement for businesses in healthcare. In July, Health Options will support electronic access to Members' claims through third-party applications in the Members' mobile devices or browser. This is just the first step in the phased roll-out, which is included in the federal requirements. Members will remain in control of their information and may choose to connect health data applications to share data such as name, date of birth, health plan information, providers used, medical, pharmacy and lab claims as well as other data. If Members choose not to share, the information will remain private.

Philanthropic Work

Last year, Health Options kicked off a Community Benefit Expenditure (CBE) to award grants that support community-based health and wellness programs in our service area. In 2020, we awarded $115,000 across 16 different community-based organizations (CBOs) that were impacted by the COVID-19 pandemic. We have just completed our 2021 spring cycle of giving, which was focused on CBOs that promote community health, with preference given to those helping to treat and manage chronic illnesses. We received 33 applications and are pleased to announce that based on our advisory council's review and recommendations, we have awarded $50,000 across 8 deserving recipients. We are currently accepting a**pplications for our**

fall grant cycle now through July 23. For additional information, please follow the link https://www.healthoptions.org/blog/fall2021grantopportunity/

2020 Annual Report

Please go to the link to view our annual report https://online.fliphtml5.com/sndzh/dqnw/#p=1. You will learn about our activities and accomplishments on behalf of all our stakeholders during a challenging year, and gain insight into future planning.