
As we enter a new year, thank you for your partnership in providing affordable, high-quality healthcare that promotes health and wellbeing for the people of Maine. We've made it halfway through winter and spring is just around the corner!

In this bulletin, we'll introduce our new chief medical officer. We'll also share why your role is so critical when it comes to managing our risk adjustment data, explain an adjustment to working with our team for claims processing, and share important information about credentialing and updating provider information, along with policy updates and essential coding information.

Dr. Lori Tishler Named New Chief Medical Officer

Please join us in welcoming Dr. Lori Tishler to Community Health Options as our new chief medical officer. Dr. Tishler joined in late January and is responsible for overseeing all of Health Options' clinical strategies and medical management initiatives. She joins from Boston-based Commonwealth Care Alliance, where she served as senior vice president, leading a team that provided direct, consultative and programmatic support in several areas, including care management and primary care for those with complex medical and behavioral needs. [Read the full news release](#) on our website.

Prior Authorization Changes

- Effective on or after **March 1, 2023**, Observation Prior Authorizations will no longer be required,
- Effective **January 1, 2023**, Health Options has removed Prior Authorization requirements for Psych and Neuropsych testing.

Your Critical Role in Risk Adjustment

Providers play a crucial role in helping patients make the best use of their health plan's benefits and have a real impact on patient care beyond an initial visit.

Importantly, documentation supported by correct coding gives Health Options a true picture of a Member's actual health status. It also alerts the Care Management team to a need for chronic illness support, along with furnishing other providers invaluable information about the patient's needs.

Let's say a physician assesses and diagnoses a patient with Type 2 Diabetes with a comorbid condition of Chronic Kidney Disease, stage 2, during an annual wellness visit. Afterward, the claim is incorrectly coded E11.9, Type 2 Diabetes mellitus without complications. Given the incorrect coding, the additional condition of Chronic Kidney Disease, stage 2, could be overlooked and inadequately considered by some members of the patient's clinical care team.

Instead, the provider should use the appropriate ICD-10 clinical codes of E11.22, Diabetes with Chronic Kidney Disease, and N18.2, Chronic Kidney Disease, stage 2. This information enables Health Options to adequately assess the risk within the patient's health plan while providing crucial information to help the Member obtain the appropriate level of care.

Health Options partners with Inovalon, Inc., for risk adjustment and uses its unique Electronic Patient Assessment Solution Suite (ePASS®), which supports the audit and gives Health Options the information necessary to help Members manage chronic conditions or remain current with their preventive healthcare. The information also helps Health Options track risks and trends and shares key details to all providers when a patient obtains care from multiple providers.

Proper clinical coding is also vital to the success of Health Options' mandated annual risk adjustment data validation audit as we provide benefits to your patients. Health Options also uses the risk adjustment information as part of its Healthcare Effectiveness Data and Information Set because it provides essential information on the effectiveness of care and outcomes for its annual NCQA rating.

Provider Credentialing and CAQH Applications

To ensure timely processing of practitioner credentialing applications, please make certain your Council for Affordable Quality Healthcare applications have been updated and have a current attestation before practitioner enrollment. Expired applications or those with a current attestation that has outdated provider data can delay the credentialing cycle.

For **credentialing inquiries**, please send any general questions about credentialing or specific questions regarding credentialing status or effective dates to credentialing@healthoptions.org.

Provider Enrollment

For **provider updates**, please email any updates, including practitioner additions, changes, or terminations to dataintegrity@healthoptions.org.

You can find forms to submit changes to practitioner, practice, and facility information on the [Health Options website](#) under Provider Resources.

Importantly, the Centers for Medicare & Medicaid Services and other regulatory bodies, as well as the [No Surprises Act of 2021](#), requires health plans to maintain and update data in provider directories—and we rely on providers to review their data and notify us of changes as they happen to ensure Members have access to accurate information, including whether your practitioners are accepting new patients.

Important Claim Service Center Update

Effective **March 1, 2023**, we will limit claim inquiries to five per call to reduce or prevent caller wait time. While we're always happy to assist with claim inquiries, using the [provider portal through Availity](#) is the fastest and most effective way to routinely check the status of a claim. If you haven't yet registered for Availity, you can find instructions on [how to do so on our website](#).

We continue work on enhancing the portal by adding more information and functionality. We value and thank you for your feedback on the user experience.

Policy Updates

✓ **Ambulance Services**

Health Options reimburses licensed transportation companies transport services in a medical emergency to the nearest medical provider capable of furnishing covered services. Additionally, Health Options will reimburse medically necessary, non-emergent ambulance transport covered when authorization is obtained.

Ambulance reimbursement is based on transportation or no transport, inclusive of supplies and services, and a separate charge for mileage. Ambulance suppliers should report one charge reflecting transport type, with a separate charge for loaded mileage. Reimbursement for other services billed in addition to the base rate transportation are considered part of the payment for the base rate and are not separately reimbursed. [See full policy.](#)

✓ **Modifier Reference Guide**

Updates include: 78 Modifier reimbursement reduced to 70% from 80% **effective 2/15/2023**; JZ modifier effective **1/1/2023**, informational only; and billing LT and RT separately on a surgical code eligible to use modifier 50 will not be reimbursed. [See the full policy](#) for more information.

✓ **Unlisted, Unspecified Miscellaneous Codes**

Providers must submit CPT/HCPCS code(s) to the highest specificity, but if none are available an unlisted code *may* be appropriate. Unlisted unspecified or miscellaneous CPT/HCPCS codes are only permissible when an established code does not exist to describe the drug, service, supply, implant, procedure or item rendered. Health Options will determine its reimbursement on an individual authorization and claim basis after reviewing the unlisted, unspecified or miscellaneous code. Such claims must contain the following information so Health Options can accurately review the claim against a Member's Benefit Agreement, Medical Management authorization requirements and Health Options' policies:

- A written description, office notes or an operative report that certifies the medical necessity for the drug, service, supply, implant, procedure or item described in the claim
- An invoice and written description detailing the product or service provided
- Documentation describing the specific number of times service/item was provided
- Date(s) when the service/item was provided
- Identification to support whether the service/item was provided independently from other services or performed at the same surgical site
- The corresponding National Drug Code (NDC) number for an unlisted drug code

[See full policy.](#)

[Quality and Accreditation: HEDIS Updates and New Measures for MY 2023](#)

Please use CPT II Codes: These are supplemental tracking codes used for performance measurement and data collection related to quality and performance measurement, including Healthcare Effectiveness Data and Information Set (HEDIS).

KED: Kidney Health Evaluation is a new measure for patients with diabetes. It measures the percentage of members aged 18–85 with type 1 or type 2 diabetes who received a kidney health evaluation, defined by **both** an estimated glomerular filtration rate (eGFR) and a urine albumin creatinine ratio (uACR) during the measurement year.

WCV: The percentage of Members aged 3–21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. **Ages 18-21 remains the largest gap** when it comes to wellness and preventive healthcare.

COL: The ages for the Colorectal Cancer Screening measure was updated to align with the updates to the U.S. Preventive Services Task Force (USPSTF) guidelines to assess for adults ages 45-75. It now measures adults **aged 45-75 who had appropriate screening for colorectal cancer** with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every five years, colonoscopy every 10 years, computed tomography colonography every five years, stool DNA test every three years.

Medical Benefit Management Update

Newly Added Medications Requiring Prior Approval through Medical Benefits

BRAND NAME	Generic Name
ALYMSYS*	<i>bevacizumab-maly</i>
AMVUTTRA	<i>vutrisiran</i>
CABENUVA	<i>cabotegravir and rilpivirine</i>
DACOGEN	<i>decitabine</i>
DENGAXIA	<i>dengue vaccine</i>
LUTRATE 505(b)(2)*	<i>leuprolide acetate depot*</i>

Medications Removed From Requiring Prior Approval

BRAND NAME	Generic Name
SOTACOR	<i>sotalol hydrochloride</i>
SUBLOCADE	<i>buprenorphine</i>

**These medications are subject to voluntary Site of Care transition.*

Medications Now Excluded from Medical Benefit

BRAND NAME	Generic Name
ACTIMMUNE	<i>interferon, gamma 1-b</i>
AVONEX	<i>interferon beta-1a</i>
BETASERON	<i>interferon beta-1b</i>
BLENREP	<i><u>belantamab mafodotin-blmf</u></i>
INFERGEN	<i>inferno alfacon-1, recombinant</i>
LARTRUVO	<i><u>olaratumab</u></i>
N/A	<i><u>bebtelovimab</u></i>
N/A	<i>respiratory syncytial virus</i>
PEGASYS	<i>pegylated interferon alfa-2a</i>
PEGINTRON	<i>pegylated interferon alfa-2b</i>
PEPAXTO	<i>melphalan <u>flufenamide</u></i>
REBIF	<i>interferon beta-1a</i>
SANOFI COVID-19 VACCINE	<i>n/a</i>

Have an idea for the bulletin?

Tell us what you want to know! Contact us at communications@healthoptions.org