# Network Provider Manual

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Introduction

HealthChoice is a managed health care program providing comprehensive health and dental benefits to over 186,000 state, education and local government employees, former employees, survivors and their covered dependents.

HealthChoice is administered by the Office of Management and Enterprise Services Employees Group Insurance Department (EGID). The HealthChoice plans are a partnership between providers, members and EGID in the delivery of health and dental care services and products that helps control costs, assists in the provision of high quality health and dental care, and enhances provider/patient relationships. The HealthChoice benefit structure offers financial incentives to encourage Plan members to utilize HealthChoice Network Providers.

EGID provides health and dental care benefits in accordance with the provisions of Oklahoma Statutes, (74 O.S. 2012, §§ 1301, et seq.). The information provided in this manual is a SUMMARY of the benefits, conditions, limitations and exclusions of the HealthChoice High, High Alternative, Basic, Basic Alternative, FOCUS, High Deductible Health Plan (HDHP) and Dental Plans. It should not be considered an all-inclusive listing.

While the HealthChoice Network Provider Manual is a summary only and is not intended to be all-inclusive, its contents should offer providers and their staff vital information regarding the most important aspects of the provider network.

Plan benefits are subject to conditions, limitations and exclusions. These conditions, limitations and exclusions are described and located in Oklahoma Statutes, Administrative Rules, and Administrative Procedures adopted by the plan administrator. You can obtain a copy of the official rules from the office of the Oklahoma Secretary of State. An unofficial copy of the rules is available on the HealthChoice website at www.healthchoiceok.com. Under the heading “About EGID”, select the link for the “Administrative Rules.” A copy of the Administrative Procedures can be obtained from the plan administrator.

Member Handbooks

A description of the plans offered by HealthChoice can be found in the member handbooks. The member handbooks for the HealthChoice health and dental plans can be accessed on the HealthChoice website at www.healthchoiceok.com/Member/Handbooks.
HealthChoice Contact Information

Plan Administrator:
Office of Management and Enterprise Services
Employees Group Insurance Department (EGID)
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
1-405-717-8701
Toll-free 1-800-543-6044
www.healthchoiceok.com

Network Management Unit
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
1-405-717-8790
Toll-free 1-844-804-2642
Fax 1-405-717-8977
EGID.NetworkManagement@omes.ok.gov

Health Care Management Unit (HCMU)
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
1-405-717-8879
Toll-free 1-800-543-6044, ext. 8879
Fax 1-405-717-8947

Medical and Dental Claims Administrator:
HP Administrative Services, LLC
(New Claims)
P.O. Box 24870
Oklahoma City, OK 73124
1-405-416-1800
Toll-free 1-800-782-5218
Fax 1-405-416-1750
TDD 1-405-416-1525
TDD toll-free 1-800-941-2160
Hours 7:30 a.m. to 6:00 p.m., Monday through Friday, excluding state holidays

Certification Administrator:
APS Healthcare
P.O. Box 700005
Oklahoma City, OK 73107-0005
1-405-416-1800
Toll-free 1-800-782-5218
Fax 1-405-416-1755
TDD 1-877-267-6367
Hours 7:30 a.m. to 6:00 p.m., Monday through Friday, excluding state holidays

Pharmacy Benefit Manager:
CVS/caremark
P.O. Box 52136
Phoenix, AZ 85072-2136
Commercial (All non-Part D Plans)
Prior Authorization Phone Line 1-800-294-5979
Customer Care Phone Line 1-877-720-9375

Subrogation Administrator:
McAfee & Taft
Tenth Floor
Two Leadership Square
211 N. Robinson
Oklahoma City, OK 73102-7103
1-405-235-9621
Toll-free 1-800-235-9621
Fax 1-405-235-0439

SilverScript (Medicare Part D)
Prior Authorization Phone Line 1-855-344-0930
Customer Care Phone Line 1-866-275-5253
Joining the HealthChoice Provider Network

The HealthChoice Provider Network is comprised of over 20,000 medical and dental care practitioners and facilities. Most providers who are licensed and/or certified in their particular state are eligible to participate in the provider network. HealthChoice Plan members have the ability to use health care providers from a wide range of specialties. The following is a list of specialties eligible to participate in the HealthChoice Provider Network:

- Ambulance
- Ambulatory Surgery Center
- Anesthesiology Assistant
- Audiologist
- Birthing Center
- Cath Lab
- Certified Nurse Midwife
- Certified Orthotist
- Certified Nurse Practitioner
- Certified Prosthetist
- Certified Registered Nurse Anesthetist
- Chiropractor
- Christian Science Nurse
- Christian Science Practitioner
- Clinical Nurse Specialist
- Dentist
- Dialysis Facility
- Dietitian
- Durable Medical Equipment Vendor
- Hearing Aid Vendor
- Home Health Care Agency
- Hospice
- Hospice Facilities
- Hospital (Medical and Psychiatric/Substance Abuse)
- Independent Diagnostic Testing Facility
- Infusion Therapy
- Laboratory
- Licensed Alcohol and Drug Counselor
- Licensed Behavioral Practitioner
- Licensed Clinical Social Worker
- Licensed Genetic Counselors
- Licensed Marriage Family Therapist
- Licensed Professional Counselor
- Long-term Acute Care Facility
- Medical Doctor
- Ocularist
- Occupational Therapist
- Ophthalmologist
- Optometrist
- Oral Surgeon
- Osteopathic Doctor
- Pathology (Individual)
- Pathology (Group)
- Perfusionist
- Pharmacist
- Physical Therapist
- Physician
- Physician Assistant
- Podiatrist
- Psychologist
- Radiology (Individual)
- Radiology (Group)
- Rehabilitation Facility
- Skilled Nursing Facility
- Sleep Study
- Speech Language Pathologist

HealthChoice also provides Network reimbursement to rural health clinics, federally qualified health centers, Veterans Health Administration facilities, military facilities, city/county health departments and Indian Health Services facilities.

Contracts and applications can be obtained online through a link on the HealthChoice Network Provider website, [www.healthchoiceok.com/Providers/Contracts_and_Applications/index.html](http://www.healthchoiceok.com/Providers/Contracts_and_Applications/index.html) or by contacting the HealthChoice Network Management Unit.
HealthChoice also accepts completed “Oklahoma Uniform Credentialing Applications” (OUCA) and OUCA supplements as HealthChoice applications for individual practitioners when accompanied by the applicable credentialing attachments and signed signature page required by the provider contract.

The Network contracts require Network Providers to make a reasonable effort to refer HealthChoice members and their dependents to other Network Providers when additional consults are necessary. EGID believes this referral process is in the best interest of the Plan member and within the dictates of good medical practice. Plan members cannot realize the full benefit of their HealthChoice Plan unless they utilize Network Providers.

**Network Management Unit**

The HealthChoice Network Management Unit is the primary source of information and assistance for Network Providers.

The network management unit is responsible for:

- Performing the day-to-day duties necessary to manage the provider network, including the distribution of contracts, applications and all other documentation utilized to obtain and store accurate provider information.
- Maintaining the network provider database, the “Find a Provider” database on the EGID website, and the claims payment system.
- Responding to provider inquiries regarding contract terms, reimbursement and basic claim issues, as well as member inquiries regarding issues that involve Network Providers.

The network management unit office hours are 7:30 a.m. to 4:30 p.m., Monday through Friday, excluding state holidays.

**Network Management Unit**
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
1-405-717-8790
Toll-free 1-844-804-2642
Fax 1-405-717-8977
EGID.NetworkManagement@omes.ok.gov

Note: For a prompt reply, providers must send all written inquiries regarding contract information or any documentation intended for the network management staff directly to the network management unit at the mailing address, email address or fax number referenced in the section above. If correspondence is addressed to the medical and dental claims administrator, there may be a significant delay in receiving a response.
Network News Newsletter

The network management unit is responsible for developing the content of the *Network News* newsletter. This newsletter is a quarterly publication specifically for Network Providers. The newsletter contains the latest information regarding Plan benefits, contracts and fee schedules. The newsletter also serves as the primary method by which providers receive notifications mandated by the terms of the provider contracts.

To distribute the newsletter as efficiently as possible, it is distributed electronically to each Network Provider’s correspondence email address. Email addresses are obtained through information submitted on contract applications. Network management also updates email addresses on a regular basis as providers submit current information connected with their practice locations.

To update email information, Network Providers can use the “Network Provider Newsletter/Correspondence Email Update Form” located at [www.healthchoiceok.com/documents/EmailProviderForm.pdf](http://www.healthchoiceok.com/documents/EmailProviderForm.pdf). Completed forms can be submitted to network management by mail, fax or email.

It is imperative providers inform network management when contact information of any type is updated. It is important providers receive communication from network management, so please make sure security settings allow this information to be accepted. The HealthChoice email address [healthchoice@service.govdelivery.com](mailto:healthchoice@service.govdelivery.com) should be added to the safe contact list so network management emails are not be returned as undeliverable.

Printed newsletters are sent via the postal service to the mailing address on record for providers without internet access or those who have undeliverable email addresses.

Network News Email Address

The *Network News* newsletter is the primary information source for HealthChoice Network Providers. Each quarterly issue provides plan update information and meets notice requirements as set out in section XII of the Network Provider Contracts.

EGID distributes electronic versions of newsletters and other communications to Network Providers from [healthchoice@service.govdelivery.com](mailto:healthchoice@service.govdelivery.com). To make sure you do not miss upcoming issues of the newsletter or other communications, be sure to add this new email address to your safe senders list.

Provider Self-Service

The “Provider Self-Service” feature of the website is the primary search tool available to Network Providers. The data is updated frequently to ensure providers have access to the most accurate information available. The “Provider Self-Service” feature also allows Network Providers to review pertinent information regarding the claim submission process, including the Practice Identification Number (PIN), service, mailing and billing addresses, phone numbers, specialties and network effective dates. To access “Provider Self-Service” go to [www.healthchoiceok.com/providers](http://www.healthchoiceok.com/providers) and select the “Provider Self-Service” link which is in the “Provider” drop-down menu at the top of the page.
Fee Schedule Requests

EGID recognizes the need to access fee schedule information to conduct financial impact assessments. For your convenience, direct access to current HealthChoice fee schedule information is available to Network Providers through the HealthChoice Network Provider website at https://gateway.sib.ok.gov/feeschedule/Login.aspx. DISCLAIMER: This fee schedule has not been publicly disclosed and is deemed confidential pursuant to 51 O.S. and should not be disseminated, distributed or copied to persons not authorized to receive the information.

Fee Schedule Updates

Fee schedule updates for services provided by HealthChoice Network Providers are scheduled for:

- Jan. 1: Add, change and delete codes for CPT/HCPCS, OP, ASC, and ADA
- Jan. 1: Quarterly fee schedule addendum and other updates as necessary for CPT/HCPCS, OP, ASC, ASA, Select, and ADA
- Feb. 1: Add, change and delete codes for ASA
- April 1: Comprehensive fee schedule update for CPT/HCPCS, OP, ASC, Select, and ADA
- July 1: Quarterly fee schedule addendum and other updates as necessary for CPT/HCPCS, OP, ASC, ASA, Select, and ADA
- Oct. 1: Quarterly fee schedule addendum and other updates as necessary for CPT/HCPCS, OP, ASC, ASA, Select, and ADA
- Oct. 1: Comprehensive fee schedule update for MS-DRG and MS-DRG LTCH

As a reminder, national medical and dental associations may change, add, correct or delete billing codes throughout the year. When these modifications occur, EGID reviews them as quickly as possible and makes any necessary updates. Additionally, EGID performs fee schedule updates on an ad hoc basis when necessary.

Inpatient and outpatient tier designations and urban/rural statuses are updated on Oct. 1 each year, based on the most current CMS fiscal year inpatient prospective payment system (IPPS) impact file for Network Providers.

Inpatient and outpatient tier designations are defined as:

- Tier 1 – Network urban facilities with greater than 300 beds
- Tier 2 – All other urban and non-Network facilities
- Tier 3 – Critical access hospitals, sole community hospitals, and Indian, military and VA facilities
- Tier 4 – All other Network rural facilities

Following each quarterly update of the HealthChoice fee schedule, outpatient rates for the procedures covered under the program will become fully phased in during the next quarterly update.

Fee schedule updates are reported in each quarterly issue of the Network News newsletter. If you need specific codes and Allowable Fees affected by these updates, please visit our website at https://gateway.sib.ok.gov/feeschedule/Login.aspx and view or download the latest fee schedule addendum. The fee schedule has not been publicly disclosed and is deemed confidential pursuant to 51 O.S. and should not be disseminated, distributed or copied to persons not authorized to receive the information. If you have questions or need additional information, please contact network management.
The following terms are used in the fee schedule:

- **BR**: By Report
- **BR1**: 60% of billed charges for Tiers 1 and 2; 70% of billed charges for Tiers 3 and 4
- **BR2**: 30% of billed charges for Tiers 1 and 2; 35% of billed charges for Tiers 3 and 4
- **BR3**: 25% of billed charges for Tiers 1, 2, 3 and 4
- **Health**: Submit to Health Plan
- **I**: Incidental
- **IC**: Individual Consideration
- **NC**: Non-Covered
- **NOC**: Non-Classified Drugs, etc.
- **Per Diem**: Per Diem Rate
- **RX**: Submit to Pharmacy Administrator
- **TM**: Use of Time

- Physician Assistant, Nurse Practitioner and Clinical Specialist is 85% of fee allowable.
- **Anesthesia Conversion Factors**
  - **2014/2015**:
    - $50 CRNA
    - $55 M.D./D.O.
  - Anesthesia Assistant is 50% of fee allowable.

**Member Responsibilities**

HealthChoice members are encouraged to utilize Network Providers for the delivery of health and dental care services and are offered financial incentives for compliance. When utilizing a HealthChoice Network Provider, the member is obligated to:

1. Provide evidence of coverage in the form of a HealthChoice ID card.
2. Assume the financial responsibility for deductibles, copays, coinsurance and non-covered services.
3. Cooperate with the provider in transactions involving any and all insurance carriers covering the member for services rendered.
4. Assist with and adhere to all aspects of the benefits offered through HealthChoice.


**Claims Submission**

**Paper Claims Submission**

Under the terms of the Network Provider contract, HealthChoice Network Providers are required to file claims for HealthChoice members. The physician shall bill EGID on forms acceptable to EGID within 60 days of providing the medical services, utilizing ICD-10 codes.

All claims must be submitted on the most current version of the appropriate claim form. For detailed information regarding how to file claims or information about the latest claim forms, consult the “HealthChoice Provider Billing Guides” online at [www.healthchoiceok.com/Providers/Billing_Guide/index.html](http://www.healthchoiceok.com/Providers/Billing_Guide/index.html).

Regardless of the claim form utilized, claims are processed according to the appropriate fee schedule.
Claims should be submitted to:

HP Administrative Services, LLC
P.O. Box 24870
Oklahoma City, OK 73124

Corrected claims and correspondence should be submitted to:

HP Administrative Services, LLC
P.O. Box 24110
Oklahoma City, OK 73124

Acceptable claim forms are:

CMS 1500
UB-04
ADA 2012

Claims can be submitted by paper, HIPAA 837 electronic claims submission, or through our online, secure portal called ClaimLink.

If you consistently have issues with the claims that do not process quickly, please verify the format your intermediary or clearinghouse uses to submit your claims. Make sure they are filing your claims electronically and not on paper because it takes much longer to process paper claims.

Use the current claim form to expedite claims processing. Accepted claim forms include the ADA 2012, CMS 1500 (02-12), and UB-04.

For faster service, and to save time and expense, dental providers should not send X-rays or molds with their claims or dental predeterminations unless we request them.

If we request additional documentation, X-rays or molds to process a claim, or if you need to file a corrected claim, please submit the information or corrected claim to:

HP Administrative Services, LLC
P.O. Box 24110
Oklahoma City, OK 73124-0110

When you submit a claim electronically and then submit a duplicate paper claim, it can significantly slow down your payment. If you submit a claim and need to verify payment, please contact our health and dental claims administrator or log in to ClaimLink to check the claim status. Resubmit a claim only if it is not already on file. When the same claim is submitted multiple times, each additional claim can deny as a duplicate and further delay the adjudication process.

If you have questions, please do not hesitate to contact our medical and dental claims administrator.

ClaimLink

ClaimLink is a valuable feature of the HealthChoice Network Provider home page. With ClaimLink, Network Providers can file claims online through direct data entry without the need for intermediary software. ClaimLink provides access to claim status the business day following submission. It also provides the ability to check real
time deductibles, out-of-pocket maximums, confirm member eligibility, obtain a “Remittance Advice” (RA) and access claim editing rationale; however, it does not currently provide editing rationale for outpatient facility claims. Outpatient facility claims are edited using the Outpatient Code Editor (OCE) as published by the Centers for Medicare & Medicaid Services. (Also refer to “ClaimCheck and Clear Claim Connection.”)

Next business day claim status check and instant access to RAs through a secure provider ClaimLink account can help improve revenue-cycle management reducing the lag time between an electronic funds transfer and receipt of the RA in the mail. Instant access to an RA can also help speed up the account reconciliation processes.

In order to ensure privacy, first-time users must register and create a user ID and password. The provider’s email address and TIN are required to register. The user ID and password are necessary for future access.

Quick start guides are available on the ClaimLink home page with no login required. The guides provide tutorials that include step-by-step processes for submitting claims, searching claims and obtaining RAs online. Adobe Reader is required to view the guides.

**Corrected claims cannot be submitted electronically or online through ClaimLink. Hard copies of corrected claims must be submitted to the correspondence address for the medical and dental claims administrator.** Access to ClaimLink is available on the Network Provider home page at [www.healthchoiceok.com/ClaimLink/ClaimLink_for_Providers/index.html](http://www.healthchoiceok.com/ClaimLink/ClaimLink_for_Providers/index.html).

**Clearinghouses**

Providers can submit claims electronically utilizing clearinghouses in conjunction with the electronic claims payer ID 22521.

All electronic transactions must conform to HIPAA 5010 standards. Claims that are not in compliance are either rejected or denied.

**Dental Predeterminations**

A dental predetermination is an itemization of proposed dental charges and their reimbursements before dental services are performed. **It should not be confused with certification.** A predetermination is not required, but is recommended when the dental treatment plan proposed by the provider is expected to exceed $200. A predetermination also shows the financial liability of the member. It should be identified as a predetermination and submitted in the same manner as a standard paper dental claim or HIPAA 837 electronic claims submission.

**Claim Payments**

As mandated by HB1086, the *Transparency, Accountability, and Innovation in Oklahoma State Government 2.0 Act* of 2011, all payments disbursed by the Office of the State Treasurer are made solely through electronic funds transfer (EFT).

All claims are paid directly to Network Providers as required under the terms of the Network Provider contract. An example of the provider RA is available at [www.healthchoiceok.com/documents/HCRemittance.pdf](http://www.healthchoiceok.com/documents/HCRemittance.pdf).

HealthChoice Network Providers who currently accept Medicare assignment receive direct claims payments.

EFT is utilized for all provider payments. RAs are processed for Network Providers on a nightly basis. Paper RAs are still mailed when utilizing EFT. Network Providers can contact the medical and dental claims administrator to stop receiving paper RAs and download them exclusively from ClaimLink.

Maintaining confidentiality is especially important to patients seeking treatment for sensitive issues and improvements in our privacy processes are made on an ongoing basis.

In order to better maintain patient confidentiality, HealthChoice began removing the “Code” header and the “Code Description” from RAs and ClaimLink for all claims processed on or after Jan. 1, 2016. The certification administrator also removed all references to coding/description from all communications.

**Electronic Remittance Advice**

The EDI 835 transaction set, or “Electronic Remittance Advice” (ERA), is part of the HIPAA standard transactions that are designed to improve claims revenue-cycle management for providers. It is part of the ASC X12 835 “Health Care Claim Payment/Remittance Advice.” If a provider wishes to enroll in 835 transactions, the enrollment forms are available on our website at [www.healthchoiceok.com/Providers/Electronic_Remittance_Advice_(ERA)/index.html](http://www.healthchoiceok.com/Providers/Electronic_Remittance_Advice_(ERA)/index.html).

Network Providers should use the form found on our website to sign up for ERA claim payments that are sent directly to their bank. If they change tax identification numbers (TIN) or NPI Numbers, they must also complete and submit this form with their change request, if ERA has already been established.

Network Providers should contact network management at 1-405-717-8790 or toll-free 1-844-804-2642, fax 1-405-717-8977, email EGID.NetworkManagement@omes.ok.gov, or send to 3545 N.W. 58th St., Ste. 110, Oklahoma City, OK 73112 with questions or to check the status of their ERA enrollment. Please allow up to 14 business days for processing prior to checking status.

Non-Network providers should contact our medical and dental claims administrator at 1-405-416-1800 or toll-free 1-800-782-5218 to check the status of their ERA enrollment.

**Combined Payments**

Combined payments are utilized for all providers. Under the combined payments feature, all payments for a given day are combined into a single RA for a single provider. Combined payments facilitate the processing of claim payments for providers. If you have questions or you need more information, contact the medical and dental claims administrator for assistance.
Coordination of Benefits

Under the terms of the Network Provider contract, the Coordination of Benefits (COB) rules are subject to change. Following is a brief description of the rules that apply to COB:

- With the exception of claims when the primary insurance carrier pays zero, HealthChoice pays the remaining balance on covered charges after the primary carrier payment.
- When the primary carrier pays zero, HealthChoice Allowable Fees, plan deductibles, copays and coinsurance apply to allowed services.
- Regardless of the primary carrier’s payment, HealthChoice must deny claims for non-covered services and services that exceed Plan limits. Plan provisions apply.

An unofficial copy of HealthChoice Administrative Rules, which include the COB rules, is available at [www.healthchoiceok.com](http://www.healthchoiceok.com).

Overpayments/Underpayments

Providers are notified in writing of all overpayments identified by the medical and dental claims administrator or pharmacy benefit manager. Overpayments are recovered either by a refund check from the provider and/or benefit reductions of subsequent claims. The provider has 60 days to reply to the initial overpayment letter. If no attempt is made to respond to the medical and dental claims administrator, subsequent benefit payments are reduced until the overpayment is satisfied. Underpaid claims are adjusted and additional benefits are issued to the appropriate payee.

ClaimCheck and Clear Claim Connection

ClaimCheck® and Clear Claim Connection® are claim processing software programs used to ensure claims are properly coded using industry-standard coding edits.

ClaimCheck is designed to detect coding discrepancies automatically. Automated reviews improve accuracy and consistency in claims adjudication and lead to improved claim turnaround times. ClaimCheck utilizes National Correct Coding Initiative (CCI), Current Procedural Terminology (CPT) guidelines as published by the American Medical Association, and the general standards of medical practice in editing claims. Editing guidelines established by the Centers for Medicare & Medicaid Services are also included in ClaimCheck rules.

Clear Claim Connection provides specific, detailed information regarding ClaimCheck’s procedure code auditing software and how it evaluates code combinations during the processing of a claim. Clear Claim Connection® allows HealthChoice Network Providers online access to claims editing rules and clinical rationale used in the auditing software.

You can access both of these applications through ClaimLink. HealthChoice encourages its Network Providers to utilize this website function to reference the Clear Claim Connection feature of the claims editing system.

In the event you disagree with any determination executed by ClaimCheck please contact the medical and dental claims administrator. You will need to provide any documented information that supports your position.
Subrogation

In the event treatment is provided to a HealthChoice member for injuries sustained in an accident, and there is a third party at fault, the Plan has subrogation rights. It is important that Network Providers are aware that their provider contract requires them to file claims with HealthChoice. In addition, the provider contract prohibits Network Providers from collecting from the member any amounts in excess of the Allowable Fee and/or that exceed the member’s deductible and coinsurance liability. The only exception is for services not covered by the Plan or if annual or lifetime benefit has been reached.

Beginning Feb. 1, 2016, the new subrogation administrator for EGID is McAfee & Taft and Healthcare Recovery Solutions (HRS). McAfee & Taft and HRS will provide subrogation services including compiling liens, pursuing and monitoring of third party cases, recovery of liens and performing all detailed investigation regarding possible subrogation claims including but not limited to the following:

- Medical claims,
- Dental claims,
- Defective medical devices,
- Dangerous prescription drugs, and/or
- Toxic exposure.

More information regarding subrogation can be found in Oklahoma Statutes, (74 O.S. 2012, §§ 1301, et seq.). Subrogation information is also available in the unofficial copy of the Administrative Rules 260:50-5-49 at www.healthchoiceok.com.

Provider Claim Appeals

Providers can appeal a claim by submitting a letter to the medical and dental claims administrator at the address designated for correspondence.

If the initial appeal is upheld and you have additional information to submit for review, a written request must be sent to the medical and dental claims administrator petitioning another appeal of the claim payment. Submit the written request for an additional appeal to the correspondence address listed on page 2. All appeals must be made in writing within two years from the date of the RA.

Dispute resolution (only Network Providers): An additional 90 days from the first notification is allowed for disputes. If the attempt to resolve the issue is not successful, payment is issued in accordance with “Dispute Resolution” as defined in the Network Provider contracts.

Utilization Review

Each HealthChoice Network Provider is required to adhere to and cooperate with EGID’s Certification and Concurrent Review procedures. These procedures do not guarantee a member’s eligibility or that benefits are payable, but assure the Provider that the medical services to be provided are covered by the Plan. If a HealthChoice member presents without an ID card, the first step in the utilization review process is to verify benefits and eligibility. To obtain this information, Network Providers must contact the medical and dental claims administrator. The provider can also utilize the ClaimLink feature and obtain the information online at www.healthchoiceok.com/ClaimLink/ClaimLink_for_Providers/index.html.
Certification

Certification is a review process used to determine if certain services are medically necessary according to HealthChoice guidelines. Certification is performed by either the HealthChoice certification administrator or by the HealthChoice Health Care Management Unit (HCMU), depending on the type of service.

The provider must obtain certification under certain situations, including when the member or the member’s covered dependents:

- Are admitted to a hospital or are advised to enter a hospital;
- Require certain surgical procedures that are performed in an outpatient facility;
- Require certain diagnostic imaging procedures; or
- Have HealthChoice as the second or third carrier.

Guidelines

Certification is required within three working days prior to scheduled hospital admissions, certain surgical procedures in an outpatient facility and certain diagnostic imaging procedures, or within one day following emergency/urgent services. To request certification, the provider must contact the certification administrator.

If certification is not initiated and approved within the time frames described above, but is approved after services are performed, and all other plan rules and guidelines are met, a 10 percent penalty is applied. **The member is not responsible for this 10 percent penalty.** If certification is denied because medical necessity guidelines are not met, either before or after services are performed, the claim is denied.

When using a non-Network provider, the member is responsible for paying the 10 percent penalty and for any services that are not deemed medically necessary according to HealthChoice guidelines.

Surgical Procedures

The following surgical procedures require certification through the certification administrator:

- Blepharoplasty – Correction to the eye lid
- Rhinoplasty – Reconstruction of the nose
- Breast implant removal – Removal of breast implants
- Scar revision – Removal of scar tissue
- Breast reduction – Reduction in breast size
- Panniculectomy – Reduction in abdomen size
- Surgical treatment of varicose veins
- Spinal cord stimulator (neurostimulator) placement
- Correction of lid retraction

Observation Stays

The following rules apply regarding observation stays:

1. **Observation Stays of 47:59 Hours or Less**
   a. Certification is not required;
   b. Charges must be billed as outpatient services; and...
c. Charges for a subsequent inpatient admission must be combined with charges for the observation stay and all charges must be billed as inpatient services.

2. Observation Stays of 48:00 Hours or Longer:
   a. Observation Stays that are longer than 48 hours are not covered; however, if charges for room and board are billed, certification is required by the certification administrator; and
   b. Charges for room and board must be billed as inpatient services.

Observation stays through the emergency room or for scheduled/non-scheduled outpatient surgery must be billed as outpatient services, unless charges for room and board are billed, then charges should be billed as inpatient services.

Organ Transplants

Certification is required for all transplants. The following transplants are covered by the Plan and require certification through the certification administrator:

- Bone Marrow
- Corneal
- Heart
- Intestinal
- Kidney
- Liver
- Lung
- Pancreas
- Peripheral Stem Cell

Diagnostic Imaging

The following diagnostic imaging procedures require certification through the certification administrator:

- Sinus CT / MRI
- Head / Brain CT / MRI
- Chest CT including spiral CT (RAD)
- Spine CT / MRI
- Shoulder MRI
- PET scans

Other Services that Require Certification

Certain services require certification through the HealthChoice Health Care Management Unit (HCMU). Providers must contact HCMU at 1-405-717-8879 or toll-free 1-800-543-6044, ext. 8879. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

- Botox injections
- Chiropractic services
- Durable medical equipment
- Home health care services
- Hospice
- Mental health outpatient services
• Non-emergency ground or air ambulance
• Oral surgery
• Physical medicine services
• Speech therapy for ages 17 and younger
• Substance use outpatient services
• TMD treatment for orthodontia age 19 and older

This list is not all-inclusive.

Inpatient Certification

The Network Provider is responsible for obtaining certification for hospital admissions. EGID requires certification of all non-emergency hospital admissions at least three working days prior to the actual admission (this excludes maternity admissions for delivery, which do not require certification). Emergency admissions require notification within 24 hours (one working day) of the actual admission date. Holiday or weekend admissions must be certified by the first working day following the date of hospital admission. The hospital, physician and member receive a letter verifying certification.

Upon initiation of the certification process, a reference number is assigned to the case (assignment of a reference number does not complete the certification process or guarantee benefits). Utilization review staff reviews medical information pertaining to the patient. If initial time frame requirements are met and the certification is approved, the 10 percent penalty is not assessed to the claim payment.

The certification administrator updates the progress of the patient at established intervals during the concurrent review process. The medical necessity of additional inpatient days is also determined during the concurrent review process. The certification administrator performs retrospective reviews/appeals. A retrospective review/appeal could be warranted in the following situations:

• Admission denied
• Surgical procedure denied
• Additional inpatient days denied

When certification is not initiated and approved within the established time frame, but is approved retrospectively, and all other Plan rules and guidelines are met, the claim payment is assessed a 10 percent penalty. The member is not responsible for paying this 10 percent penalty.

HIPAA 278 Transactions (Electronic Certifications)


The 278 facilitates the exchange of information between providers and review entities for:

• Admission certification reviews;
• Referral reviews;
• Health care services certification reviews;
• Extend certification reviews;
• Certification appeal reviews;
• Reservation of medical services; and
• Cancellation of service reservations.

The 278 transaction is one of the standard transactions covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for the health care industry to achieve administrative cost savings with electronic data interchange (EDI). It is also one of the transactions covered under section 1104 of the Patient Protection and Affordable Care Act for the use of operating rules to support implementation of HIPAA standards.

Health care service providers are not required to utilize the standard transaction; however, if you choose to submit EDI transactions, the standards and operating rules must be followed.

These transactions will be accepted in batch mode from Change Healthcare, and Change Healthcare will return responses to providers.


Facility Dispute Resolution Procedures


To initiate the dispute resolution process, the provider must request and complete a “HealthChoice Facility External Dispute Resolution Procedure Form” which is available through the legal department at 1-405-717-8729 or toll-free 1-800-543-6044, ext. 8729.

Inpatient Facility Reimbursement

EGID has established a four tier system for short-term acute facilities:

- Tier 1 – Network urban facilities with greater than 300 beds
- Tier 2 – All other urban and non-Network facilities
- Tier 3 – Critical access hospitals (CAH), sole community hospitals (SCH), Indian, military and VA facilities
- Tier 4 – All other Network rural facilities

Annual updates to the base rate:

- Tier 1 and Tier 2 – 100 percent of Medicare’s full market basket percentage
- Tier 3 – 50 percent of Medicare’s full market basket percentage
- Tier 4 – Remain frozen. For short-term acute facilities, Tier 4 remains frozen until Tier 2 base rate exceeds Tier 4
- Base rates will be reevaluated annually
Outpatient Facility Reimbursement

The following are reimbursement changes that became effective April 1, 2016.

Utilize the same tier system previously established for short-term acute facilities:

- Tier 1 – Network urban facilities with greater than 300 beds
- Tier 2 – All other urban and non-Network facilities
- Tier 3 – Critical Access Hospitals (CAH), Sole Community Hospitals (SCH), Indian, Military and VA facilities
- Tier 4 – All other network rural facilities
  - For short-term acute facilities, Tier 4 remains frozen until Tier 2 base rate exceeds Tier 4, which is estimated to occur in 2023. At that time, both short-term acute and outpatient Tier 4 facilities will move to Tier 2.

Phase in changes over three years:

- April 1, 2016
- April 1, 2017
- April 1, 2018

Code ranges that will be allowed as a tier-specific percentage of Medicare, with phase in as indicated in table below:

- Surgery and other procedures within 10000-699999 that are not packaged by Medicare
- Cardiovascular and other procedures within 92900-93999 that are not packaged by Medicare
- HCPCS “C” codes that are not packaged by Medicare

<table>
<thead>
<tr>
<th>Tier</th>
<th>April 1, 2016</th>
<th>April 1, 2017</th>
<th>April 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>220%</td>
<td>205%</td>
<td>180%</td>
</tr>
<tr>
<td>2</td>
<td>210%</td>
<td>195%</td>
<td>170%</td>
</tr>
<tr>
<td>3</td>
<td>230%</td>
<td>215%</td>
<td>200%</td>
</tr>
<tr>
<td>4</td>
<td>220%</td>
<td>205%</td>
<td>190%</td>
</tr>
</tbody>
</table>

Revenue codes

- Covered revenue codes that are currently allowed at 60 percent/70 percent of billed charges, generally packaged revenue codes, will initially be allowed at a reduced percentage of billed charges and then will be phased out.

<table>
<thead>
<tr>
<th>Tier</th>
<th>April 1, 2016</th>
<th>April 1, 2017</th>
<th>April 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>25%</td>
<td>10%</td>
<td>No Payment</td>
</tr>
</tbody>
</table>

- Covered implants will be allowed at the CPT/HCPCS Allowable Fee, or if no CPT/HCPCS code exists, then revenue codes 275, 276, 278 and 279 will be allowed at 30 percent/35 percent of billed charges.
• Colonoscopy services
  o Allowable Fees will begin at fully phased-in levels effective April 1, 2016.

<table>
<thead>
<tr>
<th>Tier</th>
<th>April 1, 2016</th>
<th>April 1, 2017</th>
<th>April 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>2</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>3</td>
<td>35%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>4</td>
<td>35%</td>
<td>35%</td>
<td>35%</td>
</tr>
</tbody>
</table>

• Revenue codes associated with colonoscopy procedures currently allowed at 60 percent/70 percent will initially be allowed at reduced percentages of billed charges and then will be phased out.

<table>
<thead>
<tr>
<th>Tier</th>
<th>April 1, 2016</th>
<th>April 1, 2017</th>
<th>April 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>180%</td>
<td>180%</td>
<td>180%</td>
</tr>
<tr>
<td>2</td>
<td>170%</td>
<td>170%</td>
<td>170%</td>
</tr>
<tr>
<td>3</td>
<td>200%</td>
<td>200%</td>
<td>200%</td>
</tr>
<tr>
<td>4</td>
<td>190%</td>
<td>190%</td>
<td>190%</td>
</tr>
</tbody>
</table>

• Allowable Fees for procedures identified for the Select program will move to fully phased-in levels beginning with the first quarter following their inclusion in the program.

Referring to Network Providers

It is required by the terms of the HealthChoice contract that Network Providers make reasonable efforts to refer their covered patients to other Network Providers for medically necessary services that they cannot provide or choose not to provide. This includes hospitals, medical supply companies, specialists, laboratories, etc.

Failure to refer to Network Providers will result in a review pursuant to the credentialing plan.

For additional information, please contact network management.

IRS Form 1099

Providers will receive one 1099 for each tax identification number (TIN). If you share a TIN with other providers, there will still be only one 1099 sent. This form will be addressed to the name registered with the Internal Revenue Service and mailed to the address indicated on your FormW-9.
Nominate a Provider

Members and providers now have the option to nominate a medical or dental provider who is not a member of the HealthChoice Provider Network, by submitting some basic information on the provider search directory webpage. The contracting process may take several weeks or longer. The provider must satisfy our business requirements and meet our contracting standards. Nomination does not guarantee the provider is eligible for participation in the network or will agree to contract with us.

Timely Claims-Filing

Claims submitted later than the last day of the calendar year immediately following the calendar year in which the service was provided are excluded from the Plan.

HealthChoice will waive the timely claims-filing deadline as it applies to Coordination of Benefits for providers who file standard HIPAA 837 claims.

HealthChoice Select

HealthChoice Select is a program designed to reduce the costs of select services by contracting with select medical facilities to provide these services and bill HealthChoice for a single amount for all costs on the date the surgery or procedure is performed.

HealthChoice Select Program is increasing the services covered under the program to include more of those with reasonably controllable cost variances, high consumer demand, and market growth.

Advantages of participating in the HealthChoice Select Program include:

- Procedures covered at 100 percent of Allowable Fees;
- No copays, coinsurance and/or deductibles to collect;
- Approximately 170,000 HealthChoice members in or near Oklahoma;
- Potential to increase patient volume;
- Dedicated provider directory on HealthChoice website; and
- Targeted marketing to HealthChoice members.

Colonoscopies and sigmoidoscopies performed on or after Jan. 1, 2016, are covered under the program. To encourage members to participate in HealthChoice Select for these services, HealthChoice provides a $100 incentive payment to members.

Be aware that participating facilities are not required to provide all of the services covered under the program. Facilities can choose any combination of services and opt-in or opt-out at any time, according to existing contract notification provisions.

To participate in HealthChoice Select, facilities must agree to and sign the contract amendment for each location choosing to participate. Network management will provide an attachment with applicable services upon request.

For more information about participating in HealthChoice Select, please contact network management.
HealthChoice FOCUS

HealthChoice FOCUS is a new plan that became available Jan. 1, 2016, to pre-Medicare former employees and surviving dependents in the designated ZIP code service areas of Canadian, Cleveland, Comanche, Garfield, Grant, Logan, McClain, Oklahoma, Payne and Stephens counties.

The HealthChoice FOCUS Provider Network is comprised of clinically-integrated providers who are committed to a collaborative approach to care and are affiliated with Oklahoma Health Network (OHN).

Please note that not all providers contracted with the HealthChoice Provider Network will be participating in the FOCUS Provider Network. The HealthChoice website, as well as the OHN website, will have links to the providers participating in the new network. HealthChoice FOCUS members will receive Network benefits only when they use a HealthChoice FOCUS Network Provider. If you have not also contracted with OHN for the HealthChoice FOCUS plan, any HealthChoice FOCUS claims will process as non-Network claims.

For more information about HealthChoice FOCUS, visit the HealthChoice website at www.healthchoiceok.com. FOCUS Plan information can be accessed under the “FAQ” section and “Find a Provider” tabs on the home page.

Questions regarding claims, eligibility or benefits should be directed to the medical and dental claims administrator. Questions regarding HealthChoice FOCUS Network Providers should be directed to OHN Customer Service at 1-405-652-1041 or toll-free 1-855-445-1471. You can also visit their website at www.ohnonline.com/focus

Network Provider Termination

The Network Provider contract gives EGID and the Network Provider the ability to terminate a contract without cause upon a 30-day, written notice. Network Providers must send letters of termination by certified mail per the terms of the Network Provider contract. The return receipt serves as verification the information has been received. The actual effective date of the termination is 30 days from the date the termination letter is received by the EGID Network Management Unit.

A provider is terminated immediately if their license is suspended or revoked, or if their professional liability insurance is cancelled or not maintained in accordance with the Network Provider contract.

A HealthChoice Network Provider terminating with or without cause from the HealthChoice Network is prevented from re-contracting with EGID as a Network Provider for a period of 12 months following the effective date of termination, unless exceptional circumstances as determined by the EGID Administrator require the HealthChoice Plan to execute a new contract.

Please make a reasonable effort to inform all of your HealthChoice patients about your termination so they can make informed decisions about future provider utilization.
HealthChoice Medical Benefits

Benefits for Preventive Services

Certain preventive procedures are covered at 100 percent of Allowable Fees for members who meet the clinical criteria. When using a HealthChoice Network Provider, members have no out-of-pocket costs. When using a non-Network provider, these services are covered according to Plan benefits. A full list of services and equipment is available on our website at [www.healthchoiceok.com/Preventive_Services.html](http://www.healthchoiceok.com/Preventive_Services.html).

**H.E.L.P. ✔ Wellness Initiative**

Primary health plan members who complete the requirements of H.E.L.P. ✔ receive an incentive payment from HealthChoice. The program is available to all primary pre-Medicare plan members ages 20 and older. HealthChoice developed a provider instruction sheet that summarizes the details of H.E.L.P. ✔. It lists the services that are available free to HealthChoice members and includes the billing codes that must be invoiced so services can be reimbursed at 100 percent of Allowable Fees.

A copy of the HealthChoice H.E.L.P. ✔ Wellness Initiative Incentive Payment which explains the details of the wellness initiative can be found at [www.healthchoiceok.com/providers](http://www.healthchoiceok.com/providers).

**Preventive Services and Use of Modifier 33**

Network Providers are reimbursed 100 percent of the Allowable Fees for evaluation and management codes when billed using modifier 33 to identify them as preventive services. CPT code modifier 33 applies only to preventive services provided to pre-Medicare patients. Do not use modifier 33 for services already identified as preventive.

**Pharmacy Benefits**

The HealthChoice Pharmacy Network includes both independent and national chain pharmacies. There is also the option of mail service. Members can fill prescriptions for up to a 90-day supply at all HealthChoice Network Pharmacies at the same cost as using mail service. For more information regarding the pharmacies participating in the Pharmacy Network, contact the pharmacy benefit manager.

HealthChoice does require all non-Medicare Part D members to fill prescriptions for specialty medications at the CVS Specialty Pharmacy. For more information contact CVS Specialty Pharmacy toll-free at 1-800-237-2767 or by going to [www.cvsspecialty.com](http://www.cvsspecialty.com).

Visit our website at [www.healthchoiceok.com](http://www.healthchoiceok.com) to find lists of commonly prescribed medications, excluded medications with Preferred alternatives, and specialty medications. These lists are also available by calling the pharmacy benefit manager.

For details regarding HealthChoice pharmacy benefits, please visit the HealthChoice “Pharmacy Benefits Information” page at [www.healthchoiceok.com/Member/Pharmacy_Benefits_Information](http://www.healthchoiceok.com/Member/Pharmacy_Benefits_Information).
Prior Authorization for Medication Process

Prior authorization is required for certain medications to be covered by HealthChoice and to request a tier exception for a member. The prior authorization process is used to establish that a particular case meets clinically driven, medically relevant criteria before the medication is approved for coverage at the appropriate tier.

Providers who request prior authorization must follow the following process:

1. The provider’s office must contact the pharmacy benefit manager (PBM). Please have the member ID number, medication name and fax number ready to give to the PBM representative.
2. The PBM will do one of two things:
   a. Fax a prior authorization form to the provider’s office. This form must be completed at the provider’s office.
   b. In some scenarios the required information can be taken verbally over the phone. In this instance the PBM representative will ask the necessary questions and record the answers given.
3. Once the PBM completes their review, the member and the provider’s office are sent notification of the review results.
4. If the medication is approved for coverage, the approval is loaded into the PBM’s system within 24 to 48 hours. Written notification of the approval is sent to the provider’s office and sent to the member within 24 to 48 hours. If the medication is not approved through the prior authorization process, written notification is faxed to the provider and sent to the member within 24 to 48 hours, along with information for appealing the denial.


Medicare Part D


Vaccines and their Administration under Pharmacy Benefits

Members and dependents who are not covered by Medicare can obtain their routine immunizations and vaccinations, in accordance with the current Centers for Disease Control and Prevention guidelines, at the pharmacy. In the past, these were available under the health plans only. The vaccine and the administration fee are also covered under the pharmacy benefits at 100 percent, if the services are provided by a Network Pharmacy.
Participants are subject to non-Network benefits and can be balance billed for amounts above the Allowable Fees, when they use the services of a non-Network pharmacy.

The existing immunization/vaccination benefits under the health plans remain the same.

Please note that under the health plans:

- Only Network Physicians/Providers/Pharmacists can provide these services.
- Mid-level practitioners such as physician assistants and nurse practitioners practicing at a free-standing ambulatory care clinic located at a pharmacy may or may not participate.
- NON-NETWORK PHARMACISTS ARE NOT RECOGNIZED AND ARE NOT COVERED.

Immunizations/Vaccinations covered under pharmacy benefits when a Network Pharmacy is used:

<table>
<thead>
<tr>
<th>Anthrax</th>
<th>Flu</th>
<th>Haemophilus Influenzae Type b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>Hepatitis B</td>
<td>Human Papillomavirus</td>
</tr>
<tr>
<td>Influenza A</td>
<td>Influenza HD</td>
<td>Japanese Encephalitis</td>
</tr>
<tr>
<td>Measles, Mumps &amp; Rubella</td>
<td>Meningococcal</td>
<td>Pneumococcal</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>Rabies, Human Diploid</td>
<td>Rabies, PF Chick-EMB Cell</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>Smallpox (Vaccinia)</td>
<td>Tetanus Booster</td>
</tr>
<tr>
<td>Tetanus, Diphtheria, Pertussis</td>
<td>Typhoid</td>
<td>Varicella</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>Zoster (Shingles)</td>
<td></td>
</tr>
</tbody>
</table>

**Guidelines for Osteopathic Manipulation, Physical/Occupational Therapy and Chiropractic Therapy**

Benefits for these services are subject to the following guidelines:

- 20 visits are allowed per calendar year without certification (refer to “Speech Therapy” section for certification exception information). A maximum of 60 visits are allowed each calendar year.
- Treatments that exceed 20 visits per calendar year must be referred to HCMU for review. Manipulative therapy performed by an osteopath or medical doctor is also subject to these guidelines.

Referral forms for chiropractic, physical medicine, occupational therapy, physical therapy and speech therapy are completed and submitted to HCMU to initiate the certification process. The professional consultant can subsequently request additional documentation from the provider. The appropriate forms are available online at [www.healthchoiceok.com/Providers/Provider_Forms/index.html](http://www.healthchoiceok.com/Providers/Provider_Forms/index.html).

The following information is required on the referral form:

- Diagnosis
- Summary of the case
- Approximate length of time treatments will be necessary
- Long/short-term goals

The following information may be requested by the professional consultant to support medical necessity:

- Complete treatment plan
- History and physical
• Assessment of the patient’s response to treatment as determined during the initial examination and reevaluation
• Progress notes

Speech Therapy

Speech therapy is considered medically necessary for restoring existing speech lost due to disease or injury. Therapy must be expected to restore the level of speech the participant had before the disease or injury. It is not covered for treatment of learning disabilities or birth defects. The plan maximum is 60 speech language pathology visits each calendar year. Certification through HCMU is required for members ages 17 and younger. Certification is not required for members ages 18 and older.

For charges incurred on or after Jan. 1, 2016, speech therapy services are also considered medically necessary for assessment and treatment of the diagnoses of pervasive developmental disorders (PDD) when the member meets any of the criteria listed below:

1. Any loss of any language at any age;
2. No two-word spontaneous (not just echolalia) phrases by 24 months;
3. No babbling by 12 months;
4. No gesturing (e.g., pointing, waving bye-bye) by 12 months; or
5. No single words by 16 months.

A request for a speech therapy evaluation for members 17 and younger must include a copy of the prescription or referral from a physician with documentation of the diagnosis. Requests for subsequent speech therapy visits must include a treatment plan from the speech pathologist that lists specific measurable goals, and the expected amount, frequency and duration for therapy. There must be an expectation that the patient’s condition will improve significantly in a reasonable and predictable period of time. If at any point in the treatment it is determined that the expectations will not be met, services will no longer constitute covered speech language pathology services. If the patient’s response to treatment is determined to be insignificant or at a plateau, continued coverage of speech services are excluded.

For additional information, please contact HCMU.

Laboratory Drug Screenings

For all charges incurred on or after Jan 1, 2016, HealthChoice covers qualified laboratory urine drug screenings one time per day per patient. As a reminder for all charges incurred on or after April 1, 2015, HealthChoice covers only the following laboratory urine drug screens when medically necessary screening tests are required:

• 80300 – Drug Screen, any number of drug classes from Drug Class List A; any number of non-TLC devices or procedures (e.g., immunoassay) capable of being read be direct optical observation, including instrument-assisted when performed (e.g., dipsticks, cups, cards, cartridges), per date of service.

• G0434 – Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter.

Clinical editing applies.
Note: No other definitive Drug Testing and Presumptive Drug Class Screening CPT codes are covered through June 30, 2016.

For charges incurred on or after July 1, 2016, HealthChoice will cover the following presumptive (qualitative) and definitive (quantitative) laboratory urine drug screenings when medically necessary. Laboratory screening and confirmation services are covered under the HealthChoice medical plan, subject to deductible, coinsurance, out-of-pocket maximums, clinical editing and all policy provisions.

1. Presumptive (qualitative) laboratory urine drug screenings are limited to 12 total per calendar year and certification is not required.
   a. 80300 DRUG SCREEN LIST A ANY NMBR NON TLC DEVICES
   b. G0477 DRUG TST PRESUMP; CPBL BEING READ DC OPT OBV ONLY
   c. G0478 DRUG TEST PRESUMP; READ BY INSTRUM-AST DC OPT OBV
   d. G0479 DRUG TEST PRESUMP; INSTRUMENTED CHEMISTRY ANLYZER

2. Definitive (quantitative) laboratory urine drug screenings are limited to four total per calendar year and certification is not required.
   a. G0480 DRUG TEST DEFINITV DR ID METH P DAY 1-7 DRUG CL
   b. G0481 DRUG TEST DEFINITV DR ID METH P DAY 8-14 DRUG CL
   c. G0482 DRUG TEST DEFINITV DR ID METH P DAY 15-21 DR
   d. G0483 DRUG TST DEFINITV DR ID METH P DAY 22/MORE DR CL

If you have any questions regarding this change, please contact our medical claims administrator.

Telehealth Services

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. The use of a telecommunications system may be substituted for an in-person encounter for specific services.

For charges incurred on or after Jan. 1, 2016, HealthChoice began recognizing some professional services submitted with appropriate CPT or HCPCS codes along with the telehealth modifier “GT.” All services must meet medical necessity guidelines and all plan provisions.

Durable Medical Equipment Suppliers

It is the intent of HealthChoice that all related and required supplies are inclusive of the rental agreement during the rent to purchase period for CPAP and BiPAP.

Effective for claims incurred on or after July 1, 2016, medically necessary supplies and replacement supplies for the proper function of CPAP and BiPAP machines will be covered every three months, after the initial 12 month rental to purchase period, subject to plan provisions.
**Home Health Care Services**

The following HCPCS procedure codes are not covered when services are provided in an office or outpatient setting:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151</td>
<td>Physical therapist in home health or hospice setting; each 15 minutes</td>
</tr>
<tr>
<td>G0152</td>
<td>Occupational therapist in home health or hospice setting; each 15 minutes</td>
</tr>
<tr>
<td>G0153</td>
<td>Speech/language pathologist in home health or hospice setting; each 15 minutes</td>
</tr>
<tr>
<td>G0154</td>
<td>Skilled nurse in home health or hospice setting; each 15 minutes</td>
</tr>
<tr>
<td>G0155</td>
<td>Clinical social worker in home health or hospice setting; each 15 minutes</td>
</tr>
<tr>
<td>G0156</td>
<td>Home health or hospice aide in home health or hospice setting; each 15 minutes</td>
</tr>
<tr>
<td>S0274</td>
<td>Nurse practitioner visit at member’s house, outside of a capitation arrangement</td>
</tr>
</tbody>
</table>

One CPT/HCPCS code will be allowed per home health care provider per day for the following codes when services are provided in an office or outpatient setting:

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99500</td>
<td>Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring</td>
</tr>
<tr>
<td>99501</td>
<td>Home visit for postnatal assessment and follow-up care</td>
</tr>
<tr>
<td>99502</td>
<td>Home visit for newborn care and assessment</td>
</tr>
<tr>
<td>99503</td>
<td>Home visit for respiratory therapy care (e.g., bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)</td>
</tr>
<tr>
<td>99504</td>
<td>Home visit for mechanical ventilation care</td>
</tr>
<tr>
<td>99505</td>
<td>Home visit for stoma care and maintenance including colostomy and cystostomy</td>
</tr>
<tr>
<td>99506</td>
<td>Home visit for intramuscular injections</td>
</tr>
<tr>
<td>99507</td>
<td>Home visit for care and maintenance of catheter(s) (e.g., urinary, drainage, and enteral)</td>
</tr>
<tr>
<td>99509</td>
<td>Home visit for assistance with activities of daily living and personal care</td>
</tr>
<tr>
<td>99510</td>
<td>Home visit for individual, family, or marriage counseling</td>
</tr>
<tr>
<td>99511</td>
<td>Home visit for fecal impaction management and enema administration</td>
</tr>
<tr>
<td>99512</td>
<td>Home visit for hemodialysis</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure</td>
</tr>
<tr>
<td>99601</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours)</td>
</tr>
<tr>
<td>S5522</td>
<td>Home infusion therapy, insertion of peripherally inserted central venous catheter (PCC), nursing services only (no supplies or catheter included)</td>
</tr>
<tr>
<td>S5523</td>
<td>Home infusion therapy, insertion of midline venous catheter, nursing services only (no supplies or catheter included)</td>
</tr>
<tr>
<td>S9097</td>
<td>Home visit for wound care</td>
</tr>
<tr>
<td>S9098</td>
<td>Home visit, phototherapy services (e.g. Bil-lite), including equipment rental, nursing services, blood draw, supplies, and other services, per diem</td>
</tr>
<tr>
<td>S9122</td>
<td>Home health aide or certified nurse assistant, providing care in the home, per hour</td>
</tr>
<tr>
<td>S9123</td>
<td>Nursing care, in the home, by registered nurse, per hour</td>
</tr>
<tr>
<td>S9124</td>
<td>Nursing care, in the home, by licensed practical nurse, per hour</td>
</tr>
<tr>
<td>S9125</td>
<td>Respite care, in the home, per diem</td>
</tr>
<tr>
<td>S9126</td>
<td>Hospice care, in the home, per diem</td>
</tr>
<tr>
<td>S9127</td>
<td>Social work visit, in the home, per diem</td>
</tr>
<tr>
<td>S9128</td>
<td>Speech therapy, in the home, per diem</td>
</tr>
<tr>
<td>S9129</td>
<td>Occupational therapy, in the home, per diem</td>
</tr>
<tr>
<td>S9131</td>
<td>Physical therapy, in the home, per diem</td>
</tr>
</tbody>
</table>

Units billed will be allowed for the following code when services are provided in an office or outpatient setting:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99602</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours) each additional hour</td>
</tr>
</tbody>
</table>

**Note: All CPT/HCPCS codes are subject to change.**

Certification for home health care services is required through HCMU. If you have questions or you want to obtain certification, contact HCMU.

**Infusion Therapy**

When filing claims, please include accurate information pertaining to services rendered, including appropriate place of service and billing codes. HealthChoice cannot provide assistance with how to bill a claim; however, all claims are reviewed for billing accuracy, including, but not limited to, claims with billing codes S9490 through S9810. Home infusion therapy services are reimbursed at a per diem rate that is inclusive of equipment and supplies. Medication is reimbursed separately.
For all infusion therapy charges incurred on or after March 1, 2016, certified home skilled nursing visits are no longer included in the HealthChoice Allowable Fee, but can be billed separately. Home health services should be billed by the provider rendering the services.

Please note that home infusion therapy requires certification through HCMU. If you have questions regarding the certification process or to request certification, please contact HCMU.

**Orthodontic Benefits**

Orthodontic benefits can be complicated, but to simplify the benefit, the chart below can explain exactly what is covered, not covered and what is all-inclusive. If you have questions, please contact the dental claims administrator.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8010</td>
<td>Limited orthodontic treatment of the primary dentition</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8020</td>
<td>Limited orthodontic treatment of the transitional dentition</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8030</td>
<td>Limited orthodontic treatment of the adolescent dentition</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8040</td>
<td>Limited orthodontic treatment of the adult dentition</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8050</td>
<td>Interceptive orthodontic treatment of the primary dentition</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8060</td>
<td>Interceptive orthodontic treatment of the transitional dentition</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8070</td>
<td>Comprehensive orthodontic treatment of the transitional dentition</td>
<td>Covered and all-inclusive</td>
</tr>
<tr>
<td>D8080</td>
<td>Comprehensive orthodontic treatment of the adolescent dentition</td>
<td>Covered and all-inclusive</td>
</tr>
<tr>
<td>D8090</td>
<td>Comprehensive orthodontic treatment of the adult dentition</td>
<td>Covered and all-inclusive</td>
</tr>
<tr>
<td>D8210</td>
<td>Removable appliance therapy</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8220</td>
<td>Fixed appliance therapy</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8660</td>
<td>Pre-orthodontic treatment visit</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8670</td>
<td>Periodic orthodontic treatment visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>D8680</td>
<td>Orthodontic retention</td>
<td>Not covered</td>
</tr>
<tr>
<td>D8690</td>
<td>Orthodontic treatment</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8691</td>
<td>Repair of orthodontic appliance</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8692</td>
<td>Replacement of lost or broken retainer</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>D8693</td>
<td>Re-bonding or re-cementing; and/or repair, of fixed retainers</td>
<td>Covered and can bill separately</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Details</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D8999</td>
<td>Unspecified orthodontic procedure, by report</td>
<td>Each claim will be reviewed for coverage. Provide written description of dental necessity.</td>
</tr>
</tbody>
</table>

**Note:** All-inclusive: Includes retainers, appliances, etc.

**Not covered:** This is the member’s responsibility.