



HealthChoice Provider Network News

Summer Edition, 2010

New Standards for Electronic Health Transactions and the Transition to ICD-10 Codes

The Centers for Medicare and Medicaid Services (CMS) will be updating the standards for electronic health care transactions to Version 5010 in preparation for the transition to ICD-10 codes.

Electronic health care transactions include claims, eligibility inquiries, and provider remittances.

Version 5010 of the Standards for Electronic Health Transactions

On January 1, 2012, standards for electronic health care transactions will be updated from Versions 4010/4010A1 to Version 5010. The current versions do not

accommodate ICD-10 codes, so Version 5010 must be in place before ICD-10 codes become standard.

ICD-10 Codes

CMS has mandated that ICD-10 codes be used by providers on all HIPAA transactions, including claims, with dates of service on or after October 1, 2013.

Providers for HealthChoice, the Department of Corrections, and the Department of Rehabilitation Services will all have to comply with these changes. Non-compliant claims submitted after the

implementation dates set by CMS will be denied. You will be able to resubmit these claims; however, it will result in reimbursement delays.

Preparations for converting to Version 5010 and adopting ICD-10 codes may require updating software, training staff, and changing your business processes. All these things will take time, so don't delay making preparations now.

You can find additional information about these changes on the CMS website at <http://www.cms.gov/ICD10/>.

Remittance Advices Available Online

As of June 1, 2010, HealthChoice Network Providers have access to their Remittance Advices (RAs) online. You can view and print your RAs by accessing your secure provider account through ClaimLink.

The ability to access RAs electronically can help improve revenue-cycle management by reducing the lag time between an Electronic Funds Transfer and receipt of the RA in the mail. Instant access to RAs can also help to speed your account reconciliation processes.

"We're very excited our providers will have electronic access to RAs," said Teresa South,

Director of Provider Relations for HealthChoice. "This represents another step in the process of moving toward electronic communications with our providers. The electronic process will save time and money, and it's also environmentally friendly," she said.

The online RAs look exactly like the hard copy versions you currently receive. Even though RAs are available on the website, HealthChoice will continue to mail hard copies unless you choose to go paperless. If you prefer to go paperless and stop receipt of

paper RAs, you must contact HP Administrative Services at 1-405-416-1800 or toll-free 1-800-782-5218.

You can access the online RAs by clicking ClaimLink in the left side menu of the Provider website at www.healthchoiceok.com/providers.



A Quick Start Guide is available in the Resources section of ClaimLink. Adobe Reader is required to view the PDF documents.

For assistance or additional information, contact HP Administrative Services at one of the numbers listed above.

Medications Now Available in Generic Form

New generic medications are now available for the brand-name medications listed below. If you prescribe any of these brand-name medications to HealthChoice members, please note that the generic medication will save them money at the pharmacy. This applies to all HealthChoice members, including members of the HealthChoice Medicare Supplement With and Without Part D Plans.



Brand-Name Medication	Generic Medication	Treatment	Launch Date
Aceon Tablets 2mg, 4mg, and 8mg	perindopril erbumine 2mg, 4mg, and 8mg	High blood pressure	April 2010
Aldara 5% Cream	imiquimod	External genital & perianal warts	March 2010
Alphagan P Ophthalmic Solution. 0.15%	brimonidine tartrate	Glaucoma	February 2010
Augmentin XR	amoxicillin/clavulanate/potassium	Various bacterial infections	May 2010
Cardizem LA	diltiazem hydrochloride extended release tablets	Hypertension	March 2010
Differin Gel	adapalene 0.1%	Acne	May 2010
Flomax	tamsulosin hydrochloride	Benign prostatic hyperplasia	March 2010
Loprox Shampoo 1%	ciclopirox 1%	Seborrheic dermatitis	March 2010
Pepcid Suspension	famotidine	GERD	January 2010
Prozac Weekly	fluoxetine delayed-release capsules	Depression	March 2010
Skelaxin 800mg	metaxalone	Muscle spasms	April 2010
Tofranil-PM	imipramine	Adult depression	April 2010
Venlafaxin HCL ER	venlafaxin HCL	Depression	May 2010
Yasmin	drospirenone and ethinyl estradiol	Contraception	June 2010

Please Note: The anticipated generic launch dates listed above are subject to change based on new or ongoing legal issues between the brand-name and generic manufacturers.

Certification Required When HealthChoice is the Second or Third Payor

Certification by APS HealthCare is required for the following admissions and procedures even when HealthChoice is the second or third payor.*

- Inpatient admissions
- Transplants
- Selected outpatient procedures including:
 - Blepharoplasty
 - Breast reduction
 - Rhinoplasty
 - Surgical treatment of varicose veins
 - Breast implant removal
 - Panniculectomy
 - Scar revision
- All observation stays greater than 24 hours (observation stays of less than 24 hours without room and board charges are excluded)

*When HealthChoice is the second or third payor, i.e., the member has other group health insurance or is Medicare primary, certification is required for the admissions and procedures listed above. This helps protect the provider and the member if the primary payor or HealthChoice denies coverage or applies coverage exclusions or limitations. For example, if the primary carrier denies a service covered by HealthChoice but the provider did not request certification prior to the admission or procedure, HealthChoice may cover the service but a 10% penalty will apply to the provider even when certification and medical necessity requirements are met (as determined by HealthChoice).

Certification also applies when a member has exhausted Medicare benefits and HealthChoice becomes the primary carrier.

Receive Your Newsletter Via Email

This *Network News* newsletter is the primary source of information for HealthChoice, DOC, and DRS Network Providers. The newsletter provides plan update information and includes notice requirements as set out in the Network Provider Contract.

Currently, the newsletter is mailed to Network Providers on a quarterly basis and is available on the HealthChoice Provider website; however, future editions of the Network News will be sent to providers via email if an email address is on file. Providers who do not have an email address on file will continue to receive the newsletter by U.S. mail.

This summer edition is being

sent to both your email address and your mailing address (on file as of the mailing date) to ensure you receive delivery of this newsletter during the initial email distribution.

Each provider's designated email contact for the mailing address on file will receive the *Network News* and can then distribute the newsletter to multiple contacts within your organization. Providers with multiple locations under one tax ID number can complete a Provider or Facility Email Update Form to register multiple contacts.

If you need additional information, you can contact Provider Relations at 1-405-717-8970 or toll-free 1-800-543-6044.

Fee Schedule Update

The MS-DRG, LTCH, and outpatient fee schedules for HealthChoice and the Department of Corrections (DOC) will be updated for charges incurred on or after October 1, 2010.

The CPT/HCPCS, ASA, and dental fee schedules for HealthChoice and DOC will be updated effective January 1, 2011.

More information regarding these updates will be available before the implementation. The updated fee schedules will be available on the HealthChoice provider website at www.healthchoicework.com/providers and the DOC provider website at gateway.sib.ok.gov/doc before the updates become effective.

Please continue to reference the HealthChoice and DOC provider websites periodically for the most up-to-date fee schedule information.

Hospital Claims Grouped Erroneously Using DRG 470

It has been determined that for a short time during 2009, some hospital* claims were incorrectly grouped using DRG 470. The error in the claims processing system was corrected and the affected claims were reprocessed. These claim corrections could result in additional payments to hospitals or may create overpayments.

*Long term acute care facilities were not affected by this error.

Transition Supply of Medication for Medicare Part D Members

A 30-day transition supply of medication is provided to members of the HealthChoice Employer PDP Medicare Supplement With Part D Plans when they receive prescriptions for non-formulary, Part D medications.

The temporary supply is provided to Medicare Part D members to help them transition to a formulary medication. This transition supply may also be provided when a member is prescribed a covered, formulary, Part D medication that is subject to prior authorization or step therapy.

The transition supply provides a temporary 30-day supply of

drugs during the transition period which should allow sufficient time for members to work with their provider and switch to an alternative, formulary medication or request a prior authorization based on medical necessity.

Once a member fills a transition supply, they receive a letter from Medco explaining the medication was filled on a one-time basis. The letter will contain instructions for the member to work with their provider to switch to a formulary medication and include an explanation of the member's right to request an exception based on medical necessity.

DRS Services Must Be Prior Authorized

The Department of Rehabilitation Services (DRS) requires prior authorization for all health and dental services or those services will be denied. Prior authorization verifies the availability of health and dental services to the DRS client and authorizes the most appropriate care. Prior authorization is based on the exact procedural code (CPT/HCPCS, ADA, ASA, etc.) specified by DRS for each service. If any additional health care services are deemed necessary, those services must also be prior authorized by DRS or payment will be denied.

Quantity Limits for Injectable Non-Insulin Drugs *Medicare Part D Members are Exempt*

Effective August 2, 2010, HealthChoice will apply quantity limits to injectable, non-insulin drugs that are used to treat type II diabetes.

The new quantity limits are listed below:

Medication	Amount of Medication per 30-day fill
Byetta	3ml
Symmlin	12,000ml
Victoza	9ml

You can request a prior authorization if your patient requires quantities that exceed the limits indicated above. To request a prior authorization, fax detailed medical documentation to the HealthChoice Pharmacy Unit at 1-405-717-8925.

Medication Therapy Management Program

Medicare Part D Plan Members Only

The Medication Therapy Management Program (MTM) is designed to help improve the results of medication therapies and promote the proper use of prescribed medications for members of the HealthChoice Employer PDP Medicare Supplement With Part D Plans. The program is directed toward members who suffer from multiple, chronic, health conditions who are being treated with multiple medications.

To qualify for this program, members must be likely to incur Medicare Part D prescription drug costs that exceed \$3,000 annually.

One significant change to the program is that it is now an opt-out versus opt-in program. Members who qualify will automatically be enrolled in the program, but they can choose to opt-out if they do not wish to participate. There is no cost to members for this program.

The MTM program offers:

- A comprehensive medication review including a personalized medication record and an action plan of reconciled medications
- One-on-one consultations focusing on patient education and the appropriate use of medications
- Interventions for both members and providers

New Benefits to Help Members Quit Tobacco ***Tobacco Cessation Products are Free or Available for \$5***

As part of our commitment to better health for our members, HealthChoice is encouraging all health plan members and covered dependents to quit tobacco now. By quitting tobacco, HealthChoice members can improve their health and take advantage of deductible credits that will be available in Plan Year 2012.*

HealthChoice is launching this quit tobacco initiative now to provide our members with plenty of time to quit tobacco before Plan Year 2012 when the deductible credit is scheduled to take effect. To qualify for the deductible credit, current employees and pre-Medicare former employees will have to complete a health risk assessment and attest that they and their covered dependents are tobacco free. To help our members quit tobacco, HealthChoice is making new tobacco cessation benefits available to current and pre-Medicare former employees effective July 1, 2010. The new benefits will be available to Medicare supplement plan members effective January 1, 2011; however, the deductible credit will not apply to the HealthChoice Medicare Supplement Plans.

Among the new benefits, HealthChoice is lowering the copay for the following prescription tobacco cessation products to \$5 per fill:

- Buproban 150mg SA Tablets
- Bupropion HCL SR 150mg Tablets
- Chantix 0.5mg and 1mg Tablets
- Nicotrol 10mg Cartridge
- Nicotrol NS 20mg/m Nasal Spray

HealthChoice will continue to cover two 90-day courses of prescription treatment each plan year. This copay reduction represents nearly \$150 in savings to our members.

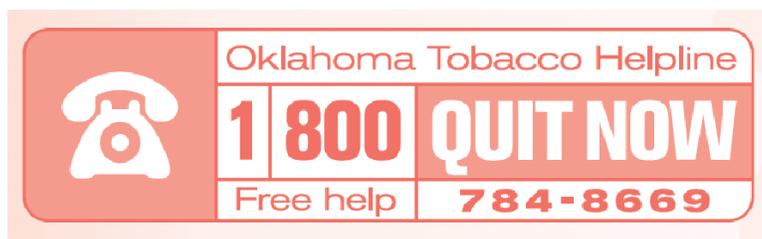
In addition to the reduced prescription copay, HealthChoice has partnered with the Tobacco Settlement Endowment Trust (TSET) and Free and Clear to provide members with over-the-counter nicotine replacement therapy products (patches, gum, and lozenges) and telephone support through a trained Quit Coach. These products and services are available at no charge to HealthChoice members or their dependents age 18 and older. Members can receive two 8-week courses of an over-the-counter nicotine replacement therapy product and up to five one-on-one telephone counseling sessions with a trained Quit Coach.

To take advantage of the benefits available through TSET, which are over and above what are offered to the general public, members must contact the OKLAHOMA TOBACCO HELPLINE at 1-800-QUIT-NOW (1-800-784-8669) and identify themselves as a HealthChoice member. The Helpline hours of operation are 7 a.m. to 2 a.m., seven days a week. Staff will return any messages left after hours. Services are also available in Spanish by calling 1-800-793-1552. The helpline number for HealthChoice members living outside of Oklahoma is 1-866-QUIT-4-LIFE (1-866-784-8454).

Since studies have shown that a combination of medication and counseling is by far the MOST EFFECTIVE WAY TO SUCCESSFULLY QUIT TOBACCO, HealthChoice members are strongly encouraged to take advantage of the professional Quit Coaches available at the numbers listed above.

HealthChoice hopes these enhanced tobacco cessation benefits will encourage members to quit tobacco, improve their health, and take advantage of the deductible credit that will be available to tobacco-free households in 2012.

** Note: While the benefits for tobacco cessation products and free counseling will be available to all members, Medicare members will not be eligible for the deductible credit.*



Changes to Reimbursement for Observation Hospital Stays

Under the previous HealthChoice benefit, an observation hospital stay, without room and board charges, that lasted longer than 24 hours was processed as an inpatient hospital stay. All inpatient hospital stays are paid based on the DRG fee schedule and require certification.

Effective June 1, 2010, HealthChoice changed the way it pays for these services. An observation hospital stay, without room and board charges, that lasts longer than 24 hours is processed as an outpatient service and paid according to the Plan's outpatient fee schedule. All observation hospital stays must be certified with the exception of observation stays less than 24 hours without room and board charges.

Please contact Provider Relations if you have questions about these changes. Contact HP Administrative Services, LLC if you have questions about claim payments.

Enhancement for Contracted Provider Claims

If you continue to receive non-Network payments under a contracted TIN, please refer to the article *Enhancement for Contracted Provider Claims* on the HealthChoice provider website at www.healthchoiceok.com/providers.

Certification for Inpatient Hospital Admissions

HealthChoice requires that all non-emergency hospital admissions be certified at least three working days prior to the actual admission. Emergency hospital admissions must be certified within 24 hours of the actual admission date, and holiday or weekend emergency admissions must be certified the first working day following the date of admission. Please note that certification is required even when HealthChoice is the second or third insurance carrier.

Network Facilities are required to notify HealthChoice of inpatient hospital admissions based on parameters set in the HealthChoice contract. Facilities are also required to provide clinical information to help establish the medical necessity

of all inpatient admissions. Claims for inpatient hospital admissions are denied if medical necessity is not confirmed.

If certification is obtained but not initiated and approved within the time frame defined by the Plan, a 10% penalty is applied. If medical necessity is not established, the claim is denied.

To request certification and provide the clinical information needed to establish medical necessity, call APS Healthcare toll-free at

1-800-848-8121. You can also fax clinical information to 1-405-416-1755.

If you have questions about the certification process, please contact HealthChoice Provider Relations. See *Contact Information* on page 8.



New! Online Claims Filing for CMS 1500

Online claims filing is available for providers who bill on a CMS 1500. This new feature, available through ClaimLink, is a more efficient process that significantly reduces processing errors and improves turnaround times for claim payments. Claim status is available the next business day on ClaimLink. A Quick Start Guide that outlines the claim submission process is also available through ClaimLink.

For additional training, please contact Kelli Nichols with HP at 1-405-416-1504 or toll-free 1-800-782-5218. OSEEGIB is also available to provide assistance at 1-405-717-8790 or toll-free 1-800-543-6044.

We welcome any questions or comments.

If you are interested in onsite training, please call OSEEGIB Provider Relations at one of the numbers listed above.



New Certification Request Forms

The HealthChoice Health Care Management Division recently updated its certification request forms. These forms must be used when requesting certification for specific medical services for HealthChoice members. Providers must begin using the updated forms immediately. If you submit an earlier version of one of these forms, it will be returned with a request to complete and submit the updated form.

For information about

certification requirements, see *Utilization Review* in the HealthChoice Provider Manual.

The updated forms are currently available online at www.healthchoiceok.com/providers.



You can complete the forms online, but you cannot save the data that is entered into the form or submit the completed form via the Internet. You must print the completed form and send it to the HealthChoice Healthcare Management Division. Please keep a copy for your records.

2011 Orthodontia Changes

Effective for all orthodontia services incurred on or after January 1, 2011, HealthChoice and DOC providers must bill as described below:

1. All banding and subsequent monthly maintenance will be paid based on the initial banding date and charges. No monthly banding will be allowed under the plan.
2. Inclusive treatment codes D8010-D8090 should not be accompanied by any other orthodontic codes.
3. Treatment specific codes D8210-D8693 (except for D8670, D8680, and D8690*) can be submitted separately, but are not typically used with the inclusive codes.
4. Code D8660 (pre-orthodontic treatment visit) is not part of any inclusive code and can be submitted separately.
5. Code D8691 (repair of orthodontic appliance), D8692 (replacement of lost or broken retainer), and D8693 (rebonding or recementing, and/or repair, as required, of fixed retainers) are post-treatment repair, replacement, and recementation services that can be submitted separately following the use of inclusive codes D8010-D8090.



This is only a summary of the general use of orthodontia ADA codes which does not guarantee benefits under the Plan. All policy provisions, exclusions, and limitations apply.

If you have any questions, please contact HP Administrative Services at 1-405-416-1800 or toll-free 1-800-782-5218

* Be aware that beginning January 1, 2011, ADA codes D8670, D8680, and D8690 will not be covered by HealthChoice or DOC.

Additional Claim Info

When a claim requires additional information for processing, the Provider Remittance Advice identifies the specific information needed to complete processing of the claim. In some instances, a letter is also sent further explaining what is required to complete the claim processing. Claims are closed until the required information is received.

Please be sure to include the member ID number and claim number when returning information to HP. Once the information is received, the claim is processed without resubmission.

Reminder – EDS Is HP Administrative Services, LLC

HP acquired EDS Administrative Services, the HealthChoice health, dental, and life claims administrator in August of 2008. All future communications sent to providers will use the new company name. While the company's name changed, all other aspects of its business remain the same. If you have questions regarding a health or dental claim, contact HP Administrative Services, LLC. See *Contact Information* on page 8.

On the Web

For more updates and articles not included in this newsletter, visit the Network Provider websites.

Refer to the *Contact Information* on page 8 for the website address of each provider network.

HealthChoice Provider Network News

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www.sib.ok.gov/providers
www.healthchoicook.com/providers

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Network Provider Contact Information

HealthChoice Providers

www.sib.ok.gov/providers
www.healthchoicook.com/providers

Health and Dental Claims

HP Administrative Services, LLC
P.O. Box 24870
Oklahoma City, OK 73124-0870
Customer Service and Claims

OKC Area 1-405-416-1800
Toll-free 1-800-782-5218
FAX 1-405-416-1750
TDD 1-405-416-1525
Toll-free TDD 1-800-941-2160

Pharmacy

Medco Health Solutions
Pharmacy Prior Authorization for
Preferred/Non-Preferred or
Brand/Generic
Toll-free 1-800-841-5409

Other Pharmacy Prior Authorization
Toll-free 1-800-753-2851

Certification

APS Healthcare
P.O. Box 700005
Oklahoma City, OK 73107-0005
Toll-free 1-800-848-8121
Toll-free TDD 1-877-267-6367
FAX 1-405-416-1755

HealthChoice Health Care Management Division

OKC Area 1-405-717-8879
Toll-free 1-800-543-6044
Ext. 8879

HealthChoice Provider Relations

OKC Area 1-405-717-8790
Toll-free 1-800-543-6044

DOC Provider Relations

<https://gateway.sib.ok.gov/DOC>

OKC Area 1-405-717-8750
Toll-free 1-866-573-8462

DOC Health and Dental Claims

HP Administrative Services, LLC
P. O. Box 268928
Oklahoma City, OK 73126-8928
Toll-free 1-800-262-7683

DRS Provider Relations

<https://gateway.sib.ok.gov/DRS>

OKC Area 1-405-717-8921
Toll-free 1-888-835-6919

DRS Health and Dental Claims

HP Administrative Services, LLC
P.O. Box 25069
Oklahoma City, OK 73125-0069
Toll-free 1-800-944-7938