HealthChoice

HealthChoice Network News Winter 2024

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Winter 2024

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News

Claim denials needing medical records

- If you receive a denial on a claim, review the denial reason code on the remittance advice to determine your next course of action. Based on the denial reason, you can file an appeal, submit additional information for certification or submit medical records though the HealthChoice Provider Portal, available 24/7 at HealthChoiceOK.com.
- RIGHTS TO APPEAL
  - The HealthChoice internal appeals process grants providers the right to request a reconsideration of any claim. You can submit your appeal online through the provider portal. Sign into the portal, select Submit an appeal and follow the steps to submit records with the appeal. Note: All claims editing denials, including modifiers 25 and 59 denials, must be appealed.
  - Alternatively, you can submit your appeal in writing to the address below. The written request for appeal should clearly indicate what is being appealed along with all applicable documentation. Appeals must be submitted within 180 days from the date of the original electronic remittance advice (ERA) to:
    HealthChoice Appeals Unit
    P. O. Box 30546
    Salt Lake City, UT 84130-0546

- CERTIFICATION
  - You can submit additional information for obtaining certification through the provider portal. Under the **myMenu** section select **Get certification** and follow the steps.

- ADDITIONAL INFORMATION NOT RELATED TO APPEALS OR CERTIFICATION
  - You can submit additional information not related to an appeal or certification through the provider portal. Under the **myMenu** section select the **Document submission** and follow the steps.

For questions, call Customer Care at toll-free 800-323-4314. TTY users 711.

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Corrected claims

You should only submit a corrected claim when changing the following fields within a claim form:

- Patient name.
- Member ID number.
- Patient relationship.
- Group number.
- Group name.

If any other information needs to be changed within the claim, please void the original claim and file a new claim. This will ensure that the claim does not deny as a duplicate.

For questions, call Customer Care at toll-free 800-323-4314. TTY users call 711.

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Direct data entry of claims and group numbers

EGID offers the direct data entry of medical claims for HealthChoice, DRS and DOC through Optum Intelligent EDI (iEDI), which is a fast, convenient and free option to enter claims directly online.

You must first register for the HealthChoice Provider Portal. Then, select iEDI claim submission. This will take you to the One Healthcare ID sign-on screen. Use the same One Healthcare ID and password used for the HealthChoice Provider Portal. If you have issues logging into iEDI or questions on how to use it, please email iEDI Technical Support at umr-business-edi@umr.com.

Once registered with the Optum portal, you will receive an email confirmation including dates and times to attend a one-on-one training class with an Optum trainer. Additionally, it will take approximately 72 hours before you can officially start using iEDI.

DentalXChange is available for the direct data entry of dental claims.

The payer ID or EDI number is a unique ID assigned to each insurance company. It allows provider and payer systems to talk to one another to verify eligibility and benefits and submit claims.

Use the following payer IDs for HealthChoice, DOC and DRS for claims processing:

- 71064 HealthChoice.
- 71065 DOC and DRS.

You will also need to use these group numbers:

- 76415077 HealthChoice (member IDs did not change).
- 76415170 Oklahoma DOC (member IDs include 365000 + DOC inmate ID number).
- 76415171 Oklahoma DRS.

For questions, call Customer Care at toll-free 800-323-4314 for HealthChoice, 800-323-3710 for DOC or 800-285-6815 for DRS. TTY users call 711.

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Fee schedules

The quarterly fee schedules feature a new look this year.

The updated fee schedules feature only the current quarter. You can view the history of a code using the Search by Code function in the fee schedule portal. This allows you to search the history of a code by selecting the specific fee schedule to which the code applies.

Once you are logged into the portal, there is one column that houses the most current fee schedules. By hovering over the link to download the fee schedule file, you can see which quarter of the fee schedule is currently posted and when it was last updated. If you need a full historical fee schedule, please contact EGID Network Management.

We consolidated several fee schedules to make it easy for you to access the information you need. We combined the CPT and HCPCS fee schedules into a single Professional fee schedule. We also combined the Outpatient, Ambulatory Surgery Center, Ambulatory Surgery Center Implant List, and Non-CMS Certified Facility fee schedules into a single OP/ASC fee schedule.

Additionally, each updated fee schedule contains new column headings and legends. You will need to review the Legends tab to understand the contents of the option_type and status_code columns.

For questions, email EGID Network Management or call toll-free 844-804-2642. TTY users call 711.

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Fee schedule updates

Future fee schedule updates for services by HealthChoice network providers are scheduled for:

Annual Fee Schedule Releases	Jan. 1	April 1	July 1	Oct. 1
Anesthesia (ASA)	Comp			
Bariatric Surgery - Inpatient	Comp	A/C/D	A/C/D	A/C/D
Bariatric Surgery - Outpatient	Comp	A/C/D	A/C/D	A/C/D
Dental (ADA)	Comp	A/C/D	A/C/D	A/C/D
Diabetes Prevention Program (DPP)	Comp			
Endodontic	Comp	A/C/D	A/C/D	A/C/D
HCPCS	A/C/D	Comp	A/C/D	A/C/D
MS-DRG				Comp
MS-DRG LTCH				Comp
NDC	Comp	Comp	Comp	Comp
Outpatient (w/ASC,ASC Implants, and Non-CMS Certified)	Comp	Comp	Comp	Comp
Outpatient Revenue	Comp	A/C/D	A/C/D	A/C/D
Preventive Services	Comp	A/C/D	A/C/D	A/C/D
Professional (CPT and HCPCS)	A/C/D	Comp	A/C/D	A/C/D
Select Inpatient (MS-DRG)	A/C/D	A/C/D	A/C/D	A/C/D
Select Outpatient/ASC	A/C/D	A/C/D	A/C/D	A/C/D

Comp = Comprehensive; A/C/D = Adds, changes, deletes and other necessary updates

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

The EGID tiers were created in part to help support the continued existence and financial viability of truly rural hospitals. EGID's tier designation process is intended to only recognize a rural reimbursement methodology if the urban or rural status is based on the ZIP code of the hospital and the status of that ZIP code in the U.S. Census Bureau's metropolitan core-based statistical area.

Inpatient and outpatient tier designations and facility urban/rural designations are updated annually on Oct. 1. These designations are determined by the most current Centers for Medicare & Medicaid Services fiscal year inpatient prospective payment system impact file or the facility's ZIP code, included in the U.S. Census Bureau's metropolitan core-based statistical area. On Jan. 1, the urban/rural indicators are updated based on the most recent CMS ZIP code to carrier locality file for all facilities that are not hospitals.

For the most part, the applicable urban tier status is based on the most current CMS fiscal year inpatient prospective payment system impact file for network providers, unless the ZIP code of its physical location is included in the U.S. Census Bureau's metropolitan core-based statistical area.

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.
- Tier 6 – Outpatient rural emergency hospitals.

Fee schedule updates are reported in each quarterly issue of the Network News. If you need specific codes and allowable fees affected by these updates, please view or download the latest fee schedule. 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.

For more information, email EGID Network Management or call 405-717-8790 or toll-free 844-804-2642. TTY users call 711.

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HealthChoice contact information

Network Management
405-717-8790
Toll-free 844-804-2642
EGID.NetworkManagement@omes.ok.gov
HealthChoiceOK.com

Medical and Dental Claims, Eligibility, Benefits and Certifications
Toll-free 800-323-4314
TTY 711
Payer ID: 71064
Provider portal

New Claims, Correspondence and Medical Records
HealthChoice
P.O. Box 30511
Salt Lake City, UT 84130-0511

Optum Pay
Toll-free 877-620-6194
Optum Pay sign in

Pre-Service Appeals
HealthChoice
P.O. Box 400046
San Antonio, TX 78229

Post-Service Appeals
P.O. Box 30546
Salt Lake City, UT 84130-0546

Pharmacy Benefit Administrator: CVS/caremark
Prior Authorization toll-free 800-294-5979
Customer Care toll-free 877-720-9375
caremark.com

SilverScript (Medicare Part D)
Prior Authorization toll-free 855-344-0930
Customer Care toll-free 866-275-5253
healthchoice.silverscript.com

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