HealthChoice Network News Spring 2024

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News

Provider customer service

Customer Care is available for all eligibility, benefits, claims, coverage, certification and appeals. Portions of this information can be viewed on the HealthChoice Provider Portal, or you can contact Customer Care at toll-free 800-323-4314. TTY users 711.

EGID Network Management is available for assistance for providers participating in the HealthChoice, DOC and DRS networks. Contact EGID Network Management for questions pertaining to contracting, updating network provider demographics, provider directory updates, fee schedules and fee schedule access.

Demographic information can be viewed and updated on the provider contracting portal. Additional information can be found in the Policies and Guidelines section of the provider website.

If you contact Customer Care and are unable to get a resolution, ask for a call reference number and then email EGID Network Management.

Office hours for EGID Network Management are 8:00 a.m-4:30 p.m., Monday through Friday, excluding state holidays. Email inquiries, or call 405-717-8790 or toll-free 844-804-2642. 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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Using the provider portal

Providers contracted with a billing service should ensure their use of HealthChoice patient information follows all federal and State of Oklahoma regulations.

The HealthChoice portal is designed with role-based access which allows providers to register and login as a provider. Contracted billing services and other billing entities should use this option to review HealthChoice claim status. Logging in as a member or on behalf of a member is considered a HIPAA privacy violation and subject to those penalties.

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

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Coming soon: submitting medical records with claims

You will soon be able to submit medical records with your electronic claims through clearinghouses that support a standard 275 submission and have an established connection with OptumInsight to transmit these transactions. This will include medical records and signed notice and consent forms when a member waives the balance billing protections

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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Payment methods

The claims administrator offers several different methods of reimbursement to select from, each with their own processing timeline.

To receive payment via direct deposit, we encourage you to enroll online with Optum Financial, a multi-payer platform, or by calling 877-620-6194. Enrolling in direct deposit assures that there are no lost payments, and payments are viewable through the Optum Pay web portal. There is often less administrative cost with receiving electronic payments.

To complete online enrollment, you need:

- Organization name, mailing address and tax identification number (TIN).
- Contact information.
- Organization's banking information, if selecting direct deposit.
- Organization's W-9 form.
- A voided check or bank letter for each account where payments will be deposited.

If already enrolled with Optum Financial for direct deposit, you have the option to switch your method of payment to virtual credit card (VCP). VCP payments are loaded onto a virtual card and are processed by using your point-of-sale credit card terminal. While no banking information is required for this payment option, there may be additional terms and conditions, including fees from your card service processor. If selecting VCP, you will receive a notification with a card number that can be loaded into your credit card terminal. VCP information is sent via mail or fax. Allow additional time if the VCP

under the No Surprises Act.

Submitting medical records at the time of claim submission will reduce claim denials for additional information and increase the potential autopayment rate.

Once implemented, electronically submitted claims with medical records attached will pend for review and no longer deny in request for medical records. This also applies to claims that would have possibly denied for certification.

OptumInsight is currently working with clearinghouses throughout 2024 for their inclusion. Please check with your clearinghouse to see if they have a connection through OptumInsight.

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

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information is being mailed. Once the VCP information has been run using your point-of-sale credit card terminal, your payment will settle in your bank account according to your credit card merchant agreement.

If you elect to not enroll with Optum Financial, you will receive payment by paper check. You should expect additional time for the paper check to be delivered to your office or P.O. Box. If you don't receive your paper check within 30 days of your claim being processed, contact Customer Care for a check to be reissued.

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

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Medicare crossover claims

A Medicare crossover claim is a claim that Medicare sends to another insurer for secondary payment.

If a Medicare beneficiary has dual eligibility (having both Medicare and Medicaid), the Medicare claims will cross over to Medicaid. This covers the Medicare cost share (i.e., deductibles, co-pays, coinsurance).

Medicare beneficiaries with supplemental insurance, such as Medigap, can have their provider report the Medigap claim information to Medicare who will automatically advise the Medigap insurer of Medicare's approved amount and payment. This eliminates the need for a separate bill to the Medigap insurer and reduce payment delays.

Medigap electronic claims		**Medigap paper claims**
Item	837 Version 5010	CMS 1500 claim form
Group policy number	2320 Loop SBR 03	Item 9a
Medigap insurer ID code	2330B Loop NM1 09	Item 9d
Release of information indicator	2320 Loop OI 06	N/A

HealthChoice participates in the Coordination of Benefits Agreement (COBA) Medicare claims crossover program for Medicare beneficiaries who also have a HealthChoice plan. Enrollee eligibility and adjudicated claim data for claim coordination is transmitted to supplemental payers.

Medicare automatically crosses over patients' HealthChoice claims to process as secondary.

If Medicare is the secondary payer, follow the CMS instructions for Medicare secondary payer (MSP). Submitting the member policy and group number on the claim is required. Use these group numbers when submitting claims:

- 76415077 HealthChoice.
- 76415170 Oklahoma DOC.
- 76415171 Oklahoma DRS.

Reducing Medicare COB payment delays.

1. Ask patients if they have secondary insurance and confirm which plan is primary. If the member has dual plans with DRS as one of their plans, DRS is always the plan of last resort.
2. Verify Medicare beneficiary status:
    - Medicare Administrative Contractors (MACs) are contractors that process enrollment and claims for Medicare providers. Each MAC offers its own online provider portal for Medicare providers in its jurisdiction. To register with their MAC's provider portal, providers can contact their MAC or access their MAC through the MAC provider portal. Each MAC also has its own automated phone system. Find the phone number for your MAC by viewing the list of MAC websites on the MAC provider portal and locate the MAC that covers your state.
    - Work with your EDI clearinghouse, software vendor or billing agency to receive HIPAA compliant transactions (270 eligibility request). The EDI payer IDs are 71064 for HealthChoice and 71065 for DOC and DRS.

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

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 A/C/D inpatient only)				

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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