Network News October 2022

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October 2022

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News

CBC code removal

Complete blood count (CBC) lab tests have previously been covered under the preventive benefit. Effective Jan. 1, 2023, these tests will no longer be covered at 100%.

The following codes will no longer be covered under the preventive benefit:

- 85025 – blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count.
- 85027 – blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count).

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

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Mammography

Mammography screenings are covered by HealthChoice at 100%.

Effective Oct. 1, 2022, HealthChoice began covering diagnostic mammography at 100%. High Deductible Health Plan (HDHP) members must meet their annual deductible before HealthChoice pays 100%.

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

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Update to contract language

For dates of service on or after Jan. 1, 2023, EGID will apply the lesser of billed charges or the HealthChoice allowable fee across all payments.

By way of this notice, we are notifying providers that all contract language has been updated to our most current versions, is available on the HealthChoice Provider website, and includes the lesser of language which will apply to all claims for DOS on or after Jan. 1, 2023.

For questions, call Network Management at 405-717-8790 or toll-free 800-543-6044.

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Update to limitations

Beginning Jan. 1, 2023, HealthChoice will allow insulin pumps to be replaced once every 48 months if medically necessary. Additionally, mastectomy bras will be limited to two per calendar year while breast prosthesis will be limited to one per year.

Providers should refer to the HealthChoice Fee Schedule(s) for coverage of codes, allowable fees and certification requirements.

For questions about eligibility and benefits, certifications or exclusions pertaining to durable medical equipment, refer to the handbook or call the Customer Care Team at toll-free 800-323-4314. TTY users call 711.

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MS-DRG and MS-DRG LTCH Fee Schedules, version 40 updates

The HealthChoice and Department of Corrections annual MS-DRG updates to acute inpatient reimbursement include updates to tier designations based on the number of beds and provider type designation as urban or rural as contained within the current year's final IPPS file.

MS-DRG

For charges incurred on or after Oct. 1, 2022, the following changes are effective for the HealthChoice and DOC MS-DRG Fee Schedules:

Tier	1	2	3	4
Outlier threshold	$189,555	$140,788	$107,949	$109,155
Marginal cost factor	0.31	0.35	0.45	0.45
Base rate	$12,266	$11,396	$12,304	$10,824

The market basket update factor is 4.3%.

The next comprehensive MS-DRG Fee Schedule update will be effective for charges incurred on or after Oct. 1, 2023.

MS-DRG LTCH

For charges incurred on or after Oct. 1, 2022, the following changes are effective for the HealthChoice and DOC MS-DRG LTCH Fee Schedules:

- Version 40 of the MS-DRG LTCH Fee Schedule has a base rate of $59,195.00. The outlier threshold is $38,518.00, while the cost-to-charge ratio is 0.224.

The next comprehensive MS-DRG LTCH Fee Schedule update will be effective for charges incurred on or after Oct. 1, 2023.

If you have any questions regarding these adjustments, call Network Management at 405-717-8790 or toll-free 800-543-6044.

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Fee schedule updates

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

Annual Fee Schedule Releases	Jan. 1	April 1	July 1	Oct. 1
Anesthesia (ASA)	Comp			
ASC and ASC Implants	A/C/D	Comp	A/C/D	A/C/D
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
Certification Requirements	Comp	Comp	Comp	Comp
CPT	A/C/D	Comp	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
Non-CMS Certified Facility	Comp	Comp	Comp	Comp
Outpatient	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
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.

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. If you need specific codes and allowable fees affected by these updates, please 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 EGID Network Management.

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- Referral staff.
- Certification staff.
- Business office staff.
- Medical records staff.
- Providers.

Contact information

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Medical and Dental Claims
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Payer ID: 71064
healthchoiceconnect.com

New Claims, Correspondence and Medical Records
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Appeals and Provider Inquiries
HealthChoice
P.O. Box 3897
Little Rock, AR 72203-3897

Health Care Management
405-717-8879
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Certification Administrator
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Fax 855-532-6780
TTY 711

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

ECHO Health Services
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providerpayments.com

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