November 2021

Medical Record Requests for Risk Adjustment

As a Medicare Advantage plan, Network Health is required to submit member diagnosis and demographic information to the Centers for Medicare and Medicaid Services (CMS). Health plans like Network Health create internal risk adjustment programs to help monitor their member population, improve quality of care and increase the accuracy and completeness of these data submissions in order to achieve the most accurate payments from CMS for their member population. T he risk adjustment model distributes payments to payers based on an expectation of what the member's health care will cost. For example, a member with type 2 diabetes and high blood pressure merits a higher payment than a healthy patient, as their cost of healthcare will differ. By risk adjusting plan payments, CMS can make accurate payments to health plans for enrollees with different expected medical costs.

Our review of medical records is a compliance measure to ensure our data submissions and payments from CMS are based upon reliable and accurate records from physicians and facilities. These chart reviews aim both to highlight missing diagnoses and to locate diagnoses that were added in error. Both should be sent to CMS to adjust their payments to us. Our goal is to capture the full burden, no more, no less, of illness each year for our members. CMS has strict criteria concerning the medical record documentation used for risk score calculation. Only records signed by approved provider types for services performed in approved locations can be used for diagnosis validation. While any healthcare provider with a National Provider Identifier (NPI) may submit claims for payment of services, only face-to-face encounters with approved specialty types are acceptable for abstracting diagnosis codes for risk score calculation.

If a chronic condition is not recaptured from a previous year, the member's risk score will

decrease for the current year. Likewise, if additional conditions are reported, the member's risk score will increase from what it was in the previous year. To maintain predictability in healthcare costs and revenue, Network Health relies on its risk adjustment program and the accurate and consistent submission of all conditions each year.

Providers have an important role to play in our risk adjustment program. An engaged partnership with Network Health is vital to bringing needed and valuable benefits to your patients. For instance, Network Health uses premiums and risk adjustment payments to offer our members enrollment in exercise programs, case or disease management, transportation to medical appointments, and other needed services. We use diagnosis codes submitted on claims to identify what types of programs are needed and who needs them.

Due to the volume of records we are reviewing, we utilize outside vendors to assist in the collection of records. You may be contacted by Inovalon or GeBBS Healthcare to submit specific records or have the vendor come on site to review the records. **This review is not a medical necessity review.** A letter outlining the program and a list requested records will be sent to you, along with several retrieval options to allow you to choose what works best for you and your staff.

We appreciate your partnership and cooperation. If you have any questions, please contact Emily Vander Heiden, Supervisor Risk Adjustment at 920-628-7107 or evanderh@networkhealth.com.

ConnectCenter Training Webinar - Q&A Available

Thank you to those who attended the ConnectCenter training webinars in November. We gathered the questions and answers from each training session and have them available here.

ConnectCenter is a free service for submitting paper claims electronically to Network Health. The benefits of signing up for this free service saves your team time, reduces administrative costs and helps you meet Network Health's electronic claims submission requirement by January 1, 2022.

Please reach out to your provider operations manager for additional information.

EDI Claim Submissions - COB and Corrected Claims

Reminder, Network Health secondary claims along with corrected claims may be submitted electronically for claim processing. Please use the correct designation payer loop(s) when submitting claims as the secondary payer.

When submitting a corrected UB04/facility claim, please use bill type XX5, XX7 or XX8 indicating it is a correction to a previous claim submission. When submitting a professional/HCFA-1500/professional claim, please indicate resubmission code 7 in box 22 along with the original claim number.

If you have additional questions, please review our Claim Submission Policy, or reach out to your provider operations manager.

Noninvasive Treatments for Acute, Subacute and Chronic Low Back Pain

This comprehensive guideline provides clinical recommendations for all primary care clinicians for noninvasive treatment of acute, subacute and chronic low back pain in adults. The recommendations include guidance for nonpharmacologic treatments as well as for patients who do not respond to nonpharmacologic treatments. This guideline was developed in 2017 and is a current guide recommended by the Centers for Disease Control (CDC). In conjunction with this guideline, multiple appendixes summarize findings for all pharmacologic, nonpharmacologic treatments and adverse events for chronic low back pain.

The American College of Physicians (ACP) developed the guideline using the ACP grading system on reviews of controlled trials and published systematic reviews.

This guideline is intended to be a resource for clinical practice. The goal of the guide is to help clinicians provide quality care for people who have chronic low back pain with the use of noninvasive treatment.

CPT and HCPCS Code Updates

The American Medical Association updates Current Procedural Terminology (CPT) codes and the Centers for Medicare & Medicaid Services updates Healthcare Common Procedure Coding System (HCPCS) codes on a quarterly basis.

There are new codes requiring prior authorization and these services fall within our current authorization, experimental and/or genetic review processes. You can find a list of all services requiring prior authorization at networkhealth.com.

If you have specific questions regarding a service, please contact our member experience or health management teams for assistance. For more information about authorization requirements, forms or services that require review under the experimental and/or genetic process visit the Authorization Information section on our website.

Please forward this information to those within your facility who will need to follow these processes. For prior authorization requests or questions, contact our population health department Monday-Friday, 8 a.m. to 5 p.m. at 920-720-1602 or 866-709-0019.

Language assistance is available for members or practitioners to discuss utilization management issues. Network Health also offers TDD/TTY services for deaf, hard of hearing or speech-impaired individuals. Anyone needing these services should call 800-947-3529. All callers may leave a message 24 hours a day, seven days a week.

CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016

This comprehensive guideline was created to improve awareness between clinicians and patients about risks and benefits of opioid use for chronic pain, improve safety and efficacy with use and reduce risk with long term therapy. It provides clinical recommendations for all clinicians in primary care with prescribing opioids for chronic pain not related to cancer treatment, end of life care or palliative care.

Recommendations are addressed to determine the start or continuation of opioids, selection of opioid as well as dosage, duration, follow-up, discontinuation and finally assessing risk and harms with use of opioids. Included with this guideline is a quick reference box with concise information on prescribing opioids for chronic pain.

The (CDC) developed the guidelines using the GRADE framework and systematic review of scientific evidence from experts, peer reviews, the public and a federally charged advisory committee. It is intended to be a resource for clinical practice. The goal of the guide is to help clinicians provide quality care for people who have chronic pain requiring the use of opioids.

Provider Information on networkhealth.com

Are you aware of our Provider Resources page on networkhealth.com? You will find resources and tools to help make your work easier.

Check out the recently added section Provider Resource Documents. It has newly created documents that will walk you through what is needed to prior authorize several frequently requested procedures or services, as well as documents to assist with the peer to peer, appeal and dispute processes.

Holiday Hours

Please note, Network Health will be closed on December 23, December 24 and December 31 due to the holidays. Please use our provider portal if you need to access member eligibility, member benefits, claims statuses and prior authorizations.
