February 2022

The pulse

network health

Keeping you in **rhythm** with **provider news** and **updates**

Changes to the 2022 Prior Authorization Requirements

Beneficial and helpful changes to Network Health's prior authorization requirements begin April 1, 2022.

Continuous positive airway pressure devices (CPAPs, BiPAPs and Auto-PAPs identified by codes E0470, E0471, E0472 and E0601) will no longer require prior authorization. Network Health trusts our providers are monitoring compliance with devices, as required.

Wheelchairs defined by HCPCs codes K0001, K0002, K0003 and K0004 will not require prior authorization until rental month four (or 91 days), as identified by the KJ modifier on your claim. This means Network Health will allow a wheelchair (as defined by the four codes above) to be rented to our members for 90 days without prior authorization. If the rental of the chair is needed beyond 90 days, the DME supplier is required to submit prior authorization. Medical documentation to justify the long term need for the wheelchair is required to process your request.

A complete 2022 listing of services that require prior authorization, as well as our claims policies, can be found here.

For all authorization requests, please visit our prior authorization portal iExchange located within the Provider Portal or call our utilization management department for medical or behavioral health authorization requests at 866-709-0019 or 920-720-1602, Monday–Friday 8 a.m. to 5 p.m.

Updated/New Payment Policies

The following updated and new payment policies begin on April 1, 2022.

- The Wheelchair Rental Policy is a new policy for all lines of business.This policy coincides with the updated authorization requirements effective April 1, 2022.
- The Anesthesia Policy is a new payment policy for our commercial lines of business, which is in alignment with the American Society of Anesthesiologists.
- The Mid-Level Practitioner/Physician Extender Policy has been updated to include APNP's, which is in alignment with the Centers for Medicare & Medicaid Services (CMS).

Please note, we develop payment policies on a regular basis and announce the updates in The Pulse. All payment policies are available on our website here.

As a reminder, please ensure your staff is up to date with all of our policies.

Reminder to Review the EDI Claims Rejections Report

As a reminder for all providers, you must review the EDI Claims Rejection Report located within the provider portal to ensure claims did not reject due to clerical errors or a provider/member was not added to the system. Network Health does not reject the claims through the EDI process.

Your clearinghouse may indicate the claim was accepted however, the claim will not come back through your clearinghouse as rejected. It is very important to check this report if you have not received payment within 30 days.

If you have any questions on how to access this report, please reach out to your provider operations manager.

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 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

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ConnectCenter – FREE Program for Providers Submitting Paper Claims

Network Health has implemented a free program for providers that submit paper claims. In partnership with Change HealthCare, providers will have the ability to submit claims electronically to Network Health with ConnectCenter. The benefit of signing up for this free service saves your team time, reduces administrative costs and assists Network Health in moving towards a paper reduction environment.

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

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 & 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. The 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 health care 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 health care 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 health care 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 use 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.

CPT and HCPCS Code Updates

Every quarter the American Medical Association (AMA) updates Current Procedural Terminology (CPT) codes and the Centers for Medicare & Medicaid Services (CMS) updates Healthcare Common Procedure Coding System (HCPCS) codes.

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 here.

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, go to the Authorization Lists by Code on our website.

Please forward this information to others at your organization who 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 by calling 800-947-3529. All callers may leave a message 24 hours a day, seven days a week.

Network Health Leadership Retirements and Promotions in 2022

Gregory Buran, MD retired as chief medical officer

Gregory Buran, MD retired in January as chief medical officer at Network Health and Mushir Hassan, MD assumed leadership of clinical operations as chief medical officer.

During his time at Network Health, Buran's leadership paved the way for Network Health to become a 5 Star Medicare Advantage PPO plan for 2022.* In addition, Buran remained a strong and steady leader navigating Network Health and its members through a global health pandemic. Although Dr. Buran is stepping down as CMO, he will remain with Network Health as a part-time medical director working with the clinical integration team and continue to support our utilization management work.

Prior to joining Network Health as medical director, Dr. Hassan spent more than two decades in primary care/internal medicine in Brookfield. This expansive background gives him the unique insight to demonstrate a truly wholistic member advocacy approach to his role leading Network Health's clinical teams. "I appreciate our provider-owned culture to engage providers early in the coordination of care for our members," said Hassan.

Dr. Hassan uses self-reflection, integrity and transparency for an objective approach to leadership. He has a deep history of community evolvement, leading both a hospital and school district through the coronavirus pandemic. Dr. Hassan, a Northwestern University–Feinberg School of Medicine graduate, resides in Brookfield.

*Every year, Medicare evaluates plans based on a 5 Star Rating system.

Colleen Singh, vice president of operations retired

Colleen Singh, vice president of operations at Network Health also retired in January and Jess Vander Zanden assumed executive leadership of operations as vice president of operations and human resources.

Since April of 2017, Singh led the charge to improve operational efficiencies at Network Health. Singh led the team to achieve substantial revenue recoveries, earn a 5 Star customer service rating for 2022, built a successful subrogation program and reached an exceptionally high claims auto-adjudication rate.

Vander Zanden started at Network Health over thirteen years ago as a social worker and built many successful programs including compliance and human resources. She earned a bachelor of science from the University of Wisconsin – Oshkosh, Masters of Social Work from the University of Wisconsin – Milwaukee and a masters of organization business from Silver Lake College.