the pulse

network health

Keeping you in rhythm with provider news and updates

April 2019

Reminder: Care Continuum Launched May 1

Network Health uses CCUM for Medical Drug Authorization

A reminder that Network Health has partnered with ESI Care Continuum (CCUM) for medical drug prior authorization effective May 1, 2019.

ESI Care Continuum will handle pre-determination and prior authorization requests for medical drug (excluding oncology drug) for all lines of business.

Providers should submit medical drug requests via the ExpressPAth portal as of May 1. Online submissions will streamline communication and improve turnaround times for these authorizations.

Providers also have seamless access to ExpressPAth through the Network Health provider portal. ExpressPAth is available 24 hours a day, seven days a week.

Visit the tutorial page on the ExpressPAth site for assistance on how to navigate the portal. For additional information, please contact Network Health's Utilization Management Department or your contract manager.

Medical Drug Claims Must Include National Drug Code (NDC)

Providers must include the National Drug Code (NDC) when submitting claims for medical drugs to Network Health.

If you are billing for an unclassified drug, you must include the NDC as well as the name and description of the drug. Claims submitted with a J999 code will automatically pend and require a medical necessity review to process.

Encourage Patients to Make Colorectal Cancer Screening a Priority

Network Health strives to maintain and improve the overall health of our members. Many people in the United States are not getting the preventive screens as recommended. They are missing the chance to prevent colorectal cancer or find it early, when treatment is most effective.

We would like to combine our efforts and spread the word of colorectal cancer awareness and inform members they have options for screenings. We strongly encourage all our members aged 50-75 to get screened for colorectal cancer. Members younger than 50 with risk factors for colorectal cancer may need screening at an earlier age. We are reaching out to you, as their providers, to share the information and make colorectal cancer screening a priority. The biggest influencer to motivate patients for preventive screenings like colorectal cancer is you and your staff. Together we can identify patients who are due for colorectal cancer screenings, talk to them about the importance and get them screened.

Our members have options for colorectal cancer screening.

- Colonoscopy every 10 years
- CT colonography every five years
- Flexible sigmoidoscopy every five years
- FIT-DNA every three years
- FIT every year
- FOBT every year

It can then be determined which screening is right for them and how often to get screened. Once our members are screened, they can be easily tracked for follow-up as needed.

Taxonomy Codes Required for Medicare Claims

In 2018, Network Health purchased Optum pricers to price Medicare claims. Optum requires a taxonomy code in order to direct the claim to the correct pricer. A taxonomy code is required in box 24J or 33B on the 1500 and box 81 on a UB. If you are going to put a taxonomy code in box 24J and 33B, they have to be the same taxonomy. If you are unsure of which taxonomy to use or would like to verify your taxonomy code, please visit: https://npiregistry.cms.hhs.gov/.

Screening Needs for Patients Prescribed Antipsychotic Medications

Patients with schizophrenia and affective disorders have 1.5 to two times higher rates of diabetes and obesity when compared with the general population. Obesity, ethnic background, family history and certain medications increase these individual's risk of developing type 2 diabetes[1].

Second generation or "atypical" antipsychotics (SGAs) pose varying risks of metabolic effects, requiring the need to monitor weight, glucose and lipids. clozapine and olanzapine carry a high risk; risperidone and quetiapine carry a moderate risk; and aripiprazole and ziprasidone are associated with lower risk, although their side effects are not yet as well documented as older medications.

Monitoring recommendations for individuals taking SGAs[2].

	Weight	Glucose	Lipids
Baseline	X	X	X
At four weeks	X		
At eight weeks	X		
At 12 weeks	X	X	X
At four months		X	
Quarterly	X		
Annually		X	
Every two - five years			X

*More frequent assessment may be warranted based on clinical status.

The HEDIS measure *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* focuses on individuals 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had an annual diabetes screening test (glucose or HbA1c meet requirement).

Please see the HEDIS 101 Guide for further information on this and other HEDIS measures.

[1] Hinds, Coutler, Hudson & Seaton. (2015). *Screening for diabetes in patients receiving second-generation atypical antipsychotics.* American Journal of Health-System Pharmacy. 2015; 72: S70-3.
[2] PL Detail-Document, Comparison of Atypical Antipschotics. Pharmacist's Letter/Prescriber's Letter. October 2012.

Do You Meet the Language Needs of Patients?

Health outcomes and quality of care are improved when providers offer services that meet the social, cultural and language needs of patients. An increasingly diverse population, however, can present many communication challenges for provider offices. The patient-doctor relationship can be strained by language barriers and cultural misunderstandings - factors that can contribute to poor health outcomes.

As an insurance payer with NCQA certified plans, Network Health must poll participating providers annually about how they are meeting the cultural and linguistic needs of plan members. Please complete our Culture and Language Survey by May 16, 2019.

Your feedback helps us develop and share diverse, culturally appropriate materials that can assist you in communicating more effectively with your patients - our members.

Network Health ID Cards Don’t Include Social Security Numbers

Network Health ID cards no longer include social security numbers for the privacy and protection of our members. Please do not ask our members to provide their social security numbers at registration.

Provider Information Forms Needed

As a reminder, if you are adding a new provider or a new location to your contract, you must fill out a provider information form or a facilities information form. All fields must be completed and sent to your contract manager. If the fields are not filled out, the form will be sent back for the missing information. These forms start the credentialing process, as well as provide the information necessary to enter into our claims payment system. If you have any questions or concerns, please contact your contract manager.

Best Practices for Transition of Care

Implementing an individualized, coordinated plan of care that empowers patients and their families to maintain the least restrictive, appropriate environment improves member outcomes, decreases risk of readmission and premature institutionalization and increases patient satisfaction and quality of care.

Successful transitions of care demonstrate the utilization of the following best practices.

1. Utilizing a single point person or organization to ensure continuity of care.

Network Health offers care management services to many of our members, at no cost. This service ensures the sharing of transfer information and functions as a resource for providers, provides reinforcement of patient/caregiver education, ensures that patient services ordered during recovery meet the patient's needs and addresses other identified needs of the patient and/or family. For more information, call 800-826-0940 or visit our care management page.

2. Ensuring effective communication between providers, patient and/or family.

There are several best practices we recommend for effective communication.

- Providing written instructions and resources as reminders for patients/caregivers, including medication reconciliation.
- Encouraging the patient to bring a friend or caregiver to appointments.
- Ensuring that medical records are shared with the PCP and/or other treating providers.
- Arranging for follow-up appointments with providers during the transition of care.

For more information regarding best practices for transition of care, contact the Network Health Quality Integration Department at QHI@networkhealth.com.

Medicare Member Events Coming in October

Coming in October, we will be having our Medicare Member Events and would like to extend an invitation to our provider partners to participate in these events. If you are interested in having a booth at these events, please contact your contract manager.

Are You Using the Online Resources Network Health offers?

In November of 2018, Network Health launched a new provider portal with updates based on real-user testing and provider feedback.

Both contracted and non-contracted providers (as well as billing firms) can set up new accounts by visiting the Create an Account page.

Providers may continue to provide feedback with the message feature inside the portal. Throughout the year, we'll be continuing to use the feedback we receive to add new enhancements to the portal. At any time, visit this page for an overview of what's being improved and enhanced.

Also, there have been many updates to our Provider Medicare Manual page, including 2019 Benefits at a Glance as well as our ESI Care Continuum Prior Authorization Drug List.

Is there something you would like to see in the next issue of The Pulse? **Email us today.**