



January 2019

### **Providers must update data quarterly**

We validate provider information quarterly and when new information is sent from a contracted group. Contracted providers and provider groups are **required** to participate in this process as part of their contractual obligation.

Dial America is a vendor that Network Health uses to update provider information as regulated by CMS. Please make sure to update your information with them when they call. If you do not provide the information to Dial America, Network Health must follow up with your staff.

If you would rather not provide information over the phone, you have the option to submit your roster via email on a quarterly basis to Provider Informatics at [provinfo@networkhealth.com](mailto:provinfo@networkhealth.com). For more information on what information is required, please read the [Provider Data Validation policy](#).

### ***Report changes in provider participation***

It is also a contract requirement to promptly (within 30 days) inform Network Health of any provider participation changes such as location changes, terminations, part-time covering or no longer accepting new patients. Failure to report this information in a timely fashion affects the state and federal continuity of care provision for our members.

### **Submit all corrected claims according to policy for payment**

Corrected claims for any line of business must be submitted to Network Health according to the [published policy](#). A corrected claim is any claim that has a change to the original. For example, changes or corrections to charges, procedure or diagnosis codes, dates of service, etc.

Corrected claims must be submitted within 18 months of the remittance advice and must follow the established guidelines outlined in the [policy](#). For example, if you need to submit a corrected claim, please remember to submit the entire claim with a cc modifier on the line you are correcting, a resubmission code 7 in box 21 for HCFA forms, and bill type XX7 for UB forms.

For more details and guidelines, please review the [policy](#). Corrected claims that don't meet all requirements will be denied.

## **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 the survey at [surveymonkey.com/r/ProviderCulture](https://surveymonkey.com/r/ProviderCulture) by February 6, 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.

## **Portal user PINs mailed only to provider office location on file**

The new [Network Health provider portal](#) launched in November 2018 and is available to contracted and non-contracted providers as well as third-party billing entities.

For security purposes, users who create a login with a non-company domain (e.g., gmail, yahoo, etc.) or unknown company domain, are asked to verify the mailing address we have in our system. Verification initiates a PIN number sent via the U.S. mail. Once users receive the PIN number, they can enter it to complete registration and gain access to all areas of the site.

As engagement with the portal continues to grow, we have had some new users request that their PIN numbers be sent to addresses other than those we have on file.

**For provider and member security, we can mail PIN numbers ONLY to an address currently on file for a provider office.**

Please watch the mail for envelopes marked “Complete Your Portal Registration” as these letters contain the PIN information required to access the site. We ask for your

cooperation in ensuring that the PIN information is forwarded to the appropriate personnel.

If you have any questions or issues registering, please contact Network Health Customer Service at 800-769-3186.

## **New CPT and HCPCS codes require prior authorization**

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

New codes are in place that will require prior authorization. These services fall within our current authorization, experimental and/or genetic review processes. A complete 2019 listing of services that will require prior authorization can be found in the [Authorization Information](#) section of networkhealth.com.

If you have specific questions regarding a service, please contact our customer service or health management teams for assistance.

For more information about authorization requirements, forms or services that require review under the experimental or genetic process visit the [Authorization Information](#) section of networkhealth.com.

Please forward this information to those within your facility who will need to follow these processes. For prior authorization requests or questions, contact our care management department at the numbers below, Monday–Friday from 8 a.m. to 5 p.m.

**Commercial:** 920-720-1600 or 800-236-0208

**Medicare:** 920-720-1602 or 866-709-0019

For questions specific to behavioral health utilization, call 920-720-1340 or 800-555-3616.

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 who needs these services should call 800-947-3529. All callers may leave a message, 24 hours a day, seven days a week.

## **Reminder: Submit authorization requests via iExchange**

Providers may now submit authorization requests directly to Network Health through the iExchange platform. You may use iExchange to submit requests for inpatient hospital stays, durable medical equipment, outpatient procedures and more.

If you are currently using iExchange with other payers, you will now see Network Health in your payer drop-down menu on the iExchange platform. You will also be able to seamlessly access your iExchange account through the [Network Health provider portal](#).

When you are logged into the portal, select the Authorizations drop down and select iExchange. When prompted, select the Tax ID for the provider making the authorization request. You will be taken directly to your iExchange dashboard to enter the authorization request.

iExchange is available 24 hours a day, seven days a week, and provides real-time entry into Network Health's Care Management Platform. For guidance, view our [Inpatient](#) and [Outpatient](#) tutorials.

## **Reminder: eviCore program expansion goes live February 1**

February 1, 2019, we are expanding the contract with eviCore healthcare to include authorizations for medical oncology, genetic laboratory testing and expanded radiation therapy. eviCore will also handle oncology drug requests (under the medical benefit, not pharmacy).

For specific program materials, FAQs, and training information, please visit the Network Health implementation page at [www.evicore.com/healthplan/nhpwi](http://www.evicore.com/healthplan/nhpwi).

eviCore uses National Comprehensive Cancer Network (NCCN) evidence-based cancer guidelines to make determinations. Anything that does not follow the NCCN guidelines, or considered experimental, will require further review (peer-to-peer review with an oncologist).

Currently, eviCore processes the following authorizations on behalf of Network Health: advanced imaging scans, large joint procedures of the hip, shoulder and knee, interventional pain management, spinal procedures, ambulatory cardiac diagnostics and radiation therapy.

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Is there something you would like to see in the next issue of The Pulse? [Email us today](#).

Self-insured plans administered by Network Health Administrative Services, LLC. HMO plans underwritten by Network Health Plan. POS plans underwritten by Network Health Insurance Corporation or Network Health Insurance Corporation and Network Health Plan. Network Health Medicare Advantage Plans include MSA, HMO and PPO plans with a Medicare contract. NetworkCares is a PPO SNP plan with a Medicare contract and a contract with the Wisconsin Medicaid program. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal.