February 2019

Providers Must Maintain Adequate Access to Covered Services

Contracted providers are required to maintain adequate access to covered services per Network Health policy. Highlights of the **policy** include the following obligations.

- Providers must have after-hour call coverage. This might include a message directing members to the ER, stating an on-call doctor will call the member back, or an after-hour call service.
- Next available appointments must meet the following standards.
    - Behavioral health or non-life-threatening emergency within 6 hours
    - Urgent care within 48 hours
    - Regular or routine within 10 days

For more information on Network Health provider policies, please visit **networkhealth.com/provider-resources/policies-and-forms.**

Reminder: Providers Are Required to Update Data with Dial America

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. If you would like to switch to email rosters, please contact your contract manager. 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 excepting new patients. Failure to report this information in a timely fashion affects the state and federal continuity of care provision for our members.

eviCore Radiation Therapy Approvals Now Based on Episode of Care

Providers who have previously submitted Radiation Therapy prior authorization requests to eviCore on the legacy CareCore National (ISAAC) utilization management system will notice several differences in authorizations approved via the ImageOne platform. On the ImageOne platform, eviCore reviews the overall treatment plans submitted, rather than the specific individual codes previously requested on the ISAAC platform.

The ISAAC platform is designed to review and approve a specific radiation therapy treatment plan. Authorizations include approvals for the radiation technique (e.g., 3D, SRS, IMRT) with or without image guidance, the number of fractions (treatment sessions) and the number of phases (or cone-downs).

The ImageOne platform provides approval for an episode of care (EOC) that is inclusive of all relevant and necessary CPT codes associated with treatment delivery and Image Guided Radiation Therapy (i.e., codes within the scope of the eviCore radiation therapy managed code list).

This new approach benefits providers in the following ways.

Minimizes Administrative Burden

Modifications in treatment delivery may occur during the course of treatment. When the program requires the review of individual CPT codes, it also necessitates reviews for each subsequent modification or correction. The additional reviews create potential for denials and delays in patient care. eviCore's EOC authorization offers a more efficient method for updates to the treatment plan because a variety of codes are covered under the authorization.

Increases Treatment Flexibility

There are many codes that can be substituted for one another dependent on the evolution of care. For example, the approved authorization might be for a 3D conformal treatment plan. Based on the evolution of the patient's care, it might be necessary to deliver a less complex dose of 3D conformal radiation (77402) versus a more complex dose of 3D conformal radiation (77407). eviCore doesn't want to limit the provider to a specific CPT code if the less complex radiation dose is more appropriate.

Facilitates Accurate Billing and Claims Payment

The EOC allows the provider and/or facility to bill according to the level of complexity rendered within the course of treatment. To participate effectively, providers must be familiar with the appropriate codes associated with an episode of care (e.g., family of codes) and should understand the various edits to minimize or eliminate claim denials. Providers should bill according to the treatment plan that was rendered, and billing should align with the national billing guidelines for radiation therapy.

For additional information related to the eviCore radiation therapy program, please visit **www.evicore.com/healthplan/nhpwi.**

Do You Meet the Language Needs of Patients? Take the NQCA Survey

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** by March 15, 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.

Utilization Management Criteria is Available Upon Request

Network Health prior authorization decisions are made using written criteria that is based in clinical evidence. Written criteria are reviewed and approved annually by doctors who actively participate in the health plan.

For its Medicare Advantage membership, Network Health follows CMS National Coverage Determinations (NCD) and Wisconsin Regional Local Coverage Determinations (LCD). When NCD or LCD information is not available, determinations are based on the written criteria.

Providers are notified of the availability of the criteria and how to request the criteria through the provider manual, denial letters and/or newsletters. Members and participants are notified of the availability of the criteria and how to request criteria

through the Practitioner Directory and Member Reference Guide, denial letters and/or newsletters.

The criteria are also available upon request to doctors, practitioners and members/participants. Requests for criteria can be submitted via telephone, fax, electronically or U.S. mail. Once the request is received, Network Health distributes criteria by mail, fax or email and it is available on our website. Network Health mails criteria to practitioners who do not have fax, email or internet access.

For criteria 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.

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.

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.

Reminder: CMS Survey Must Be Completed

For Network Health to demonstrate compliance with the Centers for Medicare and Medicaid Services (CMS) requirements, providers need to complete a short questionnaire. **You should have received an email invitation with a link to the survey**.

If you have not yet completed your survey, you will be contacted by our compliance department.

These requirements are set by our regulatory bodies, including CMS. CMS requires all providers contracted to offer health care or provide services to Network Health members to meet these requirements.

If you have any questions regarding CMS requirements or this questionnaire, please contact your assigned contract manager.

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.

Give Us Provider Portal Feedback and Receive a $50 Gift Card

Network Health is working with Blue Door Consulting of Oshkosh to test the usability of our digital products. We are seeking providers to participate in testing the new provider portal.

Blue Door leads participants through a series of questions to see how easily they locate essential items in the provider portal. In addition to guided questions, there is an opportunity to give additional thoughts on the functionality of the portal.

Testing takes place at our headquarters at 1570 Midway Place, Menasha. If you would like to participate but need to test at your facility, please contact us with your venue requirements. Testing takes approximately 30-45 minutes to complete and volunteers will be offered a $50 gift card for their time. Special IT expertise or web proficiency is not required. Network Health provides the test computer and a test user account is used to protect patient health information.

If you are interested in testing, please email us at **marketing@networkhealth.com**.

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