the pulse

network health

Keeping you in rhythm with provider news and updates

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October 2018

Network Health new provider portal to launch November 5

Through a collaborative approach with our provider partners, Network Health recently developed a new provider portal with updates based on real-user testing and provider feedback.

Important features incorporated into the new portal include:

- Ability to view patient claims and claims status
- Access to submit and view prior authorization requests
- Ability to view patient benefits and plan information
- Ability to view explanation of payment (remits)

The new portal will be live on November 5 and both contracted and non-contracted providers (as well as billing firms) will be able to set up new accounts for the portal at that time by visiting networkhealth.com/provider-resources.

Please note that all providers will need to create new accounts the first time they use the new portal. Any provider who has previously accessed the former portal will need to set up a new account.

Access to the former HealthTrio® portal will conclude on November 30, 2018.

To register, users will need their Tax Identification Number and Group NPI Number. After registering for a new account, users will have eight hours to activate the link sent in an email.

Users who create a login with a non-company domain (e.g., gmail, yahoo, etc.), or unknown company domain, will be asked to verify the mailing address we have in our system. Verification will initiate a PIN number sent via the U.S. mail. Delivery of the PIN may take up to seven business days.

Users awaiting a PIN will immediately have access to the portal dashboard, but they will need to enter the PIN to access Patients, Claims and Authorizations information. Once users receive the PIN number, they can enter it to complete registration and gain access to all areas of the site.

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

Coming soon: Providers to submit authorization requests online

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

A pilot program for iExchange was launched in September, and the full rollout to all providers will be coming soon in November.

Previously, authorization requests were received via fax transmission. With iExchange, authorization requests are automatically fed into the Aerial system, saving time and streamlining communication.

Providers can include clinical notes, attach documents and share additional relevant information in the online submission. They can also check the status of requests and will receive alerts from Network Health when a request has been reviewed and updated. Centralized communication improves turnaround times for authorization decisions, which benefits both our members and provider partners.

Keep an eye on your inbox for the iExchange launch announcement.

Network Health makes decisions based on appropriateness of care

Utilization management decisions made by Network Health are based on the appropriateness of care and service. Care and service include medical procedures, behavioral health procedures, pharmaceuticals and devices. Decisions are based on written criteria founded on sound clinical evidence and on the benefits outlined in the various plan coverage documents.

Written criteria are reviewed and approved annually by actively-participating practitioners. Criteria are available to providers, practitioners and members/participants upon request. Requests for criteria can be submitted via telephone, fax, electronically, or U.S. mail. Once the request is received, care management associates send the requested criteria via fax, electronically or U.S. mail.

Network Health does not reward in any way practitioners or other individuals conducting utilization review for denying coverage for care or service. Nor does Network Health prohibit providers from advocating on behalf of members/participants within the utilization management program.

Network Health does not use incentives to encourage barriers to care or service, and it does not make decisions about hiring, promoting or terminating practitioners or other associates based on the likelihood, or the perceived likelihood, that the practitioner or associate supports, or tends to support, denial of benefits. The medical directors, associates (or designees), care management staff and supervisors of this staff receive no financial incentive to encourage decisions that result in underutilization.

In addition, treating practitioners may discuss medical necessity denial determinations with the physician review medical director by contacting us at the numbers below.

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.

Callers have the option to leave a message, 24 hours a day, seven days a week. Messages are retrieved at 8 a.m., Monday through Friday, as well as periodically during the business day. All calls are returned promptly. Calls received after business hours are returned the next business day.

Members/Participants, practitioners and/or providers may also send inquiries to the care management department via fax, courier system and U.S. mail. You can fax the Medicare care management department at 920-720-1916 or the commercial care management department at 920-720-1903.

Network Health offers TDD/TTY services for deaf, hard of hearing or speech-impaired individuals. Anyone needing these services should call 800-947-3529. Bilingual language assistance or translation services are also available.

Providers must complete Model of Care training by December 31

The Centers for Medicare & Medicaid Services (CMS) requires that we provide Medicare Advantage SNP Model of Care training to our providers. CMS also requests that we maintain documentation showing which providers completed the training. This training is required by December 31, 2018, for any Network Health Medicare provider who may see members enrolled in our SNP plan.

To help you complete the 2018 training, we've posted a training presentation on our website. Once you've viewed the training, please fill out the attestation form and submit verification that you've completed the training.

We can accept an attestation from a panel of providers or it can be completed by each individual provider. If you have any questions or concerns about this training, please contact Laura Reinsch, MSW, CAPSW, manager of Medicare special needs plan and social services, at 920-720-1711 or lreinsch@networkhealth.com.

Don't forget to check us out on social media.

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

HMO plans underwritten by Network Health Administrative Services, LLC. POS Plans underwritten by Network Health Insurance Corporation, or Network Health Insurance Corporation and Network Health Administrative Services, LLC. Self-insured plans administered by Network Health Administrative Services, LLC. Network Health Medicare Advantage plans include MSA 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.