September 2020

# The pulse

network health

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

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## October is Breast Cancer Awareness Month - Don't Forget to Schedule Your Mammogram

For the last several months many of us have put preventive health care needs on hold due to the coronavirus pandemic. Businesses and clinics are now open to schedule annual tests including a screening mammogram. This screening test is the most reliable way to detect breast cancer early.

**What is a Screening Mammogram?**
A screening mammogram is an X-ray that radiologists use to look for signs of breast cancer.

The American Cancer Society recommends scheduling screening mammograms annually for women 45 to 54 years old. Women 55 and older can choose to switch to a mammogram every other year. Women between 40 and 44 have the option to start a screening mammogram every year.

Women who are pregnant, breastfeeding, have breast implants or a physical disability are encouraged to schedule a screening mammogram.

Mammograms can be done in several different facilities including radiology and imaging centers, mammography clinics, hospital radiology departments, mobile vans and some physicians' offices.

**Traditional (2D) vs Tomosynthesis (3D) Mammogram**
A traditional—or two-dimensional (2D)—mammogram is the most common type of screening mammogram. It takes an x-ray picture of the breast to get a single image. Most medical facilities offer 2D mammograms.

A newer type of mammogram called digital breast tomosynthesis—or three-dimensional (3D) mammography—takes several pictures of the breast which allows the computer to create a three-dimensional picture of the breast. The FDA approves 3D mammograms for women who have dense breasts. It's important to note this option is not available at all breast imaging locations.

If you have questions about which type of mammogram is best for you, ask your personal doctor.

**Risks Associated with a Screening Mammogram**
Mammograms expose you to small amounts of radiation. The 3D mammogram exposes you to a slightly longer dose of low radiation than the 2D mammogram. These levels are still within the recommended safe range per FDA guidelines and do not pose a health risk.

Either type of mammogram screening may find abnormalities that aren't cancer, such as cysts. And, neither type of mammogram is guaranteed to find all types of breast cancer.

**Preparing for a Mammogram**
Schedule your mammogram screening when your breasts are least likely to be tender.

If you're going to a breast imaging center for the first time, bring a list of the places and dates of mammograms, biopsies or other breast treatments you've had before.

If you've had mammograms at another facility try to bring those images with you or have them sent to the new facility so the radiologist can compare the new images to previous ones.

Do not use deodorant, powder, lotions or creams on your breasts or under your arms prior to the mammogram because the metallic particles in these products may interfere with the images.

Discuss any recent changes or breast problems with your doctor before getting the mammogram.

**Results**
A computer will compile the images for a radiologist to read and compare them to previous mammograms, if possible. A full report of the results will be sent to your personal doctor—he or she can discuss the results with you. It usually takes a week or two to receive your results, but the time may vary.

**Breast Cancer Screening During the Coronavirus Pandemic**
Take care of yourself and others by following these tips when you go to a medical facility.

- Wear a face mask
- Give yourself a few extra minutes because you may be screened upon entry
- Practice social distancing while in the waiting room
- Wash your hands or use hand sanitizer as needed

If you have additional questions regarding which mammogram is right for you or how to schedule a mammogram, please contact your personal doctor.

If you have questions about what is covered by your Network Health Medicare Advantage Plan, please call the member experience team at 800-378-5234 (TTY 800-947-3529) Monday–Friday, from 8 a.m. to 8 p.m.

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# Virtual Medicare Experience Network Health Events to begin in October

Network Health will host Medicare Experience Network events virtually to explain details of our 2021 Medicare plans being released on October 1.  Beginning October 5 -

October 14, Network Health will hose 33 virtual events.

In addition to hearing about changes to our plans, members will have a virtual experience with a variety of Network Health departments. Sales, pharmacy and member experience will partner together to present the information, answer questions and reinforce our brand in the counties we serve.

If members are unable to attend virtually, phone-only sessions are available. Members will also receive their annual notice of change at the end of September and plan information in Concierge in early October. Members can also call the member experience team, sales or their agent with questions about how their plans are changing for 2021.

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# Provider Data Validation Using NPPES NPI Provider Data

Network Health is asking providers to begin updating their NPPES provider data to help maintain the accuracy of their provider directories.

NPPES allows providers to attest to the accuracy of their NPI data. If a provider's information is correct, they will be able to attest to it and NPPES will record and reflect the attestation date. If the provider's information is not correct when they request any change to the NPI record, the provider will be able to attest to their changed NPI data, resulting in an updated certification date.

CMS will publish the latest certification date for each NPI in the NPI Registry as well as the NPPES dissemination file. Network Health will be using this data to aid us in the development of our provider directories, however, we can only use the most current data published, therefore, it would be imperative that you attest to the data regularly. **NPPES was recently updated to allow providers to input multiple addresses to support other work locations.**

Network Health will access core NPPES data weekly i.e., provider name, provider specialty, provider address, provider telephone number. Collectively, these data elements represent 91% of the CMS provider directory review errors found. NPPES data will be compared to your provider data which is already being submitted and serve as an important resource to improve Network Health's provider directory reliability and

accuracy.

We encourage you to access the NPPES webpage at https://nppes.cms.hhs.gov today as well as quarterly to update and/or attest to your provider data. It will be imperative to ensuring provider directory accuracy to our members.

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# Advance Care Planning Billing and Referral - What you need to know

Providing Advance Care Planning (ACP) interventions has been found to have a significant effect on patients' well-being. It has been found to decrease life-sustaining treatment, increase hospice utilization and prevent hospitalizations. It allows health care providers the opportunity to have conversations with their patients around end-of-life wishes and positively impact the quality of end of life care. The Center for Medicare and Medicaid Services (CMS) recently approved reimbursement to health providers for ACP counseling.

Medicare waives the coinsurance and the Medicare Part B deductible for ACP when you meet all the following:

- Provided on the same day as a covered Annual Wellness Visit (AWV)
- Furnished by the same provider as a covered AWV
- Billed with modifier –33 (Preventive Services)

Voluntary ACP is a preventive service when billed on the same claim with the AWV (HCPCS codes G0438 or G0439) on the same day by the same provider, so CMS waives the deductible and coinsurance for the service. If the AWV is denied for exceeding the once-per-year limit, Medicare can still make the ACP payment. In that case, CMS applies the deductible and coinsurance to the ACP service.

**The deductible and coinsurance DOES APPLY when ACP is provided outside the**

**covered AWV.**

NOTE: Critical Access Hospitals (CAHs) may bill ACP services using type of bill 85X with revenue codes 96X, 97X, and 98X. Medicare bases the CAH Method II payment on the lesser of the actual charge or the facility-specific Medicare PFS.

Network Health has trained staff to provide Care Management services to our members and can provide Advance Care Planning support. If you would like to refer a member to Care Management, visit the provider resources page at: networkhealth.com/provider-resources, select Wellness Programs, choose Care Management and then use the online form to complete your request. You may also call Care Management directly at 1-866-709-0019 Monday - Friday, from 8 a.m. to 5 p.m.

Additional information can be found here.

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# SCIO Audits for Skilled Nursing and Home Health Care

We wanted to provide some additional clarification surrounding the audit process with SCIO. SCIO reviews your claims and medical records, if there are findings, they will send you a report.

You can discuss these findings directly with SCIO. If you do not respond to their findings within 30 days, your claims will be automatically be adjusted. Additionally, you do not have to submit a corrected claim. The adjustments will be taken through our adjustment process.

SCIO follows Network Health's provider dispute process, which is one level of dispute for participating providers. It is important to submit all appropriate medical documentation for all claims that are submitted for review.

Below is a link to the SCIO provider reference guide and if you have questions regarding the audit, please reach out to your provider operations manager.

Click here to view.

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