January 2020

The pulse

network health

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

CPT and HCPCS January Code Updates

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

There are new codes that will require prior authorization and these services fall within our current authorization, experimental and/or genetic review processes. You can find a list of all services requiring prior authorization 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 and/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 departments Monday through Friday, 8 a.m. to 5 p.m.

- **Commercial** - Call 920- 720-1600 or 800-236-0208. For questions specific to behavioral health utilization, call 920-720-1340 or 800-555-3616.
- **Medicare** - Call 920-720-1602 or 866-709-0019

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

Provider Directory Compliance

On January 3, 2020, CMS released a memo and FAQ regarding the use of NPPES as a resource to improve the accuracy of plans' online provider directories. The memo provides details regarding how CMS will develop NPPES and how plans can use it to improve their own provider directories.

The FAQ can be found at the following link: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.html.

It's important providers update their information via the NPPES website, as we use this information for validation of our directories and for our Medicare claims pricers.

Availability of Utilization Management Criteria

The determination of appropriate care is based on written criteria found on sound clinical evidence. The written criteria are reviewed and approved annually by actively-participating practitioners. As available, Network Health follows CMS National Coverage Determinations (NCD) and Wisconsin Regional Local Coverage Determinations (LCD) for application to its Medicare Advantage membership. The determination of appropriateness of care for which there is not an NCD or LCD is available is based on written criteria founded on sound clinical evidence.

Criteria are available to providers, practitioners and/or members upon request.

Providers, practitioners or members may submit requests via telephone, fax, electronically, in person or USPS. 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 Provider Directory and Member Reference Guide, denial letters and/or newsletters. Once the request is received, care management associates send the requested criteria to the requestor via fax, electronically or USPS. Materials can also be picked up in person at the Network Health office.

Practitioners, members or participants that would like a copy of specific utilization criteria may call the care management department. Our associates are available Monday through Friday from 8 a.m. to 5 p.m. 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 needing these services should call 800-947-3529. Callers may leave a message 24 hours a day, seven days a week.

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Home Ventilator Claims

Effective March 1, 2020, Network Health will only allow a claim for a home ventilator to be billed with one unit every 30 days. If a claim is received with more than one unit or at a frequency less than 30 days, your claim will pend for medical necessity review, please provide pertinent medical records supporting your claim.

Skilled Nursing and Home Health Care Audit

Network Health is collaborating with SCIO Health Analytics® to implement new solutions designed to assist providers with billing accuracy and to enhance the provider experience with Network Health's claims processing. Providers may receive important correspondence and other information from them regarding claims submitted to

Network Health. SCIO uses a proprietary algorithm that can identify potential coding errors. The number of audits per provider can range from 1-25 a month dependent upon the number of errors found. The audits will have a 12-month period look back and will apply to commercial and Medicare claims.

SCIO Health Analytics®
SCIO's post-pay auditing involves retrospective provider-focused reviews for compliance with coding, documentation, medical necessity, contractual and other regulatory requirements. SCIO's efforts will supplement existing post-pay audit activities by Network Health.

For skilled nursing, the following steps will occur.

- Desk audits will be conducted which may focus on the length of stay, RUG/PDPM scores billed, revenue codes, billed charges and facility error rates.
- Medical records are requested and reviewed to ensure accuracy of the billed codes.
- RUG audit consists of one medical record request encompassing the entire member stay.
- Auditors analyze the medical records and calculate the RUG score.
- The difference between the RUG score billed and the validated RUG score are identified.
    - Elements of the verification include:
        - Compliance with MDS completion at the specified intervals
        - Accurate calculation of a RUG score and medical record supports RUG level billed
        - Total number of therapy minutes and treatment days
        - Amount and frequency of staff support utilized by the member to complete ADL activities
        - Confirm each assessment billed for the appropriate number of days

For home health, the following steps will occur.

- Desk audits will be conducted which may focus on the provider and/or patient.
- Medical records are requested and reviewed to ensure accuracy of the billed codes.
- Services reviewed are for home health agencies and include nursing and ancillary services such as physical, speech, or occupational therapies.

- Codes are described with CPT and HCPCs with details of the documentation to support the code being billed.
    - Elements of the verification include:
        - Confirmation of physician ordered for skilled services provided
        - Verification of homebound status as defined by the plan
        - Verification that services are covered as defined by the plan
        - All documents are properly signed
        - Documentation of plan of care
        - Other criteria specific to the plan or regulatory guidelines

Pricer Updates

As we begin the new year, please note the following updates.

- The Centers for Medicare & Medicaid Services (CMS) has not finalized fee schedules for January 2020. Once the fee schedules are final, Network Health has 30 days from the finalization date to implement those fee schedules in our claims processing center. We will not go back and reprocess claims back to January 1, 2020. This is in accordance with our **Contract Pricing Updates Policy** found on networkhealth.com. We will be communicating the date of the CMS final fee schedules.
- We will be making a change in how we process critical access method II claims. The professional charges on the claim will be processed according to the Wisconsin physician fee schedule effective January 1, 2020. Please note, the rates will not be updated quarterly, but will remain at the January rates. Because of this change, claims will be held until we receive notification from CMS that the Wisconsin physician fee schedule is final.

If you are not a current subscriber to The Pulse and you would like to be added to the mailing list, please email us today.

Current and archived issues of The Pulse, The Script and The Consult are available at networkhealth.com/provider-resources/news-and-announcements.

Don't forget to check us out on social media

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