March 2022

The pulse

eviCore Provider Portal Training Sessions

Provider training sessions are offered by eviCore Healthcare twice a week to help ensure smooth and timely prior authorization reviews for our provider partners. The eviCore provider portal training sessions focus on how to navigate the eviCore provider portals and what information is required to complete timely reviews. These sessions are free of charge and offered every Tuesday and Thursday.

Network Health encourages this training for all new employees as well as any current employee needing refresher training. Here is a complete list of services requiring prior authorization review from eviCore Healthcare.Your employees can register for an eviCore provider portal training session by following these steps.

- Go to eviCore.webex.com
- Select “WebEx Training” from the menu bar on the left
- Click the "Upcoming" tab-choose "eviCore Portal Training"
- Click “Register” next to the session you wish to attend
- Enter the registration information

Registrants will receive an email containing a toll-free phone number, meeting number, conference password and a link to the web portion for the session they sign up for. Please keep this registration confirmation e-mail until the day of the session for easy log-in.

New and Reminder Network Health Payment Policies

- Physical Therapy/Occupational Therapy Assistant Policy: This new payment policy is effective May 1, 2022 and is in alignment with the Centers for Medicare & Medicaid Services (CMS).
- Network Health Sequestration Policy-Medicare Advantage: Just a reminder, beginning April 1, 2022 the payment reduction will be increased to one percent per the CARES Act.

Please note, we develop payment policies on a regular basis and updates are announced in The Pulse. All payment policies are available here on our website.

As a reminder, please ensure your employees are up to date with all of our policies. Please reach out to your provider operations manager with questions.

Reminder to Review the EDI Claims Rejections Report

As a reminder for all providers, you must review the EDI Claims Rejection Report located within the provider portal to ensure claims aren't rejected due to clerical errors or because a provider/member was not added to the system. Network Health does not reject the claims through the EDI process.

Your clearinghouse may indicate the claim was accepted, however; the claim will not come back through your clearinghouse as rejected. It is very important to check this report if you have not received payment within 30 days.

If you have any questions on how to access this report, please reach out to your provider operations manager.

EDI Claim Submissions – COB and Corrected Claims

Reminder, Network Health secondary claims, along with corrected claims, may be submitted electronically for claim processing. Please use the correct designation payer loop(s) when submitting claims as the secondary payer.

When submitting a corrected UB04/facility claim, please use bill type XX5, XX7 or XX8 indicating it is a correction to a previous claim submission. When submitting a HCFA-1500/professional claim, please indicate resubmission code 7 in box 22 along with the original claim number.

If you have additional questions, please review our Claim Submission Policy, or reach out to your provider operations manager.

How to Avoid eviCore Denials and the Need to Appeal

Did you know the most common reason for denied prior authorization requests is due to missing clinical information within the case request? To avoid extra time and effort to appeal, make sure all necessary clinical information supporting the request for procedure or service is included with your eviCore prior authorization request from the start.

A list of required clinical information can be found on the Required Clinical Information Checklist.

Important: Prior authorizations for requested services following clinical and/or medical necessity guidelines are generally approved in real time (within seconds on submitting the request on the eviCore portal at eviCore.com). To connect directly to the eviCore Guidelines, please visit Clinical Guidelines.

ConnectCenter – FREE Program for Providers Submitting Paper Claims

Network Health has implemented a free program for providers submitting paper claims. In partnership with Change HealthCare, providers will have the ability to submit claims electronically to Network Health with ConnectCenter. The benefit of signing up for this free service saves your team time, reduces administrative costs and assists Network Health in moving towards a paper reduction environment.

Please reach out to your provider operations manager for additional information.

Medical Record Requests for Risk Adjustment

As a Medicare Advantage plan, Network Health is required to submit member diagnosis and demographic information to the Centers for Medicare & Medicaid Services (CMS). Health plans like Network Health create internal risk adjustment programs to help monitor their member population, improve quality of care and increase the accuracy and completeness of these data submissions in order to achieve the most accurate payments from CMS for their member population. The risk adjustment model distributes payments to payers based on an expectation of what the member's health care will cost. For example, a member with type 2 diabetes and high blood pressure merits a higher payment than a healthy patient, as their cost of health care will differ. By risk adjusting plan payments, CMS can make accurate payments to health plans for enrollees with different expected medical costs.

Our review of medical records is a compliance measure to ensure our data submissions and payments from CMS are based upon reliable and accurate records from physicians and facilities. These chart reviews aim both to highlight missing diagnoses and to locate diagnoses that were added in error. Both should be sent to CMS to adjust their payments to us. Our goal is to capture the full burden, no more, no less, of illness each year for our members. CMS has strict criteria concerning the medical record documentation used for risk score calculation. Only records signed by approved provider types for services performed in approved locations can be used for diagnosis validation. While any health care provider with a National Provider Identifier (NPI) may submit claims for payment of services, only face-to-face encounters with approved specialty types are acceptable for abstracting diagnosis codes for risk score calculation.

If a chronic condition is not recaptured from a previous year, the member's risk score will

decrease for the current year. Likewise, if additional conditions are reported, the member's risk score will increase from what it was in the previous year. To maintain predictability in health care costs and revenue, Network Health relies on its risk adjustment program and the accurate and consistent submission of all conditions each year.

Providers play an important role in our risk adjustment program. An engaged partnership with Network Health is vital to bringing needed and valuable benefits to your patients. For instance, Network Health uses premiums and risk adjustment payments to offer our members enrollment in exercise programs, case or disease management, transportation to medical appointments, and other needed services. We use diagnosis codes submitted on claims to identify what types of programs are needed and who needs them.

Due to the volume of records we review, we use outside vendors to assist in the collection of records. You may be contacted by Inovalon or GeBBS Healthcare to submit specific records or have the vendor come on site to review the records. **This review is not a medical necessity review.** A letter outlining the program and a list requested records will be sent to you, along with several retrieval options to allow you to choose what works best for you and your employees.

We appreciate your partnership and cooperation. If you have any questions, please contact Emily Vander Heiden, supervisor risk adjustment at 920-628-7107 or evanderh@networkhealth.com.

Current Clinical Practice Guideline for Adult Depression

The Department of Veterans Affairs/ Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Major Depressive Disorder version three, developed in April 2016, was adopted by Network Health in 2018.

The VA/DoD guideline has been reviewed and approved for continued use in February 2022 and remains the most up-to-date, thorough and complete U.S. based guideline for treatment of major depressive disorder.

Although developed for the VA patient population, this guideline is applicable to the population with major depressive disorder seen by Network Health contracted providers. The guideline does not provide recommendations for management of major depressive disorder in children or adolescents.

The target audience of the VA/DoD guideline includes primary care providers,

psychologists/non-physician behavioral health clinicians and social workers.

Provider Resources for New and Existing Customers

Please remind all providers, those established or new to your practice, of the following.

1. Member's Rights and Responsibilities
2. Prior Authorization Requirements
3. Payment Policies and Procedures
4. Appointment Access Standards (Network Management policy)
5. Population Health Standards and Initiatives
6. Pharmacy Formulary and Authorization Requirements
7. Credentialing Policies and Procedures

You can find all the information at networkhealth.com/provider-resources/index.

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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