May 2020

Follow-Up After Hospitalization for Mental Illness

For those aged 18-44 years old, mental health illnesses are the third most common cause of hospitalization in the United States. One study showed mental illness accounted for 18.7% of pediatric admissions, with a 30-day readmission rate of 8.0%.

Patients hospitalized for mental health issues are vulnerable after their discharge, making timely follow-up care by trained mental health clinicians critical for their health and well-being.

Mental health clinicians are specifically qualified to identify potential reactions to medication changes made during hospitalization, as well as coping difficulties patients experience while transitioning back to school, work and home.

The HEDIS measure, Follow-Up After Hospitalization for Mental Illness (FUH), assesses the percentage of adults and children six years of age and older who were hospitalized for treatment of mental health disorders and had a follow-up visit with a mental health

practitioner within seven days of discharge and within 30 days of discharge.

The measure requires follow-up to be with a mental health practitioner due to their specific qualifications to identify challenges for this population. Timely follow-up care after hospitalization for mental illness decreases the likelihood of readmission, promotes better continuity of care and results in improved outcomes.

How can health care providers impact follow-up care?

- Educate patients on the importance of following up with a mental health provider after hospitalization
- Promote early patient and family engagement in discharge planning
    - Schedule follow up appointments prior to discharge, utilizing telehealth services to bridge access gaps when appropriate
    - Provide appointment details such as date, time, provider name and address
    - Provide culturally competent care - a patient's culture and belief system can influence if they will seek help, what type of help, what coping styles and supports they have and what treatments might prove to be successful
    - Identify barriers to care such as transportation and financial concerns
    - Identify resources including community health resources
- Improve communication between inpatient and outpatient resources to ensure smooth transitions
- Connect patient to Network Health Case Management if not already established
    - Phone: 920-720-1340 or 800-555-3616

Hospital Audit Vendor Change

Network Health's hospital audit vendor, Equian, was recently bought by Optum. In the next few months you will see Equian's branding transition over to Optum's branding. Network Health will continue to use Optum for non-clinical-based hospital bill audits as we had in place with Equian. There will be no changes to the audits, just a name change of the vendor

Peer-to-Peer Process

Network Health made a slight update to our peer-to-peer (P2P) process.

The purpose of the P2P process is for the provider to supply new information or to clarify clinical presentation that wasn't available at the time of the review. It also allows them to clarify what was in the clinical record.

It is not to reiterate information conveyed in the records that we have already received, nor is it meant to be a debating forum. If providers disagree with our decision-making after we have reviewed all the pertinent clinical information, an appeal is the appropriate course of action.

A peer to peer (P2P) is available for medical necessity and experimental or investigational denials. This includes denials for services with non-participating providers/practitioners for plans with no out of network benefits available. If a service was denied as a non-covered benefit or benefit exhaustion, the next step is appeal or provider dispute as a P2P is not available.

Ideally, the person completing the P2P is the treating physician or other practicing professional/designee (physician assistant, nurse practitioner, resident or fellow etc.). We understand that at times the treating physician is not available, and a clinical colleague will fill in for the P2P. The individual completing the P2P should be on staff at the facility or otherwise display firsthand knowledge of the clinical environment.

We do not accept P2P from outside vendors (example: Optum) as they are not a clinical peer of the attending physician nor can they speak to the nuances of care at the facility. There is little value in an outside party rereading the same clinical information we have already used in our determination.

Spinal Orthosis Reminder

Just a friendly reminder on spinal orthosis (TLSO & LSO) requests from our utilization management department regarding our Medicare Advantage membership. Per CMS Local Coverage

Policy Article (A52500), a claim should not be submitted to Network Health in the following situations.

Payment for the spinal orthosis is included in the payment to a hospital or SNF if:

1. The orthosis is provided for a beneficiary prior to an inpatient hospital admission or Part A covered SNF stay; and
2. The medical necessity for the orthosis begins during the hospital or SNF stay (e.g. after spinal surgery).

-Or-

1. The orthosis is provided to a beneficiary during an inpatient hospital or a Part A covered SNF stay prior to the day or discharge; and
2. The beneficiary uses the item for medically necessary inpatient treatment or rehabilitation.

The claim is appropriate for submission to Network Health if:

1. The orthosis is medically necessary for a beneficiary after discharge from a hospital or PART A covered SNF stay; and
2. The orthosis is provided to the beneficiary within two (2) days prior to discharge home; and
3. The orthosis is not needed for inpatient treatment or rehabilitation but is left in the room for the beneficiary to take home.

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.

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

Authorization for Advanced Imaging Services Removed for Medicare

We've listened to you. To reduce administrative burden and evaluate processes that may not be impactful, effective June 1, 2020, Network Health will remove the prior authorization requirements for all advanced imaging services with eviCore for our **Medicare population only.**

The Advanced imaging program that no longer requires prior authorization for Medicare members includes the following services. Services performed on or after June 1 will not require prior authorization from eviCore.

- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET)

Authorization requirements with eviCore's advanced imaging program will continue for all Network Health commercial lines of business. A list of all services that require prior authorization from eviCore is available at www.evicore.com/implementation/healthplan/network-health-wisconsin .

For more information about authorization requirements, forms or lists of services that require review, visit the Authorization Information section of our website at www.networkhealth.com/provider-resources/authorization-information.

For prior authorization requests, or if you have specific questions regarding a service, contact our population health department Monday-Friday from 8 a.m. to 5 p.m.

Medicare: Call 920-720-1602 or 866-709-0019
Commercial: Call 920- 720-1600 or 800-236-0208

Please forward this information to those within your facility who will need to follow these processes.

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 hour a day, seven days a week.

Reminder: EDI Claim - Error Log Report

When submitting electronic claims, please review the EDI Claim/Error Log Report on a routine basis to ensure all claims submitted to Network Health are captured in our claims processing system. If there is an error with the claims data (e.g. member or provider not found), this will be displayed on the report which is in the Provider Portal/Claims/EDI Claim-Error Log Report. If you have any questions, please contact your Provider Operations Manager.

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Don't forget to check us out on social media

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