April 2020

The pulse

network health

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

CPT and HCPCS 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 on 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 Provider Authorizations section of the Network Health website.

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 department 8 a.m. to 5 p.m., Monday –Friday.

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

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

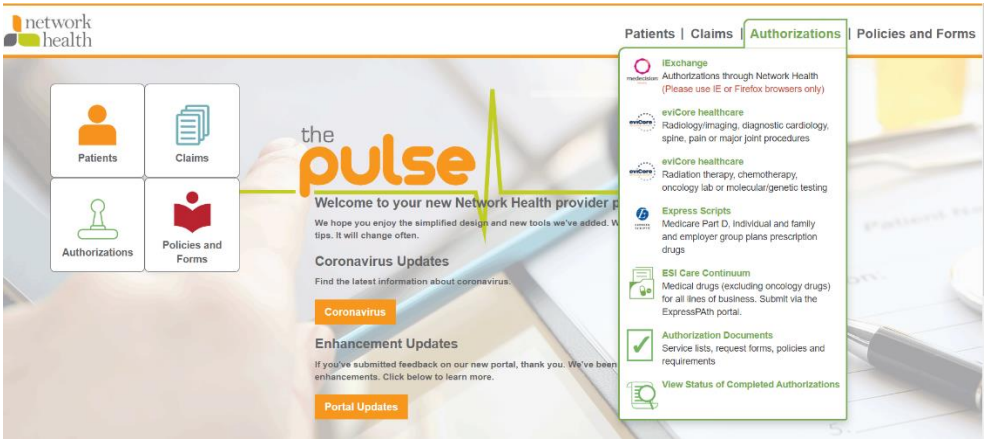
or speech-impaired individuals. Anyone needing these services should call 800-947-3529. All callers may leave a message 24 hours a day, seven days a week.

Utilization Management Survey

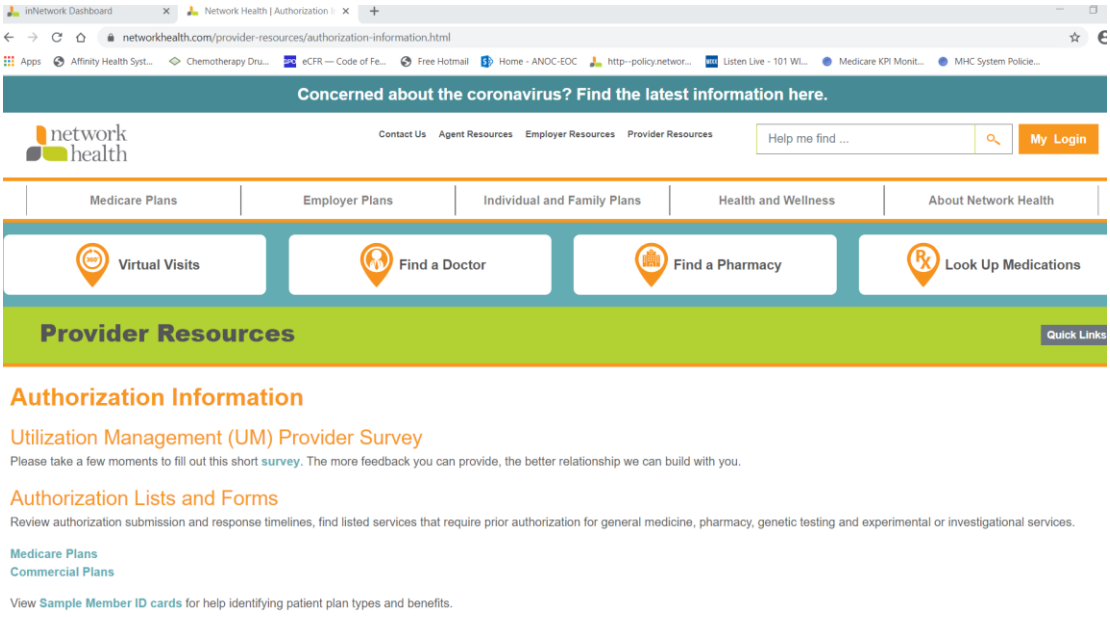
Network Health strives to be more than just another payer.
Our Hometown Advantage philosophy allows us to partner with our providers, making it easier and more efficient to do business with us. As our partner, your thoughts and opinions matter. The more information and feedback you can provide us, the better relationship we can build with you.

We have launched a survey specific to our utilization management (UM) program. We look forward to hearing from you. You can find the survey in a few locations on our provider portal and our website, please see below.

Provider Portal:



Network Health website:



Quality Measures Controlled Blood Pressure

At Network Health we pride ourselves in being the Hometown Advantage health plan and collaborating with providers to ensure high-quality care and patient experience. One of the tools utilized to measure the quality of care is the Healthcare Effectiveness and Data Information Set (HEDIS®).

The National Committee of Quality Assurance (NCQA) defines HEDIS as “a set of standardized performance measures designed to ensure that the public has the information it needs to compare organization performance.”

One of the standardized performance measurements collected to determine the quality of care and service is blood pressure.
This measure looks at members between the ages of 18 and 85 years old, who have had at least two medical office visits for hypertension. For the blood pressure to be considered adequately controlled during the measurement year, the most recent systolic and diastolic blood pressure must be less than 140/90 mm Hg.

If the member is noted to have a non-compliant reading, the provider can recheck the blood

pressure. HEDIS uses the lowest systolic and diastolic reading if multiple blood pressure readings were obtained the same day.

If you are unable to repeat a blood pressure measurement during the same visit, another option is to have the member schedule a blood pressure check for a future date.

We understand there are many factors that can affect a member's blood pressure, as well as the difficulty of the daily demands and workflow in the office. As we work together, we can improve the quality of care and patient experience members receive, as well as your HEDIS score.

Network Health Care Continuum FAQs

Please see the attached file for updates to the Network Health Care Continuum FAQs.

Click Here to View

Changes to ETF for Chiropractic

Network Health is changing how they manage chiropractic service requests for our State of Wisconsin membership beginning June 1, 2020.

Chiropractic service claims in excess of 20 visits will be reviewed for medical necessity. Please submit medical records and plan of care for review at the time of claim submission. Services deemed not medically necessary would result in provider liability for participating providers.

Network Health has developed a medical policy using review of written criteria based on sound clinical evidence. This written criterion was reviewed and approved by actively-participating practitioners. The 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.

Practitioners, members or participants who would like a copy of specific utilization criteria may call the care management department. Our associates are available from 8 a.m. to 5 p.m., Monday –Friday. 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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Medicare – 920-720-1602 or 866-709-0019

Changes to ETF for Therapy

Network Health is changing how they manage therapy requests for our State of Wisconsin membership beginning June 1, 2020.
Outpatient therapy services currently require prior authorization. All therapy requests in excess of 20 visits will be reviewed for medical necessity.

Network Health has developed a medical policy using review of written criteria based on sound clinical evidence. This written criterion was reviewed and approved by actively-participating practitioners. The 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.

Practitioners, members or participants who would like a copy of specific utilization criteria may call the care management department. Our associates are available from 8 a.m. to 5 p.m., Monday –Friday. 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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CGM Coverage with Network Health

The Buzz About Continuous Glucose Monitoring and Coverage by Network Health

People with diabetes check their blood sugar levels with some type of diabetic test strip system. Checking your blood sugar on a regular schedule helps you maintain control of your diabetes.

With Network Health, the One Touch and Accu-Chek brands are covered at a $0 cost share to Network Health Medicare members (Network*Cares* members pay 50¢). Are there other

options to check blood sugar levels? There are. Studies show that a Continuous Glucose Monitoring (CGM) system can provide this benefit for better control of blood sugar.

A CGM is not for every person with diabetes. If you qualify and are interested in being trained on how these new meters work, it may mean a big difference in keeping your blood sugar under control and avoiding hypoglycemic (low blood sugar) episodes.

Two CGM systems, Dexcom and FreeStyle Libre, are covered by Network Health. Both have their own unique features for monitoring blood sugar levels, so you can work with your personal doctor to select the most appropriate system. Both systems do not require daily finger sticking, making them a comfortable alternative to other testing systems. Both covered CGM systems require a physician to complete a Prior Authorization to make sure you are an ideal candidate for the CGM system.

Network Health is one of only two Medicare plans that covers these two CGM systems at the $0 cost share when obtained at a retail pharmacy. Other plans will cover them through a Durable Medical Equipment (DME) company, where you pay 20% of the CGM system cost.

Interested in learning more? Contact a pharmacist in the Network Health pharmacy department by calling 920-720-1696 or by emailing PharmacyBenefits@networkhealth.com. You'll receive a member-friendly brochure that reviews these two types of systems in more detail.

These CGM systems help our diabetic members keep their blood sugar under control, improving long-term health.

Vaccine Coverage under Medicare

Vaccines under Medicare can fall under Part B or Part D coverage. Getting your Part D vaccines at the pharmacy is the lowest cost option when compared to receiving it at the doctor's office.
Vaccines covered under Medicare Part B

- Hepatitis B vaccine for patients at high or intermediate risk
- Influenza vaccine
- Pneumococcal vaccine (e.g., Prevnar13 and Pneumovax 23)
- Vaccines directly related to the **treatment** of an injury or direct **exposure** to a disease or condition (e.g., receiving a tetanus shot after suffering a puncture wound)

Medicare Part D vaccine coverage

- Does not cover any vaccines already covered under Medicare Part B
- Covers all other commercially available vaccines as long as it is deemed reasonably and necessary to prevent illness
- Examples – Shingrix, tetanus boosters (not used for treatment, injury or direct exposure to a disease)

For additional questions related to Network Health reimbursement of vaccines, click here.

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.

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Don't forget to check us out on social media

networkhealth.com
1570 Midway Place
Menasha, WI 54952
800-826-0940 or 920-720-1300