January 2026

The pulse

network health

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

New Prior Authorization requirements with EviCore by Evernorth effective April 1, 2026

Effective April 1, 2026, Network Health is expanding its partnership with EviCore by Evernorth, and new prior authorization requirements will be added for Site of Care program for Medical Oncology services for Commercial and Exchange (ACA) memberships.

Providers will be directed to choose a non-hospital / preferred site of service. When a hospital or non-preferred site is selected, the requester will be required to select an appropriate exception reason to be assessed by an EviCore clinical reviewer. Services performed in conjunction with an inpatient stay, 23-hour observation or emergency room visit are not subject to authorization requirements.

- This is specific for oncology treatment delivered in a hospital setting (outpatient) and applies to Check Point Inhibitors (CPIs) when requested as monotherapy.
    - o Ipilimumab (Yervoy)
    - o Tremelimumab (Imjudo)
    - o Pembrolizumab (Keytruda)
    - o Nivolumab (Opdivo)
    - o Nivolumab SQ (Qvantig)
    - o Nivolumab and Relatlimab-rmbw (Opdualag)
    - o Atezolizumab (Tecentriq)
    - o Atezolizumab SQ (Tecentriq Hybreza)
    - o Cemiplilimab (Libtayo)

    - Dostarlimab (Jemperli)
    - Durvalumab (Imfinzi)
    - Retifanlimab-dlwr (Zynyz)
    - Tislelizumab (Tevimbra)
    - Avelumab (Bavenzio
    - Toripalimab (Loqtorzi)

- Authorizations previously approved will be honored. This new authorization requirement is for all renewals or initial requests.
- These oncology related updates will go live on April 1, 2026, but providers can reference current site of care criteria here Pharmacy Information**.**

EviCore by Evernorth will be leading orientation sessions designed to assist you and your staff with the new prior authorization program. We encourage you and your teams to attend one of these informative sessions to ensure your understanding of the prior authorization process and changes. Over the next few weeks, please watch for additional communications that will include the dates and times for these training opportunities and instructions on how to sign up for a session.

2026 Sample Member ID Cards

Our 2026 Sample Member ID cards are available on our Provider Resources page.

Please click here to view sample ID cards for our Individual and Family, Commercial, Self Funded, TPA, Family Savings and Medicare Advantage Plans.

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 our website.

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 Authorization Information section of our 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 population health department Monday through Friday; 8 a.m. to 5 p.m.

They can be reached at 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.

Updated Payment Policies

The Medicare Advantage Annual Wellness/Preventive Exam/E&M Exam policy has been updated requiring providers to submit all services on a single claim. If services are submitted on separate claims, each claim will be denied, and the provider may submit a corrected claim that includes all services on one claim. This policy is effective February 1, 2026.

The Radiopharmaceutical Reimbursement Policy (Medicare) has been updated with the current pricing for 2026.

If you have any questions on these policies, please reach out to your provider operations manager.

Reminder to Review the EDI Claim Rejection Report

Please review the EDI Claim Rejection report if you have not received a payment or denial from Network Health within 30 days of submitting your claim. This report is

available on our secure provider portal and will show whether a claim was rejected due to a member or provider billing error.

Please note that while your clearinghouse may indicate the claim was accepted, rejected claims may not be returned through the clearinghouse. If the claim is not available in our system, we are unable to review it for payment. It is the provider's responsibility to review the rejection report to confirm the claim has been accepted into our claims processing system.

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

Appointment Access Requirements

As a reminder, as part of our NCQA accreditation, our providers must meet the following appointment access times in order for us to maintain our accreditation. Here are the appointment access standards that must be met.

For Primary Care Services

1. Regular or routine care within 60 days of request
2. Urgent care appointment within 48 hours of request

For Specialist Services

1. Care within 30 days of the request
2. Non-life threating, urgent appointment within 48 hours of request

For Behavioral Health Services

1. Non-life-threatening emergency within 6 hours of request
2. Urgent care appointment within 48 hours of request
3. Initial visit for routine care within 10 business days of request
4. Follow up appointment for a routine care visit within 30 days of request

Additionally, you must have an answering service, on-call provider, or message to direct patients to the emergency room for after-hours calls.

Provider Resources for New and Existing Providers

- Member's Rights and Responsibilities
- Prior Authorization Requirements
- Payment Policies and Procedures
- Appointment Access Standards (Network Management policy)
- Population Health Standards and Initiatives
- Pharmacy Formulary and Authorization Requirements
- Credentialing Policies and Procedures You can find all the information here.

MDPP Elevator Speech

Nearly half of American adults aged 65 or older have prediabetes. Without weight loss or routine moderate physical activity, many of them will develop type 2 diabetes within a few years. People with prediabetes are also at higher risk of having a heart attack and stroke. The Medicare Diabetes Prevention Program (MDPP) , offered by Network Health, can help make lasting changes to prevent type 2 diabetes and improve overall health. The program is free for participants who are enrolled in Medicare or Medicare Advantage plans and it is part of the National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC). It is backed by years of research showing that program participants aged 60 and older can cut their risk of type 2 diabetes by 71 percent—by losing weight, eating better, and being more active.

Participants will receive a full year of support from a lifestyle coach and peers with similar goals, along with tips and resources for making lasting healthy changes. The program provides weekly 1-hour core sessions for up to 6 months and then monthly sessions for the rest of the year. Participants will also learn how to manage stress, set and achieve realistic goals, stay motivated, and solve problems. Participants may even

be able to manage other conditions like high cholesterol or high blood pressure with fewer medications.