June 2026

The pulse

network health

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

Epic Tapestry Link Implementation for Prior Authorizations Coming Soon!

Effective August 10, 2026, Network Health will be implementing Epic Tapestry Link for online authorizations (non-Evicore and non-CCUM), which will be replacing iExchange.

Here's what you need to know.

- iExchange will no longer be available as of Friday, August 7, 2026.
- As part of the transition to Epic Tapestry Link, we will provide a **14-calendar day** grace period during which providers may continue to submit prior authorization requests. Standard prior authorization timeframes resume on **Friday, August 21, 2026.**
- You will be able to access Epic Tapestry Link on Monday August 10, 2026, via our secure provider portal, and you may also SSO to EviCore and CCUM via Epic Tapestry Link.
- Please click here to register and navigate to the **"I'm a provider"** tab to register for our provider portal if you are not already a registered user. If you need assistance in registration, please reach out to your provider operations manager.
- Prior authorizations that were previously entered in iExchange will be carried over into Epic Tapestry Link.
- Additional information will continue in future newsletters, as well as direct emails from your provider operations manager.
- If you have any questions, please reach out to your provider operations manager.

Changes to Prior Authorization Requirements for Home Ventilator (E0466) Effective August 1, 2026

Effective August 1, 2026, prior authorization will be required for HCPCS code E0466 – Home ventilator, any type, used with noninvasive interface (e.g., mask, chest shell) for both Commercial and Medicare lines of business.
All requests for E0466 must be submitted to the Network Health Utilization Management department for review prior to services being rendered.

You can find a list of all services requiring prior authorization online at 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 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.

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

Effective July 1, 2026, the following services will require prior authorization from EviCore by Evernorth for Network Health members.

- Cardiac Imaging - for our Medicare lines of business (this requirement is already in place for all commercial membership)
- Cardiac Implantable Devices (CID) - for all Medicare and Commercial members in all lines of business. This includes removal and/or placement (or replacement) of: Pacemakers, Defibrillators, Cardiac Resynchronization Therapy and Pulmonary Artery Pressure Sensors.

EviCore employs board certified specialists, including cardiologists and cardiothoracic surgeons, for peer review of these requests. Peer to peer discussions can be scheduled at your convenience directly with the reviewing physician. As a reminder, approval from EviCore is limited to the procedure itself. For procedures involving a planned inpatient stay, providers must submit a separate authorization request to Network Health for the

inpatient level of care, even after the procedure has been approved.

EviCore-led trainings were held during the month of June. If you or your team were unable to attend one of these sessions, you are encouraged to review the CID program orientation slide deck and all other cardiology program resources here: https://www.evicore.com/resources/healthplan/network-health-wisconsin.

Provider Dispute Portal and Corrected Claim Submissions

Our provider dispute portal allows providers to securely submit provider disputes, view previously submitted disputes and submit medical records. If you would like to submit a corrected claim, please do not utilize the provider dispute portal as corrected claims submitted through the portal will be rejected. Please follow our Claim Submission Policy for all corrected claim submissions.

Updated Payment Policy

The Radiopharmaceutical Reimbursement Policy – Medicare has been updated with the most recent published rates. If you have any questions regarding the updates, please reach out to your provider operations manager.

Endoscopic and Bilateral Processing for Medicare Advantage Members

We should like to share a friendly reminder that endoscopic and bilateral claims specific to our Medicare Advantage members process a bit differently in our system than they do for our commercial membership. When a multiple endoscopic or 2-line bilateral claim is processed, the reimbursement is consolidated to a single claim line. The payment amount is correct, however reimbursement does not display on the subsequent line(s) because it has been rolled up to the primary procedure. This reimbursement methodology has been in place for several years and is not new configuration. If you have any questions or would like assistance reviewing a claim, please reach out to your provider operations manager.

Medicare Article: Hyaluronans Intra-articular Injections (A52420)

Effective July 1, 2026, Network Health will be enforcing the Billing and Coding: Hyaluronans Intra-articular Injections article outlined by CMS. It is expected that an injection (Synvisc-One™, Gel-One, Durolane®) or course of the injections (Synvisc®, Hyalgan®, Supartz® or Visco-3™, Euflexxa™**,** Orthovisc®, GelSyn-3™, GenVisc® 850, Hymovis®, TriVisc™, Synojoynt™, Triluron™) will not be repeated within six months time.

A repeat series of injections may be allowed when:

1. The indications continue to be met; and
2. Objective improvement in pain and functional capacity from the prior series of injections is documented in the medical record; and
3. The last injection (in a prior course) was given at least six (6) months ago.

Repeat injections for shoulder arthritis are limited to a single repeat course.

GLP-1 Bridge Program - a Resource for Providers

You may have started fielding patients' questions related to Medicare's GLP-1 Bridge program, going live on July 1, 2026, and at this point you may have more questions than answers, but you're not alone.

While the Bridge program will be operating outside of insurance, Network Health is still expecting to receive calls and indeed we have already seen an increase in Bridge-related questions coming through our member experience center.

The Centers for Medicare & Medicaid Services (CMS) may still be working on the finer details of the program, but we're happy to share with our providers what we know so far, arming you with the knowledge and resources needed for you and your patients. Please click here for details. If you have any questions, a member of our pharmacy team is happy to help, and they can be reached via phone at 920-720-1287 or via email at pharmacist@networkhealth.com.

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.

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.

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