October 2025

# The pulse

network health

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

## Register Here for Our Annual Practice Manager Meetings

Please join us for our end of year Practice Manager Meetings to review our 2026 updates. You have the option to attend in person or virtually for both sessions, and lunch will be provided for those that join us in person.

The Menasha meeting will be Wednesday, November 12 from Noon-1pm and the Brookfield meeting will be Thursday November 13 from Noon-1pm. Below is our meeting agenda, and we look forward to seeing you soon.

- Opening Remarks
- 2026 Utilization Management Updates
- 2026 Pharmacy Updates
- Credentialing and Provider Data Updates
- 2026 Benefit Updates

Register

## Provider Satisfaction Survey

Have you had a chance to complete our annual Provider Satisfaction Survey? Provider satisfaction is one of our key corporate goals, and all employees are committed to continually improving the provider experience.

To support this effort, we partner with our third-party vendor SPH to conduct an annual

Provider Satisfaction Survey, which is administered via email or telephone over a 4-6 week period. Once the survey is complete, the results are shared with our operational teams, and targeted action plans are developed based on the findings.

We recognize this is a very busy time of year, and greatly appreciate you taking the time to complete the survey. Your feedback helps to ensure the provider experience is above and beyond expectations.

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**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 online at www.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 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.

**Reminder - Annual Provider Attestation**

Network Health's annual provider attestation is available for completion on the home page of our provider portal. We would appreciate if you could complete the attestation for your office on or before November 30, 2025. If you have any questions, please reach out to your provider operations manager.

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**Updating Provider Information**

Please utilize our secure provider portal to update provider information or demographics such as adding a new provider, new location, and/or name change by selecting the **Provider Information Form** tile on the left hand side of the home page.

From here, you may select the Facility or Provider Information form, or the Provider Termination form. If you are terming a provider from your practice, please select the Provider Termination form, and provide a 30-day notice of the termination.

If you have a W-9 change, please reach out to your contract manager with the update.

Once the forms are completed, they are routed to the appropriate departments to ensure the updates are made as quickly as possible. If you have any questions, please reach out to your provider operations manager.

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**Telehealth Services Update**

We are pleased to share that we will continue offering expanded telehealth coverage for both medical and behavioral health services for our members. This includes the services that Original Medicare ended beginning October 1, 2025. Please continue providing these services to your patients and submit claims as usual-there is no change to the existing process. Providers should not bill the patient for these services.

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

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**Updated Payment Policy**

Effective 12/1/2025

Bill Audit Review– The dollar threshold was updated from $65,000 to $50,000 paid amount for the Commercial lines of business. If you have any questions, please reach out to your provider operations manager.

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**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.

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**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.

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