December 2021

Medical Record Requests for Risk Adjustment

As a Medicare Advantage plan, Network Health is required to submit member diagnosis and demographic information to the Centers for Medicare & Medicaid Services (CMS). Health plans like Network Health create internal risk adjustment programs to help monitor their member population, improve quality of care and increase the accuracy and completeness of these data submissions in order to achieve the most accurate payments from CMS for their member population. The risk adjustment model distributes payments to payers based on an expectation of what the member's health care will cost. For example, a member with type 2 diabetes and high blood pressure merits a higher payment than a healthy patient, as their cost of health care will differ. By risk adjusting plan payments, CMS can make accurate payments to health plans for enrollees with different expected medical costs.

Our review of medical records is a compliance measure to ensure our data submissions and payments from CMS are based upon reliable and accurate records from physicians and facilities. These chart reviews aim both to highlight missing diagnoses and to locate diagnoses that were added in error. Both should be sent to CMS to adjust their payments to us. Our goal is to capture the full burden, no more, no less, of illness each year for our members. CMS has strict criteria concerning the medical record documentation used for risk score calculation. Only records signed by approved provider types for services performed in approved locations can be used for diagnosis validation. While any health care provider with a National Provider Identifier (NPI) may submit claims for payment of services, only face-to-face encounters with approved specialty types are acceptable for abstracting diagnosis codes for risk score calculation.

If a chronic condition is not recaptured from a previous year, the member's risk score will decrease for the current year. Likewise, if additional conditions are reported, the member's risk score will increase from what it was in the previous year. To maintain predictability in health care costs and revenue, Network Health relies on its risk adjustment program and the accurate and consistent submission of all conditions each year.

Providers have an important role to play in our risk adjustment program. An engaged partnership with Network Health is vital to bringing needed and valuable benefits to your patients. For instance, Network Health uses premiums and risk adjustment payments to offer our members enrollment in exercise programs, case or disease management, transportation to medical appointments, and other needed services. We use diagnosis codes submitted on claims to identify what types of programs are needed and who needs them.

Due to the volume of records we are reviewing, we use outside vendors to assist in the collection of records. You may be contacted by Inovalon or GeBBS Healthcare to submit specific records or have the vendor come on site to review the records. **This review is not a medical necessity review.** A letter outlining the program and a list requested records will be sent to you, along with several retrieval options to allow you to choose what works best for you and your staff.

We appreciate your partnership and cooperation. If you have any questions, please contact Emily Vander Heiden, supervisor risk adjustment at 920-628-7107 or evanderh@networkhealth.com.

ConnectCenter – FREE Program for Providers Submitting Paper Claims:

Network Health has implemented a free program for providers that submit paper claims. In partnership with Change HealthCare, providers will have the ability to submit claims electronically to Network Health utilizing ConnectCenter. The benefit of signing up for this free service saves your team time, reduces administrative costs, and helps you meet Network Health's electronic claims submission requirement by January 1, 2022.

Please reach out to your provider operations manager for additional information.

New Payment Policy

Effective January 1, 2022, Network Health's Balance Billing policy will be effective for all lines of business. Network Health develops payment policies on a regular basis and provides notification in *The Pulse*. Please ensure your staff is familiar with our website to review any policy changes.

EDI Claim Submissions – COB and Corrected Claims

Reminder, Network Health secondary claims along with corrected claims may be submitted electronically for claim processing. Please use the correct designation payer loop(s) when submitting claims as the secondary payer.

When submitting a corrected UB04/facility claim, please use bill type XX5, XX7 or XX8 indicating it is a correction to a previous claim submission. When submitting a HCFA-1500/professional claim, please indicate resubmission code 7 in box 22 along with the original claim number.

If you have additional questions, please review our Claim Submission Policy, or reach out to your provider operations manager.

Contract Pricing Updates Procedure

Please take a moment to review our existing Contract Pricing Updates Procedure.

This policy is a helpful reminder as we look to the new year. If you have any questions, please reach out to your provider operations manager.

Provider Portal Enhancement

We've enhanced the provider portal for your convenience. Providers can now submit medical records via the claim dispute application in Network Health's provider portal.

Once signed in to the portal, select the **Claims** tab in the navigation menu and then select the **Claim Dispute/Medical Record Form** in the drop down. You may attach medical records to the specific Network Health claim number.

For additional questions regarding this enhancement, please reach out to your provider operations manager.

Part D Oncology Drugs Prior Authorization through eviCore

Network Health is expanding the Part D medical oncology prior authorization program with eviCore healthcare. Beginning January 1, 2022, eviCore, rather than Express Scripts will be completing the prior authorization request for Medicare Part D medications related only to oncology indications. Please note that all non-oncology drug requests will continue to be submitted through Express Scripts.

You are highly encouraged to attend one of the online orientation sessions. Please share this information with your provider teams, as appropriate.

Heart Failure Telemonitoring Provider Notification

In 2022, Network Health is eliminating a home telemonitoring benefit for Medicare members with heart failure. Starting January 1, 2022, we will no longer reimburse for this benefit. Eliminating this program impacts fewer than 100 Network Health Medicare members. Members were notified via the Annual Notice of Change that this benefit is being eliminated. In addition, members who have had a home telemonitoring claim in the last three months are being notified by letter. If providers or members have questions, you can contact the population health department at 866-709-0019, Monday–Friday from 8 a.m. to 5 p.m.

Frequently Asked Questions
What is the heart failure telemonitoring benefit that is being eliminated in 2022?
Prior to 2022, members with heart failure were eligible for home telemonitoring. The benefit was provided by participating home health agencies (HHA). The HHA gave the monitoring equipment to the member, evaluated the data as it was entered and contacted the member's provider, if necessary.

Why is Network Health eliminating the benefit for 2022?
We have very low utilization of this benefit.

When Network Health launched this benefit, we expected to see improvements to our members' health outcomes, such as reduced emergency department visits and reduced inpatient admissions. Over several years of gathering data through this benefit, we are not seeing improved outcomes or care patterns, and believe our members can be best served in other ways.

How many members used the benefit in the past few months?

About 80 members had a claim for the benefit in June or July of this year.

What options are available for members once the benefit sunsets?
Members can contact their cardiologist or personal doctor to learn about getting connected with a heart failure clinic.

If members are eligible for typical home care benefits, home care agencies may provide telemonitoring as an adjunct service.

Members can enroll in a provider's heart failure program or Network Health's heart failure condition management program and a nurse will reach out to them.

If you have any questions, please contact Jill Stoken directly at jstoken@networkhealth.com.

Provider Resources for New and Existing Providers

Please remind all providers, those established or new to your practice, of the following.

1. Member's Rights and Responsibilities
2. Prior Authorization Requirements
3. Payment Policies and Procedures
4. Appointment Access Standards (Network Management policy)
5. Population Health Standards and Initiatives
6. Pharmacy Formulary and Authorization Requirements
7. Credentialing Policies and Procedures

You can find all the information at: networkhealth.com/provider-resources/index.