September 2021

The pulse

network health

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

New Payment Policy

Effective November 1, 2021 Network Health will have a new payment policy for all lines of business:

• In accordance with CMS, when a claim is submitted with a CPT or HCPC code that carries a Status Code of B, the service will be denied as bundled.

The full policy will be posted shortly to our website. Please note, payment policies are developed on a regular basis, and announced in The Pulse. New and updated policies are posted to our website. Please ensure your staff is up to date with our policies.

Network Health Member Experience Call Center

Network Health is currently experiencing a staffing shortage in our member experience call center. We are known for providing outstanding service to our members, providers, and agents through our personable, experienced staff. Due to the staff shortage and upcoming Medicare Advantage and Marketplace open enrollment, there may be extensive wait times. We appreciate your patience and understanding, this is not our standard.

For faster service, please use our provider portal. You can check claim status, member eligibility, benefits, benefit accumulator, and prior authorizations. If you are not signed up on the portal and would like a demonstration, please reach out to your provider operations manager and they will be happy to assist you.

Additionally, Network Heath has 30 days to process a clean claim. If you call prior to 30 days, the member experience call center will not provide status on a roster of claims. Please use the portal for those types of inquiries and remember, Network Health does not reject claims via EDI, you must access the report via the provider portal.

These are unprecedented times for all of us and we appreciate your understanding and

cooperation. We will update you when our call center is fully staffed.

Attention Skilled Nursing Facility Providers

Important instructions for the Notice of Medicare Non-Coverage (Skilled Nursing Facility and Home Health Care Providers Only)

When Network Health Medicare Advantage members are discharged from a skilled nursing facility (SNF) or home health care (HHC) services, the Centers for Medicare and Medicaid Services (CMS) require that the standard CMS Notice of Medicare Non-Coverage (NOMNC) form be sent by providers to members on a timely basis.
You can find the NOMNC in our online **Medicare Provider Manual**.

To be compliant with the Code of Federal Regulations, 42 CFR 422.624, members must receive the NOMNC from their provider **no later than two days before the proposed end of services.**

The NOMNC informs members that their SNF or HHC services are ending and of their right to appeal through LiVanta, an independent quality improvement organization that is contracted with and paid by CMS.

The completed notice must include the following.

- Services to end
- The date coverage ends (dates must be no smaller than 12-point type, and if handwritten, notice entries must be at least as large as 12-point type and legible)
- The date the member received notification
- The member's unique identification number
- The member's signature

To access CMS' instructions on how to properly fill this out, go to the NOMNC form.

Reminder-Outpatient Physical and occupational Therapy Require Prior Authorization

Effective June 1, 2021, Network Health began requiring prior authorization for outpatient physical and occupational therapy. This includes therapy services SNFs are providing under Medicare part B coverage.

eviCore's Clinical Guidelines, CPT code lists, Frequently Asked Questions and request forms are available **here**. Please keep in mind, services performed without authorization may not be reimbursed and you may not seek reimbursement from members.

Chantix Recall

On September 16, 2021, Pfizer voluntarily issued a product-wide recall on Chantix 0.5 mg and 1 mg tablets due to the presence of nitrosamine. N-nitroso-varenicline at levels above the FDA acceptable intake limit poses a theoretical increased risk of cancer from long term ingestion. This is an expansion to their previous lot-specific recalls that occurred on July 2, July 19, and August 18.

If you prescribed this to a patient and the prescription was filled in the past 6 months, you and your patient will both receive a notification letter from Network Health, providing more detail about the drug recall and what to do. Additional information can be found here.

Varenicline, a generic version for Chantix, recently became available, providing a convenient alternative to brand name Chantix. Alternative treatment options that may be considered for smoking cessation are listed below:

Medication Name	**Medicare Cost**	**Commercial Tier**	**Healthcare Exchange Tier**
Varenicline	Tier 3	$0 cost to members 18 and older	$0 cost to members 18 and older
Bupropion HCl Products	Bupropion HCl SR – Tier 1	$0 cost to members 18 and older (Buproban and Zyban)	$0 cost to members 18 and older (bupropion HCl smoking deterrent products)
Nicoderm CQ	Over-the-counter	Over-the-counter	$0 cost to members 18 and older
Nicorette buccal gum or lozenge	Over-the-counter	Over-the-counter	$0 cost to members 18 and older
Nicotrol	Tier 3	$0 cost to members 18 and older	$0 cost to members 18 and older

Network Health Medicare Experience Events in October

Beginning October 6 to October 19, Network Health will host 15 virtual Medicare Experience Network Health events.

Sales, pharmacy, customer experience and member experience are partnering together to provide a one of a kind virtual experience for our members to discuss plan changes for 2022 and answer any questions they may have.

If members are unable to attend virtually, on demand recordings will be available. Members will also receive their annual notice of change at the end of September and plan information in “Concierge” in early October. Members can also call the member experience team, sales or their agent with questions about how their plans are changing for 2022.

Bone Mineral Density Scan Available to Medicare Members

Helping your patients receive the right care at the right time is what drives a great practice, especially after a traumatic fall that results in a bone fracture. Did you know that Medicare recommends men and women who experienced a fracture should have a bone mineral density test (BMD) within six months of the fall?

For some patients the fear of COVID-19 or the difficulty making it to the clinic for testing stops them from receiving this important follow-up care. Network Health partnered with PRN Home Health and Therapy, a local agency, to meet with members in their home and receive a complimentary bone mineral density (BMD) scan completed by a Registered Nurse.

The results are provided to the member and sent to their primary care provider to discuss a care plan to maintain bone health. The referral process is simple, just email the member details to Network Health at qi@networkhealth.com and someone from the quality health integration team will make arrangements to extend this free benefit to the member.

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

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Provider Data Validation Using NPPES NPI Provider Data

Network Health is asking providers to begin updating their NPPES provider data to help maintain the accuracy of their provider directories.

NPPES allows providers to attest to the accuracy of their NPI data. If a provider's information is correct, they will be able to attest to it and NPPES will record and reflect the attestation date. If the provider's information is not correct when they request any change to the NPI record, the provider will be able to attest to their changed NPI data, resulting in an updated certification date.

CMS will publish the latest certification date for each NPI in the NPI Registry as well as the NPPES dissemination file. Network Health will use this data to aid us in the development of our provider directories; however, we can only use the most current data published. It is imperative that you attest to the data regularly. **NPPES was recently updated to allow providers to input multiple addresses to support other work locations.**

Network Health will access core NPPES data weekly i.e., provider name, provider specialty, provider address, provider telephone number. Collectively, these data elements represent 91percent of the CMS provider directory review errors found. NPPES data will be compared to your provider data which is already being submitted and serve as an important resource to improve Network Health's provider directory reliability and accuracy.

We encourage you to access the NPPES webpage at nppes.cms.hhs.gov today as well as quarterly to update and/or attest to your provider data. It is imperative to ensure provider directory accuracy to our members.

Provider Data Validation

Network Health's Provider Informatics Department is now required by CMS and NCQA to obtain quarterly updates on provider and/or facility data. In the past, you may have

worked with an external company on behalf of Network Health.

As of February 15, 2021, Network Health has brought this process in-house. Now, someone from our Provider Informatics team will be reaching out to your group quarterly to obtain information to confirm that the information we have is accurate.

Clarifying the Difference Between Reopening, Peer to Peer and Reconsideration

Reopening, peer to peer, reconsideration. These are terms you've likely heard before. They may seem interchangeable, but they are separate processes that are uniquely regulated. Let's explore the differences and perhaps save you some time and confusion.

Peer to Peer:

The peer to peer (P2P) is an opportunity for the provider to provide new information or clarify clinical presentation that wasn't available at the time of initial review, or to provide clarity to what was in the clinical record. A P2P is not meant to reiterate information conveyed in the records that we have already received nor is it meant to be a debating forum. If the provider continues to disagree with our decision-making after we have reviewed all the pertinent clinical information, then an appeal/dispute is the appropriate course of action.

Reopening (Medicare (CMS) definition):

A reopening is a remedial action taken by a health plan to change a binding determination or decision even though the binding determination or decision may have been correct at the time it was made based on the evidence of record.

It is expected that health plans reopening process be used sparingly. CMS only allows reopening for specific reasons, the two most common are clerical errors and new and material evidence.

It is important to understand that a case cannot be reopened because the provider failed to submit the relevant clinical information in a timely fashion. New and material evidence means **it was not available or known at the time of the determination or decision** and may result in a change in that decision. There is no process for providers to formally request a reopening.

Reconsideration (First Level of Appeal):

This is the member's first step in the appeal process after a denial is issued to the member. During the reconsideration, Network Health will re-evaluate a denial determination, the

findings upon which it was based, and any other evidence submitted or obtained.

While these processes are similar, they are separate and distinct. Network Health is seeing an increase of situations where a provider, on behalf of a member, starts the reconsideration or appeal process through Network Health while simultaneously requesting a P2P with our vendor, eviCore. The best practice is to fully exercise your P2P rights before requesting a reconsideration or appeal through Network Health.

Did you know we have additional resources regarding these processes located here? networkhealth.com/provider-resources/authorization-information

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