February 2024

Change Healthcare Network Interruption

Network Health has been made aware that our vendor partner Change Healthcare (CHC) is experiencing a network interruption related to a cyber security issue. In the interest of protecting their partners and patients, Change Healthcare has disconnected their systems to prevent further impact. The national outage has affected real-time eligibility, claims submission, claims remittance advice and claims payment. This outage **does not** affect prior authorizations, pharmacy and MDLive.

Please use the provider portal to check member eligibility and claims status. As we navigate this significant outage, we will be posting updates to this page. If you have any questions or concerns, please contact your provider operations manager. If you are not registered for our provider portal, please click here, and select **I'm a provider** to begin the process. You may also contact our Member Experience team; however, you may experience longer hold times.

Networkhealth.com Provider Directory - Future Change

Network Health is excited to share we will assuming a new and improved online provider directory platform in the near future (anticipated start date April 1, 2024). This software will allow for many new innovations, incorporate Health Equity requirements, and allow for ease in our members searching for applicable providers and their information so members can make a more

informed decision on their healthcare needs. Watch for upcoming notices pertaining to the roll out of this exciting new software package.

Network Health MA Palliative Care Coverage

We've been hearing questions about Network Health's Medicare Advantage coverage of palliative care in 2024. For 2024, we want to assure you that palliative care services are covered, with appropriate copays to be applied per each member's benefit plan.

For 2024, Network Health Medicare Advantage plans removed the "Help with certain chronic conditions-palliative care benefit." In 2023, this benefit was that members paid a $0 copayment for one initial consultation and two follow up home or office-based palliative care visits for members with a diagnosis of cancer, congestive heart failure, COPD, chronic kidney disease, ESRD, rheumatoid arthritis, Alzheimer's, Parkinson's, multiple sclerosis and/or liver cirrhosis.

This supplemental benefit was intended to try and fill the need for palliative care to come into the home and reduce the cost sharing for members. We found that this specific palliative care benefit was not utilized because providers were not billing the palliative care codes Network Health was trying to cover. If your patients have questions about palliative care coverage, please have them call our member experience team at 800-378-5234.

Attention: Skilled Nursing Facility Providers

We have recently seen a disconnect related to SNF billing when a member leaves your facility and then returns within three days. Network Health follows the CMS billing requirements for interrupted stays.

The Interrupted Stay Policy effective concurrent with the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) for Medicare SNF reimbursement sets out criteria for determining when multiple SNF stays for a single member will be considered a single Part A benefit period rather than separate stays for the purposes of the assessment schedule and the variable per diem payment schedule.

The Centers for Medicare and Medicaid (CMS) define an "interrupted" SNF stay as instances where a member, who has been considered discharged from a SNF Medicare Part A stay,

subsequently readmits to the same SNF under a covered Part A stay during the “interruption window." This three-day window is marked from the first non-covered day of the initial Part A stay, to 11:59:59 p.m. on the third consecutive non-covered day. If a member readmits to the SNF under a covered Part A stay at any time during this interruption window, the admission would be considered a continuation of the previous stay.

For SNF stays under the Interrupted Stay Policy, the variable per diem schedule continues from the day of the previous discharge. An example of this would be if the member was discharged from Part A on day seventeen of their SNF stay (i.e., day seventeen is the member’s last covered day). If they readmit to the same SNF under a covered Part A stay two days after discharge, the payment rates resume at day eighteen upon readmission.

If the member is readmitted to the same SNF outside the interruption window, or to a different skilled nursing facility (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply, and the subsequent stay is considered as new stay.

Additional information is available through CMS at, helpful examples are included in the following links.

https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model#fact

https://www.cms.gov/files/document/r10024otn.pdf

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.

Medicare Diabetes Prevention Program

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.

Provider Portal

A friendly reminder that Network Health's secure provider portal is available 24/7, offering several features. All providers have single sign on, and are able to verify member eligibility & benefits, member accumulators, claim status, submit prior authorization requests for medical and pharmacy services, review prior authorizations statuses, as well as submit provider disputes. If you have not registered for the provider portal, you can find a step by step tutorial here. You may

also reach out to your provider operations manager with any questions, or if you would like provider portal training.

CMS Approved Behavioral Health Licensures

Effective January 1, 2024, CMS will recognize Marriage and Family Therapists and Counselors as billable licensures. If you have one of these licensures and would like to begin seeing Medicare Advantage members, please make sure that you are registered with CMS. If you are not currently registered, click here to begin the process. In order to see our Medicare Advantage members, you must opt-in to the CMS program.

Once we have validated that you are registered with CMS, and have a Medicare Advantage contract, we will add you to our claims payment system for that product. For those that are registered with CMS and have a Medicare Advantage contract, we are currently in the process of adding you to our claims payment system in order to see Medicare Advantage members. If you do not have a Medicare Advantage contract with us, please reach out to your contract manager.

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

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.

Current and archived issues of *The Pulse*, *The Script* and *The Consult* are available at networkhealth.com/provider-resources/news-and-announcements.

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Don't forget to check us out on social media

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