March 2024

The pulse

network health

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

Change Healthcare Outage Update

Network Health was able to quickly pivot during the Change Healthcare outage, and providers are able to submit claims via Availity or SDS. Additionally, we were able to work with our vendor, ECHO, and issue payments to our providers. We continue to explore real time eligibility vendors.

At this time, ConnectCenter is currently unavailable, with no timeframe as to when it will be available.

We have regular calls with Change Healthcare and will update you on our Change Healthcare outage page if more information becomes available. Thank you for your patience as we all work through these unforeseeable transitions.

2023 Annual Report

The 2023 Annual Community Report is now available. In this report you will see how we've invested in our members, communities and employees while maintaining excellence in quality ratings including our net promoter score which far surpasses our national competitors. Thank you for your continued partnership and helping Network Health make a difference in the lives of those we serve.

New & Updated Payment Policies

The Radiopharmaceutical Reimbursement Policy (Medicare) is effective May 1, 2024, and outlines Network Health's process when professional claims are submitted with HCPC codes A9500-A9800.

The Claim Submission Policy was updated to provide the processing requirements when a patient's coverage terminates during the date span listed on the claim.

The timely filing requirements were updated to include information for Non-Participating providers treating our Medicare Advantage members.

If you have any questions related to these policies, please reach out to your Provider Operations Manager

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CMS Approved Behavioral Health Licensure Process Change

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, and that you opt-in to the CMS program. You will receive a notice of approval of enrollment with a case number, you can check your case finalization status at ngsmedicare.com. Our Medicare pricer updates the provider enrollments on a quarterly basis, therefore, you will not need to send us any documentation. We will reprocess claims based upon the enrollment date as reflected within our pricer. If you do not have a Medicare Advantage contract with us, please reach out to your contract manager.

Adding Providers to your Practice

If you have a new provider joining your practice, please visit our secure provider portal to complete a Provider Information Form (PIF). You may also add a location by completing a Facility Information Form (FIF).

If the provider or location requires credentialing, you will receive an email from our Credentialing team with instructions to complete the credentialing application. Please note, the PIF and FIF are not credentialing applications, and if credentialing is required, care may not be rendered to a Network Health member until credentialing is completed.

Echocardiography Codes Prior Authorization Requirement Removed from eviCore

Effective April 1, 2024, Network Health has removed the prior authorization requirements for echocardiography services for all our commercial (non-Medicare) lines of business. Medicare lines of business do not have this authorization requirement in place. Providers no longer need to submit prior authorization requests for echocardiography services to eviCore. All other cardiology prior authorization requirements remain unchanged.

A complete 2024 listing of services that require prior authorization as well as our claims policies

can be found on our website at https://networkhealth.com/provider-resources/authorization-information.

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 at www.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.

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.

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.

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

Don't forget to check us out on social media

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