April 2023

How Do Health Plans Make Decisions?

Did you know that utilization decisions made about care by Network Health are based on the appropriateness of care and service? Care and service include medical services and procedures, behavioral health services and procedures, pharmaceuticals and devices. Decisions are based on written criteria founded on sound clinical evidence and on the benefits outlined in our member coverage documents. The written criteria are reviewed and approved annually by actively-practicing practitioners. Criteria are available to providers, practitioners and/or members/participants upon request. Requests for criteria can be submitted via telephone, fax to the numbers listed below. Electronic messaging through the provider portal, or USPS to our office location. Once the request is received, utilization management associates will send the requested criteria to the requestor via fax, electronically or USPS.

Network Health does not reward in any way practitioners or other individuals conducting utilization reviews for denying coverage for care or service. Nor does Network Health prohibit providers from advocating on behalf of members/participants within the utilization management program. Network Health does not use incentives to encourage barriers to care and service, and it does not make decisions about hiring, promoting or terminating practitioners or other associates based on the likelihood, or the perceived likelihood, that the practitioner or associate supports, or tends to support, denial of benefits. The medical directors, associates (or designees), utilization management staff and supervisors of this staff receive no financial incentive to encourage decisions that result in underutilization.

Network Health assures access to medical and behavioral health population health associates for our members and their practitioners and office staff seeking information about our care or utilization management programs. If you have questions about the care or utilization management program, please contact care management at 866-709-0019 (TTY 800-947-3529), Monday–Friday; 8 a.m. to 5 p.m. In addition, treating practitioners may discuss medical necessity denial determinations with a Network Health medical director by contacting us at the number above.

Callers have the option to leave a message 24 hours a day, seven days a week. Messages are retrieved at 8 a.m., Monday through Friday, as well as periodically during the business day. All calls are returned promptly. Calls received after business hours are returned the next business day. Providers may also send inquiries to the utilization management department via fax, and USPS. You can fax the utilization management department at 920-720-1916.

Network Health offers TDD/TTY services for deaf, hard of hearing or speech-impaired individuals. Anyone needing these services should call **800-947-3529**. Bilingual language assistance or translation services are also available. Callers may leave a message 24 hours a day, seven days a week.

Prior Authorization Request Forms Removal

To better serve you, our providers, our prior authorization request forms will soon be removed from our website. We encourage the use of our authorization portal, iExchange, which is available 24 hours a day, seven days a week, and provides real-time entry into Network Health's care management platform. Single sign on into iExchange is available directly from our provider portal.

iExchange information, including tutorials can be found here, https://networkhealth.com/provider-resources/authorization-information. If you need assistance or have a training need, please reach out to our utilization management team at 866-709-0019.

Osteoporosis Clinical Practice Guidelines

Network Health utilizes the American Association of Clinical Endocrinologists/American College of Endocrinology Clinical Practice Guidelines. Osteoporosis guidelines play an important role in guiding health care providers and patients by providing evidence-based recommendations for osteoporosis management. Recently, Dr. Sanders approved the clinical practice guideline. Network Health will continue to use the guideline that was approved 6/2021.

NEW Process for Adding Providers to your Practice

Effective March 1, 2023, Network Health is no longer accepting the paper Provider Information Form(s) for adding new providers to your practice. We have enhanced our Provider Portal, allowing providers to add or remove providers 24/7 via the Provider Information Form Quick Link located on the landing page of the provider portal. Please click here to review the form titled Locating and Submitting Provider, Facility and Termination Forms in the Provider Portal.* If you would like assistance locating the forms or a tutorial on how to use the forms, please reach out to your provider operations manager.

*Groups with delegated credentialing agreements may continue to submit updates via the roster process.

EDI Claim Rejection Report

If you have not received payment within 30 days of claim submission from Network Health, please review the EDI Claim Rejection Report located within the provider portal. The report will indicate if claims have been rejected due to a provider or member submission error. Your clearinghouse may indicate the claim was accepted, and the claim may not go back through your clearinghouse as rejected. If you have any questions on how to access this report, please reach out to your provider operations manager.

Member Cost Share Update When PHE Ends

As part of the COVID-19 Public Health Emergency (PHE), Network Health has been temporarily covering all COVID-19 vaccines, tests, and treatments at no cost share to the member. On January 30, 2023, the Biden Administration announced the PHE will end on May 11, 2023. This means as of May 12, 2023, Network Health plans will no longer cover COVID-19 tests and treatments at no cost share. The plan will, however, continue to cover COVID-19 vaccines received at in-network providers at no cost share. Additionally, with the end of the PHE there are no changes to the member *benefits*, for example Telehealth, which are determined based on their coverage documents. For questions, please call Member Experience at 855-580-9935.

Provider Resources for New and Existing Customers

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.

network health

Don't forget to check us out on social media

networkhealth.com
1570 Midway Place
Menasha, WI 54952
800-826-0940 or 920-720-1300