December 2024

2025 Contract Pricing Updates

Reminder for providers who are reimbursed based on governmental third party rates; Network Health has 30 days until all rates are released by the Centers for Medicare & Medicaid Services (CMS) to configure and implement the changes in our system as noted in our Contract Pricing and Coding Updates Policy. If you have any questions related to this policy, please reach out to your Provider Operations Manager.

Payer ID Codes

Please ensure you review the back of the member ID cards for the correct Network Health Payer ID. Beginning January 1, 2025, we will have 3 Payer IDs.

- Commercial - 39144
- Medicare - 77076
- Third Party Administrator (TPA) - 22344

Froedtert/Holy Family is our new TPA group effective January 1, 2025, and we plan to grow our TPA business throughout the year. Our 2025 member ID cards are coming soon and will be announced a future edition of the Pulse.

Medicare Prior Authorization Requirements with EviCore HealthCare Effective January 1, 2025

Beginning December 9, 2024, EviCore will begin accepting prior authorization requests for select radiology services for dates of service January 1, 2025 and after for Medicare Advantage members, which includes the following.

- CT, CTA (Computed Tomography, Computed Tomography Angiography)
- MRI, MRA (Magnetic Resonance Imaging, Magnetic Resonance Angiography)
- PET (Positron Emission Tomography)

If you were unable to attend one of the three training sessions offered by EviCore, click here to review the presentation.

Reminder to Review the EDI Claim Rejection Report

Please review the EDI Claim Rejection Report if you have not received a payment or denial from Network Health within 30 days of claim submission. The report is located within our secure provider portal, and 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 the claim is not in our system, we are unable to review it for claim payment

If you have any questions about how to access this report, please reach out to your provider operations manager.

Corrected Claim Submissions

Please review Network Health's Claim Submission Policy to ensure all corrected claims are submitted per our policy.

- All providers have 120 days from the date of the original claim remittance advice to submit a corrected claim.
- Network Health requires the provider submit the entire original claim electronically/EDI when submitting a corrected claim. We will not accept a corrected claim when listing only the corrected line/lines.

If a corrected claim is not appropriately marked as a corrected claim, it will be processed as an original claim submission and may be denied for timely filing or as a duplicate claim. If you have any questions, please reach out to your Provider Operations Manager.

CMS Approved Behavioral Health Licensures

Effective January 1, 2024, CMS announced they will accept these providers as billable providers under the Medicare program. In addition to this announcement, they instructed providers must do one the following.

1. Enroll with Medicare and accept Medicare assignment. This means you accept the payment under the Medicare program and cannot balance bill the member.

OR

1. Enroll with Medicare and NOT accept Medicare assignment. This means you can balance bill the member only up to 15% over the Medicare payment.

OR

1. Opt Out of Medicare. This means you cannot see any Medicare member.

If you do not have a Medicare Advantage contract with Network Health Plan and wish to enroll with Medicare and accept assignment, please reach out to your contract manager and request a Medicare Advantage contract.

If you have a Medicare Advantage contract with Network Health Plan, you must opt into Medicare and accept assignment.

If you have a Medicare Advantage contract with Network Health Plan and you choose to enroll and do not accept assignment OR you opt out of Medicare, please contact your contract manager to terminate your Medicare Advantage contract.

If you have any questions or concerns, please reach out to your Provider Operations Manager and they will be able to assist you.

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.

MDPP Elevator Speech

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.

Learn more by clicking here.

Holiday Hours

Network Health will be closed Wednesday January 1, 2025, for the holiday season. If you have questions during this time, our provider portal is available 24/7 to review claim status, as well as member benefits and eligibiilty. Happy Holidays.