January 2025

The pulse

network health

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

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 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**.

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.

Claims Submission

As a reminder to all our providers, our claims submission policy outlines our definition of a clean claim, the requirement of taxonomy code for Medicare Advantage claims, timely filing and how to submit a corrected claim. You can review the policy here.

Claim Submission Requirement

Participating providers are required to submit claims to Network Health for benefit determination of any service or item provided to a Network Health member. This includes, but is not limited to **retail items**. Network Health determines the coverage for members based on their plan documents; and this determination should not be made by the provider.

If the claim is denied based on the members benefit(s), the member will receive an Explanation of Benefits (EOB), notifying them the service is an exclusion to their policy, and it will include information regarding their appeal rights. The provider will receive a Remittance Advice (RA), notifying them the service is an exclusion to the members policy, and they may bill the member at that time. If the claim is denied as provider liability, you may not bill the member.

All participating provider contracts have Hold Harmless language and Medicare Advantage Terms and Conditions which protect our members from being charged in error for covered services.

If you have any questions regarding this process, please reach out to your provider operations manager.

Provider Portal Information

Registered providers have access to view patient eligibility, check status of claims, submit online authorizations and more. Registration is now available for both contracted and non-contracted providers. Sign up now.

Here is a video on how to navigate the portal

Froedtert/HFM TPA Plan

- Providers that have a Commercial contract are participating under the Froedtert/Holy Family TPA plan. There is no further action you have to take.
- Providers can access the provider portal here. We will be transitioning the Froedtert/Holy Family's provider portal to Network Health's provider portal in the

coming months, and we will be sending out a communication via The Pulse when the transition is complete.
- If you have questions regarding member eligibility, prior authorization or claims status, please contact our TPA Member Experience at 844-532-5200.
- If you are submitting electronic claims, please submit claims under **Payer ID: 22344**.
- If you are submitting paper claims, please mail them to PO Box 568, Menasha, WI 54952

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.

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

-OR-

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-

Opt-out of Medicare. This means you cannot see any Medicare member.

If you have not enrolled with Medicare, you may not see Network Health members and collect a fee from them.

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.

Provider Resources for New and Existing Providers

Please remind all providers, those established or new to your practice, of the following.

- Member's Rights and Responsibilities
- Prior Authorization Requirements
- Payment Policies and Procedures
- Appointment Access Standards (Network Management policy)
- Population Health Standards and Initiatives
- Pharmacy Formulary and Authorization Requirements

- Credentialing Policies and Procedures You can find all the information at: networkhealth.com/provider-resources/index

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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.