April 2025

The pulse

network health

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

Froedtert/HFM TPA Plan

- As a reminder, Providers that have a Commercial contract are participating under the Froedtert/HFM TPA plan.
- We will be transitioning the Froedtert/HFM provider portal to Network Health's provider portal in the coming weeks. Please continue to access the current provider portal here.
- For questions regarding member eligibility, prior authorization or claims status, you may contact our TPA Member Experience Team 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

If you have any question, please reach out to your provider operations manager.

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.

Medicare Diabetes Prevention Program

The Medicare Diabetes Prevention Program is part of the National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC) and 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.

We are encouraging health care providers to consider referring patients to the lifestyle change program if they are at high risk for type 2 diabetes. The program is open to those who meet the following eligibility criteria.

- Are enrolled in Medicare Part B
- BMI ≥ 25; ≥ 23 if self-identified as Asian
- A1c (HgA1c) between 5.7 and 6.4%, or a Fasting Plasma Glucose (FPG) test result of 110-125 mg/dL, or a 2-hour Post-Glucose Challenge Test result of 140-199 mg/dL (oral glucose tolerance test) within the previous 12 months.
- Have no previous diagnosis of type 1 or type 2 diabetes with the exception of a previous diagnosis of gestational diabetes
- Does not have end-stage renal disease (ESRD) at any point during the MDPP services period.

This year-long program is available to eligible Medicare participants at no cost. Your patients do not need to be a Network Health member to participate. The program is designed to help patients take actions to manage their overall health and wellness with the support of a lifestyle coach to encourage the development of new, healthy habits.

Participants receive the following.

- A yearlong structured program which includes a research-based curriculum.
- Support from a lifestyle coach, along with tips and resources for making lasting healthy changes.

- Help with stress management and learning to set and achieve realistic goals, stay motivated, and solve problems that can get in the way of your goals.

Patients look to their personal doctor more than any other source for information on promoting and preventing diseases like type 2 diabetes. Referring patients to the program can greatly increase their intention to participate and stick with their lifestyle changes. To find out when upcoming classes start, or refer a patient, you can email NHPreventT2@networkhealth.com or visit the Prevent T2 page on our website by clicking here.

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.

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