Waivers, billing and other questions

Waivers

Provider partners should not have Network Health members sign a waiver prior to any decision or denial issued.

- The plan (or it's delegate, eviCore) needs an opportunity to determine coverage and medical necessity
- The plan (or it's delegate) is required by CMS to issue appeal rights to the member for any services denied
- Providers should utilize the 7-day retrospective timeframe for authorization requests in these situations

* Network Health does not recognize or allow use of Advanced Beneficiary Notices (ABN). If the member signs a waiver, providers cannot have them sign an ABN form; CMS also states such notices are not applicable to Medicare Advantage programs.

Billing the member

Providers may bill the member for services that are denied for medical necessity when:

- The member and provider have received written notification of the denied services and member has received their appeal rights
- The provider has had a conversation with the member about the denied services and the member agrees to proceed with treatment
- The member signs a waiver at every visit that outlines:
  - ✓ The specific service to be performed were deemed not medically necessary
  - ✓ Payment for services will be the member's responsibility
  - ✓ The eviCore case denial number
  - ✓ Member signature confirms they were informed and understand

*** Similar process when treatment changes from active to maintenance. Medicare does not consider supportive / maintenance treatment medically necessary.**

Common Questions

Common questions and answers

Q: If a member already has an approved authorization on file for dates of service on or after June 1, 2021, will it be honored at go-live, or will providers need to resubmit a new authorization request?

A: All authorizations that have been issued prior to this eviCore implementation for services with dates of service on or after June 1, 2021, will be honored.

*Network Health's utilization management team has been issuing authorizations for therapy services with end dates of May 31, 2021.

Q: For individuals currently receiving treatment, and there is no authorization on file, is prior authorization for physical/occupational therapy (PT/OT) treatment continuing June 1, 2021, and after required?

A: Yes, all PT/OT services taking place on or after June 1, 2021, will require prior authorization. Providers can start submitting these requests to eviCore starting May 24, 2021.

Common questions (cont.)

Q: If a member goes to a new provider for services, will a new prior authorization request be required?

A: A new authorization is not required if the member is seeing a different provider within the same practice. When a member changes to a treating provider who is not within the same practice, a new authorization request is required.

Q: Will there be a transition period after June 1, 2021, for obtaining authorizations from eviCore? What if a provider submits requests to Network Health in error? Will Network Health send these over to eviCore or will someone be reaching out to the provider and educating them on what they need to do?

A: If a provider submits a prior authorization request to Network Health's utilization management (UM) team in error, a team member will outreach to the provider group and re-direct them to submit their request to eviCore.

Common questions (cont.)

Q: Will a plan of care be needed for additional visit requests?

A: Yes, current clinical information is required for eviCore to complete the medical necessity review process.

Q: Will authorizations reflect "visit" or "units"??

A: Authorization will be for visits. Medical necessity is determined for number of visits, which will be established based upon the plan of care and clinical documentation submitted.

If you have questions on whether a service requires prior authorization for Network Health membership, please contact our member experience team at 800-826-0940.