PROVIDER RELATIONS

NEWSLETTER **November 2023**

Provider Portal

With our Provider Portal, you have the convenience of helpful online services such as reviewing claim status and submitting non-urgent prior authorization requests.

Community Health Direct Provider Portal

Review the Provider Portal registration guide for helpful instructions on how to register for the new provider portal. Please contact us at CHDProviderRelations@ecommunity.com or 317-621-7581 if you need further assistance.

MISSION: We're deeply committed to enhancing health and well-being in the communities we serve.

Credentialing of NEW Providers:

Credentialing through Community Health Direct for ALL new providers takes anywhere from 90 to 120 days from notification until completion. You can find helpful forms and answers to frequently asked questions on our website.

Provider Credentialing Website

Monthly Provider Roster Updates:

September

- NEW providers joining Community Health Direct
- TERMED Community Health Direct providers

October

- NEW providers joining Community Health Direct
- TERMED Community Health Direct providers

IN THIS ISSUE:

Community Health Direct
PPO, HDHP and EPO Health Plans
2024 Authorization Quick Reference Guide

Community Health Direct supports the concept of the PCP as the "medical home" for its members. Services from Encore Combined and out-of-network providers will only be considered for coverage at the in-network level if those services are unavailable with an in-network provider.

Please submit requests as soon as possible to allow time for review. **Requests may be faxed to Medical Management or submitted online through the Provider Portal at** https://secure.healthx.com/chn.provider. ***Routine requests for authorizations are processed within 3 business days after receipt of all needed clinical information.***

Contact Information

Medical Management: 317-621-7575
Medical Management Fax: 317-621-7984
Provider Relations: 317-621-7581
Benefits/ Eligibility: 317-621-7565

Authorizations Required	No Authorizations Required
Requests for Encore Combined or out-of-network services at in-network coverage:* • Any requests for services not provided by the Community Health Network or in-network providers as listed in directory (an exception that is never covered is out-of-network Preventive Care Services) **Durable Medical Equipment** • Durable medical purchases over $500 –this includes CGM sensors, wheelchairs, CPAP (initial rental/purchase **ONLY**), hospital beds, insulin pump (initial purchase **ONLY**) • Prosthetics and Custom Orthotics **Inpatient Notification** • All inpatient admissions, including clinical updates for continued stay • Rehabilitation and Skilled Nursing Facilities **Medications** • Spinraza (nusinersen) • Prolia (denosumab) • Entyvio (vedolizumab) **Outpatient** • Tonsillectomies and Adenoidectomies • Cosmetic/Aesthetic Procedures • Transplant Requests • Genetic Tests and Lab Tests performed by Encore Combined & out-of-network laboratories • Focused Ultrasound Thalamotomy • Endoscopy services • Colonoscopies in patients under the age of 45 & those that are not for colorectal cancer screening • Investigational and experimental procedures • Clinical trial without Federal approval • Infertility • Surgeries of the neck and back • Rhinoplasties and Septoplasties **Radiology** • MRI- Spine (includes cervical) • Non-oncology related PET Scans **Behavioral Health** • All inpatient admissions for behavioral health treatment – this includes inpatient hospital and partial hospitalizations (PHP) for mental health and substance use disorder	**Urgent Care at Urgent Care Centers, such as Med Check and Community Clinic at Walgreens** **Laboratory** • Genetic tests performed by in-network providers • Lab tests performed by in-network providers **Durable Medical Equipment** • Medical purchases less than $500 • Bilirubin blankets for newborns • Nebulizers • CPAP supplies after initial authorization • Insulin pump supplies after initial authorization • Catheters • Other disposable supplies after initial authorization **Outpatient** • Colonoscopies for colorectal cancer screening except for patients under the age of 45 • Dialysis and Epogen administration with dialysis **Home Health Care** • Home Health Services • Hospice Care (Outpatient and Inpatient) • Total Parental Nutrition (TPN) • Home oxygen **Radiology** • All radiology services ***except*** MRI(s) Spine (includes cervical) and non-oncology related PET Scans **Miscellaneous Services** • Sleep studies performed at in-network sleep labs • Sleep studies performed in home under the direction of an in-network sleep lab **Behavioral Health** • Neuropsychological testing • Applied Behavior Analysis (ABA) **Only these pediatric services that are unavailable in-network are covered at in-network levels without a prior authorization**** Office visits and office-based testing: • Pediatric neurosurgery < 15 years old; and for members < 18 years old – pediatric cardiology, pediatric developmental clinic, pediatric endocrinology, pediatric hematology/oncology, pediatric ophthalmology, pediatric pulmonology, pediatric rheumatology, pediatric urology

***See exception for specific unavailable in-network pediatric services under *No Authorization Required* section**

****Pediatric provider must be an Encore Combined provider to qualify for in-network coverage. Out-of-network providers are not included for consideration of in-network coverage for these pediatric services without a prior authorization**

How To Submit A Change

COMPLETING A CHANGE OF INFORMATION IN SHAREPOINT (Employed CHNw practices ONLY)

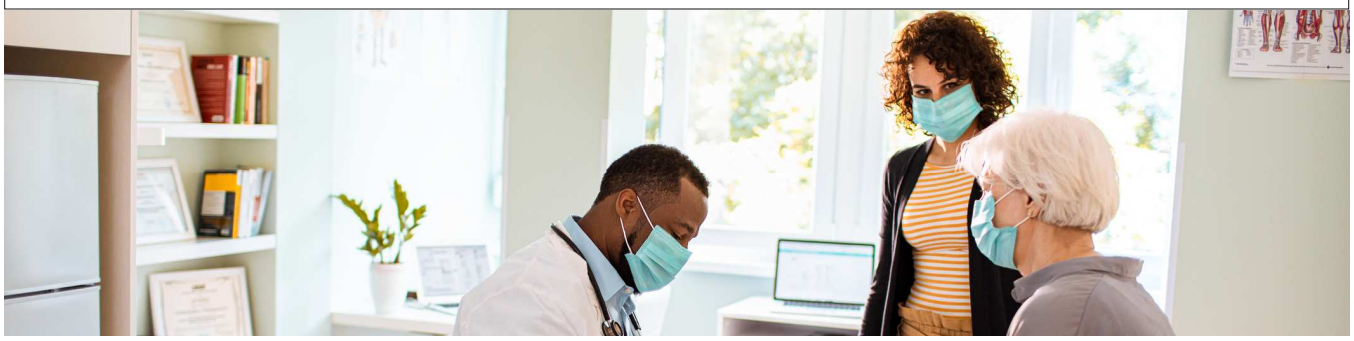
- Go to InComm, from the Tools menu, select Provider Onboarding. Click that link to the Provider Onboarding site.
- Once there, you will go the Change of Information link, found on the left side of the page, about 2/3rds down.
- From there, at top left of screen there is a plus sign that says “add new item”. Click the plus sign once and a fillable form asking for all of the details will appear.
- Select the provider and type of change and enter any notes about the change and submit.
- This kicks off the process of changing the information with the payers and it typically take 30—45 days before all payers approve and enter the change.

Feel free to share his information with any practice leadership in any Community employed group, as it’s the same process for many practice changes. If you are an operations leader and do not have access to this site for some reason, SharePoint you can contact Shawn Miller in IT and request access.

VALUES: Patients first. Relationships. Integrity. Inclusion. Diversity. Excellence.

Note From Medical Management

There is a new prior authorization process specifically for the Omnipod 5. This process will not affect any other DME. As with all insulin pumps, a prior authorization request must be sent to Medical Management on the regular form along with supporting clinical. If the request is approved, we will then send the approval information to Navitus (Epiphany) so that the item may be picked up at Walgreens. It will take Navitus about 2 business days to receive the information and place the approval in their system. As usual, we suggest that patients check with Walgreens before presenting to pick up their order to make sure it is ready.



United Healthcare Process Update

Dec. 1: Digital pre-service appeal submissions required

Affects network commercial, Medicare Advantage and Dual Special Needs Plans (D-SNP)

Last modified: Oct. 30, 2023
Update: Contact and questions section updated to reflect new chat services

Beginning Dec. 1, 2023, you'll be required to submit medical pre-service appeals electronically. No more wasting time tracking down lost or delayed mail. See your pre-service appeal status 24/7 in the UnitedHealthcare Provider Portal.

This change affects network health care professionals (primary and ancillary) and facilities that provide services to commercial, UnitedHealthcare® Medicare Advantage, and D-SNP plan members. Although not required, we also encourage UnitedHealthcare Community Plan (Medicaid) and out-of-network health care professionals to submit pre-service appeals electronically.

How to submit a pre-service appeal

You'll use the Prior Authorization and Notification tool through the **UnitedHealthcare Provider Portal**:

- From any page on **UHCprovider.com**, select Sign In at the top-right corner
- Enter your One Healthcare ID and password
  - New users who don't have a One Healthcare ID: Visit **UHCprovider.com/access** to get started
- In the menu, select **Prior Authorizations**
- Scroll down to "View Status of existing submissions, drafts and make updates" and click "Search Existing Submissions & Drafts"
- Find your service reference number (SRN) and expand to see the details
  - If the details show the coverage status as "Not Covered/Not Approved," you'll see the "File a Pre-Service Appeal or a Grievance" link
  - You can also click on the SRN to see the originally entered case details, as well as the "File a Pre-Service Appeal or a Grievance" link under the coverage status section
- Once you click the link, a new tab will open that takes you to the instructions page of the submission form
- You will be guided to complete the form, upload any supporting documents, review your information and submit
- Use Advanced Filter to search Document Library for your pre-service appeal letters

For more information, visit the UHC Resource Library or call 877-842-3210.

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