WHAT'S INSIDE

NETWORKING

HEALTH NETWORK ONE

QUARTER TWO | 2025

Profile: Provider Relations Rep Fredly Jiménez

Strong relationships with our provider partners are essential to delivering coordinated, high-quality care. From the very first conversation to ongoing support, our Provider Relations team is here to make sure you have the tools, guidance, and resources you need.

One of the people helping lead these efforts is Fredly Jiménez, who has been a Health Network One provider relations rep for 10 years. As a provider relations rep, Fredly serves as a liaison between care providers and our organization.

He is one of the first people our providers in Puerto Rico will likely connect with when joining our network because he helps them navigate the credentialing process and ensure that everything is submitted and approved on time. Fredly also supports providers with reauthorization submissions and eligibility validation. And when claims are denied or questions come up, he is a trusted resource, ready to assist.

"I value the opportunity to support providers and build trust," Fredly shared. "At the same time, by helping our providers, we're helping their patients. For me, that's very important."

In addition to onboarding and support, Fredly and the other provider relations reps provide ongoing education for providers and their staff. "We help them stay up to date on preauthorizations and claims requirements and offer training on how to use our provider portal and other online tools," Fredly explained.

He says this is the part of the job he enjoys most. "Whether I'm visiting the office or connecting by video, I like to help make things easier for providers and their staff. Our tools help ease some of the burden of administrative work, and that allows providers to focus on patient care instead."

If you or your staff have questions, need help, or would like additional training, contact your provider relations representative.

Network Updates

Here are some helpful tips and reminders for common questions and concerns that should help make your administrative work a little easier and more efficient.

Claims

Be sure to follow our claims submission guidelines to ensure your claims are processed accurately and in a timely manner. Incomplete, inaccurate, or unsupported claims may result in payment delays or denials. Your Spring 2025 Provider Bulletin includes all the details, but here are a few important highlights.

1. **Document services accurately.**
   Billed services must correspond to the care provided as documented in the clinical notes, so be sure that all claims are supported by complete and accurate details in the medical record.
2. **Code correctly.**
   Use the most current ICD-10-CM, CPT, HCPCS, and other applicable coding standards, and ensure procedure codes, diagnosis codes, and modifiers reflect the services delivered. Be sure any telehealth services are appropriately coded with applicable modifiers and place-of-service codes.
3. **Double-check provider information.**
   Verify that the correct National Provider Identifier (NPI) and provider details are included, and be sure your claims reflect the rendering provider who performed and/or supervised the service.

   ***NOTE:** If you are a behavior analysis provider, your claim form must contain the supervising provider's name AND the rendering provider's information.

   See the Provider Information section of the Spring 2025 Provider Bulletin for additional details.
4. **Verify member and payer information.**
   Be sure the insurance information and member ID are correct, and include any required authorization numbers.
5. **Submit claims without delay.**
   Claims must be submitted within the payer's specified time frame, and be sure that resubmitted and corrected claims are marked accordingly.

   Remember that claims may be submitted electronically through Direct Data Entry (DDE) via our Provider Web Portal, or through the Clearinghouse, Smart Data Solutions, using:

   - Professional Payer ID: 65062
   - Institutional Payer ID: 12k89

Provider Web Portal

The Provider Web Portal is a dynamic online tool that can streamline eligibility verifications, referrals, claims processing, and more. You can access it here. If you do not have an account, you can request one using our online form.

To help you and your team avoid access disruptions, be sure that all users have their own individual username and password. If your team is sharing a single login, please have the primary account owner add new users according to the instructions starting on page 12 of the Provider Web Portal User Manual.

Share Your Success Stories!

Every day, you're making a difference on the front lines of healthcare, managing patient needs, developing care plans, and incorporating preventive strategies. We'd love to hear how your work is making an impact.

Tell us about a time your intervention changed a patient's life.

Click to Submit Your Story

Recredentialing

Remember that to be part of our network, your credentials must always be current. To help with that process, our credentialing team will contact your office approximately 6 months prior to your credentialing deadline.

Providers can greatly simplify recredentialing by creating a CAQH profile at CAQH ProView - Sign In. CAQH facilitates the exchange of credentialing information with payers and other organizations – at no cost to providers.

If you haven't yet created a CAQH profile, we strongly encourage you to do so – even if it's not yet time for recredentialing. Contact your provider relations representative for assistance, so that you can be sure you are able to remain in our network.

Once enrolled in CAQH, please complete your quarterly attestation to ensure that your credentials are in good standing.

Change Notifications

Please be sure to report any changes to us as soon as possible so that provider directories can be properly maintained. Examples of the types of changes that should be reported to us include:

- Addition or removal of providers
- Addition or removal of services provided
- New location, even if it's just a change in suite number
- New contact information, including phone number, fax number, web address, email address, etc.

You may easily update your information by:

- Contacting your provider relations representative by phone or email
- Completing the contact form on our website
- Calling 888-550-8800 and selecting your network's dedicated provider relations line

ANNUAL TRAININGS

All providers are required to complete provider trainings within 30 days of their contract effective date and annually thereafter. Your attestation will confirm that your office has received all mandatory trainings for the year. Use this link to access your training.

FRAUD, WASTE AND ABUSE

All providers are required to report concerns about actual, potential or perceived misconduct to our Corporate Compliance Department at **866-321-5550.**

DEMOGRAPHIC UPDATES

If your practice has any demographic changes, please be sure to contact your provider relations rep at the numbers listed below for your network to update us with this information.

Annual Quality Improvement Documents

Annually the Quality Improvement (QI) department develops quality documents, which includes QI and UM evaluations, program description, and work plan. The development of the quality documents satisfies health plan and NCQA accrediting body requirements. The QI and UM evaluations analyze the QI department's previous-year quality indicators and key accomplishments as well as identify any areas needing improvement and develop action plans to improve results. The program description and work plan establish objectives, goals, QI activities, and the QI program structure for the current year.

Copies of the annual QI documents are available by contacting the QI department at the address below.

2001 South Andrews Avenue | Fort Lauderdale, FL 33316
Phone: 800-422-3672 Ext. 4701 | Fax: 305-614-0364

Affirmative Statement About UM Decision Making

All clinical staff that make utilization management (UM) decisions are required to adhere to the following principles:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.
- Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support benefit denials.

Medical Necessity Determinations

The organization uses Apollo, Milliman Care, CASP's Applied Behavior Analysis Practice Guidelines or our health plan partners' clinical guidelines (depending on the line of business) for medical necessity determinations. These guidelines are based on appropriateness and medical necessity standards. Each guideline is current and has references from peer-reviewed medical literature and other authoritative resources, such as the Centers for Medicare & Medicaid Services. For any medical necessity Recommendation of Denial, the Medical Director shall make an attempt to contact the requesting provider for peer-to-peer consultation.

The relevant clinical guidelines are annually reviewed and approved by the Health Network One Medical Advisory Committee and are available in both electronic and hard copy format. If providers would like copies of specific guidelines, they may contact their assigned provider relations representatives to request them.

Provider Hotlines

TNGA: 855-825-7818, option 1
TNFL: 888-550-8800, option 4
TNPR: 877-614-5056, option 2
TNNJ: 855-825-7818, option 2
EMI: 800-329-1152, option 2
HN1: 800-595-9631, option 2