QUARTER FOUR

2025

NETWORKING

HEALTH NETWORK ONE

WHAT'S INSIDE:

Start Strong

As we begin a new year, now is a great time to complete a few tasks that will help set the stage for a successful 2026.

- ❑ **Verify Mailing Addresses**
  Be sure you're using our updated mailing addresses as noted in the section of this newsletter specific to your specialty network.
- ❑ **Register your practice with the Council for Affordable Quality Healthcare (CAQH)**
  Create or update your free profile at https://www.caqh.org/providers. It only takes a few minutes and will automate credentialing and improve your practice's visibility to all payers.
- ❑ **Therapy Providers: Complete Your Subspecialty Survey**
  Help us better understand the various therapy services your practice offers.

Operational and Plan Updates

Enrollment System Updates for Florida Medicaid Providers

The Florida Agency for Health Care Administration (AHCA) will soon launch a new provider enrollment system as part of its enterprise modernization. This new system will make enrollment, renewal, and account maintenance faster and more secure and will:

- **Give providers 24/7 access to their provider account from any device.**
- **Provide step-by-step instructions so applications are right the first time.**

In preparation for this change, AHCA requests that providers:

- Complete pending enrollments in the current Medicaid Provider Enrollment Application Wizard.
- Review and update account information in the current Medicaid Secure Web Portal. If renewal has been triggered, complete renewal in the Medicaid Secure Web Portal.
- Ensure their accounts are created. Any active Medicaid provider who has not created an account should do so as soon as possible. If you do not have your PIN information, please see Password Resets and PINs for additional support.
- Subscribe to Florida Medicaid Health Care Alerts for updates.

To ensure your account is active and accessible, be sure you:

- Review and validate name, phone number, email address, and security questions/answers in the Account Management – Modify Contact Information section.
- Know how to reset your password in the Medicaid Secure Web Portal. Once there, select 'Reset password.'
- Keep your account active by logging in every 60 days–before your password expires.

Newly enrolled providers will receive a PIN letter within 10 business days.

To activate your account and create a username and password, go to:

https://public.flmmis.com/public/pinletter/

and follow the instructions provided in the letter.

Additional Resources:

Password Resets and PIN Instructions

Account Maintenance and Reset Password Quick Reference Guide

Secure Web Portal User Guide

Operational and Plan Updates

CMS Update: Medicare Prior Authorization Turnaround Time Now 7 Days

Starting January 1, 2026, the Centers for Medicare & Medicaid Services (CMS) reduced the standard turnaround time for Medicare prior authorizations from 14 days to 7 days. Urgent requests remain at 72 hours.

What this means for providers:

- With the shorter time frame, there is very limited opportunity to obtain missing documentation after submission.
- Incomplete requests may cause delays, requests for denial (RFD), and denials.

The new 7-day window makes accuracy and completeness critical. Therefore, be sure you submit complete clinical documentation with initial requests, including:

Prescription

Evaluation

Plan of care that includes:

Diagnosis and history • Treatment rationale
Relevant test results • Objective information
Short- and long-term goals

Review your workflows now to ensure that all clinical notes will be included at the outset of every prior authorization request.

Medicare Advantage Plan Changes

As we have shared in other communications, AvMed will discontinue its Medicare Advantage plans in Florida, and Humana will discontinue Medicare Advantage plans in Puerto Rico, effective Dec. 31, 2025.

Medical Records Documentation

Medical records documentation must meet state, federal, and contractual standards. When records are requested for quality improvement activities or quality audits, please ensure that you submit complete documentation within the timeframe specified in the request letter.

A complete medical record should be consistently maintained for every patient who receives clinical services. This ensures coordinated care and allows for timely access to information when needed for audits or quality reviews.

Network Operations

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, including changes in address, services, providers, etc., please be sure to contact your provider relations rep at the appropriate number in the Provider Hotlines section.

Annual Quality Improvement Documents

Annually, Health Network One's 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:

4565 Ponce De Leon Blvd., Suite 200
Coral Gables, FL 33146

Phone: 800-422-3672, Ext. 4701
Fax: 305-614-0364

Affirmative Statement About UM Decision Making

All Health Network One clinical staff who 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

Health Network One follows CMS guidelines to include National Coverage Determinations (NCD) and Local Coverage Determinations (LCD); health plan partner clinical guidelines (depending on the LOB) as applicable; or MCG or Apollo clinical guidelines to support benefit 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 CMS.

For any medical necessity denial or recommendation of denial, the medical director shall attempt to contact the requesting provider for peer-to-peer consultation. Applied clinical guidelines are available in both electronic and hard copy format. For copies of the guidelines, you may contact your assigned provider relations representative. For access to the guideline links, visit our website at www.healthnetworkone.com. For health plan specific guidelines, please refer to the respective health plan website.

Provider Hotlines

Therapy – Georgia: 855-825-7818, option 1

Therapy – New Jersey: 855-825-7818, option 2

Therapy – Florida: 888-550-8800, option 4

Therapy – Puerto Rico: 877-614-5056, option 2

Dermatology, Podiatry, Gastroenterology, & Urology: 800-595-9631, option 2

Eye Management – EMI: 800-329-1152, option 2

Eye Management – Premier Eye Care: 800-738-1889

Updates by Network

Therapy Network

Subspecialty Survey: Tell Us More About Your Services

We'd like to hear about the full range of services your practice offers, so we can make smarter, faster placements when our health plan partners request services for members.

Please take a few minutes to complete our short survey. Your input is essential to strengthening care coordination and supporting better outcomes.

Click Here to Complete the Short Survey

Mailing Address Changes

We recently changed our mailing addresses. Please verify that you have updated your records to ensure that mail, claims, forms, and documentation are directed to our new addresses.

Please submit claims to:

Health Network One
PO Box 240385
Apple Valley, MN 55124

Please send all other correspondence to:

Health Network One
PO Box 980216
West Sacramento, CA 95798-0216

Eye Management

Mailing Address Changes

We have changed our mailing addresses. Please update your records to ensure that mail, claims, forms, and documentation are directed to our new addresses.

Please submit claims to:

EMI - Health Network One
PO Box 240247
Apple Valley, MN 55124

Please send all other correspondence to:

Health Network One
PO Box 980216
West Sacramento, CA 95798-0216

Premier Eye Care

CPT Category II Codes for all HEDIS® EED Performance Measures

As part of our commitment to improving outcomes for our members and quality scores for our contracted health plans, we are now requiring providers to add CPT category II codes to all claims for services for the Eye Exam for Patients with Diabetes (EED).

CPT Category II codes are informational codes that enhance data accuracy, confirm that an Eye Exam for Patients with Diabetes (EED) was completed for members with Diabetes Mellitus Type 1 or 2 and describe the results of the examination. Our goal is to improve the provider experience by utilizing the most efficient process to obtain quality codes up front, track quality metrics, and increase performance measurement.

What this means for you: Submitting claims with CPT Category II codes in addition to CPT Category I codes (exam codes) will decrease your need to submit medical records for chart reviews, which will minimize the burden of the HEDIS® EED performance measure. In addition, using CPT Category II codes helps ensure that members receive continuous and appropriate care and may also identify opportunities for improvement.

Therefore, please begin including these CPT category II codes when applicable:

CPT II Codes	Quality Code Description
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)2
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)2
2024F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)

If you have questions about this request, please call our HEDIS team at 855-353-4910, option 2.

Mailing Address Changes

Please note that while our claims mailing address remains unchanged, we've updated our general correspondence address.

Please verify that you have noted this change and are now sending all non-claims correspondence to:

Health Network One
PO Box 980216
West Sacramento, CA 95798-0216

As always, claims may be submitted to:

Premier Eye Care
P.O. Box 21503
Eagan, MN 55121

Regional Networks: Dermatology, Podiatry, Gastroenterology, Urology

Podiatry Surgical Requests

To meet established criteria set by our health plan partners, please be sure to include the following necessary components when submitting a podiatry surgical request:

1. X-ray showing deformity
2. Interpretation of the X-ray
   a. Angle of deformity (IM or HV) in degrees (for bunionectomies)
3. Documentation of failure of pre-procedure conservative treatment, including length of conservative treatment and type of treatment attempted, when appropriate. If conservative treatment is not appropriate, documentation must be contained in the medical record that explains why the treatment is not reasonable.

If you have questions about this requirement, please contact your provider representative using the contact information on page 3.

Mailing Address Changes

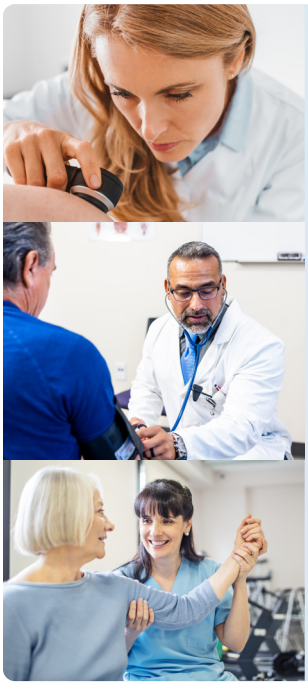
We have changed our mailing addresses. Please update your records to ensure that mail, claims, forms, and documentation are directed to our new addresses.

Please submit claims to:

Health Network One
PO Box 240328
Apple Valley, MN 55124

Please send all other correspondence to:

Health Network One
PO Box 980216
West Sacramento, CA 95798-0216



SHARE YOUR SUCCESS STORIES!

Submit a brief summary of your story using this form.

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. Your story could be shared as a success story with our health plan partners.