



NETWORKING



WHAT'S INSIDE:

Operational and Plan Updates

Page 2

Medical Records Documentation

Page 2

Network Operations

Page 3

Updates by Network

Therapy Page 4

Premier Eye Care Page 4

Dermatology, Podiatry,
Gastroenterology,
and Urology Page 6

Share Your Success Stories!

Page 6

Your Uncashed Checks May Be at Risk

After a specified period of time, which may vary by state or territory, Health Network One is required by law to turn over uncashed provider payments to appropriate government agencies.

Read the article on page two to understand what you can do to prevent losing funds and how you can avoid this risk in the future.

[Read More](#)



Operational and Plan Updates

Your Uncashed Checks May Be at Risk

If your practice has uncashed checks from a Health Network One entity, such as Therapy Network or HS1 Medical Management, please deposit them immediately.

After a designated period of inactivity, which may vary according to your state or territory, Health Network One may be legally obligated to remit uncashed provider payments to appropriate government agencies. These requirements ensure funds are held by the state or territory until claimed by their rightful owners.



Ensure You Receive Your Payments

To ensure you receive payment for your services, please:

- Deposit all outstanding checks
- Sign up for electronic funds transfer (EFT), so your payments are deposited to your account rather than mailed to you



[Sign Up for EFT](#) or call 855-388-8374.

If you have questions or need additional information regarding these regulatory requirements or your uncashed provider checks, please contact your provider relations representative using the contact information on page 3.

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 utilization management (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 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 line of business) 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

Follow CMS Billing Guidelines to Prevent Reimbursement Delays

For commercial plan claims, please follow CMS billing guidelines to ensure proper processing and faster payments. When commercial claims are billed with Medicaid-style units, this results in processing and reimbursement delays.

To avoid delays, please review and update your workflows for Medicaid and commercial billing. This will ensure accurate, timely reimbursement for your practice.

Premier Eye Care

Required Documentation for Devoted Health Claims

Devoted Health uses the following modifiers as audit triggers. Therefore, Premier Eye Care providers serving Devoted Health members must submit supporting medical records with claims that include any of the following modifiers:

- **24** – Unrelated E/M service during a postoperative period
- **25** – Significant, separately identifiable E/M service on the same day
- **57** – An E/M service that resulted in the initial decision to perform surgery
- **59** – Distinct procedural service
- **79** – Unrelated procedure during a postoperative period

Claims submitted without documentation may be denied, or claims may be paid but Devoted Health may later request medical records and recoup payment if adequate documentation is not provided.

To avoid denials and recoupments:

- Always attach complete medical records when billing modifiers 24, 25, 57, 59, or 79 for Devoted Health members.
- Ensure documentation clearly supports use of the modifier.
- Submit records at the time of claim submission, not after a request.

Examples of acceptable documentation:

- Progress notes
- Procedure notes
- Operative reports
- Diagnostic results supporting medical necessity
- Any documentation demonstrating that the modifier is appropriate

Close EED Care Gaps with Our Easy Tele-SCREEN Program

Meet quality targets and enhance care management by completing the eye exam for patients with diabetes (EED) for those who still need it.

With our handheld retinal cameras, you can complete a quick, non-invasive screening in minutes—right in your office. We provide the tools you need, including the retinal camera, required training, and image interpretation services.

For more information about this program can help you strengthen quality scores with minimal workflow disruption, please contact our HEDIS® team at hedisteam@premiereyecare.net.

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.

Regional Networks: Dermatology, Podiatry, Gastroenterology, Urology

Required Documentation for Devoted Health Claims

Devoted Health uses the following modifiers as audit triggers. Therefore, providers serving Devoted Health members must submit supporting medical records with claims that include any of the following modifiers:

- 24 – Unrelated E/M service during a postoperative period
- 25 – Significant, separately identifiable E/M service on the same day
- 57 – An E/M service that resulted in the initial decision to perform surgery
- 59 – Distinct procedural service
- 79 – Unrelated procedure during a postoperative period

Claims submitted without documentation may be denied, or claims may be paid but Devoted Health may later request medical records and recoup payment if adequate documentation is not provided.

To avoid denials and recoupments:

- Always attach complete medical records when billing modifiers 24, 25, 57, 59, or 79 for Devoted Health members.
- Ensure documentation clearly supports use of the modifier.
- Submit records at the time of claim submission, not after a request.

Examples of acceptable documentation:

- Progress notes
- Procedure notes
- Operative reports
- Diagnostic results supporting medical necessity
- Any documentation demonstrating that the modifier is appropriate



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.