QUARTER TWO

2026

NETWORKING

HEALTH NETWORK ONE

WHAT'S INSIDE:

Required Annual Training Now Underway

If you are required to complete annual training, you should have received an email with a link to your training materials. Be sure to complete the training as soon as possible to maintain active network status.

See your network's updates in this newsletter for additional details.

Operational and Plan Updates

Tips for Accurate Claims Submission and Expedited Provider Payments

Claims that accurately reflect the services provided will help ensure timely payment processing. Here are some claim submission tips to minimize processing delays and expedite reimbursement for your practice.

1. Ensure Accurate Documentation

- Make sure each claim is supported by complete and accurate documentation in the patient's medical record.
- Submit claims that reflect the care provided and be sure your clinical documentation supports your claims.

2. Use Correct, Up-to-Date Coding

- Use the latest ICD-10-CM, CPT, HCPCS, and other applicable code sets.
- Double-check that diagnosis codes, procedure codes, and modifiers accurately reflect the care provided.
- Avoid using "unspecified" codes unless there are no more accurate ways to represent the services provided.

3. Verify Date and Place of Service

- Confirm that all dates of service and sites of care – such as office or telehealth – are correct.

4. Confirm Provider Information

- Ensure your National Provider Identifier (NPI) and provider details are accurate.
- Report the rendering provider who performed or supervised the service.
- Bill exactly as you are registered with the state, including your practice's ZIP code and 4-digit ZIP code extension.
- Submit one claim per rendering provider.

5. Keep your Provider Information Up-to-Date

- Notify your Health Network One provider relations representative if any changes occur, such as roster changes, address or phone number updates, etc.

6. Submit Claims Without Delay

- Submit claims within each payer's specified time frame.
- Ensure that resubmitted and corrected claims are marked accordingly.
- Utilize electronic claims submissions through our Provider Web Portal or the Smart Data Solutions clearinghouse.
    - Professional Payer ID 65062
    - Institutional Payer ID 12k89

Operational and Plan Updates Continued

You Can Help Support Quality Improvement

Providers play a vital role in supporting quality reporting, audit activities from the Centers for Medicare & Medicaid Services (CMS), and population health initiatives. As part of these efforts, providers may receive requests for medical records to help validate care provided to members and support required reporting activities. Responding promptly with complete and accurate documentation helps reduce follow-up requests and keeps these important programs running smoothly.

To help make the medical record review process as smooth and efficient as possible, we ask providers to:

- Respond promptly to medical record requests and meet the specified timeframe.
- Ensure records are complete, legible, and relevant to the request.
- Submit through approved secure channels with proper identifiers.
- Communicate promptly if records are unavailable or clarification is needed.

Timely record submission supports our responsibility to our health plan clients currently engaged in CMS Risk Adjustment Audits. We need your help to ensure we provide the medical records to support these audits.

Please remember that CMS requires medical records to be retained for 10 years. In addition, per your provider agreement, requested records – including paper copies – must be provided at no cost.

Risk Adjustment Data Validation Audit Reminder

CMS is actively conducting Risk Adjustment Data Validation (RADV) audits across all Medicare Advantage plans.

If you receive a request for medical records, please submit the requested documentation by the specified deadline to remain compliant. Turnaround times for these audits are short, so prompt response is essential to avoid compliance issues or potential impacts to your organization.

As a reminder, CMS requires providers participating in the Medicare Managed Care program to retain patient medical records for a minimum of 10 years.

If you have questions or need assistance, contact the Quality Improvement department at QI@healthnetworkone.com. Additional details on medical record retention are available through your Medicare contractor or in the Medicare Learning Network in MLN Matters Article #SE1022.

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 representative 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

Complete Your Annual Training

Annual training materials are now available online and should be completed as soon as possible. Use the link sent to you by email or click here to access your Therapy Network training.

Complete your training and attestation today to remain active in our network. Timely completion helps ensure continued compliance with health plan requirements and uninterrupted participation in the provider network.

After finishing the training, please submit your attestation confirming that all required training has been completed by your team.

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

Eye Management

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Changes for Your Florida Blue Group Members

As of January 1, 2026, some Florida Blue groups transitioned to the National Alliance benefits platform. Members with NetworkBlue/BlueOptions,® BlueCare® HMO, and BlueChoice® PPO plans will be affected by this change. Please reference the chart for the specific member ID card prefix updates that may impact your patients.

Member ID Card Prefix Updates

Original Prefix	New Prefix
CVJ	FRU
OTA	FRU
PJZ	FOH
UGA	FRU
XJB	FAE, FPS, or FRU
XJG	FOH

Providers should continue to verify eligibility and benefits (E&B), submit prior authorization requests, and other functions via Availity Essentials. Note that BlueCare HMO remains an open access plan for which no referrals are required; however, prior authorization requirements still apply.

Although member ID cards may look different, they will still feature the Florida Blue logo at the top. For authorizations and contact information, including the telephone number for provider services, please refer to the information on the back of the card.

Eye Management Continued

Changes for Your Florida Blue Group Members

What This Means for You

- Services performed in your office will still require a control number issued by EMI prior to treatment.
- EMI will issue a Surgical Control Number for these members for the professional component of the claim. You must obtain authorizations for the ASC or OP Hospital Surgical Suite (POS 24 or POS 22) from Availity.
- You must submit all claims to EMI for services performed in your office.
- You must submit all professional claims to EMI for services performed in an ASC or OP Hospital Surgical Suite (POS 24 or POS 22). The facility claim will continue to go directly to Florida Blue and will be matched to the authorization number you obtained in Availity.
- If you need to refer a member to a tertiary facility (e.g. Bascom Palmer Eye Institute), you must submit this request directly via Availity.

Important Details About Authorizations

The steps below will help you identify the correct record, confirm E&B, and manage authorizations accurately and efficiently.

- **Enter the full member ID number (including alpha prefix)** as shown on the member ID card. Please also include the member's name and date of birth (DOB).
- **Avoid searching with partial information** (e.g., name and DOB only). This may incorrectly return an "inactive" status under "Member Status."

If an authorization appears to be missing:

- Double check E&B using all member details mentioned above.
- Contact the National Alliance provider service line listed on the member's ID card: 1-800-868-2510 or call 1-888-376-6544 for preauthorization.

If an authorization or E&B inquiry returns an "out-of-network" message, it may be an incorrect message due to a system error.

There is no change in your network participation status for the plans listed in this article, and this update will not impact your participation agreement or fee schedule. If you have confirmed your participation in the EMI network and the member's E&B, you can proceed with the authorization inquiry or request.

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

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Important Reminder: Devoted Contract Exclusions

To help you avoid billing issues and unnecessary denials, please note that the following items are **not included** in your Devoted contract and should not be billed under your participation agreement:

- Out-of-network providers
- Trauma and emergency care
- Facility fees
- Drugs and injectables
- Laboratory and pathology diagnostic services performed outside of your office (unless provided by a contracted provider)
- Durable medical equipment (DME)
- Tertiary services

When coordinating these services, refer to the Devoted provider directory to identify in-network vendors. You can also reach out to your Health Network One Provider Relations representative at 800-595-9631, option 2, for guidance.

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

Submit a brief summary of your story using this form.