network health

Care Continuum
Frequently Asked Questions

What is Care Continuum?
Certain medications, like injectables, infusions and some specialty drugs are part of Network Health's medical benefits (rather than the plan's pharmacy benefits). Our pharmacy benefit manager, Express Scripts, manages pharmacy benefits for Network Health members. In addition, through their company Care Continuum, they can also manage medications under Network Health's medical benefits.

Care Continuum will manage the prior authorization process and reconciling the subsequent medical drug claim against the prior authorization and the appropriate dose and use for the medication. This is referred to as the medical claims edit process.

Which Network Health plans does Care Continuum provide service for?
Care Continuum will perform prior authorizations through the EviCore provider portal, and medical claim editing for all Network Health plans and product lines.

How do I register for the EviCore provider portal?
Registration for the portal is quick and easy. Simply follow the steps below. You can also find a step-by-step guide on how to register by clicking **here**.

- Visit **evicore.com**
- Follow the simple steps to register
- Log in right away to begin submitting prior authorizations online

For web portal issues, call 800-646-0418, select option 2 or email **portal.support@eviCore.com**.

How can I contact Care Continuum outside of the portal?
You can reach Care Continuum by calling 877-787-8705 or faxing 877-860-8866.

How do I know which medications are managed under the medical benefit and which are managed under the pharmacy benefit?
Many injectable, infusion and specialty medications are managed under Network Health's medical benefits. Submitting prior authorization requests eliminates the need to differentiate between medical and pharmacy benefits. Prior authorization requests for both can be submitted through the provider portal at **evicore.com**.

You can also find which medications are managed under Network Health's medical benefits by using our online **Look Up Medications** search.

What drugs will require prior authorization?
A list of medical drugs requiring prior authorization and their respective J-codes can be found on the **Provider Resources** page of our website. Existing prior authorizations will be applied until their expiration date provided in the original authorization.

What is the average turnaround time for a drug review in the provider setting?
It generally takes less than 10 minutes to complete a medical drug review through the online portal. Care Continuum follows all state and federal regulations regarding turnaround times. If a method other than the online portal is used, Care Continuum will still comply with turnaround times based on the urgency of the case.

What if I want to appeal a decision made by Care Continuum?

All medical drug appeals are handled directly by Network Health's Appeals and Grievances Department. Use the contact information below to submit an appeal.

Commercial Customer Service: 800-826-0940
Medicare Customer Service: 800-378-5234
Fax number: 920-720-1832

What if authorization is needed for both medical and pharmacy benefits?

An example illustrating this is the use of Stelara for Crohn's disease. The initial loading dose can be done via IV infusion. A medical prior authorization can be provided for this initial dose. Subsequent SQ doses would go through Network Health's pharmacy benefit and require another authorization. The good news is that both medical and pharmacy benefits can be authorized through **evicore.com**.

What can I do in the EviCore provider portal?

The portal is available 24 hours a day, seven days a week at **evicore.com** with the following features.

- Create new requests (eliminating the need to call or send faxes)
- View the status of previously submitted requests
- Complete or edit existing requests that may require additional information
- Search for a previously submitted requests
- Search by patient details such as member number, date of birth, etc.
- Renew an approved request that will expire in the next 90 days

When a provider calls Care Continuum about coverage or a prior authorization, what does that process look like and how is the determination made?

- When a provider's office calls Care Continuum, they'll speak to a prior authorization representative.
- The representative will ask the provider's office questions based upon clinical decision trees formed from the utilization management programs.
- If the criteria are met, the provider will receive an authorization number and an approval letter will be sent to their office.
- If the criteria are not met, the case will be sent to a nurse for further review.
- If the further review by a nurse requires additional information, the nurse will call and send a letter to the provider requesting the additional information.
- If the further review substantiates that the criteria have not been met and a denial is necessary, a Care Continuum provider will review the case.
- If the Care Continuum provider reviews the case and agrees with the nurse, the request will be denied.

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