JUNE 2023

Provider News

For participating physicians, dentists, other health care professionals and facilities

Work with us to support health equity

All people should have an equal opportunity to achieve wellness as part of a health care system that prioritizes diversity, equity and inclusion. BridgeSpan's commitment to whole-person support for our members means we take into consideration all the drivers of health—acknowledging that 80% of health outcomes are driven by non-clinical factors. When members have barriers to accessing care or fully engaging in their treatment plans—from transportation, to cost burdens or a lack of trust in medical care providers (as can be the case for members in underrepresented communities)—these challenges can have a major impact on their health outcomes and overall costs.

Health equity gaps impact your patients' access to treatment; length and quality of life; rates and severity of disease; and disability and death. There are several ways we can partner together to advance equitable access, experience and outcomes.

Provider directory information

We know many patients prefer providers who share their race or ethnicity, or who speak the same language, which can improve communication and care quality. Providers who validate their patients' identities can make a positive difference in health outcomes.

Our provider directory includes information to help our members connect with providers they feel best meet their health care needs and individual preferences. The demographics and areas of interest include:

- Language
- Pronouns
- Gender identity
- Race and ethnicity
- LGBTQ+-inclusive care

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Easily find information

Did you know that you can search for words in this newsletter by holding down the **Ctrl** key on your keyboard and then the letter **F**? A pop-up window will appear asking if there's a word or phrase you need to find.

Subscribe today

Subscribe to receive email notifications when new issues of our publications are available.

Using our website

When you first visit **bridgespanhealth.com**, you will be asked to select an audience type (individual or provider) and enter a ZIP code for your location. This allows our site to display content relevant to you.

Stay up to date

View the What's New section on the home page of our provider website for the latest news and updates.

BridgeSpan Health
2890 E Cottonwood Parkway Salt Lake City, UT 84121

Contents

■ Critical update
★ Stars Ratings/Quality
▲ DME
‡ Radiology
● Dental

We encourage you to read the other articles because they may apply to your specialty.

Click on a title to read the article.

About Provider News

This publication includes important news, as well as notices we are contractually required to communicate to you, including updates to our policies (medical, dental, reimbursement, medication) and pre-authorization lists. In the table of contents, this symbol indicates articles that include critical updates: ■. To save you time, you can click on the titles to go directly to specific articles. You can also return to the table of contents from any page by clicking on the link at the bottom of each page.

Provider News includes information for BridgeSpan Health in Idaho, Oregon, Utah and Washington. When information does not apply to all four states, the article will identify the state(s) to which that specific information applies.

Issues are published on the first day of the following months: February, April, June, August, October and December.

The information in this newsletter does not guarantee coverage. Verify members' eligibility and benefits via Availity Essentials at **availity.com**.

The Bulletin

We publish a monthly bulletin as a supplement to this bimonthly provider newsletter. *The Bulletin* provides you with updates to medical and reimbursement policies, including changes we are contractually required to communicate to you.

Share your feedback

If you have additional comments about our newsletter or bulletin, please send us an email at **provider_communications@bridgespanhealth.com**.

COVID-19 updates

The federal public health emergency (PHE) ended on May 11, 2023. The Outbreak Period is now extended through July 10, 2023. This allows additional time for timely claims filing and appeals submissions. Visit the homepage of our provider website for COVID-19 updates.

Dental policy updates

Effective September 1, 2023, we will remove dental policies from our provider website and dental policies will not be updated after June 1, 2023.

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The information you provide about your race and ethnicity, gender identity, pronouns and whether you provide LGBTQ+-inclusive care will be displayed on Find a Doctor, our online provider directory. Members will be able to find culturally responsive care and select providers who are LGBTQ+-affirming and have competence in behavioral health and transgender medicine. This information helps our members build trusting relationships with their health care providers, resulting in more appropriate care and better health outcomes.

Together, we can advance diversity, equity and inclusion on behalf of our members and the communities we serve.

Resources for working with diverse populations

Culture, language, customs, personal beliefs and experiences all impact how patients participate in their health care. To help you support a patient with unique needs or preferences regarding their care, we created an online library that connects you to national standards and essential resources. These resources focus on ways to provide culturally sensitive health care to diverse populations, including behavioral health, health literacy, interpreter services and health equity.

You can find the Cultural Competency and Health Literacy Resources page on our provider website: Programs> Quality Program>Cultural Competency. We encourage you to bookmark this page.

Submit SDoH Z codes to help connect patients to services and resources

Collecting and tracking social determinants of health (SDoH) information about our members is important because it helps us:

- Close health equity gaps
- Understand barriers to care
- Supports equitable access to quality health care and health education

The SDoH ICD-10-CM Z codes make it possible to measure social risk factors and social needs. They add greater specificity to capture a more holistic view of a patient's health and challenges.

Resources

- Centers for Medicare & Medicaid Services (CMS), 2023 ICD-10-CM updates: **cms.gov/medicare/icd-10/2023-icd-10-cm**
- CMS *ICD-10-CM Official Guidelines for Coding and Reporting*: **cms.gov/files/document/ fy-2023-icd-10-cm-coding-guidelinesupdated-01/11/2023.pd**f

Social need screening and intervention

A new Healthcare Effectiveness Data and Information Set (HEDIS®) measure, Social Need Screening and Intervention (SNS-E), has been added in 2023. It measures the number of patients screened for food, housing and transportation needs and, among those who screened positive, how many received an appropriate intervention. The National Committee for Quality Assurance (NCQA) allows the use of a variety of evidence-based, validated screening instruments. They also recommend that detailed assessment of these social needs be documented in medical records to support evidence-based interventions.

More information on this new measure will be available in the next publication of our *Quality Measures Guide*.

Help when you need it

Many questions we receive can be easily and quickly answered using one of our online resources—without the need to call or email for help.

Reimbursement schedules

Participating providers with standard agreements can view reimbursement schedules and other pricing documents after signing into Availity Essentials: Claims & Payments> Fee Schedule Listing.

Self-Service Tool

Use our Self-Service Tool to review helpful answers to our most frequently asked questions and quickly navigate our tools and website resources—saving you a phone call or email. Information is organized by topic to make it easier for you to find the resources you need. The tool is available on our provider website: Quick Links>Self-Service Tool.

Availity Essentials

Use Availity Essentials to securely:

- Verify member eligibility and benefits
- Submit claims and check claims status
- View electronic remittance advice (ERA)
- Enroll for electronic funds transfers (EFT)
- Submit appeals and check appeals status
- Access the Care Gap Management Application (CGMA)
- View onboarding tasks or credentialing and contracting status
- Access reimbursement schedules and other pricing documents
- View requests for claim attachments and submit documentation
- View medical pre-authorization requirements and submit requests

Provider Contact Center

Our Provider Contact Center is available for questions that cannot be answered by using Availity Essentials, our Self-Service Tool or provider website. Our Interactive Voice Response (IVR) system is available 24/7. Hours of operation and phone numbers are published in the Contact Us section of our provider website.

Risk adjustment audit beginning

In June 2023, we will begin requesting and reviewing medical records in to support a Risk Adjustment Data Validation (RADV) audit by the U.S. Department of Health and Human Services (HHS) for dates of service in 2022. We have partnered with the vendor Advantmed to assist us in the collection of medical records for this audit.

Learn more about risk adjustment on our provider website: Programs>Risk Adjustment.

Pricing dispute resources

Pricing disputes occur when contracted providers disagree with the contracted allowable rate applied to a claim or claim line items. Pricing disputes differ from provider appeals, and therefore follow timely claims filing guidelines for claim adjustments.

We created a checklist to help you quickly identify and submit valid pricing disputes. It includes examples of valid pricing disputes, resources to help you validate your dispute and tips for gathering required supporting documentation. We also list examples of invalid pricing disputes and circumstances that may delay a valid dispute.

To receive the most efficient response, review your claims issue against our pricing dispute checklist and validate your dispute against available resources.

View the pricing dispute checklist and learn more about disputes and appeals on our provider website: Claims & Payment>Payment>Appeals. If you need additional help determining whether your claims issue meets the criteria for a pricing dispute or appeal, contact our Provider Contact Center.

Appointment accessibility results

This past winter, we conducted our annual *Provider Access Survey* of PCPs, behavioral health providers, and providers in high-volume and high-impact specialties related to patient appointment access. Your answers helped us measure compliance with our published standards for after-hours phone coverage and appointment wait times.

Overall, we found that members' access to primary care appointments met our standards, with some delays for both urgent appointments and non-urgent, persistent symptom appointments. Timely access to specialty non-urgent care and routine behavioral health care for established patients also met our standards, though specialty urgent care and routine behavioral health care for new patients did not meet the timely access standard. We recognize and appreciate your efforts to deliver timely care for our members despite tremendous ongoing challenges.

After the survey, we contacted a sample of providers to learn more about the challenges you face in meeting access standards. Your open and honest responses have helped us better understand the challenges you and our members face concerning timely access to care.

Access to primary care

During our discussions with providers, common themes emerged:

- Some providers continue to face long-term COVID-19-related impacts that affect scheduling, such as backlogs and long wait lists.
- Many offices are continuing to work with reduced staff and are struggling to hire in a highly competitive environment, particularly when recruiting to rural and coastal areas.
- Despite these obstacles, offices try to schedule patients as quickly as possible or help them find care elsewhere if they cannot be seen in the office as soon as needed.

Access to specialty care

The survey showed us that scheduling patients for urgent specialty care appointments within 24 hours remains difficult, while patient access to non-urgent appointments within 30 calendar days improved after the scheduling difficulties of the past few years. We also learned that some specialties continue to experience long wait times while others are seeing decreasing wait times.

From our outreach, we learned that many providers have processes in place to triage members and help them get the right care at the right time, which may not be within 24 hours. We ask that you remain mindful of the urgent care requirement to ensure patients can get timely care when needed.

Access to behavioral health care

The survey data shows us that scheduling new patients for behavioral health care within 10 business days continues to be difficult. We recognize the unprecedented demand for behavioral health care services, and from our outreach, we learned of ways that you are working hard to meet this growing need. Offering extended hours and adding more virtual visit opportunities are helping members receive behavioral health care as quickly as possible.

We appreciate your commitment to meeting our members' behavioral health needs and working to provide them access to care. We recognize the need for additional behavioral health providers and are actively recruiting providers to increase accessibility.

Please be mindful of the access requirements for behavioral health care:

- Non-life-threatening emergency (crisis) will be treated within six hours or directed to the nearest emergency room, crisis line or crisis unit.
- Urgent care appointments will be scheduled within 48 hours or directed to the nearest emergency room, crisis line or crisis unit.
- Routine office visits will be scheduled within 10 business days.

Our standards are published on our provider website: Programs>Quality Program>Accessibility and Availability Standards.

Update your directory information

Accurate provider directories are essential to help members find providers who best meet their health care needs and individual preferences. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

The Consolidated Appropriations Act (CAA), 2021, requires health plans to establish a process to verify and update provider directory information no less frequently than every 90 days. Accurate provider directories are also a requirement for compliance with CMS and the Affordable Care Act (ACA).

Our *Provider Directory Attestation Requirements for Providers* policy requires:

- Providers to review for accuracy and submit all updated information about their practice at least every 90 days
- Providers to continue to notify us promptly of changes to directory information
- All participating providers who are eligible to display in directories based on their specialty and current credentialing status to be displayed in our provider directories
- All participating providers to comply with our policies and procedures related to furnishing information necessary to ensure provider directories are up-to-date, accurate and complete pursuant to federal and state law, including 45 C.F.R. 156.230(b); this information includes, but is not limited to, accepting new patients, provider practice location, contact information, specialty, medical group and other institutional affiliations
- Providers to review, update and return roster validation requests

Please follow the instructions to verify your directory information on our provider website at least every 90 days: Contact Us>Update Your Information.

As part of your routine review of provider directory information, also review your National Provider Identifier (NPI) data in CMS' National Plan & Provider Enumeration System (NPPES). Visit NPPES help for more information: **nppes.cms.hhs.gov**.

Enema system code removed from NRS list

We have removed HCPCS A4459 from our non-reimbursable services (NRS) list as if never non-reimbursable. This durable medical equipment (DME) code for manual enema systems has been removed from the *Clinical Edits by Code List* on the Coding Toolkit section of our provider website.

Responding to documentation requests

When medical records or supporting documentation are needed for claims processing, we request them through Availity's Attachments application, fax, email or USPS. If you receive a request for medical records, please respond using the same format in which the request is received. If you receive a request via Availity Essentials, you must submit requested records using the Availity Attachments application.

To avoid claim-processing delays, please set up access to the Availity Attachments application today. This will ensure you receive notification and can submit documentation when requested.

Learn more about claim attachments and view the *Getting Started Guide* on our provider website: Claims & Payment> Claims Submission>Claims Attachments. Find on-demand and live training options on Availity Essentials: Help & Training>Get Trained, then search for Attachments—New.

Pre-authorization determination letters in Availity

Determination letters for pre-authorizations you submit via Availity Essentials are now available on the Authorization/ Referral Dashboard, making it even easier to manage your pre-authorizations.

Availity's Electronic Authorization application checks patient benefits and whether a service is excluded from coverage or requires pre-authorization. You can quickly submit a medical pre-authorization request and supporting clinical documentation, or check the status of requests you have submitted or have been named in.

Learn more about Availity's authorization application on our provider website: Pre-authorization>Electronic Authorization.

Compliance program requirements

We want to remind you that all providers and their staff, including any board or trustee members must meet the requirements of our Government Programs compliance program, including:

- Monthly verification that they are not on an exclusion list
- Completion of annual compliance and fraud, waste and abuse (FWA) trainings

We contract with CMS to provide health care services to members with coverage on Qualified Health Plans (QHP). Through these contracts, we must oversee the downstream and delegated entities (DDEs) that assist us in providing services for our QHP beneficiaries.

Exclusion lists

All QHP-contracted providers, medical groups, facilities and suppliers are required to check the Office of Inspector General (OIG) and General Services Administration (GSA) federal exclusion lists for all employees prior to hire and monthly thereafter. If an employee is confirmed to be excluded, they must immediately be removed from working on our government programs. We are prohibited from paying government funds to any entity or individual found on these federal lists:

- GSA exclusion list: **sam.gov/content/exclusions**
- OIG exclusion list: **oig.hhs.gov/exclusions**

Documentation of these verifications must be maintained and made available upon request by either BridgeSpan or CMS. We ask contracted entities to verify that the entity is compliant with this requirement during initial credentialing and at recredentialing.

Required compliance training

FWA and general compliance trainings are a contractual requirement for participation in our QHP networks. This training must be completed within 90 days of hire and annually thereafter.

Please ensure that your staff complete required training and maintain documentation for auditing purposes.

Compliance for board and/or trustee members

Your organization's board or trustee members are required to participate in all BridgeSpan Government Programs compliance activities, including:

- Signing a conflict of interest disclosure at appointment and annually thereafter
- Completing OIG and GSA screenings prior to appointment and monthly thereafter
- Completing FWA and general compliance training within 90 days of appointment and annually thereafter

Documentation must be maintained and made available upon request by either BridgeSpan or CMS.

Learn more

More information about our compliance program and related resources are available on our provider website:

- Library>Policies & Guidelines>Guidelines>Government Programs Compliance Tips
- Qualified Health Plans section of the *Administrative Manual*: Library>Administrative Manual

Pre-authorization updates

Effective September 1, 2023, we will remove the option to submit pre-authorization requests using the online form. You can continue to submit pre-authorization requests via more efficient methods, including Availity Essentials or by fax.

Procedure/medical policy	**Added code effective February 1, 2023**
Evaluating the Utility of Genetic Panels (Genetic Testing #64)	- 0242U
Procedure/medical policy	**Added codes effective April 1, 2023**
Digital Therapeutic Products (Medicine #175)	- E1905
Digital Therapeutic Products for Chronic Low Back Pain (Medicine #175.03)	- E1905, 98978, A9291
Procedure/medical policy	**Changes effective September 1, 2023**
Genetic testing – biomarker testing	- Removing pre-authorization exemption for Washington members for diagnosis codes Z800-Z803, Z8041 and Z8042
Negative Pressure Wound Therapy in the Outpatient Setting (Durable Medical Equipment #42)	- Changing 97607 and 97608 to be denied as investigational
Tumor Treatment Field Therapy (TTFT) (Durable Medical Equipment #85)	- Adding E0766

Our complete *Pre-authorization List* is available in the Pre-authorization section of our provider website. Please review the list for all updates and pre-authorize services accordingly. You can submit standard medical pre-authorizations through Availity Essentials' Electronic Authorization application.

Carelon revising clinical guidelines

Effective September 10, 2023, Carelon Medical Benefits Management (Carelon) will revise the following radiology guidelines:

- Imaging of the Extremities
- Imaging of the Spine
- Vascular Imaging

Visit Carelon's website to view the revised guidelines: **guidelines.carelonmedicalbenefitsmanagement.com/category/coming-soon**.

Changes to skin substitute codes in emergency care

Effective September 1, 2023, we will no longer allow bioengineered skin substitute codes that are considered investigational by plan medical policy to be reimbursed when submitted with an emergency room place of service (POS 23) or revenue codes 0450-0459.

Claims will result in an investigational denial when billed with one of the following ICD-10-CM diagnosis codes:

- L551, L552
- T2020XA, T2020XD, T2020XS
- T20211A, T20211D, T20211S
- T20212A, T20212D, T20212S
- T20219A, T20219D, T20219S
- T2022XA, T2022XD, T2022XS
- T2023XA, T2023XD, T2023XS
- T2024XA, T2024XD, T2024XS
- T2025XA, T2025XD, T2025XS
- T2026XA, T2026XD, T2026XS
- T2027XA, T2027XD, T2027XS
- T2029XA, T2029XD, T2029XS
- T2030XA, T2030XD, T2030XS
- T20311A, T20311D, T20311S
- T20312A, T20312D, T20312S
- T20319, T20319A, T20319D, T20319S
- T2032XA, T2032XD, T2032XS
- T2033XA, T2033XD, T2033XS
- T2034XA, T2034XD, T2034XS
- T2035XA, T2035XD, T2035XS
- T2036XA, T2036XD, T2036XS
- T2037XA, T2037XD, T2037XS
- T2039XA, T2039XD, T2039XS

This change is supported by our *Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products* (Medicine #170) medical policy. Accept the disclaimer to view our *Medical Policy Manual*, available on our provider website: Policies & Guidelines>Medical Policy.

Avoid confusion in breast MRI requests

To avoid confusion for members, when submitting a request to Carelon for a breast MRI, providers should enter the CPT code of the requested procedure rather than entering the group descriptor MRI-breast. The group descriptor MRI-breast defaults to the unilateral procedure description—"MRI breast without contrast material, unilateral"—even though the default grouper code and description includes both unilateral and bilateral procedures (CPT 77046-77049).

Most breast MRI requests are for bilateral procedures, so using the CPT code when submitting your request ensures the member will receive the most accurate representation of services requested in their approval notices, preventing confusion.

Check whether procedures at hospitals require pre-authorization

Reminder: Select procedures will require pre-authorization for the site of service when performed at an outpatient hospital surgical site effective July 1, 2023.

Specialty area	CPT codes requiring pre-authorization when performed outpatient hospital
Digestive system	- 42821, 42826, 42831, 43260, 43261, 46505, 46607, 49082, 49422
Genitals	- 54150, 54161-54164, 54300, 54450, 54840, 55040, 55041, 55700, 56810, 57283, 58263
Hematologic and lymphatic system	- 38221, 38222
Integumentary system	- 11755, 14040, 14060, 15850, 17311, 17313
Nervous system	- 62270, 63661, 63663, 64418, 64425, 64530, 64610, 64642, 64644, 64646, 64702, 64718, 64719, 64721, 64774, 64795, 64831
Ophthalmologic	- 65756, 65779, 65780, 65855, 66183, 66761, 66840, 66850, 67028, 67218, 68320
Respiratory system	- 30130, 30140, 30520, 30802, 31200, 31205, 31525, 31574, 31591, 32408, 32555, 32557
Urinary system	- 50430, 51715, 52001, 52235, 52287, 52450, 53445

These site-of-service pre-authorization requirements are for services where a lower level of care may be appropriate. Sites of service will not require pre-authorization when performed at an ambulatory surgical center (ASC) or physician office.

We consider an individual's health status, facility and geographic availability, specialty requirements, physician privileges and other factors when determining the appropriate site of service.

Use Availity to save time and effort

For the fastest review, submit requests through Availity Essentials' Electronic Authorization application. The Availity process incorporates additional questions related to site of service, so you don't need to fill out and submit the *Surgical Site of Service Additional Information Form*. Some requests will receive automated approvals.

If you fax a request, you will need to submit a completed and signed *Surgical Site of Service Additional Information Form*.

New Availity feature: The Electronic Authorization application now lets you submit your pre-authorization requests for these and most other procedures approximately one month prior to the effective date of a pre-authorization change. This improvement ensures you receive accurate pre-authorization reviews for procedures scheduled to occur on or after July 1, 2023, and improves your ability to schedule procedures with confidence.

Additional information

- The complete list of codes requiring pre-authorization and the *Surgical Site of Service Additional Information Form* for faxed requests are available on the Pre-authorization list on our provider website. In addition to the site of service, the services performed may require pre-authorization.
- View the *Surgical Site of Service – Hospital Outpatient* medical policy on our provider website: Library>Policies & Guidelines>Medical Policy.

The Bulletin recap

We publish updates to medical and reimbursement policies in our monthly publication, *The Bulletin*. You can read issues of *The Bulletin* or subscribe to receive an email notification when issues are published on our provider website: Library>Bulletins.

Medical policy updates

We provided 90-day notice in the April 2023 issue of *The Bulletin* about updates to the *Investigational Gene Expression, Biomarker, and Multianalyte Testing* (Laboratory #77) medical policy, which are effective July 1, 2023.

We provided 90-day notice in the May 2023 issue of *The Bulletin* about the following medical policies, which are effective August 1, 2023:

- *Identification of Microorganisms Using Nucleic Acid Probes* (Genetic Testing #85)
- *Temporary Implanted Nitinol Device (e.g., iTind) for Benign Prostatic Hyperplasia* (Surgery #230)

The *Medical Policy Manual* includes a list of recent updates and archived policies and is available on our provider website: Library>Policies & Guidelines>Medical Policy>Recent Updates.

Reimbursement policy updates

No reimbursement policies in the April 2023 or May 2023 issues of *The Bulletin* required 90-day notice. View our *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

Virtual care policy updates

In the May 2023 issue of *The Bulletin*, we announced changes to our *Virtual Care* (Administrative #132) reimbursement policy that concern in-person visits that occur shortly before or after some types of virtual services, among other changes.

Policy changes

- Revised to state that audio-only services, virtual check-ins and store-and-forward services will not be separately reimbursed when 1) performed within seven days of a related office visit or 2) they resulted in an office visit 24 hours or soonest appointment after the virtual visit
    - **Our system will restrict reimbursement for these types of claims submitted on or after August 1, 2023, regardless of the date the service was provided**; we will identify and correct claims billed or paid on or after May 1, 2022, for dates of service back to 2020
- Clarified that store-and-forward codes CPT 99451 and 99452 are not subject to the "greater than 50% of time devoted to medical consultative … discussion" requirement
- Added HCPCS G2088, 0733T, 0734T and 0488T to the policy as reimbursable when criteria are met
- Clarified that some remote monitoring services—such as CPT 98978, 0740T and 0741T—may be reimbursable when our reimbursement and medical policy criteria are met

Resources on our provider website

- The updates, effective May 1, 2023, were announced in the May 2023 issue of *The Bulletin*: Library>Bulletins.
- Accept the terms to view our *Reimbursement Policy Manual*: Library>Policies & Guidelines>Reimbursement Policy.

Medication policy updates

Listed below is a summary of medication policy additions and changes. Links to all medication policies, medication lists and pre-authorization information for our members, including real-time deletions from our pre-authorization lists, are available on our provider website: Programs>Pharmacy. **Note**: Policies are available online on the effective date of the addition or change.

Pre-authorization: Submit medication pre-authorization requests through **covermymeds.com**.

Expert feedback: We routinely assess our medication policies based on updated medical literature, national treatment guidelines, practicing provider feedback and pharmaceutical market changes. If you'd like to provide feedback or be added to our distribution list, please email us at **BridgeSpanRxMedicationPolicy@bridgespanhealth.com** and indicate your specialty.

New U.S. Food & Drug Administration- (FDA-) approved medications: New-to-market medications are subject to pre-authorization based on their FDA-labeled indication, pivotal trial criteria and dosage limitations until we complete a full medication review and develop a coverage policy.

Product not available (PNA) status: We allow a 90-day grace period to use any existing supply for medications that CMS has designated as PNA before they become ineligible for reimbursement. See our *Non-Reimbursable Services* (Administrative #107) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

Effective April 15, 2023	Description
New policies	
Briumvi, ublituximab-xiiy, dru739	- Added to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Elahere, mirvetuximab soravtansine-gynx, dru738	- Limited coverage to patients with FRα-positive, platinum resistant, epithelial ovarian, fallopian tube or primary peritoneal cancer who have received at least one prior systemic therapy; prior therapy must have included both a platinum agent and bevacizumab
Imjudo, tremelimumab-actl, dru737	- Limited coverage in combination with Imfinzi (durvalumab) as a front-line therapy for patients with unresectable, Child-Pugh class A hepatocellular carcinoma (uHCC); and, in combination with Imfinzi (durvalumab) and a platinum doublet as a front-line therapy for metastatic non-small cell lung cancer (NSCLC) when no sensitizing EGFR or ALK gene alterations are present
Monoclonal antibodies for Alzheimer's disease, dru740	- New combination policy incorporates Aduhelm (dru670) and the newly FDA-approved Leqembi (lecanemab) - The use of Leqembi is considered investigational, and therefore, not covered because of a lack of high-quality evidence of clinically meaningful health benefit
Pedmark, sodium thiosulfate, dru736	- Limited coverage to pediatric and adolescent patients with non-metastatic cancer to prevent cisplatin-induced ototoxicity
Rebyota, fecal microbiota live-jslm, dru741	- The use of Rebyota is considered not medically necessary, and therefore, not covered because it has not been proven to provide any additional safety or efficacy benefit over other treatment options (fecal microbiota transplants [FMTs]) sourced from different independent distributers) yet is significantly more costly
Tzield, teplizumab, dru742	- The use of Tzield is considered not medically necessary, and therefore, not covered, because of a lack of high-quality evidence that it improves clinically relevant outcomes compared to established treatment options

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Revised policies	
Imfinzi, durvalumab, dru500	- Added coverage for NSCLC as first-line therapy when used in combination with Imjudo (tremelimumab) and a platinum doublet, a new FDA-approved indication - Added coverage for unresectable hepatocellular carcinoma (HCC) as a first-line therapy when used in combination with a priming dose of Imjudo (tremelimumab), a new FDA-approved indication
Immune Globulin Replacement Therapy, dru20	- Clarified Guillain-Barré syndrome (GBS) criteria to include, but not be limited to, acute inflammatory demyelinating polyneuropathy (AIDP) to account for the non-demyelinating GBS variants; no change to intent
Medications for Amyotrophic Lateral Sclerosis (ALS), dru734	- Updated Relyvrio (sodium phenylbutyrate and taurursodiol) criteria to allow for forced vital capacity (FVC) or slow vital capacity (SVC) > 60%
Medications for Multiple Myeloma, other cancers, and other hematologic disorders, dru672	- Added newly FDA-approved Tecvayli (teclistamab) to policy; limits coverage to patients with multiple myeloma (MM) that is relapsed or is refractory to at least four prior therapies, including an anti-CD38 monoclonal antibody, a proteosome inhibitor and an immunomodulatory agent when there has been no prior therapy directed against B-cell maturation antigen (BCMA) - Removed Blenrep (belantamab mafodotin) because it is no longer sold
Polivy, polatuzumab vedotin-piiq, dru600	- Added front-line use in diffuse large B cell lymphoma (DLBCL) as not medically necessary based on newly published study and pending indication; data is limited to progression-free survival (PFS); there is no evidence it is safer or more effective than R-CHOP (same National Comprehensive Cancer Network [NCCN] placement) but is more costly
Site of Care Review, dru408	- Briumvi added to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Archived policies	
Arzerra, ofatumumab, dru196	- Arzerra is no longer sold
Lumoxiti, moxetumomab pasudotox-tdfk, dru564	- Lumoxiti is no longer sold

Effective June 1, 2023	Description
Revised policies	
Anabolic Bone Medications, dru612	- Removed postmenopausal criterion from Tymlos (abaloparatide) to allow for coverage of new expanded indication in males
Fibroblast growth factor receptor (FGFR) inhibitors, dru695	- Added newly FDA-approved Lytgobi (futibatinib) to policy; limits coverage to patients with progressive, unresectable cholangiocarcinoma when an FGFR2 gene rearrangement is present, up to the dose shown to be safe and effective in clinical trials
Hetlioz, tasimelteon, dru349	- Added generic tasimelteon to policy and updated criteria to require use of generic tasimelteon before coverage of branded Hetlioz
Isocitrate Dehydrogenase-1 (IDH1) inhibitors, dru558	- Added newly FDA-approved Rezlidhia (olutasidenib); limits coverage to patients with relapsed or refractory IDH1-mutated acute myeloid leukemia (AML) after at least one prior cytotoxic chemotherapy regimen for AML has been ineffective and when there has been no disease progression on prior IDH1-inhibitor therapy (e.g., ivosidenib)

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Effective June 1, 2023	Description
Revised policies (continued)	
Keveyis, dichlorphenamide, dru433	- Updated criteria to require use of generic dichlorphenamide before coverage of branded Keveyis
KRAS G12C Inhibitors, dru683	- Added newly FDA-apprvoed Krazati (adagrasib); criteria for coverage are identical to those for Lumakras (sotorasib) - Limited coverage to patients with KRAS G12C-mutated, locally advanced or metastatic NSCLC when disease progresses on or after at least one prior PD-1/PD-L1 inhibitor or platinum-based therapy
Mitogen-activate extracellular signal-regulated kinase (MEK) Inhibitors, dru727	- Added coverage of Cotellic (cobimetinib) in histiocytic neoplasms, a newly FDA-approved indication
Non-Preferred Injectable Insulins, dru372	- Added unbranded products for Tresiba and Toujeo as preferred products
Ravicti, glycerol phenylbutyrate, dru312	- Added additional step therapy requirement for Pheburane (sodium phenylbutyrate) - Reauthorization will now require annual review and confirmation that both lower-cost alternatives Buphenyl (sodium phenylbutyrate) and Pheburane (sodium phenylbutyrate) are not treatment options
Archived policies	
High-cost ophthalmic prostaglandin analogues and prostaglandin agonists, dru476	- Travatan Z no longer requires pre-authorization - The other products in dru476 continue to require pre-authorization
Nexavar, sorafenib, dru134	- Nexavar no longer requires pre-authorization

Effective September 1, 2023	Description
New policies	
Multiple Sclerosis Treatments, dru753	- New combination policy will incorporate Non-Preferred Multiple Sclerosis Treatments (dru511), Non-Preferred Glatiramer Products (dru570), Ocrevus (dru479), Briumvi (dru739), Tysabri (dru111) and Zeposia (dru674) - Adding new step therapy requirements for relapsing-remitting, clinically isolated syndrome and active secondary progressive multiple sclerosis: • Generic dimethyl fumarate, generic fingolimod, generic glatiramer and generic teriflunomide will continue to not require pre-authorization • Preferred branded products will now require pre-authorization and trial of a generic product • Non-preferred branded products will require trial of a generic and preferred product

Join the IntegratedRx® - Medical network

As stewards of our member's health care expenses, we are committed to delivering sustainable high-quality care to meet member needs. The price trend of many specialty medications has been growing at double the rate of inflation for years. This trend is even greater for provider-administered specialty medications in certain settings.

We've received increased requests for white-bagging solutions from employer groups. However, we feel providers should be part of the dispensing process, so we've designed a holistic solution that keeps the provider-patient relationship intact. We're one of the first health plans in our region to adopt this type of strategy. This approach has been successful in other parts of the country.

To move toward equitable and sustainable costs for provider-administered specialty medications in all settings, our pharmacy benefit manager, Prime Therapeutics, will launch IntegratedRx - Medical, a specialty medication provider network for BridgeSpan members, effective January 1, 2024. We'll also implement a new benefit for members, called BridgeSpan EquaPathRx™, to support this.

Join the Prime Therapeutics IntegratedRx - Medical Network

Beginning January 1, 2024, we'll require certain specialty medications for members included in BridgeSpan EquaPathRx to be fulfilled using the IntegratedRx - Medical Network.

Prime Therapeutics is now contacting providers to start the credentialing and contracting process for this new network. If you have already begun this process, please continue to engage with Prime Therapeutics.

- Each provider group or facility that offers administration of specialty medications will need to be credentialed and contracted as a dispensing provider with Prime Therapeutics.
- If your organization operates a specialty pharmacy that you want included in this network, they'll need to complete the credentialing and contracting process to be included, even if they have an existing pharmacy contract with Prime Therapeutics.
- Your contract with Prime will have a reimbursement schedule that includes the medications in the BridgeSpan EquaPathRx program.

Prime Therapeutics will continue to reach out to providers who have not started this process.

How the new network will work

Effective January 1, 2024, for members included in BridgeSpan EquaPathRx, we'll no longer provide coverage for select provider-administered medications except when obtained through the new IntegratedRx - Medical Network.

When you join the IntegratedRx - Medical Network, you'll be able to submit medication claims directly to Prime Therapeutics without patient interruption or a requirement to change administration sites. Prime will reimburse you for the medication at the rates on your Prime reimbursement schedule, and the medical claim for any administration-related services will still be submitted to BridgeSpan, as it is today. Participation in the network also:

- Ensures the claim meets payment criteria before you administer the medication
- Allows flexibility for provider procurement of medication; you can procure medication through existing methods, including 340B or specialty pharmacy

If you don't join the IntegratedRx - Medical Network, you'll need to use a participating IntegratedRx - Medical Network specialty pharmacy to fill these medications in 2024.

Impacts to reimbursement for medications

We understand this change will impact reimbursement and operational processes for some medications, but it's necessary to meet our goal of ensuring costs remain predictable and affordable for our groups and members—your patients.

We believe the Prime Therapeutics reimbursement schedule for the IntegratedRx - Medical Network is fair and reasonable to accomplish our goal with the least interference to your current processes for prescribing and administering these specialty medications. Participation in the IntegratedRx - Medical Network won't affect your ability to use the 340B pathway to acquire medications.

The list of medications (with HCPCS and NDC codes) that will be included in this program effective January 1, 2024, is on our provider website: Programs>Medical Management>Pharmacy.

What's next

If you have been contacted by Prime but haven't started the credentialing and contracting process, please do that as soon as possible.

We'll share more information in these communications:

- The October 2023 issue of *The Connection*℠ will include medication policy changes and 2024 product updates.
- The October 2023 issue of *The Bulletin* will include any related updates to reimbursement or medical policies.

In addition, later this year, we'll work with Prime to provide:

- Instructions for verifying member benefits
- Detailed instructions for claims submission, including training opportunities for you and your staff

We look forward to your inclusion in the IntegratedRx - Medical Network.

Behavioral health corner

About behavioral health corner

This section highlights the articles that affect behavioral health providers. We also recommend you use the search function (**Ctrl + F**) on your computer to search for keywords that concern your practice.

Additionally, the following recurring articles often have policy updates that may affect your practice:

- Update your directory information
- Pre-authorization updates
- *The Bulletin* recap
- Medication policy updates

Updated list of specialized virtual providers

Because timely behavioral health care is integral to patients' overall well-being, we continue to improve access by expanding the types of specialized virtual behavioral health providers in our networks. These providers' diverse areas of focus include eating disorders, obsessive compulsive disorder (OCD), substance use disorder (SUD) and comprehensive therapy programs to treat a variety of age ranges, from age 6 through adulthood.

Contact information on our provider website

- Find an up-to-date list of these providers in the Telehealth section of our Behavioral Health Toolkit: Behavioral Health>Behavioral Health Toolkit.
- Learn about additional national behavioral health vendors available to some members: Care Options>Telehealth.

Connect members to care

Members can call the Customer Service number on the back of their ID card or chat online with Customer Service to verify a provider group is in-network. They can also use the Find a Doctor tool on our member website, **bridgespanhealth.com**, to search Places by Name.

Help increase post-discharge care rates

To improve our members' outcomes and reduce or avoid readmissions, it is important that patients are seen by a behavioral health clinician within seven days of discharge.

Timely follow-up visits can occur any time between days one and seven and may be held in person, via telehealth or through billable visits by phone. (**Note**: Discharge appointments do not count as follow-up appointments.)

Care coordination and telehealth can help ensure members receive timely care.

Improve outcomes and set patients up for success

Care coordination is a vital aspect of good treatment planning and plays a critical role in improving outcomes. By working with us, the member and the member's family or support system, we can collectively ensure members have successful discharge plans and are able to function to their highest ability when they leave the hospital setting. We encourage communication among a member's providers and the health plan.

To begin care coordination, call (253) 382-7747 or email **BHCarecoordinator@bridgespanhealth.com**.

Our care management team will:

- Determine a follow-up plan during the inpatient review process
- Assist in securing follow-up appointments, including locating new providers if needed
- Offer support by contacting members after their discharge to discuss the follow-up plan
- Help our members understand the importance of follow-up appointments
- Encourage timely outpatient follow-up with a licensed behavioral health provider

Your facility should:

- Begin follow-up planning at the time of inpatient admission and involve and educate the patient's family about the follow-up plan
- Discuss the follow-up plan with your patient and the importance of follow-up visits
- Schedule follow-up appointments, including one within seven days of discharge
    - Consider choosing telehealth to help meet the HEDIS® standard for timely follow-up care and/or ongoing care
- Ensure accurate post-discharge contact and follow-up information
- Call your patient to remind them of the follow-up appointment
- Encourage your patients to sign an *Authorization to Disclose Protected Health Information* form, if needed, available on our provider website: Library>Forms.
    - A release of information (ROI) is required for coordinating with SUD providers or facilities.
    - Most behavioral health information can be shared among treating providers—even those in different organizations—without an ROI for the purposes of coordinating care. Additionally, requesting an ROI before coordinating care can delay appropriate care and lead to poor outcomes.

Telehealth can bridge the gap

Telehealth helps ensure our members receive follow-up care within seven days of discharge by allowing members to receive care using a computer, phone and/or tablet. We continue to add virtual care behavioral health providers to our networks to increase access to outpatient professional appointments. **Related**: See *Updated list of specialized virtual providers* on page 16.

Measuring success

The HEDIS measure Follow-Up After Hospitalization for Mental Illness (FUH) tracks post-discharge behavioral health care to ensure members transition safely from an acute hospital setting back to their home environments. To meet the measure's standard, behavioral health clinicians should provide the following types of services within seven days of discharge:

Qualifying clinician types	Qualifying services
- Psychiatrist - Licensed clinical social worker (LCSW) - Licensed marriage and family therapist (LMFT) - Licensed professional counselor (LPC) - Psychiatric nurse - Psychologist - Providers rendering services via incident-to billing criteria; see our *Incident to Services* (Administrative #148) reimbursement policy	- Intensive outpatient (IOP) - Partial hospitalization program (PHP) - Residential treatment center (RTC)

Help members find convenient care

Our members have several care options that can be used when your office is closed or as an alternative to an emergency room (ER) visit.

Connect your patients to care

- Encourage your patients to sign in to **bridgespanhealth.com** and select **Find Care** to see their medical and behavioral health in-person, virtual, urgent or at-home care options, where available.
- Our Customer Service team is also able to help members identify their care options. Our Customer Service numbers are listed on the back of member ID cards.

Our care managers proactively reach out to members who've had several ER visits. In addition, we educate our members about their care options through emails, our member websites, social media and blogs.

Virtual care

If you offer telehealth services, as many of our providers do, remind patients how they can schedule an appointment. Most of our members also have access to telehealth vendors that offer convenient appointment times.

Advice24 nurse triage

Most members have access to immediate support through Advice24, for everyday health issues and questions that might otherwise lead to unnecessary urgent care or ER visits. Members can call the Advice24 nurse triage line, or in some cases send a chat message, to connect directly with a registered nurse in seconds. The registered nurse can help navigate the member to the most appropriate care setting, whether it is in-person, virtual or home care. Members may also receive follow-up calls, depending on their clinical need.

Urgent care

Many urgent care clinics are conveniently located and more accessible than ERs. Remind your patients when to visit an urgent care clinic versus an ER.

In-home, on-call medical care

With DispatchHealth, **dispatchhealth.com**, members can receive care in the comfort of their home and avoid a trip to urgent care or the ER.

- DispatchHealth providers serve patients in the greater Portland, Oregon; and Olympia, Seattle and Tacoma, Washington areas.
- They are available after-hours (operating 7 days a week, including holidays, from 8 a.m.-10 p.m.) and during capacity constraints at a cost similar to an urgent care visit.

Their medical team can provide many of the same services as an urgent care facility, including:

- Onsite labs
- Sutures and lancing
- IV placement with fluids
- Urinary catheter insertion
- Medication and antibiotics
- Ordering additional services (e.g., EKG)

Easily connect your patients to DispatchHealth:

- Download this overview to share with providers in your office: **dispatchhealth.sharepoint.com/:b:/s/DHMarketing/Ed2idcct0z5HpJcJ1RCusEMBCJI-6PhTJ4c6T4z2J7lcgA?e=Qn0tUb**.
- Share this flyer with your patients to help educate them about this option: **beonbrand.getbynder.com/m/6abd52697008eba6/original/Member-One-Pager-DispatchHealth.pdf**.
- When care is needed, you or your patient can call 1 (833) 652-0539 or use the online portal to request a visit at **dispatchhealth.com/locations**.
- After you or the member requests care, a team of trained emergency medical professionals, a physician assistant or nurse practitioner, and a medical technician will arrive at the member's location.
- The on-site medical team will coordinate care at the bedside, as appropriate, and direct the member to you for follow up.
- You will receive the patient's clinical encounter notes from DispatchHealth summarizing the visit.

Resources on our provider website

- Find information about these care alternatives, as well as virtual behavioral health vendors available to some members in the Care Options section.
- We list specialized virtual in-network behavioral health providers in the telehealth section of our Behavioral Health Toolkit: Behavioral Health>Behavioral Health Toolkit.
  - **Related**: See *Updated list of specialized virtual providers* on page 16.
- If you provide telehealth services, review our standard and expanded telehealth guidance: Care Options> Telehealth.
  - **Related**: See *Virtual care policy updates* on page 11.

Schedule routine checkups

To help your patients stay healthy and avoid health emergencies, it's critical that they keep regularly scheduled appointments, especially for immunizations, screenings, preventive care and chronic disease management. In addition, it's important for your patients to continue taking all medications exactly as prescribed.

Our member website, **bridgespanhealth.com**, and social media channels encourage members to receive the care they need to stay healthy. Our site includes tips to help members schedule and prepare for in-person routine or follow-up medical or dental care. By logging into their account, members can also see the behavioral health options available to them.

Preventive vs. diagnostic care

When scheduling appointments, please remind your patients that diagnostic care to treat a new symptom or an existing problem ordered during a preventive care visit is subject to cost share (e.g., copay, coinsurance or deductible) amounts, just as additional services ordered during a non-preventive visit would be.

View our preventive care list

View the complete list of preventive services that we cover, broken out for members of all ages, pregnant members and children (available in English and Spanish): **bridgespanhealth.com/member/use/preventive-care-list**.

QIP tips and reminders

2022 program payout

Checks for earned incentives will be mailed by the end of June. Checks will be mailed to the address listed on file.

Using the CGMA dashboard

Our CGMA is a helpful tool for reviewing and closing patient care gaps. Signing into your CGMA and using the dashboard makes it easy for you to:

- Review your 2023 QIP program data
- View measures that are attributed to your members
- Review open care gaps
- See your member rosters

Note: If you have not signed into your CGMA account this year, we encourage you to do so. CGMA accounts that are inactive for 120 calendar days are locked.

Following up on patient test results

Our members' experiences with the health care delivery system are measured as part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. We are keeping a close eye on two measures regarding how well providers follow up with test results and do so in a timely manner.

Studies show that ineffective management of test results—both following up with test results and following up in a timely manner—can lead to waste in health care by causing additional and unnecessary tests to be ordered, or diagnoses or needed medication changes to be missed, leading to serious patient safety issues.

While we know that many of our provider partners are currently working to restaff support staff positions that would typically help with workflows related to following up with test results, we encourage you to consider these tips related to test result processes to ensure that follow-up is happening in a timely manner:

- Follow up on all test results, both normal and abnormal.
- Follow up using patients' preferred method of communication (mail, phone or email) to ensure they are notified of their results.
- Leverage your electronic medical record to its highest potential for test tracking and follow-up, to distinguish between abnormal and normal test results, and for communication between staff, as well as communication with patients through your patient portal.
- Communicating the standard process for following up with test results (e.g., within two to three business days) can help set patients' expectations and improve the experience for patients and staff.

Consider test result follow up and following up timely as a quality improvement project for your 2023 or 2024 quality program year. Here are some resources that can help:

- The Institute for Health Improvement *Plan-Do-Study-Act (PDSA) Worksheet* can help guide almost any quality improvement project: **ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx**
- The Agency for Healthcare Research and Quality *Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement* may be helpful for improving processes and workflows within your practice: **ahrq.gov/hai/tools/ambulatory-care/lab-testing-toolkit.html**

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Well-child visits are important

Well-child visits provide opportunities for infants and young children to receive recommended preventive care screenings, immunizations and vaccinations; chronic condition prevention and management; identification and treatment of major illnesses; early identification of special health care needs; and other important services. These visits can also address identified needs and provide referrals to community resources to help build and support strong families who are able to successfully care for children.

Pediatric PCPs are a trusted resource for parents and caregivers regarding their children's health and have a vital role in ensuring children receive timely well-child care.

One of our 2023 goals is to increase the number of children who receive six or more well-child visits with a PCP during the first 15 months of life as measured using HEDIS criteria. The American Academy of Pediatrics (AAP) schedule includes at least six visits at the following times:

- Birth
- Three to five days following birth
- By one month of age
- One visit each at two, four, six, nine, 12 and 15 months of age

We support the AAP recommendations for preventive pediatric health care, and we encourage you to provide well-child services at appropriate intervals and to remind parents of the need for these visits and their timing by:

- Scheduling office visits in advance, based on the recommended schedule
- Pursuing missed appointments with letters and reminder calls
- Submitting claims for well-child services using the following codes:
  - CPT 99381-99385, 99391-99395 or 99461
  - HCPCS G0438, G0439 or S0302
  - ICD-10-CM Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1 or Z76.2

Resources

- Look for the **Well-child visits** category in the Quality Improvement Toolkit, available in the Toolkits section on the homepage of our provider website.
- Bright Futures Health Care Professionals Tools and Resources: **brightfutures.aap.org/clinical-practice/Pages/default.aspx**
- Vaccination schedules for children and adolescents, as well as catch-up schedules, published by the Centers for Disease Control and Prevention (CDC): **cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html**
- Healthwise's Knowledgebase, available on our provider website: Programs>Member Programs & Tools
  - Search Healthwise's Knowledgebase for materials in English and Spanish:
    - Immunizations
    - Vaccinations
    - Well visit (View information about well-child visits for patients ages birth to four weeks, one week, two months, four months, six months, twelve months and 14 to 15 months)

Women's health: Screening reminders

We cover the following preventive health services at 100% for most members:

- Cervical cancer screening (Pap) (ages 21 and older)
- Screening for gonorrhea, syphilis and chlamydia
- HIV screening and counseling (ages 15 to 65 or at high risk)
- Human papillomavirus (HPV) screening, every three years (ages 30 and older) and HPV immunizations (up to age 45)
- Screening mammogram (ages 40 and older or at high risk)
- Sexually transmitted disease counseling during wellness exams

Members may not be aware that these services are covered at 100%. They can view the list of covered services on our member website or by calling the Customer Service number on the back of their member ID card.

Cervical cancer screening

We encourage you to schedule cervical cancer screenings with your patients who may be overdue. These screenings may find cancers earlier—when they are more easily treated. Women who have not been screened face the greatest risk of developing invasive cervical cancer.

Our most recent HEDIS results, based on 2021 care, indicate that only 45% of our members who are eligible received the screening.

The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer with the Pap test alone every three years in women ages 21 to 29. In women ages 30 to 65, the USPSTF recommends the Pap test alone every three years or HPV testing, with or without Pap co-testing, every five years.

Chlamydia screening

Because people often do not have symptoms, many chlamydia infections go undetected and untreated, which can have severe long-term health consequences.

The HEDIS specifications for chlamydia recommend screening one time per year in women ages 16 to 24 who are sexually active. The USPSTF recommends screening for chlamydia in sexually active women 24 and younger and in older women who are at increased risk for infection.

Resources

- Look for the **Chlamydia screening** category in the Quality Improvement Toolkit, available in the Toolkits section on the homepage of our provider website.
- List of preventive care services covered at no cost for our members: **bridgespanhealth.com/member/use/preventive-care-list**
- Healthwise's Knowledgebase, including the video *Why Get a Chlamydia Test*, available on our provider website: Programs>Member Programs & Tools
- Chlamydia—CDC Fact Sheet: **cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm**

Resources for you

Use our Self-Service Tool, available 24/7, to review helpful answers to our most frequently asked questions and quickly navigate our provider website resources.

Publications team

Sara Perrott: Publications editor and writer

Sheryl Johnson: Managing editor and writer

Cindy Price: Designer and writer

Carrie White: Writer

Jayne Drinan: Writer

Janice Farley: Editor