DECEMBER 2024

Provider News

For participating physicians, other health care professionals and facilities

Resources and reminders for a strong start to 2025

To help you prepare for 2025, here are some key reminders and resources to keep in mind.

Member ID card reminders

New member cards are often issued in January, so it's essential to ask for your BridgeSpan patients' most current card at each visit to ensure prompt and accurate claims processing. **Note**: Remember to copy the front and back of the card for reference and verify that the member number submitted on claims matches the card exactly.

Resources to help you thrive

We're committed to supporting you and your practice. The Contact Us section of our provider website has some valuable resources to help you navigate the new year:

- **Availity Essentials**: Access member eligibility to verify coverage, view benefits and claims information, and submit pre-authorization requests online.
- **Self-Service Tool**: Find answers to frequently asked questions about claims submission, pre-authorization and more.
- **Provider Contact Center**: Reach out for assistance with questions that can't be answered through Availity Essentials or our Self-Service Tool.

Additional resources

For more resources to support your practice and patients, explore the provider toolkits on the homepage our provider website for topics like behavioral health, pain management, health equity, care options, coding and quality improvement.

Thank you for your partnership and commitment to excellence!

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.

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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. 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.

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

Are our publications meeting your needs? Send us your comments.

Remote EMR service for efficient HEDIS medical record retrieval

To support Healthcare Effectiveness Data and Information Set (HEDIS®), we send annual medical record requests. We know these requests can be time-consuming for your office to fulfill. We're excited to offer a remote electronic medical record (EMR) service. Granting access to your EMR allows us to pull the required documentation for HEDIS. This aids your office in reaching compliance while reducing the time and resources associated with medical record retrieval.

How it works

Our EMR team works with multiple EMR systems and undergoes extensive training annually on HIPAA, EMR systems and HEDIS measure updates. This expertise enables us to efficiently and securely retrieve medical records on your behalf, reducing the need for manual requests.

Benefits of remote EMR service

By using our remote EMR service, you can:

- Reduce the number of medical record requests we send to your office each year
- Save time and resources by not having to manually retrieve and send medical records
- Ensure that medical records are retrieved and stored securely, in compliance with HIPAA guidelines

Our commitment to security and compliance

We take the security and confidentiality of medical records seriously. Our remote EMR service is designed to ensure that we only access the minimum necessary information to fulfill HEDIS measure requirements. Specifically:

- We only save medical records to file, without physically printing any personal health information.
- We only retrieve medical records that have claims evidence related to HEDIS measures.
- We only access medical records of members pulled into the HEDIS sample using specific demographic data.
- We access the least amount of information needed for use or disclosure, or we access only the specific medical records requested.

Get started with our remote EMR service

We're here to support you and help you streamline your HEDIS-related tasks. If you're interested in learning more about our remote EMR service and how it can help reduce medical record requests for the upcoming HEDIS chart collection beginning in February 2025, please:

- Email Brenda Taylor or call (208) 798-2042
- Email Kellee Mills or call (208) 750-2758

Responding to documentation requests

If you receive a request for claims-related medical records or supporting documentation, 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. Follow instructions on our provider website: Claims & Payment>Claims Submission> Claims Attachments.

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 and that they are completing annual trainings about compliance and fraud, waste and abuse (FWA).

We contract with CMS to provide health care services to members with coverage on Qualified Health Plans (QHPs). 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
- OIG exclusion list

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

Verify 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.

Provider directories, verified and updated at least every 90 days, are a requirement for compliance with the Consolidated Appropriations Act (CAA, the Affordable Care Act (ACA) and your agreement as a network provider with BridgeSpan.

- Review our *Provider Directory Attestation Requirements for Providers* policy.
- Follow the instructions to verify your directory information on our provider website at least every 90 days: Contact Us>Update Your Information.

Expanded directory information

Many patients prefer providers who share their race or ethnicity, or who speak the same language, which can improve communication and care quality. However, finding providers who share their racial and ethnic background can be a challenge.

We've expanded our provider directory information to include information about provider race and ethnicity. Additional practice information includes LGBTQIA+-affirming care, culturally specific services, expanded language access and disability competent care. The information you provide about your practice is displayed in our provider directory, Find a Doctor. This makes it easier for our members to find a provider they feel best meets their health care needs and individual preferences.

To learn more about providing culturally competent and linguistically appropriate services, view *An Implementation Checklist for the National CLAS Standards* (available in English and Spanish). Links to these checklists are included in our Health Equity Toolkit, available on the homepage of our provider website.

Process change for some joint management site-of-care reviews

We review select services scheduled in an outpatient hospital setting when a lower level of care, such as an ambulatory surgical center (ASC), may be appropriate. We are changing the pre-authorization process for site-of-care reviews for some joint surgeries.

For services delivered on or after March 1, 2025, our internal teams will review the site of care for joint surgeries that do not require medical necessity review. These reviews are addressed in our *Surgical Site of Care – Hospital Outpatient* (Utilization Management #19) medical policy, available on our provider website: Library>Policies & Guidelines>Medical Policy.

eviCore healthcare (eviCore) currently reviews select joint services for:

- Medical necessity—*eviCore will continue to review*.
- Site of care
- Both medical necessity and site of care—*eviCore will continue to review*.

Notes

- **Setting**: We only review the site of care when a surgery is scheduled in an outpatient hospital setting. We do not require site-of-care review for services performed at an ASC or physician office.
- **Other considerations**: We consider an individual's health status, facility and geographic availability, specialty requirements, physician privileges and other factors when determining the appropriate site of care.

Save time and effort with Availity

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

If you're faxing a pre-authorization request, you will need to submit the *Surgical Site of Care Additional Information Form* to provide attestation-based supporting documentation. **Failure to submit a completed and signed form will delay review.**

Affected codes will be moved to the **Surgical Site of Care—Hospital Outpatient** section of our Pre-authorization List alongside the *Surgical Site of Care Additional Information Form* for faxed requests.

Pre-authorization updates

Procedure/medical policy	Adding codes effective March 1, 2025
Surgical site of care – Hospital outpatient	- BridgeSpan will review the following codes: 20520, 20525, 20670, 20680, 20693, 20694, 23415, 23450, 23460, 23465, 23515, 23550, 23615, 23630, 23655, 23665, 24105, 24305, 24340-24343, 24345, 24346, 24357-24359, 24505, 24516, 24530, 24538, 24545, 24546, 24575, 24579, 24586, 24605, 24620, 24635, 24655, 24665, 24666, 24685, 25000, 25107, 25111, 25112, 25118, 25210, 25215, 25240, 25260, 25270, 25280, 25290, 25295, 25310, 25320, 25360, 25390, 25447, 25505, 25515, 25545, 25565, 25574, 25575, 25600, 25605- 25609, 25628, 25645, 25652, 25825, 26011, 26020, 26055, 26080, 26121, 26123, 26145, 26160, 26236, 26320, 26340, 26350, 26356, 26370, 26410, 26418, 26426, 26440, 26445, 26480, 26516, 26520, 26525, 26540, 26541, 26608, 26615, 26650, 26665, 26676, 26725, 26727, 26735, 26746, 26756, 26765, 26785, 26850, 26860, 26951, 26952, 27335, 27424, 27605, 27606, 27612, 27620, 27625, 27626, 27650, 27652, 27654, 27659, 27675, 27676, 27680, 27685, 27687, 27690, 27691, 27695, 27696, 27698, 27705, 27752, 27762, 27766, 27769, 27781, 27784, 27786, 27788, 27792, 27810, 27814, 27818, 27822, 27823, 27840, 28002, 28005, 28008, 28010, 28022, 28035, 28060, 28062, 28080, 28086, 28090, 28092, 28110, 28112, 28113, 28116, 28118-28120, 28122, 28124, 28160, 28190, 28192, 28200, 28208, 28230, 28232, 28234, 28238, 28250, 28270, 28272, 28285, 28288, 28289, 28291, 28292, 28295-28300, 28304, 28306, 28308, 28310, 28313, 28315, 28322, 28415, 28445, 28465, 28475, 28476, 28485, 28505, 28515, 28525, 28555, 28585, 28615, 28645, 28715, 28725, 28740, 28750, 28755, 28810, 28820, 28825, 29834, 29837, 29838, 29844, 29846, 29848

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 the Availity Essentials electronic authorization tool.

Carelon revising radiology guidelines

Effective March 23, 2025, Carelon will revise the following advanced imaging clinical guidelines:

- Imaging of the Abdomen and Pelvis
- Imaging of the Chest
- Oncologic Imaging

Visit the Coming Soon section of Carelon's website to view the revised guidelines.

EDC Analyzer reviews delayed

We will apply Optum's Emergency Department Claim (EDC) Analyzer to review emergency department (ED) claims pre-payment beginning February 19, 2025. We had previously announced plans to begin using the tool at an earlier date.

The EDC Analyzer provides an ED visit-level analysis and code validation. Using this tool is part of our continued efforts to reinforce accurate coding practices and identify claims that might have otherwise resulted in inaccurate payment.

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 October 2024 issue of *The Bulletin* about changes to the *Treatment of Adult Sepsis* (Medicine #172) medical policy, which are effective January 1, 2025.

We provided 90-day notice in the November 2024 issue of *The Bulletin* about changes to the following medical policies, which are effective February 1, 2025:

- *Ablation of Peripheral Nerves to Treat Pain* (Surgery #236)—new policy
- *Lumbar Spinal Fusion* (Surgery #187)
- *Power Wheelchairs - Group 2 and Group 3* (Durable Medical Equipment #37)

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

Reimbursement policy updates

No reimbursement policies in the October and November 2024 issues of *The Bulletin* required 90-day notice.

View our *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines> Reimbursement Policy.

Modifier 25 and Global Days reimbursement policy updates

As stewards of our members' health care dollars, we are updating policies to address redundant reimbursement for professional practice expenses (e.g., nonclinical labor, building space, office supplies, utilities and equipment) included in both evaluation & management (E&M) codes and minor procedure codes. We support using Modifier 25 to pay providers for separate services on the same day. With this change, providers will continue to be paid for their services, but we will only reimburse for professional practice expenses once.

CMS assigns relative value units (RVUs) to CPT codes, including E&M services, to calculate reimbursement for health care providers. RVUs identify the cost components of medical services, including the cost of provider services, liability insurance and practice expenses, like rent, office supplies and nonclinical labor.

Currently, when a member sees a provider for both a minor procedure and a significant, separately identifiable E&M service on the same day, the provider's reimbursement for each code covers the distinct services they perform and their malpractice expenses for each service. Additionally, professional practice expenses are reimbursed for each code, leading to reimbursement for the same professional practice expenses twice.

For services delivered on or after March 1, 2025, when modifier 25 is appended to an E&M service (CPT 92002, 92004, 92012, 92014, 99202-99205, 99211-99215) delivered on the same date as a minor procedure (i.e., services with a global surgery indicator of 00 or 10) performed by the same provider, we will reduce E&M reimbursement by 50% to offset the redundant practice expenses.

This change:

- Will initially apply only to select minor procedures, which are identified in the *Minor Procedure Codes with Global Indicators* documents within the relevant reimbursement policies:
  - PDF
  - Excel
- Applies only to professional claims; it does not affect the reimbursement of facility claims
- Will not increase administrative requirements

We currently adjust payment for E&M services when performed at the same time as preventive visits for our commercial members.

Relevant global surgery indicators

- 00 codes identify endoscopies or some minor surgical procedures (0-day post-operative period).
- 10 codes identify other minor procedures (10-day post-operative period).

Reimbursement changes effective March 1, 2025

Type of service	Coding	Effect on reimbursement
E&M with modifier 25	CPT 92002, 92004, 92012, 92014, 99202-99205, 99211-99215	50% adjustment to reflect redundant reimbursement
Select minor procedures listed in *Minor Procedure Codes with Global Indicators* • PDF • Excel	Global surgery indicator 00 or 10	No change—Pays at 100% of the allowed amount

Resources

This policy change includes all services with a global surgery indicator of 00 or 10, though only those codes described in the linked resources above will be impacted on March 1, 2025. We will roll out this change to include the remaining minor procedures in the next 12 months. Look for advance notice of affected minor procedures in this newsletter.

To view the full scope of the procedures that will be affected:

- Download the most recent Physician Fee Schedule.
- Add a filter to the header row (row 10), and then select **000** and **010** from column O (the global days column)

To view resources on our provider website:

- Our updated policies are published in our *Reimbursement Policy Manual*: Library> Policies & Guidelines>Reimbursement Policy.
- We announced this change to our *Modifier 25; Significant, Separately Identifiable Service* (Modifier #103) and *Global Days* (Administrative #101) reimbursement policies in the December 2024 issue of *The Bulletin*: Library>Bulletins.

Updates to secondary editor room and board reviews

We are providing courtesy notice that our secondary editor will start applying denials when the room and board daily service charge is inconsistent with claims data for claims received on or after December 20, 2024.

For example:

- Pediatric room and board should only be billed for pediatric patients.
- Oncology room and board should only be billed for patients with an oncology diagnosis.

These reviews are supported by our *Correct Coding Guidelines* (Administrative #129) reimbursement policy.

We implemented a secondary claims editor program in 2021 to ensure consistent application of our policies and billing standards.

We regularly enhance our secondary editor to capture quarterly and mid-year coding rule changes and to enforce current medical and reimbursement policies. If we identify an overpayment, the secondary editor will apply a change prepayment with a detailed explanation that can be reviewed on the remittance advice.

Learn more about our secondary editor in the Coding Toolkit, available on the homepage of our provider website.

Clinical Practice Guideline updates

Clinical Practice Guidelines are systematically developed statements on medical and behavioral health practices that help providers make decisions about appropriate health care for specific conditions.

We reviewed the following Clinical Practice Guidelines, effective November 1, 2024:

- Cholesterol Management in Adults
- Continuing to recommend the American College of Cardiology (ACC)/American Heart Association (AHA) Task Force on Clinical Practice Guidelines
- Guidelines for the Diagnosis and Treatment of Asthmas in Children, Adolescents, and Adults
- Continuing to recommend the Department of Veterans Affairs and Department of Defense (VA/DoD) Clinical Practice Guideline for the Primary Care Management of Asthma (Version 3.0, 2019)
- Management of Heart Failure in Adults
- Updated the AHA/ACC/Heart Failure Society of America (HFSA) Guideline for the Management of Heart Failure to the 2022 recommendations
- The 2022 guideline replaces the 2013 ACC Foundation (ACCF)/AHA Guideline for the Management of Heart Failure, as well as the 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure.
- Preventive Services Guidelines for Children and Adolescents
- Updated to the 2024 Child and Adolescent Immunization Schedule
- Updated to the 2023 Preventive Pediatric Health Care Recommendations
- Treatment for Diabetes in Adults
- Updated the VA/DoD reference for the treatment and care of adults (age 18 and older) with diabetes to the 2024 recommendations

View the guidelines on our provider website: Library>Policies & Guidelines>Clinical Practice Guidelines.

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>Medical Management>Pharmacy. **Note**: Policies are available online on the effective date of the addition or change.

Pre-authorization: Submit medication pre-authorization requests through CoverMyMeds**.**

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 our Medication Policy team and indicate your specialty.

New 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 December 1, 2024	Description
New medication policies	
Anktiva, nogapendekin alfa inbakicept-pmln, dru791	- Limits coverage to patients with a diagnosis of non-muscle invasive bladder cancer (NMIBC) who are ineligible for (or have elected not to undergo cystectomy) and whose disease is unresponsive to Bacillus Calmette-Guerin (BCG), Keytruda (pembrolizumab) and Adstiladrin (nadofaragene firadenovec) - Requires reauthorization after each induction cycle
Imdelltra, tarlatamab-dlle, dru792	- Limits coverage to patients with extensive-stage small cell lung cancer (ES-SCLC) when there has been disease progression on or after a platinum-based therapy regimen
Ohtuvayre, ensifentrine, dru794	- Considers use of Ohtuvayre not medically necessary (and, therefore, not covered) due to lack of proven additional benefit in meaningful clinical outcomes over many other guideline-directed standard of care options
Xolremdi, mavorixafor, dru793	- Limits coverage to patients with warts, hypogammaglobulinemia, infections and myelokathexis (WHIM) syndrome diagnosed by a specialist with confirmed CXCR4 mutation when their ANC <400 cell/uL and step therapy with either immunoglobulin replacement or granulocyte colony-stimulating factor was ineffective, not tolerated or not a treatment option - Added to the Cycle Management Program
Revised medication policies	
Afrezza, inhaled insulin, dru371	- Updated criteria to remove metformin requirement due to change in standard of care
Anabolic bone Medications, dru612	- Added newly available generic teriparatide (620mcg/2.48ml) to policy on parity with brand Forteo, requiring step therapy through both generic teriparatide (600mcg/2.4ml) and Tymlos (abaloparatide) - Added additional criterion to define "very high risk" (T score ≤ -3 regardless of fracture history) to align with American Association of Clinical Endocrinologists (AACE) guidelines

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Effective December 1, 2024	Description
Revised medication policies (continued)	
BRAF inhibitors, dru728	- Added newly FDA-approved Ojemda (tovorafenib) to policy; limits coverage to patients with relapsed or refractory low-grade glioma (LGG) after prior systemic chemotherapy when the tumor harbors a BRAF alteration - Simplified LGG criteria (removed "use after surgery" criterion)
Branded topical antifungal nail solutions, dru384	- Removed Kerydin from policy as it has been discontinued
Chimeric Antigen Receptor (CAR) T-cell Therapies, dru523	- Added coverage criteria for newly FDA-approved indication for Breyanzi (lisocabtagene maraleucel) for CLL/SLL, limits coverage to relapsed or refractory disease after at least three prior systemic therapies, which must have included a Bruton's tyrosine kinase (BTK) inhibitor and Venclexta- (venetoclax-) based regimens - Added coverage criteria for newly FDA-approved indication for Breyanzi (lisocabtagene maraleucel) for follicular lymphoma, limits coverage to after at least two prior therapies, which mirrors coverage criteria for Yescarta (axicabtagene ciloleucel) for the same indication - Added coverage criteria for newly FDA-approved indication for Breyanzi (lisocabtagene maraleucel) for mantle cell lymphoma, limits coverage to after at least two prior therapies which mirrors coverage criteria for Tecartus (brexucabtagene autoleucel) for the same indication - Simplified CAR-T criteria for mantle cell lymphoma to remove "no active central nervous system (CNS) disease" due to the expansion of patient population in Breyanzi trial
Drugs for chronic inflammatory diseases, dru444	- Added Tremfya (guselkumab) and Skyrizi (risankizumab) as Level 1 treatment options for ulcerative colitis, including IV induction - Added Kevzara (sarilumab) as a Level 4 self-administered treatment option for active polyarticular juvenile idiopathic arthritis - Updated QL for Adbry (tralokinumab) to include new SC autoinjector formulation - Clarified that preferred product criteria for Cimzia (certolizumab pegol) self-administered syringes for Crohn's disease is now adalimumab and one other Level 1 or Level 2 therapy
Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors, dru621	- Moved Lucentis (ranibizumab) from Level 3 product to Level 2 due to decrease in unit cost - Added newly FDA-approved Eylea biosimilars Ahzantive (afibercept-mrbb), Enzeevu (aflibercept-abzv) and Pavblu (aflibercept-ayyh)] to policy as level 3 products at parity with Eylea (aflibercept)

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Effective December 1, 2024	Description
Revised medication policies (continued)	
Jemperli, dostarlimab, dru673	- Removed Jemperli (dostarlimab) criterion requiring use in mismatch repair deficient (dMMR) tumors in front-line endometrial cancer due to a new survival analysis that has now shown overall survival (OS) benefit across both dMMR and mismatch repair proficient (pMMR) tumors
Keytruda, pembrolizumab, dru367	- Expanded coverage in endometrial cancer to include pMMR tumors due to new data; previously only covered in dMMR tumors
Medications for Epidermolysis Bullosa, dru759	- Added newly FDA-approved Filsuvez (birch triterpenes) to policy, with use considered investigational (and, therefore, not covered) in the treatment of all conditions, including Epidermolysis Bullosa, due to lack of high-quality evidence of clinically meaningful health benefit - Policy was previously named *Vyjuvek, beremagene geperpavec-svdt*
Medications for primary biliary cholangitis, dru464	- Added newly FDA-approved Iqirvo (elafibranor) to policy, limits coverage to patients with primary biliary cholangitis when ursodeoxycholic acid (UDCA) has been ineffective and when prescribed by a specialist; this mirrors the coverage criteria for Ocaliva (obeticholic acid) - Policy was previously named *Ocaliva, obeticholic acid*
Monoclonal antibodies for Alzheimer's disease, dru740	- Added newly FDA-approved Kisunla (donanemab-azbt) to policy with use considered investigational (and, therefore, not covered) in the treatment of all conditions including Alzheimer's disease (AD) due to lack of high-quality evidence of clinically meaningful health benefit and insufficient evidence to determine its benefit-to-risk balance
Neonatal Fc Receptor (FcRn) Antagonists, dru696	- Added coverage criteria for Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) for newly FDA-approved indication for chronic inflammatory demyelinating polyneuropathy (CIDP), limits coverage to patients diagnosed and prescribed by/in consultation with a neurologist, when at least two other lower-cost therapies (immunoglobulin treatment, steroids, plasmapheresis) were ineffective, not tolerated or not a treatment option
Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620	- Added Hercessi (trastuzumab-strf) to policy as non-preferred
Prolia, denosumab, dru223	- Added additional criterion to define "very high risk" (T score ≤ -3 regardless of fracture history) to align with AACE guidelines
Tropomyosin receptor tyrosine kinase (TRK) inhibitors, dru724	- Moved Augtyro (repotrectinib) to policy from dru776 - Added coverage criteria for newly FDA-approved indication for Augtyro limits coverage to patients with locally advanced or metastatic solid tumors with an NTRK gene fusion when surgical resection is likely to result in severe morbidity, who have progressed following treatment where applicable, and who have tried a lower-cost TRK inhibitor [Rozlytrek (entrectinib)] - Updated Augtyro quantity limit to reflect available dosage forms - Updated step therapy requirement for Vitrakvi (larotrectinib) to include Augtyro, in addition to Rozlytrek, with no change to intent

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Effective January 1, 2025	Description
Revised medication policies	
Drugs for chronic inflammatory diseases	- Moving Entyvio SC (vedolizumab) from non-preferred (Level 3) to preferred (Level 1) self-administered option for Crohn's disease and ulcerative colitis - Moving Omvoh (mirikizumab) from non-preferred (Level 3) to preferred (Level 2) self-administered option for ulcerative colitis - Moving Sotyktu (deucravacitinib) from a Level 2 to a Level 1 self-administered option for chronic plaque psoriasis - Adding new Stelara (ustekinumab) biosimilars (Pyzchiva, Selarsdi, Wezlana) to policy as non-preferred
Medications for Multiple Myeloma, other cancers, and other hematologic disorders, dru672	- Updating coverage criteria for pomalidomide (Pomalyst) in Kaposi sarcoma, removing prior chemotherapy requirement
Non-Preferred Drugs, dru670	- Adding bexagliflozin (generic Brenzavvy) to policy as non-preferred - Adding Zituvimet/XR (sitagliptin/metformin) to policy as non-preferred

Effective February 1, 2025	Description
Revised medication policies	
Trodelvy, sacituzumab govitecan-hziy, dru645	- Removed coverage for bladder cancer based on manufacturer withdrawal of indication.

Effective March 1, 2025	Description
Revised medication policies	
Tarpeyo, budesonide delayed-release capsules, dru712	- Adding step therapy requirement through an SGLT2-inhibitor
Filspari, sparsentan, dru752	- Adding step therapy requirement through an SGLT2-inhibitor
Monoclonal antibodies for asthma and other immune conditions, dru538	- For Cinqair, adding step therapy requirement through both provider-administered Fasenra and Nucala

Medications for Hereditary Angioedema (HAE), dru535	- Clarifying that diagnosis must be established by an allergist, immunologist or hematologist
	- Updating criteria for the following laboratory requirements:
	  • HAE Type II: normal or high C1-INH protein level
	  • Acquired Angioedema: Low serum C4 protein level
	- Clarifying reauthorization requirements, to explicitly require documentation of details of attacks, response to therapy, and justification of requested doses

Medications for Lysosomal Storage diseases: Gaucher disease and Niemann-Pick Disease (NPC), dru649	- Adding newly FDA-approved Miplyffa (arimoclomol) and Aqneursa (levacetylleucine) to policy; will limit coverage to genetically-confirmed NPC. - Updating coverage criteria for miglustat products (generic, Yargesa, Zavesca) to also require genetic confirmation
Zepzelca, lurbinectedin, dru658	- Adding additional step therapy requirement through conventional second-line chemotherapy

BridgeSpan EquaPathRx™ reminders

Pre-authorization

As a reminder, when submitting pre-authorization requests for members with the Provider-Administered Specialty Drugs benefit, be sure to complete all the information on the form, including the servicing provider's name, address, phone number and TIN to ensure we have all the information necessary to review the request.

Medications included in the BridgeSpan EquaPathRx program must be pre-authorized according to our medication policies; these medications are listed in the *Provider-Administered Specialty Drugs* (dru764) policy, available on our provider website: Policies & Guidelines>Medication Policies.

Join the IntegratedRx – Medical Network

Prime Therapeutics is still contracting and credentialing providers for the IntegratedRx – Medical Network. Reach out to your Prime contact now for help completing the process. If you don't have a Prime contact established, please email Prime Provider Relations.

To start IntegratedRx - Medical Network credentialing, you can also visit Prime's credentialing website.

Upcoming transition dates

- **Oregon**: Q2 2025
- **Washington**: Transition is delayed as we continue network development

Look in future issues of this newsletter for updates.

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

Therapy code reimbursement to increase for Idaho providers

Idaho-based providers: Effective March 1, 2025, we will increase reimbursement rates for CPT 90837 (*psychotherapy, 60 minutes with patient*) for behavioral health providers on standard *Professional Services Agreements*. This is an off-cycle reimbursement change.

The updated reimbursement rates will be posted by the effective date in Availity Essentials: Claims & Payment> Fee Schedule Listing.

Pre-authorization requests deadlines extended

On October 1, 2024, we liberalized the time frames for chemical dependency and mental health facilities to request pre-authorization.

The following types of facilities require pre-authorization requests **within three business days of admission**:

- Inpatient psychiatric, eating disorder or American Society of Addiction Medicine (ASAM) 4.0 detoxification
- Residential levels of care (LOC)—includes chemical dependency residential (ASAM 3.5 or 3.7), mental health residential and eating disorder residential requests

The following types of facilities and services require pre-authorization requests **within seven calendar days of starting services**:

- Partial hospitalization and intensive outpatient treatment—includes mental health, eating disorder and chemical dependency (ASAM 2.1 or 2.5)
- Transcranial magnetic stimulation (TMS)
- Applied behavior analysis (ABA)

Get reimbursed for integrated care and e-consults

PCPs often care for patients who need behavioral health services, and any patients with mild to moderate behavioral health needs can be treated in a rapid and effective manner within the primary care setting. But PCPs may lack the clinical expertise and/or clinical resources to provide effective behavioral health treatment for some patients.

Integrating behavioral health providers in primary care settings and using psychiatric electronic consultations (e-consults) or the Collaborative Care Model (CoCM) can help support the work of PCPs and improve patient outcomes.

Integrated care

We recognize the value of behavioral health integration (BHI) and encourage providers to participate in the CoCM approach to treat and support members with complex needs.

According to the American Psychiatric Association (APA), among the BHI models, the CoCM has the most evidence demonstrating "effective and efficient integration in terms of controlling costs, improving access, improving clinical outcomes and increasing patient satisfaction in a variety of primary care settings—rural, urban and among veterans."

The model consists of a team of three individuals delivering care: A PCP, a behavioral health care manager and a psychiatric consultant. Its integrated behavioral health services include the following types of care:

- Counseling
- Medication support
- Care planning for behavioral health conditions
- Ongoing assessment of the patient's condition
- Other recommended treatment, if needed

This is accomplished through three core elements:

- Care coordination and management provided by a behavioral health care manager or psychiatric consultant working closely with the PCP
- Regular treatment and monitoring with standardized outcome measures/rating scales based on targeted quality outcomes
- Regular caseload review with a psychiatrist whose primary responsibility is to make treatment recommendations

We encourage integration of behavioral health providers into primary care settings and reimburse:

- Behavioral health services provided in the primary care setting
- CoCM codes CPT 99492-99494 and HCPCS G2214

E-consults

These consultations may help alleviate the challenges PCPs face with treating complex medical and behavioral health conditions. We recognize the value of timely access to specialty consultations, and we reimburse both PCPs and consulting specialists for e-consults.

E-consults are asynchronous consultations between providers, either over a shared EMR system or via a web-based platform. During an e-consult, physicians or other qualified health care professionals collaborate and coordinate the care of their patient with a consulting specialist. E-consults are typically requested by a PCP seeking expert consultation on a clinical issue. A specialist (e.g., psychiatrist, dermatologist, endocrinologist, etc.) then reviews the pertinent records and provides a brief written consultation report back to the PCP.

The following e-consult codes are reimbursable:

- **CPT codes for the treating PCP**: 99354-99359 and 99452
- **CPT codes for the consulting specialist**: 99446-99449 and 99451

These visits can support and improve the delivery of health care services in primary care by providing timely specialist advice, especially for providers who don't otherwise have access to specialists—including psychiatrists—in their community.

Specialty e-consults can:

- Address medication-related issues
- Provide evaluation and management recommendations and assist with clarifying diagnostic considerations
- Determine whether a patient acutely needs a referral for in-person specialty care

For both CoCM and e-consults, PCPs should first obtain informed consent from their patients and notify the patient that they may be responsible for their cost share (e.g., copay, coinsurance or deductible).

Resources

- Review our *Collaborative Care Codes* (Behavioral Health #100) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.
- The Behavioral Health Integration Services booklet from CMS discusses the roles of care team members and CoCM service components and includes full code descriptions.
- The APA has information about the CoCM and reducing inequities in care and provides CoCM training for PCPs, behavioral health care managers and psychiatrists.
- Learn more about What E-consults Can do for Your Patients—and Your Practice from the American Medical Association.

Peer support program now available

We are excited to announce that our peer support program is now open to BridgeSpan members.

What is peer support?

Peer support is a program that offers acceptance and validation to people recovering from mental health conditions and/or substance use disorders (SUD). It allows people with lived experience to help others develop goals and strategies through non-clinical, strengths-based support.

Benefits of peer support

- Improves patient engagement and treatment retention
- Provides a safe environment for members to share their experiences and receive support
- Empowers individuals to direct their own recovery process
- Considers the member's level of functioning, co-morbid conditions and other life factors

What does the peer support program offer?

- Self-advocacy skills
- Employment readiness
- Peer counseling and role modeling
- Connection and referral to other community resources
- Development of a Wellness Recovery Action Plan (WRAP)
- Education on various topics, such as nutrition, exercise and mental illness

Who can benefit from peer support?

- Members who struggle to stay engaged in their treatment and with their health and self-care
- Members who have previously declined care management

Members who have recently experienced increased health care needs, such as:

- Two or more mental health inpatient admissions in a six-month period
- Two or more ED visits in a six-month period
- Readmission to a mental health inpatient facility within 30 days

Example scenarios

- A member with a history of alcohol dependency begins dialysis and later stops treatment, slipping into depression. The provider refers the member for behavioral health care, but the member needs additional support.
- A member is recently diagnosed with a behavioral health condition that will require significant intervention. The member declines case management because they have trust issues with providers.

In both scenarios, the member could benefit from a referral to the peer support program.

The referral process

We encourage providers to consider referring their eligible patients to this supportive program.

Refer a member to our Case Management team by:

- Calling our Provider Contact Center at 1 (855) 522-8894
- Calling the Customer Service number on the back the member's ID card

Quartet Care Connections agreement ending in Washington

We are discontinuing Quartet's Care Connections service for our members in Washington state effective December 31, 2024.

The service, which matches members with behavioral health providers, will no longer accept referrals beginning December 7, 2024. Members will be directed to BridgeSpsn Customer Service to find available providers.

To find a behavioral health provider that best meets a patient's needs, providers and members may:

- Use the Find a Doctor tool on our provider and member websites
- Call the Customer Service number on the back of the member's card
    - Our internal teams currently assist members residing in all other states with locating behavioral health services.

Quartet Medical Group, also known as InnovaTel, will remain in-network for outpatient mental health services for adults.

Bringing on-call medical care to your patients' home

DispatchHealth brings on-call medical care to your patients' door. They deliver in-home care in the Portland, Oregon; Salt Lake City, Utah; Olympia, Seattle, Spokane, Tacoma and Vashon Island, Washington, areas.

By partnering with DispatchHealth, you can offer your patients a high-quality, cost-effective alternative to the ED. Benefits of referring your patients include:

- **Convenient care**: Patients, especially those who lack access to transportation, appreciate the convenience and comfort of receiving urgent medical care in their own homes.
- **Reduced wait times**: No more lengthy wait times or crowded waiting rooms. Patients are typically seen within the same day.
- **Streamlined communication**: DispatchHealth keeps the patient's care team informed every step of the way, with timely updates and treatment plans.

What they treat

Their medical teams are equipped to treat 95% of the top ED diagnoses in the home, including:

- Respiratory infections (e.g., pneumonia, bronchitis)
- Urinary tract infections (UTIs)
- Skin infections (e.g., cellulitis, abscesses)
- Minor injuries (e.g., sprains, strains, lacerations)
- Gastrointestinal issues (e.g., nausea, vomiting, diarrhea)
- And many more conditions

How to refer your patients

Referring patients to DispatchHealth is easy. Simply:

- Use DispatchHealth's HIPAA-compliant online care request platform, DispatchExpress, to request a visit for your patient within minutes.
- Call their dedicated referral line at:
    - **Oregon**: (503) 917-4904
    - **Utah**: (801) 895-3071
    - **Washington**: (425) 651-2473

Break the antibiotic over-prescribing cycle

As a provider, you've likely seen the devastating impact of antibiotic over-prescription on your patients and the broader community. But did you know that acute bronchitis and bronchiolitis are two of the most common conditions that are inappropriately treated with antibiotics?

The CDC reports that more than 2.8 million antibiotic-resistant infections occur in the U.S. each year, and more than 35,000 people die as a result. But it's not just patients who are at risk—over-prescription can have serious consequences for the whole health care system.

We monitor antibiotic prescribing rates for bronchitis/bronchiolitis through the HEDIS Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) measure. Measure criteria include:

- Members three months and older
- A diagnosis of acute bronchitis/bronchiolitis
- The member is not dispensed an antibiotic prescription on the date of diagnosis or within three days of diagnosis

A higher rate indicates appropriate treatment for the condition (i.e., the percentage of episodes that were not prescribed an antibiotic).

Our providers rate well on the HEDIS measure for treating upper respiratory infections, but there is an opportunity to improve rates for treatment of acute bronchitis and bronchiolitis. Our data indicates that more than 40% of acute bronchitis and bronchiolitis cases are not treated appropriately.

Best practices for treating acute bronchitis and bronchiolitis

Here are a few best practices to follow:

- Help patients and caretakers understand the difference between bacterial and viral infections.
- Educate patients and caretakers on home treatment to relieve acute bronchitis/bronchiolitis symptoms.
- For patients with a comorbid condition requiring an antibiotic prescription, be sure that documentation and coding accurately reflect the diagnosis code for the comorbid condition (or bacterial infection).

Resources to help you succeed

Look for the Bronchitis category in the Quality Improvement Toolkit, available on the homepage of our provider website. The toolkit includes best practices and action items, along with a variety of flyers you can share with your patients.

Empowering your patients with diabetes

As a health care provider, you play a vital role in helping your patients manage diabetes. With more than 133 million Americans living with diabetes or prediabetes, it's essential to prioritize early detection, education and support.

Early detection and education

The CDC recommends screening non-pregnant patients ages 35 to 70 who are overweight or obese and have no current symptoms of diabetes.

Disparities in diabetes prevalence affect certain racial and ethnic minority groups. According to the American Diabetes Association, the rates of diagnosed diabetes in adults by race/ethnic background are:

- 13.6% of American Indians/Alaskan Native adults
- 12.1% of non-Hispanic Black adults
- 11.7% of Hispanic adults
- 9.1% of Asian American adults
- 6.9% of non-Hispanic White adults

Consider screening patients at an earlier age or lower BMI as appropriate. For valuable information to support health equity in your practice, read the USPSTF's Prediabetes and Type 2 Diabetes Screening recommendation.

Best practices for diabetes management in primary care

- **Leverage EMRs**: Use registries and prompts to alert providers and staff when it's time to order recommended diabetic screenings and tests.
- **Support staff**: Have support staff reach out to patients who are due for diabetic screenings and tests.
- **Complete screenings and labs**: Complete screenings and order diabetic labs during the office visit to ensure patients receive necessary care.
- **Collaborate with clinical pharmacists**: Work with clinical pharmacists to support patients who need additional help managing their diabetes.
- **Additional resources**: Consider referring patients to health coaches, diabetic specialists or nutritionists for extra support.

Resources for you and your patients

The Healthwise Knowledgebase has helpful resources in English and Spanish, including:

- *Diabetes Care Plan*: A comprehensive plan to share with patients, outlining appointment preparation, test results and scheduling.
- *Taking Medicines as Prescribed*: Content to discuss medication adherence with patients.
- *Dilated Eye Exam*: Information about the exam, including what to expect and how it's performed.

Our Quality Improvement Toolkit, available on the homepage of our provider website, has a link to the Healthwise Knowledgebase and other helpful tools.

Our Health Equity Toolkit includes resources to address health disparities and advance health equity.

Help patients achieve a healthy weight

Maintaining a healthy weight can reduce the risk of diseases and health conditions, including type 2 diabetes, heart disease, high blood pressure, arthritis, sleep apnea and stroke. By initiating conversations about weight management, you can empower your patients to take control of their health and reduce their risk of these conditions.

Starting the conversation

Discussing weight can be a sensitive topic for patients. To start the conversation, consider framing it around the health risks associated with obesity and being overweight. Help your patients feel more comfortable and receptive to your guidance by asking if they're open to discussing how their weight impacts their overall health

Connecting patients to behavioral health providers

Mental and emotional health are also essential factors in maintaining a healthy weight. Consider connecting patients to in-network behavioral health providers. Members can find in-network providers and vendors that offer virtual care services by logging in to their member account on bridgespanhealth.com.

Addressing health disparities in weight management

Certain populations—such as racial and ethnic minorities, low-income communities and individuals with disabilities—are disproportionately affected by obesity and related health conditions. To address these disparities, it's crucial to take a culturally sensitive approach to weight management. This includes adapting weight management strategies to accommodate different cultural norms and values, addressing language barriers and providing resources in multiple languages.

Social determinants of health (SDoH), such as food insecurity and lack of access to safe physical activity spaces, can also impact weight management. Providers can address these factors by connecting patients with local resources, such as food banks or nutrition assistance programs, and recommending safe and accessible physical activity spaces in the patient's community.

Measuring BMI

Measuring your patients' body mass index (BMI) regularly may help you identify who may benefit from weight loss information and counseling. Your EMR system may include an alert that will automatically calculate the BMI. When coding for obesity, code for both the obesity diagnosis (e.g., ICD-10 E666.1-E666.3, E666.8 or E66.9) and the BMI Z codes.

Resources

Find helpful resources in English and Spanish to share with your patients by searching for the Maintaining a Healthy Weight category in our Quality Improvement Toolkit, available on the homepage of our provider website.

Our Health Equity Toolkit includes resources to address health disparities and advance health equity.

Refer expectant mothers to our pregnancy program

Our pregnancy program, Bump2Baby, is designed to improve the utilization of prenatal services and provide important support to expectant members and families-to-be to improve pregnancy and birth outcomes. The program supports and reinforces your treatment plan.

Benefits of program participation

By participating in Bump2Baby, your patients can:

- Improve their overall health and well-being
- Reduce their risk of pregnancy-related complications
- Receive personalized support and education during pregnancy

Research shows that Black women experience serious pregnancy-related complications at consistently higher rates than White women, regardless of age or income. To help lower these risks, we are enhancing our Bump2Baby program to offer more equity-centered support and resources for members during and after their pregnancy.

This includes:

- Screening members for social risk and connecting them to necessary resources
- Factoring in social risk scores in identifying high-risk pregnancies
- Reaching out to members with high-risk pregnancies to offer care management
- Training our care managers to help members navigate concerns around maternal health inequities and discrimination
- Educational resources for members about maternal health, disparities, warning signs of complications and more

This program fosters a close partnership between care managers and members to integrate whole-person health while supporting the care you provide.

Eligible members will receive:

- A welcome packet
- Quarterly newsletters
- Access to a 24-hour nurse line staffed by skilled clinicians

Refer your patients

Verify whether your patients are eligible for Bump2Baby by calling 1 (888) 569-2229.

QIP: Updates and reminders

Our Quality Incentive Program (QIP) rewards PCPs who provide timely, evidence-based preventive care to Individual on-exchange patients. PCPs earn a per gap incentive for closing care gaps for the Quality Rating System (QRS) measures included in the program.

As a PCP, you can review identified quality care gaps for patients attributed to you as part of your pre-visit planning on our Care Gap Management Application (CGMA).

2025 QIP program

We're looking forward to rolling out the 2025 QIP program starting March 2025. Updated 2025 QIP program information, including a complete list of included measures, will be added to our provider website by January 1, 2025: Programs>Quality Incentive.

Using the CGMA dashboard

The CGMA is a convenient and helpful tool for identifying and reviewing patient care gaps. To close a care gap, providers must submit a complete condition profile for the member. **Note**: For QIP care gaps, this is done through claims submission.

Opt-in to participate

The 2025 program will require you to opt-in. To be eligible to receive incentive, you must sign in to the CGMA by June 30, 2025, and indicate that you wish to participate in the 2025 program.

2024 QIP reminders

As a reminder, below are the cutoff dates to close gaps for the 2024 program:

- **December 31, 2024**—Last day to perform services for the 2024 program
- **February 28, 2025**—
  - Last day to submit structured supplemental data files
  - Last day to review 2024 gaps in the CGMA
- **March 31, 2025**—Last day to submit 2024 medical or pharmacy claims
- **June 30, 2025**—Incentive payment for 2024 QIP participants

The CGMA will continue to display 2024 data through June 2025 to allow you to monitor your 2024 performance up to payout.

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.

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