APRIL 2021

Provider News

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

COVID-19 updates and resources

COVID-19 treatment

We will cover the cost of U.S. Food and Drug Administration- (FDA-) authorized treatment for COVID-19 received from in-network providers without any out-of-pocket costs into 2021.

We will continue to monitor the health of our community and will communicate changes in coverage at least 30 days in advance.

COVID-19 vaccines

With the FDA Emergency Use Authorization (EUA) recently given for the use and distribution of the third (Janssen/Johnson & Johnson) COVID-19 vaccine, vaccines are becoming more readily available.

Our COVID-19 Vaccine Toolkit includes the following information for medical and Oregon- and Washington-based dental providers:

- Vaccine and administration codes
- Claims submission guidelines and provider reimbursement

The toolkit is also designed to help you proactively share information with your patients about:

- Emergency-use authorizations
- States' distribution plans
- Coverage for our members (The vaccine is covered at no cost for all members.)
- A COVID-19 vaccination flyer that includes information about where to get vaccinated and vaccine safety

CONTINUED ON PAGE 2

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.

Stay up to date

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

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.

Subscribe today

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Contents

■ Critical update ⁎ Behavioral health must read ▲ Dental must read ‡ DME must read	We encourage you to read the other articles because they may apply to your specialty.

Click on a title below to read the article.

CONTINUED FROM PAGE 1

Discharging members to post-acute settings

For dates of service on or after April 16, 2021, if hospitals need to transfer BridgeSpan patients to post-acute care settings or home-based care (i.e., skilled nursing facilities, long-term acute care hospitals or inpatient rehabilitation), pre-authorization will be required. Our pre-authorization lists are available in the Pre-authorization section of our provider website, **bridgespanhealth.com**.

Get the latest

We are dedicated to keeping you informed. Visit our website frequently for COVID-19 updates.

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 the Availity Provider Portal 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.

Subscribe today

It's easy to receive email notifications when new issues of the newsletter and bulletin are available. Simply complete the subscription form available in the Library section of our provider website at **bridgespanhealth.com**.

Encourage everyone in your office to sign up.

Share your feedback

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

Availity tools and services

Did you know BridgeSpan providers and their office staff have access to more than 15 electronic tools and services via the Availity Provider Portal, **availity.com**?

The Availity Portal gives you free, real-time, online access to many health plans, including BridgeSpan. You can easily check member eligibility and benefits, submit requests for medical pre-authorizations, get patient cost estimates, as well as submit electronic claims, inquire about claim status and receive remittances for claims payment details.

New-to-BridgeSpan providers: Register to use the portal then:

- Register for electronic funds transfer (EFT) via Availity's Transaction Enrollment tool available on the main menu: My Providers>Enrollments Center> Transaction Enrollment. **This is a requirement for participation in our provider networks**.
- Determine how you'd like to obtain your claims processing and payment details:
  - To receive 835 electronic remittance advices (ERAs), enroll using Availity's Transaction Enrollment tool.
  - To view or print payment information, use Availity's Remittance Viewer: Claims & Payments> Remittance Viewer.
- Set up Express Entry: Set up providers your organization frequently uses in transactions, such as eligibility and benefits, authorizations, referrals, claim status, and more. The providers you set up in the Express Entry app are listed in the Select a Provider fields that display on various transaction pages.
- Explore Payer Spaces: View BridgeSpan-specific applications, resources and reimbursement schedules, plus news and announcements. **Related**: See *Explore Availity's Payer Spaces* on page 4.
- Check out the Help & Training feature to find payer-specific help, learn about using Availity's tools, receive support from Availity and view network outages.

Once registered, you'll have access to these tools and features:

- **Eligibility and benefits inquiry**: Verify a patient's eligibility and confirm the benefits covered under a member's contract
- **Patient Cost Estimator**: Give patients an estimate of their costs before medical or dental services are received. Obtain a real-time estimate from the eligibility and benefits inquiry screen. **Related**: See *Designate oral cavity codes or tooth information on patient cost estimates* on page 4.
- **Authorizations**: Submit medical pre-authorization requests, including authorizations for eviCore healthcare (eviCore) and AIM Specialty Health (AIM).
- **Auth/referral inquiry**: View the results of an existing authorization or referral or inquire about the status of a request.
- **Auth/referral dashboard**: View authorization and referral requests that were created on the Availity Portal to check the status, to view or print detailed information about a request, or to update or void a request.
- **Claim status**: Research claims your organization has submitted that BridgeSpan has processed.
- **Remittance Viewer**: View, search and reconcile ERA or 835 data.
- **Claims**: Submit real-time, electronic professional, facility or dental claims or encounters.
- **Attachments**: Respond to requests for required documentation necessary to support a claim.
- **Reporting via Availity 360**: Use transaction reporting options to display transaction volume metrics and details.
- **Fee schedule listing:** Enter up to 20 procedure codes or a range of codes to view standard contracted reimbursement amounts. Other reimbursement schedules are available in Payer Spaces

AIM and eviCore pre-authorizations

Did you know you can request to be routed to the provider portals for AIM and eviCore via single sign-on from the Availity Portal? This makes it easier for you to submit electronic authorizations for radiology or Physical Medicine program services that require authorization from AIM or eviCore.

Simply click the "Take Me to AIM" or "Take Me to eviCore" button on the electronic authorization tool.

Change to EFT

The EFT enrollment tool on the Availity Portal moved April 1, 2021. The Transaction Enrollment tool is now available on the main menu: My Providers> Enrollments Center>Transaction Enrollment. You can now view a dashboard with updates and the status of your EFTs.

As a reminder, receiving claim payments via EFT is a requirement for participation in our networks. If you're already receiving your claims payments electronically, no action is required.

Designate oral cavity codes or tooth information on patient cost estimates

Dental providers: When using Availity's Patient Cost Estimator tool, on **availity.com**, you must now select either tooth information or an oral cavity code, whichever is applicable.

For your convenience, a link to the list of procedure codes that require an oral cavity code is available on the Patient Cost Estimator tool.

Including the correct code helps eliminate errors that may delay the completed estimate. It may also decrease the claims processing time.

Explore Availity's Payer Spaces

View BridgeSpan-specific applications, resources, news and announcements

Payer Spaces has applications and resources on the Availity Portal as well as links to content on our provider website.

Find information on the Applications, Resources and News and Announcements tabs. Here are some highlights from each tab:

- Applications
  - **Provider reports for your Organizatio**n is an application on the Availity Portal where you can obtain credentialing, maintenance and value-based reports for your organization.
- Resources
  - **Reimbursement schedules** are available in the Fee Schedule Listing tool are for standard contracted medical codes. Use the Reimbursement Schedules resources for dental, durable medical equipment (DME), FEP or non-participating reimbursement schedules and to obtain fees prior to January 1, 2020, and supplemental information documents.
  - **CoverMyMeds** links to CoverMyMeds' website for medications requiring pre-authorization.
- **News and announcements** connects you quickly to telehealth and COVID-19 resources on our provider website.

Tips for finding eligibility and benefits information on the Availity Portal

Benefits showing "Active" or "Inactive"

An Active or Inactive indicator for a specific benefit service type (BST) indicates whether the member's health plan has that benefit (e.g., vision [optometry], dental care, mental health, pharmacy).

To obtain benefit details for Active benefits:

1. Edit your inquiry.
2. Review the list of BSTs in the Benefit/Service Type drop-down box.
3. Select the BST for the appropriate benefit details.

Massage therapy

To obtain massage therapy benefits, select the Physical Therapy BST.

Notes:

- Physical therapy by licensed massage therapists and other licensed providers is covered under the patient's rehabilitation benefit.
- For groups with a special massage therapy-specific benefit and/or limit, the detail is listed separately under the Physical Therapy BST.

Tiered benefits

Many of our groups have tiered benefit plans and the benefit changes depending on the provider's contract status (participating or non-participating).

- Tier 1 benefits are applicable when the member sees a provider who is in-network for their plan (e.g., a provider that is contracted with the preferred network for a PPO product).
- Tier 2 benefits are applicable when the member receives services from a Participating provider.
- Tier 3 benefits are applicable when the member receives services from a provider who is out-of-network (a non-contracted provider).

If a separate tier 2 benefit (Participating provider) is not listed, then the in-network benefit applies to both Preferred and Participating providers.

Pre-authorization updates

Procedure/medical policy	Added codes effective April 1, 2021
Expanded Molecular Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	CPT® 0244U
Genetic and Molecular Diagnostic Testing (Genetic Testing #20)	CPT 0244U
Powered Knee Prosthesis, Powered Ankle-Foot Prosthesis, Microprocessor-Controlled Ankle-Foot Prosthesis, and Microprocessor-Controlled Knee Prosthesis (Durable Medical Equipment #81)	HCPCS K1014
Procedure/medical policy	**Adding HCPCS codes effective July 1, 2021**
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	A6460, A6461, C1849, Q4100-Q4102, Q4105-Q4107, Q4114, Q4116, Q4122, Q4128, Q4132, Q4133, Q4140, Q4151, Q4154, Q4159, Q4186, Q4187, Q4168

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 Portal, **availity.com**. Learn more on our provider website: Pre-authorization>Electronic Authorization.

Clinical Practice Guidelines update

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 *Perinatal Care* Clinical Practice Guideline, effective February 1, 2021. We will continue to endorse the American Academy of Pediatrics and American College of Obstetricians and Gynecologists *Guidelines for Perinatal Care*. We also updated the link to the Veterans Affairs/Department of Defense (VA/DoD) *Management of Pregnancy* Clinical Practice Guideline.

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

Medical policy reviews

Our medical policies are reviewed for the following reasons:

- Updates from CMS
- Regularly scheduled review
- Changes in published scientific literature
- Requests from physicians, other health care professionals or facilities
- Addition, deletion or revision of codes published in the CPT, HCPCS and ICD-10 manuals

Tips for submitting eviCore authorizations

If you submit pre-authorization requests to eviCore healthcare (eviCore) for spinal surgeries, pain/joint management or physical medicine and therapies (physical, speech or occupational therapy; chiropractic, acupuncture, massage), the following resources are available to help you and your staff with the pre-authorization process.

- This checklist has tips for speeding up the pre-authorization process: **evicore.com/-/media/files/evicore/provider/training-resources/how-to-speed-up-prior-authorization.pdf**.
- eviCore's 24/7 portal lets you submit your request—with the option to save your progress if you need to step away. You can also check case status, schedule a peer-to-peer consultation, view and print authorization information and upload requested clinical information: **eviCore.com**.
- eviCore hosts ongoing one-hour sessions about the resources available to you. Find a time that fits your schedule: **eviCore.webex.com**; go to the menu icon in the top left corner, select "WebEx Training" and then search for "Provider Resource Review Forum" to find and register for a session.
- eviCore's website includes clinical guidelines, clinical worksheets and a variety of training materials: **evicore.com/provider**.
- eviCore's Client & Provider Operations team can help with questions: **clientservices@evicore.com**.

The Bulletin recap

We publish updates to medical policies, reimbursement policies and Clinical Position Statements 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 February 2021 issue of *The Bulletin* about the following medical policies, which are effective May 1, 2021:

- Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia (Transplant #45.36)
- Surgical Treatments for Hyperhidrosis (Surgery #165)

The *Medical Policy Manual* includes a list of recent updates and archived policies: Library>Policies & Guidelines> Medical Policy>Recent Updates.

All medical policies and Clinical Position Statements are available on our provider website: Library> Policies & Guidelines.

Reimbursement policy updates

We provided 90-day notice in the February 2021issue of *The Bulletin* about the following reimbursement policies, which are effective May 1, 2021:

- DME Purchase and Rental Limitations (Administrative #131)

We provided 90-day notice in the March 2021 issue of *The Bulletin* about the following reimbursement policies, which are effective June 1, 2021:

- COVID-19 Testing (Administrative #137)
- Facility DRG Validation (Facility #111)

Our reimbursement policies are reviewed on an annual basis.

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

To see how a claim will pay, access the Clear Claim Connection tool on the Availity Portal at **availity.com**: Payer Spaces>Resources>Claims and Payment> Research Procedure Code Edits.

Dental policy updates

We review our dental policies on an annual basis. Included below are changes to our policies.

Our *Dental Reimbursement Policy Manual* is also available our provider website: Library>Policies & Guidelines> Dental Policy.

Dental policies	Description of changes
Diagnostic	**Effective April 1, 2021**
Assessment of Salivary Flow by Measurement (#72)	- Revised policy statement for clarification
Bacteriologic Studies, Culture (#04)	- Archived policy
- Blood Glucose Level Test (#71) - HbA1c In-office Testing (#69)	- Shortened policy titles
Restorative	**Effective June 1, 2021**
Dental Restorations (#77)	- Postponing new policy's effective date two months - Specifying that multiple restorations on the same tooth will be treated as one restoration with multiple surfaces

Non-reimbursable services

Our *Non-Reimbursable Services* (Administrative #107) reimbursement policy, which explains services that are considered to be non-reimbursable, is located on our provider website: Library>Policies & Guidelines> Reimbursement Policy. If billed, non-reimbursable services (NRS) are considered not payable, are denied as a provider write-off and cannot be billed to our member.

View specific CPT and HCPCS codes that are considered NRS in the *Clinical Edits by Code List* located on our provider website: Claims & Payment>Coding Toolkit.

If the Centers for Medicare & Medicaid Services (CMS) has designated a medication as product not available (PNA) for 90 days, we consider it an NRS and not eligible for reimbursement. We allow this time to use any existing supply. We review medication codes quarterly and update any medications with a PNA code status to NRS.

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 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. **Related**: See *Non-reimbursable services* on page 6.

New medication policies	Description of changes
Effective February 15, 2021	
Amondys 45, casimersen, dru661	- Use is considered investigational in the treatment of all conditions, including Duchenne muscular dystrophy (DMD) that is amenable to exon 45 skipping; the available clinical trial data is insufficient to demonstrate a clinical benefit, such as improved ambulation
Effective April 1, 2021	
Onureg, azacitidine, dru660	- Coverage is limited to patients with acute myeloid leukemia (AML) who have intermediate or poor-risk cytogenetics, are not a candidate for stem cell transplant (SCT), are in first complete response after intensive induction chemotherapy, and did not tolerate injectable azacitidine
Inqovi, decitabine-cedazuridine, dru659	- Coverage is limited as a monotherapy for patients with intermediate- or high-risk myelodysplastic syndrome (MDS) or chronic myelomonocytic leukemia (CMML) for whom intravenous decitabine was not tolerated or when there are contraindications to the injectable product
Monjuvi, tafasitamab-cxi, dru652	- Coverage is limited to patients with relapsed or refractory diffuse large b-cell lymphoma, not otherwise specified (diffuse large B-cell lymphoma, not otherwise specified [DLBCL NOS]) when used in combination with lenalidomide in patients who are not candidates for a stem cell transplant and whose disease has progressed after at least one prior anti-CD20-based regimen - Patients who have had progression of disease on Monjuvi and/or lenalidomide (Revlimid) are not eligible for coverage as retreatment has not been shown to be effective
Gavreto, pralsetinib, dru653	- Coverage is limited to patients with RET fusion-positive metastatic non-small cell lung cancer (NSCLC), RET-mutated metastatic medullary thyroid carcinoma (MTC), and RET-mutated, radioactive iodine (RAI)-refractory thyroid cancers (when RAI therapy is appropriate) - Because of potential tolerability issues and its extremely high cost, Gavreto is included in the Cycle Management Program

CONTINUED ON PAGE 8

CONTINUED FROM PAGE 7

Revised medication policies	Description of changes
Effective April 1, 2021	
High-cost medications for overactive bladder, dru460	- Added newly FDA-approved vibegron (Gemtesa) to policy
Non-preferred multiple sclerosis treatments, dru511	- Added newly FDA-approved monomethyl fumarate (Bafiertam) to policy as a non-preferred disease modifying treatment - Added brand name Tecfidera to policy; generic dimethyl fumarate does not require pre-authorization
Epidiolex, cannabidiol, dru569	- Added coverage criteria for seizures associated with tuberous sclerosis complex (TSC), a newly FDA-approved indication
Drugs for chronic inflammatory diseases, dru444	- Added coverage criteria for tofacitinib (Xeljanz) as a preferred self-administered option for polyarticular juvenile idiopathic arthritis (PJIA), a newly FDA-approved indication - Added coverage criteria for vedolizumab (Entyvio) in immune-mediated colitis
Wakix, pitolisant, dru618	- Added coverage criteria for narcolepsy with cataplexy
Cystic fibrosis transmembrane conductance regulator (CFTR) modulators, dru544	- Initial authorization period reduced to six months - Reauthorization criteria updated requiring the documentation of objective markers that demonstrate clinical benefit to the therapy
Lynparza, olaparib, dru389	- Coverage criteria for metastatic castration resistant prostate cancer (mCRPC) modified to only cover BRCA mutations - Coverage criteria for ovarian advanced/metastatic ovarian cancer simplified to no longer specify specific treatment regimen (monotherapy or use with bevacizumab)
Sodium oxybate-containing medications, dru093	- Added pitolisant (Wakix) as a step therapy requirement for narcolepsy with cataplexy for new starts
Trodelvy, sacituzumab govitecan, dru645	- Removed platin requirement from coverage criteria
Spinraza, nusinersen, dru485	- Broadened prescriber requirement to include non-pediatric neuromuscular specialists
Rubraca, rucaparib, dru494	- Removed step through taxane chemotherapy for metastatic castration-resistant prostate cancer (mCRPC) - Modified authorization duration to may be reviewed annually to align with other PARP inhibitor policies
Arikayce, amikacin liposome inhalation suspension, dru572	- Revised definition of prior antibiotic ineffectiveness based on newly published clinical guidelines from 12 months of guideline-based therapy (GBT) without culture conversion, to 6 months
Onpattro, patisiran, dru577	- Clarified criteria to allow for coverage in patients with symptoms of polyneuropathy without functional impairment
Tegsedi, inotersen, dru579	- Clarified criteria to allow for coverage in patients with symptoms of polyneuropathy without functional impairment
High-cost topiramate extended-release products, dru602	- Removed requirement for one lower-cost alternative (other than topiramate immediate release) from criteria

CONTINUED ON PAGE 9

CONTINUED FROM PAGE 8

Revised medication policies	Description of changes
Effective May 1, 2021	
Botulinum toxin type A injection, dru006	- Updating criteria for hyperhidrosis: • Clarifying that secondary infection or skin maceration are considered separate complications • Adding inability to satisfy demands of employment as an example of a complication • Adding a requirement that antiperspirant or anticholinergics (topical or oral) have been tried - Adding coverage criteria for thoracic outlet syndrome (TOS) in patients with functional impairment
Myobloc, rimabotulinumtoxinB	- Revising urinary incontinence criteria to match Botox policy (no change to intent)
Effective July 1, 2021	
Non-Preferred Products with Available Therapeutically Interchangeable Biosimilars/ Reference Products, dru620	- Adding Rituxan Hycela SC and Herceptin Hylecta SC to policy - Coverage of these products will require documentation of intolerance or contraindication to the preferred therapeutically-equivalent product - Preferred products do not require pre-authorization; the preferred rituximab product is Ruxience and the preferred trastuzumab product is Trazimera

Archived medication policies	Description of changes
Effective April 1, 2021	
High-cost naloxone products (Evzio), dru483	- Brand name Evzio discontinued in September 2020 with no remaining available inventory

Specialty and home delivery pharmacy reminder

As a reminder, our preferred specialty and home delivery vendors changed to Accredo and Express Scripts Pharmacy® from AllianceRx Walgreens Prime, effective April 1, 2021.

Specialty medications

Accredo is our preferred specialty pharmacy for Oregon, Utah and Washington BridgeSpan members who have Specialty Select (specialty force fill list). These members must fill their specialty drugs at Accredo to be covered by the health plan. We are coordinating the transition to Accredo from AllianceRx Walgreens Prime to ensure members' treatment is not interrupted. For members who do not have Specialty Select, Accredo is a new specialty option.

Accredo is a new in-network option for all BridgeSpan Idaho members. Members can choose to change their pharmacy; we will not automatically transfer prescriptions. Pricing may be lower with Accredo, depending on the medication.

Submitting a prescription to Accredo for growth hormone therapy

Federal law requires growth hormone therapy to be dispensed only for FDA-approved indications. Each prescription undergoes a rigorous clinical review to ensure appropriateness of therapy, which may include evaluation of dose/product selection per age and indication, available test results/lab values, concurrent medication therapy and evaluation of prescriber intent.

As we transition specialty prescriptions to Accredo, we want you to be aware of an important step in the process for growth hormone therapy for some members. Accredo requires the authorizing prescriber to complete a *Prescriber Certification for Human Growth Hormone Indication* form prior to dispensing for:

- Any patient 18 or older
- Pediatric patients younger than 18 who are not seeing a pediatric endocrinologist or nephrologist (for certain diagnoses)

If the prescriber does not complete this form, Accredo is unable to dispense growth hormone. The certification remains in place as long as the prescriber stays the same. Refills are monitored for clinical changes.

For more information, please visit the Accredo website at **accredo.com/prescribers/manage_referrals**. The *Prescriber Certification for Human Growth Hormone Indication* form can be downloaded at **accredo.com/sitecore/media/Accredo/PDF/HGH_Certification.pdf**.

Home delivery

Express Scripts Pharmacy is our preferred home delivery pharmacy. Express Scripts Pharmacy has been serving members with prescription delivery for more than 30 years, with multiple locations across the U.S., allowing prescriptions to be routed for fast processing and dispensing.

We notified Oregon, Utah and Washington members who currently use home delivery of the change with instructions about how to register with Express Scripts Pharmacy.

Express Scripts Pharmacy is a new in-network option for all members. Members can choose to change their pharmacy; however, we will not require them to transfer their prescriptions in 2021. Pricing may be lower with Express Scripts Pharmacy, depending on the medication.

National Healthcare Decisions Day

National Healthcare Decisions Day, observed annually on April 16th, aims to inspire, educate and empower the public and providers about the importance of advance care planning.

We encourage you to begin or continue advance care planning (ACP) conversations with all your patients who may have a change in diagnosis or experience a life-changing event (e.g., marriage, divorce, birth of a child or diagnosis of serious illness). We reimburse providers who bill for ACP conversations with members, regardless of age or health status.

ACP conversations may include:

- Designating a medical decision-maker
- Discussing current medical status and prognosis
- Management of physical/psychological symptoms
- Reviewing documents such as an advance directive, durable power of attorney or POLST/MOLST form
- Reviewing or editing information provided in previous ACP documents, such as social, cultural and/or spiritual strengths; values, practice concerns and goals of care

Resources

- Our provider website: Programs>Medical Management> Personalized Care Support
- National POLST Paradigm: **polst.org**
- The Conversation Project: **theconversationproject.org**
- Vital Talk: **vitaltalk.org**

Cancer screenings

An estimated 30% to 50% of all cancers are preventable. According to the National Cancer Institute, cancer is the second leading cause of death in the U.S.

We cover a variety of preventive services at no cost (no copay and no deductible) to our members. Preventive services can help detect the following cancers before symptoms appear and when treatment is more likely to be successful:

- Breast cancer
- Cervical cancer
- Colorectal cancer (colon cancer)
- Lung cancer
- Skin cancer

View our preventive care list

View the complete list of preventive services that we cover in English and Spanish, listed by members of all ages, pregnant members and children: **bridgespanhealth.com/member/members/preventive-care-list**.

Help reduce hypertension and risk for heart disease

The principal risk factors for heart disease include high blood pressure, high cholesterol, smoking and obesity. According to the Centers for Disease Control and Prevention (CDC), nearly half of adults in the U.S. have high blood pressure and only about one in four people with high blood pressure have their condition under control. Regular office visits that stress medication compliance, increased exercise, weight loss and smoking cessation can result in cardiovascular disease mitigation.

We encourage you to contact your patients with hypertension who have not been seen for recommended follow-up. Remind them of the importance of following their treatment plans and taking prescribed medication, if appropriate. For all office visits, we recommend you submit blood pressure results on your claims using CPT level II codes to lessen our requests for medical records and to support our quality reporting.

Million Hearts

Million Hearts® 2022 is a national initiative to prevent one million heart attacks and strokes within five years. It focuses on implementing a small set of evidence-based priorities and targets that can improve anybody's cardiovascular health. The initiative brings together communities, health systems, nonprofit organizations, federal agencies and private-sector partners from across the country to fight heart disease and stroke. We invite you to join in this initiative. You can learn more and find helpful resources on the Million Hearts website: **millionhearts.hhs.gov**.

Recommendations

To support patient education about hypertension, blood pressure monitoring and the lifestyle changes that can help patients live healthier lives, we recommend resources found in the Conditions section of the American Heart Association website at **heart.org**. Health education flyers addressing *High Blood Pressure, High Blood Pressure ACE Inhibitors and ARBs*, and *High Blood Pressure: Adding DASH to Your Life* can be emailed to you by sending an email to the Quality Team at **quality@bridgespan.com**.

Behavioral health resources for PCPs

Mental and emotional health is critical to overall health. Many people experiencing mental health concerns often first disclose these concerns to their primary care provider (PCP). Others may not disclose these concerns at all and would benefit from a routine screening by their PCP.

Not all plans will have the same benefits, so it is important for you to verify member eligibility and benefits using the Availity Portal at **availity.com**.

Providers can use our Pain Management Toolkit. It includes helpful tips, related policies and guidelines, other tools and resources to help support you as you care for patients needing pain management or who are struggling with opioid addiction. The toolkit is available on our provider website: Pre-authorization>Pharmacy> Pain Management Toolkit.

Member tools and resources

We offer several resources and tools to our members. Members can see the behavioral health options available to them under their health plan by signing in to **bridgespanhealth.com**.

Resources range from well-being support to acute care, and include:

- **NEW - Boulder Care** is an evidence-based, person-centered virtual care provider for addiction treatment to address the growing need for accessible substance use disorder (SUD) treatment options. BridgeSpan has partnered with Boulder Care to offer most members in-network access to the telehealth provider's evidence-based, virtual addiction treatment, effective March 15, 2021. Learn more on Boulder Care's website, **boulder.care**.
- **Individual Assistance Plan**, (Reliant Behavioral Health), which provides free behavioral health sessions, and other help, such as legal and financial guidance.
- **Doc on Demand** has expanded its provider mix and now includes access to clinical psychologists, licensed social workers and licensed therapists.

Administrative Manual updates

The following updates were made to our manual sections.

March 1, 2021

Appeals for members

- Added link to member authorization to disclose information

April 1, 2021

Facility Guidelines

- Clarified that revenue code 0762 is used for observation
- **Washington and Idaho sections**: Updated contact information

Introduction

- Updated the responsibilities of participation list

Medical Management

- Updated the Personalized Care Support program description

Policies

- Updated contact information

Our manual sections are available on our provider website: Library>Administrative Manual.

Reminder: Change to outpatient facility MUEs

Editing for outpatient facility medically unlikely edits (MUEs) moved to ClaimsXten clinical editing for dates of service beginning September 1, 2020.

The ClaimsXten MUE edits allow reimbursement up to the specified MUE limitation and deny any units exceeding the specified value. Read more about ClaimsXten on our provider website: Claims and Payment> Claims Submission>Coding Toolkit>ClaimsXten.

Modifier GZ

Modifier GZ is not required on facility claims that bill units exceeding MUE limits. For more information, read our *Maximum Daily Units* (Administrative #120) reimbursement policy: Library>Policies & Guidelines> Reimbursement Policy.

Hearing aid DMEPOS reimbursement schedule update

Effective July 1, 2021, we will add hearing aids and associated devices, supplies and services to the *DMEPOS Reimbursement Schedule for Unlisted Codes/Codes with no Fees*. This will apply to plans that do not specify a benefit cap. You can verify members' eligibility and benefits via the Availity Portal at **availity.com**.

As a reminder, BridgeSpan reserves the right to set a fee schedule amount for codes not listed or listed without a fee in the CMS Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule, available at **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule**. We may assign a payment rate that is the lesser of billed charges, a specific fee schedule amount or 150% of wholesale charges.

View our reimbursement schedule on the Availity Portal: Payer Spaces>Resources. Select Reimbursement Schedules, then DMEPOS Reimbursement Schedule for Unlisted Codes/Codes with no Fees. Notification of new fees that are established will continue to be included in this newsletter.

View our *Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Reimbursement* (Administrative #118) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

Submitting claims for dates of service spanning multiple years

The CMS coding guidelines require facility claims that span from one calendar year to another to be split into separate claims by year. This allows proper processing of all aspects of the claim. The CMS guidance is:

FL 6. Statement covers period (from - through)

- These fields cannot exceed eight positions in either "from" or "through" portion allowing for separations (nonnumeric characters) in the third and sixth positions.
- The "from" date must be a valid date that is not later than the "through" date.
- The "through" date must be a valid date that is not later than the current date.
- With the exception of Home Health PPS claims, the statement covers period may not span 2 accounting years.

In a review of facility claims, we identified that these claims were not being submitted according to this guideline consistently. To ensure that our claims processing is accurate, timely and meets the requirements in national coding guidelines, we will stop processing claims that span two accounting years and don't qualify for an exception.

Facility claims (ANSI 837I claims) received on or after July 1, 2021, that span from one calendar year to the next (e.g., December 28, 2020, to January 3, 2021), will be denied automatically if they are submitted on the same claim.

Providers are responsible for submitting accurate and complete claims for all medical, dental and surgical services, supplies and items rendered to members using industry standard coding guidelines. Please refer to our *Correct Coding Guidelines* reimbursement policy (Administrative #129) on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

Code pair updates

Effective July 1, 2021, CPT 29200, 29240, 29260, 29280, 29520, 29530, 29540, 29550 and 29799—which represent casting/splinting/strapping services—will be denied when billed on the same date of service as a therapeutic procedure code—CPT 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032-97036, 97039, 97110, 97112, 97113, 97116, 97124, 97129, 97139, 97140, 97150, 97530, 97597, 97602, 97605-97608, 97610, 97799, 97810, 97813, 98925-98929, 98940-98943 and HCPCS G0283. Modifiers will not be allowed to bypass these denials.

Retroactive bundling edit changes

Claim issues can often be resolved by appending an appropriate bypass modifier. We recommend using the web-based Clear Claim Connection tool to model claim editing and determine which modifier(s) would be appropriate. By using this tool, you may be able to reduce claim denials and appeal filings. To access the tool, sign in to the Availity Portal, **availity.com**: Payer Spaces>Resources>Claims and Payment> Research Procedure Code Edits.

Use these helpful resources to determine whether a bypass modifier is appropriate based on the services provided:

- CMS NCCI Policy Manual: **cms.gov/Medicare/Coding/NationalCorrectCodInitEd**
- The correct code editor (CCE) rationale posted on our provider website: Coding Toolkit>Bundling Edits

As a reminder, our Coding Toolkit includes quarterly updates to edits approximately one month after the effective date retroactive to the first day of the quarter. For example, second quarter edits are expected to be applied April 25, 2021, and will be retroactive to April 1. This calendar is posted on the Coding Toolkit page of our provider website.

Reminders

- Outpatient code editor (OCE) edits are excluded from this quarterly process. Claims processed before our systems are updated will not be adjusted.
- Appeals will not result in an adjustment of your claim.

Compliance for board and/or trustee members

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

We would like to remind you that your organization's board or trustee members are required to participate in all BridgeSpan compliance program activities, including:

- Signing a conflict of interest disclosure at appointment and annually thereafter
- Completing fraud, waste and abuse (FWA) and general compliance training within 90 days of appointment and annually thereafter
- Completing Office of Inspector General (OIG) and General Services Administration (GSA) screenings prior to appointment and monthly thereafter

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

Information regarding the BridgeSpan Compliance program and related resources is available on our provider website: Library>Policies and Guidelines>Guidelines.

Coding Toolkit updates

Our Coding Toolkit lists our clinical edits and includes information specific to Medicare's National Correct Coding Initiative (NCCI). These coding requirements are updated on a monthly basis in the *Clinical Edits by Code List* in the Coding Toolkit.

We have enlisted the support of Change Healthcare and their claims management solution for ClaimsXten bundling edits. Additional ClaimsXten correct coding edits will continue to be implemented on an ongoing basis. The Coding Toolkit provides a high-level description of the ClaimsXten-sourced edits. These edits are proprietary to Change Healthcare and, therefore, we cannot provide the editing detail.

July 1, 2021, ClaimsXten change: An edit will be added to deny professional claims when a 10- or 90-day global fracture care code is billed with place of service 23 (emergency room) and submitted without modifier 54 (surgical care only).

Our Correct Code Editor (CCE), also located in the Coding Toolkit, has additional CPT and HCPCS code pair edits that we have identified and are used as a supplement to Medicare's NCCI. This supplemental list of code groupings in the CCE is updated quarterly in January, April, July and October. We reserve the right to take up to 30 calendar days to update our systems with CCE updates, CMS-sourced changes and Change Healthcare-sourced changes. Claims received before our systems are updated will not be adjusted. The Coding Toolkit is available on our provider website: Claims & Payment>Coding Toolkit. We perform retrospective review on claims that should be processed against our clinical edits. We follow our existing notification and recoupment process when we have overpaid based upon claims processing discrepancies and incorrect application of the clinical edits. View the notification and recoupment process on our provider website: Claims & Payment>Payment>Overpayment Recovery.

Please remember to review your current coding publications for codes that have been added, deleted or changed and to use only valid codes.

Secondary claims editor to begin July 1

Beginning July 1, 2021, we will use a secondary editor supporting our existing claims edits. Edits will be applied in line with our medical and reimbursement policies and, as part of adjudication, will correct payments that automated solutions would miss.

Between analysis and payment, the secondary editor adds a level of human expertise to examine claims, when appropriate, combining automation with expert clinical review. This editor targets such complex issues as contradictory or overlapping services and suspect billing patterns that are generally not addressed by computer alone.

Change to OCE CCI editing

Editing for Outpatient Code Editor Correct Code Initiative (OCE CCI) will be moved to ClaimsXten clinical editing for dates of service beginning August 1, 2021. The OCE CCI works to eliminate mutually exclusive code pairings and codes considered to be components of more comprehensive services.

The ClaimsXten edit will require anatomical modifiers RT and/or LT to be appended on both codes in a code pair to be considered for payment.

CPT codes being billed	Beginning August 1, 2021
29805-RT 12032-LT	There will be no change; both codes will be allowed.
29805 with no modifier 12032-LT	CPT 12032 will deny.
29805-59 12032-LT	CPT 12032 will deny.

Keep your information current

Our members rely on the information in our online provider search tool, Find a Doctor, to determine whether physicians, dentists, other health care professionals and facilities are included in their health plan's provider network.

When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

We require verification of your practice information and the networks you participate in at least once every 30 days.

Validate your practice information

We require you to verify your practice information and the networks you participate in at least once every 30 days. Take time now to validate your practice information, including whether you are accepting new patients, by following the steps outlined on our provider website: Contact Us>Update Your Information.

Each month, please verify that we have correctly listed your specialty, degree, primary care designation (if appropriate) and whether you are accepting new patients. This helps members find you when they need specialty care or a particular service. If your clinic is a retail health clinic, let us know so we can update your information.

Submit changes or corrections

Please contact your provider experience representative if your information has changed or is listed incorrectly. Thank you for helping our members connect with you.

Referring to in-network providers

As a reminder, except in cases of an emergency, you must refer members to participating in-network medical, dental and behavioral health providers, including laboratories.

Referring members to in-network providers, including laboratories, is critical for our exclusive provider organization (EPO) members. EPO members are responsible for 100 percent of out-of-network costs.

Making referrals to in-network providers and facilities helps your patients make more informed choices about how they spend their health care dollars. By staying in-network, your patients will:

- Minimize their out-of-pocket expenses
- Receive the highest level of medical and dental benefits
- Ensure that they have convenient access to quality services

Referrals to non-participating providers should only be made after notifying the member in writing that services may not be covered or may result in higher out-of-pocket costs.

Use the Find a Doctor tool on our provider website to locate in-network providers. Locate providers by name, location or specialty type.

Resources for you

Visit the Contact Us section of our provider website for information about the Availity Portal, **availity.com**, and other resources for your office.

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