JUNE 2024

Provider News

For participating physicians, other health care professionals and facilities

Work with us to support health equity

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

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

Provider directory information

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

- Language
- Pronouns
- Gender identity
- Race and ethnicity
- Culturally-specific care
- LGBTQ+-inclusive care
- Disability-competent care

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Easily find information

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

Subscribe today

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

Using our website

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

Stay up to date

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

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Contents

■ Critical update
★ Stars Ratings/Quality

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 at **availity.com**.

The Bulletin

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

Share your feedback

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

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LGBTQ+ people who see an LGBTQ+ or queer-affirming provider who validates their identity can make a big difference for their health outcomes. By indicating LGBTQ+-inclusive care, members can select providers who have competence in behavioral health and transgender medicine. It also helps our members build trusting relationships with their health care providers, resulting in more appropriate care and better health outcomes.

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

Resources for working with diverse populations

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

Offer language services (e.g., interpreters, forms in multiple languages) during office visits and other health care-related services (e.g., pharmacy, social work, physical therapy, dietician, nutritionists, etc.). Members can call the Customer Service number on the back of their member ID card for interpreter services. Our provider website also includes helpful resources for language access and services.

You can find these resources in our recently updated Health Equity Toolkit (formerly named the Cultural Competency Toolkit) on the homepage of our provider website. We encourage you to bookmark this page. **Note**: The toolkit will have new navigation by July 1, 2024, making it easier for you to quickly find the resources you need.

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

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

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

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

Resources

- CMS, 2024 ICD-10-CM updates: **cms.gov/medicare/coding-billing/icd-10/2024-icd-10-cm**
- CMS ICD-10-CM Official Guidelines for Coding and Reporting: **cms.gov/files/document/ fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf**

Social need screening and intervention

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

More information on this measure is included in our *Quality Measures Guide*, available in on our provider website: Programs>Quality Incentive.

Are you?

√ **Using our toolkits**: Our toolkits include helpful resources that can assist you with patient care and save your office time. Visit the homepage of our provider website to access the Behavioral Health, Care Options, Health Equity, Pain Management, Quality Improvement and Self-Service toolkits.

√ **Enrolled in the free Redefining Access to Improve Patient Experience webinar**: We have partnered with Press Ganey to offer a free webinar series, providing best-in-class insights, tools and techniques to improve patient experience. **Related**: See *Join us for a webinar to improve patient experience* on page X for registration links.

√ **Registered for Availity Essentials**: All contracted providers are required to register with Availity Essentials, submit claims electronically and receive payments via electronic funds transfer (EFT). Use Availity Essentials to access eligibility, benefits, claims-related information and submit your medical pre-authorization requests and pre-authorization determination appeals. Register today at **availity.com**.

Join us for a webinar to improve patient experience

We recognize that access to care and its impacts on patient experience are a challenge across the health care industry. We have partnered with Press Ganey Consulting to offer a free webinar series, providing best-in-class insights, tools and techniques to improve patient experience. Attendees can earn 1.0-hour continuing education (CE).

Redefining access to improve patient experience

The webinar will cover the following topics:

- Redefining access to improve quality and experience
- Providing access throughout the patient journey
- Setting expectations to support access to care for both PCPs and specialty care
- Specific interventions that promote access beyond traditional face-to-face appointments
- Applying tactics that can be implemented starting your next day at the office

Join us for a 60-minute webinar on one of the following dates:

- June 7, 2024, noon (PT): Register
- August 2, 2024, noon (PT): Register

We are excited to offer this opportunity and hope you can join.

Administrative Manual updates

The following updates were made to our manual on June 1, 2024:

Introduction

- Clarified medical record request requirements and updated references to provider website

Medical Record Requirements

- New section to clarify and outline requirements for medical records documentation and signature authentication in alignment with CMS rules.

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

Upcoming code edits

Beginning September 1, 2024, we will implement code edits for the following billing scenarios:

- Inappropriate diagnosis code billing
- Incorrect modifiers on evaluation and management (E&M) codes
- Incorrect reporting of telehealth/telemedicine modifiers
- When a 10- or 90-global-day dislocation procedure code is billed on a professional claim with place of service (POS) 23 (emergency room) and submitted without modifier 54 (surgical care only)—this is an expansion of an existing edit

Reminder: Use of non-covered services form

As a participating provider, you have agreed to hold patients responsible only for copay, coinsurance and deductible amounts, and, when a consent form is signed, for services not covered by their benefit contract. If you bill a member prior to the processing of a claim, the bill should clearly indicate that you have submitted the claim to us. Prior to processing of the claim, **you may require member payment only for services known to be non-covered and for estimated copay, coinsurance and deductible amounts**. **Note**: After the claim is processed, a balance may be due to the member for any funds they paid upfront in excess of the final amount due.

A *Non-covered Services Member Consent Form* should be signed by the member before collecting for services that may not be covered. View a sample form on our provider website, under the Miscellaneous section: Library>Forms.

In addition, we encourage providers to verify their patients' benefits using Availity Essentials and to refer members to in-network providers. The Correct Code Editor (CCE), located in our Coding Tookit, can also be used to identify codes, their description, edit type and comment (e.g., 77085; Dxa bone density study; investigational denial; Always considered investigational; investigational services are denied member liability). The Coding Toolkit is available on the homepage of our provider website.

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 annual trainings on compliance and fraud, waste and abuse (FWA).

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

Exclusion lists

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

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

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

Required compliance training

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

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

Compliance for board and/or trustee members

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

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

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

Learn more

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

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

Update your directory information

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

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

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

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

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

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

We have expanded our provider directory information to help our members connect with providers they feel best meet their health care needs and individual preferences. Update your demographics and indicate if your office offers LGBTQ+-affirming care, culturally-specific services, expanded language access and disability competent care by following the instructions on your provider website: Contact Us>Update Your Information. 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.

Pre-authorization determination appeals coming to Availity

Beginning June 15, 2024, Availity's Appeals application will be expanded to include medical pre-authorization determination appeals.

The application streamlines the appeals process, making it faster and easier to submit appeals directly from Availity Essentials.

Instead of manually completing and submitting a separate *Provider Appeal Form,* portal users can submit a medical pre-authorization determination appeal with required documentation directly from the Authorization dashboard, receive immediate confirmation of submission and review the status of their appeal—all in one place.

The Appeals dashboard will show the status of submitted appeals. Access it from Availity Essentials: Claims & Payments>Appeals.

Get trained for free

View the training options available by clicking the Help & Training link in the Availity Essentials menu.

Look for announcements about the pre-authorization appeals launch on our provider website and Availity Essentials.

Responding to documentation requests

If you receive a request for 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.

Learn more on our provider website: Claims & Payment>Claims Submission>Claims Attachments.

Reminder: Cardiology program adding services

We are expanding our cardiology program to review additional outpatient cardiovascular tests, procedures and certain cardiac devices. The program requires pre-service medical necessity review and pre-authorization through Carelon Medical Benefits Management (Carelon) and will include the following additional non-emergency outpatient cardiac services delivered on or after July 1, 2024:

- Ambulatory cardiac rhythm monitoring
- Cardiac ablation
- Electrophysiology studies
- Wearable cardioverter defibrillator—for commercial only

We have updated the cardiology section of our pre-authorization list to include the following additional codes, effective July 1, 2024: CPT 33285, 93650, 93653, 93654, 93656, 93228 and 93229, and HCPCS C1764, E0616 and K0606.

About the program

Carelon administers our cardiology program, which reviews outpatient cardiovascular tests, procedures and certain cardiac devices.

Providers will be able to contact Carelon to request pre-authorization for these additional services beginning June 17, 2024.

- **Online**: The Carelon ProviderPortal is available 24/7 and processes requests in real-time using clinical criteria, providerportal.com.
- **By phone**: Call Carelon at (877) 291-0509, Monday through Friday, 8 a.m.-5 p.m. (PT).

Learn more

- Program details are available on our provider website: Programs>Medical Management>Cardiology.
- View a complete list of codes included in the program on our Pre-authorization list.

Carelon revising cardiology clinical guidelines

Effective October 20, 2024, Carelon will revise the following clinical guidelines:

- Cardiac Resynchronization Therapy
- Permanent Implantable Pacemakers

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

Pre-authorization updates

Procedure/medical policy	Added code effective January 1, 2024
Radioembolization, Transarterial Embolization (TAE), and Transarterial Chemoembolization (TACE) (Medicine #140)	- C9797
Procedure/medical policy	**Added code effective April 1, 2024**
Definitive Lower Limb Prostheses (Durable Medical Equipment #18)	- L5841
Procedure/medical policy	**Expanding application of codes effective September 1, 2024**
Applied behavior analysis (ABA)	- 0362T, 0373T, 97151-97158 - **Related**: See *Change to ABA authorization for members younger than 18* on page 18.

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.

Reimbursement changes to modifier 25 and global periods

Modifier 25

Effective September 1, 2024: When modifier 25 is appropriately appended to an evaluation & management (E&M) service and is submitted on the same date of service as a minor procedure, by the same physician or other qualified health care provider, the E&M service will be reimbursed at 50% of the allowed amount.

We announced this change to our *Modifier 25; Significant, Separately Identifiable Service* (Modifier #103) and *Global Days* (Administrative #101) reimbursement policies in the June 2024 issue of *The Bulletin*.

Suture removal

Effective August 1, 2024: We are adding language to our *Global Days* (Administrative #101) reimbursement policy to state that suture removal is not eligible for separate reimbursement regardless of the surgical global period.

We will begin post- and prepayment reviews of all global days claims. These reviews will include payments that were made separately from the global surgical package and are within the state's timeliness rules.

We announced this change in the May 2024 issue of *The Bulletin*.

More information

View the announcements and policies on our provider website:

- *The Bulletin*: What's New & Publications>Bulletins
- Our *Reimbursement Policy Manual*: Library> Policies & Guidelines>Reimbursement Policy

The Bulletin recap

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

Medical policy updates

We provided 90-day notice in the May 2024 issue of *The Bulletin* about changes to the *Knee Surgeries* (Surgery #229) medical policy, which are effective August 1, 2024.

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

We provided 90-day notice in the May 2024 issue of *The Bulletin* about changes to the following reimbursement policies, which are effective August 1, 2024:

- *Anesthesia Reimbursement and Services Reporting* (Anesthesia #102)
- *Global Days* (Administrative #101)
- *Virtual Care* (Administrative #132)

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

Recoupment for medical record requirements

Participating providers agree to comply with all applicable laws, regulations and CMS instructions. This includes requirements relating to medical record documentation and authentication. We request medical records post-payment to support required data submissions for programs, such as risk adjustment or HEDIS.

You must ensure that your patient's medical records are properly authenticated to satisfy CMS documentation requirements, including—but not limited to—ensuring the records contain the proper provider signature, credentials and signature date. Records submitted for review that are not properly authenticated or signed may be subject to claim recoupment. A provider may amend the record to properly authenticate the record (including by recording a valid signature) within 180 days of the date of service.

Effective September 1, 2024

Starting with medical record reviews, including but not limited to Medicare risk adjustment reviews, claims audits, etc., that begin on or after September 1, 2024, if we determine that CMS authentication or documentation requirements, outlined in the Medical Records Requirements section of our Administrative Manual are not met, processed claims may be subject to recoupment.

Please ensure that you are following the CMS standards for medical record documentation and authentication. For reference, see the following Medicare Learning Network (MLN) fact sheets:

- Medical Record Maintenance & Access Requirements (MLN4840534): **cms.gov/files/document/mln4840534-medical-record-maintenance-and-access-requirements.pdf**
- Complying with Medical Record Documentation Requirements (MLN909160): **cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/certmedrecdoc-factsheet-icn909160.pdf**
- Complying with Medicare Signature Requirements (MLN905364): **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf**

Note: Some updates to your electronic medical record (EMR) system can override your signature settings and you may need to re-verify your settings during or after an update.

For more information about medical recordkeeping, please see the Medical Records Requirements section of the *Administrative Manual*. Our manual sections are available on our provider website: Library>Administrative Manual.

Start using real-time pharmacy benefit check tool

We understand that identifying which medications are available to patients on their health plan formularies can be challenging and time-consuming. To create easier access to a preferred medication database for our members, we've partnered with Arrive Health to integrate a real-time benefit check tool for prescribed medications that works within your EMR system.

Arrive Health works with many of the larger, national EMR systems (e.g., Epic and Cerner) to provide you quick access to pharmacy benefit checks. With 99% transaction accuracy and over 10 million transactions per month, Arrive Health is a trusted partner to help patients get the right medication at the right price.

Using real-time benefit check can improve the patient experience, decreasing their financial strain and improving medication adherence. It can also lead to better provider and patient conversations about treatment plans and reduce your time spent on administrative tasks.

How it works

Real-time benefit check information will display when the following criteria are met:

- Patient eligibility has been pulled (workflow varies by EMR system)
- Patient's pharmacy benefits are covered by a participating pharmacy benefits manager (PBM) (e.g., Prime Therapeutics)
- You have entered the national drug code (NDC), preferred pharmacy NPI, quantity and days supply

The tool will present the following patient-specific coverage information:

- Coverage status (covered, not covered, covered with restrictions)
- Coverage alerts (pre-authorization required, quantity limit issue, refill too soon, step therapy, etc.)
- Out-of-pocket costs for the patient
- Formulary-driven medication alternatives
- Pharmacy options

Note: This tool is only for medications filled at pharmacies, not those dispensed or administered in the provider office.

Available now

This tool is available for all members now.

Learn more

Visit **arrivehealth.com** to learn more about Arrive Health for providers.

Connect through your EMR vendor

Contact your EMR vendor to find out how to connect your system to the Arrive Health solution.

BridgeSpan EquaPathRx™ program implementation change

As the cost of health care continues to rise—especially costs for provider-administered specialty medications—our customers continually explore ways to lower costs and look to us for solutions. Some employers have resorted to forced white-bagging options through third-party pharmacy benefit managers (PBMs) to solve for affordability.

Our BridgeSpan EquaPathRx program is an approach that continues to reimburse designated providers to obtain and administer specialty medications. **It also allows claims submission and processing to remain unchanged.** Our program:

- Keeps the provider-patient relationship intact
- Delivers predictable costs for members and employer groups
- Includes a Provider-Administered Specialty Drugs member benefit that requires medications to be supplied and administered by a provider who is participating in Prime Therapeutics' IntegratedRx - Medical® Network

New timeline for implementation

The Provider-Administered Specialty Drugs benefit is in effect as plans renew throughout 2024. To ensure a smooth transition, we're adjusting our implementation timelines for benefit administration transition to the IntegratedRx – Medical network as follows:

October 1, 2024:

- Idaho
- Utah

January 1, 2025:

- Oregon
- Washington

Here's what this means for you:

- **From now through the transition date for each service area**: As we work with providers to contract with the Prime IntegratedRx - Medical Network, all BridgeSpan network providers are considered to be designated providers under the Provider-Administered Specialty Drugs benefit and are eligible to provide medications included in theBridgeSpan EquaPathRx program (subject to otherwise applicable conditions) to members with this benefit. **This means members can continue to receive medications from you as they do today, and claims for medications included in this program will be processed based on your existing agreement terms with us.**
  - Medications included in this 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>Commercial Policies.
- **On the transition date**: Providers must be included in the IntegratedRx - Medical Network to be considered a designated provider under the benefit and reimbursed for administering medications included in the BridgeSpan EquaPathRx program to members with this benefit.
  - The medication portion of the claim will be adjudicated under the terms and rates of the executed agreement you have for this program. The administration portion of the claim will be adjudicated under the terms and rates of your medical services agreement.
  - Medications included in this program must be pre-authorized according to our medication policies and require administration by a designated provider (participating IntegratedRx - Medical provider) to be covered under the member's benefits. We'll notify you in advance of any additions or changes to the medications included in the program through this newsletter (see below.)
  - If you haven't contracted with Prime to participate in the IntegratedRx – Medical Network, provider-administered medications under the BridgeSpan EquaPathRx program will not be covered for members with the Provider-Administered Specialty Drugs benefit and claims will be denied as provider responsibility.
    Note: If you haven't yet contracted with Prime by 90-120 days before the transition date listed above, we'll work closely with you and our members to ensure they have uninterrupted access to their treatment on and after the implementation date.

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Medication policy change effective October 1, 2024

In preparation for the new transition dates listed above, we're making the following changes to our *Provider-Administered Specialty Drugs* (dru764) medication policy effective October 1, 2024:

Medications added to policy effective October 1, 2024

Note: These medications require pre-authorization review for medical necessity and designated program provider status.

Medication name	HCPCS	Associated medication policy
Adstiladrin, nadofaragene firadenovec-vncg	J9029	dru743
Elfabrio, pegunigalsidase alfa-iwxj	J2508	dru575
Izervay, avacincaptad pegol	J2782	dru517
Lamzede, velmanase alfa-tycv	J0217	dru426
Pombliti, cipaglucosidase alfa-atga	J1203	dru426
Rystiggo, rozanolixizumab-noli	J9333	dru696
Syfovre, pegcetacoplan, intravitreal	J2781	dru517
Vyjuvek, beremagene geperpavec-svdt	J3401	dru759
Vyvgart Hytrulo, efgartigimod alfa/ hyaluronidase-qvfc	J9334	dru696
Zynyz, retifanlimab-dlwr	J9345	dru751

Prime Therapeutics contracting and credentialing

If you haven't already, please reach out to your Prime contact now to complete the process of credentialing and contracting for the IntegratedRx - Medical Network. Your Prime contact will help you complete the process. If you don't have a Prime contact established, please email Prime Provider Relations at **providerrelations@primetherapeutics.com**.

To start IntegratedRx - Medical Network credentialing, you can also visit Prime's credentialing website: **pharmacy.primetherapeutics.com/content/primetherapeutics/en/provider-credentialing.html**.

Idaho and Utah: Medications added to policy effective October 1, 2024

Note: These medications require pre-authorization review to confirm designated program provider status.

Medication name	HCPCS
Alimta, pemetrexed	J9305
Avsola, infliximab-axxq	Q5121
Belrapzo, bendamustine HCl	J9036
Bendamustine HCl	J9033
Bendeka, bendamustine HCl	J9034
Benlysta, nelimumab	J0490
Bortezomib	J9046, J9048, J9049
Erbitux, cetuximab	J9055
Fulphila, pegfilgrastim-jmdb	Q5108
Halaven, eribulin mesylate	J9179
Jevtana, cabazitaxel	J9043
Kanjinti, trastuzumab-anns	Q5117
Krystexxa, pegloticase	J2507
Nyvepria, pegfilgrastim-apgf	Q5122
Pemetrexed	J9304, J9314
Pemrydi RTU, pemetrexed	J9324
Ruxience, rituximab-pvvr	Q5119
Trazimera, trastuzumab-qyyp	Q5116
Treanda, bendamustine HCl	J9033
Truxima, rituximab-abbs	Q5115
Vectibix, panitumumab	J9303
Velcade, bortezomib	J9041
Vivimusta, bendamustine HCl	J9056

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. See our *Non-Reimbursable Services* (Administrative #107) reimbursement policy on our provider website: Library.Policies & Guidelines>Reimbursement Policy.

Effective April 1, 2024	Description
New medication policies	
Drugs for chronic inflammatory diseases (for UMP plans), dru900	- Added Omvoh (mirikizumab-mrkz) to policy as non-preferred provider-administered option for ulcerative colitis (UC) - Changed Stelara (ustekinumab) from a non-preferred to preferred provider-administered option

Effective April 15, 2024	Description
New medication policies	
Non-Cosmetic Use of Medications and Products, dru780	- New administrative policy facilitates benefit check and approval as appropriate for medications with cosmetic and non-cosmetic indications
Medications for molluscum contagiosum, dru773	- Limits coverage of Ycanth (cantharidin) and Zelsuvmi (berdazimer) to patients with molluscum contagiosum (MC) not previously treated with Ycanth/ Zelsuvmi; patients MC must be severe as defined by presence for at least six months, extremely bothersome or concomitant atopic dermatitis/bacterial infection
Loqtorzi, toripalimab-tpzi, dru774	- Limits coverage to recurrent unresectable or metastatic nasopharyngeal carcinoma with no prior use of PD-1 inhibitors and in one of the following settings: • In combination with cisplatin/gemcitabine when there has been no prior therapy in advanced setting • As monotherapy when there has been disease progression on or after platinum-containing chemotherapy

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Effective April 15, 2024	Description
Revised medication policies	
Medications for Thrombotic Thrombocytopenic Purpura (TTP), dru598	- Added coverage criteria for Adzynma (ADAMTS13, recombinant-krhn), a newly FDA-approved enzyme replacement therapy for the treatment of congenital thrombotic thrombocytopenic purpura - Limits coverage to this indication when diagnosed by a specialist and confirmed by genetic testing, ADAMTS13 activity <10% and absence of any other TTP-like disorder diagnosis - When used for prophylactic therapy, coverage requires a history of at least one acute TTP event in the last year, currently receiving plasma-based prophylactic therapy and the patient is not currently having an acute TTP event
Enzyme Replacement Therapies, dru426	- Added coverage criteria for Pombiliti (cipaglucosidase alfa) in combination with Opfolda (miglustat), two newly FDA-approved medications for late-onset Pompe disease; limits coverage of these medications to this indication when diagnosed by a specialist and confirmed by acid alpha glucosidase (GAA) enzyme deficiency and/or genetic mutation - Pombliti was also added to Site of Care Program; when administered by a provider, this medication must be given at an approved Site of Care location
Medications for Primary Hyperoxaluria, dru668	- Added coverage criteria for Rivfloza (nedosiran), a newly FDA-approved medication indicated to lower urinary oxalate levels in patients with primary hyperoxaluria type 1 (PH1) and relatively preserved kidney function; coverage criteria mirrors Oxlumo requiring genetically confirmed PH1 (AGXT mutation), kidney dysfunction and failure of medical management (i.e., hydration therapy, crystallization inhibitors and pyridoxine) - Concomitant use with Oxlumo (lumasiran) is considered investigational
Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620	- Added Udenyca On-Body (pegfilgrastim-cbqv) and Ryzneuta (efbemalenograstim alfa-vuxw) to policy as non-preferred
Reblozyl, luspatercept-aamt, dru631	- The use of Reblozyl (luspatercept) in erythropoietin-stimulating agent- (ESA-)naïve myelodysplastic syndrome- (MDS-)associated anemia is considered not medically necessary and, therefore, not covered due to lack of clinically meaningful difference relative to significantly lower cost standard of care ESA therapy. - **Note**: The current policy allows for coverage in patients with transfusion-dependent MDS-associated anemia when ESAs were ineffective, not tolerated or not a treatment option
Opdivo, nivolumab, dru390	- Updated melanoma criteria to allow for coverage of early-stage (IIB/C) disease in addition to advanced disease (stage III/IV), which was already included in policy; this update is based on an FDA expanded indication in melanoma

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Effective April 15, 2024	Description
Revised medication policies (continued)	
Gene therapies for beta thalassemia, dru698	- Renamed policy and added coverage criteria for Casgevy's newly FDA-approved indication for the treatment of transfusion dependent β-thalassemia (TDT) - Limits coverage to patients who are at least 12 years old with TDT diagnosed by a hematologist and confirmed via genetic mutation - Coverage also requires transfusion dependence, clinical stability, failure of or contraindication to red blood cell transfusion (RBCT) and iron chelation therapy (ICT), contraindication to hematopoietic stem cell transplant (HSCT) and no prior gene therapy or HSCT
Elahere, mirvetuximab soravtansine-gynx, dru738	- Updated epithelial ovarian, fallopian tube and primary peritoneal cancer coverage criteria to remove prior bevacizumab requirement based on a newly published confirmatory phase 3 randomized-controlled trial with mature outcomes data
Tepezza, teprotumumab-trbw, dru632	- Updated criteria to allow for coverage with clinical activity score (CAS) less than four when patient has proptosis plus significant medical complication (e.g., diplopia, eye pain or inability to perform critical activities of daily living or employment); this update is based on newly published evidence to support the use of Tepezza in low-activity disease

Effective June 1, 2024	Description
New medication policies	
Xdemvy, lotilaner 0.25% ophthalmic solution, dru772	- Limits coverage to patients with demodex blepharitis diagnosed by a specialist for whom step therapy with at least one standard of care treatment was ineffective
Augtyro, repotectinib, dru776	- The use of Augtyro for ROS1-positive advanced non-small cell lung cancer (NSCLC) is considered not medically necessary and, therefore, not covered due to its relative high cost versus similar therapeutic NCCN-recommended alternatives (entrectinib and crizotinib); use of Augtyro for other conditions is considered investigational
Ojjaara, momelotinib, dru777	- Limits coverage for myelofibrosis when the patient is anemic at baseline
Fruzaqla, fruquintinib, dru775	- Limits coverage to patients with metastatic colorectal cancer with disease progression on all the following: fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy; an anti-vascular endothelial growth factor (VEGF) therapy; and an anti-estimated glomerular filtration rate (eGFR) therapy when RAS wild type and medically appropriate
Medications for Weight Management, dru778	- Limits coverage to patients with obesity or adult patients with overweight with at least one weight-related comorbidity. Also requires concurrent use of lifestyle modification(s); reauthorization requires at least a 5% weight loss from pretreatment baseline - Benefit language supersedes this policy, which only applies for members whose benefit covers weight management medications

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Effective June 1, 2024	Description
New medication policies (continued)	
High-cost medications for cholesterol, dru779	- New combination policy incorporates PCSK9 inhibitors (dru697) and Evkeeza (dru680) - Added Nexletol (bempedoic acid) and Nexlizet (bempedoic acid/ezetimibe) to policy; limits coverage of Nexletol and Nexlizet to the following indications: heterozygous familial hypercholesterolemia (HeFH), clinical atherosclerotic cardiovascular disease (ASCVD) or at risk for ASCVD event - Expanded the ASCVD risk category to include secondary prevention with diabetes, chronic kidney disease or very high LDL-C at baseline - Based on treatment guideline updates, LDL-C goal updated and coverage added for primary prevention for very high LDL-C with multiple risk factors for an ASCVD event
Revised medication policies	
High-cost medications for dry eye disease, dru472	- Added newly FDA-approved Vevye (cyclosporine 0.1% solution) to policy
Non-Preferred Drugs, dru760	- Added authorized generics for Farxiga (dapagliflozin propanediol) and Xigduo (dapagliflozin propanediol/metformin extended release) as non-preferred SGLT2 inhibitor-containing medications
PI3K Inhibitor Medications for Breast Cancer	- Added coverage criteria for Truqap (capivasertib), a newly FDA-approved medication for HR+, HER2-, locally advanced or metastatic breast cancer with one or more PIK3CA/AKT1/PTEN-alterations; limits coverage to patients with this indication and disease progression on/after an aromatase inhibitor
Isocitrate Dehydrogenase-1 (IDH1) inhibitors, dru558	- Added coverage criteria for Tibsovo (ivosidenib) for treatment of MDS; limits coverage to relapsed/refractory MDS with IDH1 mutation when at least one prior cytotoxic chemotherapy regimen has been ineffective
Bruton's tyrosine kinase (BTK) inhibitors, dru691	- Added coverage for newly FDA-approved indication for Jaypirca (pirtobrutinib) for chronic lymphocytic leukemia or small lymphocytic lymphoma (CLL/SLL) who have received at least two prior lines of therapy, including a BTK inhibitor and a BCL-2 inhibitor
Voxzogo, vosoritide, dru687	- Removed age restriction based on FDA label age expansion from ages 5 years and older to all pediatric patients; also updated quantity limit to reflect age expansion
Dupixent, dupilumab, dru493	- Removed eosinophilic esophagitis (EoE) age restriction based on FDA label age expansion from age 12 down to one year; also updated quantity limit to reflect age expansion
Medications for pulmonary arterial hypertension (PAH), dru633	- For Adempas (riociguat), Uptravi (selexipag oral) and Orenitram (treprostinil oral), updated step therapy as follows: 1) sildenafil OR tadalafil (previously just sildenafil) and 2) bosentan or generic ambrisentan (previously required both)

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Effective July 1, 2024	Description
Revised medication policy	
Drugs for chronic inflammatory diseases, dru444	- Adding Bimzelx (bimekizumab-bkzx) to policy as a non-preferred (Level 4) self-administered option for chronic plaque psoriasis - Adding Omvoh (mirikizumab-mrkz), Velsipity (etrasimod) and Entyvio SC (vedolizumab) to policy as non-preferred (Level 3) self-administered options for ulcerative colitis (UC); the provider-administered loading doses for Omvoh will follow coverage of the self-administered product - Changing Sotyktu (deucravacitinib) from a Level 3 to a Level 2 self-administered option for chronic plaque psoriasis - Adding coverage criteria for Cosentyx (secukinumab) for treatment of hidradenitis suppurativa - Updating Adbry (tralokinumab) atopic dermatitis age restriction from age 18 down to 12 years old based on FDA age expansion

Effective October 1, 2024	Description
New medication policies	
Products without individual medication policies subject to Site of Care review, dru789	- Limiting coverage of Benlysta IV (belimumab) and Trogarzo (ibalizumab-uiyk) to when Site of Care Program criteria are met - When administered by a provider, these medications must be given at an approved location
Revised medication policies	
Alpha-1 proteinase inhibitors, dru382 Amondys 45, casimersen, dru661 Enjaymo, sutimlimab-jome, dru716; Exondys 51, eteplirsen, dru480 Givlaari, givosiran, dru630	- Adding to the Site of Care Program; when administered by a provider, these medications must be given at an approved location
Drugs for chronic inflammatory diseases, dru444	- Adding Ilumya to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Gaucher Disease Treatments, dru649	- Adding Elelyso to the Site of Care Program (in addition to Cerezyme and VPRIV); when administered by a provider, this medication must be given at an approved location
Interleukin-1 Antagonists, dru677	- Adding Ilaris to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Medications for Hereditary Angioedema (HAE), dru535	- Adding Cinryze to the Site of Care Program; when administered by a provider, this medication must be given at an approved location

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Effective October 1, 2024	Description
Revised medication policies (continued)	
Medications for transthyretin-mediated amyloidosis, dru733	- Adding Amvuttra and Onpattro to the Site of Care Program; when administered by a provider, these medications must be given at an approved location
Monoclonal antibodies for asthma and other immune conditions, dru538	- Adding Tezspire to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Provider-Administered Specialty Drugs, dru764	- Updating the Provider-Administered Specialty Drug list - **Related**: See *BridgeSpan EquaPathRx program implementation change* on pages 10-11.
Site of Care Review, dru408	- The following medications will be added to the Site of Care Program; when administered by a provider, these medications must be given at an approved location: • Alpha 1 proteinase inhibitors (Glassia, Prolastin-C, Aralast NP, Zemaira), J0256 and J0257 • Amondys 45, casimersen (J1426) • Amvuttra, vutrisiran, J0225 • Benlysta IV, belimumab, J0490 • Cinryze, plasma-derived C1-INH, J0598 • Elelyso, taliglucerase alfa, J3060 • Enjaymo, sutimlimab-jome, J1302 • Exondys 51, eteplirsen, J1428 • Givlaari, givosiran, J0223 • Ilaris, canakinumab, J0638 • Ilumya, tildrakizumab-asmn, J3245 • Onpattro, patisiran, J0222 • Tezspire, tezepelumab, J2356 • Trogarzo, ibalizumab-uiyk, J1746 • Viltepso, viltolarsen, J1427 • Vyondys, golodirsen, J1429
Viltepso, viltolarsen, dru640	- Adding to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Vyondys 53, golodirsen, dru606	- Adding to the Site of Care Program; when administered by a provider, this medication must be given at an approved location

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
- *Administrative Manual* updates
- Pre-authorization updates
- *The Bulletin* recap
- Medication policy updates

Change to ABA authorization for members younger than 18

Effective September 1, 2024: ABA services for members younger than 18 will require pre-authorization. We currently require pre-authorization for ABA services for members 18 and older.

Failure to receive pre-authorization may result in an administrative denial, claim non-payment and provider write-off. Members may not be balance billed.

These pre-authorization reviews are supported by our *Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder* (Behavioral Health #18) medical policy.

Our *Pre-authorization List* has been updated to reflect this change. **Related**: See *Pre-authorization updates* on page 8.

ABA reimbursement update

Effective September 1, 2024, we will update reimbursement rates for ABA services. Rates for all 10 ABA codes will increase.

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

State programs offer psychiatric consultations to support PCPs

Through support from state programs in Oregon, Utah and Washington, medical practitioners can access no-cost psychiatric consultations by phone.

The state-wide psychiatric consult services support PCPs in meeting the treatment needs for their patients' mental health by:

- Improving access to the limited availability of psychiatric services
- Helping to serve patients at no cost to providers or patients
- Clarifying diagnostic information or offering other informational support
- Answering questions about medication adjustment or treatment planning
- Ensuring appropriate referrals for patients with serious behavioral health concerns

Expanding the availability of high-quality mental health treatment via timely psychiatric consultation has numerous beneficial effects, including:

- **Early interventions**: Improved quality of care and health outcomes
- **Whole health**: Promotes and improves mental health and physical health integration

Requesting a consultation is simple, and they don't require additional patient authorization because provider-to-provider consultation is covered under the Health Insurance Portability and Accountability Act (HIPAA).

Important: Psychiatric consultations are intended to discuss best practices for treatment and support. **If a patient is in crisis, call 911.**

Note: Idaho does not currently have a state-funded consultation line.

	Oregon	Utah	Washington
Program	Oregon Psychiatric Access Line (OPAL)	Consultation Access Link Line to Utah Psychiatry (CALL-UP)	Partnership Access Line (PAL)
Consultation line	1 (855) 966-7255 or (503) 346-1000	(801) 587-3636	(866) 599-7257
Hours	9 a.m. to 5 p.m. PT, weekdays	Noon to 4:30 p.m. MT, weekdays	8 a.m. to 5 p.m. PT, weekdays
Collaborators	- Oregon Health and Science University (OHSU) divisions of Child and Adolescent Psychiatry and Adult Psychiatry - Oregon Pediatric Society - Oregon Council of Child and Adolescent Psychiatry	- Huntsman Mental Health Institute - Office of Substance Use and Mental Health	- Washington's Health Care Authority - Mental Health Referral Service for Children and Teens - Frontier Behavioral Health, which offers the Supporting Adolescents and Families Experiencing Suicidality (SAFES) program
Ages served	- Adults - Children and adolescents, including consultations with developmental behavioral pediatrics (DBP)	- Adults - Children and adolescents	- Children and adolescents, up to age 19
Website	**ohsu.edu/opal**	**healthcare.utah.edu/hmhi/programs/call-up**	**seattlechildrens.org/healthcare-professionals/community-providers/pal/wa-pal**
Additional information	- For questions, email **OPAL@ohsu.edu**. - Consultations can be provided the same day. - DBP requests must be made by phone.	- For questions, email **Callup@hsc.utah.edu**. - Consultation requests can be made online.	- Calls connect directly to a PAL child and adolescent psychiatrist. - PAL publishes an annual report for PCPs about child mental health.

Help increase post-discharge care rates

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

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

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

Improve outcomes and set patients up for success

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

Our care management team will:

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

Providers can connect to our case management team by calling 1 (866) 543-5765 or the Customer Service number on the back the member's card.

Your facility should:

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

Telehealth can bridge the gap

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

To learn more about telehealth options available to our members, view the toolkits available on the homepage of our provider website:

- The Telehealth section of the Behavioral Health Toolkit includes an up-to-date list of these providers. **Related**: See *Specialized virtual providers without a referral* on page 21.
- Learn about additional national behavioral health vendors available to some members in the Care Options Toolkit.

Measuring success

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

Qualifying clinician types	Qualifying services
- Psychiatrist - Licensed clinical social worker - Licensed marriage and family therapist - Licensed professional counselor - Psychiatric nurse - Psychologist - Providers rendering services via incident-to billing criteria	- Intensive outpatient - Partial hospitalization program - Residential treatment center

See our *Incident to Services* reimbursement policy in our *Reimbursement Policy Manual* on our provider website: Policies & Guidelines>Reimbursement Policy.

Specialized virtual providers without a referral

Because timely behavioral health care is integral to patients' overall well-being, we continue to improve access by expanding the types of specialized virtual behavioral health providers in our networks.

Members can easily find virtual providers who offer the appropriate specialty care, and they don't need a referral to begin treatment. These providers' diverse areas of focus include eating disorders, obsessive compulsive disorder (OCD), substance use disorders (SUD) and comprehensive therapy programs to treat a variety of age ranges, from age 5 through adulthood.

To view a complete list of in-network virtual specialized behavioral health provider groups, visit our Behavioral Health Toolkit, available on the homepage of our provider website.

To confirm a telehealth provider is in-network, members can:

- Use the Find a Doctor tool on our member website, **bridgespanhealth.com**, and search Places by Name.
- Chat online with Customer Service.
- Call the Customer Service number on the back of their member ID card.

Members can then contact the provider to schedule treatment.

Telehealth provider	Specialty area
AbleTo **ableto.com**	Structured, eight-week series of one-on-one cognitive behavioral therapy (CBT) by phone or video with medication management and digital tools
Array Behavioral Care **arraybc.com**	One of the largest telepsychiatry providers in the country, employing psychiatry and behavioral health clinicians with diverse specialties
Boulder Care **boulder.care**	Addiction treatment that includes medication-assisted treatment (MAT) for opioid use disorders (OUD), peer coaching, care coordination and other recovery tools
Charlie Health **charliehealth.com**	Intensive outpatient treatment for teens and young adults, as well as their families
Eleanor Health, available in Washington state only **eleanorhealth.com/washington**	Addiction and SUD treatment with evidence-based outpatient care and recovery tools
Equip **equip.health**	Family-based treatment of eating disorders for individuals ages 6 to 24 that includes a five-person care team
Headway **headway.co**	Local clinicians with diverse specialties available in the next few days for telehealth and/or in-person visits
NoCD **treatmyocd.com**	Specialized care for OCD using exposure and response prevention (ERP) treatment
Talkspace **talkspace.com/partnerinsurance**	Mental health counseling available 24/7/365 via text, audio or video messaging

Connect patients to convenient in-home care with DispatchHealth

DispatchHealth, **dispatchhealth.com**, provides medical attention in the comfort of the member's home in these metro areas:

- Portland
- Seattle
- Tacoma
- Olympia
- **New**: Salt Lake City—Launching July 11, 2024

The benefits of using DispatchHealth

DispatchHealth:

- Can deliver in-home care to hard-to-reach populations (e.g., older populations or those unable to easily leave home, working parents and busy professionals)
- Can reduce unnecessary ED visits, hospital admissions and readmissions
- Can help improve health outcomes and reduce health care costs
- Shares valuable insights into social determinants of health (SDoH)
- Connects patients back to their PCP/specialist for all follow-up care and ongoing management and communicates with the patient's care team after every visit (They provide detailed notes to the patient's PCP or care team.)
- Has earned a 95% patient satisfaction score

DispatchHealth services

In-home on-call acute care (urgent care)

Available in: Portland, Seattle, Tacoma, Olympia and launching in Salt Lake City on July 11, 2024

DispatchHealth complements and extends your practice by delivering on-demand urgent medical care to high-acuity patients in the comfort of their homes. Their credentialed medical professionals can treat a variety of conditions, including cuts, lacerations and abrasions, infections, mild to moderate abdominal pains, severe cold and flu symptoms, and sprains and strains. They can also order prescriptions for patients.

Their services are:

- **Accessible**: DispatchHealth operates from 8 a.m. to 6 p.m. in Oregon and 8 a.m. to 10 p.m. in Washington (and Utah starting on July 11, 2024), 365 days a year—weekends and holidays included. (They see 48% of patients outside of standard office hours.)
- **Fast**: The average time from appointment request to the patient's doorstep is three hours
- **Affordable**: DispatchHealth's services are in-network, and the costs for a visit are typically the same as an urgent care visit.

In-home care for patients after hospital discharge (Bridge Care)

Available in: Portland, Seattle, Tacoma, Olympia and launching in Salt Lake City on July 11, 2024

DispatchHealth offers in-home care for patients after they've been discharged from a hospital, skilled nursing facility (SNF) or inpatient rehabilitation stay. This service, known as Bridge Care, is provided upon referral by a member's inpatient provider or BridgeSpan care manager.

Within 24 to 72 hours of discharge, DispatchHealth visits the member's home to conduct a history and physical assessment of patient's progress since discharge, assess their condition and symptoms, assess their home and environment, reconcile medications and provide education to promote self-management. Dispatch ensures patients have everything they need to recover—including coordinating follow-up care with their PCP or specialists.

In-home hospital-alternative care (Advanced Care and Extended Care)

Available in: Tacoma only

DispatchHealth offers an advanced level of in-home clinical care to help patients recover from their acute illness over multiple days as an alternative to hospital admission. DispatchHealth can also provide comprehensive care for patients transitioning from a hospital who need extended specialized care. By offering advanced and extended care, they can help patients avoid unnecessary hospital admissions and post-acute facility-based care.

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How it works

Request an appointment for your patient

- Set up an account at DispatchExpress, **dispatchhealth.com/dispatchexpress**, so you can easily request an appointment for your patient and receive visit updates.
- You can also call DispatchHealth.
  - **Oregon**: (503) 917-4904
  - **Utah**: (801) 895-3071 (available July 11, 2024)
  - **Washington**: (425) 651-2473
- DispatchHealth will reach out to your patient to finish scheduling the appointment.

A care team is sent to your patient's home

- A DispatchHealth care team will arrive at your patient's home with everything needed to treat your patient's illness or injury.
- The care team will include a physician associate or nurse practitioner and a medical technician, virtually supported by an emergency medicine physician, if necessary.
- All team members wear personal protective equipment and use sterilized equipment.

Follow-up communication and coordination of care

- DispatchHealth will call in any prescriptions needed, send clinical notes of the encounter back to you, and handle billing directly with BridgeSpan.
- **They always direct patients back to you for follow-up care.**

Learn more about DispatchHealth's

- Service areas and hours: **dispatchhealth.com/locations**
- Acute care services (Urgent care): **dispatchhealth.com/partners/care-management-provider-group**
- Post-discharge care services (Bridge Care): **dispatchhealth.com/blog/category/partner-resources-tips/post-hospital-bridge-care-for-the-patient**
- Hospital-alternative care services (Advanced Care): **dispatchhealth.com/blog/category/partner-resources-tips/advanced-care-for-case-management**

Help members plan ahead for care

To help your patients save time and money, we encourage you to help them plan ahead for the next time they need sudden medical care.

Resources for our members

We continue to educate our members about their care options to ensure that they are receiving the care they need in a setting that's clinically appropriate and most cost-effective.

We recently updated our member site to make it even easier for our members to find information about their care options by signing in to their **bridgespanhealth.com** account. The Find Care section includes quick links to our:

- Provider and pharmacy directories
- Immediate care options, including nearby urgent care clinics and EDs
- Virtual care options, including scheduling doctor's appointments, asking a pharmacist and behavioral health support (**Related**: See *Specialized virtual providers without a referral* on page 21.)
  - If you offer telehealth services, share information with your patients about how they can schedule a virtual appointment with you. To indicate whether you offer telehealth services, update your directory information on our provider website: Contact Us> Update Your Information.
  - **Note:** Certain populations may experience equity-based barriers to telehealth, such as age, income, disability, race, ethnicity, language, literacy, health literacy and digital literacy. In addition, lack of affordable broadband in some rural and urban areas can be a barrier to patients' having access to telehealth services. When recommending telehealth services to patients, be prepared to help them understand the value of and situations for using it. Having tech support and translation services/language accessibility resources can help patients who encounter difficulties with their appointments.
- In-home care

Our members can also call the Customer Service number on the back of their member ID card for help with finding care, including registering for a **bridgespanhealth.com** account and navigating to the Find Care section.

Resources for providers

View the Care Options Toolkit on the homepage of our provider website. It includes:

- Information for providers about members' care options, including virtual medical and specialized behavioral health providers, our 24/7 nurse line, urgent care and more.
- A member FAQ with information about virtual, in-person (including urgent care centers) and emergency care.

Schedule routine checkups

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

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

Preventive vs. diagnostic care

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

View our preventive care list

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

Following up on patient test results

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

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

We encourage you to consider these tips related to test result processes to ensure that follow-up is happening promptly:

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

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

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

Women's health: Important reminders

Screenings

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

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

Members may not be aware that these services are covered at 100%. They can view the list of covered services on our member website, **bridgespanhealth.com/member/use/preventive-care-list**, or by calling the Customer Service number on the back of their member ID card.

Cervical cancer screening

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

Our most recent HEDIS results, based on 2022 care, indicate that only 58.78% of our members who are eligible received the screening, which put our health plans at the 50th percentile nationally for this measure.

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

Chlamydia screening

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

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

Resources

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

Maternal health

The U.S. has some of the worst maternal and infant health outcomes among high-income countries, and people of color are disproportionally affected. Analysis of our claims data found that postpartum provider visit rates are low, especially for Black and Hispanic/Latinx members. We encourage providers to ensure all their patients' maternal health and postpartum visits are scheduled so that mothers receive the support they need when they need it.

Our members have access to convenient, digital tools to support their maternity journey. Our Bump2Baby program provides personalized support from nurse care managers. We have also partnered with Charlie Health, **charliehealth.com**, to offer virtual maternal mental health services to commercial members on most of our plans. Learn more about Bumb2Baby on our provider website: Programs>Member Programs & Tools.

Our Health Equity Toolkit includes links to free maternal health training and resources for you and your staff. The Health Equity Toolkit is available on the homepage of our provider website.

Well-child visits are important

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

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

In the U.S., racial disparities exist in well-child visit completion rates. In an imputed analysis of our claims data, we found a significant gap in well-child visit completion rates for Hispanic/Latinx children. Barriers to care include language accessibility and cultural differences.

One of our 2024 goals members is to increase the number of children who receive six or more well-child visits with a PCP during the first 15 months of life as measured using HEDIS criteria. The American Academy of Pediatrics (AAP) schedule includes at least six visits at the following times:

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

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

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

Resources

- Look for the Well-child visits category in the Quality Improvement Toolkit, available on the homepage of our provider website for materials in English and Spanish about well-child visits.
- Bright Futures Health Care Professionals Tools and Resources: **brightfutures.aap.org/clinical-practice/Pages/default.aspx**
- Vaccination schedules for children and adolescents, as well as catch-up schedules, published by the CDC: **cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html**

The benefits of continuous glucose monitors for diabetes

Continuous glucose monitors (CGMs) are a valuable tool for many patients with diabetes, not just those with type 1 diabetes. The table below from UpToDate, a clinical decision support solution from Wolters Kluwer, shows that lifestyle changes result in a 1-2% decrease in HbA1C, which is just as impactful—if not more—than most other interventions. Adding a CGM for patients with diabetes could teach them that lifestyle changes are needed for a predictable blood sugar reading.

Intervention	Expected decrease in HbA1C with monotherapy (%)
Initial therapy	
Lifestyle change to decrease weight and increase activity	1 to 2
Metformin	1 to 2
Additional therapy	
Insulin (usually with a single daily injection of intermediate- or long-acting insulin initially)	1.5 to 3.5
Dual GLP-1 and GIP receptor agonist (once-weekly injections)	2 to 2.5
Sulfonylurea (shorter-acting agents preferred)	1 to 2
GLP-1 receptor agonist (oral or daily to weekly injections)	0.5 to 2
Thiazolidinedione	0.5 to 1.4
Glinide	0.5 to 1.5
SGLT2 inhibitor	0.5 to 0.7
DPP-4 inhibitor	0.5 to 0.8
Alpha-glucosidase inhibitor	0.5 to 0.8
Pramlintide	0.5 to 1

Using a CGM can encourage medication adherence and may even lead to deprescribing, which can be a patient-motivating factor. CGMs can be life-changing and have been shown in studies to significantly improve A1C levels. CGMs can enable patients to fine-tune and optimize their blood glucose control. Empowering patients to make healthy changes can be a long-lasting and effective tool.

CGMs can empower and motivate patients

- Not every food has the same effect on everyone's blood sugar level, and a CGM can help patients pinpoint the foods that are best or worst for them.
- Most people will notice that their blood sugar level drops during exercise. But intense exercise, like a strenuous training session or run, can cause blood sugar to rise. CGMs can help patients understand how they respond to different types of exercise.
- When patients are ill or if they take an over-the-counter (OTC) medication for their cough/cold symptoms, they can monitor their blood glucose with a CGM.
- Long-term stress may raise blood glucose, and having a CGM can help patients be aware so they take steps to decompress.

Most providers would agree that cost is the biggest hurdle to supplying patients with diabetes a CGM. BridgeSpan covers CGMs and their supplies as Tier 3 or Tier 4 on our drug list, depending on the plan. Manufacturer rebates may be available.

The benefits of CGMs extend beyond type 1 diabetes patients and can have a significant impact on glycemic control and hypoglycemic reductions for people with type 2 diabetes as well. As health care providers, it is important to consider the value for patients with diabetes and work to incorporate them into your patients' treatment plans.

GLP-1 agonist-containing medications for diabetes

Glucagon-like-peptide-1 (GLP-1) agonists indicated for treatment of type 2 diabetes mellitus (T2DM) have been available since 2005. Due to their strong track record of safety and efficacy in managing T2DM, the American Diabetes Association 2023 Guidelines were updated to designate GLP-1s as a first-line treatment option. As a result, GLP-1 use in T2DM has increased significantly in the last few years.

GLP-1s are also proven safe and effective for chronic weight management when used as an adjunct to reduced-calorie diets and increased physical activity in adult and pediatric patients with specified high body mass index (BMI).

Note: Use of these medications for weight loss in the absence of coverable medical conditions is generally a benefit exclusion.

Because of high demand, you may expect GLP-1 agonist shortages to continue. To help patients stay adherent to therapy when there is a shortage:

- Consider switching to a lower dose.
- Consider changing to a GLP-1 agonist that's given at the same interval and has a comparable dose. For example, if a patient using semaglutide 0.5 mg weekly for T2DM, consider switching to dulaglutide 1.5 mg weekly, starting when the next dose is due.

When starting GLP-1 agonists or stepping up doses, patients can expect modest, temporary GI upset (nausea, etc.). To help patients stay adherent to therapy:

- Consider starting with a low dose and titrating up slowly
- Encourage patients to eat smaller meals, eat slowly and stop eating before they feel full.
- For nausea, advise patients to ingest crackers, apples, mints or ginger-based drinks 30 minutes after GLP-1 dose and to avoid strong smells. If needed, consider short-term antiemetics and prokinetics.
- For diarrhea, advise patients to hydrate and consume chicken broth, rice, carrots and very ripe fruit without skin while avoiding sports drinks, dairy, caffeine, alcohol and soft drinks. If needed, consider probiotics, antidiarrhea agents (such as loperamide) or metformin dose reduction.
- Lastly, consider a temporary dose reduction or set a lower max dose for tolerability.

As a reminder, educate patients to promptly report severe gastrointestinal pain, which can be a red flag for rare pancreatitis, gallbladder issues or bowel obstruction.

GLP-1 agnostic equivalent dosing chart

Agent	Frequency	Equivalent dose			
Exenatide	Weekly (QW)	-	-	2 mg	-
Dulaglutide	QW	-	0.75 mg	1.5 mg	-
Semaglutide	QW	-	0.25 mg	0.5 mg	1 mg
Liraglutide	Daily (QD)	0.6 mg	1.2 mg	1.8 mg	-
Lixisenatide	QD	10 mcg	20 mcg	-	-
Oral semaglutide	QD	3 mg	7 mg	14 mg	-
Exenatide	Twice daily (BID)	5 mcg	10 mcg	-	-

QIP reminders

Payout for 2023 QIP

We expect to mail checks for earned incentives for the 2023 program year on June 30, 2024.

Risk adjustment reports

Reports highlighting risk adjustment care gaps are now available. Risk adjustment gaps are available as a separate monthly downloadable report in the Care Gap Management Application (CGMA). This report enhances your overall understanding of each member to ensure all health conditions are being addressed during their visit. **Note**: Risk adjustment care gaps are accessible to offer additional insights to a patient's health and wellbeing. We do not currently offer an incentive for closing risk adjustment care gaps.

Opt-in for 2024 QIP

As a reminder, our 2024 program requires you to opt-in. To do this, you must sign in to the CGMA by October 1, 2024, and indicate that you wish to participate in the 2024 program.

CGMA access

The CGMA is a helpful tool for reviewing and closing patient care gaps. Access to the CGMA is managed by your QIP Primary Contact. If you need access to the CGMA, have your QIP Primary Contact email us at **QIPQuestions@bridgespanhealth.com** to add you as a new user. Include the following information about the new CGMA user: First and last name, title, phone number, email address, provider group name and provider group tax identification number(s) (TINs).

QIP resources

You can learn more about the QIP on our provider website: Programs>Quality Incentive Program.

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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