OCTOBER 2024

Provider News

For participating physicians, other health care professionals and facilities

National Breast Cancer Awareness Month: A time for action

October is a crucial time to raise awareness about the importance of early breast cancer detection. As the most common cancer in women, breast cancer affects one in eight women during their lifetime. As a health care provider, you play a vital role in encouraging women to take proactive steps toward early detection.

The U.S. Preventive Services Task Force (USPSTF) recommends women ages 40 to74 get a screening mammogram every two years.

Health disparities in breast cancer screening

Significant health disparities exist among women of different racial and ethnic backgrounds when it comes to screening mammograms. According to 2022 American Cancer Society statistics, about 82% of Black women, 76% of White women, 74% of Hispanic women, 67% of Asian women, and 59% of American Indian and Alaska Native women of screening age had a screening mammogram in the two years prior.

Patient outreach, education and access to care initiatives help ensure that all women have an equal opportunity to receive timely and effective breast cancer screening and treatment.

Coverage for mammogram screenings

Most of our health plans cover screening mammograms at no cost for women 40 and older when an in-network provider is selected.

Resources

- Our Quality Improvement Toolkit
- USPSTF breast cancer screening
- CDC resources:
  - Risk factors
  - Patient education

Easily find information

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

Subscribe today

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

Using our website

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

Stay up to date

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

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

Click on a title to read the article.

About Provider News

This publication includes important news, as well as notices we are contractually required to communicate to you. In the table of contents, this symbol indicates articles that include critical updates: ■. To save you time, you can click on the titles to go directly to specific articles. You can also return to the table of contents from any page by clicking on the link at the bottom of each page.

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

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

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

The Bulletin

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

Share your feedback

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

Are you?

- √ **Prepared for 2025 changes**: A new year brings product and network changes. Make sure you're up to date on changes that impact your patients. **Related**: See *2025 product and network updates* on page 20.
- √ **Talking with your patients about mental health**: As the seasons change, remember to discuss important mental health concerns with your patients, including depression, anxiety and seasonal affective disorder, to help them cope with the challenges of cooler temperatures and shorter days. **Related**: See *Diagnosing and treating depression in primary care*, *Seasonal affective disorder* on page 17.
- √ **Helping your patients know where to go for care**: When your patients need medical or behavioral health attention, knowing where to go for health care can help save them time and money—and assure that they get the care they need. View the Care Options Toolkit on the home page of our provider website. **Related**: See *DispatchHealth: Urgent medical care in your patient's home* on page 18.

Administrative Manual updates

The following update was made to our manual on October 1, 2024.

Facility Guidelines

- Revised the reference to *Surgical Site of Care - Hospital Outpatient* (Utilization Management #19) medical policy

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

PAP supply claims to be reviewed post-payment

To ensure consistent application of our policies and billing standards, we are providing courtesy notice that we will begin post-payment reviews of claims for positive airway pressure (PAP) device supplies effective October 1, 2024. We currently review these claims pre-payment.

If we identify an overpaid claim, we will request recoupment via adjustment of a future claim payment.

These reviews support our *Positive Airway Pressure (PAP) Supplies* (Administrative #127) reimbursement policy.

2025 brings code changes for services and supplies

Please remember to review your 2025 CPT, HCPCS and CDT coding publications for codes that have been added, deleted or changed and to use only valid codes.

You can purchase the:

- CDT manual online through the American Dental Association or by calling 1 (800) 947-4746
- CPT and HCPCS manuals through your preferred vendor or online through the American Medical Association (AMA)

Reimbursement schedules are available on Availity Essentials: Claims & Payments>Fee Schedule Listing.

This notice serves as an Amendment to your Participating Agreement. You have the right to terminate your Agreement in accordance with the amendment provisions of the Participating Agreement.

Risk adjustment diagnosis reporting using CPT 99499

It is important for providers to evaluate, document and submit all active conditions at least once per calendar year to maintain an accurate picture of the member's health. Submission of complete and accurate encounter and diagnostic data for all services rendered is fundamental to our ability to:

- Support the needs of our members with care management programs
- Report accurate health status for our members to CMS and the Department of Health & Human Services (HHS)

You can submit claims with additional diagnosis codes for risk adjustment purposes using CPT code 99499 when:

- Your patient has more than 12 diagnosis codes identified for a single professional claim.
- Your system truncates diagnosis codes for claim submission.
- You use a clearinghouse that submits fewer diagnosis codes per claim than your patient has.

Criteria for CPT 99499

To submit CPT 99499, please ensure that the claim meets the following criteria:

- All CPT 99499 claims must be submitted in support of a primary claim with an evaluation and management (E&M), annual wellness visit (AWV) or preventive care CPT code submitted from a face-to-face encounter.
- All ICD-10 codes must be supported in the medical record documentation with management, evaluation, assessment and treatment (MEAT) during the face-to-face encounter.
- All provider billing and rendering provider criteria, date of service, member demographics, etc., must match the primary claim containing the E&M code.
- No other services should be billed on the CPT 99499 claim.
- Multiple claims for CPT 99499 can be billed on the same date of service with modifier 25 on all applicable claims after the first CPT 99499 claim.

Submission instructions for CPT 99499 claims

1. Submit a primary claim with applicable E&M, AWV or preventive care CPT visit code and 12 diagnosis codes for a professional claim.
2. To submit additional diagnosis codes, submit a second claim using CPT 99499 with a billed charge of $.00. If your billing system will not allow zero-dollar claims, you may bill us $.01. **Note**: CPT 99499 must be the **only** CPT code on this claim.
3. If additional diagnosis codes remain, submit an additional 99499 claim with modifier 25 with a billed charge of $.00 or $.01. **Note**: CPT 99499 must be the **only** CPT code on this claim.

New form streamlines faxed admission notifications

Providers have options when notifying us of a patient's hospital admission or discharge—including a new form for faxed notifications. As a reminder, we require notification within 24 hours of hospital admission.

Using PointClickCare (PCC)

PCC is our preferred method for receiving notification of admission or discharge. If you are connected through PCC, please do not fax notifications that are available in PCC.

Faxing

If you notify us of admissions and discharges via fax, use our new *Hospital Admit and Discharge Notification Form*, available in the Fax section of our pre-authorization list. The form:

- Ensures that faxed records include all necessary information
- Provides a singular form that can be used for admission and discharge

If you fax notification to us and do not use this form, please verify that your notification includes all of the elements on the form.

Simplified discharge process: To streamline the discharge process, simply retain the faxed form from admission, complete the discharge information in Section 5 and re-fax it. If you no longer have the original form, complete a new form, add the discharge information in Section 5, then fax it.

Using electronic medical records (EMRs)

If your facility has granted our clinical team full access to your EMR system, it is your responsibility to ensure we have access to necessary records, including making your patient's records visible. If you are connected through EMR, please do not fax medical records available in the EMR.

Update your directory information

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

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

Our Provider Directory Attestation Requirements for Providers policy requires:

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

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

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

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 LGBTQIA+-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 updates

Procedure/medical policy	Added codes effective October 1, 2024
Anterior Abdominal Wall (Including Incisional) Hernia Repair (Surgery #12.03)	- K42.9
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	- 0485U, 0487U
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	- 0498U, 0499U
Targeted Genetic Testing for Selection of Therapy for Non-Small Cell Lung Cancer (NSCLC) (Genetic Testing #56)	- 0478U
Procedure/medical policy	**Adding codes effective January 1, 2025**
Surgical Treatments for Lymphedema and Lipedema (Surgery #220)	- 15832-15839, 15876-15879

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.

Reminder: Additional services added to cardiology program

Effective November 1, 2024: Our cardiology program will include the following additional outpatient cardiovascular tests and procedures:

- Dialysis circuit procedures
- Electrophysiology (EP) studies
- Transcatheter septal defect closure
- Vascular embolization or occlusion

Providers will be able to contact Carelon to request pre-authorization for these additional services beginning October 21, 2024.

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

About the program

If a provider does not verify that a pre-authorization request has been approved before performing an outpatient cardiac service, the claim may be denied as provider responsibility or pended for post-service review, depending on the line of business.

To view the affected codes, see the Pre-authorization List on our provider website.

Program details are available on our provider website: Programs>Medical Management>Cardiology.

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 August 2024 issue of *The Bulletin* about changes to the following medical policies, which are effective November 1, 2024:

- *Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder* (Behavioral Health #18)
- *Applied Behavior Analysis Initial Assessment for the Treatment of Autism Spectrum Disorder* (Behavioral Health #33)

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

- *ClonoSEQ Testing for the Assessment of Measurable Residual Disease (MRD)* (Genetic Testing #88)
- *Rhinoplasty* (Surgery #12.28)

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 August 2024 issue of *The Bulletin* about changes to the following reimbursement policies, which are effective November 1, 2024:

- *Anesthesia Reimbursement & Services Reporting* (Anesthesia #102)
- *Emergency Department Visits: Level of Service* (Facility #110)
- *Radiation Oncology* (Administrative #151)

We provided 90-day notice in the September 2024 issue of *The Bulletin* about changes to the *Frenotomy* (Surgery #102) reimbursement policy, which are effective December 1, 2024.

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

New tool to review ED claims pre-payment

Beginning November 1, 2024, we will apply Optum's Emergency Department Claim (EDC) Analyzer to review emergency department (ED) claims pre-payment. The EDC Analyzer provides an ED visit-level analysis and code validation.

We are implementing this tool as part of our continued efforts to reinforce accurate coding practices and identify claims that might have otherwise paid incorrectly.

Note: The EDC Analyzer will not apply to professional E&M coding, inpatient claims (as determined by type of bill and setting) and non-ED claims.

Resources on our provider website

- We announced that we will begin using the EDC Analyzer tool for coding review of ED E&M claims in the August 2024 issue of *The Bulletin*: Library>Bulletins.
- Review our *Emergency Department Visits: Level of Service* (Facility #110) reimbursement policy in our *Reimbursement Policy Manual*: Library>Policies & Guidelines>Reimbursement Policy.

Update on Modifier 25

We announced in the August 2024 issue of our newsletter that we were postponing updates to our *Modifier 25; Significant, Separately Identifiable Service* (Modifier #103) and *Global Days* (Administrative #101) reimbursement policies. We continue to review these policies and will provide updates in future publications.

eviCore updating musculoskeletal guidelines

Effective January 1, 2025, eviCore healthcare (eviCore) will revise the following advanced musculoskeletal clinical guidelines:

Joint surgery & interventional pain

- Discography

Spine surgery

- Cervical Microdiscectomy
- Posterior Cervical Decompression (Laminectomy/ Hemilaminectomy/Laminoplasty) with or without Fusion

Visit eviCore's website and select the **Future** tab to view the revised guidelines.

Medication policy updates

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

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

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

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

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

Effective July 1, 2024	Description
Archived medication policy	
Non-preferred injectable insulins, dru372	- Novo Nordisk insulin products (Novolin, Novolog, Fiasp) moved to preferred list and no longer require pre-authorization - The rest of the products in dru372 continue to require pre-authorization under dru760

Effective July 15, 2024	Description
New medication policies	
Amtagvi, lifileucel, dru784	- Coverage is limited to patients with unresectable or metastatic cutaneous melanoma with disease progression on the following: anti-PD-1-based regimen and a combination BRAF/MEK inhibitor therapy if BRAF V600 mutation-positive
Complement Inhibitors for the Eye, dru762	- Coverage is limited for Syfovre (pegcetacoplan) and Izervay (avacincaptad pegol) to patients with geographic atrophy (GA) secondary to age-related macular degeneration (AMD) that has been established by a specialist in ophthalmology - Coverage of Izervay is additionally limited to GA located outside the foveal center
Duvyzat, givinostat, dru786	- Coverage is limited to ambulatory patients with genetically confirmed Duchenne muscular dystrophy (DMD) that has been established by a neurology specialist and when used in combination with a corticosteroid
Lenmeldy, atidarsagene autotemcel, dru781	- Coverage is limited to patients less than seven years old with certain subtypes of metachromatic leukodystrophy that has been established by a specialist and confirmed via ARSA enzyme activity, genetic mutation and positive urinary analysis for sulfatides
Tevimbra, tislelizumab-jsgr, dru785	- Coverage is limited to patients with a diagnosis of unresectable or metastatic esophageal squamous cell carcinoma after disease progression on or after frontline chemotherapy

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Effective July 15, 2024	Description
Revised medication policies	
Chimeric Antigen Receptor (CAR) T-cell, dru523	- Updated coverage criteria for Abecma (idecabtagene vicleucel) and Carvykti (ciltacabtagene autoleucel) for multiple myeloma based on new evidence that led to expanded FDA indications
Gene therapies for hemophilia B, dru735	- Added newly FDA-approved Beqvez (fidanacogene elaparvovec-dzkt) to policy - Coverage is limited to patients 18 and older with severe or moderate-severe phenotype, no factor IX inhibitors and negative for AAVRh74 var antibodies when exogenous factor IX prophylaxis is ineffective
Keytruda, pembrolizumab, dru367	- Added coverage criteria for the newly FDA-approved indication for treatment of resectable non-small cell lung cancer in combination with platinum-containing chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment after surgery - Added coverage criteria for the newly FDA-approved indication for treatment of locally advanced unresectable or metastatic biliary tract cancer in combination with gemcitabine/cisplatin - Added coverage criteria for the newly FDA-approved indication for first-line treatment of locally advanced unresectable or metastatic HER2-positive gastric or GEJ adenocarcinoma when tumors express PD-L1 and used in combination with chemotherapy; coverage is limited to tumors expressing PD-L1 CPS >1 - Added coverage criteria for the newly FDA-approved indication for first-line treatment of locally advanced and unresectable or metastatic HER2-negative gastric or GEJ adenocarcinoma when used in combination with fluoropyrimidine- and platinum-containing chemotherapy; coverage is limited to tumors expressing PD-L1 CPS >1 - Added coverage criteria for the newly FDA-approved indication for locally advanced or metastatic urothelial cancer when used with Padcev (enfortumab vedotin) or as monotherapy; coverage is limited to members not eligible for platinum-containing chemotherapy - Revised coverage criteria for hepatocellular carcinoma (HCC) based on updated FDA indication - Added coverage criteria for the newly FDA-approved indication for FIGO 2014 stage III-IVA cervical cancer when used with chemoradiotherapy; coverage is limited to specific histologies

Effective August 1, 2024	Description
New medication policy	
GLP-1 Agonist-Containing Medications for Non-Diabetic Indications, dru787	- New policy for GLP-1 agonist-containing medications for non-diabetic indications - Incorporates criteria for obesity and overweight previously in dru778 when a covered benefit on the member's plan - Added coverage criteria for Wegovy (semaglutide) for reducing risk of major adverse cardiovascular events (MACE) in adults with established cardiovascular disease (CVD) and either obesity or overweight, a newly FDA-approved indication

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Effective September 1, 2024	Description
New medication policies	
Ogsiveo, nirogacestat, dru783	- Coverage is limited to patients with progressive, morbid or symptomatic desmoid tumors when sorafenib is not a treatment option
Rezdiffra, resmetirom, dru782	- Coverage is limited to patients with biopsy confirmed NASH/MASH when prescribed with a gastroenterologist or hepatologist; additional requirements include failure of lifestyle modifications, and F2 or F3 liver fibrosis
Revised medication policies	
BRAF inhibitors, dru728	- Added coverage criteria for Braftovi (encorafenib) for the treatment of locally advanced or metastatic NSCLC with a BRAF V600E mutation when used in combination with Mektovi (binimetinib) or as monotherapy if previous combination therapy with Braftovi/Mektovi was not tolerated, a newly FDA-approved indication
Ileal Bile Acid Transporter (IBAT) Inhibitors, dru699	- Added coverage criteria for Livmarli (maralixibat), for newly FDA-approved indication for the treatment of cholestatic pruritus in patients five years of age and older with progressive familial intrahepatic cholestasis (PFIC); criteria mimics that of Bylvay (odevixibat) with an additional step for Livmarli through Bylvay for PFIC1 and PFIC2 subtypes
Immune Globulin Replacement Therapy, dru020	- Added newly FDA-approved IVIG product Alyglo (immune globulin intravenous, human-stwk) to policy as not medically necessary and therefore not covered
Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors, dru621	- Added newly FDA-approved aflibercept biosimilars [Opuviz (aflibercept-yszy), Yesafili (aflibercept-jbvf)] to policy at parity with Eylea
Medications for pulmonary arterial hypertension (PAH), dru633	- Added newly FDA-approved Opsynvi (macitentan/tadalafil) to policy; criteria aligns with that of Opsumit (macitentan), Letairis (branded ambrisentan) and Tracleer (branded bosentan) - Added newly FDA-approved Winrevair (sotatercept-csrk) to policy; coverage is limited to patients with WHO Group 1 (functional class II and III PAH) as an add-on to a double or triple regimen
Medications for thrombocytopenia, dru648	- Added newly FDA-approved Alvaiz (eltrombopag choline) to policy; coverage mimics that of Promacta
Medications for transthyretin-mediated amyloidosis, dru733	- Added newly FDA-approved Wainua (eplontersen) to policy - Coverage is limited to patients with hATTR-PN confirmed by genetic testing and established by a specialist, with impairment due to neuropathy and symptoms consistent with polyneuropathy and no prior liver transplant - Coverage criteria mirrors that of Tegsedi (inotersen)
Mitogen-activate extracellular signal regulated kinase (MEK) Inhibitors, dru727	- Added coverage criteria for Mektovi (binimetinib) for the treatment of locally advanced or metastatic NSCLC with a BRAF V600E mutation when used in combination with Braftovi (encorafenib), a newly FDA-approved indication
Monoclonal antibodies for asthma and other immune conditions, dru538	- Added coverage criteria for Xolair (omalizumab) for IgE-mediated food allergy, a newly FDA-approved indication

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Effective September 1, 2024	Description
Archived medication policy	
lapatinib (generic, Tykerb), dru145	- lapatinib and Tykerb no longer require pre-authorization as of September 1, 2024

Effective October 1, 2024	Description
Revised medication policy	
Drugs for chronic inflammatory diseases, dru444	- Added the biosimilar Simlandi (adalimumab-ryvk) to policy as a preferred adalimumab product along with Hadlima and Humira - Added the unbranded products adalimumab-adbm (Quallent Pharmaceuticals), adalimumab-ryvk (Quallent Pharmaceuticals) and adalimumab-adaz (Cordavis) to policy as not medically necessary and therefore not covered - Added Entyvio SC (vedolizumab) as a Level 3 self-administered option for Crohn's disease (CD), a newly FDA-approved indication - Updated Entyvio SC (vedolizumab) criteria for ulcerative colitis to coverage after two Level 1 or 2 alternatives (previously required three Level 1 or 2 alternatives) - Added Rinvoq (upadacitinib) as a Level 2 self-administered option for polyarticular juvenile idiopathic arthritis (PJIA), a newly FDA-approved indication - Added Rinvoq LQ (upadacitinib), a newly FDA-approved oral solution formulation, to policy at parity with Rinvoq - Added the biosimilars Tofidence IV (tocilizumab-bavi) and Tyenne IV (tocilizumab-aazg) to policy as non-preferred and preferred tocilizumab products, respectively - Updated coverage criteria for Spevigo (spesolimab-sbzo) to include subcutaneous formulation and also newly FDA-approved indication for maintenance treatment of generalized pustular psoriasis (GPP).

Effective December 1, 2024	Description
Revised medication policy	
Anabolic bone medications, dru612	- Coverage of brand name Forteo and teriparatide 620mcg/2.48 ml will require step therapy through generic teriparatide 600mcg/2.4ml and Tymlos

Effective January 1, 2025	Description
Revised medication policies	
Drugs for chronic inflammatory diseases, dru444	- Moved Actemra (tocilizumab) IV and SC to non-preferred for all applicable indications. Added its biosimilar [Tyenne SC (tocilizumab-aazg)] to policy as preferred.

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Effective January 1, 2025	Description
Revised medication policies (continued)	
Mesenchymal-epithelial transition (MET) Inhibitors, dru642	- Adding monotherapy requirement
Rybrevant, amivantamab-vmjw, dru682	- Will be considered not medically necessary, and therefore not covered, when used after progression with Tagrisso
Opdivo, nivolumab, dru390 Tecentriq, atezolizumab, dru463 Bavencio, avelumab, dru499 Imfinzi, durvalumab, dru500 Libtayo, cemiplimab-rwlc, dru565 Jemperli, dostarlimab, dru673 Opdualag, nivolumab-relatlimab-rmbw, dru718 Zynyz, retifanlimab-dlwr, dru751 Loqtorzi, toripalimab, dru774 Bispecific T-cell engager (BiTE) Therapies for B-cell Lymphoma, dru761	- Adding reauthorization requirement at six months

BridgeSpan EquaPathRx™ updates

As a reminder, the Provider-Administered Specialty Drugs benefit is in effect as plans renew throughout 2024. Here are some updates about our benefit administration transitions.

Oregon and Washington providers

The transition dates have changed. Oregon's transition date will be in Q2 2025, and Washington's transition date is delayed, as we continue network development. Look in future issues of this newsletter for updates to the timeline.

From now through the transition dates for Oregon and Washington, all BridgeSpan network providers are considered designated providers in the Prime IntegratedRx - Medical Network under the Provider-Administered Specialty Drugs benefit and are eligible to provide medications included in the BridgeSpan EquaPathRx program (subject to otherwise applicable conditions). **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 the terms of your existing agreement.**

Notes:

- 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. We'll notify you in advance of any additions or changes to the medications included in the program through this newsletter.
- We have begun outreach to specific members in Oregon and Washington who are receiving a BridgeSpan EquaPathRx medication from a provider who is not yet participating on the IntegratedRx - Medical network. If you aren't yet contracted with Prime, we'll work closely with you and our members to ensure they have uninterrupted access to their treatment on and after the implementation date.

Idaho and Utah providers

Effective October 1, 2024, 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 applicable to your participation in the IntegratedRx – Medical Network. 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.
- If you are not designated as a participating IntegratedRx - Medical Network provider, 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.

Specialty pharmacy option for nonparticipating providers

If you are not a designated provider in the IntegratedRx - Medical Network on or after the transition date, you can continue to provide medications included in the Provider-Administered Specialty Drugs benefit to your patients when you use Accredo Specialty Pharmacy, a participating specialty pharmacy.

The pharmacy will work with you and BridgeSpan to ensure the medication is pre-authorized before distributing it to your office for administration.

Identifying members

You can identify whether your patient has the Provider-Administered Specialty Drugs benefit and is subject to the terms of this program during the medication pre-authorization request process. For patients with this benefit, you will see one of the following messages:

- The drug is part of the Provider Administered Specialty Drug benefit. You may continue and submit your authorization request for *medical drug review*.
- The drug is part of the Provider Administered Specialty Drug benefit. You may continue and submit your authorization request for an *administrative review*.

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.

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

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

Virtual provider spotlight: Equip for eating disorder treatment

Equip offers fully virtual eating disorder treatment for patients of all ages with:

- Anorexia
- Bulimia
- Binge eating disorder
- Avoidant/restrictive food intake disorder (ARFID)
- Other specified feeding or eating disorder (OSFED) and co-occurring diagnoses

Equip uses evidence-based modalities including family-based treatment, enhanced cognitive behavioral therapy (CBT-E); CBT for avoidant/restrictive food intake disorder CBT-AR and dialectical behavior therapy (DBT).

Equip offers a five-person multidisciplinary care team that includes a therapist, a family mentor, a peer mentor, a medical provider and a dietitian. They have one-year treatment plans.

- Months one to four are an intensive phase.
- Months five to 12 focus on holistic care and treating comorbidities.
- Additional support is available as needed for another year.

Equip has no waitlist and offers eating disorder treatment that works in the member's home:

- Patients see progress in the first eight weeks of treatment.
- 81% of patients see improvements in their eating disorder symptoms.
- 83% of patients needing to restore weight will gain weight.
- 73% of patients report improvements in depression or anxiety.

Equip is licensed in all 50 states, including Washington, DC.

How to refer:

- Online
- Email
- Call (855) 387-4378

Check for signs of seasonal affective disorder

As the days get shorter and the winter months settle in, some of your patients may start to experience symptoms of seasonal affective disorder (SAD).

SAD is a type of depression that most often occurs during the winter season and is thought to be caused by a lack of sunlight. The signs and symptoms of SAD can mirror those of depression and can include:

- Oversleeping
- Having low energy
- Restlessness and agitation
- Overeating and weight gain
- Feeling sluggish or agitated
- Having difficulty concentrating

SAD can be treated using traditional forms of care, such as psychotherapy and antidepressant medication. Patients may also benefit from light therapy and vitamin D supplements.

To help identify SAD in your patients:

- Ask about mental health issues during the patient's physical exam.
- Check for symptoms of depression by asking patients about their thoughts, feelings and behavior patterns.
- Consider using a diagnostic tool, such as the *Seasonal Pattern Assessment Questionnaire* or the *Patient Health Questionnaire 9 (PHQ-9)* quick depression assessment.

Toolkit resources

- The *PHQ-9* is available in the Depression section of the Behavioral Health Toolkit, which also includes support for treating many types of behavioral health conditions.
- Healthwise's Knowledgebase has helpful information about SAD. To share materials in English and Spanish with your patients, access the Knowledgebase site via our Quality Improvement Toolkit.
- Racial and ethnic groups, the LGBTQIA+ community, people with lower socioeconomic status, and other underrepresented and underserved groups experience disparities in behavioral health diagnosis, access to care and treatment. To learn more about behavioral health disparities, visit our Health Equity Toolkit, which includes resources to address these disparities, as well as continuing medical education (CME) opportunities.

Behavioral health corner

Specialized virtual providers without a referral

Because timely behavioral health care is integral to patients' overall well-being, we encourage members to consider treatment from virtual, in-network behavioral health providers.

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, to search for virtual providers or 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	- 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	- One of the largest telepsychiatry providers in the country, employing psychiatry and behavioral health clinicians with diverse specialties
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	- Intensive outpatient treatment for teens and young adults, as well as their families
Eleanor Health, available in Washington state only	- Addiction and SUD treatment with evidence-based outpatient care and recovery tools
Equip	- Family-based treatment of eating disorders for individuals ages 6 to 24 that includes a five-person care team - **Related**: See *Virtual provider spotlight: Equip for eating disorder treatment* on page 15.
Headway	- Local clinicians with diverse specialties available in the next few days for telehealth and/or in-person visits
NoCD	- Specialized care for OCD using exposure and response prevention (ERP) treatment
Talkspace	- Mental health counseling available 24/7/365 via text, audio or video messaging

Behavioral health corner

Diagnosing and treating depression in primary care

As a PCP, you play a crucial role in your patient's mental health and substance use treatment, which are integral to a person's overall health.

Depressive disorders are the number one cause of disability and the most common types of mental health conditions. Depression can often go unnoticed by others—even by those afflicted—and having depression increases the risk for other medical illness by 40%.

During the COVID-19 pandemic, rates of depression skyrocketed across age groups, with one in three American adults reporting symptoms in 2021. Some estimates put that figure as high as 40%. Youth experienced an even greater increased prevalence of depression, with teenage girls showing the highest rates. This highlights the critical need for depression screening across age groups, as well as pursuing additional assessment and treatment for positive screens.

Best practices

Routine depression screenings in the primary care setting are considered a best practice for intervention and treatment. Patients may feel more comfortable with their PCP, with whom they have an established relationship, rather than seeking help from a behavioral health provider. Additionally, those suffering may not seek treatment because they don't recognize their symptoms or don't want to acknowledge them.

Fortunately, many primary care groups have integrated licensed behavioral health professionals who can take "warm handoffs" to begin further assessment and initial treatment without needing an outside referral.

Recognize the risk factors

Many factors may put a patient at risk of having depression. They include but are not limited to:

- Being female
- Having a history of trauma
- Having alcohol use disorder
- Death or loss of a loved one
- Low income or financial instability
- Being pregnant or recently giving birth
- Having a personal and/or family history of depression
- Having comorbid chronic medical conditions, including chronic pain

Be aware of health disparities

Additionally, minoritized populations often experience inequitable access to behavior health care. Research shows that certain racial and ethnic populations, as well as the LGBTQIA+ community, are much less likely to receive behavioral health services:

- The percentage of Asian Americans and Native Hawaiian and Pacific Islanders who reported having any mental illness (AMI) in 2021 was 16% and 18%, respectively. However, only 25% of Asian Americans received mental health services compared to non-Hispanic Whites (52%).
- 21% of Black and African Americans reported having a mental illness, compared to 23.9% of non-Hispanic Whites. However, just 39% of Black and African Americans received mental health services compared to non-Hispanic Whites (52%).
- Nearly 22% of Hispanic and Latino Americans reported having a mental illness compared to 23.9% of non-Hispanic Whites. However, only 36% of Hispanic and Latino Americans received mental health services compared to non-Hispanic Whites (52%).
- American Indian and Alaska Native populations experience the highest rates of suicide of any minority group within the U.S., and rates have been increasing since 2003. These groups also experience high rates of substance use disorder (SUD) involving both illicit drugs and alcohol use.
- Two-thirds of LGBTQIA+ people (67%) reported needing a mental health service during the past two years, a considerably higher rate—39%—than non- LGBTQIA+ people. Only about half of LGBTQIA+ people with a reported need sought and received mental health services.

Common signs and symptoms

- Loss of motivation
- Weight gain or loss
- Decreased concentration
- Fatigue or lack of energy
- Neglecting responsibilities
- Unexplained aches and pains
- Loss of interest in personal appearance
- Psychological symptoms: Anger, anxiety, sadness, irritability, mood swings, lack of emotional responsiveness, feelings of worthlessness or helplessness and, in the extreme, thoughts of suicide or self-harm

Resources for PCPs

The Behavioral Health Toolkit on our provider website is designed to support PCPs. It includes an extensive list of screening tools, including the *PHQ-9*, which can be used to screen for and diagnose depression. The *PHQ-9* is both highly sensitive and specific for depression. It can be used to measure the severity of depression, as well as response to treatment.

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Behavioral health corner

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The toolkit also includes:

- A list of in-network virtual providers with a variety of areas of expertise; telehealth visits may allow members to start treatment sooner and provide more flexible scheduling
- A presentation titled *Depression: Screening and treatment in the primary care setting*
- Information to help PCPs determine the best path forward in the early stages of a patient's evaluation and treatment
- Information about our care management services, including case management
- Resources for treating members who may have the following diagnoses and challenges:
  - Anxiety
  - Alcohol use
  - Attention-deficit/hyperactivity disorder (ADHD)
  - Bipolar disorder
  - Eating disorders
  - Gender identity
  - Opiate use
  - Pain management
  - Post-traumatic stress disorder (PTSD)
  - Substance use disorder
  - Suicide prevention

Additionally, our Health Equity Toolkit includes:

- Resources to address behavioral health disparities
- Our Improving Care for Latinx Patients flyer, which provides tips for depression screening
- Continuing medical education (CME) opportunities

Knowing when to refer

If a patient may be at imminent risk of suicide, **call 911 immediately**.

PCPs should consider psychiatric consultation prior to treatment in the following circumstances:

- Need for hospitalization
- Uncertainty about the diagnosis
- Comorbid psychiatric disorders

Providers in Oregon, Utah and Washington can learn more about accessing state-funded psychiatric consultations at no cost in our Behavioral Health Toolkit.

DispatchHealth: Urgent medical care in your patient's home

DispatchHealth can help your moderate- to high-risk patients by bringing urgent medical care to the comfort of their homes. Whether it is after hours, on weekends or holidays, or during times of high patient volume, you can rely on DispatchHealth to help treat your patients.

They are available in the following areas:

- Portland, Oregon
- Salt Lake City, Utah
- Olympia, Seattle, Spokane, Tacoma and **NEW** Vashon Island, Washington

DispatchHealth works as an extension of your medical team to help you:

- Extend your care after hours, on weekends or holidays, or during capacity constraints
- Improve health outcomes and patient experience
- Gain valuable insight into social determinants of health (SDoH)
- Reduce non-emergent emergency department (ED) usage, hospital admissions and readmissions
- Reduce overall health care costs

They can treat 95% of the top ED diagnoses in the home.

Visit our Care Options Toolkit on the homepage of our provider website to learn more.

The importance of medication reviews

As a PCP, your important roles include acting as an information resource about all the medications your patients take. Our members often take several medicines, vitamins and supplements from different sources, which can lead to duplicate therapy or potentially adverse interactions if they have multiple prescribers.

Facilitating memorable conversations

To facilitate memorable conversations about medications, many offices ask patients to bring all their medications, vitamins, supplements, herbal remedies and other products they are taking to an office visit at least once per year. During that visit, the PCP, a nurse or pharmacist can:

- Review the medications
- Identify any concerns with the medications
- Make sure the patient is taking them as prescribed
- Make sure the patient understands each product's purpose

Techniques for improving patient recall

Using techniques like the teach-back method—as well as reviewing any medication changes again at the end of an office visit and highlighting changes on an after-visit summary—are great ways to help patients remember having had a conversation.

Patient resources

Educational handouts and flyers are another great way to help patients remember conversations about their medications, and they can help PCPs and staff facilitate these conversations. We have several flyers (available in English and Spanish) that address medication management and can be shared with your patients. Look for the **Medications and Member Experience with Medications** category in the Quality Improvement Toolkit, available on the homepage of our provider website.

QIP: Reminders for a successful Q4

To maximize your performance in the 2024 Quality Incentive Program (QIP), please review these important reminders for the final quarter of the year.

2024 program deadlines

December 31, 2024—Last day to perform services

February 28, 2025—Last day to submit supplemental data

February 28, 2025—Last day to work in the CGMA and submit compliant evidence to close gaps

March 31, 2025—Last day to submit claims

QIP primary contact

As a reminder, you need to identify a QIP primary contact for your office/group.

The QIP primary contact is the:

- Person who can approve CGMA access for other users associated with your TIN or roll-up group
- Person who can verify or provide your QIP payout address

CGMA user audit in progress

Our annual CGMA audit began in September. If you have not yet provided your information, please do so by logging into CGMA and entering your information in the audit prompt on the page.

Note: If you have not recently signed into your CGMA account, you must sign in to keep your account active. CGMA accounts that are inactive for 120 calendar days are locked and will need to be reactivated.

If you need to request access to the CGMA, please email our QIP team.

New *Quality Measures Guide* available

We updated our *Quality Measures Guide* for 2024. The guide includes information about a variety of quality and member experience measures that are reported or monitored most frequently for QIP.

The guide is available on our provider website: Programs>Quality Incentive.

2025 program year

The 2025 QIP launches January 1, 2025, with minor changes to the program. We will include more information about the 2025 program in the December 2024 issue of this publication.

2025 product and network updates

Our product portfolio will include exclusive provider organization (EPO) products in Oregon, Utah and Washington. EPO members only have in-network benefits, and members will be responsible for 100% of out-of-network costs except:

- Out-of-network emergency room, ambulance services and urgent care will be covered at the in-network benefit level. Urgent care services may be subject to balance billing.
- When traveling out of our service area, urgent care, emergency room and ambulance services are covered with no balance billing if the member sees a participating MultiPlan provider.

The open enrollment period for individuals seeking coverage beginning on January 1, 2025, is from November 1, 2024, through January 15, 2025. Individuals may qualify for special enrollment periods outside of this period if they experience certain life events.

Members whose plans are being discontinued have received notice from us about options available to them in 2025.

Provider networks and products

The RealValue Network:

- Supports on-exchange members in Oregon, Utah and Washington and members who travel to Idaho
- **Idaho network area**: Ada, Bannock, Bear Lake, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Butte, Canyon, Caribou, Camas, Cassia, Clark, Clearwater, Elmore, Franklin, Fremont, Gem, Gooding, Idaho, Jefferson, Kootenai, Latah, Lewis, Lincoln, Madison, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton, Valley and Washington counties
- **Oregon network service and sales area**: Statewide
- **Utah network service and sales area**: Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Emery, Juab, Morgan, Rich, Salt Lake, Summit, Tooele, Uintah, Utah and Weber counties
- **Washington network and sales service area**: Benton, Clark, Columbia, Franklin, King, Kitsap, Klickitat, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla and Yakima counties; **Note for products sold in Washington**: The Washington Healthplan Finder includes Cascade Select plans (public option plans that are not available through BridgeSpan) and Cascade Care plans (which are available through BridgeSpan). If you are part of the RealValue Network in Washington, you are in-network for the corresponding Cascade Care plan.

Benefit highlights

- The mobile urgent medical care service DispatchHealth will be available to treat common to complex injuries and illnesses at the member's home in select metro areas in Oregon, Utah and Washington. **Related**: See *DispatchHealth: Urgent medical care in your patient's home* on page 18.
- In addition to having access to telehealth services from in-network providers, members will have access to telehealth services for urgent care and behavioral health through the national telehealth vendor Doctor on Demand.
- Most members will have access to either telephone or chat nurse triage lines (depending on their plan), available 24/7.
- Hinge Health, a personalized virtual exercise program, is available to help eligible members manage mobility and pain in joints, spine and muscles.
- We are updating coverage for continuous glucose monitors (CGMs).
- **Related**: Benefits (e.g., congenital anomalies, hearing aids, and neurodevelopmental therapy) will be updated to comply with ACA Section 1557; See *ACA Section 1557: Ensuring nondiscrimination in health care* on page 21 for more information.

Verify network participation

Verify your network participation and find other in-network providers using our provider directory, the Find a Doctor tool, on our website.

Verify eligibility and benefits

You can verify your patients' eligibility and benefits on Availity Essentials.

More information

Information about our 2025 products will be available in the Products and Networks section of our provider website in January 2025.

ACA Section 1557: Ensuring nondiscrimination in health care

Section 1557 of the Affordable Care Act (ACA) is a crucial provision that prohibits discrimination in health care programs and activities to ensure all patients have access to high-quality care, regardless of their race, color, national origin, disability, age or sex.

By understanding and complying with this provision, providers (including hospitals, clinics and physician practices) and health plans can promote health equity, improve patient outcomes, and ensure that all individuals receive the care they deserve.

We have implemented and will continue to implement changes to benefits to comply with this provision. For example, on some plans we will remove age limits on benefits where they are not clinically supported (e.g., congenital anomalies, hearing aids, and neurodevelopmental therapy). In Idaho and Utah, we are also reviewing our transitional plans and making changes, most notably, in maternity coverage. Benefits will be updated upon renewal.

Resources

- U.S. Department of Health and Human Services: Section 1557 of the Patient Protection and Affordable Care Act outlines the requirements for providers and health plans.
- Our Health Equity Toolkit, available on the homepage of our provider website, includes trainings, continuing medical education (CME) courses and other resources to address health disparities and advance health equity.
- Verify your members' benefits using Availity Essentials.

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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