AUGUST 2024

Provider News

For participating physicians, other health care professionals and facilities

Help patients know where to go for care

There can be big differences between visits to a PCP, urgent care or the emergency department (ED), including cost, time spent waiting for care and whether or not follow up care is provided. We encourage you to talk to your patients about their care options before they need sudden medical care.

Care options

In-person care

- Share your office hours with your patients, especially if you offer extended hours.
- If your patient does not have a PCP, encourage them to use the Find a Doctor tool on our website or call Customer Service at the phone number on the back of their member ID card for help finding an in-network provider.

In-home care

- With DispatchHealth, an in-network provider, members can receive urgent medical care in the comfort of their home to avoid a trip to an urgent care clinic or ED.
- They are available 7 days a week, including holidays, in the Portland, Oregon; Salt Lake City, Utah; and Olympia, Seattle, Spokane and Tacoma, Washington, areas.

Nurse line

- For questions about common health issues and whether they should see a provider, most members can contact BridgeSpan Advice24.

Virtual care

- 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 provider directory information on our provider website: Contact Us>Update Your Information.
- Our members have access to in-network telehealth vendors and behavioral health providers.

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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 homepage of our provider website for the latest news and updates.

BridgeSpan Health
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▲ DME
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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?

√ **Helping your patients know where to go for care**: Help your patients save time and money, by reminding them about their care options before they need sudden medical care. **Related**: See *Help patients know where to go for care* on pages 1-3 and *DispatchHealth: In-home urgent medical care* on page 3.

√ **Educating your patients about the importance of routine immunizations**: Providers play a key role in educating patients and parents about the importance of vaccinations. Your recommendation can help protect your patients against serious diseases. **Related**: See *National Immunization Month* on page 15, *Flu season is just around the corner* on page 15 and *Childhood Immunizations* on page 16.

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ED care

- Educate patients about visiting the ED if they are experiencing acute or life-threatening symptoms, such as chest pain, shortness of breath, signs of a possible stroke, uncontrollable bleeding, severe burns, head injuries (especially loss of consciousness) or seizures.
- To help our members have a better understanding of their care options, our care advocates contact members who had three or more ED visits in a six-month period or who had one or more avoidable ED visits to provide information about alternative treatment options.

Resources for providers and members

Our Care Options Toolkit, available on the homepage of our provider website, has information for providers about members' care options, including virtual medical and specialized behavioral health providers, our 24/7 nurse line, urgent care and more.

Related:

- *DispatchHealth: In-home urgent medical care* on page 3
- *Appointment Accessibility Results* on page 6
- *Tools for PCPs* on page 13

DispatchHealth: In-home urgent medical care

DispatchHealth, a provider of in-home urgent medical care for non-life-threatening medical needs, is part of our provider network for members living in select ZIP codes in Portland, Oregon; Salt Lake City, Utah; Olympia, Seattle, Spokane and Tacoma, Washington.

DispatchHealth complements and extends your practice by delivering on-demand urgent medical care to high-acuity patients at home. Their credentialed medical professionals can treat 95% of the most common ED diagnoses.

What sets DispatchHealth apart:

- **Accessible**: DispatchHealth operates from 8 a.m. to 6 p.m. in Oregon and from 8 a.m. to 10 p.m. in Utah and Washington, 365 days a year—weekends and holidays included.
- **Affordable**: DispatchHealth's services are in-network and a visit is often billed the same as a walk-in urgent care clinic.
- **Comprehensive**: DispatchHealth can treat a wide range of conditions, including UTIs, injuries, swelling, confusion, weakness, nausea, vomiting, diarrhea, rash, cellulitis, abscesses and more.
- **Seamless**: After the visit, DispatchHealth sends detailed notes to provider on record for continuity of care and directs patients back to you for follow-up if necessary. They also call in prescriptions and handle billing through the patient's insurance.

In-home care for patients after discharge

DispatchHealth Bridge Care is a proactive, high-acuity medical intervention in a patient's home within 72 hours post-discharge from the hospital or skilled nursing facility.

Designed for moderate- to high-risk patients with a medical condition that warrants reevaluation after discharge, this service helps ensure a smooth transition from facility to home to optimize recovery; avoid readmission; and safely "bridge" patients back to their PCP or specialist.

Get started today

- Use DispatchHealth's HIPAA-compliant online care request platform, DispatchExpress, to request a visit for your patient within minutes.
  - If you are new to DispatchExpress, request an account.
  - Already have an account? Log in.
- You can also call DispatchHealth at (503) 917-4904 in Oregon, (801) 895-3071 in Utah and (425) 651-2473 in Washington.

After submitting the visit request, DispatchHealth will contact your patient to finish scheduling their appointment.

Learn more in the Care Options Toolkit, available on the home page of our provider website.

Changes coming to medical policies and forms

We have migrated our medical policies and online forms to a new platform. This migration brings design changes and increased security, as well as new features, to make using this content even easier.

The following content is now available on the same platform as the rest of our public websites:

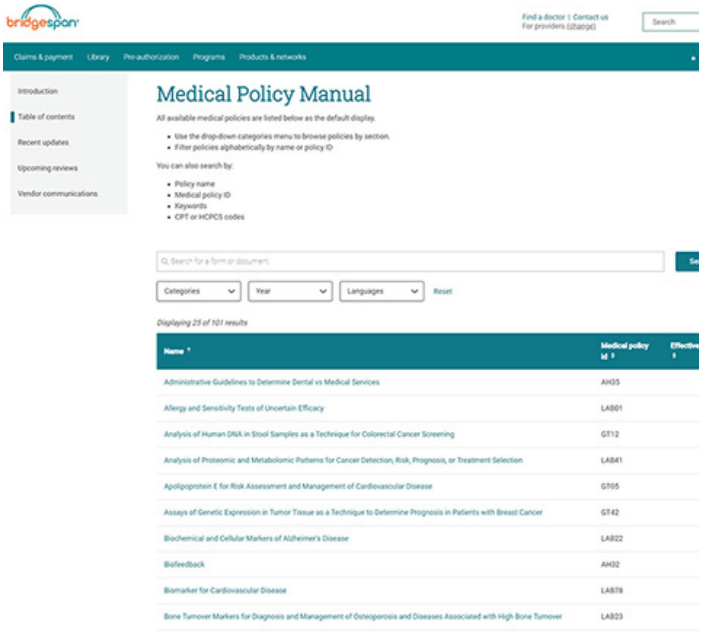
- Medical policies
- Clinical Practice Guidelines
- Provider forms

With this migration you'll find:

- Design of this content will be consistent with the rest of our provider website
- New search functionality will allow medical policies to be searched by line of business, CPT or HCPCS code or keywords
- All medical policies will display on the same page and can be browsed by category or section—reducing the number of clicks needed to find the appropriate policy
- New forms functionality will allow conditional display of content, formatted fields and calendar date pickers

Test drive soon

We invite you to visit the new-look for medical policies soon. Look for announcements and links to visit the new content on the homepage of our provider website. In late August, we will update our links to automatically send you to the new content.



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, providing best-in-class insights, tools and techniques to improve patient experience. Attendees can earn 1.0-hour of continuing education (CE) credit.

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 August 2, 2024, at noon (PT)

Register

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

Oregon PCP selection requirements

Oregon Senate Bill 1529 (2023), now in effect, intends to expand access to care and improve health outcomes for Oregon members covered by commercial medical plans. The bill has several components. On January 1, 2024, we implemented the component that addresses cost-share for the first three PCP visits.

PCP selection and assignment

Another key component of the bill, effective July 1, 2024, requires health insurers to assign a PCP to applicable members if members have not chosen a PCP by the 90th day of their plan year. These members are not required to see the PCP assigned to them, and they can switch to a different provider at any time.

We are contacting members, encouraging them to select a PCP before the 90th day of their plan year. For those who do not choose a PCP, we will automatically assign one, based on claims history, provider availability and/or proximity to the member's home address. We will do our best to find a good match.

Accepting new patients

For us to comply with this mandate, it is important that you keep us notified of your current practice capacity and any changes to your practice. Please report your status for accepting new patients or other demographic changes by following the instructions to verify your directory information on our provider website at least every 90 days: Contact Us>Update Your Information.

Verification of member PCP assignment

You can verify whether a member has selected you or been assigned to you by viewing your PCP roster on Availity Essentials: Payer Spaces>Provider Reports for your Organization>Credentialing & Maintenance Reports. PCP information is also returned in an eligibility and benefits request on a per member basis.

Oregon physician associates title update

The Oregon legislature passed House Bill 4010, which changed the title of physician assistant to physician associate, effective June 6, 2024. There are no changes to licensing requirements or scope of practice for these providers.

We are in the process of updating references on our policies and website to reflect this change for Oregon providers. For more information, see the Oregon Medical Board FAQ on this topic.

Reminder: DME billing during an admission

During an admission, durable medical equipment (DME) is only payable if billed on the admission date or within 48 hours of discharge.

Payable DME periods during admission

DME period	Payable	Not payable
On admission date	✓	
Within 48 hours of discharge	✓	
After admission date but more than 48 hours prior to discharge		✓

Learn more

We apply the following CMS policies to billing DME during admission:

- Section 110.3 of Chapter 20 of the Medicare Claims Processing Manual describes scenarios for pre-discharge DME delivery.
- The Medicare DMEPOS Payments While Inpatient MLN Fact Sheet addresses DME billing during admission, including prior to discharge.

Appointment accessibility results

This past winter, we conducted our annual Provider Access Survey related to patient appointment access for:

- PCPs
- Behavioral health providers
- Providers in high-volume and high-impact specialties

Your answers helped us measure compliance with our published standards for after-hours phone coverage and appointment wait times.

Our findings include:

- **Primary care**: We found that members' access to primary care appointments met our standards, with some delays for urgent appointments and for non-urgent appointments for persistent symptoms.
- **Behavioral health care**: Timely access to routine behavioral health care for established patients met our standards. Access for non-life-threatening crisis behavioral health and routine behavioral health care for new patients fell a little short of our standards.
- **Specialty care**: Timely access to specialty non-urgent care met our standards. Access for specialty urgent care fell a little short of our standards.

We recognize and appreciate your efforts to deliver timely care for our members despite ongoing challenges. After the survey, Provider Relations contacted a sample of providers to learn more about the challenges you are facing in meeting access standards. Your open and honest responses have helped us better understand the challenges you and our members face when it comes to timely access to care.

During our discussions with providers, common themes emerged:

- Many clinics are facing staffing shortages and are struggling to hire in a highly competitive environment, particularly when recruiting in rural locations.
- Some offices experience challenges accommodating member preferences of provider and time of service availability.
- Some offices remain inundated even after this long post-COVID-19 pandemic.
- Despite these obstacles, offices try to schedule patients as quickly as possible or help them find care elsewhere if they cannot be seen in the office as soon as needed.

Related: See *Help your patients know where to go for care* on pages 1-3 and *DispatchHealth: In-home urgent medical care* on page 3.

Access to specialty care

The survey showed us that scheduling patients for urgent specialty care appointments within 24 hours remains difficult, while patient access to non-urgent appointments within 30 calendar days improved following the scheduling difficulties of the last few years.

From our outreach, we learned that the urgent appointment requirement in rural locations is still a challenge due to lack of practitioner's availability for many specialties. However, many providers have processes in place to triage members and help them get the right care at the right time, which may or may not be within 24 hours. We ask that you remain mindful of the urgent care requirement to ensure patients can get timely care when needed.

Access to behavioral health care

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

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

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

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

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

Update your directory information

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

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

Our Provider Directory Attestation Requirements for Providers policy requires:

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

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

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

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.

Submit pre-authorization appeals in Availity

Availity's Appeals application has been expanded to include medical pre-authorization determinations. The application streamlines the appeals process, making it faster and easier to submit appeals directly from Availity Essentials.

A medical pre-authorization determination appeal can be submitted with required documentation directly from the Authorization dashboard, allowing you to receive immediate confirmation of submission and the ability to check the status of their appeal—all in one place.

Any pre-authorization on the Authorization dashboard can be appealed using the new appeals function. This can be through submitting a pre-authorization request using the Authorization application on Availity Essentials, or by submitting an inquiry and pinning the authorization to the Authorization dashboard.

The Authorization/Referral dashboard shows the status of submitted appeals. Access it from Availity Essentials: Patient Registration>Authorization & Referrals>Authorization/Referral Dashboard.

Get trained for free

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

Pre-authorization updates

Procedure/medical policy	Added codes effective July 1, 2024
Anterior Abdominal Wall (Including Incisional) Hernia Repair (formerly Ventral [Including Incisional] Hernia Repair) (Surgery #12.03)	Diagnosis code K42.9
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	0473U
Invasive Prenatal Fetal Diagnostic Testing for Chromosomal Abnormalities (Genetic Testing #78)	0469U
KRAS, NRAS, and BRAF Variant Analysis and MicroRNA Expression Testing for Colorectal Cancer (Genetic Testing #13)	0471U
Procedure/medical policy	**Added codes effective August 1, 2024**
Transcatheter Heart Valve Procedures for Mitral or Tricuspid Valve Disorders excluding Transcatheter Edge-to-Edge Repair (TEER) (Surgery #221)	0483T, 0484T
Procedure/medical policy	**Adding codes effective September 1, 2024**
Applied Behavior Analysis for the Treatment of Autism Spectrum Disorders (Behavioral Health #18)	0362T, 0373T, 97151-97158
Procedure/medical policy	**Adding codes effective November 1, 2024**
Cardiology	36901-36909, 37241-37244, 93600, 93602, 93603, 93610, 93612, 93618-93620, 93624, 93642, 93644, 0823T, 0825T, C7513-C7515, C7530

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.

Cardiology program to include additional services

We are expanding our cardiology program to review additional outpatient cardiovascular tests and procedures. The program will require pre-service medical necessity review and pre-authorization through Carelon Medical Benefits Management (Carelon) for the following types of cardiac services delivered on or after November 1, 2024:

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

About the program

Carelon administers the program, which reviews outpatient cardiovascular tests, procedures and implantable cardiac devices. **Note**: Procedures performed in an inpatient setting or on an emergent basis are not subject to this program's pre-authorization requirements.

Providers will be able to contact Carelon to request pre-authorization for these additional services in October 2024. Read the October 2024 issue of this newsletter for more details.

- **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).

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.

Learn more

- 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 June 2024 issue of *The Bulletin* about changes to the following medical policies, which are effective September 1, 2024:

- *Charged Particle (Proton) Radiotherapy* (Medicine #49)
- *Screening for Vertebral Fracture or Fracture Risk with Dual X-ray Absorptiometry (DXA)* (Radiology #48)
- *Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders* (Medicine #148)

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

- *Anterior Abdominal Wall (Including Incisional) Hernia Repair* (Surgery #12.03)
- *Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products* (Medicine #170)

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

Related: See *Changes coming to medical policies and forms* on page 4.

Reimbursement policy updates

We provided 90-day notice in the June 2024 issue of *The Bulletin* about changes to the following reimbursement policies:

- *Global Days* (Administrative #101)
- *Modifier 25; Significant, Separately Identifiable Service* (Modifiers #103)

Updates to these policies have been postponed.
Related: See *Modifier 25 reimbursement policy update* on this page.

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

Modifier 25 and Global Days reimbursement policy updates

We are postponing updates to the *Modifier 25; Significant, Separately Identifiable Service* (Modifier #103) and *Global Days* (Administrative #101) reimbursement policies.

We had previously announced in the June 2024 issues of *The Bulletin* and *Provider News* that we would update these policies effective September 1, 2024.

Look for more information in the October 2024 issues of our bulletin and newsletter.

View the current policies in our *Reimbursement Policy Manual*, available on our provider website: Policies & Guidelines>Reimbursement Policy.

Updates to secondary editor modifier reviews

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

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

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

Effective for claims received on or after September 6, 2024

Our secondary editor will start applying denials when:

- Modifiers RT or LT are incorrectly reported with a contradictory right or left diagnosis
- Modifiers 76 or 77 are incorrectly reported

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

Effective for services provided on or after November 1, 2024

Claims for anesthesia services must include a role modifier (i.e., AA, AD, QK, QX, QY or QZ). Our secondary editor will start applying denials when appropriate role modifiers are not included on these claims.

This change is supported by revisions to our *Anesthesia Reimbursement & Services Reporting* (Anesthesia #102) reimbursement policy, which we announced in the August 2024 issue of *The Bulletin*.

eviCore updating pain and joint guidelines

Effective November 1, 2024, eviCore healthcare (eviCore) will revise the following interventional pain and joint surgery clinical guidelines:

Interventional pain

- Ablations/Denervations of Facet Joints and Peripheral Nerves
- Anesthesia Services for Interventional Pain Procedures
- Discography
- Epidural Steroid Injections
- Facet Joint Injections/Medial Branch Blocks
- Greater Occipital Nerve Blocks
- Implantable Intrathecal Drug Delivery Systems
- Sacroiliac Joint Procedures

Joint surgery

- Knee Replacement/Arthroplasty
- Knee Surgery–Arthroscopic and Open Procedures
- Lumbar Decompression
- Lumbar Microdiscectomy

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

Carelon revising defibrillator guidelines

Effective November 17, 2024, Carelon Medical Benefits Management (Carelon) will implement revised Implantable Cardioverter Defibrillators clinical guidelines.

View the revised guidelines on Carelon's website.

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 October 1, 2024	Description
New medication policy	
Imcivree, setmelanotide, dru788	- Will limit coverage to patients with obesity due to POMC, PCSK1 or LEPR deficiency confirmed by genetic testing or Bardet-Biedl syndrome (BBS)
Effective November 1, 2024	**Description**
Revised medication policies	
Complement Inhibitors, dru385	- Adding two recently FDA-approved drugs for paroxysmal nocturnal hemoglobinuria (PNH) to policy: Fabhalta (iptacopan) and Voydeya (danicopan) - For Empaveli, removing step therapy requirement through Ultomiris in treatment-naive PNH to align with standard of care - High-dose Soliris (doses above 900mg every 12 days) will be considered not medically necessary, and therefore not covered for PNH due to several available options for breakthrough PNH
Synagis, palivizumab, Respiratory syncytial virus (RSV) immune prophylaxis, dru029	- In alignment with Academy of Pediatrics (AAP) Red Book and CDC recommendations, coverage of Synagis will require documentation that Beyfortus (nirsevimab-alip) is contraindicated unless prior therapy was not tolerated or Beyfortus is unavailable due to manufacturer shortage

BridgeSpan EquaPathRx™ updates

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

October 1, 2024:

- Idaho
- Utah

January 1, 2025:

- Oregon
- Washington

Before the transition date

From now through the transition date listed above for each service area, 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**

Note: 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: Library>Policies & Guidelines>Medication Policies. We'll notify you in advance of any additions or changes to the medications included in the program through this newsletter.

On or after 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 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.

Note: We have begun outreach to specific members in Idaho and Utah who are receiving a BridgeSpan EquaPathRx medication from a provider who is not yet participating on the IntegratedRx - Medical network. Oregon and Washington providers, if you haven't yet contracted with Prime by 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.

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.

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.

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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

Reminder: Upcoming ABA changes

The following changes to applied behavioral analysis (ABA) services are effective September 1, 2024.

Pre-authorization for members younger than 18

We will require pre-authorization for services provided to members younger than 18. ABA services for members 18 and older currently require pre-authorization.

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

Reimbursement rates

We are increasing reimbursement rates for all ABA services. The updated reimbursement rates will be posted by the effective date in Availity Essentials: Claims & Payment>Fee Schedule Listing.

Tools for PCPs

We recognize that PCPs serve a vital role in discussing, diagnosing and treating behavioral health conditions.

Our Behavioral Health Toolkit, available on the homepage of our provider website, includes condition-specific screening tools and trusted resources for 12 diagnoses or challenges, as well as information about:

- In-network virtual care providers
    - Virtual providers can improve access to care, don't require a referral, and are available to treat many specialty areas.
- No-cost psychiatric consultations available to providers in Oregon, Utah and Washington
- Ongoing condition management
- Our care management services, including case management
- Determining the best path forward in the early stages of a patient's evaluation and treatment

Related: See *Screening for behavioral health conditions in primary care* on page 14.

Additionally, PCPs are often uniquely suited to discussing members' social risk factors and social needs. Tracking members' social determinants of health (SDoH) helps us understand barriers to care and support equitable access to quality health care and health education. **Related**: See *Social determinants of health resources* on page 17.

Screening for behavioral health conditions in primary care

Reminder: We reimburse PCPs for behavioral health screening and encourage them to screen patients for behavioral health conditions.

Because some patients may not schedule routine wellness exams, we recommend that PCPs also include behavioral health screening during non-preventive encounters. View the U.S. Preventive Services Task Force (USPSTF) recommendations regarding screening for anxiety, depression and suicide risk in children, adolescents and adults.

We have expanded our network of behavioral health providers to treat members with positive screening results, and we continue to broaden the number of network providers, resources and treatment options available to our members.

Our networks include specialized virtual behavioral health providers with diverse areas of focus to treat a variety of age ranges, from age 6 through adulthood, including:

- Eating disorders
- Substance use disorders (SUD)
- Comprehensive therapy programs
- Obsessive compulsive disorder (OCD)

Find out more about these virtual providers, including contact information, in the Resources section of the Behavioral Health Toolkit, available on the homepage of our provider website. **Related**: See *Tools for PCPs* on page 13.

To find in-network behavioral health providers, members should call Customer Service at the number on their member ID card or use the Find a Doctor tool on our member website.

Improving care for patients treated with antipsychotics

We continue to monitor the following Healthcare Effectiveness Data and Information Set (HEDIS®) measures evaluating the care of children, adolescents and adults who are prescribed antipsychotics. Results for each of these measures remain below national benchmarks:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics assesses annual glucose and cholesterol testing for children and adolescents on antipsychotics
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications assesses annual diabetes screening for people with schizophrenia or bipolar disorder taking antipsychotic medications
- Diabetes Monitoring for People with Diabetes and Schizophrenia assesses annual glucose and cholesterol monitoring for people with diabetes and schizophrenia

Collaborating with primary care and behavioral health providers attending our Provider Advisory Council (PAC), we work to identify actions that can improve patient care. Providers acknowledged that metabolic testing and monitoring recommended for patients taking antipsychotics can require additional coordination between primary care and psychiatry. The PAC developed these suggestions to improve the safety of care for patients treated with antipsychotics.

Best-practice suggestions for PCPs

- Ensure you are aware of antipsychotic prescriptions by encouraging patients to bring all medications to their scheduled wellness appointments.
- When children, adolescents or adults are taking antipsychotics, ensure recommended annual HbA1c and cholesterol tests are ordered.

Best-practice suggestions for psychiatrists

- When prescribing antipsychotics, communicate with the PCP to confirm roles in ordering tests, reviewing results, following up and managing the patient's health based on lab results.
- Establish a process for ordering labs if you are practicing telehealth exclusively.
- Coordinate care with your patients' PCPs to co-monitor and co-manage abnormalities associated with prescribed psychiatric medications.

National immunization month

National Immunization Awareness Month (NIAM) is observed each August to highlight the importance of routine vaccination for people of all ages.

Providers play a key role in educating patients and parents about the importance of vaccination. Your recommendation can help protect your patients against serious diseases, such as whooping cough, influenza, COVID-19, HPV, meningitis and shingles.

According to the National Vaccine Advisory Council disparities in immunization rates exist for many underserved and underrepresented populations, including racial or ethnic minorities, rural communities, people with disabilities, and the LGBTQIA+ community. Addressing immunization disparities is an opportunity to improve health outcomes for individuals and increase protection in the overall health of our communities. To learn more, visit the Partnering for Vaccine Equity Resource Hub.

We appreciate your continued efforts to ensure your patients receive necessary vaccinations. Ensuring patients are up to date on all vaccines and other preventive care can protect them and help them maintain good health. This is important because many people, especially children, are often behind on regular vaccinations.

Resources

Preventive care list: We cover preventive care services at 100%. View our preventive care lists (available in English and Spanish).

Healthwise's Knowledgebase: This resource has helpful immunization information and tools. Our Quality Improvement Toolkit has a link to the Healthwise Knowledgebase, where you can search for materials in English and Spanish to share with your patients:

- Immunizations
- Vaccinations
- Or search for specific vaccines (e.g., coronavirus, hepatitis B)

CDC: Visit the CDC's NIAM website for resources to help you discuss routine vaccinations with your patients and parents during NIAM and throughout the year.

Related: See *Childhood immunizations* on page 16.

Flu season is just around the corner

The CDC estimates there were at least 31 million flu illnesses, 14 million medical visits, 360,000 hospitalizations and 21,000 deaths from flu during the 2022-2023 flu season. It's difficult to know what the 2024-2025 flu season will bring, so prevention is the best protection.

The CDC recommends that everyone six months and older (with rare exceptions) be vaccinated every flu season to reduce flu illness and serious outcomes. The flu vaccine is especially important for those considered high-risk, including older adults because they are at a higher risk of getting seriously ill from influenza and serious cases of flu can lead to hospitalization or death.

Tips to consider as we approach flu season:

- Educate support staff about the importance of the flu vaccine.
- Update your standing orders and protocols for the 2024-2025 flu season.
- If you don't currently have standing orders and protocols for vaccines, consider creating them.
- Make resources about the flu vaccine available to patients to encourage informed decision-making.
- If vaccines are not included in your pre-visit planning, consider adding vaccines to your pre-visit workflow.
- With pre-visit planning, consider adding the word "flu" to the appointment note for patients who are due for their vaccine. This will help remind the care team that a patient needs their vaccine when they come in for their appointment.
- Consider hosting flu clinics or outreach campaigns to schedule patients for a vaccination appointment with a nurse or medical assistant.

Patient resources

Educational flyers about the importance of the flu vaccine are available in English and Spanish. You can use these to reinforce the conversation with your patient or make them available for review in the waiting room before an appointment. Look for the **Influenza immunization** category in the Quality Improvement Toolkit, available in the Toolkits section on the homepage of our provider website.

Childhood immunizations

On-time vaccination throughout childhood helps provide immunity before children are exposed to potentially life-threatening diseases. Childhood immunization rates for our health plan currently fall below the national average. These lower rates may have contributed to a whooping cough outbreak identified in Oregon earlier this year, in which at least 178 cases were reported.

The CDC has observed disparities in childhood immunization rates for racial and ethnic minorities, children living in rural communities, and low-income families. Addressing immunization disparities is an opportunity to improve health outcomes for individuals and increase protection in the overall health of our communities. To learn more, visit the Partnering for Vaccine Equity Resource Hub.

As a PCP, you are a trusted resource and educator to parents and caregivers about the importance of routine checkups and recommended vaccination schedule. Scheduling office visits in advance can help parents and caregivers ensure their child stays on track.

Vaccine schedules recommended by agencies and organizations, such as the CDC, the American Academy of Pediatrics and the American Academy of Family Physicians, include different vaccine types, frequencies, intervals and considerations for special situations.

Sometimes, parents and guardians are concerned about the safety of vaccines. View the CDC's resources to help you and your staff prepare for conversations around vaccine hesitancy.

- Vaccinate with confidence
- Encourage routine vaccinations
- Prepare for questions parents may ask about vaccines

Here are some tips for talking to parents who are hesitant to vaccinate their children:

- Tailor your message
- Counter any misinformation
- Ask why the parent is hesitant
- Understand the parent's concerns
- Address the parent's fears about side effects
- Prepare your staff to answer questions

In addition, as part of our efforts to improve childhood immunizations, our Quality Incentive Plan (QIP) provides incentives for administering all of the immunizations required for children. **Related**: See *QIP Reminders* on page 18.

Resources

Healthwise's Knowledgebase has helpful information and tools about immunizations and vaccinations to share with your patients. Our Quality Improvement Toolkit has a link to the Healthwise Knowledgebase. Search Healthwise's Knowledgebase for materials in English and Spanish:

- *Childhood Immunization Schedule: Ages 0 to 6 Years*
- *Childhood Immunization Schedule: Ages 7 to 18 Years*
- *Why Get Your Child Immunized?* video

New *Quality Measures Guide* coming soon

Editor's note (8/29/24): Updated the date for when the guide will be available to September 13, 2024

We are updating 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 the following programs and initiatives:

- HEDIS medical record reviews
- Quality Incentive Program (QIP)
- Value-based agreements (VBAs)

Note: The guide does not include information about all HEDIS or Star-related measures.

You can view the guide on our provider website on September 13, 2024: Programs>Quality Incentive Program.

Improving health care for all

We believe that everyone should have access to affordable, quality care. That's why we're partnering with providers to address health disparities and advance health equity.

We recently updated the Health Equity Toolkit on our provider website. This toolkit includes resources to help you learn more about health disparities and to develop and improve your cultural competency and health literacy best practices as you and your staff provide care for our members.

What's inside?

- Explore tools, trainings, continuing medical education (CME) courses and other resources to help you and your practice develop the mindset and core capabilities to advance health equity.
- Find resources to support underserved and underrepresented groups that experience health disparities.
- Learn about accreditation or distinction programs that can help your organization develop foundational health equity capabilities and earn recognition in the industry.

Social determinants of health resources

Non-clinical factors can significantly impact the health and wellbeing of your patients. The majority of health outcomes (80%) are driven by the conditions in places where people live, work and play. Known as social determinants of health (SDoH), these powerful factors include housing stability, food security and transportation access, among others.

Connect your patients to:

- **Community resources**: Individuals can find support to address social needs, such as food insecurity, housing instability, transportation access and more by visiting 211.org or findhelp.org.
- **BridgeSpan Customer Service**: Members can call the number on the back of their member ID card for help with SDoH resources, finding a PCP, understanding their benefits and more.

We encourage you to include SDoH Z codes in your patients' medical records. Including these codes will help us identify opportunities to provide support to our members, such as transportation or in-home care, as well as connections to food banks and other community resources.

QIP reminders

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.

Risk adjustment care gap reports

As a reminder, reports highlighting risk adjustment care gaps are available in the CGMA as a separate downloadable report. 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.

2023 program year payout

Thank you for participating in our 2023 program. Payout checks for the 2023 program have been sent to participants. If you did not receive your payout or have questions, please email our QIP team.

Clinical Practice Guideline reviews

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

We renewed the following Clinical Practice Guidelines, effective July 1, 2024, with no changes to the guidelines' recommendations:

- Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: We continue to recommend the Veterans Affairs and Department of Defense (VA/DoD) guidelines.
- Management of Chronic Noncancer Pain with Opioids in Adults: We continue to recommend the Substance Abuse and Mental Health Services Administration (SAMHSA) TIPS publication.
- Preventive Services Guideline for Adults: We continue to recommend the USPSTF screening recommendations.
- Screening and Management of Substance Use Disorders in Adults: We continue to recommend the VA/DoD guidelines.

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

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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