FEBRUARY 2021

Provider News

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

Courage. Commitment. Resilience.

We recognize that 2020 brought unprecedented challenges. COVID-19 has required providers to put themselves at risk while also impacting office resources and day-to-day operations.

With vaccines being administered, we greet 2021 with optimism. And we want you to know we're grateful for the care you continue to provide to our members and the people in our communities. Thank you!

Prepare to administer COVID-19 vaccines and answer patient questions

During the public health emergency, the federal government will pay for the cost of COVID-19 vaccines for all individuals. Depending on the individual, additional costs associated with administering the vaccine will be covered by the federal government or the member's health plan.

Our COVID-19 Vaccine Toolkit, available on our provider website at **bridgespanhealth.com**, includes information to help you prepare to administer vaccines and answer questions from your patients.

The toolkit includes information about:

- Coverage for our members
- Claims submission guidelines and provider reimbursement

In addition, the toolkit includes links to the:

- States' distribution plans
- Vaccine and administration codes
- Other helpful resources

Stay up to date

Check the COVID-19 Updates and Resources section of our provider website for updates.

Easily find information

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

Stay up to date

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

Using our website

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

BridgeSpan Health
2890 E Cottonwood Parkway Salt Lake City, UT 84121

Contents

■ Critical update
⁎ Dental must read
▲ DME must read
‡ Rehabilitation must read

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

Click on a title below to read the article.

About Provider News

This publication includes important news, as well as notices we are contractually required to communicate to you, including updates to our policies (medical, dental, reimbursement, medication) and pre-authorization lists. In the table of contents, this symbol indicates articles that include critical updates: ■. To save you time, you can click on the titles to go directly to specific articles. You can also return to the table of contents from any page by clicking on the link at the bottom of each page.

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

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

The information in this newsletter does not guarantee coverage. Verify members' eligibility and benefits via the Availity Provider Portal at **availity.com**.

The Bulletin

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

Subscribe today

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

Encourage everyone in your office to sign up.

Share your feedback

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

2020 newsletter and bulletin survey results

Thank you for completing our annual newsletter and bulletin survey.

Most respondents agree that the newsletter and bulletin are easy to read and navigate. In addition, most respondents indicate that the topics of newsletter articles are useful to their practice.

Key survey findings

- **Table of contents**: Respondents use the key in the table of contents to quickly and easily identify articles for their specialty type (e.g., behavioral health and dental).
- **Most read newsletter content**: The topics identified as the most-read include administrative and billing updates; medical and reimbursement policy updates, pre-authorization list updates, information about the Availity Portal and programs that impact providers.

New for 2021

- *The Bulletin* now includes updates to our reimbursement and medical policies (**Related**: See *January 2021 Bulletin recap* on page 6.)
- We have updated the Newsletter and Bulletin sections of our provider website to make it easier to find the current issues of these publications.

Additional comments

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

Annual HEDIS medical record collection

Our measurement year 2020 Healthcare Effectiveness Data and Information Set (HEDIS®) medical record reviews will begin this month, continuing through May 2021. We have contracted with Inovalon to contact providers and collect data using a HIPAA-compliant process. We appreciate your help during this process, and Inovalon will work with your office to collect medical records by fax, mail or onsite visit (for larger clinics).

As a reminder, it is your responsibility as a participating BridgeSpan provider to respond to these requests in a timely manner. Unless your provider agreement specifically states otherwise, you are required to provide access to member records to us or our vendor for these purposes free of charge. A signed release from your patient—our member—is not required for us to obtain these records.

You can learn more about this year's review on our provider website: Programs>Quality Program>HEDIS Reporting.

Interoperability, patient access and you

The Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final rule (CMS-9115-F) focuses on giving patients access to their health information when they need it most and in a way they can best use it. The final rule moves the health care system toward greater interoperability, allowing data to flow more freely between providers, payers and patients using CMS authority to regulate Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP) and Qualified Health Plan (QHP) issuers on the federally facilitated exchanges (FFEs).

Secure data exchange will help all parties achieve truly coordinated care, improved health outcomes and reduced costs. Under the final rule, CMS-regulated payers are required to provide access to provider and patient claims and clinical data via secure, standards-based application programming interfaces (APIs). The technical standard for APIs adopts the Health Level 7® (HL7) Fast Healthcare Interoperability Resources® (FHIR) release 4.0.1. This standard allows patients to easily access their claims and encounter information, including cost, as well as specific clinical information through participating third-party applications of their choice.

The final rule includes new policies:

- Patient Access API (applicable January 1, 2021; enforced after July 1, 2021) to allow patients to easily share clinical data and claims and encounter information with third-party applications of their choice.
- Provider Directory API (applicable January 1, 2021; enforced after July 1, 2021) to make provider directory information publicly available via a standards-based API. This will allow third-party application developers to create services that help patients find providers for care and treatment and allow other providers to enable care coordination.
- Payer-to-Payer Data Exchange (applicable January 1, 2022) to allow the exchange of certain patient clinical data, at the patient's request, allowing the patient to take their information with them as they move from payer to payer over time to help create a cumulative health record with their current payer.

Members who purchased their health plans on the Exchange in Oregon and Utah will be empowered to share their health records with participating third-party applications. We will educate our eligible members about:

- How to provide and manage their consent (applies to members 18 and older)
- What it means to provide their data to third-party applications
- What information they need to know before sharing their data
- Carefully selecting which third-party application has access to their information
- What protection we will execute to protect their data

We have created FHIR-compliant Provider Directory and Patient Access APIs that allow third-party application developers connectivity for sharing and receiving member health and directory data. If your practice uses third-party applications for transferring patient health information, you can learn more about accessing our APIs, at **bridgespanhealth.com/member/terms-of-use/interoperability** and **bridgespanhealth.com/for-developers**.

Learn more about the Interoperability and Patient Access final rule (CMS-9115-f) on CMS' website: **cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index**.

Pre-authorization updates

Procedure/medical policy	Added CPT codes effective January 1, 2021
Balloon Dilation of the Eustachian Tube (Surgery #206)	69705, 69706
Genetic and Molecular Diagnostics – Single Gene or Variant Testing (Genetic Testing #20)	0232U, 0234U, 0235U, 0238U, 81351, 81352, 81419
Genetic Testing for Epilepsy (Genetic Testing #80)	0232U, 81419
Genetic Testing for Hereditary Breast and Ovarian Cancer and Li-Fraumeni Syndrome (Genetic Testing #02)	0235U, 81351, 81352
Genetic Testing for Lynch Syndrome and APC-associated and MUTYH-associated Polyposis Syndromes (Genetic Testing #06)	0238U
Genetic Testing for Myeloid Neoplasms and Leukemia (Genetic Testing #59)	81351, 81352
Genetic Testing for PTEN Hamartoma Tumor Syndrome (Genetic Testing #63)	0235U
Genetic Testing for Rett Syndrome (Genetic Testing #68)	0234U
Genetic Testing; Reproductive Carrier Screening for Genetic Diseases (Genetic Testing #81)	81243, 81244
Magnetic Resonance (MR) Guided Focused Ultrasound (MRgFUS) and High Intensity Focused Ultrasound (HIFU) Ablation (Surgery #139)	55880, C9747
Radiology – AIM Specialty Health	71271

Our complete *Pre-authorization List* is available in the Pre-authorization section of our provider website. Please review the list for all updates and pre-authorize services accordingly.

You can submit standard medical pre-authorizations through the Availity Portal, **availity.com**. Learn more on our website: Pre-authorization>Electronic Authorization.

January 2021 *Bulletin* recap

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

Medical policy updates

We provided 90-day notice in the December 2020 issue of *The Bulletin* about the following medical policies, which are effective March 1, 2021:

- Cryosurgical Ablation of Miscellaneous Solid Tumors Outside of the Liver (Surgery #132)
- Gastric Electrical Stimulation (Surgery #111)
- Hematopoietic Cell Transplantation for Multiple Myeloma and POEMS Syndrome (Transplant #45.22)
- Implantable Peripheral Nerve Stimulation for Chronic Pain of Peripheral Nerve Origin (Surgery #205)
- Occipital Nerve Stimulation (Surgery #174)
- Powered Knee Prosthesis, Powered Ankle-Foot Prosthesis, Microprocessor-Controlled Ankle-Foot Prosthesis, and Microprocessor-Controlled Knee Prosthesis (Durable Medical Equipment #81)
- Sacral Nerve Neuromodulation (Stimulation) for Pelvic Floor Dysfunction (Surgery #134)

We provided 90-day notice in the January 2021 issue of *The Bulletin* about the following medical policies, which are effective April 1, 2021:

- Donor Lymphocyte Infusion for Malignancies Treated with an Allogeneic Hematopoietic Cell Transplant (Transplant #45.03)
- General Medical Necessity Guidance for Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) (Durable Medical Equipment #88)
- Hyperbaric Oxygen Therapy (Medicine #14)
- Intensity Modulated Radiotherapy (IMRT) for Tumors in Close Proximity to Organs at Risk (Medicine #167)

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

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

Reimbursement policy updates

We began publishing updates to reimbursement policies in our monthly publication, *The Bulletin*, on January 1, 2021.

No reimbursement policies published in the January 2021 issue required 90-day notice.

Our reimbursement policies are reviewed on an annual basis.

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

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

Clinical Position Statements to be converted to medical policies

To improve transparency regarding our position for the indications we have historically addressed in our Clinical Position Statements, we are in the process of converting those statements into medical policies. This move will make it easier for you to find our position on certain medical treatments, tests or medications.

We publish medical policy updates in our monthly publication, *The Bulletin*. Clinical Position Statements, which do not require pre-authorization review, and medical policies, which may require pre-authorization review, are available in the Medical Policy Manual on our provider website: Library>Policies & Guidelines>Medical Policy.

New medical policies developed from previous Clinical Position Statements will include the following statement:

- **Note**: Services described in this medical policy are not routinely reviewed for medical necessity, but utilization may be subject to audit. Some devices or services are subject to the health plan's reimbursement policy manual or not covered based on benefit contracts. Claim adjudication is also subject to claim processing guidelines and provider contracts.

Clinical Practice Guidelines updates

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

We reviewed the following Clinical Practice Guidelines, effective November 1, 2020:

- **Management of Heart Failure in Adults**: We continue to endorse the American College of Cardiology Foundation and the American Heart Association task force guideline for the management of heart failure in adults.
- **Preventive Services Guideline for Children and Adolescents**: We continue to endorse the American Academy of Pediatrics recommendations for well-child schedules and Centers for Disease Control and Prevention (CDC) immunization recommendations.

We reviewed the following Clinical Practice Guidelines, effective January 1, 2021:

- **Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease**: We made edits to reflect the 2020 update to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) Guideline on the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease.

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

Dental policy updates

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

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

Dental policies	Description of changes
Adjunctive General Services	**Effective February 1, 2021**
- Occlusal Adjustments (#61) - Reimbursement for Dental Anesthesia Procedures (#56)	- Archived policies
Prosthodontics	**Effective February 1, 2021**
Provisional Retainer Crown (#41A)	- Archived policy
Restorative	**Effective February 1, 2021**
- Direct Resin Restorations (#12) - Provisional Crown (#16A)	- Archived policies
Restorative	**Effective April 1, 2021**
Buildups (#18)	- Revising formatting - Adding CDT D2951
Dental Restorations (#77)	- New dental policy stating that multiple restorations on the same tooth will be treated as one restoration with multiple surfaces

Non-reimbursable services

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

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

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

DME codes to be added

Effective May 1, 2021, we will add the following HCPCS codes to our NRS list:

- **S1015**: IV Tubing Extension Set
- **S1030**: Continuous noninvasive glucose monitoring device, purchase
- **S1031**: Continuous noninvasive glucose monitoring device, rental
- **S8096**: Portable Peak Flow Meter
- **S8100**: Holding chamber or spacer for use with an inhaler or nebulizer; without mask
- **S8101**: Holding chamber or spacer for use with an inhaler or nebulizer; with mask
- **S8120**: Oxygen contents, gaseous, 1 unit equals 1 cubic foot
- **S8185**: Flutter device
- **S8186**: Swivel adaptor
- **S8431**: Compression bandage, roll
- **S8450**: Splint, prefabricated, digit (specify digit by use of modifier)
- **S8451**: Splint, prefabricated, wrist or ankle
- **S8452**: Splint, prefabricated, elbow

Reminder about supply codes

In the December 2020 issue of this newsletter, we notified you that effective March 1, 2021, we will add 84 HCPCS codes to our NRS list.

These NRS codes will be included in our Coding Toolkit list of codes and edits.

Related: See *Coding Toolkit updates* on page 12.

Medication policy updates

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

Pre-authorization: Submit medication pre-authorization requests through **covermymeds.com**.

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

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

Product not available (PNA) status: We allow a 90-day grace period to use any existing supply for medications that CMS has designated as PNA before they become ineligible for reimbursement. **Related**: See *Non-reimbursable services* on page 9.

New medication policies	Description of changes
Effective February 15, 2021	
Blenrep, belantamab mafodotin-blmf, dru651	- Limits coverage to patients with relapsed or refractory multiple myeloma (MM) whose disease has progressed after a minimum of four prior therapies, including a CD38-directed mAb, a proteosome inhibitor and an immunomodulatory agent, the setting in which it was studied and has a labeled indication

Revised medication policies	Description of changes
Effective February 15, 2021	
Cyramza, ramucirumab, dru355	- Updating prerequisite therapy for hepatocellular carcinoma (HCC) from "prior sorafenib" to "at least one prior systemic HCC regimen"
daratumumab-containing products (Darzalex, Darzalex Faspro), dru435	- Aligning daratumumab/hyaluronidase (Darzalex Faspro) with daratumumab (Darzalex) criteria to allow coverage for all the same indications
Medications for Hereditary Angioedema (HAE), dru535	- Adding newly FDA-approved product Orladeyo (berotralstat) to policy - Removing the Haegarda step for lanadelumab (Takhzyro)
Non-Preferred Products with Available Biosimilars, dru620	- Adding newly FDA-approved biosimilar Riabni (rituximab-arrx) to policy as a non-preferred product
Pertuzumab-containing medications, dru281	- Adding newly FDA-approved product Phesgo (pertuzumab/trastuzumab/hyaluronidase) to policy

In the December 2020 issue of our newsletter, we notified you that effective April 1, 2021, *Drugs for chronic inflammatory diseases, dru 444*, would require a trial of Simponi Aria or Remicade prior to coverage of Orencia IV or Actemra IV for polyarticular juvenile idiopathic arthritis (PJIA). We have decided not to implement this change effective April 1, 2021; you can disregard our previous notice.

Administrative Manual update

Our Facility Guidelines section was updated February 1, 2021, to add information regarding ambulatory surgical centers (ASCs) billing bilaterally or billing multiple procedures.

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

ASCs billing bilateral procedures

Ambulatory surgical centers (ASCs) cannot append modifier 50 when billing bilaterally. ASCs must bill bilateral procedures on two separate lines with an RT and an LT modifier.

When billing multiple procedures, ASCs must bill each procedure on a separate line with a unit of 1.

Edits to review unit discrepancies

We review claims to ensure correct coding and charges. For claims received on or after May 1, 2021, reviews will include revenue codes that have unit discrepancies between the itemized bill and submitted claim. Charges denied as a result of these reviews will include a message regarding line-by-line denials.

Claims submission reminder for massage therapists and acupuncturists

As a reminder, all claims must be submitted under the rendering provider's National Provider Identifier (NPI), including those for massage therapy and acupuncture. Your NPI is unique to you and is only to be used by you. If another provider in your office is providing massage therapy services, their NPI and name must be used when submitting a claim for those services.

More information about billing is available on our provider website: Claims & Payment>Claims Submission.

Provider compliance reminder

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

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

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

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

Are you?

- ✓ **Registered for the Availity Portal**: Verify member eligibility and benefits, view claims-related information and submit medical pre-authorization requests electronically using the Availity Portal. Register today at **availity.com**.
- ✓ **Receiving payments via EFT**: All participating providers are required to receive claims payments via electronic funds transfer (EFT). The EFT Enrollment Tool is available on the main menu of the Availity Portal: My Providers>Enrollments Center> EFT Enrollment. Register now; it's easy and only takes a few minutes.
- ✓ **Submitting electronic authorizations**: Use Availity's electronic authorization tool to quickly see if a pre-authorization is required for a medical service or to submit your medical pre-authorization request. Some procedures may receive instant approval. Access the tool from Availity's home page: Authorizations & Referrals.

Keep your information current

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

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

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

Validate your practice information

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

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

Submit changes or corrections

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

Coding Toolkit updates

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

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

Our Correct Code Editor (CCE), also located in the Coding Toolkit, has additional CPT and HCPCS code pair edits that we have identified and are used as a supplement to Medicare's NCCI. This supplemental list of code groupings in the CCE is updated quarterly in January, April, July and October. We reserve the right to take up to 30 calendar days to update our systems with CCE updates, CMS-sourced changes and Change Healthcare-sourced changes. Claims received before our systems are updated will not be adjusted. The Coding Toolkit is available on our provider website: Claims & Payment>Coding Toolkit.

We perform retrospective review on claims that should be processed against our clinical edits. We follow our existing notification and recoupment process when we have overpaid based upon claims processing discrepancies and incorrect application of the clinical edits. View the notification and recoupment process on our provider website: Claims & Payment>Payment> Overpayment Recovery.

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

Resources for you

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

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