DECEMBER 2022

# Provider News

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

## Talking to your patients about diabetes

According to the Centers for Disease Control and Prevention (CDC), more than 37.3 million people in the U.S. have diabetes, and 1 in 5 of them don't know they have it. The U.S. Preventive Services Task Force (USPSTF) recommends that providers consider screening non-pregnant patients ages 35 to 70 who are overweight or obese and have no current symptoms of diabetes.

Disparities in diabetes prevalence disproportionately affect some racial and ethnic minority groups and groups with lower socioeconomic status and, therefore, clinicians should consider screening at an earlier age or lower BMI for these patients as appropriate. For valuable information to help support health equity in your practice, read the USPSTF's *Final Recommended Statement Prediabetes and Type 2 Diabetes: Screening*, available at **uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes#bootstrap-panel--6**.

In addition to diagnosing diabetes, providers play an important role in helping their patients manage their diabetes—whether their patients are newly diagnosed or have been living with diabetes for a while. We encourage you to discuss the importance of diabetes management with your patients, including eating well, getting regular exercise, controlling blood sugar levels, scheduling eye exams and discussing ways to keep their feet healthy.

### Best practices for diabetes management in the primary care office

- Leverage your electronic health records and use registries and prompts to alert providers and staff when it's time to order recommended diabetic screenings and tests (e.g., A1c, urine microalbumin, lipid panel, eye exam, foot exam).
- Consider support staff that can help with outreaching to patients who are due for diabetic screenings and tests.
- Complete diabetic labs and screenings in the primary care office during the office visit to ensure that patients due for screenings or tests get the care they need.

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## Easily find information

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

## Subscribe today

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

## Using our website

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

## Stay up to date

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

**BridgeSpan Health**
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■ Critical update
▲ DME must read
‡ Dental must read
✶ Radiology must read

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, 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 Availity Essentials at **availity.com**.

### The Bulletin

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

### Share your feedback

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

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- Utilize clinical pharmacists to help manage patients who may need more support managing their diabetes.
- Consider additional resources that patients may need to help manage their diabetes (e.g., health coaches, diabetic specialists, nutritionists).

### Resources

The Healthwise Knowledgebase has several helpful resources for you and your patients:

- ***Diabetes Care Plan***: This can be shared with your patients and includes a list of what to bring to every appointment; current measurements for weight and blood pressure; home blood glucose testing goals; recent test results (e.g., A1c and cholesterol); and tests to schedule (e.g., foot exams and eye exams).
- ***Taking Medicines as Prescribed***: This content can help you discuss the importance of medication adherence with your patients.
- ***Dilated Eye Exam***: This content includes information about the exam (i.e., how it is performed and what to expect after the test).

For copies of these Healthwise materials, available in English and Spanish, email **Quality@bridgespanhealth.com**.

### Diabetes management

Our care managers (registered nurses and/or case managers) are available to help members with diabetes and support your care plan. Learn more on our provider website: Programs>Medical Management>Care Management.

## COVID-19 updates

As we enter the winter months, experts are predicting another surge of COVID-19 cases in the United States. We will continue to update the COVID-19 section of our website to make sure you have the latest COVID-19-related information and helpful resources. In addition, we will include updates in future issues of this newsletter.

**Note:** When we learn that the COVID-19 federal public health emergency is ending, we will provide as much notice as possible about any changes to members' benefits or provider reimbursement.

## Updated after-hours availibility requirement

We require all providers to meet our appointment accessibility and availability standards to ensure that our members—your patients—have access to quality care. This includes minimum requirements to provide or arrange for covered services to members on a 24/7 basis.

We have changed our appointment accessibility and availability standards related to after-hours care to improve understanding and compliance with the requirement. Please review this new standard and, if necessary, take steps to make sure that your office meets the requirements.

### After-hours answering systems

To assist our members in accessing services after their provider's regular office hours, please instruct your patients about options for after-hours care. This coverage could include:

- An answering service that can contact the on-call provider or another designated network provider
- An on-call pager
- Call forwarding to the provider's home or other location
- A recorded phone message with instructions that direct the member to a provider for instruction in after-hours care; please avoid giving direction to another recording
- An after-hours recording on the office phone that instructs members to call 9-1-1 or go to a hospital emergency room (ER) for needed emergency services

You can view all of our accessibility and availability standards on our provider website: Programs>Quality>Accessibility & Availability Standards.

# Administrative Manual updates

The following updates were made to our manual on December 1, 2022:

### Facility Guidelines

- Added information about claims that span calendar years

### Provider Appeals

- Added requirement to submit provider appeals via Availity Essentials effective March 1, 2023

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

# Supporting our dental networks with USAble Life

We are committed to providing top-tier dental care to our members. To best serve our members and participating dental providers, we are partnering with USAble Life to support our BridgeSpan dental networks in early 2023.

Under this partnership, USAble Life will provide the administration for BridgeSpan dental networks, including provider data management.

We will also launch a new dental-specific website to give you access to dental policies, forms, resources and who to contact for support. **Note:** Dental providers should continue to use Availity Essentials to access eligibility, benefits and claims-related information.

Additional information will be published in the February 2023 issue of this newsletter.

**Editor's note (updated February 13, 2023)**: The incorrect vendor information was initially published for implanted device audits.

# Implanted device, ED and DRG audits begin in 2023

For services delivered on or after March 1, 2023, we will conduct post-payment review of implanted devices, emergency department evaluation and management (ED E&M) and diagnosis-related group (DRG) claims for pricing and payment accuracy.

Performant will perform ED E&M or DRG audits. CERIS will perform implant audits.

Our vendors will contact your office if your claim is selected for this review:

- To validate the services billed on the claim
- To verify the pricing method applied is correct
- To verify the payment rendered is appropriate to the member's benefits

If you disagree with our vendor's findings, you can appeal to the vendor. Their contact information is provided on the determination letter. We will request recoupment via adjustment of a future claim payment.

# 2023 brings code changes for many services and supplies

Please remember to review your 2023 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 by calling the American Dental Association at 1 (800) 947-4746 or online at **store.ada.org**
- CPT and HCPCS manuals through your preferred vendor or online through the American Medical Association (AMA) at **commerce.ama-assn.org/store**

Reimbursement information is available on Availity Essentials.

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.

# Claims that span multiple years

The Centers for Medicare & Medicaid Services (CMS) coding guidelines require institutional claims that span from one calendar year to another to be split into separate claims by year. This allows proper processing of all aspects of the claim. CMS' general guidance is:

FL 6. Statement covers period (from - through)

- These fields cannot exceed eight positions in either "from" or "through" portion, allowing for separations (non-numeric characters) in the third and sixth positions.
- The "from" date must be a valid date that is not later than the "through" date.
- The "through" date must be a valid date that is not later than the current date.

Facility claims (ANSI 837I claims) that span from one calendar year to the next (e.g., December 28, 2022, to January 3, 2023) will be denied automatically if they are submitted on the same claim. The following claim types are exceptions that do not need to be split:

- Home health prospective payment system (PPS) claims
- Outpatient hospital observation or ER visits
- Facility inpatient claims

The Facility Guidelines section of our Administrative Manual was updated on December 1, 2022, with this information.

# Changes to ambulance reimbursement

Reimbursable ambulance services provided on or after March 1, 2023, will be limited to the base fee for transportation and mileage. Services including—but not limited to—oxygen, medications, additional attendants, supplies, electrocardiograms (EKGs) and night differentials will be denied when billed as part of an ambulance transportation service.

### More information

- Chapter 15 of CMS' *Medicare Claims Processing Manual*: **www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf**
- Our *Ambulance Guidelines* (Administrative #121) reimbursement policy, available on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

# Changes to DME codes with no fees

Effective March 1, 2023, we will make the following reimbursement changes to durable medical equipment (DME):

- HCPCS E0118 (crutch substitute) and K0891 (pediatric power wheelchair) rental reimbursement rates will be reduced.
- The following HCPCS codes will no longer be reimbursable when billed with rental modifier RR: A4206-A4209, A4211, A4213, A4215, A4218, A4281-A4286, A4600, A4606, A4627, A4660, A4663, A4670, A6198, A6206, A6208, A6213, A6215, A6250, A6261, A6530, A6533-A6541, A6545, A9274, A9276-A9278, A9282, A9283, E0240, E0241, E0243-E0245, E0247, E0248, E0445, E0486, E0603, E2291-E2294, E2331, L3202, L3203, L3206, L3208, L3209, L3211, L3215, L3216, L3219, L3221, L3222, L3260, L3265, L8010, L8692, S1040, S8265, S8420-S8428, V5011, V5014, V5030, V5040, V5050, V5060, V5070, V5080, V5090, V5100, V5110, V5120, V5130, V5140, V5150, V5160, V5171, V5172, V5181, V5190, V5200, V5211-V5215, V5221, V5230, V5240-V5261, V5264, V5266, V5268-V5273, V5275, V5281-V5290 and V5336

# Battery code to be added to NRS list

Effective March 1, 2023, we will add HCPCS A4611 to our non-reimbursable services (NRS) list. This DME code will be added to the *Clinical Edits by Code List* on our provider website: Claims & Payment>Coding Toolkit.

This change is supported by our *Non-Reimbursable Services* (Administrative #107) reimbursement policy.

# Compliance program requirements

We want to remind you that all providers and their staff, including any board or trustee members, must meet the requirements of our Government Programs compliance program, including monthly verification that they are not on an exclusion list and that they are completing annual trainings about compliance and fraud, waste and abuse (FWA).

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

## Exclusion lists

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

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

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

## Required compliance training

**FWA and general compliance trainings are a contractual requirement for participation in our QHP networks**. This training must be completed within 90 days of hire and annually thereafter. Please ensure that your staff complete required training and maintain documentation for auditing purposes.

## Compliance for board and/or trustee members

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

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

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

## Learn more

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

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

# Update your directory information

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

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

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

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

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

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

# Provider appeals must be submitted via Availity

**Effective March 1, 2023, we will require all post-service provider appeals to be submitted using the Appeals application on Availity Essentials.**

The only disputes and appeals that **should not be** submitted via Availity Essentials are:

- Pricing disputes, which are not appeals and are subject to a separate pricing dispute process
- Disputes that meet our "extenuating circumstances" criteria, which must be submitted via fax
- Appeals that Availity cannot process because of file size limits, which may be submitted via our secure file transfer protocol

Providers must submit all other provider appeals via the Availity Essentials Appeals application. Provider appeals sent via an improper method will be returned to the provider with directions to submit using the Availity application on Availity Essentials.

The Appeals application is a more efficient way of receiving appeals and communicating determinations to providers. The application:

- Streamlines the appeals process by making it easy to submit appeals directly from the Claim Status screen
- Gathers all required information about the claim being disputed
- Prevents duplicate appeals submission

The Appeals dashboard shows the status and history of submitted appeals, eliminating the need for providers to contact us for status information.

### Appeals application and exception criteria

Learn more about the Appeals application and view our exception criteria on our provider website: Claims & Payment>Receiving Payment>Pricing Disputes & Appeals.

### Accessing the Appeals application

The Appeals application is available on Availity Essentials: Claims & Payments>Appeals. If you do not have access to the Appeals application, please contact your Availity Essentials administrator and request the Claim Status role.

### Training resources

View guides on Availity Essentials: Help & Training> Find Help>Appeals. A recorded training demonstration is also available by searching for Appeals: Help & Training> Get Trained.

# Biomarker testing exempt from pre-authorization in Washington

Engrossed Substitute House Bill (HB) 1689 requires health plans issued or renewed in the state of Washington on or after January 1, 2023, to exempt biomarker testing from pre-authorization for members with:

- Stage 3 or 4 cancer; or
- Recurrent, relapsed, refractory or metastatic cancer

The biomarker testing must be:

- Recommended in the latest version of nationally recognized guidelines or biomarker compendia
- Approved by the U.S. Food and Drug Administration (FDA) or a validated clinical laboratory test performed in a clinical laboratory certified under the Clinical Laboratory Improvement Amendments or in a CMS-approved laboratory program
- A covered service
- Prescribed by an in-network provider

**Notes:**

- HB 1689 does not mandate coverage of biomarker testing.
- A health plan may require a biomarker test prior to approving a drug or treatment.
- CPT 81401-81408 and 81479 may require pre-authorization; please review our Pre-authorization list for all updates and pre-authorize services accordingly.

Our pre-authorization list has been updated to reflect this exemption.

# Changes to radiology program

### Requests for supporting documentation

Beginning March 1, 2023, AIM Specialty Health (AIM) may request additional clinical information for radiology pre-authorization requests.

If requested, providers will need to submit documentation from the patient's medical record to ensure services are clinically appropriate. AIM will request this documentation only for select procedures when certain clinical indications are present.

### AIM revising clinical guidelines

Effective April 9, 2023, AIM will revise the following radiology guidelines:

- Imaging of the Brain
- Imaging of the Head and Neck
- Imaging of the Chest
- Imaging of the Abdomen/Pelvis
- Oncologic Imaging
- Cardiac Imaging
    - Stress testing with imaging
    - CT coronary angiography (CCTA)
    - Fractional flow reserve from CCTA (FFR-CT)
    - Stress cardiac MRI
    - Resting cardiac MRI
    - Resting transthoracic echocardiography (TTE)

View the revised guidelines: **aimguidelines.wpengine.com/category/coming-soon.**

### Fewer imaging services to require an order number

Ordering providers may notice in 2023 that fewer advanced imaging services require an order number from AIM. Providers should continue to check Availity Essentials to determine whether services for a particular member require an order number.

AIM will continue to review radiology requests for medical necessity.

View a complete list of codes included in our radiology program on our Pre-authorization list.

# Cardiac program launching

As a reminder, non-emergency cardiac services delivered on or after January 1, 2023, will require pre-service medical necessity review through AIM.

Providers can begin contacting AIM on December 19, 2022, for these services using AIM's ProviderPortal, **providerportal.com**, or by calling AIM at (877) 291-0509, Monday through Friday, 8 a.m.-5 p.m. (PT).

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

### Services requiring review

Contact AIM to obtain an authorization number for the following non-emergency, outpatient cardiac tests and procedures:

- Diagnostic coronary angiography with or without right or left heart catheterization
- Arterial duplex
- Physiologic study arterial
- Percutaneous coronary intervention (e.g., coronary stents and balloon angioplasty and atherectomies); post-service review will be performed within 10 days of the service

The following cardiograph services will continue to require pre-authorization as part of our radiology program:

- Stress echocardiography (SE)
- Resting echocardiography (TTE)
- Transesophageal echocardiography (TEE)

### Resources and training

AIM has resources to help your practice get started with the cardiology program with useful information and tools, such as checklists and clinical guidelines: **aimprovider.com/cardiology**. To view upcoming webinars, click **Webinar Training Calendar**.

# Admission and discharge notification

As a reminder, effective January 1, 2023, we will require notification of all admissions and discharges for hospitals and inpatient hospice within 24 hours. We will remove the 24-hour exemptions for holidays and weekends from our pre-authorization list.

Continue to submit notifications as you do today.

# In-home sleep studies will no longer require pre-authorization

In-home sleep studies performed on or after January 1, 2023, will no longer require pre-authorization.

Facility-based sleep studies will continue to require pre-authorization.

Our Sleep Medicine program, managed by AIM, improves clinical appropriateness of sleep testing and therapy services, and helps members find the highest-value place of service for these services.

# Reminder: Fax additional form with gastrointestinal requests

Our *Surgical Site of Service – Hospital Outpatient* (Utilization Management #19) commercial and Medicare Advantage medical policies require pre-authorization for gastrointestinal procedures performed at a hospital outpatient place of service:

- **Colonoscopy**: CPT 45378-45381, 45384-45386, 45390 and 45398
- **Endoscopy**: CPT 43235-43239, 43242, 43245-43251 and 43254

As a reminder, providers faxing these pre-authorization requests should include the *Surgical Site of Service Additional Information Form*, available on our Pre-authorization list. Failure to submit this form will delay review of faxed requests.

Requests submitted through Availity Essentials do not require the attestation form because the process incorporates additional questions related to site of service.

# *The Bulletin* recap

We publish updates to medical policies 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 October 2022 issue of *The Bulletin* about our new *Biofeedback* (Allied Health #32) medical policy, which is effective January 1, 2023.

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

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

### Reimbursement policy updates

We provided 90-day notice in the October 2022 issue of *The Bulletin* about the following reimbursement policies, which are effective January 1, 2023:

- *Cellular and Gene Therapy Products* (Medicine #112)
- *Diabetic Supplies* (Administrative #128)
- *DME Purchase and Rental Limitations and Reimbursement* (Administrative #131)
- *Non-Reimbursable Services* (Administrative #107)
- *Transportation of Portable X-Ray Equipment* (Administrative #147)

We provided 90-day notice in the November 2022 issue of *The Bulletin* about the following reimbursement policies, which are effective February 1, 2023:

- *Cellular and Gene Therapy Products* (Medicine #112)
- *Timely Receipt of Records* (Administrative #145)

Our reimbursement policies are reviewed on an annual basis.

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

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

# Clinical Practice Guidelines update

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 *Management of Heart Failure in Adults* Clinical Practice Guideline, effective October 1, 2022, and updated the hyperlink to the guideline with no changes to the guideline recommendation.

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

# Reimbursement policy reminders

### Billing for chiropractic and osteopathic treatments

We evaluate claims for proper reimbursement of chiropractic and osteopathic treatments based on coding guidelines, and diagnoses and documentation provided.

As a reminder, when billing for chiropractic and osteopathic treatments, all CPT codes must include a supporting ICD-10-CM diagnosis code for the level of care provided.

**Note:** If a claim has been submitted without the proper diagnosis code, you must submit a corrected claim to include the required diagnosis code rather than submitting an appeal.

### Billing for allergy immunotherapy

As a reminder, for professional services of the provision of antigens for allergy immunotherapy, CPT 95165, units billed should reflect the actual number of doses the provider plans to administer as the patient's course of treatment when the antigen is initially prepared.

For more information, review our *Chiropractic and Osteopathic Treatments* (Administrative #138) and *Allergy Immunotherapy* (Administrative #100) reimbursement policies on our provider website: Policies & Guidelines>Reimbursement Policy.

# Medication policy updates

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

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

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

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

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

| Effective October 15, 2022 | Description |
|---|---|
| **New medication policy** | |
| Pluvicto, lutetium Lu 177 vipivotide tetraxetan, dru722 | - Limits coverage to patients with prostate-specific membrane antigen (PSMA)-positive, metastatic castration-resistant prostate cancer after progression of disease on taxane-based chemotherapy and at least one prior androgen receptor inhibitor |
| **Revised medication policies** | |
| Chimeric Antigen Receptor (CAR) T-cell Therapies, dru523 | - Added coverage criteria for the use of Kymriah in relapsed or refractory follicular lymphoma, a newly FDA-approved indication; the criteria mirror the follicular lymphoma (FL) criteria for coverage of Yescarta<br>- Added coverage criteria for the use of Breyanzi in relapsed or refractory diffuse large B cell lymphoma (DLBCL), a newly FDA-approved indication; the criteria mirror the DLBCL criteria for coverage of Yescarta<br>• Use in patients who are transplant ineligible is considered investigational and cannot be covered because of the lack of meaningful health outcomes evidence |
| Opdivo, nivolumab, dru390 | - Added coverage criteria for Opdivo as a combination therapy (with chemotherapy or Yervoy [ipilimumab]) for first-line treatment of locally advanced or metastatic esophageal squamous cell cancer (ESCC), based on new evidence and a new FDA-approved indication; limits coverage to ESCC that is not amenable to therapy with curative intent when used in the front-line setting in combination with standard-of-care chemotherapy or ipilimumab and when tumor PD-L1 expression is >1% |
| Prolia, denosumab, dru223 | - Added criteria for coverage of "very-high risk of fracture," despite completion of a full course of an anabolic bone medication |

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| Effective October 15, 2022 | Description |
|---|---|
| **Revised medication policies (continued)** | |
| Yervoy, ipilimumab, dru238 | - Added coverage criteria for Yervoy in combination with Opdivo (nivolumab) for first-line treatment of locally advanced or metastatic ESCC based on new evidence and a new FDA-approved indication; limits coverage to ESCC that is not amenable to therapy with curative intent when used in the front-line setting in combination with nivolumab and when tumor PD-L1 expression is > 1%<br>- Added use of Yervoy as a neoadjuvant therapy (prior to surgical excision) for resectable melanoma, either alone or in combination with other medications, as investigational; there is insufficient evidence to support this use at this time |

| Effective December 1, 2022 | Description |
|---|---|
| **New medication policies** | |
| Rearranged During Transection (RET) Inhibitors, dru726 | - New combination policy replacing individual policies for Retevmo (dru643) and Gavreto (dru653) with no change to criteria intent |
| Tyrosine Kinase Inhibitors (TKIs) for Gastrointestinal Stromal Tumors (GIST), dru725 | - New combination policy replacing individual policies for Ayvakit (dru624) and Qinlock (dru644) with no change to criteria intent |
| Vijoice, alpelisib, dru730 | - Limits coverage to patients with severe, life-threatening manifestations of PIK3CA-related overgrown spectrum (PROS) that are PIK3CA mutation positive, when prescribed in consultation with a specialist, when medical interventions (including sclerotherapy, surgery, laser, or radiotherapy) are not an option or have been ineffective, and prior therapy with sirolimus was ineffective, not tolerated or contraindicated |
| Ztalmy, ganaxolone, dru732 | - Limits coverage to the treatment of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) when at least 2 prior anti-convulsants have been ineffective or not tolerated |
| **Revised medication policies** | |
| Dupixent, dupilumab, dru493 | - Added coverage criteria for the newly FDA-approved indication for eosinophilic esophagitis (EoE). Limits coverage to patients with symptomatic biopsy-confirmed EoE steroids when prescribed by a specialist after highest tolerated dose of proton pump inhibitors (PPIs) and topical steroids have been ineffective or are contraindicated |
| Growth Hormone, dru015 | - Simplified laboratory criteria for confirmation of growth hormone (GH) deficiency with no change to intent |
| Lynparza, olaparib, dru389 | - Added coverage criteria for newly FDA-approved indication; limits coverage to patients with HER2-negative, early-stage breast cancer that is BRCA1/2 mutated, when prescribed by or in consultation with an oncologist, for patients who have previously received either neoadjuvant or adjuvant chemotherapy and are considered high risk |
| Non-preferred Testosterone Replacement Therapy Products, dru548 | - Added newly FDA-approved testosterone undecanoate products (Tlando and Kyzatrex) to policy as non-preferred |
| Opzelura, ruxolitinib cream, dru679 | - Use for the newly FDA-approved indication vitiligo will be considered cosmetic per contract definitions |

CONTINUED ON PAGE 13

CONTINUED FROM PAGE 12

| Effective December 1, 2022 | Description |
|---|---|
| **Revised medication policies (continued)** | |
| Pituitary Disorder Therapies, dru488 | - Added newly FDA-approved self-administered product Recorlev to policy; limits coverage to patients with endogenous Cushing's syndrome when prescribed by or in consultation with an endocrinologist, where surgery is not an option or has not been curative, and prior therapy with ketoconazole was ineffective<br>- Added newly available generic single source lanreotide to policy; coverage aligns with brand Somatuline<br>- Removed step through octreotide (Sandostatin LAR) in acromegaly for pediatric patients<br>- Simplified initial authorization quantity limits on octreotide (Sandostatin LAR) |
| Tagrisso, osimertinib, dru441 | - Broadened coverage for EGFR-susceptible mutations to include rare mutations based on National Comprehensive Cancer Network (NCCN) guideline updates |
| Tibsovo, ivosidenib, dru558 | - Added coverage criteria for patients with newly diagnosed acute myeloid leukemia with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation, a newly FDA-approved indication |
| Trientine-containing Products, dru417 | - Added newly FDA-approved Cuvrior (trientine tetrahydrochloride) to policy<br>- The use of Cuvrior is considered not medically necessary and therefore not covered because of the lack of proven additional benefit versus lower-cost similar agents |
| Xalkori, crizotinib, dru265 | - Added coverage criteria for immune myofibroblastic tumor (IMT) |
| **Archived medication policy** | |
| Vizimpro, dacomitinib, dru581 | - Vizimpro will no longer require pre-authorization |

| Effective January 1, 2023 | Description |
|---|---|
| **Revised medication policies** | |
| Non-preferred Intra-Articular Hyaluronic Acid Derivatives, dru351 | - Adding Synojoynt (1% sodium hyaluronate) to policy as non-preferred |
| Non-preferred Pegfilgrastim Products, dru563 | - Adding newly approved biosimilar Stimufend (pegfilgrastim-fpgk) to policy as non-preferred<br>**Related**: See *Pegfilgrastim coverage change* on page 14. |

| Effective March 1, 2023 | Description |
|---|---|
| **Revised medication policies** | |
| Medications for Hereditary Angioedema (HAE), dru535 | - Clarifying criteria for acute treatment<br>- Removing requirement for step therapy through attenuated androgens<br>- Adding step therapy requirement for Ruconest through Berinert<br>- Adding Sajazir (icatibant) to policy |
| CDK 4/6 Inhibitors for Breast Cancer, dru611 | - Removing step therapy requirement on Kisqali<br>- Adding step therapy requirement for Ibrance through Kisqali or Verzenio |

# Pegfilgrastim coverage change

As a reminder, **beginning January 1, 2023, Fulphila and Ziextenzo will be our preferred pegfilgrastim products; they will be the only pegfilgrastim products that do not require pre-authorization**.

### Pegfilgrastim pre-authorization (PA) requirements effective January 1, 2023

| Medication | PA required? | HCPCS code |
|---|---|---|
| **Fulphila** (pegfilgrastim-jmdb) | No | Q5108 |
| **Ziextenzo** (pegfilgrastim-bmez) | No | Q5120 |
| Nyvepria (pegfilgrastim-apgf) | Yes | Q5122 |
| Fylnetra (pegfilgrastim-pbbk) | Yes | unlisted |
| Stimufend (pegfilgrastim-fpgk) | Yes | unlisted |
| Udenyca (pegfilgrastim-cbqv) | Yes | Q5111 |
| Neulasta (pegfilgrastim) | Yes | J2506 |
| Neulasta Onpro (pegfilgrastim) | Yes | J2506 |

If your patient has an existing pre-authorization for one of the non-preferred medications (e.g., Neulasta) that extends past January 1, 2023, you do not need to submit a new pre-authorization request.

Members who currently use Udenyca will not be grandfathered. To continue to use pegfilgrastim without pre-authorization, you can prescribe either Fulphila or Ziextenzo. If the preferred products are not a treatment option and your patient needs to continue Udenyca beyond December 31, 2022, you must submit a pre-authorization request.

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

**Related:** See *Medication policy updates* on page 13.

# Simplifying formulary tier names

Drug tier names have historically described the category of medications found in each tier, such as generic, brand and specialty. However, basing formulary design on value and efficacy rather than drug category allows for more flexibility in formulary design to provide the highest value medications for members while containing medication costs. Effective January 1, 2023, tiers will no longer be categorized by type and may include both brand and generic medications, depending on efficacy and value.

# Avoid antibiotics for acute bronchitis and bronchiolitis

Over-prescribing antibiotics can have detrimental effects on the overall population and individuals, resulting in an increase of antibiotic-resistant infections and exposing people to avoidable adverse events. The CDC reports that more than 2.8 million antibiotic-resistant infections occur in the U.S. each year, and more than 35,000 people die as a result.

Acute bronchitis/bronchiolitis is a common condition that is generally self-limiting yet is often inappropriately treated with antibiotics.

A Healthcare Effectiveness Data and Information Set (HEDIS®) measure was created to monitor the antibiotic prescribing rate for acute bronchitis/bronchiolitis. This measure reports the percentage of members three months and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic prescription on the date of diagnosis or within three days of diagnosis. A higher rate indicates appropriate treatment for the condition (i.e., the percentage of episodes that were not prescribed an antibiotic).

Our providers rate well on the HEDIS measure for treating upper respiratory infections, but there is opportunity to improve rates for treatment for acute bronchitis and bronchiolitis. Our data indicates that more than 50% of acute bronchitis and bronchiolitis cases are not treated appropriately. Please consider this in your approach to treating acute bronchitis and bronchiolitis. Here are a few best practices to follow:

- Help patients and caretakers understand the difference between bacterial and viral infections.
- Educate patients and caretakers on home treatment to relieve acute bronchitis/bronchiolitis symptoms.
- For patients with a comorbid condition requiring an antibiotic prescription, be sure that documentation and coding accurately reflect the diagnosis code for the comorbid condition (or bacterial infection). Some examples of comorbid conditions include HIV, malignant neoplasm, emphysema, chronic obstructive pulmonary disorder (COPD) and immune system disorders.

If you would like copies of our *Using Antibiotics Wisely* and *Treatment for Acute Bronchitis/Bronchiolitis* flyers, available in English and Spanish, email us at **Quality@bridgespanhealth.com**.

# 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

## New forms for ABA and TMS services

New forms are now available for applied behavior analysis (ABA) and transcranial magnetic stimulation (TMS) pre-authorization requests:

- *Applied Behavioral Analysis (ABA) Initial Request Form*
- *Applied Behavioral Analysis (ABA) Concurrent Request Form*
- *Transcranial Magnetic Stimulation rTMS Request Form*—for both initial and concurrent TMS requests

These forms replace our previous *Behavioral Health Pre-Authorization Request Form* and are available on our provider website: Library>Forms.

## AbleTo offers personalized virtual therapy

Members 18 and older can access AbleTo's Therapy+ program, a structured, eight-week series of one-on-one therapy by phone or video with a licensed therapist and digital tools for support between sessions. People who have used AbleTo's services have reported clinically significant declines in depression, anxiety and stress, as well as dramatic improvements in workplace productivity.

This virtual cognitive behavioral therapy (CBT) program helps patients recognize and change behavior patterns. In 2023, AbleTo will add a digital self-help program available 24/7 to its Therapy+ program.

AbleTo's programs include the option for additional care, if needed, follow-up assessments and self-care tools.

Providers and members can search "AbleTo" in our Find a Doctor tool for contact information.

Members can also learn more about the program and schedule their first appointment at **ableto.com**.

# Get reimbursed for integrated care

We recognize the value of behavioral health integration (BHI) and encourage providers to participate in the Collaborative Care Model (CoCM) approach to treat and support members with complex needs.

According to the American Psychiatric Association (APA), among the BHI models, the CoCM has the most evidence demonstrating "its effective and efficient integration in terms of controlling costs, improving access, improving clinical outcomes and increasing patient satisfaction in a variety of primary care settings—rural, urban and among veterans."

The model consists of a team of three individuals delivering care: A PCP, a behavioral health care manager and a psychiatrist. Its integrated behavioral health services include the following types of care:

- Counseling
- Medication support
- Care planning for behavioral health conditions
- Ongoing assessment of the patient's condition
- Other recommended treatment, if needed

**We encourage integration of behavioral health providers into primary care homes and reimburse behavioral health services provided in the primary care setting, including CoCM codes CPT 99492-99494 and HCPCS G2214**.

### Resources

- Review our *Collaborative Care Codes* (Behavioral Health #100) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.
- The *Behavioral Health Integration Services* booklet from CMS discusses the roles of care team members and CoCM service components, as well as providing full code descriptors: **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf**.
- The APA has information about the CoCM and reducing inequities in care, as well as providing CoCM training for PCPs, behavioral health care managers and psychiatrists: **psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn**.

# Help your patients stop smoking

Tobacco use is the leading cause of preventable disease, disability and death in the U.S., accounting for more than 480,000 deaths per year, according to the CDC. Cigarette smoking is linked to diseases of nearly all organs of the body, particularly cardiovascular, metabolic and pulmonary diseases.

As a health plan, the rate at which our members are advised to quit smoking is measured. Currently, our score for this measure is lower than national benchmarks, indicating that this is an area of opportunity for us. Our providers play a key role in helping patients decrease tobacco use by encouraging them to use smoking cessation tools and resources.

A team approach is the best way to treat tobacco use and dependence. Integrating treatment into the routine clinical workflow and engaging the entire health care team in treatment delivery can make a difference. Here are some suggestions:

- Advise patients to quit.
    - Talk to patients at every visit about their tobacco use. Even brief advice can influence a patient's decision to quit smoking.
    - Advise patients that quitting is one of the most important things they can do to improve their health and prognosis.
    - Remind patients that it is never too late to quit smoking. Quitting is beneficial at any age.
    - Provide patients support, regardless of their readiness to quit.
- Offer a combination of counseling and medications for treatment.
- Refer patients to additional support (e.g., cessation resources and programs in your health system and community).
- Follow up.
    - Assess your patients' progress over time and provide additional support. It may take several attempts for them to quit smoking.
    - Try new strategies (e.g., new medications the patient hasn't tried, medication combinations or new approaches to handling triggers).
    - Provide ongoing support to encourage members to quit.

### Resources

**Healthwise Knowledgebase flyers**
The Healthwise Knowledgebase has several helpful resources for you and your patients:

- *Quitting Smoking: My Quit Plan*
- *Quitting Smoking: My Reasons to Stop*
- *Quitting Smoking: Track Your Triggers*
- *Smoking: Should I Take Medicine to Quit*

The flyers are designed to reinforce learning objectives after a coaching encounter. They use motivational interviewing and behavioral science techniques to help members. They can also be made available for patients to review in the waiting room before an appointment. For copies of these Healthwise materials, available in English and Spanish, email **Quality@bridgespanhealth.com**.

**CDC website**
The CDC also has information about tobacco use, including resources to help people quit using tobacco: **cdc.gov/chronicdisease/resources/publications/factsheets/tobacco.htm**.

# Help patients manage their weight

As a provider, you play a vital role in helping patients better understand how maintaining a healthy weight can reduce the risk of diseases and health conditions, including type 2 diabetes, heart disease, high blood pressure, arthritis, sleep apnea and stroke.

Patients may have a hard time talking about their weight. You may want to start with mentioning the health risks associated with obesity and being overweight and ask if you could talk to them about how weight impacts their overall health. Mental and emotional health are also factors in maintaining a healthy weight. Consider connecting patients to in-network behavioral health providers. Members can find in-network behavioral health providers and vendors that offer virtual care services by logging in to their member account on **bridgespanhealth.com**.
**Related**: See *On-demand care options* on page 18.

Measuring your patients' body mass index (BMI) regularly may help you identify who may benefit from weight loss information and counseling. Your electronic medical record system may include an alert that will automatically calculate the BMI. When coding for obesity, code for both the obesity diagnosis (e.g., ICD-10 E666.1-E666.3, E666.8 and E66.9), as well as the BMI Z codes.

The Healthwise Knowledgebase has several helpful resources for you and your patients. For copies of Healthwise materials about weight management, available in English and Spanish, email **Quality@bridgespanhealth.com**.

# On-demand care options

We offer members several options for access to medical care via phone, video, chat or at the member's location. These options can be affordable alternatives to the ER or urgent care for some health needs.

Our members have coverage for telehealth services provided through in-network providers. In addition, we contract with vendors to provide members on-demand urgent, primary and behavioral health virtual care options.

**Doctor on Demand** is a national telehealth vendor that provides urgent medical care services, 24/7/365, across all 50 states, as well as scheduled behavioral health services for talk therapy and psychiatry. All providers are licensed and board certified. Available via audio or video, BridgeSpan members can access these services using a web browser or mobile device. The telehealth providers can send prescriptions to a local pharmacy and in some cases, send lab orders. In 2023, Virtual Primary Care (VPC) via Doctor on Demand will be on some plans.

With **DispatchHealth, dispatchhealth.com**, members can avoid a trip to the ER and receive urgent medical attention from the comfort of their home. After requesting care, a team of trained emergency medical professionals, a physician assistant or nurse practitioner and a medical technician, will arrive at the member's location. Among the conditions DispatchHealth can treat are chronic obstructive pulmonary disease and exacerbations; severe cold and flu symptoms; urinary tract infection; breaks, sprains and bruises; lacerations, abrasions and infections; mild to moderate stomach pains, nausea, vomiting and dehydration. The medical team can run onsite labs and order additional services such as X-rays and prescriptions. It is a reliable, convenient way for members to receive in-home care at a similar cost to receiving services at an urgent care facility. DispatchHealth is available in the following areas:

- Boise, Idaho
- Portland, Oregon
- Olympia, Washington
- Seattle, Washington
- Spokane, Washington
- Tacoma, Washington

Members can view a list of in-network providers, including behavioral health providers, and view their on-demand care options through their **bridgespanhealth.com** member account and checking their Resources.

# Changes to DME coverage for CGMs

As a reminder, DME coverage for continuous glucose monitors (CGMs) will transition to a pharmacy-only benefit in 2023. This change will apply members with both medical and pharmacy benefits through BridgeSpan.

As plans renew on or after January 1, 2023, medical benefits will state that non-therapeutic CGM machines are excluded as a treatment option and cannot be billed as medical. Pharmacy benefits will also only cover therapeutic machines and supplies.

- Beginning January 1, 2023, Medtronic will no longer be a covered CGM supply brand.
- Dexcom and Freestyle Libre are comparable products and can be conveniently purchased from a pharmacy without pre-authorization.
- Members using a Guardian CGM will need to switch to Dexcom or Freestyle Libre by January 1, 2023, and members will need to request a new pharmacy prescription from their provider.

This change does not apply to children younger than six who meet criteria for an insulin pump.

# Earn incentives through our QIP

Our Quality Incentive Program (QIP) rewards PCPs who provide timely, evidence-based preventive care to patients. PCPs can earn a per gap incentive for closing care gaps in the program's Quality Rating System (QRS) measures.

As a PCP, you can review identified quality care gaps for patients attributed to you as part of your pre-visit planning by using our Care Gap Management Application (CGMA) through Novillus LLC.

### Dates to remember

As a reminder, our 2022 QIP program ends December 31, 2022. Providers currently participating in the program should continue to close gaps through December 31, 2022. We will issue incentive payments by June 30, 2023, for the 2022 QIP.

The 2023 QIP will begin January 1, 2023, and will provide incentives for gaps closed during 2023. There are no changes to the program and the same list of incentives will be used.

### Identifying and closing gaps

To identify and close gaps for this program:

- Locate each patient in the CGMA as part of your pre-visit planning. The tool will identify care gaps for patients attributed to you to help you schedule screenings or chronic condition management services.
- Refer your patient for any procedures or tests that cannot be completed in your office.
- Ensure that your medical record documentation for each visit is complete.
- Submit a claim for the date of service with all appropriate diagnosis and procedure codes that were part of the visit. Most QRS gaps for members must be closed via claim submission.

### How to access the CGMA

To get access to the CGMA tool and start closing gaps, email **QIPQuestions@bridgespanhealth.com** the following information about the new CGMA user:

- First and last name
- Title
- Phone number
- Email address
- Provider group name
- Provider group TIN(s)

### Learn more

For more information about the program, including the list of individual incentive measures, eligibility and gap closure tips, visit our provider website: Programs> Quality Incentive Program.

## Resources for you

Use our Self-Service Tool, available 24/7, to review helpful answers to our most frequently asked questions and quickly navigate our provider website resources.


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