FEBRUARY 2022

Provider News

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

Help reduce hypertension and risk for heart disease

February is American Heart Month and is observed to help raise awareness about cardiovascular health. The principal risk factors for heart disease include high blood pressure, high cholesterol, smoking and obesity. According to the Centers for Disease Control and Prevention (CDC), nearly half of adults in the U.S. have high blood pressure and only about one in four people with high blood pressure have their condition under control.

Rates of high blood pressure control vary

Uncontrolled high blood pressure is common. However, certain groups of people are more likely to have high blood pressure:

- A greater percentage of men (50%) have high blood pressure than women (44%).
- High blood pressure is more common in non-Hispanic black adults (56%) than in non-Hispanic white adults (48%), non-Hispanic Asian adults (46%) or Hispanic adults (39%).
- Among those recommended to take blood pressure medication, blood pressure control is higher among non-Hispanic white adults (32%) than in non-Hispanic black adults (25%), non-Hispanic Asian adults (19%) or Hispanic adults (25%).

We encourage you to educate your patients with hypertension on the importance of tracking their blood pressure, taking prescribed medications, if appropriate, and implementing lifestyle changes to reduce their risk of the disease. To identify patients who are due for follow-up appointments, use registries within your electronic medical record to review dates of past prescription refill requests and the last office visit note for follow-up instructions.

For all office visits, we recommend you submit blood pressure results on your claims using CPT level II codes to lessen our requests for medical records and to support our quality reporting for Healthcare Effectiveness Data and Information Set (HEDIS®).

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Easily find information

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

Subscribe today

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

Using our website

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

Stay up to date

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

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■ Critical update ⁎ Behavioral health must read ▲ Dental must read ‡ Rehabilitation 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.

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Million Hearts

Million Hearts® 2022 is a national initiative to prevent one million heart attacks and strokes within five years. It focuses on implementing a small set of evidence-based priorities and targets that can improve anybody's cardiovascular health. The initiative brings together communities, health systems, nonprofit organizations, federal agencies and private sector partners from across the country to fight heart disease and stroke. We invite you to join in this initiative. You can learn more and find helpful resources on the Million Hearts website: **millionhearts.hhs.gov**.

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.

Subscribe today

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

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**.

Annual HEDIS medical record collection

Our HEDIS medical record reviews for measurement year 2021 will begin this month, continuing through May 2022. We have contracted with Inovalon to contact providers and collect data using a HIPAA-compliant process. We appreciate your help during this process and 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 us or our vendor access to member records 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.

Self-Service Tool

Our Self-Service Tool gives you the information you need, on demand, online 24/7. Review helpful answers to our most frequently asked questions and quickly navigate our website resources—all without the need to call or email for help. Easily access the tool in the Quick Links section of our provider website.

Administrative Manual updates

The kidney health program information in our Medical Management section was updated February 1, 2022.

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

Pricing disputes versus appeals

We created a new pricing dispute workflow, intake form and response team to address the number of pricing disputes being incorrectly submitted as appeals. By reducing the number of intake points for pricing disputes, we can ensure the most efficient handling.

We respond to pricing disputes submitted using our new *Pricing Dispute Form* within 30 days. When pricing disputes are incorrectly submitted as an appeal, they can take up to 50 days for a response and will require the provider to resubmit the issue using the pricing dispute process.

To receive the most efficient response, submit your pricing dispute using the correct process and validate your dispute against available resources.

Pricing disputes occur when contracted providers disagree with our decision about how a claim or claim line was processed. Some examples include disagreeing with the:

- Allowed amount on a claim line
- Percent of billed charges paid
- Diagnosis-related group (DRG) on a facility claim

Appeals may concern:

- Adverse determinations
- Provider contract termination
- External audit and investigation
- Medical or reimbursement policy reconsideration

Learn more on our provider website: Claims & Payment> Payment>Appeals. For help determining which process to follow, contact our Provider Contact Center.

Directory attestation to be required every 90 days

Accurate provider directories are essential for members to use when making informed health care decisions. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills. The Consolidated Appropriations Act (CAA), 2021, effective January 1, 2022, requires health plans to establish a process to verify and update provider directory information no less frequently than every 90 days. Accurate provider directories are also a requirement for compliance with the Centers for Medicare & Medicaid Services (CMS), the Affordable Care Act (ACA) and your agreement as a network provider with BridgeSpan.

Effective March 1, 2022, our *Provider Directory Attestation Requirements for Providers* policy will require:

- 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
- All participating providers to comply with BridgeSpan 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)
- Providers to review, update and return roster validation requests from BridgeSpan

Failing to verify directory information is grounds for removal from our provider directory and/or termination of the provider's agreement with BridgeSpan.

We are researching ways to make the process of validating directory information as easy as possible, including launching a tool on Availity Essentials. If you or your organization do not already have an Availity Essentials account, please register at the tax ID level today at **availity.com**.

View our *Provider Directory Attestation Requirements for Providers* policy and instructions for verifying your directory information on our provider website: Contact Us> Update Your Information.

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.

We require verification of your practice information and the networks you participate in at least once every 30 days through February 28, 2022. Beginning March 1, 2022, you will need to validate your practice information no less frequently than every 90 days.

Validate your practice information

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.

Reminder: Include place of service on professional claims

Professional claims billed with a facility place of service code require the facility's National Provider Identifier (NPI) to process the claim accurately. Including the NPI allows us to process the claim timely and ensure that our members are receiving the appropriate benefit, including balance billing protection when applicable.

Effective January 1, 2022: Professional claims from out-of-network providers that identify a place of service (inpatient/outpatient hospital, ambulatory surgical center, emergency room, inpatient psychiatric facility, psychiatric facility partial hospital and comprehensive inpatient rehabilitation facility) but do not reflect the facility NPI number will be denied back to the provider. The denial code (GVH) will indicate: "Place of service requires service facility information."

Note: The service location should not be the same as the billing provider NPI.

When appropriate, the service facility NPI should be included in loop 2310, segment NM109 on an ANSI 837P claim.

A facility NPI can be provided by the facility or by searching the National Plan & Provider Enumeration System (NPPES), **npiregistry.cms.hhs.gov**.

All providers are responsible for submitting accurate and complete claims for all medical, dental and surgical services, supplies and items rendered to members using industry standard coding guidelines. Please refer to the *Correct Coding Guidelines* (Administrative #129) reimbursement policy on our provider website: Library>Policies and Guidelines>Reimbursement Policy.

Health care provider requirements regarding surprise medical billing

Effective January 1, 2022, the No Surprises Act established new federal protections against most surprise out-of-network (OON) medical bills.

Section 104 of the No Surprises Act states that out-of-network health care providers (including facilities, physicians and other health care professionals) may not balance bill patients for covered emergency services or certain covered non-emergency services provided at in-network facilities unless certain conditions are met. Health care provider requirements regarding surprise medical billing:

- Prohibit OON facilities providing emergency services and out-of-network providers at in-network facilities from balance billing patients
- Permit OON providers to continue to balance bill if they give the patient written notice that includes all of the following information:
    - Their network status
    - A list of in-network providers at the facility
    - Information about pre-authorization or care management limitations
    - An estimate of charges 72 hours prior to receiving the OON care
    - **Note**: The patient must also provide consent to receive the OON care for a provider to balance bill.
- Do not apply to providers furnishing ancillary services in the exception and prohibit them from balance billing patients with or without consent regardless of their specialty; ancillary services include emergency medicine, anesthesiology, pathology, radiology, laboratory, neonatology, hospitalists, assistant surgeons and intensivists.
- Prohibit using the notice and consent option in instances where the OON provider is the only provider at the in-network facility who can perform the service (i.e., the patient cannot choose someone in-network).
- State law does not allow Washington providers to obtain notice and consent.

Learn more about the No Surprises Act on the CMS website: **cms.gov/nosurprises**.

EFT required

Effective May 1, 2022, we will require all participating providers to receive claims payment via electronic funds transfer (EFT). Failure to receive claims payment via EFT is grounds for termination of the provider's agreement with us. Use the Transaction Enrollment tool in Availity Essentials to enroll today at **availity.com**: My Providers>Enrollments Center>Transaction Enrollment. The Transaction Enrollment dashboard will display the status and progress of your enrollments.

Notes:

- Only your organization's administrator, administrator assistant and users with the Transaction Enrollment role may enroll for EFT and change or update EFT setup.
- For security purposes, our EFT enrollment team will call you to validate the information you provide.
- If your EFT enrollment was completed prior to April 2021, your dashboard will not reflect that you are currently setup for EFT—only organizations that enrolled for EFT after April 2021 will show on the dashboard.

Learn more about EFT and view a step-by-step guide to enrolling or changing your EFT setup on our provider website: Claims & Payment>Receiving Payment.

Availity tips for authorizations

Use the Authorization tool in Availity Essentials, **availity.com**, to quickly see if a pre-authorization is required for a medical service and to submit your medical pre-authorization request. Some procedures may receive instant approval.

Pre-authorizations through third-party vendors

Pre-authorizations for sleep medicine, physical medicine or complex radiology services can be started in the Availity Authorization tool. If the authorization needs to be completed with a third-party vendor, such as AIM Specialty Health (AIM) or eviCore healthcare (eviCore), the user will be routed to the appropriate site to complete the request. If errors are received after being routed to the third-party site, the user must contact the vendor directly.

Coodination of benefits (COB) error during a medical pre-authorization request

Occasionally, if a member has a dental plan as primary in our claims system, the medical pre-authorization request cannot be completed and the user will receive an error message during the member eligibility check. When this occurs, the user will need to submit the request manually via our provider website: Pre-authorization.

Authorization attachment limitations

Acceptable file types for attachments are TIF, JPG, PDF, and DOCX. Acceptable file size must be less than 60 MB, and the total combined size of all attachments for a single request cannot exceed 150 MB.

Get free training

View the training options available by clicking the Watch a demo link in the Authorizations tool.

Learn more about electronic pre-authorizations on our provider website: Pre-authorization> Electronic Authorization.

Look for more Availity Essentials tips in our April 2022 newsletter.

Behavioral health corner

Inpatient behavioral health to require new forms

Effective May 1, 2022, we will require providers to submit a behavioral health intake form for the following:

- Initial intake
- Concurrent review
- Stepdown request to a lower level of care
- Discharge confirmation

Standardizing our behavioral health utilization management process will greatly reduce the turnaround time needed for reviews and approvals.

The new forms will be available on our provider website in April 2022. You will be able to submit them to our behavioral health team by email or fax. Additionally, initial intake forms can be attached to new initial pre-authorization requests in Availity Essentials, **availity.com**.

Look for additional information, including where to find the forms on our provider website, in the April 2022 issue of this newsletter.

ABA reimbursement update

Effective May 1, 2022, we will update reimbursement rates for applied behavior analysis (ABA) services.

The updated reimbursement rates will be posted by May 1, 2022, in Availity Essentials, **availity.com**: Claims & Payment>Fee Schedule Listing> Fee Schedules. Select the plan name and then enter the organization, tax ID and NPI. Click Next. Select the Actions button on the right to enter specific codes or a code range.

About behavioral health corner

Behavioral health corner is a new section in which we highlight 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.

This newsletter contains the following articles that pertain to behavioral health care.

We also recommend you review the following articles because they often have policy updates that may affect your practice.

Pre-authorization updates

Procedure/medical policy	Added codes effective January 1, 2022
Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer (Genetic Testing #42)	81523
Bariatric Surgery (Surgery #58)	43845
Chromosomal Microarray Analysis (CMA) or Copy Number Analysis for the Genetic Evaluation of Patients with Developmental Delay, Intellectual Disability, Autism Spectrum Disorder, or Congenital Anomalies (Genetic Testing #58)	81349
Digital Health Products (Medicine #175)	0702T, 0703T
Digital Health Products for Attention Deficit Hyperactivity Disorder (Medicine #175.01)	0702T, 0703T
Digital Health Products for Substance Use Disorders (Medicine #175.02)	0702T, 0703T
Evaluating the Utility of Genetic Panels (Genetic Testing #64)	81349
Gait Analysis (Medicine #107)	0693T
Gender Affirming Interventions for Gender Dysphoria (Medicine #153)	54400, 54401, 54405, C2622
Genetic and Molecular Diagnostic Testing (Genetic Testing #20)	81349
Genetic Testing for the Evaluation of Products of Conception and Pregnancy Loss (Genetic Testing #79)	81349
Genetic Testing; Reproductive Carrier Screening for Genetic Diseases (Genetic Testing #81)	81161
Hypoglossal Nerve Stimulation (Surgery #215)	64582, 64583
Invasive Prenatal Fetal Diagnostic Testing for Chromosomal Abnormalities (Genetic Testing #78)	81349
Laser Interstitial Thermal Therapy (Medicine #177)	61736, 61737
Preimplantation Genetic Testing of Embryos (Genetic Testing #18)	81349
Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy of Intracranial, Skull Base, and Orbital Sites (Surgery #213)	77301, 77338
Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy for Tumors Outside of Intracranial, Skull Base, or Orbital Sites (Surgery #214)	77301, 77338
Transcutaneous Bone-Conduction and Bone-Anchored Hearing Aids (Surgery #121)	69716, 69719, 69726, 69727
Procedure/medical policy	**Added codes effective March 13, 2022**
Radiology: AIM Specialty Health	0042T, 0648T, 0649T
Procedure/medical policy	**Added codes effective April 1, 2022**
Negative Pressure Wound Therapy in the Outpatient Setting (Durable Medical Equipment #42)	CPT 97605-97608; HCPCS E2402

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 Availity Essentials, **availity.com**. Learn more on our provider website: Pre-authorization>Electronic Authorization.

Pre-authorization requirements to end for chiropractic, acupuncture and massage services

Pre-authorization will no longer be required for most chiropractic, acupuncture and massage services delivered April 1, 2022, or later. Currently, providers submit pre-authorization requests for these services to eviCore.

Pre-authorization will still be required for services occurring through March 31, 2022.

Use Availity Essentials, **availity.com**, to check whether services require pre-authorization.

Telehealth reminders

Our *Virtual Care* (Administrative #132) reimbursement policy was updated on January 1, 2022.

Updates to the policy include, but are not limited to:

- Claims for eligible telehealth services must be billed with place of service (POS) 02 or POS 10, as appropriate, and modifier GT. The updated policy includes the procedure codes that will be considered telehealth when billed with the appropriate POS modifier. View the CMS guidelines for the appropriate use of the POS codes at **cms.gov/files/document/mm12427-newmodifications-place-service-pos-codes-telehealth.pdf**.
- Claims for audio-only telehealth services should use modifier FQ.
- **Washington providers**: The policy includes the definition of an established provider-patient relationship and the requirement of the established relationship for audio-only services. Member consent must be obtained and documented in the medical record prior to a virtual service performed using audio-only technology.
- Providers must be licensed in both the state where the member is located, as well as the state where the provider is physically located.

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

Notification about the update to this policy was also included in the February 2022 issue of *The Bulletin*.

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 December 2021 issue of *The Bulletin* about changes to the *Extracorporeal Membrane Oxygenation (ECMO) for the Treatment of Cardiac and Respiratory Failure in Adults* (Medicine #152) medical policy, which are effective March 1, 2022.

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

- *Bariatric Surgery* (Surgery #58)
- *Negative Pressure Wound Therapy in the Outpatient Setting* (Durable Medical Equipment #42)

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 December 2021 issue of *The Bulletin* about changes to the *Associated Claims* (Administrative #119) reimbursement policy, which are effective March 1, 2022.

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

- *Cellular and Gene Therapy Products* (Medicine #112)
- *Modifier 90; Reference (Outside) Laboratory* (Modifiers #118)
  - We updated our January 2022 bulletin on January 4 to add the following statement: Laboratory codes submitted with modifier 90 when billed by a physician or other qualified health care provider will result in a recommended denial because of a ClaimsXten edit.

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.

Vitamin D testing reminder

We cover vitamin D testing for members with a clinically documented underlying disease or condition which is specifically associated with vitamin D deficiency or decreased bone density or in the evaluation or treatment of conditions associated with defects in vitamin D metabolism.

The U.S. Preventive Services Task Force (USPSTF) and the Institute of Medicine have found a lack of evidence to support routine testing for vitamin D levels in healthy patients. Therefore, we do not cover routine testing for vitamin D levels in otherwise healthy patients because it is not considered medically necessary. Billing for services that are not medically necessary will be denied as a provider write-off. Verify member benefits using the Patient Cost Estimator Tool on Availity Essentials, **availity.com**.

For more information, view the following resources on our provider website:

- Coding Toolkit: Claims & Payment: Coding Toolkit> Other Edits>Other Specific Edits
- *Vitamin D* (Laboratory #52) medical policy: Library>Policies & Guidelines>Medical Policy

Medication policy updates

Effective June 1, 2022, we are updating the following medication policies:

- *Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors* (dru621)
  - Coverage of Susvimo will require a trial of bevacizumab and Lucentis
- *Interleukin-1 Antagonists* (dru677)
  - For existing utilizers new to the Plan, clarifying Continuation of Therapy (COT) criteria; adding step therapy requirement with anakinra (Kineret) when medically reasonable
  - For new starts, adding step therapy with anakinra (Kineret) for periodic fever syndromes [CAPS (NOMID, MWS, FCAS), FMF, TRAPS, HIDS/MKD] and DIRA, as the lowest-cost IL-1 antagonist

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

Strive Health kidney care expands to Idaho, Utah and Washington

Strive Health is our new kidney health management partner for members living in Idaho, Utah and Washington. We partnered with Strive in 2021 to serve members in Oregon and Clark County, Washington. Strive began contacting providers with eligible members in Idaho, Utah and Washington in January 2022.

In this time of unprecedented health system constraints, this program supports providers and their patient care plans. It also helps members with chronic kidney disease (CKD) stages 3 to 5 or end-stage renal disease (ESRD) by providing a continuum of care management and direct clinical care as their disease progresses.

Partnering for wraparound care

Kidney care sometimes focuses on dialysis alone after a patient's health has deteriorated, but Strive's goal is to engage members early and throughout their entire kidney care journey, supporting modality choice aligned with each member's needs. Early identification and high-touch engagement:

- Improves health outcomes
- Simplifies the member's experience
- Lowers health care costs

Strive partners with the patient's primary care provider (PCP) and/or nephrologist to provide wraparound care and to ensure effective care coordination. They assist patients with adherence to providers' care plans, acting as an extension of that provider's services. Strive does not replace the PCP and/or nephrologist; instead, it deploys a multi-disciplinary team to provide high-touch support to patients between provider visits. Strive will contact you about your eligible patients to discuss how they can best support your care plan, but most of their outreach is member-focused.

Eligible members can receive assistance with finding cost-effective and convenient dialysis and kidney transplant options. Support is customized to fit the patient's needs and preferences.

Members may choose to opt out of Strive's program.

Related: See *Administrative Manual updates* on page 3.

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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