** See page 3 for changes at the end of the PHE.

APRIL 2023

Provider News

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

National Healthcare Decisions Day

National Healthcare Decisions Day, observed annually on April 16, aims to inspire, educate and empower all of us to share our preferences for medical treatment should an unexpected illness occur.

We encourage you to begin or continue advance care planning (ACP) conversations with all your patients as part of the preventive and treatment services you provide.

We reimburse providers who bill for ACP conversations with members, regardless of age or health status.

ACP conversations may include:

- Designating a medical decision-maker
- Discussing current medical status and prognosis
- Discussing important personal elements that often influence treatment choices (e.g., personal values, social, cultural and spiritual beliefs)
- Reviewing, editing or creating documents, such as an advance directive, durable power of attorney or POLST/MOLST form

Serious Illness Messaging Toolkit

Terms like hospice, palliative care and advance care planning can be confusing to patients. The Serious Illness Messaging Toolkit includes tips for how to talk about serious illness using evidence-based research. The toolkit is available at **seriousillnessmessaging.org/using-the-toolkit**.

Other resources

- Our provider website: Programs>Medical Management>Personalized Care Support
- National POLST Paradigm: **polst.org**
- The Conversation Project: **theconversationproject.org**
- Vital Talk: **vitaltalk.org**

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
2890 E Cottonwood Parkway Salt Lake City, UT 84121

Contents

■ Critical update ✶ Behavioral health must read ▲ Rehabilitation 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**.

What you need to know about the end of the public health emergency

On January 30, 2023, the Biden administration announced the intent to end the federal public health emergency (PHE) at 11:59 p.m. on May 11, 2023. Included below are the member benefit and provider reimbursement changes that will occur for dates of service on and after May 12, 2023.

Benefits that will roll back to non-PHE status

- COVID-19 testing performed in the provider's office and treatment will be covered at regular plan cost shares for in- and out-of-network services.
- Out-of-network COVID-19 testing claims will be priced at allowed amounts rather than a negotiated or cash price. For commercial members, balance billing may apply depending on the service.
- We will return to our standard credentialing process for locum tenens and expedited credentialing.
- **Washington only**: We will no longer cover costs for personal protective equipment.
- We will no longer cover over-the-counter (OTC) tests.

Benefits that will be updated based on federal guidance

- COVID-19 vaccines will be covered as preventive care, with no member cost share for in-network services, and the vaccines will be covered at regular plan cost sharing for out-of-network services. COVID-19 vaccines for Oregon members will be covered with no member cost share for in- or out-of-network services.
    - **Note**: Providers must submit claims for the vaccine using the appropriate codes.
- Paxlovid will be covered as a Tier 3 Preferred drug. All other antivirals will be covered as Tier 4.
- Telehealth:
    - We will continue to cover expanded telehealth services through December 31, 2024.
    - Some of the temporary telehealth services allowed during the PHE have been added to our Virtual Care (Administrative #132) reimbursement policies to permanently expand telehealth coverage to include such services as home visits, behavioral health counseling and therapy, nutritional counseling and more.
    - View our Virtual Care (Administrative #132) reimbursement policies: Library>Policies & Guidelines>Reimbursement Policy Manual.

Other PHE updates

We are still evaluating how the end of the federal PHE will impact other benefits and provisions, such as expanded timeframes for claim submission, appeals, special enrollment and premium grace periods.

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 the Centers for Medicare & Medicaid Services (CMS) and the Affordable Care Act (ACA).

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

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

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

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

Administrative Manual updates

The following updates were made to our manual sections on April 1, 2023:

Alternative Care

- Updated treatment plans section

Medical Management

- Updated company name for Carelon Medical Benefits Management (Carelon, formerly AIM Specialty Health)
- Added site of service requirements for joint surgeries

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

Audit vendors

CERIS will conduct post-payment review of implanted device claims for services delivered on or after April 1, 2023, and second-pass diagnosis-related group (DRG) claims for services delivered on or after July 1, 2023, on our behalf.

Additionally, Performant is conducting skilled nursing facility (SNF), emergency department evaluation and management (ED E&M) and initial DRG reviews on our behalf.

These 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 the vendor's findings, you can appeal to the appropriate vendor. Their contact information is provided on the determination letter. If recoupment is necessary, we will adjust a future claim payment.

Social determinants of health resources

We are working tirelessly to close health equity gaps to ensure simpler, better, more affordable health care for those we serve—from all backgrounds and walks of life. This includes collecting and tracking social determinants of health (SDOH) information about our members to understand barriers and support equitable access to quality health care and health education.

SDOH have a major impact on people's health, well-being and quality of life. Examples of SDOH include:

- Polluted air and water
- Language and literacy skills
- Racism, discrimination and violence
- Education, job opportunities and income
- Safe housing, transportation and neighborhoods
- Access to nutritious foods and physical activity opportunities

The SDOH ICD-10-CM Z codes make it possible to measure social risk factors and social needs. They add greater specificity to capture a more holistic view of a patient's health.

Resources

- CMS, 2023 ICD-10-CM updates: **cms.gov/medicare/icd-10/2023-icd-10-cm**
- CMS *ICD-10-CM Official Guidelines for Coding and Reporting*: **cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelinesupdated-01/11/2023.pdf**
- *Everything Payers Need to Know About the SDoH ICD-10 Code Expansion*: **https://f.hubspotusercontent40.net/hubfs/500440/ SDoH_Code_Expansion_White_Paper.pdf**
- ICD10data.com: **icd10data.com/ICD10CM/Codes/Z00-Z99**

Billing drug administration without a drug code

Reminder: Drug administration codes billed without an accompanying HCPCS drug code will be denied. When a provider bills the administration code and another provider is to be reimbursed for the drug code, the administering provider must include a charge on their claim with a phantom drug code for a penny ($.01) or less, depending on system limitations.

Medical record requirements

We would like to remind you of the following requirements and guidelines for medical record documentation and requests for review.

Record requests

We request medical records to support a variety of requirements and compliance activities, including claim review, risk adjustment, Healthcare Effectiveness Data and Information Set (HEDIS®), government required activities, audits and more. We often contract with vendors to obtain medical records for these purposes. It is your responsibility as a participating BridgeSpan provider to respond to these requests in a timely manner.

Note: Records submitted for review that are not properly authenticated or signed may be subject to claim recoupment. A provider may amend the record with a valid signature within 180 days of date of service.

Requirements

Each entry or page in the patient's medical record must include:

- The patient's name, date of birth and date of service to verify who the patient is and what date services were provided.
- The rendering provider's signature at the completion of the chart note, medical records, operative report or any other medical document in a patient's file. If an entry spans multiple pages, the signature is required at the end of the entry, but the patient identifiers must be on each page.
- **Note**: CMS has specific requirements for providers to include their electronic signature on electronic medical records. Each signature must include the provider credentials, provider name, date and time stamp.

In addition, the following should be included:

- Information on advance directives
- Specific and clear treatment plans
- Complete, accurate and legible documentation
- Complete history, examination and medical decisions
- Identification of all providers participating in the patient's care
- Diagnostic testing, laboratory tests, radiology reports and results
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Complete descriptions of the patient's concerns and reason for seeking medical care
- A problem list, including significant illnesses and medical and psychological conditions
- Evaluation and assessment of the provider's findings and a complete list of all diagnoses
- Information on allergies and adverse reactions or a notation that the patient has no allergies or history of adverse reactions

All medical records must be maintained for at least 10 years after the date of medical services. For more information about medical recordkeeping, please see the site review standards on our provider website: Programs> Quality Program>Site Review Standards.

Responding to documentation requests

If you receive a request for medical records or supporting documentation, please respond using the same format in which the request is received. If you receive a request via Availity Essentials, you must submit requested records using the Availity Attachments application.

To avoid claim-processing delays, please set up access to the Availity Attachments application today. This will ensure you receive notification and can submit documentation when requested.

Learn more on our provider website: Claims & Payment> Claims Submission>Claims Attachments.

Availity tips: EFT enrollment and tracking

We require participating providers to receive claims payment via electronic funds transfer (EFT). To enroll for EFT, use the Transaction Enrollment application on Availity Essentials: My Providers>Enrollments Center> Transaction Enrollment.

- To enroll, change a current enrollment or cancel a previous enrollment, click the blue **Enroll** button and choose **Enroll a provider** to begin the registration.
- After you submit the enrollment, we will receive the registration and begin validation.

For security purposes, our EFT enrollment team will contact you to confirm the information you provide. **You must confirm your enrollment details with us to complete the EFT enrollment process.**

Note: If your enrollment cannot be validated after multiple validation attempts, it may be rejected.

To see the progress of your EFT registration, view process notes or action items, be sure to check the Transaction Enrollment application until your enrollment is complete:

- Open the Transaction Enrollment application
- Apply filters as needed from the column on the left
- Click anywhere on your enrollment request
- Review process notes displayed under your request
- Make note of any actions you need to take

Learn more about EFT on our provider website: Claims & Payment.

Pre-authorization updates

Procedure/medical policy	Added codes effective March 1, 2023
Gender Affirming Interventions for Gender Dysphoria (Medicine #153)	15771, 15773
Procedure/medical policy	**Added codes effective April 1, 2023**
ClonoSEQ® Testing for the Assessment of Measurable Residual Disease (MRD) (Genetic Testing #88)	0364U
Expanded Molecular Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	0379U
Procedure/medical policy	**Adding codes effective July 1, 2023**
Surgical site of service – outpatient hospital	11755, 14040, 14060, 15850, 17311, 17313, 30130, 30140, 30520, 30802, 31200, 31205, 31525, 31574, 31591, 32408, 32555, 32557, 38221, 38222, 42821, 42826, 42831, 43260, 43261, 46505, 46607, 49082, 49422, 50430, 51715, 52001, 52235, 52287, 52450, 53445, 54150, 54161-54164, 54300, 54450, 54840, 55040, 55041, 55700, 56810, 57283, 58263, 62270, 63661, 63663, 64418, 64425, 64530, 64610, 64642, 64644, 64646, 64702, 64718, 64719, 64721, 64774, 64795, 64831, 65756, 65779, 65780, 65855, 66183, 66761, 66840, 66850, 67028, 67218, 68320
Ventral (Including Incisional) Hernia Repair (Surgery #12.03)	Code 15734 will require pre-authorization for diagnosis codes K42.0, K42.1, K42.9 K45.0, K45.1, K45.8, K46.0, K46.1, K46.9 and M62.0

Our complete *Pre-authorization List* is available in the Pre-authorization section of our provider website. Please review the list for all updates and pre-authorize services accordingly. You can submit standard medical pre-authorizations through the Availity Essentials Electronic Authorization application. Learn more on our provider website: Pre-authorization> Electronic Authorization.

Procedures at hospitals to require pre-authorization

In 2022, we began reviewing colonoscopy and endoscopy services when performed in an outpatient hospital setting. We are expanding these site-of-service pre-authorization requirements to include additional services where a lower level of care may be appropriate.

Effective July 1, 2023, select procedures affecting many specialties will require pre-authorization for the site of service when performed at an outpatient hospital surgical site:

- Digestive
- Genitals (male and female)
- Hematologic and lymphatic
- Integumentary
- Nervous
- Ophthalmologic procedures
- Respiratory
- Urinary

The sites of service will not require pre-authorization when performed at an ambulatory surgical center (ASC) or physician office. We consider an individual's health status, facility and geographic availability, specialty requirements, physician privileges and other factors when determining the appropriate site of service.

Related: View the list of codes in our *Pre-authorization updates* on page 7.

The *Surgical Site of Service – Hospital Outpatient* (Utilization Management #19) medical policy updates were announced in the April 1, 2023, issue of *The Bulletin*, available on our provider website: Library>Bulletins.

Save time and effort with Availity

For the fastest review, submit requests through Availity Essentials' Electronic Authorization application. Some requests will receive automated approvals. The Availity process incorporates additional questions related to site of service, so you don't need to fill out and submit the *Surgical Site of Service Additional Information Form*.

Submit the *Surgical Site of Service Additional Information Form* with faxed pre-authorization requests to provide attestation-based supporting documentation. **Failure to submit a completed and signed form will delay review.**

Additional information

The complete list of codes requiring pre-authorization and the *Surgical Site of Service Additional Information Form* for faxed requests are available on the Pre-authorization list on our provider website. In addition to the site of service, the services performed may require pre-authorization.

View the *Surgical Site of Service – Hospital Outpatient* medical policy on our provider website: Library> Policies & Guidelines>Medical Policy.

Radiology services don't require order number

Radiology requests no longer require an order number from Carelon, formerly AIM. If a provider requests an order number, they will receive the following message in Carelon's ProviderPortal:

"Based on the Date of Service entered, the selected member is currently not eligible for an Order ID. Please contact the health plan."

This message means the service does not require an order number or pre-authorization through Carelon. Providers do not need to call BridgeSpan.

Radiology requests may require additional documentation

Beginning July 1, 2023, Carelon (formerly AIM) may request additional clinical information for radiology pre-authorization requests for commercial and Medicare Advantage members. If requested, providers will need to submit documentation from the patient's medical record to demonstrate that services are clinically appropriate. Carelon will request this documentation only for select procedures when certain clinical indications are present. Examples include:

- CT of the sinuses for sinusitis
- CT of the chest for pulmonary nodules or as follow-up to previous imaging that indicated abnormality
- MRI of the brain for headaches
- MRI of a lower extremity for a tendon injury
- MRI of the lumbar spine as follow-up to previous imaging that indicated abnormality

This additional information will be requested during the provider's regular submission process. A request cannot be submitted unless the requested information is included, but you can save your entry to finish the request later.

Joint surgery pre-authorization changes delayed one month

eviCore healthcare (eviCore) will begin reviewing the site of service for outpatient hospital joint surgeries performed on or after June 1, 2023; this date is one month later than previously announced. These site of service reviews include codes that do not require pre-authorization for the service.

Joint surgeries should be performed in ambulatory surgical centers (ASCs) unless an outpatient hospital setting is medically necessary.

Provider website resources

- View our complete Pre-authorization List
- Physical Medicine program information: Programs>Medical Management>Physical Medicine

New diagnoses to require pre-authorization for hernia repair code

For hernia repair surgeries performed on or after July 1, 2023, CPT 15734 will require pre-authorization for the following ICD-10-CM codes:

- M62.0 for diastasis
- K42.0, K42.1, K42.9 for umbilical hernias
- K45.0, K45.1, K45.8, K46.0, K46.1, K46.9 for other abdominal wall hernias

CPT 15734 already requires pre-authorization for other diagnoses' codes.

This change is supported by our *Ventral (Including Incisional) Hernia Repair* (Surgery #12.03) medical policy.

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 information

No policy updates in the February or March 2023 issues of *The Bulletin* required 90-day notice.

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

Reimbursement policy updates

We provided 90-day notice in the March 2023 issue of *The Bulletin* about the new *Physician Concierge Services* (Administrative #130) commercial reimbursement policy, which is effective June 1, 2023.

We review reimbursement policies on an annual basis. View our *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

New specialty medication provider network coming

As stewards of our member's health care expenses, we are committed to delivering sustainable high-quality care to meet member needs. The price trend of many specialty medications has been growing at double the rate of inflation for years. This trend is even greater for provider-administered specialty medications in certain settings.

We've received increased requests for white-bagging solutions from employer groups. However, we feel providers should be part of the dispensing process, so we've designed a holistic solution, called BridgeSpan EquaPathRx™, that keeps the provider-patient relationship intact. We're one of the first health plans in our region to adopt this type of strategy. This approach has been successful in other parts of the country.

To move toward equitable and sustainable costs for provider-administered specialty medications in all settings, our pharmacy benefit manager, Prime Therapeutics, will launch IntegratedRx™ - Medical, a specialty medication provider network for BridgeSpan members, effective January 1, 2024. We'll also implement a new benefit for members to support this.

Join the Prime Therapeutics IntegratedRx - Medical Network

Beginning January 1, 2024, we'll require certain specialty medications for members included in BridgeSpan EquaPathRx to be fulfilled using the IntegratedRx - Medical Network.

Starting in April 2023, Prime will contact providers to begin the credentialing and contracting process for this new network.

- Each provider group or facility that offers administration of specialty medications will need to be credentialed and contracted as a dispensing provider with Prime Therapeutics.
- If your organization operates a specialty pharmacy that you want included in this network, they'll need to complete the credentialing and contracting process to be included, even if they have an existing pharmacy contract with Prime Therapeutics.
- Your contract with Prime will have a reimbursement schedule that includes the medications in the BridgeSpan EquaPathRx program.

How the new network will work

Effective January 1, 2024, we'll no longer provide coverage for select provider-administered medications except when obtained through the new IntegratedRx - Medical Network.

When you join the IntegratedRx - Medical Network, you'll be able to submit medication claims directly to Prime Therapeutics without patient interruption or a requirement to change administration sites. Prime will reimburse you for the medication at the rates on your Prime reimbursement schedule, and the medical claim for any administration-related services will still be submitted to BridgeSpan, as it is today. Participation in the network also:

- Ensures the claim meets payment criteria before you administer the medication
- Allows flexibility for provider procurement of medication; you can procure through existing methods, including 340B or specialty pharmacy as desired

If you don't join the IntegratedRx - Medical Network, you'll need to use a participating IntegratedRx - Medical Network specialty pharmacy to fill these medications in 2024.

Impacts to reimbursement for medications

We understand this change will impact reimbursement and operational processes for some medications, but it's necessary to ensure costs remain predictable and affordable for our groups and members—your patients.

We believe the Prime Therapeutics reimbursement schedule for the IntegratedRx - Medical Network is fair and reasonable to accomplish that goal with the least interference to your current processes for prescribing and administering these specialty medications. **Participation in the IntegratedRx - Medical Network won't affect your ability to use the 340B pathway to acquire medications.**

The list of medications (with HCPCS and NDC codes) that will be included in this program effective January 1, 2024, is available on our provider website: Programs>Medical Management>Pharmacy

What's next

We'll share more information about BridgeSpan EquaPathRx throughout 2023. Look for these communications:

- The October 2023 issue of *Provider News* will include more information about BridgeSpan EquaPathRx, including medication policy changes and product updates for 2024.
- The October 2023 issue of *The Bulletin* will include any related updates to reimbursement or medical policies.

In addition, later this year, we'll work with Prime to provide instructions to verify member benefits and detailed claim submission instructions, including training opportunities for you and your staff.

We value the care and consideration you give to our members, especially as we work together to ensure economically sustainable, high-quality care is available with providers our members know and trust. We look forward to your inclusion in the IntegratedRx - Medical Network.

Medication policy reminders

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 website: Programs>Medical Management>Pharmacy.

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: Policies & Guidelines> Reimbursement Policy.

Improving members' experience with medications

There are many factors that influence members' experience with obtaining medications and adhering to their treatment plan. We are working to increase the support and assistance we offer for members to improve their health outcomes and experience.

Reasons your patient may not be taking medications you prescribed

Sometimes members are prescribed medications they cannot obtain for various reasons (e.g., cost, nonformulary, pre-authorization or step therapy requirements or medications excluded from coverage.) These barriers can lead to untreated or poorly controlled conditions and impact the quality of care the patient feels they received.

Look for the **Medications and member experience with medications** category in the Quality Improvement Toolkit, available in the Toolkits section on the home page of our provider website. The toolkit includes best practices and action items, along with a variety of flyers you can share with your patients.

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

Behavioral health toolkit for the primary care setting

Proper mental health and substance use treatment are integral to a person's overall health. We recognize that PCPs serve a vital role in discussing, diagnosing and treating behavioral health conditions.

Our behavioral health toolkit includes condition-specific screening tools and trusted resources for 12 diagnoses or challenges, as well as information about:

- In-network virtual care providers
- Our care management services, including case management
- Determining the best path forward in the early stages of a patient's evaluation and treatment
- Ongoing condition management

The toolkit is available on our provider website: Behavioral Health>Behavioral Health Toolkit.

Understanding incident-to services rules for behavioral health services

Incident-to services help us meet member's care needs by expanding the provider types that can provide services. In incident-to scenarios, the supervising provider bills for services, and claims process according to the supervising provider's agreement.

Supervision requirements

Providers rendering services via incident-to billing criteria must be supervised by a credentialed provider with equal or higher-level education.

Provider searches

If your patient asks whether they can receive in-network services from a provider not in our network, let them know the associate provider is considered in-network when rendering services under a supervision arrangement with an eligible behavioral health provider.

Providers rendering incident-to services aren't eligible to submit their own claims, and therefore, won't appear in a provider search. However, the credentialed provider under which the associate provider performs incident-to services will appear in a provider search.

More information

- The CMS Physician Fee Schedule: **cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched**
- View the *Incident to Services* (Administrative #148) reimbursement policy in our *Reimbursement Policy Manual*: Policies & Guidelines>Reimbursement Policy

Telehealth can support PCP and facility care

Timely access to behavioral health care is critical to patients' overall well-being. Telehealth appointments can help meet that need.

PCPs: If your patient needs a referral for behavioral health evaluation or treatment, you can recommend they check whether the following providers are in their network.

For facilities: To improve our members' outcomes and to reduce or avoid readmissions, it is important that patients are seen by a behavioral health provider within seven days of discharge from an inpatient or residential facility. We encourage you to share the following telehealth options with your patients to help them receive needed post-discharge care. **Note**: Discharge appointments do not count as follow-up appointments.

No referral needed

Members can use the Find a Doctor tool on our member website, **bridgespanhealth.com**, and search Places by Name for the telehealth providers listed below. They can also call or chat online with Customer Service for assistance. Members can then contact these providers to begin treatment.

Not all telehealth options are available to all members. Members can call the Customer Service number on the back of their card to verify a provider group is in-network.

In-network providers across our four-state region

- **AbleTo**: The Therapy+ program is a structured, eight-week series of one-on-one cognitive behavioral therapy (CBT) by phone or video with a licensed therapist, with medication management and digital tools for support available between sessions
  - **ableto.com**
- **Boulder Care**: Addiction treatment—including medication-assisted treatment (MAT) for opioid use disorders (OUD), which can begin in the ED—that offers support through peer coaching, care coordination and other recovery tools
  - **boulder.care**
- **Charlie Health**: Mental health intensive outpatient treatment for teens and young adults, as well as their families
  - **charliehealth.com**
- **Equip**: Family-based treatment of eating disorders for individuals ages 6 to 24 that includes a care team consisting of a therapist, a physician, a family mentor, a peer mentor and a dietician
  - **equip.health**
- **NoCD**: Specialized care for obsessive compulsive disorder (OCD) using exposure and response prevention (ERP) treatment
  - **treatmyocd.com**
- **Talkspace**: Mental health counseling available 24/7/365 via text, audio or video messaging
  - **talkspace.com/partnerinsurance**

Washington-only telehealth provider

- **Eleanor Health**: Addiction and substance use disorder treatment provider with integrated evidence-based outpatient care and recovery for opioid and other substance use disorders
  - **eleanorhealth.com/locations/washington**

Resources

- The providers listed in this article are available on our provider website: Behavioral Health>Behavioral Health Toolkit
- Learn more about other telehealth options, including national behavioral health vendors not mentioned here, on our provider website: Care Options>Telehealth
- Providers can check members' standard telehealth benefits by performing an eligibility and benefits inquiry in Availity Essentials: Eligibility and Benefits>Benefit Type>Professional (Physician) Visit—Home
- Read about the Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure, which helps ensure members transition safely from an acute hospital setting back to their home environments: Behavioral Health>Facilities>HEDIS Post-Discharge Follow-Up

Help your patients know where to go for care

We encourage you to help educate your patients about the care options that can be used when your office is closed or as an alternative to an emergency room (ER) visit for non-acute or non-life-threatening conditions.

Care options

Virtual care

If you offer telehealth services, as many of our medical and behavioral health providers do, remind patients how they can schedule an appointment. Most of our members also have access to telehealth vendors that offer convenient appointment times.

Related: For more information about virtual behavioral health options, see *Telehealth can support PCP and facility care* on page 13.

Advice24 nurse triage

Most members have access to immediate support through Advice24 for everyday health issues and questions that might otherwise lead to unnecessary urgent care or ER visits. Members can call the Advice24 nurse triage line, or in some cases send a chat message, to connect directly with a registered nurse in seconds. The registered nurse can help navigate the member to the most appropriate care setting, whether it is in-person, virtual or home care. Members may also receive follow-up calls, depending on their clinical need.

Urgent care

Many urgent care clinics are conveniently located and more accessible than ERs. Remind your patients when to visit an urgent care clinic versus an ER.

Remind patients to consider urgent care clinics for illnesses and injuries beyond the scope of virtual care, such as migraine; abdominal pain; sprains, strains and cuts; and severe cold and flu symptoms.

Connect your patients to care

- Remind your patients to sign in to **bridgespan health.com** and select **Find Care** to view their in-person, virtual, urgent and at-home care options.
- Our Customer Service team is also able to help members identify their care options. Customer Service numbers are listed on the back of member ID cards.

Our care managers proactively reach out to members who have had several ER visits. In addition, we educate our members about their care options through emails, our member websites, social media and blogs.

On-call medical care at home with DispatchHealth

With DispatchHealth, **dispatchhealth.com**, members in the greater Boise, Idaho; Portland, Oregon; and Olympia, Seattle and Tacoma, Washington, areas can receive care in the comfort of their home and avoid a trip to urgent care or the ER.

Related: See *On-call medical care at home* on page 15.

Emergency room

Remind patients to go to the ER if they are experiencing acute or life-threatening symptoms, such as chest pain, shortness of breath, signs of a possible stroke, uncontrollable bleeding, severe burns, head injuries (especially loss of consciousness) or seizures.

On-call medical care at home with DispatchHealth

With DispatchHealth, **dispatchhealth.com**, members can receive care in the comfort of their home and avoid a trip to urgent care or the ER.

- DispatchHealth providers serve patients in the greater Boise, Idaho; Portland, Oregon; and Olympia, Seattle and Tacoma, Washington, areas.
- They are available after-hours (operating 7 days a week, including holidays, from 8 a.m.-10 p.m.) and when offices or clinics are experiencing capacity constraints at a cost similar to an urgent care visit.

DispatchHealth treats these conditions and more:

- Urinary tract infections
- Breaks, sprains and bruises
- Severe cold and flu symptoms
- Lacerations, abrasions and infections
- Chronic obstructive pulmonary disease (COPD) and exacerbations
- Mild to moderate stomach pains, nausea, vomiting and dehydration

Their medical team can provide many of the same services as an urgent care facility, including:

- Onsite labs
- Sutures and lancing
- IV placement with fluids
- Urinary catheter insertion
- Medication and antibiotics
- Ordering additional services (e.g., EKG)

Easily connect your patients to DispatchHealth:

- Download this overview to share with providers in your office: **dispatchhealth.sharepoint.com/:b:/s/DHMarketing/Ed2idcct0z5HpJcJ1RCusEMBCJI-6PhTJ4c6T4z2J7lcgA?e=Qn0tUb**.
- Share this flyer with your patients to help educate them about this option: **beonbrand.getbynder.com/m/6abd52697008eba6/original/Member-One-Pager-DispatchHealth.pdf**.
- When care is needed, you or your patient can call 1 (833) 652-0539 or use the online portal to request a visit at **dispatchhealth.com/locations**.
- After you or the member requests 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.
- The on-site medical team will coordinate care at the bedside, as appropriate, and direct the member to you for follow up.
- You will receive the patient's clinical encounter notes from DispatchHealth summarizing the visit.

Watch these short videos to learn about DispatchHealth's:

- In-home treatment capabilities: **vimeo.com/779300678**
- Medical kits and how DispatchHealth can care for patients at home: **vimeo.com/560986386**
- Ability to care for high-risk patients with urgent needs or transportation issues: **vimeo.com/779298483**

Members can find the DispatchHealth contact information by signing in to their **bridgespanhealth.com** account and selecting **Find Care**. Members can also contact Customer Service.

Encouraging preventive cancer screenings

An estimated 30% to 50% of all cancers are preventable. According to the Centers for Disease Control and Prevention (CDC), cancer is the second leading cause of death in the U.S.

We cover a variety of preventive services at no cost (no copay and no deductible) to our members. Preventive services can help detect the following cancers before symptoms appear and when treatment is more likely to be successful.

Screening coverage for commercial members

- Breast cancer prevention counseling (for those at high risk) and screening mammogram (ages 40+ or at high risk)
- Cervical cancer screening (Pap smear test) (ages 21+)
- Colon cancer screening (ages 45+)
- Lung cancer (ages 50-80 with history of smoking)
- Skin cancer counseling (ages 6 months-24 years for those with fair skin type)

Member reminders for colon cancer, breast cancer and cervical cancer

Eligible members receive opt-in texts asking whether they would like to receive preventive screening reminders. If the member agrees, they receive a text message emphasizing the importance of the screening and that they might be due to schedule theirs. The text links to an educational video about the importance of the missing screening. The member can respond to the text with a request for help scheduling an appointment, which will trigger a call from a BridgeSpan Care Advocate. The text also allows the member to indicate barriers preventing them from being screened, which a Care Advocate can help address.

Preventive vs. diagnostic care

When scheduling appointments, please remind your patients that during the preventive care visit, if diagnostic care is needed to treat a new symptom or an existing problem, cost share (e.g., copay, coinsurance or deductible) amounts may apply for these additional services.

View our preventive care list

View the complete list of preventive services that we cover in English and Spanish, listed for members of all ages, pregnant members and children: **bridgespanhealth.com/member/use/preventive-care-list**.

Best practices and member flyers

Our Quality Improvement Toolkit includes best practices and resources you can share with your patients that address the importance of breast, cervical and colon cancer screenings: Programs>Quality>Quality Improvement Toolkit.

What you need to know about QIP

2023 program

We are excited to announce our 2023 Quality Incentive Program (QIP). PCPs participating in the program can earn incentives for closing Quality Rating System (QRS) gaps in patient care, resulting in improved health outcomes for patients. Participating providers can now review their patient care gaps in the Care Gap Management Application (CGMA).

Using the CGMA

Current CGMA users can sign in and view their attributed members and care gap information. Visit our provider website to learn how to identify and close gaps, how to use the CGMA tool, or about member attribution and qualifying QRS measures: Programs>Quality Incentive Program.

If you do not have access to the CGMA, email the following information to **QIPQuestions@bridgespanhealth.com**:

- User first and last name
- Title
- Phone number
- Email address
- Provider group name
- Provider group tax IDs

2022 payout reminder

We are currently verifying payment addresses for PCPs who participated in our 2022 QIP program. Addresses can also be updated online through CGMA. You can sign in to CGMA to review your end-of-year payout calculations. Incentive payments will be mailed in June 2023.

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.

Publications team

Sara Perrott: Publications editor and writer

Carrie White: Managing editor and writer

Sheryl Johnson: Designer and writer

Cindy Price: Writer

Jayne Drinan: Writer

Janice Farley: Writer