Provider Newsletter

February 2025
Quality Management

2025 HEDIS Medical Record Data Retrieval

Aspirus Health Plan's Release of information (ROI) Vendor (Datavant on behalf of Optum) May contact your offices To retrieve medical record data. As outlined in our provider agreements, please work with that team to supply the required clinical and administrative datapoints.

As a reminder, this activity is for our annual Healthcare Effectiveness Data and Information Sets (HEDIS) project. HEDIS measures are nationally used by all accredited Health Plans. Medical record review is an important component of HEDIS compliance and associated audits.

Why is HEDIS important to physicians? HEDIS measures track a health plan's and physician's ability to manage health outcomes. Generally, strong HEDIS performance reflects enhanced quality of care. With proactive population management, physicians can monitor care to improve quality while reducing costs. It's not just about the scores. It's about the woman whose pap smear led to early detection and treatment of her cervical cancer. Or the toddler who didn't get whooping cough because he received the appropriate scheduled immunizations. Or the 65-year-old who kept up with screenings that revealed increased cholesterol. As a result, he received appropriate treatment and potentially avoided another heart attack.

We would appreciate your cooperation with collecting medical record review information at your clinic site(s). We appreciate your clinic's assistance in making this a smooth process.

Serving a Culturally and Linguistically Diverse Membership

Cultural and linguistic competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by their patients/consumers to the health care encounter. Cultural and linguistically appropriate services lead to improved outcomes, efficiency, and satisfaction.

The Wisconsin Department of Health and Human Services offers online learning and resources for the National Cultural Competency and Language Access (CLAS) Standards. For a listing of DHS Resources visit: Cultural Competency and Language Access | Wisconsin Department of Health Services. The CLAS Standards are aimed at health care professionals and organizations to ensure equitable, respectful care is provided to diverse populations.

For more information regarding National CLAS Standards, click on the following link, Culturally and Linguistically Appropriate Services - Think Cultural Health (hhs.gov).

Culture Care Connection is an online learning and resource center, developed by Stratis Health, aimed at supporting health care providers, staff, and administrators in their ongoing efforts to provide culturally competent care to their patients.
For more information regarding Stratis Health's resource center, click on the following link, http:// www.culturecareconnection.org/.

Mental Heath Crisis Line and Medication Resources

After-hours mental health options are available both locally and nationally for individuals with urgent mental health needs. In Wisconsin, support services for those facing a mental health crisis include the option to call, text, or message online for all types of issues that can cause emotional distress. Local County Crisis Line* and National Crisis Service** contact information is provided below.

Mental health medication accessibility is considered when determining our formulary. There are medications used to treat mental health conditions on our Tier 1 formulary. Medication coverage can be accessed in the electronic medical record (EMR) at point-of-prescribing by accessing the ePrescribing tool within the EMR application. Prescribers can also access Aspirus Health Plan Formularies by logging into the Prescriber Portal with their NPI and State on the Navitus website: Prescribers (navitus.com).

*Wisconsin County Crisis Line contact information - https://www.preventsuicidewi.org/county-crisis-lines
**National Crisis Service resources are also available 24/7 across the United States by calling or texting to 988 or chat online at 988lifeline.org

Reminding Patients of Yearly Preventive Screenings

We want to encourage all our practitioners to remind and encourage their patients to make an appointment for their annual preventive screenings. In the wake of the COVID-19 pandemic, annual preventive screenings, especially for older adults and those with chronic or pre-existing conditions, decreased. Now with robust vaccination programs and effective safety protocols in place patients can feel safe to visit their primary care practitioner and have their annual preventive screenings performed.

Network Management

Additions –

01-01-2025 effective date - Updated policy for Readmission to the same hospital within 30 days.

POLICY:

1. If more than one admission occurs for a given Enrollee with a related diagnosis or same Major Diagnostic Category (MDC) as determined by Aspirus Health Plan within a 30-day period, Hospital shall be financially responsible for facility charges for Services rendered to the Enrollee for the readmission.

2. At Aspirus Health Plan's discretion, both admissions may be considered as one continuous stay when the second admission is less than 24 hours.

3. If the readmission is a different MDC but is related to the initial admission as a result of post-op infection (MS DRG 856 – 863), Hospital shall be financially responsible for facility charges for Services rendered to the Enrollee for the readmission.

4. The following DRGs are excluded from this policy:

MS-DRGs: 765 - 768, 774 - 775, 789 – 795, 783 – 788, 796 – 798, 805 – 807, 945, 946, 98x when diagnosis or procedure code indicates a delivery, and DRGs with revenue codes 128 and 118.

5. The following list does not apply:

• A transfer from acute facility to rehab or long

term care facilities/swing beds or a transfer from a rehab or longer term care facilities/swing beds to an acute facility (including but not limited to discharge status of 03, 06, 61, 62, 63)

• A transfer from acute facility to Substance Abuse/Mental Health or a transfer from a Substance Abuse/Mental health to an acute facility (including but not limited discharge status of 04, 65)

Updated – multiple Service procedure discounts **Effective 08/26/2024**

When multiple procedures are performed on the same date of service, Aspirus Health Plan will select the procedure classified in the highest payment group for the primary procedure. This procedure will be reimbursed at 100% of Aspirus Health Plan's contracted rate. Subsequent allowable procedures will be reimbursed at the following rate: 50% for the second procedure, 25% for the third procedure and $0 for any additional surgical procedures.

Full policies are always available on the provider portal on the website www.aspirushealthplan.com

Medical Management

Affirmative Statement About Incentives

Aspirus Health Plan does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for utilization management decision-makers do not encourage decisions that result in under-utilization. Utilization management decision making is based only on appropriateness of care and service and existence of coverage.

Member's Rights and Responsibilities

Aspirus Health Plan presents the Member Rights & Responsibilities with the expectation that observance of these rights will contribute to high quality patient care and appropriate utilization for the patient, the providers, and Aspirus Health Plan. Aspirus Health Plan further presents these rights in the expectation that they will be supported by our providers on behalf of our members and an integral part of the health care process. It is believed that Aspirus Health Plan has a responsibility to our members. It is in recognition of these beliefs that the following rights are affirmed and presented to Aspirus Health Plan members. (See final page of this Provider Newsletter for a copy of the Statement of Member's Rights & Responsibilities.

Out of Network Forms (OON):

- **Retrospective OON requests will no longer be considered for an authorization decision** as there is no opportunity to evaluate the necessity to go OON since the service/visit has already been provided. Any submitted OON retrospective requests will be returned to the requesting provider.
- Before submitting an out of network (OON) request, please first confirm if there are available same/similar in-network providers in the member's area and whether or not the member has out of network benefits and

include that information in your OON authorization submission, along with all other required OON authorization information, as these are key considerations in the OON authorization decision process.

Authorization Requests: When submitting authorization requests, please:

- Consider using the provider portal as the means of submission as this is the quickest method to get the request in front of the UM team for review
- **Submit a separate authorization request per member**, even when the authorization requests are for the same family members
- Regardless of the method of submission, in order for authorization requests to be processed and a decision communicated as soon as possible, **at a minimum, please include**:
    - Member data: name, ID number, date of birth, demographics
    - Your (provider) Tax ID and/or NPI# and contact information: fax, phone number and address
    - All procedure code(s) being requested that requires prior authorization
    - Number of units/items/days being requested per requested service/item
    - Dates of services being requested per requested service/item
    - Supporting clinical information

Use of Expedited/Urgent Priority: Expedited/urgent priority should only be requested when the member's health condition requires a quick decision and waiting for the standard processing time (typically 15 calendar days) could significantly jeopardize their health or well-being. Going forward, if an expedited/urgent authorization request does **not** meet these criteria, the Aspirus Health Plan UM team will process the request following the **standard** authorization decision timeframe, so please be sure to allow sufficient time between scheduling a service/procedure and submitting the authorization request.

Provider Portal: Aspirus Health Plan's provider portal features single sign on access to the Prior Authorization site. The site must be accessed via www.aspirushealthplan.com. Do not share or use any other URL addresses. The Prior Authorization site has been updated to give providers the ability to select and run InterQual criteria on all **initial emergent/urgent inpatient** authorization requests. Running the InterQual criteria will give you an **immediate authorization decision** – no waiting to learn if the initial emergent/urgent admission can be approved or not. Please click on the InterQual criteria option on the portal which will run the criteria on all initial emergent/urgent inpatient submissions and give you a decision

Home Health: When requesting an authorization for any home health service, **please consider using Aspirus Home Healthcare Agency as the servicing agency**. Aspirus Home Healthcare Agency **provide coverage across the state of WI and offers the full range of home health services**, including home infusions, intravenous medications, medical therapies (PT, OT, Speech) and skilled nursing services, among others.

Authorization Requirement Changes and Reminders:

- All Medical and Behavioral Health Facility **elective** admissions and all continued stays require prior authorization. Authorization requests for emergent admissions must be submitted 1 business day from date of admission.
- PT/OT/Speech: requires prior authorization after the evaluation and up to the initial 6 visits
- Home Health: requires prior authorization after the evaluation and up to the initial 6 visits
- All services/items on the prior authorization list including but not limited to: IMRT, genetic testing, medical injectables, varicose vein procedures, hyperbaric oxygen services, etc. require prior authorization before they can be scheduled

Adverse Determination – To Speak to a Physician Reviewer

Aspirus Health Plan attempts to process all reviews in the most efficient manner. We look to our participating practitioners to supply us with the information required to complete a review in a timely fashion. We then hold ourselves to the timeframes and processes dictated by the circumstances of the case and our regulatory bodies. Practitioners may, at any time, request to speak with a peer reviewer at Aspirus Health Plan regarding the outcome of a review by calling (866) 631-5404, option 4 and the Intake Department will facilitate this request. You or your staff may also make this request of the nurse reviewer with whom you have been communicating about the case and she/he will facilitate this call. If, at any time, we do not meet your expectations and you would like to issue a formal

complaint regarding the review process, criteria or any other component of the review, you may do so by calling or writing to our Customer Service Department.

Phone number: (866) 631-5404, Option 4
Address: Aspirus Health Plan, Grievance Department
P.O. Box 1890
South Hampton, PA. 18966

If you are planning on performing a potentially cosmetic procedures, please call Customer Service first, to verify if the procedure is a covered benefit.

MEDICAL POLICY
Medical Policy documents are available on the Aspirus Health Plan website to members and to providers without prior registration. The most current version of Medical Policy documents are accessible under the Medical Policy section on the Aspirus Health Plan website (https://www.aspirushealthplan.com/). (Click on Providers on the bottom of the page then choose Medical Policies).

If you wish to have paper copies of these documents, or you have questions, please contact the Medical Policy Department telephonically at (866) 631-5404

Prior Authorization List
- Dental, coverage for anesthesia, hospitalization under Medical benefit: added CPT 00170
- Laboratory Testing: added PLA codes 0476U, 0477U, 0478U, 0481U, 0498U, 0499U, 0501U, 0516U, 0517U

Durable Medical Equipment, Prosthetics, Supplies and Orthotics List
- Updated with 2024 HCPCS codes, Quantity Limits(QL) and QL references

Please visit https://www.aspirushealthplan.com/ for the most current version.

Medical Clinical Policies for Medical Necessity Determination
- New: None

Medical Clinical Policies for Coverage Benefit Determination
- New: None
- Retired: None

Medical/Surgical and Behavioral Health Care Services Investigative List
- Additions: None
- Revisions: None
- Deletions: None

Please visit https://www.aspirushealthplan.com/ for the most current version.

Pharmacy

Pharmacy Policy documents for coverage of provider-administered drugs are available on the Aspirus Health Plan website to members and to providers without prior registration. The most current version of Pharmacy Policy documents are accessible under the Pharmacy Policies area on the Aspirus Health Plan website (https://www.aspirushealthplan.com/). (Click on Providers on the bottom of the page then choose Pharmacy Policies).

If you wish to have paper copies of these documents, or you have questions, please contact the Pharmacy Policy Department telephonically at (866) 631-5404.

Pharmacy criteria documents for coverage of drug requests under the Pharmacy benefit are available at OptumRX.com PH# 844-284-0142 by clicking on Prescriber Portal, then choosing Prior Authorization.

Pre-Payment, Post Service Claim Edit Program (PSCE)
The official PSCE program was terminated effective 1/1/24. All drugs should still be dosed to follow FDA labeling. Anything outside of what is approved by the FDA should be requested through the PA process. The request will be reviewed according to policy, Off-Label Drug Use PP/O002.

Prior Authorization List

Complex Case Management

Our RN Complex Care Coordinators Can Make a Difference for Your Patients

RN Complex Care Coordinators are here to help our mutual customers by:

- Coordinating health care among providers
- Providing education regarding their health care needs, concerns and adherence to treatment plans
- Supporting and advocating for improved health care experiences and outcomes
- Locating available community resources
- Assisting them to become better health care consumers

The RN Complex Care Coordination team are RN's who work one-on-one with your patients, treating each person as an individual with unique needs and challenges. The goal and efforts have been aimed at optimizing connections both within the health care system and community to support the patient, set and work on health-related goals, and make the patient more confident in their ability to achieve their optimal health status.

The RN Complex Care Coordination team is ready to help with your patients. If you have a patient, you feel might benefit from the service, please contact the RN Complex Care Coordination Team at 715-843-1061 or CDMHRT-AspirusInc-Intake@aspirus.org.

Coding

Coding Appeal Request Form

All claim appeals related to a Coding service disallow are required to have a completed Coding Appeal Request Form (cover sheet) submitted with the validating records. This form is available on the main Aspirus internet link - https://aspirushealthplan.com/ - and located via this link – https://aspirushealthplan.com/webdocs/60043-AHP-Claims-Coding-Appeal-Request-Form_SE.pdf.

Any appeal received without this Coding Appeal Request Form will be rejected. It is important we know exactly what the appeal entails in order to appropriately address the disallowed service(s).

Examples of Coding Appeals for disallowed services (not all inclusive list);

- CPT® and HCPCS code(s)
- ICD-10-CM (diagnosis) code(s))
- ICD-10-PCS (inpatient procedure code(s))
- Place of Service (POS) code(s)
- Clinical Edits, not all inclusive list;
    - Code(s) restricted to certain age limits
    - Bundling per National Correct Coding Initiative (NCCI) code combinations
    - Unit maximums
    - Modifier(s) submitted or not submitted
    - Unlisted code documentation (please see the May Provider Newsletter for this Coding article)
- Internal payer edits, eg., frequency limits, services limited by Medical Policy criterion
- 837I (UB-04 form) fields;
    - Type of Bill (TOB)
    - Revenue Code(s)
    - Diagnosis Related Groups (DRGs)

In network provider (INN) contractual fee schedule (pricing) agreements are ***not*** a Coding Appeal inquiry and should be addressed with your Provider Relations Representative.

Out of network (OON) pricing and reimbursement concerns are ***not*** a Coding Appeal inquiry and are addressed by Customer Service.

Corrected claim submissions are to be submitted electronically as they usually are not considered an appeal.

ICD-10-CM Reminder

Category or Header codes are non-specific and **non-billable diagnosis code(s)** and are NOT valid for the submission of HIPAA-covered transactions (claims). The heading of a category of codes that are further subdivided by the use of 4th, 5th, 6th or 7th character or digit (a code with a higher level of specificity for a diagnosis), is/are required for claim submission.

Providers are accountable for knowing the annual update of ICD-10-CM becomes effective October 1, *every year*. These updates include new, revised and expired codes. Please update any documents and training at your site, in order to submit the most current diagnosis(ses) at the appropriate level of specificity.

Minimize Claim Denial

DME Date Span Reporting

When submitting a claim for HCPCS codes that allow multiple units as item dispensed covers several days, weeks, months, etc., it's advisable to submit a date span and not a one-day span on the claim form.

Example:

From Date	To Date	POS	Code	Units
09/01/24	09/30/24	12	B4035	30

Modifier Hierarchy/Sequencing Guidelines

General order of sequencing modifiers is (1st) pricing ; (2nd) payment; (3rd) location.

Location modifiers, in all coding situations, are coded “last”.
EXCEPTION: Global Surgery – payment modifier is first followed by the pricing modifier(s) and then location modifier.
When reporting two pricing modifiers that include either a professional or technical component (26 or TC), always use the 26 or TC first, followed by the second pricing modifier, eg., 76 (repeat service)
Examples:

- Anatomic modifiers : E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- Pricing modifiers: 26, 27, 50, 52, 53, 54, 55, 57, 58, 62, 66, 73, 74, 80, 81, 82, AA, AD, TC, AS, QK, QX, QY, QZ
- Payment modifiers : 22, 24; 25, 27, 58, 59, 76, 77, 78, 79, 90, 91, 96, 97, GN, GO, GP, QW, XE, XS, XP, XU

Splitting of Radiological Services from Same Radiological Practice
CMS - If the same provider group is performing both the technical and professional component of a service, the global service *(i.e. the procedure code without the TC or 26 Modifier)* is to be reported. Splitting the service between modifiers 26 and TC, either on the same claim or separate claims increases the likelihood of a claim denial.

Co-management of Cataract Surgery (Shared Post-op Care)
Two modifiers represent the complementary roles of surgical co-management:

- Modifier –54, surgical care only
- Modifier –55, postoperative care only

Scenario = Ophthalmologist performs cataract surgery on left eye on 10/1/24 and then sees patient on 10/2/24 for a post-op visit. Expected reporting of services;

- 66982–54–LT
- 66982–55–LT, with the date for the 1 day of post-op care plus date care was transferred to the optometrist indicated in item 19 of the 837P (CMS-1500)

Optometrist (not in the same group practice as the ophthalmologist) renders the remaining post-op care days. Expected reporting of service;

- 66982–55–LT, with the date range for the 89 days of post-op care indicated in item 19 of the 837P (CMS-1500)

An optometrist and surgeon in the same group practice do not report co-management care.
Chart documentation of the post-op days provided should match the claim submission details.
In the event of any complication(s) requiring the patient to return to the ophthalmologist, the claim should be corrected to accurately reflect the number of post-op days provided by the ophthalmologist.

Member Rights and Responsibilities

Aspirus Health Plan is committed to maintaining a mutually respectful relationship with you that promotes high-quality, cost-effective health care. The member rights and responsibilities listed below set the framework for cooperation among you, practitioners, and us.

As our member, you have the following rights and responsibilities:

1. A right to receive information about us, our services, our participating providers and your member rights and responsibilities.
2. A right to be treated with respect and recognition of your dignity and right to privacy.
3. A right to available and accessible services, including emergency services, 24 hours a day, 7 days a week.
4. A right to be informed of your health problems and to receive information regarding treatment alternatives and risks that are sufficient to assure informed choice.
5. A right to participate with providers in making decisions about your health care.
6. A right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
7. A right to refuse treatment.
8. A right to privacy of medical and financial records maintained by us and our participating providers in accordance with existing law.
9. A right to voice complaints and/or appeals about our policies and procedures or care provided by participating providers.
10. A right to file a complaint with us and the Wisconsin Office of the Commissioner of Insurance and to initiate a legal proceeding when experiencing a problem with us. For information, contact the Wisconsin Office of the Commissioner of Insurance at 1.800.236.8517 and request information.
11. A right to make recommendations regarding our member rights and responsibilities policies.
12. A responsibility to supply information (to the extent possible) that participating providers need in order to provide care.
13. A responsibility to supply information (to the extent possible) that we require for health plan processes such as enrollment, claims payment and benefit management, and providing access to care.
14. A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
15. A responsibility to follow plans and instructions for care that you have agreed on with your providers.
16. A responsibility to advise us of any discounts or financial arrangements between you and a provider or manufacturer for health care services that alter the charges you pay.

For information about claims, complaints or grievances visit **AspirusHealthPlan.com**.