Provider Newsletter

February 2026

2026: A Fresh Start and Key Updates

Happy New Year from Aspirus Health Plan! As we kick off 2026, we want to thank you for your continued partnership and the exceptional care you provide to our members every day. We look forward to another year of collaboration focused on supporting providers, simplifying processes, and improving outcomes across our network.

In this first quarterly newsletter of the year, you'll find key updates, reminders, and resources designed to help your practice start 2026 on the right foot. Topics include prior authorization guidance, operational best practices, quality and care-coordination updates, and tools to support both clinical workflows and member education. We hope these insights help you and your teams navigate the year ahead with clarity and confidence.

Thank you for your continued partnership and for all you do to support Aspirus Health Plan members. We look forward to another year of collaboration, shared progress, and meaningful impact.

Here's what you'll find in this edition:

Clarification: Chiropractic Prior Authorization (PA) Requirements

Aspirus Health Plan is providing this clarification to address questions regarding the updated Prior Authorization List (PAL) language for chiropractic services. This is not a change to practice or policy, but a clarification only. The PAL update, effective November 1, 2025, states: "Chiropractic services require prior authorization after the evaluation and a maximum of 6 visits."

To ensure consistent application for all contracted providers, the guidance below clarifies when the six (6)-visit count begins and how it is applied in practice.

How the 6-Visit Threshold Applies

The 6-visit count begins at the start of each member's plan year.

- For most members, the plan year starts January 1.
- Some employer groups may have different plan year dates (e.g., July 1).

Once a member has had their evaluation plus six (6) chiropractic visits within that plan year, prior authorization is required for any additional chiropractic services. The plan year—not the calendar year and not the PAL publication date—determines when a prior authorization is required after the evaluation and six (6) visits.

Illustrative Examples				
Sample Scenario:	**#1** Member w/ January 1, 2025, Plan Year	**#2** Member w/ July 1, 2025, Plan Year	**#3** Member w/ January 1, 2026, Plan	**#4** Member w/ July 1, 2026, Plan Year
Evaluation	August 20, 2025	August 20, 2025	January 10, 2026	September 3, 2026
Visits Complete:	6 Sept 23, 30 Oct 7,13, 20, 27	6 Sept 23, 30 Oct 7, 13, 20, 27	6 Jan 15, 22, 29 Feb 5, 12, 19	6 Sept 10, 17, 24 Oct 1, 8, 15
PA Required:	Visit # 7 On/After Nov 1, 2025	Visit # 7 On/After Nov 1, 2025	Visit # 7 On/After Feb 20, 2026	Visit # 7 On/After Oct 16, 2026

Additional Clarification for Sample Scenarios #1 and #2

- Because the PAL revision became effective November 1, 2025, any visit on or after this date that exceeds the six (6)-visit threshold **for that plan year** requires prior authorization.
- Additional visits through December 31, 2025, also required PA.
- Even though the six (6) visits occurred before the PAL effective date, once the PAL takes effect, PA is required for any services beyond the six (6)-visit threshold within the same plan year.
- The visit count will reset on January 1, 2026, or at the start of the next plan year.

Outpatient Medical Therapy Services

(including services provided in the home)

Occupational Therapy, Physical Therapy, and Speech Therapy all require prior authorization after the evaluation and a maximum of six (6) visits in the same plan year.

- This scenario can be applied to a member with a July 1, 2025, plan year start date (or any other plan year start date in 2025 that is before November 1, 2025), where the evaluation and six (6) visits occurred after the plan year start date and before the November 1, 2025, updated PAL effective date.

Recommended Provider Action to Avoid Denials

- Track a member's chiropractic visits within their plan year.
- Submit a prior authorization request before any visit beyond the six (6)-visit threshold.
- Refer to the updated PAL for applicable CPT codes: 98940, 98941, 98942, 98943.

Ensuring Accuracy in Unit Requests Prevents Authorization Delays

To support timely and accurate processing of authorization requests, we are asking providers to submit **the exact number of units being requested** on all prior authorization submissions. Beginning immediately, our clinical nurses will **no longer adjust units on behalf of the provider** unless explicit clarification or authorization is provided directly by the submitting clinician.

If the units listed on an authorization request are unclear, inconsistent, or appear incorrect, our team will reach out for clarification. **If we are unable to obtain timely clarification, the request may be denied** due to insufficient or conflicting information.

Clear and precise unit submission tips:

- Prevent authorization delays
- Reduce the need for outreach and resubmissions
- Ensure members receive timely access to care

We appreciate your partnership in improving the efficiency and accuracy of the review process.

100-Day Fills: A Quick Win for Medication Adherence

Extended-day supplies reduce refill gaps—one of the most common drivers of nonadherence. A 100-day fill lowers the number of refill opportunities each year, helping patients more easily meet PDC adherence thresholds and improving outcomes for chronic conditions.

Key Benefits to Your Patients

- Fewer gaps in therapy: Only three fills per year instead of multiple 30- or 90-day cycles.
- Better disease control: More consistent access for conditions like hypertension, diabetes, and hyperlipidemia.
- Improved convenience: Fewer trips to the pharmacy and fewer chances to run out of medication.

How Clinicians Can Help

- Review eligibility during routine visits—most maintenance medications qualify.
- Recommend 100-day supplies when initiating or adjusting therapy.
- Update prescriptions proactively for patients with prior refill gaps.
- Coordinate with pharmacies, including mail order options to streamline transitions for patients who may benefit most.

The Bottom Line

A simple shift to 100-day fills is an easy, high-impact tool to strengthen adherence, support better clinical outcomes, and improve quality performance across your patient panel. For more information, please contact Provider@aspirushealthplan.com.

Helping Members Understand When to Use the ER

Supporting members in choosing the right care setting is one of the most effective ways providers can improve outcomes, reduce unnecessary emergency department (ED) visits, and enhance overall member experience. As avoidable ER utilization continues to be a major driver of cost and care fragmentation, your role in educating patients at the point of care is essential.

Why This Matters

Recent internal initiatives show that many conditions prompting ER visits can be safely and efficiently managed through urgent care or telehealth. Virtual solutions—such as real-time provider chat or on-demand urgent care platforms—have resolved a large share of member issues without requiring in-person emergency services. These resources help members receive timely care while avoiding the high cost, long wait times, and care fragmentation associated with unnecessary ER use.

At the population level, the systemwide ER Reduction Program aims to decrease avoidable ER visits by 20%, with Care Navigators and Case Managers providing outreach and education on alternative care options. Provider reinforcement is a critical part of this effort.

Key Messages to Share with Your Patients

You can significantly influence member decision-making by consistently communicating the following concepts during visits, after-hours messages, and follow-up conversations:

Telehealth Is Often the Fastest First Step

Many acute—but non-emergent—needs can be addressed safely through virtual care, including:

- Cough, cold, and flu-like symptoms
- Skin issues
- Minor infections
- Medication refills and questions

Virtual urgent care platforms are available 24/7 and typically connect members with a clinician within minutes, making them an excellent option when symptoms are concerning but not emergent. These services also offer substantial cost savings compared with ER visits and often resolve the issue during a single telehealth encounter.

Urgent Care is Appropriate for Many Same-Day Needs

- Sprains, strains, and minor fractures
- Ear and sinus infections
- Mild asthma exacerbations
- Minor cuts and burns

Internal outreach materials—including urgent-care grids and hours of operation—help members identify nearby facilities and understand estimated costs and wait times. Reinforcing the availability of these resources helps steer members toward timely, appropriate care.

Understanding What Requires Emergency Care

Members should always be directed to the nearest ER or instructed to call 911 when experiencing:

- Chest pain, severe shortness of breath, or signs of stroke
- Major injuries, heavy bleeding, or head trauma
- Sudden confusion or loss of consciousness
- Severe abdominal pain

Providers can reduce uncertainty by reviewing examples of true emergencies with patients during routine and follow-up visits.

How Providers Can Support This Effort

Reinforce Care Pathways During Visits

A brief discussion on care options—especially during visits for conditions that often lead to downstream ER use—can significantly reduce future avoidable visits.

Integrate After-Hours Messaging

Ensure that your after-hours voicemail or answering service directs members to the appropriate options, such as nurse lines, telehealth services, or urgent care, when clinically appropriate.

Partner with Care Navigators & Case Managers

Members identified as high-frequency ER utilizers receive targeted outreach. Providers play a crucial role by reinforcing the same messaging and ensuring follow-up pathways are clear.

Thank You for Partnering in This Work

Reducing unnecessary ER utilization is a shared responsibility across the care continuum. Your consistent communication, education, and guidance help empower members, lower costs, and improve quality of care across our population. For more information, please contact Provider@aspirushealthplan.com.

Enhancing Patient Outcomes: Coordinated Care Among Providers

In today's complex healthcare landscape, patients often receive care from multiple providers across various specialties and settings. While this multidisciplinary approach can improve access to expertise, it also introduces challenges in communication, continuity, and overall care quality. Coordinating care among providers is not just a best practice—it's essential for delivering safe, efficient, and patient-centered care.

Why Care Coordination Matters

Poor coordination can lead to fragmented care, duplicated tests, medication errors, and increased hospital readmissions. Conversely, effective coordination:

- Improves patient outcomes and satisfaction
- Reduces unnecessary costs
- Enhances provider collaboration and efficiency
- Supports value-based care initiatives

Strategies for Effective Care Coordination

Establish Clear Communication Channels

- Use secure messaging platforms and shared electronic health records (EHRs) to ensure timely exchange of information.
- Standardize documentation practices to reduce ambiguity and improve clarity.

Designate a Care Coordinator or Lead Provider

- Assign a primary provider or care coordinator to oversee the patient's care plan and serve as the central point of contact.

Implement Shared Care Plans

- Develop and maintain a unified care plan accessible to all involved providers.
- Include goals, interventions, medications, and follow-up schedules.

Engage Patients and Families

- Educate patients about their care plan and encourage active participation.
- Provide tools for self-management and clear instructions for navigating between providers.

Leverage Technology and Data Analytics

- Use population health tools to identify high-risk patients who may benefit most from coordinated care.
- Monitor outcomes and adjust care plans based on real-time data.

Foster Interdisciplinary Collaboration

- Encourage regular case conferences or team huddles involving all relevant providers.
- Promote a culture of mutual respect and shared responsibility.

Coordinated care is not a one-time effort but an ongoing commitment to collaboration, communication, and patient-centeredness. By working together across disciplines and settings, providers can ensure that care is seamless, effective, and aligned with the needs and preferences of each patient.

Proper Use of the "Retro" Priority on the Provider Portal

We have noticed an increase in providers selecting the **"Retro"** authorization priority on the portal in situations where it does not apply. Selecting "Retro" inappropriately triggers a **30-day turnaround time (TAT)** and may delay processing of requests that should otherwise follow standard time frames.

The **"Retro"** priority should only be used when services have already been rendered, and the request is being submitted after the date of service due to circumstances permitted under policy

Examples of **incorrect** use:

- Pre-service or concurrent review requests
- Requests for future-dated services
- Submissions made retroactively for administrative convenience

Using the correct priority setting helps ensure accurate TAT assignment and timely review. We appreciate your attention to this detail and your continued collaboration.

Recommended 90-Day Date Ranges for Requests

To improve consistency and expedite review, we request that providers submit a 90-day authorization date range on all standard prior authorization submissions. A 90-day time frame reflects the typical approval length for the majority of service types and allows for smoother coordination of care.

Please note the following exceptions:

- **Durable Medical Equipment (DME)** – Authorizations may be approved for up to 6 months to include rentals.
- **Medication and drug-related requests** – May also receive **up to 6 months** of coverage depending on clinical criteria and benefit limits

Submitting standardized date ranges helps reduce avoidable clarifications and ensures our team can process requests efficiently and consistently. Thank you for helping streamline this important step in the authorization process.

HEDIS® 2026 Provider Summary: What You Need to Know

NCQA has released updates in HEDIS Volume 2, adding several new measures—many of which use Electronic Clinical Data Systems (ECDS). These changes aim to enhance data accuracy, improve patient outcomes, and streamline reporting. Below is an overview of the key updates along with recommended actions for providers:

Acute Hospitalizations Following Outpatient Procedures

These new measures track preventable hospitalizations after outpatient procedures such as colonoscopy, general surgery, orthopedic surgery, and urologic surgery.

Provider Recommendations

- Strengthen Pre-Operative Evaluation
- Enhance Patient Education
- Improve Post-Operative Follow-Up - Schedule follow-up appointments before the patient leaves the care setting.
- Document Thoroughly

Lead Screening in Children

Provider Recommendations

- Improve Screening Completion
- Enhance Parent Education
- Strengthen Documentation

Follow-Up After Acute/Urgent Asthma Visits

Provider Recommendations

- Care Coordination
- Medication Management
- Education & Environmental Control

Statin Therapy Measures

Provider Recommendations

- Medication Optimization
    - Initiate statins for eligible patients unless documented contraindication exists.
    - If the member cannot tolerate the statin medication for reasons such as statin-associated muscle symptoms (SAMS), end stage renal disease, active liver or hepatic disease or insufficiency, please be sure to document that in the medical record.

Blood Pressure Control for Patients with Diabetes

Provider Recommendations

- Accurate Measurement
- Treatment & Monitoring
    - Address barriers such as medication cost, side effects, or poor adherence.
    - Encourage home blood pressure monitoring and review and document the readings during visits.

Tobacco Use Screening & Cessation Intervention

Provider Recommendations

- Effective Screening
- Provide Brief Interventions
- Follow-Up Support

Disability Description of Membership (DDM)

Provider Recommendations

- Improve Data Quality
    - Ensure disability and frailty information is captured consistently in designated EHR fields. Review and update functional status and accessibility needs during chronic condition visits.
- Advance Equity
    - Identify and address barriers such as transportation needs, interpreter services, or caregiver support. Collaborate with care management for patients requiring extra support to follow treatment plans.

Provider HEDIS® Checklist for 2026

- Enter all data in structured fields (critical for ECDS reporting)
- Strengthen follow-up workflows after acute events
- Focus on foundational chronic disease management
- Use patient education and teach-back strategies
- Coordinate care across teams and settings
- Document everything that impacts patient care or eligibility

Heads Up: 2026 Surveys Coming Early

The Clinic Accessibility Survey and Directory Accuracy Survey will be conducted earlier than usual for 2026. Please watch for your survey letter and respond as soon as possible once received. Your timely participation helps ensure accurate information and supports the needs of the members we serve.

Using CPT Category II Codes

Strengthen Risk Assignment & Close Care Gaps

Accurate and timely risk adjustment is essential to ensuring that patients receive the resources they need and that providers are appropriately supported under value-based care models. One often underutilized tool that can significantly improve accuracy is CPT Category II (CPT II) coding.

What are CPT II Codes?

CPT II codes are **optional, supplemental tracking codes used for performance measurement**, designed to capture specific clinical actions—such as lab results, screenings, assessments, and interventions—that are typically embedded within Evaluation & Management or clinical services. They are always **five-character alphanumeric codes ending in "F."**

These codes **do not affect reimbursement** but provide payers with detailed insights into quality metrics, helping reduce administrative burden and improve data accuracy.

How CPT II Codes Support Risk Adjustment

While CPT II codes themselves do not assign diagnoses, they play an important role in providing supplemental clinical detail that supports accurate interpretation of a patient's health status. This, in turn, assists health plans and provider organizations in identifying:

- Completed preventive services (e.g., retinal eye exams, blood pressure monitoring)
- Documentation that supports chronic disease management
- Quality measures linked to HEDIS® and other performance programs

Capturing these services clearly and consistently reduces the likelihood of missing data that can affect a patient's risk score.

For example, CPT II codes such as those used for blood pressure readings or diabetic eye exams help confirm that required quality elements have been completed, improving accuracy and reducing the need for retrospective chart reviews.

Benefits of Using CPT II Codes

Fewer Medical Record Requests

Reporting CPT II codes allows payers to confirm services without requesting charts, easing administrative burden on provider offices.

More Accurate Risk Adjustment & Population Insights

More precise clinical data helps health plans develop a holistic picture of the patient's health status and drives improved accuracy in risk adjustment modeling.

Improved Quality Performance

By using CPT II codes to close care gaps in near real time, providers may see improved scores on HEDIS and other quality programs that influence value-based reimbursement.

Enhanced Patient Care Coordination

CPT II coding supports proactive care management by giving payer and provider teams clearer visibility into completed and outstanding preventive services.

CPT II Codes in 2026: Still Relevant and Supported

The American Medical Association continues to maintain and update CPT II codes, noting that they are recognized under HIPAA as part of the national coding set and remain available for performance measurement.

CMS also recently expanded guidance to allow CPT II codes to be submitted on Rural Health Clinic claims, recognizing their importance for value-based care and quality reporting.

Tips for Successful Implementation in Your Practice

- Ensure codes are built into your EMR/PM workflows and can be selected during routine documentation.
- Check payer-specific guidelines, as submission rules may vary.

- Automate where possible. Some EMRs can translate structured clinical data into CPT II codes to streamline usage.
- Use a nominal charge (e.g., $0.00 or $0.01) when required to ensure claims submission compatibility.

Takeaway

CPT II codes are a simple yet powerful mechanism to enhance clinical documentation, strengthen quality performance, and support more accurate risk adjustment. Consistent use helps ensure that patient complexity is captured accurately, care gaps are addressed early, and the entire care team benefits from reduced administrative friction.

Examples of CPT II codes relevant to the impact on HEDIS Quality Measures include:

- HbA1c results (3044F)
- Blood pressure readings (3074F-3080F)
- Medication reconciliation (1111F)
- Medication list and medication review (1159F & 1160F)
- Diabetic Eye Exam
- Dilated retinal exam with evidence of retinopathy (2022F)
- Dilated retinal exam with no evidence of retinopathy (2023F)
- Diabetic eye exam without retinopathy in the prior year (3072F)
- 7-standard-field stereoscopic photos with evidence of retinopathy (2024F)
- 7-standard-field stereoscopic photos with no evidence of retinopathy (2025F)

First Quarter Provider Checklist

Use this short checklist to ensure your practice starts the year aligned with health plan requirements, operational updates, and best practices.

Annual Administrative Updates

- Verify and update your practice information with Aspirus Health Plan (addresses, phone, fax numbers, credentialed locations, panel status). For updates, use the Practitioner Change Form.
- Submit any changes in tax ID, ownership, or billing entities using the Contracted Provider Tax ID Change Notification Form.

Credentialing & Licensure

- Check for upcoming expirations:
  - State licensure
  - DEA certificates
  - Board certifications
  - Professional liability insurance
- Respond promptly to credentialing requests from Aspirus Health Plan to avoid unnecessary claim or participation disruptions.

Policies & Prior Authorization Changes

- Download or review the 2026 medical and pharmacy policy updates, located at Aspirus Health Plan Provider Resources.
- Review any new or revised prior authorization requirements.
- Ensure front-office or referral teams are using current forms and PA channels, located here.

Early Preventive Care & Quality

Even though commercial plans don't have Medicare Stars, many quality measures still apply and are in the best interest of Aspirus Health Plan members. Identify patients due for:

  - Annual wellness/preventive visits
  - Cancer screenings
  - Diabetes monitoring
  - Hypertension follow-up

Care Management & Referral Pathways

- Review any new in-network specialists, facilities, or ancillary partners added for 2026.
- Ensure referral coordinators are using current network directories and resources.
- Share updated care management contact information with clinical teams.

Provider Education

- Watch for any Aspirus Health Plan provider webinars, training sessions, or materials covering:
  - Policy changes
  - Claims trends
  - Portal updates
- Make sure new providers and staff have portal accounts and know how to access tools at AspirusHealthPlan.com.

Year-Start Compliance Review

- Refresh staff on HIPAA privacy/security practices.
- Validate that billing and documentation processes follow guidelines.
- Confirm your practice maintains required fraud, waste, and abuse (FWA) program elements

Q1 Quick Checklist

- ☐ Update practice demographics
- ☐ Complete credentialing/renewals
- ☐ Review 2026 medical policies & PA rules
- ☐ Encourage preventive care scheduling
- ☐ Refresh referral pathways
- ☐ Attend provider education
- ☐ Complete annual compliance refresh

Essential Contacts for Your Practice

To support quick resolution and help you connect with the right teams, we've compiled contact information for resources available to assist with your questions, escalations, and day-to-day needs. For your convenience, the table below outlines the most frequently used Customer Service, Provider Relations, and other operational contacts so you can access the right support when you need it.

Service	Contact Information	
AHP Customer Service	Email Phone Fax	CustomerService@AspirusHealthPlan.com (866) 631-5404 (763) 847-4010
AHP Medicare Advantage Member Services	Email Phone	MemberServicesMA@AspirusHealthPlan.com (855) 931-4850
AHP Specialty Pharmacy	Phone	(855) 355-9573, Ext. 5
Claims Department	Email	CustomerService@AspirusHealthPlan.com
Coding Department	Email Fax Mailing	Pone_Appeals@Optum.com (763) 847-4957 P.O Box 1890, Southampton, PA 18966
Credentialing Department	Email	CredentialingAHP@Optum.com
New Provider Contracting Inquiry	Email	Info@AspirusHealthPlan.com
Prior Authorization	Email Email Fax Mailing	Pone_UMClaimsAndAppeal@Optum.com (Appeals) Pone_Intake@Optum.com (Requests, Questions) (763) 847-4014 P.O Box 1890, Southampton, PA 18966
Provider Relations	Email	ProviderRelationsAHP@Optum.com