Quality Management

Exchange of Information

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment, and referral. Aspirus Health Plan would like to take this opportunity to stress the importance of communicating with your patient's other health care practitioners. This includes primary care physicians and medical specialists, as well as behavioral health practitioners. While we realize in this age of electronic medical records, many records are available to other practitioners in the same care system, currently across systems there is not this coordination of information about your patients.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Aspirus Health Plan urges all its practitioners to obtain the appropriate permission from these patients to coordinate care between behavioral health and other health care practitioners at the time treatment begins.

We encourage all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.

2. Obtain a signed release from the patient and file a copy in the medical record.

3. Document in the medical record if the patient refuses to sign a release.

4. Document in the medical record if you request a consultation.

5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.

6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
   - Diagnosis
   - Treatment plan
   - Referrals
   - Psychopharmacological medication (as applicable)

We appreciate your efforts to provide coordinated care among our membership population and ensuring your patients and their entire medical team is informed about patients' medical treatment plans and outcomes.

HEDIS Measurement and Specification

HEDIS measures are nationally used by all accredited health plans and Aspirus also has an obligation to collect HEDIS data on an annual basis. The measures listed below are hybrid measures; this means the data can be collected both from administrative data and chart information. What you may not realize is that the difficulty of collecting this information from clinic records could be lessened if practitioners were to use appropriate codes when submitting their billing statements. These measures have appropriate codes that would assist Aspirus in collecting this information administratively through claims data.

- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:**
  This measure examines the percentage of members 3-17 years of age who had an outpatient office visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity.

Please ensure that for adolescents that a BMI is both calculated, and a percentile is coded and documented accordingly.

Description	CPT	ICD-10-CM Diagnosis	HCPCS
BMI Percentile		Z68.51-Z68.54	
Counseling for nutrition	97802-97804	Z71.3	S9470, S9452, S9449, G0270-G0271, G0447
Counseling for physical activity		Z02.5, Z71.82	S9451, G0447

- **Controlling High Blood Pressure**
  This measure examines the percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Description	CPT	ICD-10-CM Diagnosis	HCPCS
Systolic Blood Pressure	3074F (systolic < 130mmHg, 3075F (systolic 130-139mmHg, 3077F (> or = 140 mmHg)	I10	
Diastolic Blood Pressure	3078F (diastolic <80mmHg), 3079F (diastolic 80-89 mmHg), 3080F (diastolic > or = 90 mmHg)	I10	

We encourage practitioners to use the above coding specifications to reduce the burden of chart review that will need to be performed at your clinic in the following year.
If you have questions about these measures you may visit NCQA's website at *www.ncqa.org.*

HEDIS Data
We would like to thank all of our provider groups for their cooperation and collaboration during our recent HEDIS medical record review process. We realize that this process is burdensome to clinics and staff and appreciate your willingness in working with our vendor to ensure our HEDIS results for measurement year 2023 are accurate. Thank you!

Reminding Patients of Yearly Physical Exam
We want to encourage all our practitioners to remind and encourage their patients to make an appointment for their annual physical exam. In the wake of the COVID-19 pandemic, annual 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 screenings performed.

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 taken into account 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

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
Please ensure you are using the most recent version of Aspirus Health Plan Out-of-Network Referral Request Form. This is found on the Provider Resources section. Incomplete/outdated forms may result in a delay in processing the out-of-network request.

Prior Authorization Forms
Please ensure you are using the most recent version of Aspirus Health Plan Prior Authorization Request form(s). These are found on the Medical Policy section of the Aspirus Health Plan website. Incomplete/outdated forms may result in a delay in processing the prior authorization request.

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 1062
Minneapolis, MN 55400

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 (763)-847-4477 or 1-800-940-5049 ext. 4477.

Prior Authorization List

- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies: deleted HCPCS K1022 and added L5926
- Gender Reassignment, surgical procedure for reassigning biological gender: deleted CPT 57111
- Laboratory Testing: added CPTs 0423U, 0425U, 0426U, 0428U, 0434U, 0438U, and 0448U

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies List

- No revisions

Medical Clinical Policies for Medical Necessity Determination

- New: None
- Revised (substantive clinical revisions): None
- Retired: Behavioral Health, Mental Health Disorders: Intensive Residential Treatment Services (IRTS) (MC/M023)

Medical Clinical Policies for Coverage Benefit Determination

- New: None
- Revised
  - Ambulance Services (MP/A006) - revised to specify that requests for non-emergency air transportation will be reviewed on a case-by-case basis
  - New/Emerging Technology/Health Care Services, Omnibus Code List (MP/N003) – revised to update the policy to align with newly released CPT, HCPCS, PLU, and MAA codes
- 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 (763)-847-4477 or 1-800-940-5049 ext. 4477.
Pharmacy criteria documents for coverage of drug requests under the Pharmacy benefit are available at Navitus.com by clicking on Prescriber Portal, then choosing Prior Authorization.

Prior Authorization List

Additions (effective 06/2024)

- Columvi (glofitamab-gxbm) J9286 (06/15/2024)
- Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), subcutaneous injection J9334 (06/20/2024)

- Elevidys (delandistrogene moxeparvovec-rokl) J1413 (06/22/2024)
- Rystiggo (rozanolixizumab-noli) J9333 (06/27/2024)
- Roctavian (valoctocogene roxaparvovec-rvox) J1412 (06/29/2024)

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

MODIFIER 22 - Increased Procedural Service

Modifier 22 is used when the work required to provide a procedural service is substantially greater than typically required. Documentation must support the substantial additional work and the reason for the additional work. Electronic submission of the procedural/operative note as an attachment with the claim form, is advised, to expedite claim processing. A concise statement can also be submitted on the claim form.

Appropriate application and substantiation

- Only report with procedure codes that have a 0, 10, or 90-day global period.
- Documentation clearly supports substantial additional work that is far beyond the difficulty of other procedures of the same type, such as:
    a. increased intensity or time (how much longer)
    b. technical difficulty of the procedure not described by a more comprehensive code
    c. severity of the patient's condition
    d. increased physical and mental effort required
- Clear indication and explanation of the difficulty during the procedure, beyond the norm.

Inadequate application and substantiation

- Vague phrases, without detailed explanation, such as:
    a. Surgery took an extra two hours
    b. This was a difficult surgery

    c. Surgery was for an obese patient
    d. Surgery was harder/longer than average
    e. Distorted anatomy
- Appended to an Evaluation & Management (E/M) code.
- Appended to any other type of time-based code.
- Appended to a service reported with an unlisted code

UNLISTED PROCEDURE CODE Submission(s)

If no specific CPT® (Current Procedural Terminology), HCPCS (Healthcare Common Procedure Coding System) or ADA (American Dental Association) code exists, then the procedure must be reported using an appropriate "unlisted" code.

Reporting Requirements
Reporting an unlisted procedure frequently requires additional attention before and after the procedure than reporting a procedure that has an existing CPT, HCPCS or ADA code.

When submitting an unlisted procedure, a concise description of the procedure must be included on the 837P (1500), 837I (UB04) or 837D (Dental) claim form. On the electronic form, this concise statement must be 80 characters or less. Even if the description can be summarized in this small space, it is best to send additional claim attachments such as a cover letter, a Certificate of Medical Necessity, discharge summary, and a copy of the operative report, along with supporting information outlining the decision-making process and the medical rationale for performing the operation. These attachments are to be electronically sent with the original claim to expedite claim processing.

Other Reporting Requirements
- The unit value is "1" regardless of the length of the service.
- Location modifiers allowed as appropriate.
- Assistant Surgeon modifier may be considered, dependent on description and intensity of the service.
- Co-Surgeon modifier may be considered, dependent on the submitted details of the service.
- Dental services require tooth numbers.

Pricing
Charge for the unlisted procedure is to represent the entirety of the procedure. To support the charge, it is recommended to attach a cover letter with the following information:
- Choose a comparison code that is similar to the unlisted procedure performed. This code should represent surgery on the same body area.
- List two or three factors that make the unlisted procedure the same work, or more or less difficult than the comparison code. For example, indicate the unlisted procedure required a different operative approach and approximately 30 minutes of additional operative time than the comparison code.
- Indicate the difference in work between the unlisted procedure and the comparison code using a percentage. For example, estimate that the unlisted procedure required 30% more time for exposure, exploration, and closure than the comparison code.
- Indicate the normal fee for the comparison code and the fee for the unlisted code based on the percentage of more or less work required and documented in the letter. For example, indicate the normal fee for comparison code is $1,000, and therefore you have set the fee for the unlisted procedure at $1,300 because it required 30% more time for exposure and exploration.

Summary
When reporting an unlisted code to describe a procedure or service, it is necessary to submit supporting documentation along with the claim to provide an adequate description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service.

COVER LETTER SAMPLE

(Date)

Attn: (Contact Name) (Title)
(Insurance Company Name)
(Address)
Re: (Patient's Name)
Group Number:
Subscriber/Policy Number:
Date of Birth:
Dates of Service:

Dear (Contact Name):
On (date of service), I performed a (name of procedure) on the above-mentioned patient. (Patient's Name) was diagnosed with (Diagnosis). This patient also has (List any associated symptoms or co-morbidities). (If applicable, include additional information such as alternative treatments that have failed and what health problems may have occurred if the patient did not undergo the procedure. Describe anticipated outcomes and the medical benefits of the treatment).

There is no specific CPT code for this procedure; therefore, I am submitting the following unlisted procedure code (insert CPT code and descriptor). This procedure may be reasonably compared to the existing CPT code (code number and description) in terms of physician work and practice expense. (Define what the procedure entailed and how much more/less difficult it was than the comparable CPT code). My charge for (the comparator CPT code) is $_____. I estimated the charge for the submitted unlisted procedure to be (list percentage that current procedure is less or more difficult than the comparator code) for the reasons mentioned above. Therefore, I have submitted a charge of $_____ for this procedure.

Attached, please find a detailed copy of my operative report, office notes, published articles supporting this procedure and a claim form for (patient's name).

Sincerely,
(Physician's Signature)
(Practice Name)

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**.