

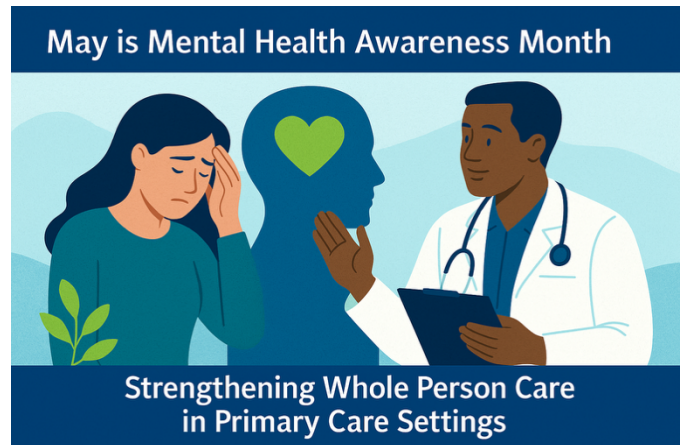
Provider Newsletter

May 2026

May 2026 Newsletter: Provider Updates & Practice Support

Thank you for the care you provide to our members every day. In this newsletter, we’re sharing timely updates and practical guidance to support your workflows, strengthen care coordination, and help patients access the right care at the right time.

This edition highlights Mental Health Awareness Month and the role of primary care in routine behavioral health screening and referral pathways, along with important operational reminders—from improving authorization accuracy in the Provider Portal to billing guidance (including modifiers 26/TC and Revenue Code 510). You’ll also find an update on what’s changing in the July provider survey and a women’s health focus on preventive screenings and maternity care coordination.



Please share these updates with your teams. Reach out to your [Provider Relations](#) contact if you have questions or need support implementing any of the guidance included in this issue.

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Ensuring Urgent Access to Care: What Providers Need to Know

Clarifying urgent access expectations and practical pathways to care within 24 hours

Providing patients with timely access to care is a shared priority for our provider partners and Aspirus Health Plan. Recent network reviews and provider survey responses have identified challenges meeting urgent access standards, particularly in behavioral health and other high-impact specialties. These reviews also highlighted opportunities to clarify urgent-access expectations and align workflows to support timely care—especially in multi-specialty and rural-serving settings.

This article outlines what qualifies as urgent access, practical operational approaches, and next steps to support compliant and sustainable workflows.

What Is “Urgent Access” and What It Is Not

Urgent care refers to medically necessary care that does not meet the definition of emergency care but requires timely clinical evaluation to protect a patient’s health or safety. Under Aspirus Health Plan policy, and codified in your provider agreement with the health plan and the provider manual, you have committed to providing urgent access to such care within 24 hours.

It is important to distinguish:

- Emergency care: Requires immediate treatment, typically through the emergency department.
- Urgent care: Requires clinical evaluation within 24 hours and may be addressed through office visits, telehealth, advanced practice providers, or triage-based pathways.
- Routine care: Preventive or follow-up care that can be scheduled beyond 24 hours.

Urgent access does not require:

- A same-day, in-person visit with the originally requested clinician
- An open slot in a specific provider’s personal schedule
- What does matter is that the patient has a clear, timely pathway to appropriate clinical assessment.

Operational Best Practices That Support Compliance

Many provider groups reporting challenges meeting the 24-hour standard already have elements of compliant workflows in place. The following best practices have proven effective across clinical settings.

Effective triage workflows

- Use RN-, APP-, or clinician-led triage to assess urgency and direct patients appropriately
- Escalate urgent needs based on symptoms and risk—not appointment type or specialty preferences

Call-routing and after-hours protocols

- Ensure urgent calls are not routed exclusively to voicemail without escalation
- Document and clearly communicate after-hours coverage pathways to staff and patients, including on-call answering systems
- Partner with an after-hours services when appropriate
 - For behavioral health urgent access, Aspirus Health Plan members have access to MD Live, which can support timely evaluation and stabilization when in-person care is not immediately available

- Additional information is included in “Behavioral Health Access Options and FAQs” in this newsletter

Standardized scheduling practices

- Reserve limited urgent appointment slots and ensure staff are aware of how to use them
- Allow urgent patients to be scheduled with covering clinicians, rather than limiting access to a single provider

Examples

- Compliant: A patient with worsening neurological symptoms receives same-day triage and a next-day APP visit or virtual consult
- Non-compliant: A patient with urgent symptoms is told the next available evaluation is weeks away without triage or alternate options

Using Telehealth to Expand Access

Telehealth is an important enabling tool for meeting urgent-access requirements, particularly for high-demand specialties and patients traveling from rural areas.

Appropriate uses of telehealth include:

- Initial evaluation or triage of urgent symptoms
- Medication management or short-term stabilization
- Determining whether in-person follow-up or higher-level care is needed

Telehealth supports compliance when it provides timely clinical evaluation within the required timeframe, even if additional in-person care is required later. Clear telehealth workflows can reduce access delays while improving the patient experience without adding unnecessary strain to clinic schedules.

Why Network Adequacy Matters to Providers and How It Is Measured

Each provider group’s participation directly affects network adequacy and regulatory compliance, including NCQA access and availability standards. These standards are designed to ensure members can obtain needed care without undue hardship.

Aspirus Health Plan is an NCQA-accredited health plan, and provider participation agreements include commitments and obligations to support compliance with NCQA and other accreditation requirements. Annual provider access surveys and attestations are aggregated and used to:

- Demonstrate that members can access care when needed
- Identify specialties or geographic areas requiring additional support
- Inform network planning and resource allocation

Consistent urgent-access workflows across clinics and departments help reduce variation, protect provider groups contractually, and ensure patients receive appropriate care without delay.

What Providers Should Do Now

To support compliance with urgent-access standards and prepare for the upcoming provider resurvey and attestation, provider groups should:

- Review urgent-access workflows to ensure patients requiring urgent care can receive clinical evaluation within 24 hours
- Use triage and telehealth pathways (including behavioral health telehealth resources, where appropriate) to manage capacity constraints
- Identify and address known access gaps, particularly in high-demand or high-volume specialties
- Promptly complete the upcoming NCQA resurvey (anticipated July 2026), as responses are used to assess network compliance and guide improvement efforts

Provider groups that identify barriers to meeting the standard are encouraged to engage early so that operational support and improvement strategies can be aligned proactively.

If Your Group Struggles to Meet the Standard

We recognize that workforce shortages, capacity constraints, and rising demand are real challenges. If your group cannot consistently meet the 24-hour urgent-access standard, consider which visit types are most constrained and leverage triage, telehealth, and partner-provider pathways where feasible.

Please share specific challenges or questions with [Provider Relations](#). Targeted support can be coordinated as needed.

Moving Forward Together

Urgent access is a shared responsibility, and we appreciate your continued partnership in improving access for Aspirus Health Plan members. If you have questions about urgent-access standards, telehealth use, or operational best practices, please contact your [provider relations representative](#) or participate in upcoming network office hours.

Office Hours Information & Schedule

Office hours will be offered on three different dates and times, to accommodate schedules. This will be time available for you and your teams to attend to discuss requirements and expectations urgent access to care as well as to share ideas and learn from each other on operational best practices that can alleviate access challenges and improve patient experience.

- Thursday, May 7: 2pm – 3pm CT
- Tuesday, May 12: 3pm – 4pm CT
- Friday, May 15: 10am-11am CT

Please dial into the call using the information below:

- [Click here to join \(MS Teams\)](#)
- Meeting ID: 217 449 757 512 639
- Passcode: tJ772Ej2

Behavioral Health Access Options

Trusted Mental Health Care Powered by MD Live

MD Live offers comprehensive virtual mental health services, including talk therapy and psychiatry, to support your patients' emotional and behavioral health needs.

Our network helps care for patients experiencing:

- Anxiety and stress
- Depression
- Life transitions
- Feeling overwhelmed or in need of additional support

Patients can choose from a large network of licensed therapists and board-certified psychiatrists, with initial therapy appointments typically available within one week or less. Flexible scheduling, including evenings and weekends, allows patients to access care without disrupting work or family responsibilities.

MD Live Supports Continuity of Care

Patients may see the same therapist or psychiatrist for ongoing visits. However, providers can be changed at any time based on patient preference or clinical fit.

The MD Live virtual care model enables patients to receive care privately from home, helping reduce access barriers while maintaining high clinical standards. Cost-sharing is transparent, with no surprise charges for patients.

MD Live serves as a convenient extension of care, helping you ensure patients receive timely, appropriate mental health support when additional resources are needed.

Learn more at mdlive.com/aspirushealthplan.

Frequently Asked Questions: MD Live

What is MD Live Behavioral Health?

MD Live Behavioral Health provides virtual outpatient therapy and psychiatry services delivered through secure audio or video technology. Services include mental health counseling and medication management through a confidential, HIPAA-compliant platform.

What are the benefits of MD Live virtual behavioral health visits?

Access to Care

- Convenient access to outpatient behavioral health services
- Appointment availability up to 4x faster than industry norms
- Reduced appointment no-show and abandonment rates
- Care coordination with primary care and other treating providers Productivity & Functioning
- Reduced time away from work or daily responsibilities

- Evidence supports depression treatment as improving work function and symptom reduction

Cost Impact

- Potential reductions in lost productivity, disability claims, and absenteeism

Are virtual behavioral health visits as effective as in-person care?

Studies show virtual behavioral health care can be as effective as in-person treatment for appropriate patients and helps reduce barriers such as travel and scheduling constraints.

Who is appropriate for MD Live?

- Lowest level outpatient behavioral health support
- Ages 10 and older
- Primary members and covered dependents

Which conditions are treated?

- Anxiety, depression, bipolar disorder
- Trauma, PTSD, stress management
- Panic disorders, grief, relationship issues
- Addictions (when appropriate)
- Life transitions and adjustment disorders

What types of services are provided?

- Therapy: 60-minute initial sessions, 45–60 minute follow-ups
- Psychiatry: 30-minute initial evaluation, 15–30 minute follow-ups

What types of providers are available?

Psychiatrists, psychologists, clinical social workers, professional counselors, marriage and family therapists, and mental health counselors

Are medications prescribed?

Prescribing Guidelines

- Non-controlled medications only
- Initial assessment required
- Up to 90-day supply when clinically appropriate

Medications Not Prescribed

- DEA-controlled substances
- Stimulants, benzodiazepines
- Detox medications, medical marijuana
- Medications requiring lab monitoring when labs are unavailable

Are there any exclusions that should be considered?

MD Live is not appropriate for:

- Psychiatric emergencies or crisis
- Active psychosis
- Moderate to severe autism spectrum disorders
- Conditions requiring detox or higher level of care

How do patients get started?

Please have your patient contact MD Live by following one of the options below:

- mdlive.com/aspirushealthplan
- 1-888-632-2738

When are appointments available?

- Therapy: typically within 5 days
- Psychiatry: typically within 7 days

What about continuity of care?

Patients typically see the same provider unless a change is requested.

take care of your mental health this season.

MDLIVE is here to help.



Spring is the perfect time to check your mental health if you're not feeling like yourself. MDLIVE licensed therapists and board-certified psychiatrists care for hundreds of conditions, including:

- Anxiety
- Depression
- Grief & Loss
- Life Changes
- Relationship Issues
- Stress Management
- Trauma & PTSD
- And more

how it works

You can have your first therapy appointment in a week or less, from the comfort and privacy of home:

- Create your secure account.
- Browse through our network of professionals.
- Select an appointment that works best for you.
- Speak with the same professional for every appointment, or switch at any time, for any reason.¹



MDLIVE Well-being Tools

Your MDLIVE psychiatrist or therapist may assign you Well-being Tools through the MDLIVE Health Coaching app.² These digital tools support your mental health journey and include CBT-based action plans, guided meditation, journaling, and trackers for mood, anxiety and sleep.

for secure, confidential support, schedule a session with an MDLIVE mental health provider.





Meet Sophie, your personal assistant.
Text aspirus to 635483 to create an account.

Create your account today.
mdlive.com/aspirushealthplan | 888.632.2738

¹Patients may switch providers up to two times following their first appointment but may not exceed three providers in total.
²Well-being Tools are available to patients ages 18 and older at no additional cost.
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Provider Education Corner: Facility Type Errors

Avoiding Facility Type Errors When Entering Authorizations in the Provider Portal

Aspirus Health Plan has identified a trend of “Facility Type” errors when providers submit authorizations through the Provider Portal. We know submission errors can cause undue frustration, as these errors delay review, cause authorizations to pend unnecessarily, and often require follow-up outreach to clarify provider or facility information.

To support a smoother experience, our team collaborated with clinical operations and system experts to walk through the portal workflow and highlight the key steps where errors most commonly occur. The following guidance is intended to help providers and their staff enter authorizations accurately the first time.

Where Facility Type Errors Happen

Most errors occur during the Provider/Facility selection step, where the portal asks users to search for servicing, billing, or rendering providers. Selecting an incorrect facility type (or selecting a record different from the service location) may trigger an “Invalid Facility” error downstream. Please note that not all outpatient services require a facility to be entered. In those cases, please leave the facility field blank when following the process outlined below.

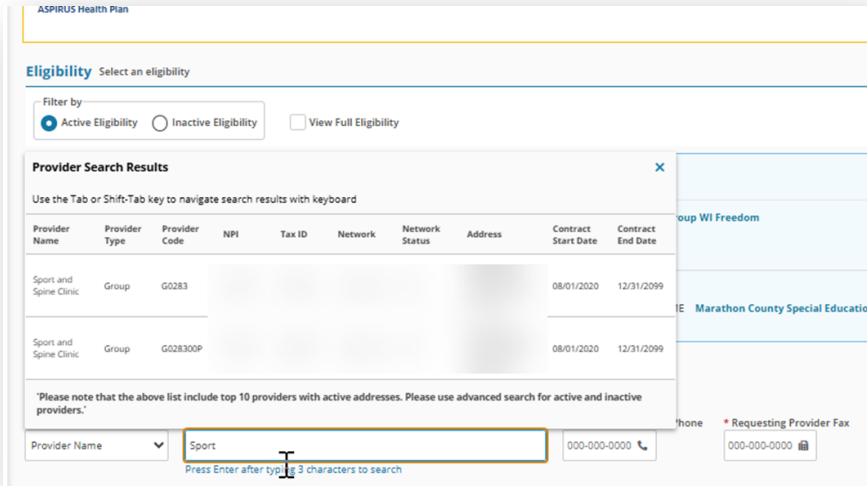
How to Enter Authorizations Correctly in the Provider Portal

1. Start by Selecting the Member in Focus

Once you enter the authorization creation screen, you will see the Member in Focus at the top.

2. Begin Provider Search

Under the servicing or billing provider section, start typing at least three letters of the provider or facility name. The portal will automatically populate a list of matching records.

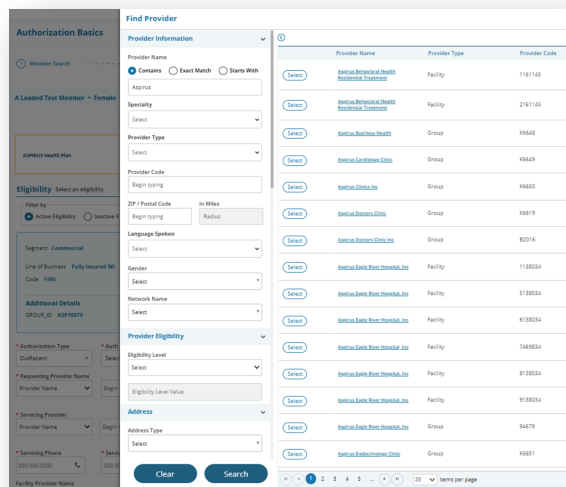


3. Use Advanced Search When Needed

If the quick search doesn't return the correct facility, click the magnifying glass to access Advanced Search.

You can refine your lookup by:

- Provider name
- NPI
- Address or city
- Specialty or type, where applicable



4. Validate the Provider/Facility Information Before Submitting

Before finalizing the authorization request, double-check:

- NPI matches the place of service
- Facility Type aligns with the services requested

- Location is correct for where the member will receive care
- This is the final checkpoint to prevent an “Invalid Facility” error.

Why This Matters

Submitting accurate provider and facility information is essential to ensuring authorization requests move swiftly and smoothly through the review process. When the correct facility type, NPI, and service location are selected, authorizations can be reviewed more quickly, minimizing delays and reducing the need for follow-up outreach to clarify errors. This not only streamlines provider workflows but also supports timely access to care for members. Our analysis indicates that a small number of provider organizations account for a majority of recurring facility type errors, which underscores the importance of accurate provider selection and validation within the portal. Strengthening this step helps improve processing efficiency, reduces administrative burden, and minimizes friction in the overall provider experience.

We’re Here to Help

If you have questions about:

- Which facility type to choose
- How to use Quick Search or Advanced Search
- How to identify correct billing vs. servicing NPIs

Please reach out to the [Aspirus Health Plan Customer Service team](#). We appreciate your partnership in helping ensure timely and accurate authorization processing.

Important Tips

- If multiple results appear, confirm the facility type, address, and NPI before selecting.
- Do not select the parent health system or a similarly named clinic if the actual place of service is different.
- Using Advanced Search helps verify you’re selecting the designated billing or servicing location.

Common Fixes to Common Issues

Many Facility Type errors occur when providers choose:

- A professional NPI instead of a facility NPI
- An administrative location instead of a service location
- An incorrect site within a multi-clinic system

Clean Authorization Requests

- Speed up review
- Reduce outreach and rework
- Ensure timely access to care for members
- Improve provider and patient experience

Documentation Matters: Tips to Support Quality Scoring

Avoiding Common Documentation Misses

Accurate, complete documentation is essential to reflecting the quality of care delivered and ensuring that clinical performance is accurately captured in quality reporting and scoring. Even when care is provided appropriately, missing or incomplete documentation can lead to gaps in quality measures.

To support providers and care teams, Aspirus Health Plan highlights the following documentation tips and common areas where quality opportunities are frequently missed.

Documentation Tips That Support Quality Performance

Document Preventive Care Clearly

- Capture that preventive services were completed, not just discussed or recommended.
- Ensure dates, results, and interpretations are included in the medical record for screenings, labs, and assessments.

Close the Loop on Results and Follow Up

- Document review of test results and any follow up actions taken, including patient notification.
- Include referrals, treatment plans, or watchful waiting decisions when clinically appropriate.

Use Specific Diagnoses and Clinical Details

- Ensure diagnoses are clearly linked to the visit and supported by clinical findings.
- Avoid vague or unspecified diagnosis codes when more specific documentation is available.

Reflect Condition Management Each Year

- Chronic conditions should be documented with an assessment and plan annually.
- Include ongoing management, medication reviews, and patient education when applicable.

Leverage Structured Fields in the EHR

- Enter data in designated fields (not free text only) when possible, to support accurate data capture.
- Confirm problem lists, medication lists, and health maintenance sections are up to date.

Common Documentation Misses That Impact Quality Scoring

- Preventive screenings ordered but no documented completion or results
- Results reviewed but follow-up actions not documented
- Chronic conditions listed on the problem list without current assessment or plan
- Missing dates for services performed outside the practice
- Care discussed during visits but not clearly documented in the clinical note

These gaps can result in quality measures appearing incomplete, even when care was provided.

Partnering for Accurate Quality Reporting

High quality documentation supports continuity of care, improves patient safety, and ensures that provider performance is accurately reflected in quality reporting. Small documentation improvements can have a meaningful impact on quality scores and reduce the need for retrospective chart reviews or outreach.

Aspirus Health Plan appreciates your continued partnership and commitment to delivering high quality, well documented care to our members.

Integrated care models have been shown to improve patient experience, strengthen care coordination, and support better health outcomes over time.

Supporting Patients Beyond the Exam Room

Primary care practices also play an important role in connecting patients to community-based resources, crisis services, and specialty care when needed. Normalizing mental health discussions and offering consistent screening helps reduce stigma and reinforces that behavioral health is an essential part of whole person care.

As we recognize Mental Health Awareness Month this May, we encourage providers to continue incorporating behavioral health screening and integration strategies into everyday practice to support early identification, timely intervention, and improved outcomes for the populations you serve.

Modifiers 26/TC: Global Reporting

Modifiers 26 and TC are mostly associated with specific radiology and other diagnostic procedures. Appropriate reporting of these modifiers is essential for accurate reimbursement and elimination of denials. The below guidelines are applied to Commercial claims.

Modifier 26 – Professional Component

- Only for the professional component (supervision, analysis, interpretation and report).
- Provider **does not** own the equipment.

Modifier TC – Technical Component

- Only for the technical component (equipment, supplies, technician time)
- Equipment is **owned by the site** (hospital, imaging centers, clinics)

Selections from the Medicare Claims Processing Manual

10.2.1 – Global Billing (Rev. 4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

Global billing is acceptable when both the TC and 26 modifiers are performed by the same entity and both the TC and the 26 modifiers are furnished within the same Medicare Physician Fee Schedule (MPFS) payment locality. The TC and 26 may be furnished in different locations as long as they are furnished within the same MPFS payment locality.

If the global diagnostic test code is billed, report the name, address and NPI of the location where the technical component was furnished in Items 32 and 32a (or the 837P electronic claim equivalent).

Global Billing (No Modifier Needed)

- If the same provider/facility owns the equipment **and** provides the interpretation, the claim is billed **without TC or 26**.
- This represents the **global service**—both the technical and professional components bundled together.
- A physician's office with equipment and interpretation - bills globally (no modifier).

Reminder: Please Submit Provider Updates Promptly

To ensure accurate directories, claims processing, and member access to care, please notify us as soon as possible when your practice information changes. Timely updates help prevent claim delays, misrouted correspondence, and inaccurate provider listings. [Summary](#)

- **Report changes promptly** (add/term practitioners, name changes, address/address-type changes, and other demographic updates) and include the **effective date**.
- **Find the forms** under **Provider Resources** on www.aspirushealthplan.com.
- Use the right form: Practitioner Change Form for practitioner-type changes; **Provider Information Change Form** for clinic-type changes.
- **Submit completed forms** (and supporting documentation, if needed) to [AHP Credentialing](#).

What to Update

- **Practitioner roster changes:** add new practitioners, term practitioners, or change practitioner status (as applicable).
- **Name changes:** practitioner name changes and practice/entity name changes (legal name and “doing business as,” if applicable).
- **Address updates:** add, term, or correct service location(s); update mailing address; update billing/remittance address.
- **Address type changes:** when an address should be listed as service vs. mailing vs. billing/remittance (or other address types your organization uses).
- **Contact information:** phone, fax, email, office hours, and website (if applicable).
- **Provider attributes (when applicable):** specialty changes, taxonomy/NPI updates, and other demographic corrections.

When to Submit Updates

Please submit changes as soon as they are known and include the **effective date** of the change. If your contract requirements specify a reporting timeframe (for example, within a set number of business days), that timeframe applies.

How to Submit Updates

Primary submission method: Please use the forms available under **Provider Resources** on www.aspirushealthplan.com. Use the **Practitioner Change Form** for practitioner-type changes (including adding or terming practitioners) and the **Provider Information Change Form** for clinic-type changes.

- **Step 1:** Download and complete the appropriate form under Provider Resources on www.aspirushealthplan.com (**Practitioner Change Form** for practitioner-type changes; **Provider Information Change Form** for clinic-type changes).
- **Step 2:** Email the completed form(s) and any supporting documentation to [AHP Credentialing](#).

Provider Secured Portal

Providers can also register for the provider secured portal. Portal access allows you to manage certain information online and stay informed of contract updates.

- Register to receive notifications when practitioners are added to your contract.
- View enrollment data.

Portal registration information is available on www.aspirushealthplan.com under **Provider Registration**.

Information to Include (Helps Us Process Your Request Faster)

- Provider/practice name and **NPI** (individual and/or group, as applicable)
- Tax ID (if applicable for the change requested)
- Clear description of what is changing (add/term/change)
- **Effective date** for each change
- For roster updates: practitioner full name, NPI, specialty, and associated service location(s)
- For address updates: address type (service/ mailing/ billing), phone/fax for the location, and office hours (if applicable)
- Any required supporting documentation (for example, for legal name changes)

Need Help?

If you have questions about which update form to use or what to include, please email the [Aspirus Health Plan Credentialing team](#) or [Provider Relations team](#). Thank you for helping keep provider information accurate and up to date.

Information on Billing Revenue Code 510

Aspirus Health Plan has implemented a claims processing directive under which facility clinic charges billed with Revenue Code 510 are **not separately reimbursed when associated with a professional evaluation and management (E/M) service** for the same date of service. In these situations, reimbursement is limited to the professional claim, as the clinic-related costs are considered included in the overall outpatient visit payment methodology.

We have found claims with Rev 510 and G0463 that were denied in error. These are being adjusted to be allowed.

This approach aligns with outpatient clinic billing considerations under CMS OPPTS guidelines and reflects Aspirus Health Plan's internal payment policy for these services. As a result, claims billed with Revenue Code 510 in conjunction with professional services may deny, even when previously reimbursed.

If you believe a claim was denied in error or billed without an associated professional service, you may submit the claim for reconsideration through the standard claims appeal process with supporting documentation. Questions regarding specific claims should be directed to Provider Customer Service.

Clinical Documentation for Imaging Requests, Spinal Injections, and Spine/Joint Surgery

As a friendly reminder, please include supporting clinical documentation when submitting prior authorization requests for radiology/imaging requests (i.e.- MRI, CTs), spinal injections, and spinal and joint surgical procedures. Helpful information includes documentation of conservative therapy, duration and response (i.e.- physical and occupational therapy, NSAIDs, etc.), relevant imaging results (when applicable), and prior treatment history.

Providing this information at the time the PA request is submitted helps support medical necessity review and allows us to process requests as efficiently as possible, reducing follow up and avoiding delays in care. Thank you for your continued partnership in supporting timely access to care for Aspirus Health Plan members.

Provider Survey Update: What's Changing in July and How to Respond

Updated urgent access question, clearer response options, and telehealth support for members

In July, Aspirus Health Plan will send our annual Provider Survey to contracted providers. This year, the survey includes updated wording and response options for the urgent access-to-care question. The goal is to improve clarity, reduce free-text interpretation, and better identify where additional support or alternative pathways (including telehealth) may be helpful.

What's changing in the 2026 Provider Survey

We made four key updates to the urgent access-to-care question to help ensure responses reflect true operational capability and align with access standards.

- Includes “Emergency Care” definition to increase clarity when defining “Urgent Care”
- Additional discreet responses to ensure clarity in the data and to better pinpoint future intervention opportunities; Removes free-text response option
- Specifies urgent access to care to avoid confusion with other definitions of “urgent care” (e.g., walk-in clinics)
- References definition again to guide respondent to read the definition

Previous Survey Question

Urgent Care: Defined as access to medically necessary care which does not meet the definition of emergency care but indicates that medical care is needed as soon as possible for the physical health and safety of the patient.

Question: Patients are able to access an urgent care appointment within 24 hours?

Responses: Yes / No

If No: Please describe (free text)

Updated Survey Question

Urgent Care: Defined as access to medically necessary care which does not meet the definition of emergency care but indicates that medical care is needed as soon as possible for the physical health and safety of the patient.

Emergency Care: Defined as medically necessary care, which must be immediately rendered in order to preserve life, prevent serious impairment to bodily functions, organs, or parts, and/or prevent placing the physical or behavioral health of the patient in serious jeopardy (based on the judgement of a prudent layperson).

Question: Do you provide urgent access to care for patients, defined as “Urgent Care” above, within 24 hours?

Responses: Yes / No

If No, please provide further detail: Partner provider / Aim to but cannot meet 24-hour standard / Don’t provide urgent access as defined / Not applicable to our specialty

How to answer the updated question (best practices)

- **Read the definitions first.** The survey now includes both **Urgent Care** and **Emergency Care** definitions to help distinguish urgent access (within 24 hours) from conditions that require immediate emergency evaluation.
- **For a “No” response, pick the option that best fits your pathway today.** The updated survey replaces free text with discrete choices so we can better understand where support is needed.
- **Include partner pathways only if they are established and consistently provide evaluation within 24 hours.** If so, select the partner-provider option.
- **Use “Not applicable to our specialty” only when urgent access as defined does not apply to the services you provide.** If your patients may still present with urgent needs related to your scope, please answer based on your ability to provide timely clinical evaluation or a defined pathway to care.

Tip: The question is about **urgent access to care** within 24 hours, not whether a patient can be scheduled into a specific provider’s personal template or a traditional walk-in “urgent care clinic.” A triage-based pathway that results in timely evaluation can meet the standard.

Women's Health Focus: Preventive Screenings & Maternity Care Coordination

Aspirus Health Plan remains committed to supporting women's health across every stage of life. As trusted partners in care, providers play a key role in improving outcomes through timely preventive screenings and coordinated prenatal and postpartum care. Below are key focus areas for 2026.

Preventive Screenings: Closing Gaps in Care

Routine preventive screenings support early detection, reduce complications, and improve long term health outcomes for our members. We encourage providers to prioritize the following during preventive and problem focused visits:

Breast Cancer Screening

- Ensure age-appropriate mammography is discussed and ordered per clinical guidelines.
- Use visit opportunities to identify patients overdue for screening and reinforce the importance of early detection.

Cervical Cancer Screening

- Confirm appropriate cervical cancer screening and follow up testing based on age and risk.
- Accurate documentation and timely results review remain critical for closing quality gaps.

Osteoporosis Screening

- Identify patients at risk for osteoporosis, including post-menopausal women and others with risk factors.
- Order bone density testing when clinically indicated and initiate follow up care as appropriate.

Tip: Incorporating EHR reminders and preventive visit checklists can help reduce missed screening opportunities and support quality performance.

Prenatal & Postpartum Care: Supporting Moms Before and After Delivery

Coordinated maternity care improves outcomes for both mother and baby. Aspirus Health Plan encourages providers to focus on the full maternity care continuum:

Prenatal Care

- Promote early entry into prenatal care and encourage consistent follow up throughout pregnancy.
- Assess for medical, behavioral, and social risk factors that may affect pregnancy outcomes.

Postpartum Care

- Reinforce the importance of timely postpartum visits following delivery.
- Address physical recovery, behavioral health needs, chronic condition management, and contraceptive planning.

Care Coordination & Referrals

- Collaborate with care management programs when additional support is needed, particularly for high-risk pregnancies or postpartum complications.
- Early identification of needs and timely referrals can reduce preventable complications and readmissions.

Partnering for Better Health Outcomes

Your proactive engagement in preventive screenings and maternity care coordination directly supports Aspirus Health Plan's quality improvement goals and, most importantly, the health of our members. Thank you for your continued partnership and commitment to advancing women's health across our communities.

Billing Multiple Surgical Procedures on One 837I (UB04) Line

In the 837I charge area, revenue codes are listed in FL 42, and the total charge is in FL 47. *Each line should represent a distinct service or charge.*

When It's Not Allowed

- **Separate, distinct procedures:** If the procedures are distinct and separately payable (e.g., two different surgeries on the same day). *Most commercial payers require them to be billed separately with their own revenue codes and charges.*
- **Multiple procedure rules apply:** If the procedures are subject to the NCCI multiple procedure reduction (MPI 2), *each must be billed separately*, and payment is based on the highest-valued procedure plus reductions for the rest.
- **Different surgeons or teams:** If co-surgeons or different providers perform distinct surgeries, each must be billed separately.

When It's Allowed

- **Incidental or component procedures:** If the second or subsequent procedure is a component of the primary procedure (e.g., a biopsy during a surgical resection), it is not separately billable and should be included in the primary procedure's revenue code and charge.
- **Same operative session:** If all procedures are performed by the same surgeon(s) during the same operative session, they may be bundled under one line if they are *not separately payable* under NCCI or other payer rules.
- **Add-on codes:** Some add-on codes are valued to account for being performed alongside a primary service, so they can be included in the same line.

Multiple surgical procedures on one 837I line and one total charge is allowable, **only** if they are components, incidental to, or part of the same operative session and not separately payable. If they are distinct and separately payable, ***must be billed separately*** to comply with Commercial payer rules.

May is Mental Health Awareness Month: Strengthening Whole Person Care in Primary Care Settings

Each May, **Mental Health Awareness Month** provides an opportunity to reaffirm the important role mental and behavioral health play in overall health and wellbeing. Primary care practices are often the **first point of contact** for patients experiencing depression, anxiety, substance use concerns, or stress related conditions. Early identification and timely intervention can significantly improve outcomes for patients and families.

The Value of Routine Behavioral Health Screening

Integrating mental health screening into routine primary care visits helps normalize conversations around behavioral health and supports early recognition of concerns that may otherwise go undetected. **Validated screening tools** are brief, evidence based, and easily incorporated into existing workflows, including annual wellness visits, chronic condition follow-up, and new patient visits.

Commonly used screening tools include:

- PHQ 2 / PHQ 9 – Depression
- GAD 2 / GAD 7 – Anxiety
- AUDIT C or SBIRT – Alcohol and substance use
- Suicide risk screeners (when clinically indicated)

These tools support structured clinical conversations and help guide next steps, including further assessment, treatment planning, or referral. Screening is most effective when practices have **clear follow-up and referral pathways** in place.

Integrating Behavioral Health Into Primary Care

Behavioral health integration allows primary care teams to address both physical and mental health needs in a coordinated, patient centered way. Practical approaches to integration may include:

- Embedding screening tools into intake or rooming workflows
- Using care teams (e.g., care managers, social workers) to support follow-up
- Coordinating referrals and sharing information with behavioral health providers
- Engaging patients in shared decision making around treatment options