Network Management

MEDICARE APC GROUPER UPDATE

On the last weekend of May 2022, PreferredOne loaded the April 2022 Medicare APC grouper into production so that new diagnoses codes would group and price. The weight and rate files did not change, so there should be no impact to reimbursement.

PAYMENT POLICIES REMINDER

As a friendly reminder to our contracted provider partners, we've included the Aspirus Health Plan (AHP) Timely Filing, Late Charges/Corrected Claims, and Provider Appeals payment policies below. These policies include important information around claim filing and claim appeal timelines. Payment policy documents can also be found by logging in to the AHP secure provider portal and clicking on the link titled Office Procedures Manual.

P-29 Timely Filing

PURPOSE: To require that a Provider submit claims for Covered Services within 120 days (unless stated otherwise in your provider agreement) from the date the Covered Services are provided, or within 60 days from the date of the primary payer's explanation of benefits when Payer is not the primary payer of such Covered Services.

POLICY: Provider will submit claims for Covered Services within 120 days from the date the Covered Services are provided, or within 60 days from the date of the primary payer's explanation of benefits when Payer is not the primary payer of such Covered Services.

Failure to comply will result in denial of payment. Payer will have no obligation to pay but will consider appeals from claims denied for timely filing only if Payer receives such appeals within 60 days from the date of the initial denial. Appeals will be denied if not submitted within the employer's payment guidelines.

In no event will the payer be obligated to pay any claims submitted more than 365 days after the date the charges were incurred.

PROCEDURE:

1. Provider may appeal a timely filing denial to Aspirus Health Plan by including supporting documentation of previous billing or other causes for late submission within 60 days from the date of the initial denial.
2. Timely filing denials must be appealed with supporting documentation to your designated Provider Relations Representative either via email, fax or mail to:
   Aspirus Health Plan
   Attn: Provider Relations Representative
   6105 Golden Hills Drive
   Golden Valley, MN 55416

3. Claims may be reconsidered for payment for the following reasons:
    - Previous billing
    - Coordination of Benefits (COB)
    - Long term hospital stays
    - Inaccurate Payer information provided by member
4. A Remittance Advice will be sent to the provider indicating the results of the appeal.

002 Late Charges/Corrected Claims

PURPOSE: To provide reimbursement guidelines for late charges to ensure timeliness of the claims adjudication process and to decrease adjustments, manual intervention, incorrect payment, and rework by having all charges submitted together.

POLICY:

1. Aspirus Health Plan will not accept any billings that include only late charges.
2. To assure correct adjudication and payment of services, Aspirus Health Plan requires all related services to be submitted on a single facility claim (UB-04 or 837I).
3. A late charge must be billed as a corrected claim. A corrected claim is required using the type of bill XX7 to indicate that it is a corrected claim. Late charges billed in any other format will be denied back to the provider.
4. All corrected claims must be received in our office within 60 days of remittance date of the original claim.

DEFINITIONS: A late charge refers to those charges that are submitted after the original admit-through-discharge claim. A late charge is defined as those charges omitted from the original billing.

005 Provider Appeals

PURPOSE: To inform Providers of Aspirus Health Plan's appeal process.

POLICY:
1. All appeals must be submitted and received by Aspirus Health Plan within 60 days of the date of the original remittance.
2. The Provider should submit a written appeal along with any supporting documentation to the appropriate department within 60 days of the date of the original remittance.
    a. Coding reviews should be sent directly to the coding department along with supporting documentation.
    b. Timely filing, pricing and claims adjustment appeals should be sent directly to the provider relations department along with supporting documentation.
3. In no event will Aspirus Health Plan be obligated to review appeals submitted after 180 days of the original remittance date.

DEFINITIONS:
An appeal is a written request for review.

REFERENCES:
Pricing & Payment Policy Late Charges\Corrected Claims Reference #002
Pricing & Payment Policy Timely Filing Reference #001

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 underutilization.

Utilization management decision making is based only on the appropriateness of care and service and existence of coverage.

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 (aspirushealthplan.com/group-individual). (Click on Providers then choose Provider Resources then click on 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) 847-3386 or online at Heather.Hartwig-Caulley@AspirusHealthPlan.com.

Prior Authorization List

- Cardiovascular: Left Atrial Appendage – added CPT codes 33267, 33268, 33269
- Gender Reassignment – added CPTs 14000, 14001, 14041, 1534, 15738, 15750, 15757, 15758, 15769, 15771, 15772, 15773,15774, 53410, 58180, 58554, 58720, 58940, 64856, 64892, 64896 and deleted CPTs 56810, 57106, 57107, 57291, 57292, 58263, 58275
- Laboratory Testing: Comparative Genomic Hybridization - added CPTs 81349, 0209U, S3870
- Molecular Testing, Gene Expression – added CPTs 81523, 0287U, 0288U – deleted 0208U
- Pharmacogenetic/Pharmacogenomic testing added CPTs 0029U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U, 0175U
- Neurology: Hypoglossal nerve stimulation – added CPTs 64582, 64586 and deleted CPTs 0466T, 0467T
- Radiofrequency ablation – added CPTs 64627, 64659 – deleted HCPCS C9752, C9753
- Obstructive Sleep Apnea Surgery, Adult: replaced Uvulopalatopharyngoplasty with Palatopharyngoplasty (same CPT Code).

Prior Authorization Form

- Clinical Trial Notification – new

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies List

- Revisions
    - Compression burn garments – revised quantity limit verbiage
        - A6501, A6502, A6503, A6509, A6510, A6511, A6512, A6513 – 12 per year changed to 1 per month
        - A6504, A1505, A6506, A6507, A6508 - 24 per year changed to 2 per month
    - Positioning cushion/pillow/wedge
        - Added HCPCS E0190 as non-covered
        - Deleted the entry that it would be allowed for infants with severe GERD
- Deletions: Intermittent limb compression device, NOS (HCPCS E0676)

Medical Clinical Policies

- New
  - Gender Reassignment, Surgical Treatment for Gender Dysphoria (MC/G019)
  - Pharmacogenetic Testing, CYP2C19 and CYP2D6 (MC/L027)

- Revisions (substantive clinical revisions)
  - Dental Services, Pediatric Orthodontic Coverage Under Medical Benefit (MC/B003) –Roman numeral I. revised statement related to cleft lip/cleft palate
  - DMEPOS, Continuous Glucose Monitoring Systems for Long-term Use (MC/L008) and DMEPOS, Insulin Infusion Pump (MC/L011) - revised age range for the TSlim X2 with Control-IQ technology
  - Intervertebral Disc Prosthesis, Cervical and Lumbar (MC/F022) – Revised Contraindications I.E.3 statement related to lordosis of the cervical spine
  - Molecular Testing, Gene Expression (MC/L012) – Revised Roman numeral II.C. Prostate, deleted indications regarding life expectancy and revised Decipher's medical necessity requirements
  - Pharmacogenetic/Pharmacogenomic Testing (MP/P013)
    - FoundationOne CDx is now approved as a companion diagnostic test for melanoma and non-small cell lung cancer (NSCLC)
    - Oncomine DX is now approved as a companion diagnostic test for the use of Rybrevant (amivantamab-vmjw) for NSCLC
  - Preventive Coverage for Colorectal Cancer Screening (MP/P014)
    - Addition of new Coverage Statement
    - The age to allow any of the Colorectal Cancer Screening preventive/no cost-sharing services is lowered to age 45. The coverage goes through age 75; ends on 76th birthday
    - Deleted Barium enema as a test for colorectal cancer screening
    - Revised various diagnosis to procedure code requirements
  - Preventive Coverage for Osteoporosis Screening (MP/P016) - Covered procedures has been revised; Removed the limitation to allow once per lifetime, only; cost-sharing versus no cost-sharing is driven by the diagnosis code submitted on the claim
  - Preventive Coverage for Prenatal Services (MP/P015)
    - Revision of the last paragraph, under Background, to align with the COC and SPD coverage language
    - Addition of the new coverage for provision on Counseling for Healthy Weight and Weight Gain During Pregnancy (Released May 2021; Effective June 2022 and upon group renewal, thereafter)
    - Expansion of coverage for ultrasounds, by the addition of CPT codes 76811, 76812, 76816 and 76817 for groups subject to Minnesota state statutes
  - Radiofrequency Ablation (MC/F024) - addition of the statement under the Site of Care indications Roman numeral I.D.
  - Special Coverage for the COVID-19 Pandemic (MP/C016) – revised included services
  - Speech Therapy, Outpatient Setting (MC/N004) - Combined the previous A and C statements, into one new statement (A) and added language and hearing as other areas where a functional defect/physical impairment may occur (beyond speech or swallowing), and for which speech therapy may be allowed

- Retired
  - Gender Reassignment, Non-Surgical Treatment for Gender Dysphoria (MC/G014)
  - Hospice Services (MP/H007)

Medical Investigative List

- Addition: Skin and soft tissue substitutes; does not include the products under Comments

- Revisions
  - Acellular and cellular dermal replacement products from human placental membrane and umbilical tissue for wound care has been revised to allow Epifix® or Grafix® (GrafixPL, GrafixPL PRIME) for treatment of diabetic foot and chronic venous ulcers, only; all other uses are investigative
  - Cerebral perfusion analysis using computed tomography – is now proven effective for acute cerebral ischemia (acute stroke, only); all other uses remain investigative
  - Extensive code revisions made throughout the Investigative List
  - Implantable subcutaneous target stimulator / peripheral subcutaneous field stimulation (PSFS)/ peripheral nerve field stimulation (PNFS); Comments/definitions revised to include the name of a device, the Sprint PNS System and to also include chronic migraine prevention or treatment as examples of investigative uses

- Deletions
  - Computed tomography scan for purpose of biomechanical computed tomography analysis CPT 0558T
  - Pharmacogenetic/pharmacogenomic testing, GeneSight Psychotropic panel
  - Prosthesis, lower limb - powered microprocessor components – deleted HCPCS code L5859

Please visit www.aspirushealthplan.com for the most current version.

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	3008F
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	3079F(diastolic 80-89mmHg), 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 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 2021 are accurate. Thank you!

Reminding Patients of Yearly Physical Exam
As the end of 2022 rapidly approaches, 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.

CODING

ICD-10-CM Coding Reminders
Z79.01 - Z79.899Long-term (current) drug therapy
PreferredOne receives claims with diagnosis Z79.899 (Other long term (current) drug therapy) on claims for drug testing (CPT® codes 80305 – 80307, 80320 – 80377, HCPCS codes G0480 – G0484 and G0659). This is incorrect and will result in the claim being denied for incorrect diagnosis. Resource for this determination is the ICD-10-CM Official Guidelines for Coding and Reporting, Chapter 21: Factors influencing health status and contact with health services (Z00 – Z99).

Subcategory Z79); Codes from this category indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs. This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms in patients with drug dependence (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug dependence instead.