Provider Newsletter

August 2026

August 2026 Newsletter: Coding Updates & Quality Push

Thank you for your commitment to caring for our members. In this issue, we are highlighting important updates and practical reminders to support providers in delivering timely, coordinated, and well-documented care. Topics include provider survey changes, coding and billing guidance, authorization submission tips, influenza and immunization opportunities, maternity and prenatal billing changes, HEDIS performance updates, and documentation best practices.

These updates are important because they directly affect provider workflows, claim accuracy, authorization processing, preventive care outreach, quality performance, and the member experience. By reviewing and sharing this information with your teams, practices can help reduce avoidable delays and denials, close care gaps, strengthen care coordination, and ensure the care delivered is accurately reflected in quality reporting.

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.

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

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

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

Every July, Aspirus Health Plan sends our annual Provider Survey to contracted providers. As you prepare to complete your survey, please be aware of 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 has Changed 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	***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.* **Question:** Patients are able to access an urgent care appointment within 24 hours? **Responses:** Yes / No **If No:** Please describe (free text)	***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

Best Practices for Answering the Updated Survey Question

- **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.

Avoiding Denials for UNLISTED LAB CODE Submissions

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

When submitting an unlisted lab code, a detailed description or the lab test name must be included on the 837P (1500) or the 837I (UB04) claim form. On the electronic form, the description must be 80 characters or less. Even if the description can be summarized in this small space, it is ok to send additional claim attachments such as a cover letter, lab order, etc. Any attachment is to be electronically sent with the original claim to expedite claim processing**. Failure to provide a detailed description or test name will result in a line item denial of the code.**

Any appeal submitted that continues to not identify the exact test performed will not be considered for adjustment. Simply submitting lab test records is inadequate as providers of the service are accountable for knowing why a code was submitted and for what service.

Examples of frequently submitted unlisted lab codes:

- 80299 Quantitation of therapeutic drug, not elsewhere specified
- 83520 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified
- 86317 Immunoassay for infectious agent antibody, quantitative, not otherwise specified
- 87799 Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism
- Any code with descriptors of "…, not specified, not elsewhere classified, unspecified, etc.", contained within the description

Preparing for the 2026–2027 Influenza Season:

Protecting Patients Through Vaccination

As we prepare for the 2026–2027 influenza season, practices may consider beginning patient outreach and planning for annual influenza vaccination. Influenza remains a significant cause of illness, hospitalization, and preventable complications, particularly among older adults, pregnant individuals, young children, and patients with chronic medical conditions. Annual vaccination remains the most effective strategy for reducing the risk of influenza infection and related complications.

Key Messages for Providers

Support vaccination at the appropriate time. For most patients who need one dose, September and October are generally the preferred months, with vaccination ideally completed by the end of October. Vaccination should continue throughout the season while influenza viruses are circulating. Most adults—particularly those age 65 and older—should generally avoid vaccination in July and August unless later vaccination may not be possible.

Vaccination is recommended for nearly everyone. The CDC recommends annual influenza vaccination for all individuals 6 months of age and older who do not have contraindications. A clear provider recommendation remains one of the most influential factors in a patient's decision to be vaccinated.

Focus on patients at higher risk. Consider additional outreach and access support for patients at increased risk for severe influenza-related complications, including, but not limited to:

- Adults age 65 years and older; when available, offer a high-dose inactivated, recombinant, or adjuvanted influenza vaccine. If none is available, administer another age-appropriate influenza vaccine.
- Pregnant individuals.
- Children younger than 5 years.
- Individuals with asthma, COPD, diabetes, cardiovascular disease, chronic kidney disease, immunocompromising conditions, or other chronic medical conditions.
- Residents of long-term care facilities.

Collaborative Strategies to Support Vaccination

Practices may consider the following approaches based on their patient population, staffing, and existing workflows:

- Assess vaccination status during routine office visits.
- Use standing orders and reminder systems where appropriate.
- Leverage patient portals, text messages, and outreach campaigns.
- Provide clear education on the safety and effectiveness of influenza vaccination.
- Offer vaccination opportunities during chronic care and preventive visits.
- Document vaccine administration—or confirmed receipt from another provider or pharmacy—in the medical record and applicable immunization registry.

Supporting influenza vaccination efforts can complement broader preventive care initiatives and help reduce seasonal illness among patients.

Addressing Common Patient Concerns

When questions arise, providers can reinforce that:

- Flu vaccines cannot cause influenza illness.
- Vaccine formulations are updated annually to target the strains most likely to circulate during the season.
- Even when vaccinated individuals develop influenza, vaccination may reduce illness severity and the risk of hospitalization.

Partnering to Support Patient Vaccination

MY2025 results identified opportunities to improve influenza and other immunization rates across our member population. These findings reinforce the value of using existing practice and CIN workflows to identify open preventive care needs, coordinate outreach, support member education, and ensure vaccines administered in the office, pharmacy, or other settings are accurately documented and reflected in quality reporting.

As trusted healthcare professionals, your recommendation plays a critical role in helping patients protect themselves, their families, and their communities. Practices may consider incorporating influenza vaccination discussions into routine patient encounters and beginning outreach early enough to support vaccination at the clinically appropriate time.

By strengthening the patient outreach, preventive care, vaccination, and documentation workflows already in place across the CIN, we can improve immunization rates, reduce preventable illness and avoidable utilization, and support better outcomes for our members.

Together, we can improve influenza vaccination rates, reduce preventable illness, and support healthier communities throughout the influenza season.

Sources: CDC, 2026–2027 Flu Season; CDC/ACIP Influenza Vaccination Recommendations. Accessed July 17, 2026.

Payer ID renamed to Aspirus Health Plan

EDI Announcement: The names associated with our payer IDs at the EDI clearinghouses will be renamed to "Aspirus Health Plan" this fall. The payer IDs themselves are not changing—only the associated name. The name changes are expected to take place during the fourth quarter of 2026. Please reach out to ProviderRelationsAHP@Optum.com if you have any questions about the name changes.

Tips for Outpatient Occupational Therapy/Physical Therapy to Avoid Common Submission Errors

When submitting **PT and OT** authorization requests for the following codes, please include PT (GP) and OT (GO) modifiers. Failure to include modifiers on authorization requests may result in delayed processing.

- Physical Therapy Modalities (97010- 97039) require modifier on auth request
- Therapeutic Procedure Modalities (97110- 97150) require modifier on auth request
- Functional & Adaptive Training (97530- 97546) require modifier on auth request
- Caregiver Training (97550- 97552) require modifier on auth request
- Wound Care & Tissue Removal (97597- 97610) require modifier on auth request
- Physical Medicine and Rehabilitation Tests and Measurements (97750- 97755) require modifier on auth request
- Orthotic Management and Training and Prosthetic Training (97760- 97763) require modifier on auth request
- Other Physical Medicine and Rehabilitation Service or Procedures (97799) require modifier on auth request

Modifier	Discipline
GP	**Physical Therapy**
GO	**Occupational Therapy**

Include Required Therapy Modifiers on Authorization Requests

To support accurate processing of outpatient therapy authorizations, Aspirus Health Plan is reminding providers to include the appropriate modifier when submitting authorization requests for applicable therapy modality codes.

Required Action

When submitting authorization requests for applicable therapy modality codes, please:

- Include the modifier associated with the therapy discipline being provided.
- Use the same modifier you intend to bill on the claim.
- Include the modifier when submitting requests through the authorization portal or via fax. Based on the meeting discussion, the expectation is to provide the modifier at the time of authorization submission because authorization requests cannot be modified after receipt.

Why This Matters

Authorization and claims teams cannot add, remove, or change modifiers after a request has been submitted. Requests must be submitted accurately to support efficient authorization review and claims processing.

Requests submitted without the appropriate modifier may:

- Require additional follow-up or provider outreach.
- Delay authorization processing.
- Result in mismatches between the authorization and submitted claim.
- Create claim-processing issues that require additional review.

Who This Applies To

This reminder applies to providers submitting authorization requests for:

- Physical Therapy (PT)
- Occupational Therapy (OT)

Particular attention should be given when submitting therapy modality codes that require a modifier to identify the therapy discipline.

Providers should continue to follow current coding guidance and use the appropriate modifier for the therapy discipline being billed. Code lists may change over time.

Additional Guidance

Please refer to the attached Provider Therapy Modifier Quick Guide for submission examples and additional modifier guidance.

Questions or Support

Aspirus Provider Relations: providerrelationsahp@optum.com

Thank you for your partnership and continued commitment to accurate authorization submissions.

2027 CPT Maternity Care Coding Changes

Effective January 1, 2027, CPT® maternity care coding will undergo significant changes. The current global maternity care codes that simplified billing and represented 9 months of care as a single service, no longer reflects the evolution of team-based maternity care due to complexity, specialized postpartum monitoring and use of telehealth. Maternity care reporting will reflect actual services rendered which should lead to more accurate data for risk adjustment, quality measures, population health reporting and evolving payment models.

Maternity care will be identified by 4 separate phases:

- Antepartum care
- Labor management care
- Delivery care
- Postpartum services

Highlights of the changes (additional detailed information will be published at a later date):

- Revision of 6 codes
- Addition of 12 codes
- Deletion of 17 codes
- Relocation of a few codes
- New subsections and guidelines

The American Medical Association (AMA) has multiple resources on these changes at

CPT® 2027 Maternity Care Services code changes | American Medical Association

NEW Maternity/Prenatal Billing eff 1/1/27 with Phase in Period

The American Medical Association (AMA) is eliminating the global maternity/prenatal package and ALL services will be individually billed starting 1/1/27. ACOG (the American College of Obstetricians and Gynecologists) is heavily involved and offering feasible recommendations in hopes of eliminating tons of denials and revenue loss.

One phase-in recommendation from ACOG:

ACOG recommends providers switch to billing by component for members who begin prenatal care in 2026 and are expected to deliver in 2027.

- For members who begin prenatal care in 2026 and are expected to deliver in 2027, providers should bill each prenatal visit using the appropriate Evaluation and Management (E/M) code (99202–99499); and append the TH modifier to indicate the visit is for obstetric care. ACOG recommends providers begin this by June 1, 2026, and no later than **Sept. 1, 2026**.
- Providers can separately bill services that were previously bundled into the global code, including nutrition counseling and other medically necessary services, in the new coding structure. Bill these using the appropriate codes with the E/M visit and TH modifier.

HEDIS Performance & Quality Improvement Opportunities:

Measurement Year 2025 Results | Commercial and Exchange

Partnering for Better Member Outcomes

The strong results achieved in MY 2025 reflect the dedication of our provider community and the value of coordinated care across the Aspirus clinically integrated network (CIN). Provider efforts contributed to meaningful improvement in behavioral health follow-up, blood pressure control, kidney health evaluation, medication adherence, and maternal care. The remaining opportunities are shared priorities for the health plan and CIN—particularly preventive care, referral closure, complete documentation, and member engagement. Strengthening these existing capabilities can improve patient outcomes, quality performance, avoidable utilization, and total cost of care.

2025 Quality Highlights

Behavioral Health Follow-Up Improved

Strong gains were achieved in Follow-Up After Hospitalization for Mental Illness (FUH), particularly for the Exchange 30-day rate and Commercial 7-day and 30-day rates.

Measure	Commercial 2024	Commercial 2025	Exchange 2024	Exchange 2025
FUH 7-Day	50.88%	60.00%	61.90%	62.96%
FUH 30-Day	82.46%	86.67%	80.95%	92.59%

Chronic Disease Management Successes

- Controlling High Blood Pressure increased to 81.36% in Commercial and remained above 81% in Exchange.
- Glycemic control improved in Commercial, with more members achieving glycemic status below 8.0%.
- Statin therapy for members with cardiovascular disease improved in Commercial to 90.48%.
- Kidney Health Evaluation rates exceeded 73% across both Commercial and Exchange populations.

Maternal Health Remains Strong

Prenatal and postpartum care measures continued to demonstrate relatively strong performance across both lines of business. While MY 2025 rates for both Prenatal and Postpartum Care remain below MY 2023 performance levels across both the Exchange and Commercial lines of business, Exchange results showed year-over-year improvement for both Timeliness of Prenatal Care and Postpartum Care. Within the Commercial line of business, Postpartum Care improved modestly, while Timeliness of Prenatal Care declined. These results support continued focus on existing provider engagement, care management, and scheduling processes designed to identify pregnancies early, facilitate timely prenatal and postpartum visits, and address documentation gaps that may affect measure performance.

Line of Business / Measure	2023	2024	2025	Trend Note
Commercial – Timeliness of Prenatal Care	89.04%	88.37%	86.41%	Below 2023; declined from 2024
Commercial – Postpartum Care	95.19%	94.19%	94.57%	Improved from 2024; below 2023
Exchange – Timeliness of Prenatal Care	97.30%	60.87%	90.00%	Improved from 2024; below 2023
Exchange – Postpartum Care	94.59%	82.61%	90.00%	Improved from 2024; below 2023

Shared opportunity: Continue strengthening existing outreach, scheduling, and care coordination processes to support timely prenatal and postpartum care.

Shared Quality Improvement Opportunities

Shared CIN and Value-Based Care Opportunity

The MY 2025 findings are an opportunity to strengthen existing system capabilities—not reinvent the wheel. Reliable gap lists, coordinated outreach, referral closure, care management support, structured documentation, and improved data exchange can help practices close care gaps while advancing patient outcomes, reducing avoidable utilization, improving quality performance, and managing total cost of care.

How Aspirus Health Plan can support practices

- Actionable gap lists and member-level data
- Coordinated member outreach and care management support
- Documentation and measure guidance
- Referral and data-exchange improvement
- Performance feedback to identify where additional support is needed

Diabetic Eye Exams

Diabetic retinal eye exam completion declined across both product lines. This represents a shared opportunity to strengthen existing referral, follow-up, and documentation processes so completed care is visible and reflected in quality reporting.

Line of Business	2024	2025
Commercial	63.02%	54.12%
Exchange	46.72%	35.29%

- Review retinal examination needs during diabetes care and place referrals when clinically appropriate.
- Reinforce the value of early detection of diabetic retinopathy through routine patient education.

- Use existing referral follow-up processes to identify and address incomplete specialist visits.
- Capture and exchange retinal exam results through established EHR and health information workflows.

Pediatric Preventive Care

Several pediatric wellness measures declined, including child and adolescent well-care visits, weight assessment and counseling, nutrition counseling, physical activity counseling, and selected immunization measures. Existing preventive-care workflows can be used to identify open gaps and support families in completing recommended services.

- Use existing scheduling workflows to support annual wellness visit completion.
- Capture BMI percentile, nutrition counseling, and physical activity counseling in structured EHR fields.
- Review immunization status during appropriate visits and address gaps based on clinical guidance.
- Coordinate health plan and practice outreach for members who need preventive visits or vaccinations.

Substance Use Disorder Treatment

Exchange results identify a continued opportunity to improve initiation and engagement in substance use disorder treatment. Progress will depend on coordinated screening, warm referral pathways, follow-up, and member engagement across primary care, behavioral health, and care management.

Measure	Exchange 2025
Initiation of SUD Treatment	33.04%
Engagement of SUD Treatment	4.35%

- Use validated screening tools, such as CAGE-AID or NIDA tools, when clinically appropriate and consistent with organizational workflows.
- Support timely follow-up after diagnosis using existing scheduling and care coordination processes.
- Strengthen warm handoffs and closed-loop communication for behavioral health referrals.
- Coordinate member engagement and follow-up through practice and health plan care management resources.

Depression Screening and Follow-Up

Current HEDIS reporting requirements reinforce the importance of consistent depression screening, structured documentation, and timely follow-up. The priority is to strengthen existing clinical workflows—not create a parallel process.

- Use PHQ-2 and PHQ-9 screening tools according to clinical guidelines and established organizational workflows.
- Document screening results in structured EHR fields so the care provided can be reliably measured.
- Use existing follow-up and care coordination pathways for members with positive screening results.
- Maintain clear referral pathways and closed-loop communication with behavioral health services.

Immunization Opportunities

Several immunization measures remain below desired performance levels, particularly in the Exchange population. Provider recommendations remain important, and existing CIN and practice workflows can support gap identification, outreach, vaccination, and complete documentation.

Adult Immunizations	Adolescent Immunizations	Childhood Immunizations
Influenza Hepatitis B Pneumococcal Td/Tdap Zoster	HPV Combination 2 Series Meningococcal Tdap	DTaP MMR Hepatitis A Combo 10 Series Influenza

Documentation Matters

HEDIS Documentation Reminder

Many HEDIS measures rely on complete, accurate, and timely documentation. Care may not be fully reflected in quality reporting when results are not captured in structured fields, received from specialists or pharmacies, or transmitted through established data-exchange processes. The health plan and CIN can help practices identify documentation gaps and improve visibility of care already delivered.

☐ BMI percentile ☐ Nutrition counseling

☐ Physical activity counseling ☐ Retinal eye exam results

☐ Depression screening results ☐ Immunization administration

☐ Follow-up appointments ☐ Behavioral health referrals and completed services

Key Takeaways

Areas of Strength	Areas of Focus
Behavioral health hospitalization follow-up Blood pressure control Kidney health evaluation Medication adherence Maternal care performance	Diabetic eye exam completion Preventive care visits Childhood and adolescent immunizations Depression screening documentation SUD treatment initiation and engagement Referral closure and data exchange Weight assessment and counseling

Thank you for your continued partnership. By strengthening the workflows already in place across the CIN, we can improve patient outcomes, close care gaps, reduce avoidable utilization, and ensure the care delivered is accurately reflected in quality performance.

Reporting Recommendations for Ambulatory Infusion Suite (AIS) of the Home Infusion Therapy (HIT) Providers

HIT providers may also operate an AIS health care facility where highly skilled RNs and Registered Pharmacists (RPh; PharmD), provide clinical care for physician prescribed infusion/specialty drug administration.

The National Home Infusion Association (NHIA) recommends the following for reporting of these provider's services rendered in an AIS:

- Place of Service (POS)
    - 12 (*location, other than a hospital or other facility, where the patient receives care in a private residence*)
- Nursing Codes
    - 99601 (*Home infusion/specialty drug administration, per visit (up to 2 hours)*)
    - 96602 (*Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure*)
- Pharmacy Services
    - HCPCS "S----" codes from the Home Services Temporary National Codes section
- Modifier SS (*Home infusion services provided in the infusion suite of the IV therapy provider*)