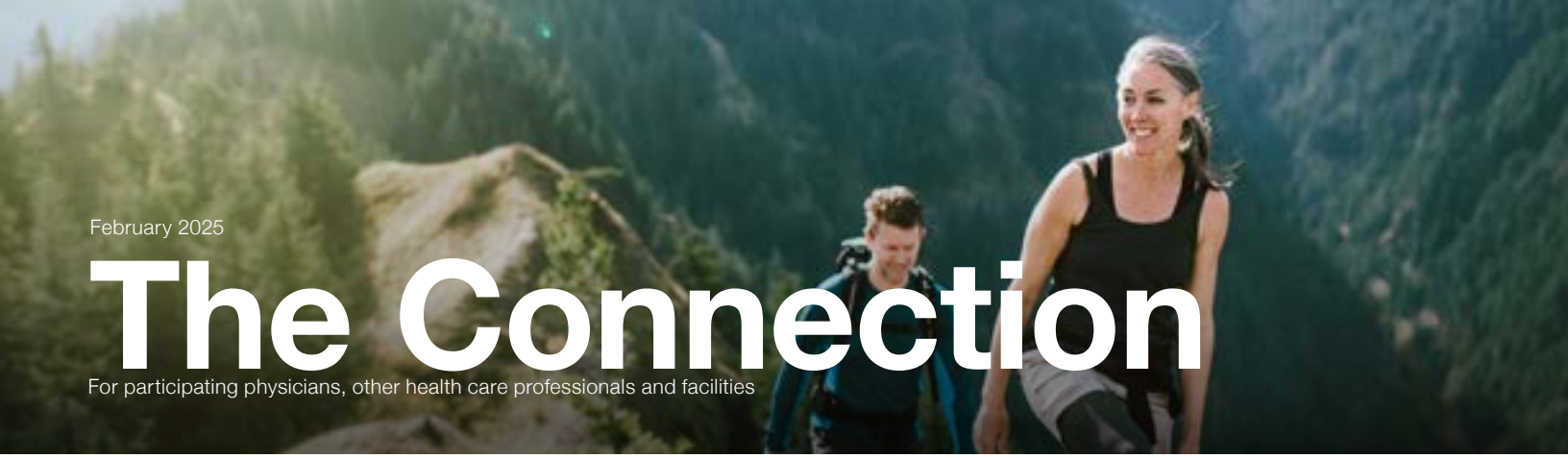


February 2025

The Connection

For participating physicians, other health care professionals and facilities

Resources to reduce hypertension and heart disease risk

This month, as we observe American Heart Month, it's essential to raise awareness about cardiovascular health and the importance of managing hypertension. According to the CDC, nearly half of adults in the U.S. have high blood pressure, and only about 25% of people with high blood pressure have their condition under control.

Rates of blood pressure control

Certain groups are more likely to have high blood pressure, including:

- Men (50%) more than women (44%)
- Non-Hispanic Black adults (56%) more than non-Hispanic White adults (48%), non-Hispanic Asian adults (46%) or Hispanic adults (39%)

Blood pressure control varies among those recommended to take medication, with non-Hispanic White adults (32%) having higher control rates than non-Hispanic Black adults (25%), non-Hispanic Asian adults (19%) or Hispanic adults (25%).

Empowering patients to take control

As a health care provider, you play a vital role in educating patients with hypertension about the importance of:

- Tracking their blood pressure
- Taking prescribed medications, if appropriate
- Implementing lifestyle changes to reduce their risk of disease

To support your efforts, we recommend using registries within your electronic medical record (EMR) to review dates of past prescription refill requests and the last office visit note for follow-up instructions.

Continued on page 3

Easily find information

Did you know that you can search for words in this newsletter by holding down the **Ctrl** key on your keyboard and then the letter **F**? A pop-up window will appear asking if there's a word or phrase you need to find.

Subscribe today

Subscribe to receive email notifications when new issues of our publications are available.

Using our website

When you first visit **asuris.com**, you will be asked to select an audience type (individual, employer, producer or provider) and enter a ZIP code for your location. This allows our site to display content relevant to you.

Stay up to date

View the What's New section on the homepage of our provider website for the latest news and updates.

ASURIS NORTHWEST HEALTH

Asuris Northwest Health

528 East Spokane Falls Blvd, Suite 301
Spokane, WA 99202

Contents

■ Critical article
● Cardiology
▲ Radiology
★ Star Ratings/Quality

We encourage you to read the other articles because they may apply to your specialty.

Click on a title to read the article.

About *The Connection*

This publication includes important news, as well as notices we are contractually required to communicate to you. In the table of contents, this symbol indicates articles that include critical updates: ■. To save you time, you can click on the titles to go directly to specific articles. You can also return to the table of contents from any page by clicking on the link at the bottom of each page.

Issues are published on the first of the following months: February, April, June, August, October and December on our provider website: Library>Newsletters.

The information in this newsletter does not guarantee coverage. Verify members' eligibility and benefits via Availity Essentials.

The Bulletin

We publish a monthly bulletin as a supplement to this bimonthly provider newsletter. *The Bulletin* provides you with updates to medical and reimbursement policies, including changes we are contractually required to communicate to you. It is available on our provider website: Library>Bulletins.

Share your feedback

Are our publications meeting your needs? Send us your comments.

Continued from page 1

Streamlining claims and supporting quality reporting

For all office visits, please submit blood pressure results on your claims using CPT level II codes. This will help reduce our requests for medical records and support our quality reporting for Healthcare Effectiveness Data and Information Set® (HEDIS®) and Medicare Star Ratings.

Programs

Omada for Hypertension is available as a buy-up option for administrative services only (ASO) groups. Learn more on our provider website: Programs> Medical Management>Hypertension.

Resources

Visit the Quality Improvement Toolkit, available on the homepage of our provider website, for the latest resources and information on hypertension management and cardiovascular health:

- **American Heart Association**: Patient education resources on hypertension, blood pressure monitoring and lifestyle changes
- **Healthwise flyers**: On the Quality Improvement Toolkit, select **Hypertension** to view flyers that are available for printing and sharing with patients, and cover such topics as high blood pressure, angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs), as well as the dietary approaches to stop hypertension (DASH) diet.
- **Hypertension Control Change Package**: A resource from Million Hearts that lists process improvements for outpatient clinical settings to achieve optimal hypertension control
- **Live to the Beat**: A campaign aimed at reducing cardiovascular disease risk among Black adults ages 35-54
- **Million Hearts**: A national initiative to prevent one million heart attacks and strokes within five years

2024 publications survey results

We recently conducted a survey to gather feedback from our providers about our newsletter and bulletin.

Key findings:

- **Most-read content**: The majority of respondents found the following topics to be the most useful:
  - Administrative and other updates (e.g., claim submission reminders, coding tips)
  - Availity Essentials
  - Medical policies
  - Reimbursement policies
  - New programs impacting the provider community
- **Ease of navigation**: The majority of respondents found the newsletter to be easy to navigate.
- **Specialty-specific content**: Many respondents requested more specialty-specific content. We will continue to highlight specialty-specific topics in the table of contents and behavioral health topics in the Behavioral health corner.

Subscribe to receive an email when new issues are available.

Thank you for taking the time to participate in our survey. We value your feedback and look forward to continuing to improve our newsletter and services to meet your needs.

Administrative Manual updates

The following updates were made to the manual on February 1, 2025:

Medical Record Requirements

- Clarified that e-signatures also require date/time stamp and credentials

Medicare Advantage Plans

- Updated section for 2025

Our manual sections are available on our provider website: Library>Administrative Manual.

New PRIA enhancements expand financial insights

We are excited to announce the addition of new functionality to our Provider Reporting Insights & Analytics (PRIA) platform: Medicare Financial Estimates report and automatic scheduling for Quality Gaps. These enhancements are designed to offer providers on alternative payment model (APM) arrangements even more actionable insights to help them deliver high-value, patient-centered care.

Medicare Financial Estimates report

The Medicare Financial Estimates report offers early and directional financial estimates for Medicare Advantage agreements. The report was made available in January 2025 and contained 2024 data. 2025 data will be available beginning in April 2025.

Automated Quality Gap reports

Quality Gap reports can now be scheduled to run automatically, allowing you to stay up to date with gap closure opportunities with ease. Running this report was previously a manual process, and we're excited to bring you this time-saving convenience.

The power of PRIA

PRIA is a cutting-edge business intelligence and analytics platform designed to support providers in APM arrangements with over 1,000 attributed members. With PRIA, providers can:

- Access their data anywhere, anytime, with unprecedented depth of detail
- Use interactive dashboards and self-service reporting for unparalleled convenience and ease of sharing
- Drive high-value care with actionable insights

Designed for you, supported by us

PRIA is designed to be user-friendly, regardless of your role or analytical skills. As we continue to evolve and enhance PRIA, we're committed to staying focused on the needs of our providers. Whether through new features, expanded support or innovative solutions, we're dedicated to helping providers succeed in an ever-changing health care landscape. Together, we can unlock the power of data-driven insights and drive high-value, patient-centered care.

Your feedback matters

Your input is crucial in helping us make PRIA the best it can be for you and your team. We encourage you to share your feedback, suggestions and insights with your provider relations executive, including:

- What you like about the new features and how you're using them
- Any challenges or difficulties you're experiencing with the platform
- Ideas for future enhancements or features that would make PRIA even more user-friendly and effective for you

View resources on our provider website: Contracting & Credentialing>APM Resources.

Annual HEDIS medical record collection

Our HEDIS medical record reviews for measurement year 2024 will begin this month, continuing through May 2025. We have contracted with Virtix Health/Complex Care Solutions (CCS) to contact providers and collect data using a HIPAA-compliant process. We appreciate your help during this process and will work with your office to collect medical records by fax, mail or onsite visit (for larger clinics).

As a reminder, it is your responsibility as a participating Asuris provider to respond to these requests in a timely manner. Unless your provider agreement specifically states otherwise, you are required to provide us or Virtix Health/CCS access to member records for these purposes free of charge. A signed release from your patient—our member—is not required for us to obtain these records. If you contract with a copy service, please remember that you are responsible for guaranteeing they deliver the charts on time and at no cost to us or Virtix Health/CCS.

You can learn more about this year's review on our provider website: Programs>Quality>Quality Program>HEDIS Reporting.

Introducing our new chatbot

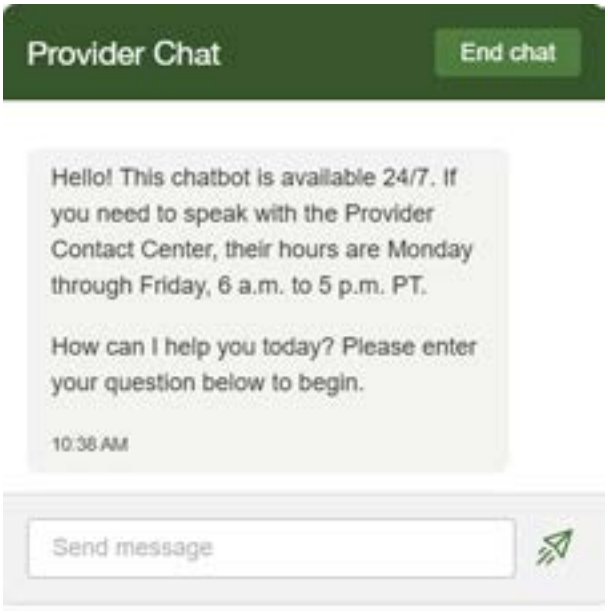
We are excited to announce the launch of a new interactive chatbot on our provider website. Chatbot is designed to provide you with quick and easy access to the information and support you need, 24/7. Provider chatbot can help you with these frequently asked questions:

- **Claims information**: Learn about electronic claims submission and how to check Availity Essentials for information about submitted claims
- **Provider directory validation**: View instructions for using our Find a Doctor tool to verify information about your practice and quickly submit changes
- **Provider networks**: Easily check the networks open to participation and start the onboarding process

We're committed to continuously improving and expanding our chatbot's capabilities. Soon, you can expect the following features to be added:

- **Contracting status**: Learn where to find your contracting status in Availity Essentials.
- **Credentialing status**: Check the current processing date for submitted applications.
- **Pre-authorization**: View the codes we require pre-authorization for and submit a request.
- **Pricing disputes**: Find more information on pricing disputes and submit a dispute.
- **Provider appeals**: Learn about the appeals process and options available to you.

Chatbot is available on the Contact Us and Self-Service Tool pages of our provider website.



New edit to review drug codes

CMS has established HCPCS codes for drugs that are product- or manufacturer-specific for generic drugs.

We are implementing a new ClaimsXten edit on May 1, 2025, that will deny claim lines when the HCPCS and national drug code (NDC) combination should not be reported together.

Example code pair that would be denied

- HCPCS J0131 is a general code for acetaminophen injection, 10 mg.
- NDC 63323-0434-41 indicates acetaminophen injection, 10 mg, manufactured by Fresenius Kabi.
- Because the manufacturer information doesn't match, the claim line would be denied and would need to be resubmitted with the correct HCPCS/NDC code combination.

Example code pair that would be reimbursable

- HCPCS J0134 indicates acetaminophen injection, 10 mg, manufactured by Fresenius Kabi.
- NDC 63323-0434-41 indicates acetaminophen injection, 10 mg, manufactured by Fresenius Kabi.
- The manufacturer information and generic drug names match, and the claim line would be reimbursable.

The edit will review services rendered by the same provider to the same member on the same date of service and on the same claim.

This edit will apply to:

- Commercial—professional and facility claims
- Medicare Advantage—professional claims only

Learn more about ClaimsXten in our Coding Toolkit, available on the homepage of our provider website.

Reminder: EDC Analyzer reviews

Beginning February 19, 2025, we will apply Optum's Emergency Department Claim (EDC) Analyzer to review emergency department (ED) claims pre-payment. The tool provides an ED visit-level analysis and code validation and is part of our continued efforts to reinforce accurate coding practices and payment.

Pricing disputes versus appeals

Many providers are unsure whether to submit a concern as an appeal or a pricing dispute, and many pricing disputes are incorrectly submitted as appeals. We understand this uncertainty is frustrating. Inaccurate submissions can also lead to:

- Delays in resolving your concerns
- Inefficient use of resources
- Resubmitting the issue using the correct process

What is a pricing dispute?

A pricing dispute is not an appeal. A pricing dispute occurs when a contracted provider disagrees with a decision about how a claim or claim line was processed. Some examples include disagreeing with the:

- Allowed amount on a claim line
  - **Example**: The allowed amount on Line 4 of this claim was $50. It should have been $70.
  - **Exceptions**: Unlisted codes or modifier 22.
- Percent of billed charges paid
  - **Exceptions**: Member cost share or benefit application.
- Diagnosis-related group (DRG) on a facility claim in absence of an audit finding issued
  - **Example**: The DRG on our facility claim was downgraded from 177 to 179. Our reimbursement should have been higher.

How to submit a pricing dispute

1. Confirm your issue is a valid pricing dispute stemming from disagreement with the contractual pricing of a claim or claim line item.
2. Validate your dispute using all available resources, including, but not limited to:
   - Your most recent reimbursement schedule
   - Your most recent agreement terms
   - Resources on our provider website, Availity Essentials or the Provider Contact Center
3. Gather supporting documentation.
4. Submit the pricing disputes using the Pricing Dispute Form on our provider website: Claims & Payment>Receiving Payment>Pricing Disputes & Appeals.

Notes:

- Pricing disputes cannot be submitted via Availity Essentials or fax
- The Balance Billing Dispute process does not apply to contractual pricing disputes
- Pricing disputes follow timely claims filing guidelines for claim adjustments

What is an appeal?

An appeal may concern more complex issues, such as:

- Adverse determinations relating to claims or line items denied as provider responsibility
- Administrative denial disputes when a claim is denied because pre-authorization requirements were not followed
- Provider contract termination
- Special Investigations Unit audits
- Medical or reimbursement policy reconsideration
- Pre-authorization determination appeals

How to submit an appeal

Pre-authorization determination and post-service provider claims appeals should be submitted using the Appeals application on Availity Essentials.

Learn more about the appeals process on our provider website:

- Claims & Payment>Receiving Payment>Pricing Disputes & Appeals
- Library>Administrative Manual> Appeals for Providers

If you need additional help determining which process to follow, call our Provider Contact Center.

Reminder: Billing same-day services on one claim

In accordance with our administrative guidelines, professional services for the same date of service must be billed on the same claim. Effective March 1, 2025, we will enhance our clinical editor to capture this requirement when an office visit is billed separate from the procedures performed on the same service date for the same provider. Services billed on separate claims will need to be resubmitted.

The importance of in-network referrals

As a health care provider, you play a vital role in guiding your patients towards making informed decisions about their health care. One crucial aspect of this is referring them to in-network providers for all services, including laboratory and genetic testing.

Why in-network referrals matter

By referring your patients to in-network providers, you're helping them:

- Minimize their out-of-pocket expenses
- Receive the highest level of medical and dental benefits
- Ensure convenient access to quality services

For some health plans, in-network referrals are particularly important because members may have limited or no out-of-network coverage, leaving them responsible for a large portion or all the out-of-network costs.

The risks of out-of-network referrals

Referring patients to non-participating providers can result in unexpected costs and reduced benefits. To avoid this, it's essential to notify your patients in writing that services may not be covered or may lead to higher out-of-pocket costs.

Easily find in-network providers

To locate in-network providers or verify your network participation, use the Find a Doctor tool on our provider website. You can search by name, location or specialty type, making it easy to find the right provider for your patients.

By prioritizing in-network referrals, you're not only ensuring your patients receive the best possible care but also helping them spend their health care dollars wisely.

CCD+ reassociation with EFTs and ERAs

In accordance with health care operating rules mandated by the Affordable Care Act (ACA), effective January 1, 2025, we include "1" as the prepended value in the TRN03 field of the Electronic Funds Transfer (EFT) Corporate Credit or Debit Entry Plus Addenda Record (CCD+). For example, TRN*1*0123456789***1**999999999~.

You may need to update your system accordingly to prevent a potential discrepancy when you re-associate your EFT with your electronic remittance advice (ERA).

Learn more about reconciling your payments with EFTs and ERAs on our provider website: Claims & Payment>Receiving Payment.

Verify your directory information

Accurate provider directories are essential to help members find providers who best meet their health care needs and individual preferences, such as

- Language access
- LGBTQIA+-affirming care
- Culturally specific services
- Disability-competent care

When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

Provider directories, verified and updated at least every 90 days, are a requirement for compliance with the Consolidated Appropriations Act (CAA), CMS, the Affordable Care Act (ACA) and your agreement as a network provider with Asuris.

- Review our *Provider Directory Attestation Requirements for Providers* policy.
- Follow the instructions to verify your directory information on our provider website at least every 90 days: Contact Us>Update Your Information.
- Review your National Provider Identifier (NPI) data in CMS' National Plan & Provider Enumeration System (NPPES). Visit NPPES help for more information.

Reminder: TRICARE T5 provider network

As a reminder, the TRICARE T5 provider network, administered by TriWest, went into effect on January 1, 2025. This network serves military service members and their families. We have partnered with TriWest to manage credentialing and contracting for participation in the TRICARE network.

If you are interested in joining the network but have not yet done so, please email us for more information.

Participating TRICARE providers with claims or authorization questions should visit the new TRICARE provider website for guidance or call TriWest Customer Service at 1 (888)TRIWEST (874-9378).

Temporary referral waiver

On January 23, 2025, the Defense Health Agency implemented a temporary waiver through March 31, 2025, of outpatient referral requirements for eligible TRICARE West Region beneficiaries enrolled in a TRICARE Prime plan. The temporary waiver allows TRICARE Prime patients to seek outpatient TRICARE-covered services through March 31, 2025, that would otherwise require approval from TriWest.

Enhancing patient care through interoperability

Health care providers face challenges in accessing and sharing patient information across different health care systems. To address this issue, CMS has introduced an interoperability and prior authorization mandate, and Washington state has passed House Bill 1357. These mandates aim to enhance patient care, reduce administrative burdens and increase transparency.

CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)

CMS-0057-F promotes seamless data exchange between providers, payers and patients. The mandate will ensure that patients can access and use their health data through third-party applications and technology platforms of their choice. Compliance with the mandate requires payers and providers to adopt standardized application programming interfaces (APIs) to facilitate the sharing of patient data, including medical history, medications and treatment plans. In addition, this mandate will require payers to create APIs that will allow providers to submit and complete pre-authorization requests directly from their EMR systems.

The rule applies to Medicare Advantage members.

Washington House Bill 1357 (WA HB 1357)

WA HB 1357 is focused on the pre-authorization process for health care services and prescription drugs. It will establish timelines for pre-authorization decisions and standardize processes across health plans.

It requires providers to adopt interoperable EMRs and to participate in a statewide health information exchange (HIE). The bill aims to improve patient care coordination, reduce health care costs and enhance population health management.

The bill applies to Washington fully insured large groups, small groups, individuals and public employees.

Piloting solutions

Asuris has been national leader in API powered interoperability with providers for several years. In 2022, we implemented the country's first production implementation of API- powered pre-authorization that has now been mandated by CMS-0057-F. In addition, we are currently exploring and testing innovative solutions to address the technical and operational challenges associated with interoperability.

Our goal is to ensure a smooth transition and minimize disruptions to patient care. We encourage any providers who have the technical capabilities to leverage these APIs today or in the future to contact us so we can begin implementation.

Our commitment to you

We're dedicated to helping you navigate these changes. Over the coming months, we will share more information about the progress we are making, including resources and support to help you meet these new requirements.

Streamline your workflow with Availity Attachments

As a valued provider, we want to encourage you to take advantage of the Availity Attachments application in Availity Essentials. This tool allows you to manage payer requests for supporting documentation, submit documentation, and view the history of requests and documentation submitted by your organization.

Why use Availity Attachments?

By using Availity Attachments, you can:

- Receive notifications and submit documentation when requested, reducing claim-processing delays
- View the status and history of submitted records in the attachments dashboard
- Message us directly from the application if you have questions
  - **Note**: Messaging is only available for open requests. If a request has expired and is in the history tab on the dashboard, you will need to call our Provider Contact Center to request it be reopened.
- Enjoy fast, easy and secure transmission of supporting documentation

What types of attachments may be requested?

We may request the following types of attachments from providers:

- Certificates of medical necessity
- Chart notes
- Dental or medical records
- Laboratory reports
- Operative reports
- X-rays

Avoid claim-processing delays

To avoid claim-processing delays, please set up access to the Availity Attachments application today. This will ensure you receive notification and can submit documentation when requested.

Getting started

Getting set up for the Availity Attachments application is easy. Your organization's Availity administrator can assign the medical attachments role to users who need access to Attachments—New. Find on-demand and live training options on Availity Essentials: Help & Training>Get Trained, then search for Attachments.

Tips and reminders

- Do not submit medical records with a claim unless indicated on the *Clinical Edits by Code List*, on our provider website: Claims & Payment>Coding Toolkit.
- If medical records are required, we will send you a request.
- Sending unsolicited attachments can delay the processing of your claim. Only use the Attachments application to submit documentation when you receive a notification in your Availity Essentials work queue.
- Please continue to respond to requests using the same format in which it was received to avoid claims-processing delays.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective December 1, 2024
Gender Affirming Interventions for Gender Dysphoria	- 15769, 15772
Procedure/medical policy	**Added codes effective January 1, 2025**
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	- 0530U
Digital Therapeutic Products (Medicine #175)	- G0552-G0554
Digital Therapeutic Products for Attention Deficit Hyperactivity Disorder (Medicine #175.01)	- G0552-G0554
Digital Therapeutic Products for Chronic Low Back Pain (Medicine #175.03)	- G0552-G0554
Digital Therapeutic Products for Post-traumatic Stress Disorder and Panic Disorder (Medicine #175.05)	- G0552-G0554
Digital Therapeutic Products for Substance Use Disorders (Medicine #175.02)	- G0552-G0554
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	- 0523U
Extracranial Carotid Angioplasty and Stenting (Surgery #93)	- C7563
Magnetic Resonance (MR) Guided Focused Ultrasound (MRgFUS), and High Intensity Focused Ultrasound (HIFU) Ablation, and Transurethral Ultrasound Ablation (TULSA) (Surgery #139)	- 61715
Radiofrequency Ablation (RFA) of Tumors Other Than the Liver (Surgery #92)	- 60660, 60661
Sacroiliac Joint Fusion (Surgery #193)	- C1737
Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy of Intracranial, Skull Base, and Orbital Sites (Surgery #213)	- G0563
Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy for Tumors Outside of Intracranial, Skull Base, or Orbital Site (Surgery #214)	- G0563
Procedure/medical policy	**Adding code effective April 1, 2025**
Cardiology – Carelon Medical Benefits Management (Carelon)	- 0913T

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Procedure/medical policy	Codes require site of care review effective May 1, 2025
Radiology site of care - Carelon	- 70336, 70450, 70460, 70470, 70480-70482, 70486-70488, 70490-70492, 70496, 70498, 70540, 70542-70549, 70551-70553, 71250, 71260, 71270, 71271, 71275, 71550-71552, 71555, 72125-72133, 72141, 72142, 72146-72149, 72156-72159, 72191-72198, 73200-73202, 73206, 73218-73223, 73225, 73700-73702, 73706, 73718-73723, 73725, 74150, 74160, 74170, 74174-74178, 74181-74183, 74185, 75635, 77046-77049, 77084

Medicare Advantage

Procedure/medical policy	Added codes effective December 1, 2024
Gender Affirming Interventions for Gender Dysphoria (Medicine #153)	- 15769, 15772

Procedure/medical policy	Added codes effective January 1, 2025
Ablation of Peripheral Nerves to Treat Pain (Surgery #236)	- C9808, C9809
Biochemical and Cellular Markers of Alzheimer's Disease (Laboratory #22)	- 82233, 82234, 84393, 84394
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- 15011-15018, C8002, Q4346-Q4353
Devices for Treatment of Benign Prostatic Hyperplasia, Urethral Stricture, and Urethral Stenosis (Surgery #230)	- 53865, 53866, 0941T-0943T
Digital Therapeutic Products for Attention Deficit Hyperactivity Disorder (Medicine #175.01)	- G0552-G0554
Digital Therapeutic Products for Chronic Low Back Pain (Medicine #175.03)	- G0552-G0554, E1905
Digital Therapeutic Products for Post-traumatic Stress Disorder and Panic Disorder (Medicine #175.05)	- G0552-G0554
Digital Therapeutic Products for Substance Use Disorders (Medicine #175.02)	- G0552-G0554
Electrical Stimulation and Electromagnetic Therapy Devices (Durable Medical Equipment #83)	- 0906T, 0907T
Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	- 0527U, 0528U
Genetic and Molecular Diagnostics – Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83)	- 0523U, 0530U, 0403U
Magnetic Resonance (MR) Guided Focused Ultrasound (MRgFUS), and High Intensity Focused Ultrasound (HIFU) Ablation, and Transurethral Ultrasound Ablation (TULSA) (Surgery #139)	- 51721, 55881, 55882, 61715, 0947T

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Procedure/medical policy (continued)	Added codes effective January 1, 2025
Percutaneous Transluminal Angioplasty (PTA) and Stenting (Surgery #207)	- C7563
Radiofrequency Ablation (RFA) of Tumors Other Than the Liver (Surgery #92)	- 60660, 60661
Radiofrequency and Ultrasound Ablation of the Renal Sympathetic Nerves as a Treatment for Uncontrolled Hypertension (Surgery #235)	- 0935T, C1735, C1736
Sacroiliac Joint Fusion (Surgery #193)	- C1737
Vagus Nerve Stimulation (VNS) (Surgery #74)	- 0908T, 0909T, 0911T, 0912T
Procedure/medical policy	**Adding code effective April 1, 2025**
Cardiology – Carelon Medical Benefits Management (Carelon)	- 0913T

Our complete pre-authorization lists are available in the Pre-authorization section of our provider website. Please review the lists for all updates and pre-authorize services accordingly. You can submit standard medical pre-authorizations through the Availity Essentials Electronic Authorization application.

Reminder: Sepsis policy to remain in place

We announced in the January 2025 issue of *The Bulletin* that we are not archiving our *Treatment of Adult Sepsis* (Medicine #172) medical policy at this time. The policy will continue to support sepsis-related reimbursement reviews.

View the policy in the *Medical Policy Manual* on our provider website: Library>Policies & Guidelines>Medical Policy.

Upcoming changes to radiology program

MRIs and CTs to be reviewed for site of care

Carelon Medical Benefits Management (Carelon) will begin reviewing the site of care for MRIs and CTs performed in the outpatient hospital setting on or after May 1, 2025. **Advanced imaging facilities will need to register with OptiNet prior to this effective date.**

Overutilization of radiology services, such as MRIs and CTs, in an outpatient hospital setting increases health care costs without corresponding improvements in member health outcomes.

Performing these services safely and effectively at a freestanding imaging center ensures they happen in the most appropriate and cost-effective setting.

Carelon will review requests for commercial members to determine whether an outpatient hospital setting is medically necessary. If not, they will redirect services to a freestanding imaging center when geographically available.

The site-of-care reviews are an extension of our radiology program. Use the Availity Essentials Electronic Authorization application to check whether a member's services are subject to the radiology program's pre-authorization requirements.

Affected codes have been added to the Commercial Pre-authorization List on our provider website.
Related: See *Pre-authorization updates* on pages 10-12. View program information on our provider website: Programs>Medical Management>Radiology.

OptiNet registration required

Advanced imaging facilities should register with OptiNet for site-of-care reviews by March 1, 2025. OptiNet is an online application accessed through the Carelon provider portal that supports the site-of-care program by collecting service and capability information about outpatient providers.

Providers report information about their imaging locations in OptiNet. When a pre-authorization request is submitted, that information is used to determine available sites.

Providers who bill with the following places of service (POS) are required to register:

- POS 11, 49 or 81, designated as a freestanding imaging facility (physician group)
- POS 19 or 22, designated as an outpatient hospital department

To register for OptiNet or update your site information, sign in to the Carelon provider portal and select **Access Your OptiNet Registration**.

Upcoming webinars

Carelon will offer webinars for providers and office staff to learn more about the site-of-care program, using the Carelon provider portal and registering with OptiNet. Register today.

Carelon revising radiology guidelines

Effective May 1, 2025, Carelon will revise the following advanced imaging clinical guidelines:

- Imaging of the Abdomen and Pelvis
- Oncologic Imaging

Visit the Coming Soon section of Carelon's website to view the revised guidelines.

Reminder: Change to some joint surgery reviews

For services delivered on or after March 1, 2025, the Asuris clinical team will review the site of care for joint surgeries that do not require medical necessity review. eviCore healthcare (eviCore) currently handles these reviews. As a result of this transition, pre-authorization requirements may change for some groups.

To confirm pre-authorization requirements and for the fastest review, submit requests through Availity Essentials' Electronic Authorization application. Some requests will receive automated approvals. The Availity process incorporates additional questions related to site of care, so you don't need to submit the *Surgical Site of Care Additional Information Form*.

eviCore will continue joint site-of-care reviews when the service is also reviewed for medical necessity.

You can begin submitting pre-authorization requests for affected services on February 5, 2025.

About site-of-care reviews

- **Medical policy**: Some joint surgeries are subject to pre-authorization site-of-care review under our *Surgical Site of Care – Hospital Outpatient* (Utilization Management #19) medical policy, which reviews select services scheduled in an outpatient hospital setting when an alternative, lower level of care—such as an ambulatory surgical center (ASC)—may be appropriate. This policy is available on our provider website: Library> Policies & Guidelines>Medical Policy.
- **Pre-authorization list**: Affected codes are listed in the **Surgical Site of Care—Hospital Outpatient** section of our Commercial Pre-authorization List alongside the *Surgical Site of Care Additional Information Form* for faxed requests.
- **Setting**: We only review the site of care when a surgery is scheduled in an outpatient hospital setting. We do not require site-of-care review for services performed at an ASC or physician office.
- **Other considerations**: We consider an individual's health status, facility and geographic availability, specialty requirements, physician privileges and other factors when determining the appropriate site of care.

The Bulletin recap

We publish updates to medical policies and reimbursement policies in our monthly publication, *The Bulletin*. You can read issues of *The Bulletin* or subscribe to receive an email notification when issues are published on our provider website: Library>Bulletins.

Medical policy updates

We provided 90-day notice in the December 2024 issue of *The Bulletin* about changes to the following medical policies, which are effective March 1, 2025:

- *Surgical Site of Care – Hospital Outpatient* (Utilization Management #19)
- *Screening Laboratory Testing* (Laboratory #80)—commercial and Medicare Advantage

We provided 90-day notice in the January 2025 issue of *The Bulletin* about changes to to the *Intensity Modulated Radiotherapy (IMRT) of the Thorax, Abdomen, Pelvis, and Extremities* (Medicine #165) medical policy, which are effective April 1, 2025.

The *Medical Policy Manual* includes a list of recent updates and archived policies and is available on our provider website: Library>Policies & Guidelines.

Reimbursement policy updates

We provided 90-day notice in the December 2024 issue of *The Bulletin* about changes to the following reimbursement policies, which are effective March 1, 2025:

- *Global Days* (Administrative #101)
- *Modifier 25; Significant, Separately Identifiable Service* (Modifiers #103)

No reimbursement policies in the January 2025 issue of *The Bulletin* required 90-day notice.

View our *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines> Reimbursement Policy.

Virtual care reimbursement policies updated

We revised our Virtual Care (Administrative #132) commercial and Medicare Advantage reimbursement policies effective January 1, 2025, with the following code updates:

	Commercial	Medicare Advantage
Telephone codes	- Removed CPT 99441-99443 - Use the appropriate E&M code with an audio-only modifier.	- Removed CPT 99441-99443 - Use the appropriate E&M code with an audio-only modifier.
Telehealth E&M codes	- Added new CPT codes 98000-98015, which are reimbursable when appended with the appropriate modifier (GT, FQ, 93) and place of service (02, 10) - We continue to reimburse for CPT 99202-99215.	- We continue to reimburse for CPT 99202-99215; CPT 98000-98015 are not reimbursable.
Virtual check-in codes	- Added CPT 98016 - Removed HCPCS G2012	- Added CPT 98016 - Removed HCPCS G2012
New 2024 and 2025 codes*	- Added HCPCS G0011 and G0013 (HIV PrEP) and HCPCS G0560 (crisis safety plan intervention)	- Added HCPCS G0011 and G0013 (HIV PrEP) and HCPCS G0560 (crisis safety plan intervention)

** Codes have also been added to members' telehealth benefits.*

Our commercial and Medicare Advantage plans follow CMS in our reimbursement of HCPCS G2211 when billed as an add-on to additional services (e.g., annual wellness visits).

Additionally, for our Medicare Advantage plans:

- We continue to cover telehealth services when the originating site is the member's home.
- Medicare now allows reimbursement for some therapies (physical, occupational, speech, cardiac) when performed via telehealth: CPT 92507, 92508, 92521-92524, 92526, 92609, 97110, 97112, 97116, 97129, 97130, 97161-97168, 97530, 97535, 97550, 97551, 97552, 93797 and 93798 and HCPCS G0422 and G0423.

Resources on our provider website

- The January 2025 issue of *The Bulletin*: Library>Bulletins
- Our *Reimbursement Policy Manual*: Library>Policies & Guidelines>Reimbursement Policy

Related: See *Accessing virtual behavioral health care: No referral required* on page 22.

Clinical Practice Guideline update

Clinical Practice Guidelines are systematically developed statements on medical and behavioral health practices that help providers make decisions about appropriate health care for specific conditions.

We reviewed our *Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (COPD)* Clinical Practice Guideline, effective January 1, 2025. We continue to use the Global Initiative for Chronic Obstructive Lung Disease (GOLD) and the Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease.

View the guidelines on our provider website: Library>Policies & Guidelines>Clinical Practice Guidelines.

Medication policy updates

Listed below is a summary of medication policy additions and changes. Links to all medication policies, medication lists and pre-authorization information for our members, including real-time deletions from our pre-authorization lists, are available on our provider website: Programs>Pharmacy. **Note**: Policies are available online and pre-authorization requests can be submitted on the effective date of the addition or change, but not before.

Pre-authorization: Submit medication pre-authorization requests through CoverMyMeds.

Expert feedback: We routinely assess our medication policies based on updated medical literature, national treatment guidelines, practicing provider feedback and pharmaceutical market changes. If you'd like to provide feedback or be added to our distribution list, please email our Medication Policy team and indicate your specialty.

New FDA-approved medications: New-to-market medications are subject to pre-authorization based on their FDA-labeled indication, pivotal trial criteria and dosage limitations until we complete a full medication review and develop a coverage policy.

Product not available (PNA) status: We allow a 90-day grace period to use any existing supply for medications that CMS has designated as PNA before they become ineligible for reimbursement. See our *Non-Reimbursable Services* (Administrative #107) reimbursement policy on our provider website: Library> Policies & Guidelines>Reimbursement Policy.

Effective January 15, 2025	Description
Revised policies	
Bispecific T-cell engager (BiTE) Therapies for B-cell Lymphoma, dru761	- Added coverage criteria for newly FDA-approved indication for Epkinly (epcoritamab-bysp) for follicular lymphoma; limits coverage to monotherapy in patients with relapsed or refractory follicular lymphoma after two or more lines of systemic therapy, which must include an anti-CD20 monoclonal antibody agent and an alkylating agent - Moved Lunsumio (mosunetuzumab) to policy from dru745 with existing criteria
Blincyto, blinatumomab, dru388	- Added coverage criteria for B-cell acute lymphoblastic leukemia (ALL) in the consolidation phase in response to new evidence
Medications for primary biliary cholangitis (PBC), dru464	- Added newly FDA-approved Livdelzi (seladelpar) to policy; limits coverage to patients with: • Primary biliary cholangitis diagnosed by a specialist • Compensated liver disease and • When step therapy with ursodeoxycholic acid (UDCA) has been ineffective

Effective February 1, 2025	Description
New policy	
PD-1 and PD-L1 Inhibitor Monoclonal Antibody Therapies, dru797	- New combination policy incorporating Keytruda (dru367), Opdivo (dru390), Tecentriq (dru463), Bavencio (dru499), Imfinzi (dru500), Libtayo (dru565), Jemperli (dru673), Opdualag (dru718), Zynyz (dru751), Loqtorzi (dru774) and Tevimbra (dru785) - Added newly FDA-approved Tecentriq Hybreza SC (atezolizumab and hyaluronidase-tqjs) to policy at parity with the IV formulation

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Effective March 1, 2025	Description
New policies	
Lazcluze, Lazertinib, dru796	- Use will be considered not medically necessary for non-small cell lung cancer due to the lack of outcomes data and uncertainty of any tolerability benefit over available options
Niktimvo, axatilimab-csfr, dru802	- Will limit coverage to patients with chronic graft-versus-host disease after allogeneic hematopoietic stem cell transplant who have steroid-refractory disease and have failed at least two additional systemic therapies
Rytelo, imetelstat, dru799	- Will limit coverage to patients with transfusion dependent low- to intermediate-1 myelodysplastic syndromes without a del(5q) cytogenetic abnormality, when prescribed by a hematologist, and when step therapy with Reblozyl (in those with positive sideroblasts) and erythropoiesis-stimulating agents (ESAs) were ineffective
Tecelra, afamitresgene autoleucel, dru800	- Will limit coverage to patients with unresectable or metastatic synovial sarcoma and certain HLA-A subtypes, with progression on two or more systemic therapies, MAGE-A4 expression, no previous gene therapy, good performance status, adequate kidney, liver and cardiac function, and no systemic infections
Voranigo, vorasidenib, dru801	- Will limit coverage to patients with a diagnosis of grade 2 astrocytoma or oligodendroglioma, with an IDH1 or IDH2 mutation, when used following surgery with presence of residual disease or disease recurrence, and no prior anti-cancer treatment
Yorvipath, palopegteriparatide, dru795	- Will limit coverage to patients with hypoparathyroidism when established with a specialist and lower cost standard of care therapies were ineffective (i.e., calcium, active vitamin D, teriparatide)
Revised policies	
Balversa, erdafitinib, dru593	- Removing coverage for FGFR2 genetic alterations based on new evidence (now only covered for FGFR3 alterations) - Changing step therapy of two prior therapies with requirement of platinum-based chemotherapy to one prior therapy, which includes a programmed cell death protein 1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor based on new evidence and changing practice standards
Complement Inhibitors, dru385	- Adding newly FDA-approved PiaSky (crovalimab-akkz) to policy; will limit coverage to patients with symptomatic paroxysmal nocturnal hemoglobinuria, defined as transfusion-dependent or major vascular event from thromboembolism, despite prior therapies when prescribed by or in consultation with a specialist - Adding coverage criteria for Fabhalta's newly FDA-approved indication for immunoglobulin A nephropathy (IgAN); will limit coverage to patients with biopsy-confirmed and high-risk IgAN when prescribed by a specialist and when step therapy with standard of care options and Filspari [sparsentan] were not effective - Adding new Soliris (eculizumab) biosimilars to policy at parity with Soliris: Bkemv (eculizumab-aeeb) and Epysqli (eculizumab-aagh) - Adding these biosimilars to Site of Care Program; when administered by a health care professional, these medications will be required to be given at an approved Site of Care location

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Effective March 1, 2025	Description
Revised policies, continued	
dasatinib (generic, Sprycel), dru137	- Adding dasatinib (generic Sprycel) to policy
Drugs for chronic inflammatory diseases, dru444	- Adding newly FDA-approved Leqselvi (deuruxolitinib) to policy; will limit coverage to patients with severe alopecia areata when prescribed by a specialist and treatment with oral immunosuppressants and corticosteroid/topical immunotherapy were ineffective - Adding Cimzia (certolizumab) as a Level 3 treatment self-administered option for its newly FDA-approved indication in polyarticular juvenile idiopathic arthritis (PJIA) - Adding Bimzelx (bimekizumab) as a Level 3 self-administered treatment option for its newly FDA-approved indications in nrAS, AS and psoriatic arthritis - Adding these newly FDA-approved Stelara (ustekinumab) biosimilars to policy as non-preferred: Imuldosa (ustekinumab-srlf) and Otulfi (ustekinumab-aauz) - Updating Tremfya (guselkumab) quantity limit to include new 200 mg dosage form and the autoinjector pens
High-Cost Topical Medications, dru723	- Adding new strength of Zoryve (roflumilast 0.15% cream) to policy; will limit coverage to patients with atopic dermatitis when other therapies (topical corticosteroid and calcineurin inhibitor) were ineffective - Moving Eucrisa (crisaborole 2% ointment) and Opzelura (ruxolitinib 1.5% cream) to this policy with existing criteria (previously in dru492 and dru679, respectively)
Ileal Bile Acid Transporter (IBAT) Inhibitors	- Updating the quantity limit for Livmarli (maralixibat) for Alagille syndrome (ALGS) and progressive familial intrahepatic cholestasis (PFIC) due to new dosage form
Medications for Hyperhidrosis, dru561	- Changing title of policy to incorporate broader range of drugs than just Qbrexza - Adding newly FDA-approved Sofdra (sofpironium) to policy; use is considered not medically necessary (and therefore not covered) for the treatment of axillary hyperhidrosis due to lack of additional efficacy or safety benefit over other treatment options, yet it is more costly
Medications for multiple sclerosis, dru753	- Adding subcutaneous Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq) at parity with Ocrevus (ocrelizumab) - Adding this new formulation to Site of Care Program; when administered by a health care professional, this medication will be required to be given at an approved Site of Care location
Medications for Sickle Cell Disease, dru628	- Adding L-glutamine (generic Endari) to policy as not medically necessary (and therefore not covered)
Medications for T-cell lymphoma, dru705	- Adding newly FDA-approved Lymphir (denileukin diftitox) to policy; will limit coverage to patients with stage I to III mycosis fungoides (MF) after progression on at least one prior systemic therapy

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Effective March 1, 2025	Description
Revised policies, continued	
Monoclonal antibodies for asthma and other immune conditions, dru538	- Adding coverage criteria for newly FDA-approved indication for Fasenra (benralizumab); will limit coverage to patients with Eosinophilic Granulomatosis with Polyangiitis (EGPA) when diagnosed by a specialist, a duration of at least six months, and trials of both an oral corticosteroid and oral disease-modifying antirheumatic drugs were ineffective
Monoclonal antibodies for skin and other inflammatory conditions, dru493	- Changing title of policy to incorporate broader range of drugs than just Dupixent - Adding newly FDA-approved Nemluvio (nemolizumab) to policy; will limit coverage to patients with moderate to severe prurigo nodularis (defined by itch scale and number of lesions) when diagnosed by a specialist and treatment with topical steroids, phototherapy/systemic therapy and Dupixent (dupilumab) have been ineffective - Adding newly FDA-approved Ebglyss (lebrikizumab) to policy; will limit coverage to patients with moderate to severe atopic dermatitis when prescribed by a specialist and other therapies including corticosteroids and topical tacrolimus were ineffective - Adding coverage criteria for Dupixent for newly FDA-approved indication for chronic obstructive pulmonary disease; will limit coverage to patients with an eosinophilic phenotype when prescribed by a pulmonologist who have had disease exacerbations despite maximal standard-of-care triple inhaler therapy - Moving Adbry (tralokinumab) to this policy from dru444 with existing criteria
nilotinib (Danziten, Tasigna), dru151	- Adding Danziten (nilotinib) to policy as non-preferred product requiring step therapy through Tasigna (nilotinib); Danziten is a new tablet formation of Tasigna (capsule)
Non-preferred testosterone replacement therapy products, dru548	- Adding Azmiro (testosterone cypionate) to policy as non-preferred - Adding Undecatrex (authorized generic for Kyzatrex) to the policy as not medically necessary (and therefore not covered)
Rybrevant, amivantamab-vmjw, dru682	- Adding newly FDA-approved indication to policy; the use of Rybrevant (amivantamab) in combination with Lazcluze (lazertinib) in the first line setting for locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R mutation is considered not medically necessary (and therefore not covered) due to the lack of outcomes data and uncertainty of any tolerability benefit over available options
Site of Care Review, dru408	- Adding Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq), Soliris biosimilars (Bkemv and Epysqli), and edaravone IV (generic Radicava) to Site of Care Program; when administered by a health care professional, these medications will be required to be given at an approved Site of Care location

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Effective March 1, 2025	Description
Revised policies, continued	
Spravato, esketamine, dru605	- Adding psychologists with prescriptive authority in states where approved legally as a prescriber
Welireg, belzutifan, dru685	- Adding newly FDA-approved indication to policy; the use of Welireg (belzutifan) for advanced clear cell renal cell carcinoma not associated with von Hippel-Lindau disease is considered not medically necessary (and therefore not covered) due to its higher cost relative to similar therapy options

Effective May 1, 2025	Description
Revised policies	
Provider-Administered Specialty Drugs, dru764	- Adding Tyenne (tocilizumab-aazg) and Tofidence (tocilizumab-bavi) to drug list

Asuris EquaPathRx™ reminders

Pre-authorization

As a reminder, when submitting pre-authorization requests for members with the Provider-Administered Specialty Drugs benefit, be sure to complete all the information on the form, including the servicing provider's name, address, phone number and TIN to ensure we have all the information necessary to review the request.

Medications included in the Asuris EquaPathRx program must be pre-authorized according to our medication policies; these medications are listed in the *Provider-Administered Specialty Drugs* (dru764) policy, available on our provider website: Policies & Guidelines>Medication Policies>Commercial Policies.

Join the IntegratedRx – Medical Network

Prime Therapeutics is still contracting and credentialing providers for the IntegratedRx – Medical Network. Reach out to your Prime contact now for help completing the process. If you don't have a Prime contact established, please email Prime Provider Relations.

To start IntegratedRx - Medical Network credentialing, you can also visit Prime's credentialing website.

Transition timeline

Our benefit administration transition is delayed as we continue network development

Look in future issues of this newsletter for updates.

Behavioral health corner

About behavioral health corner

This section highlights the articles that affect behavioral health providers. We also recommend you use the search function (**Ctrl + F**) on your computer to search for keywords that concern your practice.

Behavioral health corner

Accessing virtual behavioral health care: No referral required

Timely behavioral health care is essential for overall well-being. That's why we encourage our members to access virtual, in-network behavioral health providers—without the need for a referral.

Finding virtual providers

Our members can easily find virtual providers who offer specialized care in a variety of areas, including eating disorders, obsessive compulsive disorder (OCD), substance use disorders (SUD), and comprehensive therapy programs for all ages.

Confirming in-network status

Members can contact behavioral health providers directly to schedule treatment. To confirm a telehealth provider is in-network, members can:

- Use the Find a Doctor tool on our member website, **asuris.com**
- Chat online with Customer Service
- Call the Customer Service number on the back of their member ID card

The complete list of in-network, virtual provider groups is available on our Behavioral Health Toolkit on the homepage of our provider website.

Telehealth providers

We're proud to offer a range of telehealth providers who specialize in behavioral health care.

Telehealth provider	Specialty area
AbleTo	Structured, eight-week series of one-on-one cognitive behavioral therapy (CBT) by phone or video with medication management and digital tools
Array Behavioral Care	One of the largest telepsychiatry providers in the country, employing psychiatry and behavioral health clinicians with diverse specialties
Boulder Care	Addiction treatment that includes medication-assisted treatment (MAT) for opioid use disorders (OUD), peer coaching, care coordination and other recovery tools
Charlie Health	Intensive outpatient treatment for teens and adults, as well as their families
Eleanor Health	Addiction and SUD treatment with evidence-based outpatient care and recovery tools
Equip	Family-based treatment of eating disorders for individuals 6 and older that includes a five-person care team
Headway	Local clinicians with diverse specialties available in the next few days for telehealth and/or in-person visits
NoCD	Specialized care for OCD using exposure and response prevention (ERP) treatment
Talkspace	Mental health counseling available 24/7/365 via text, audio or video messaging

Related: See *Virtual care reimbursement policies* updated on page 15.

Enhancing care and quality ratings with member surveys

Member surveys help us understand our members' experiences and needs, enabling us to make informed decisions to improve care and services. By working together with our provider partners, we can enhance the overall quality of care and improve member satisfaction.

Enhancements to the Member Satisfaction Survey

As part of our 2025 Quality Program measures, we're updating our member satisfaction survey to better align with our quality initiatives and to provide more actionable insights. Key changes include:

- Switching to a new survey vendor
- Triggering surveys after claim-based events throughout the year, rather than once annually
- Conducting surveys across all plans, including Medicare and commercial

These changes will provide more timely and actionable feedback, informing our incentive programs and helping us make data-driven decisions to improve care and services.

For questions about member surveys, email us.

Advancing health equity

To support your efforts in delivering high-quality, patient-centered care to diverse patient populations, we have developed a comprehensive resource.

The Health Equity Toolkit, available on the homepage of our provider website, offers a range of resources to help you improve health outcomes, enhance patient satisfaction and reduce health care disparities, including:

- Cultural competency framework: A structured approach to integrating cultural competency into your practice, including assessment tools and strategies for improvement.
- Patient engagement strategies: Tips and techniques for building trust and fostering effective communication with patients from diverse backgrounds.
- Health literacy resources: Tools and materials to support clear and effective communication with patients, including those with limited English proficiency.
- Cultural awareness training: Educational resources and training modules to enhance your understanding of diverse cultures and their impact on health care.
- Language access services: Information on language access services, including interpretation and translation resources.

By working together, we can advance health equity and improve health outcomes for all patients.

Quality toolkit available to help improve member experience

We are committed to ensuring that our members receive the best possible care, engage in meaningful conversations with their providers and have access to the resources they need to lead healthier lives.

Our Quality Improvement Toolkit, available on the homepage of our provider website, is designed to support this effort by providing valuable information, resources and best practices for health care providers to help improve the member experience and clinical quality measures such as HEDIS measures. The toolkit includes information about member benefits and resources for having conversations with your patients about these topics:

- Advance care planning
- Bronchitis
- Cancer screening
- Care coordination
- Chlamydia screening
- Fall risk coaching
- Getting care quickly
- Hypertension
- Incontinence management
- Influenza immunization
- Low back pain
- Maintaining a healthy weight
- Medications and member experience with medications
- Monitoring physical activity
- Overall rating of health care
- Pneumonia immunization
- Tobacco cessation
- Well-child visits
- Wellness and preventive visits for Medicare Advantage members

Optimizing UTI care: Convenient care options

As we continue to prioritize our members' health and well-being, we want to highlight the various care options available to them for quickly and effectively addressing urinary tract infections (UTIs). Leveraging these convenient alternatives can reduce unnecessary emergency room visits and ensure the right care at the right time.

Understanding UTIs

Urinary tract infections are a common condition affecting millions of people each year. Symptoms can range from mild to severe and may include burning during urination, frequent urination and abdominal pain. If left untreated, UTIs can lead to more serious complications, such as kidney damage or sepsis.

Care options for our members

To provide our members with easy access to UTI care, we offer the following options:

- **Virtual care**: Our members can schedule virtual consultations with board-certified physicians, allowing them to receive a diagnosis and treatment plan from the comfort of their own homes. This convenient option is ideal for those with mild to moderate symptoms.
- **In-home visits**: DispatchHealth offers urgent medical services, including treating UTIs, in the comfort of patients' own homes. They are available in the Spokane area.
- **PCP visits**: For members with more severe symptoms or underlying medical conditions, a visit to their PCP is recommended. PCPs can provide comprehensive care, including diagnostic testing and treatment, as well as coordinate follow-up appointments as needed.
- **Urgent care centers**: For members who require in-person care, urgent care centers offer extended hours and minimal wait times. These centers are equipped to provide diagnostic testing, including urinalyses and cultures, and can prescribe antibiotics as needed.
- **Retail clinics**: Many retail clinics, such as those found in pharmacies, offer walk-in UTI treatment services. Their providers can evaluate symptoms, perform diagnostic tests and prescribe medication.

Learn more in our Care Options Toolkit, available on the homepage of our provider website. Easily find in-network providers using the Find a Doctor tool on our provider website.

What you can do

As a provider, you play a vital role in educating our members about these care options and encouraging them to seek timely treatment. Here are some ways you can support these efforts:

- Review the Agency for Healthcare Research and Quality's Best Practices in the Diagnosis and Treatment of Asymptomatic Bacteriuria and Urinary Tract Infections
- Inform your patients about the available care options and their benefits
- Emphasize the importance of seeking medical attention if symptoms persist or worsen
- Coordinate care with our network of urgent care centers and retail clinics as needed
- Encourage members to schedule follow-up appointments to ensure successful treatment and prevent future UTIs

By working together, we can ensure our members receive the best possible care for UTIs while reducing unnecessary emergency room visits.

Active patients, better outcomes

As a health care provider, you know that regular physical activity is essential for overall health and well-being. Encouraging physical activity in your patients also improves their health outcomes and reduces the risk of chronic diseases.

Why physical activity matters

Regular physical activity can help reduce the risk of heart disease, stroke and diabetes, as well as improve mental health and well-being. But many patients struggle to get started or stay motivated. You can encourage and motivate your patients to become or stay active when you assess their level of physical activity and fitness during a visit.

Tips for encouraging physical activity

Here are some tips for making the Monitoring Physical Activity Medicare Star Rating measure a part of your workflow:

- **Share the benefits**: Explain to your patients why physical activity is important for their health and well-being.
- **Implement exercise as a vital sign**: Add exercise or physical activity as a vital sign into your rooming process and EMR. The CDC has identified simple screening tools that can be used for this purpose.
- **Include physical activity in your patient's care plan**: Help your patients develop a realistic exercise plan that includes goals and strategies for overcoming barriers.
- **Involve your team**: Work with your team to encourage patients to stay physically active, including health coaches, patient navigators and care managers as needed.
- **Encourage social support**: Encourage patients to seek out social support from family and friends to help them stay motivated.

Additional resources

We have a range of resources to help you encourage physical activity in your patients, including:

- **Flyers**: Available in our Quality Improvement Toolkit, these flyers provide tips and information on fitness and physical activity, including the following topics:
  - *Exercise: How to Start*
  - *Exercise: Stay Motivated*
  - *Fitness: What's Getting in Your Way*
  - *Exercise: Setting Goals to Get Active*
  - *Exercise: Finding Activities That Work for You*
- **Silver&Fit**: A benefit of our Medicare Advantage and Medigap plans, Silver&Fit offers healthy activities, information and support for everyone.
- **Online resources**: Check out the Healthwise Knowledgebase on our provider website for additional resources and tools on physical activity and other health topics: Programs> Member Programs & Tools.

Get started today

Encouraging physical activity in your patients is an important step in improving health outcomes and reducing the risk of chronic diseases. Start implementing these tips and resources today, and help your patients get moving toward a healthier future.

Optimizing low back pain treatment

Low back pain is a common and debilitating condition that affects millions of people worldwide. As a provider, you play a critical role in helping your patients manage their symptoms and find effective treatment options.

We're committed to supporting evidence-based treatment for low back pain. That's why we're measured on the appropriate use of technology in diagnosis through the HEDIS measure *Use of Imaging Studies for Low Back Pain*.

Patients often look to their providers to refer them for expensive imaging studies, such as MRIs and CT scans, to support the diagnosis of low back pain; however, these technologies often are not needed.

The measure looks at the percentage of members with a primary diagnosis of low back pain who **did not** have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. Asuris scored in the 75th percentile for this measure when compared to similar plans nationally.

Resources to support your patients

Care support flyers, available in our Quality Improvement Toolkit on the homepage of our provider website, help address different aspects of back pain, including:

- How to protect the back
- Exercises for low back pain
- How to relieve low back pain
- How to keep low back pain from coming back
- Information about whether the patient should have an MRI to help diagnose back pain
- Information about options to treat back pain, including surgery, spinal manipulation or use of pain medicine

We depend on our providers to use the best evidence-based guidelines available when making decisions about how to diagnose and treat back pain. We hope these tools help you provide the most efficent, high-quality care possible.

Medicare corner

MOON required for Medicare members

All hospitals and critical access hospitals (CAHs) are required to provide written notification and an oral explanation to Medicare beneficiaries receiving outpatient observation services for more than 24 hours using the *Medicare Outpatient Observation Notice (MOON)* form CMS-10611.

View the notice and accompanying instructions. A link to this form is also available on our provider website: Library>Forms.

The MOON is designed to inform Medicare beneficiaries when they are an outpatient receiving observation services and are not an inpatient of the hospital or CAH. The notice must include the reasons the individual is receiving outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility (SNF) services. Hospitals and CAHs must deliver the notice to the health plan within 36 hours of the start of observation services or sooner if the individual is transferred, discharged or admitted.

Medicare corner

Medicare Advantage incentive program reminders

2024 Medicare Advantage Quality Incentive Program (MA QIP)

December 31, 2024, was the last day to provide services or screenings to close gaps for the 2024 program. You may continue to submit gap closure information for the 2024 MA QIP according to the following deadlines:

- **February 28, 2025**:
  - Last day to submit structured supplemental data submission files (SDS)
  - Last day to submit compliant evidence to close gaps on the CGMA
- **March 31, 2025**: Last day to submit medical or pharmacy claims

The CGMA will display 2024 data through June 2025 to allow you to monitor your progress.

Jumpstart your 2025 incentive performance

Start scheduling members for their preventive care visits (PCV) or annual wellness visits (AWV) today.

We recommend that you **see every member every year** for their PCV/AWV and use this visit as an opportunity to assess your patient's chronic conditions and address all their preventive care needs.

PCV/AWV tips

- AWVs are reimbursable on the same day as acute care visits (excluding visits at rural health centers and federally qualified health centers). Ensure that your documentation represents that both visits took place.
- AWV and PCV will be reimbursed separately when billed on the same date of service. Ensure that your documentation represents that both visits took place.
- We will reimburse for AWVs and PCVs billed once per calendar year. There is no requirement to wait 11 months between visits.

Flu vaccines

Encouraging patients to get their annual flu vaccination is a year-round project.

- Our Annual Flu Vaccine measure does not include a timing component:
  - Report that your patient had a flu shot at any time in 2025 and earn credit for 2025 gap closure in the MA QIP.
  - It is acceptable to bill HCPCS M1299 by itself on a $0.00 claim after receiving verbal confirmation that a member received their flu vaccine from another provider and documenting this in the medical record.
- No matter when you see your patients throughout the year:
  - Talk to your patient about the importance of having a flu shot this year.
  - Remind your patient that you want to know if they got their shot from another provider.
  - Ask your patient to call the office and report when and where they receive their immunizations.
  - If you give vaccinations in your office, schedule your member to come back in the fall to receive their vaccination.

2025 program deadlines

- **June 30, 2025**: Last day to opt in to the 2025 program
- **December 31, 2025**: Last day to perform services for all Medicare Advantage incentives.
- **January 31, 2026**:
  - Last day to submit compliant evidence to close gaps on the CGMA
  - Last day to submit SDS files
- **March 31, 2026**: Last day to submit medical or pharmacy claims

Resources for you

Use our Self-Service Tool, available 24/7, to review helpful answers to our most frequently asked questions and quickly navigate our provider website resources.

Publications team

Written, designed and edited by the Provider Communications team.