October 2024

The Connection

For participating physicians, other health care professionals and facilities

National Breast Cancer Awareness Month: A time for action

October is a crucial time to raise awareness about the importance of early breast cancer detection. As the most common cancer in women, breast cancer affects one in eight women during their lifetime. As a health care provider, you play a vital role in encouraging women to take proactive steps toward early detection.

The U.S. Preventive Services Task Force (USPSTF) recommends women ages 40 to 74 get a screening mammogram every two years.

Health disparities in breast cancer screening

Significant health disparities exist among women of different racial and ethnic backgrounds when it comes to screening mammograms. According to 2022 American Cancer Society statistics, about 82% of Black women, 76% of White women, 74% of Hispanic women, 67% of Asian women, and 59% of American Indian and Alaska Native women of screening age had a screening mammogram in the two years prior.

Patient outreach, education and access to care initiatives help ensure that all women have an equal opportunity to receive timely and effective breast cancer screening and treatment.

Coverage for mammogram screenings

Most of our health plans cover screening mammograms at no cost for women 40 and older when an in-network provider is selected.

Resources

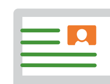
- Our Quality Improvement Toolkit
- USPSTF breast cancer screening
- CDC resources:
  - Risk factors
  - Patient education

Alternative payment model (APM) providers

Improve your financial and quality performance with the PRIA platform. Learn more on page 4.

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.

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Click on a title to read the article.

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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.

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.

Share your feedback

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

Mailing address change

We have changed our mailing address. The Contact Us section of our provider website has been updated.

To notify us of a network termination, closing a practice, or to notify us about a third-party service provider, use this address:

Asuris Northwest Health
Attention: Network Management
200 SW Market St., 11th Floor
Portland, OR 97201

Are you?

✓ **Prepared for 2025 changes**: A new year brings product and network changes. Make sure you're up to date on changes that impact your patients. **Related**: See *2025 commercial products and networks* on page 23 and *2025 Medicare Advantage products* on page 26.

✓ **Talking with your patients about mental health**: As the seasons change, remember to discuss important mental health concerns with your patients, including depression, anxiety and seasonal affective disorder, to help them cope with the challenges of cooler temperatures and shorter days. **Related**: See *Diagnosing and treating depression in primary care* and *Check for signs of seasonal affective disorder* on pages 17-19.

✓ **Helping your patients know where to go for care**: When your patients need medical or behavioral health attention, knowing where to go for health care can help save them time and money—and assure that they get the care they need. View the Care Options Toolkit on the homepage of our provider website. **Related**: See *DispatchHealth: Urgent medical care in your patient's home* on page 21.

Administrative Manual updates

The following update was made to the manual on October 1, 2024:

Facility Guidelines

- Revised reference to *Surgical Site of Care—Hospital Outpatient* (Utilization Management #19) medical policy

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

Are you ready to serve TRICARE members in 2025?

We've partnered with TriWest to serve active-duty service members, military families and retirees, building a provider network for their Community Care Network (CCN) and TRICARE T-5 programs. To ensure seamless care for TRICARE members starting January 1, 2025, we encourage providers to join the network promptly.

How can providers join the network?

We emailed agreements or amendments to providers on standard agreements to add them to the TRICARE provider network.

- **If you are already a participating CCN provider**, no action is needed. You were automatically sent an amendment to be included in the network.
- **If you are not currently a participating CCN provider**, you need to electronically sign the agreement via DocuSign to be added to the T-5 program.

Learn more

To learn more about the TRICARE provider network, you can:

- Visit TriWest's provider website
- Email our TriWest Contracting Team

PAP supply claims to be reviewed post-payment

To ensure consistent application of our policies and billing standards, we are providing courtesy notice that we will begin post-payment reviews of claims for positive airway pressure (PAP) device supplies effective October 1, 2024. We currently review these claims pre-payment.

If we identify an overpaid claim, we will request recoupment via adjustment of a future claim payment.

These reviews support our *Positive Airway Pressure (PAP) Supplies* (Administrative #127) reimbursement policy, which applies to our commercial and Medicare Advantage members.

Unlock the power of financial and quality information with PRIA

In today's fast-paced health care environment, having access to accurate and timely information is crucial for driving high-value care and controlling costs. That's why we created Provider Reporting Insights & Analytics (PRIA), a cutting-edge business intelligence and analytics platform designed to support providers in alternative payment model (APM) arrangements who have more than 1,000 attributed members.

Convenience at your fingertips

With PRIA, you can access your data however and wherever you need it, at an unprecedented depth of detail. Our interactive dashboards and self-service reporting provide:

- **Unparalleled convenience**: Get the information you need, when you need it, without relying on our staff to create reports.
- **Ease of sharing**: Quickly share reports and insights with your team, eliminating communication barriers.
- **Depth of information**: With data available at summary, claims and patient levels, you can quickly identify care gaps and treatment opportunities that drive clinical and financial impact.

Empower data-driven decision-making

PRIA's sophisticated on-demand data enables you to:

- Visualize and generate clinical insights, identifying trends and opportunities for improvement
- Create and execute data-driven population health management interventions that improve quality while reducing costs
- Make informed decisions, backed by data, to drive high-value care and accelerate performance

Designed for you, supported by us

PRIA is designed to be user-friendly, regardless of your role or analytical skills. Our platform is supported by:

- Comprehensive training and onboarding provided by our Provider Relations team
- Ongoing support and collaboration with our Asuris teams to improve affordability and health outcomes
- Resources on our provider website: Contracting & Credentialing>APM Resources.

New reports now available

Two new reports have been recently added to PRIA:

- **CPT II Code Usage**: This report is used to analyze CPT II code utilization, and drills down to usage by tax identification number (TIN), provider and specific procedure codes. CPT II codes are supplemental tracking codes used for performance measurement and are the fastest way to close quality gaps. The CPT II Code Usage report is found in Reports>Quality. CPT II codes used for reporting related to Star Ratings Measures gap closure are included in the dashboard, which is filtered to Medicare members only.
- **Pharmacy Opportunities**: This report can be used to analyze pharmacy utilization and potential savings opportunities. The report summarizes retail Rx and medical injections. The Pharmacy Opportunities report is found in Reports>Cost and Utilization.

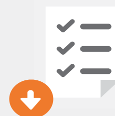
PRIA is expanding to more provider groups

PRIA is part of a suite of services we offer providers on APM arrangements to ensure you meet or exceed your contractual and patient care goals. Several large provider groups are already experiencing the benefits of PRIA. Our Provider Relations team is actively offering training and access to additional providers on APM arrangements. Look for opportunities to unlock the power of on-demand information and drive high-value care in your organization with PRIA.

Provider comments about PRIA

"We like that we can see provider groups' quality data at any time, so we can get member care gaps for the groups."

"PRIA is user-friendly and has so much robust information."



"It's easy to navigate and has great information available at my fingertips. I'm looking forward to pulling information about high-acuity patients."

Medicare Advantage home health reimbursement schedule update

In our efforts to reward high-quality care provided to Asuris Medicare Advantage members, we review the quality ratings of participating home health agencies annually. We utilize CMS' Quality of Patient Care Star Ratings—which are available each July and reflect the prior calendar year's data—to determine the quality rating for each home health agency.

Effective January 1, 2025:

- Asuris will use the ratings reported in July 2024.
- Reimbursement based on the quality rating will be applied at the National Provider Identifier (NPI)/ location level, rather than the TIN level.

View your home health agency's CMS Quality of Patient Care Star Ratings. The criteria for determining the quality rating for home health agencies is outlined in the Facility Guidelines section of the *Administrative Manual*, available on our provider website: Library> Administrative Manual.

Reminders:

- Reimbursement is based on a percentage of the current CMS Home Health Prospective Payment System (PPS) fee schedule.
- We announce fee updates annually in the October issue of our newsletter. Subscribe to receive an email when new issues of this publication are available.

Risk adjustment diagnosis reporting using CPT 99499

It is important for providers to evaluate, document and submit all active conditions at least once per calendar year to maintain an accurate picture of the member's health. Submission of complete and accurate encounter and diagnostic data for all services rendered is fundamental to our ability to:

- Support the needs of our members with care management programs
- Report accurate health status for our members to CMS and the Department of Health & Human Services (HHS)

You can submit claims with additional diagnosis codes for risk adjustment purposes using CPT code 99499 when:

- Your patient has more than 12 diagnosis codes identified for a single professional claim.
- Your system truncates diagnosis codes for claim submission.
- You use a clearinghouse that submits fewer diagnosis codes per claim than your patient has.

Criteria for CPT 99499

To submit CPT 99499, please ensure that the claim meets the following criteria:

- All CPT 99499 claims must be submitted in support of a primary claim with an evaluation and management (E&M), annual wellness visit (AWV) or preventive care CPT code submitted from a face-to-face encounter.
- All ICD-10 codes must be supported in the medical record documentation with management, evaluation, assessment and treatment (MEAT) during the face-to-face encounter.
- All provider billing and rendering provider criteria, date of service, member demographics, etc., must match the primary claim containing the E&M code.
- No other services should be billed on the CPT 99499 claim.
- Multiple claims for CPT 99499 can be billed on the same date of service with modifier 25 on all applicable claims after the first CPT 99499 claim.

Submission instructions for CPT 99499 claims

1. Submit a primary claim with applicable E&M, AWV or preventive care CPT visit code and 12 diagnosis codes for a professional claim.
2. To submit additional diagnosis codes, submit a second claim using CPT 99499 with a billed charge of $.00. If your billing system will not allow zero-dollar claims, you may bill us $.01. **Note**: CPT 99499 must be the **only** CPT code on this claim.
3. If additional diagnosis codes remain, submit an additional 99499 claim with modifier 25 with a billed charge of $.00 or $.01. **Note**: CPT 99499 must be the **only** CPT code on this claim.

Medicare crossover claim reminders

When submitting claims to Medicare for members who have Medicare as their primary coverage, please wait 30 calendar days from the Medicare remittance date before submitting the claim to Asuris.

Why wait 30 days?

In most cases, you will not need to submit the claim to us because Medicare will send us the claim through the crossover process.

Crossed-over claims

If the indicator on the Medicare remittance advice shows that the claim was crossed-over (claim status code 19: "Medicare paid primary and the Intermediary sent the claim to another insurer"), Medicare has forwarded the claim on your behalf to us for processing. You do not need to file a claim for the Medicare supplemental benefits.

The Medicare crossover process may take up to 14 business days. This means we are receiving the claim from Medicare at the same time you receive a Medicare remittance advice. As a result, it may take up to 30 additional calendar days for you to receive payment or instructions from us after you receive the Medicare remittance.

We will return or reject any Medicare primary claims that you submit directly to Asuris that crossed over and are received within 30 calendar days of the Medicare remittance date or contain no Medicare remittance date.

Receiving payment

After processing the claim, we will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid directly, and you will need to bill the member.

Claims that don't crossover

If the indicator on the Medicare remittance advice does not indicate the claim was crossed over (claim status code 1: "Paid as primary" may appear; claim status 19 will not appear), file the claim and the payment advice to Asuris. We will pay you the Medicare supplemental benefits.

Statutorily excluded services

When you provide services or supplies that are statutorily excluded by Medicare (e.g., home infusion therapy and hearing aids), you can submit the claim directly to Asuris without waiting 30 days after the Medicare remittance date. Claims for the service that is excluded or not covered by Medicare should be submitted with **modifier GY** on each line.

Learn more about Medicare crossover and claims for statutorily excluded services on our provider website:

- Claims & Payment>Claims Submission>Benefit Coordination>Medicare Crossover
- Claims & Payment>Claims Submission>Medicare Statutorily Excluded Services

Professional VBR program updates

Reimbursement adjustment based on prior year performance

2024 adjustment based on calendar year 2023

Last year, Asuris providers on standard professional agreements within six predominant specialties (dermatology, family medicine, internal medicine, obstetrics and gynecology, ophthalmology and psychiatry) were incorporated into our Professional Value-Based Reimbursement program (Professional VBR).

As of July 1, 2024, providers who meet program criteria within the six predominant specialties can access a performance report published on Availity Essentials. This report is based on their performance for services provided in calendar year 2023. **Note**: Providers must use their performance report to determine whether their reimbursement will be adjusted based on quality performance.

The first performance-based adjustment went into effect October 1, 2024.

Program eligibility

Providers outside of the six predominant specialties received no changes to reimbursement.

If a provider with an eligible predominant specialty did not have credible data as defined by the program summary, reimbursement did not change, and they will not see a VBR ScoreCard Report in Availity. Providers can find the program summary on our provider website: Contracting & Credentialing>APM Resources.

2025 brings code changes for services and supplies

Please remember to review your 2025 CPT, HCPCS and CDT coding publications for codes that have been added, deleted or changed and to use only valid codes.

You can purchase the:

- CDT manual online through the American Dental Association or by calling 1 (800) 947-4746
- CPT and HCPCS manuals through your preferred vendor or online through the American Medical Association (AMA)

Reimbursement schedules are available on Availity Essentials: Claims & Payments>Fee Schedule Listing.

This notice serves as an Amendment to your Participating Agreement. You have the right to terminate your Agreement in accordance with the amendment provisions of the Participating Agreement.

Update your directory information

Accurate provider directories are essential to help members find providers who best meet their health care needs and individual preferences. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

The Consolidated Appropriations Act (CAA), 2021, requires health plans to establish a process to verify and update provider directory information no less frequently than every 90 days. Accurate provider directories are also a requirement for compliance with CMS, the Affordable Care Act (ACA) and your agreement as a network provider with Asuris.

Our *Provider Directory Attestation Requirements for Providers* policy requires:

- Providers to review for accuracy and submit all updated information about their practice at least every 90 days
- Providers to continue to notify us promptly of changes to directory information
- All participating providers who are eligible to display in directories based on their specialty and current credentialing status to be displayed in our provider directories
- All participating providers to comply with our policies and procedures related to furnishing information necessary to ensure provider directories are up-to-date, accurate and complete pursuant to federal and state law, including 45 C.F.R. 156.230(b); this information includes, but is not limited to, accepting new patients, provider practice location, contact information, specialty, medical group and other institutional affiliations
- Providers to review, update and return roster validation requests

Please follow the instructions to verify your directory information on our provider website at least every 90 days: Contact Us>Update Your Information.

As part of your routine review of provider directory information, also review your National Provider Identifier (NPI) data in CMS' National Plan & Provider Enumeration System (NPPES). Visit NPPES help for more information.

We have expanded our provider directory information to help our members connect with providers they feel best meet their health care needs and individual preferences. Update your demographics and indicate if your office offers LGBTQIA+-affirming care, culturally-specific services, expanded language access and disability competent care by completing the *Provider Information Update Form* on our provider website: Contact Us>Update Your Information.

To learn more about providing culturally competent and linguistically appropriate services, view *An Implementation Checklist for the National CLAS Standards* (available in English and Spanish). Links to these checklists are included in our Health Equity Toolkit, available on the homepage of our provider website.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective October 1, 2024
Anterior Abdominal Wall (Including Incisional) Hernia Repair (Surgery #12.03)	- K42.9
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	- 0485U, 0487U
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	- 0498U, 0499U
Targeted Genetic Testing for Selection of Therapy for Non-Small Cell Lung Cancer (NSCLC) (Genetic Testing #56)	- 0478U
Procedure/medical policy	**Adding codes effective January 1, 2025**
Surgical Treatments for Lymphedema and Lipedema (Surgery #220)	- 15832-15839, 15876-15879

Medicare Advantage

Procedure/medical policy	Added codes effective October 1, 2024
Amplitude-Modulated Radiofrequency Electromagnetic Fields (AM RF-EMF) for Cancer Treatment (Durable Medical Equipment #96)	- E0767
Biochemical and Cellular Markers of Alzheimer's Disease (Laboratory #22)	- 0479U, 0503U
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- A2027-A2029, Q4336-Q4345
Electrical Stimulation and Electromagnetic Therapy Devices (Durable Medical Equipment #83)	- A4544, E0743
Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	- 0480U, 0483U, 0484U, 0493U, 0500U, 0502U, 0504U, 0505U, 0508U, 0509U, 0516U
Genetic and Molecular Diagnostics – Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83)	- 0360U, 0478U, 0481U, 0485U-0487U, 0490U-0492U, 0495U, 0497U-0499U, 0502U, 0506U, 0507U, 0510U, 0512U, 0513U
Lower Extremity Sensory Prostheses (Durable Medical Equipment #95	- L8720, L8721
Transcutaneous electrical nerve stimulator, stimulates nerves in the auricular region (Medicine #146)	- E0721

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.

New form streamlines faxed admission notifications

Providers have options when notifying us of a patient's hospital admission or discharge—including a new form for faxed notifications. As a reminder, we require notification within 24 hours of hospital admission.

Using PointClickCare (PCC)

PCC is our preferred method for receiving notification of admission or discharge. If you are connected through PCC, please do not fax notifications that are available in PCC.

Faxing

If you notify us of admissions and discharges via fax, use our new *Hospital Admit and Discharge Notification Form*, available in the Fax section of our pre-authorization lists. The form:

- Ensures that faxed records include all necessary information
- Provides a singular form that can be used for admission and discharge

If you fax notification to us and do not use this form, please verify that your notification includes all of the elements on the form.

Simplified discharge process: To streamline the discharge process, simply retain the faxed form from admission, complete the discharge information in Section 5 and re-fax it. If you no longer have the original form, complete a new form, add the discharge information in Section 5, then fax it.

Using electronic medical records (EMRs)

If your facility has granted our clinical team full access to your EMR system, it is your responsibility to ensure we have access to necessary records, including making your patient's records visible to us if needed. If you are connected through EMR, please do not fax medical records available in the EMR.

eviCore updating musculoskeletal guidelines

Effective January 1, 2025, eviCore healthcare (eviCore) will revise the following advanced musculoskeletal clinical guidelines:

Joint surgery & interventional pain

- Discography

Spine surgery

- Cervical Microdiscectomy
- Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Fusion

Visit eviCore's website and select the **Future** tab to view the revised guidelines.

Reminder: Additional services added to cardiology program

Effective November 1, 2024: Our cardiology program will include the following additional outpatient cardiovascular tests and procedures for commercial and Medicare Advantage members:

- Dialysis circuit procedures
- Electrophysiology (EP) studies
- Transcatheter septal defect closure
- Vascular embolization or occlusion

Providers will be able to contact Carelon to request pre-authorization for these additional services beginning October 21, 2024.

- **Online**: The Carelon ProviderPortal is available 24/7 and processes requests in real-time using clinical criteria.
- **By phone**: Call Carelon at (877) 291-0509, Monday through Friday, 8 a.m.-5 p.m. (PT).

About the program

If a provider does not verify that a pre-authorization request has been approved before performing an outpatient cardiac service, the claim may be denied as provider responsibility or pended for post-service review, depending on the line of business.

To view the affected codes, see the Pre-authorization lists on our provider website.

Program details are available on our provider website: Programs>Medical Management>Cardiology.

New tool to review ED claims pre-payment

Beginning November 1, 2024, we will apply Optum's Emergency Department Claim (EDC) Analyzer to review emergency department (ED) claims pre-payment. The EDC Analyzer provides an ED visit-level analysis and code validation.

We are implementing this tool as part of our continued efforts to reinforce accurate coding practices and identify claims that might have otherwise paid incorrectly.

Note: The EDC Analyzer will apply to claims for commercial and Medicare Advantage members. It will not apply to professional E&M coding, inpatient claims (as determined by type of bill and setting) and non-ED claims.

Resources on our provider website

- We announced that we will begin using the EDC Analyzer tool for coding review of ED E&M claims in the August 2024 issue of *The Bulletin*: Library>Bulletins.
- Review our *Emergency Department Visits: Level of Service* (Facility #110) reimbursement policy in our *Reimbursement Policy Manual*: Library>Policies & Guidelines>Reimbursement Policy.

Update on modifier 25

We announced in the August 2024 issue of our newsletter that we were postponing updates to our *Modifier 25; Significant, Separately Identifiable Service* (Modifier #103) and *Global Days* (Administrative #101) reimbursement policies. We continue to review these policies and will provide updates in future publications.

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 August 2024 issue of *The Bulletin* about changes to the following medical policies, which are effective November 1, 2024:

- *Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder* (Behavioral Health #18)
- *Applied Behavior Analysis Initial Assessment for the Treatment of Autism Spectrum Disorder* (Behavioral Health #33)

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

- *ClonoSEQ Testing for the Assessment of Measurable Residual Disease (MRD)* (Genetic Testing #88)
- *Rhinoplasty* (Surgery #12.28)

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 August 2024 issue of *The Bulletin* about changes to the following reimbursement policies, which are effective November 1, 2024:

- *Anesthesia Reimbursement & Services Reporting* (Anesthesia #102)—commercial and Medicare Advantage
- *Emergency Department Visits: Level of Service* (Facility #110)
- *Radiation Oncology* (Administrative #151)

We provided 90-day notice in the September 2024 issue of *The Bulletin* about changes to the *Frenotomy* (Surgery #102) reimbursement policy, which are effective December 1, 2024.

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

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 July 1, 2024	Description
Archived medication policy	
Non-preferred injectable insulins, dru372	- Novo Nordisk insulin products (Novolin, Novolog, Fiasp) moved to preferred list and no longer require pre-authorization - The rest of the products in dru372 continue to require pre-authorization under dru760

Effective July 15, 2024	Description
New medication policies	
Amtagvi, lifileucel, dru784	- Coverage is limited to patients with unresectable or metastatic cutaneous melanoma with disease progression on the following: anti-PD-1-based regimen and a combination BRAF/MEK inhibitor therapy if BRAF V600 mutation-positive
Complement Inhibitors for the Eye, dru762	- Coverage is limited for Syfovre (pegcetacoplan) and Izervay (avacincaptad pegol) to patients with geographic atrophy (GA) secondary to age-related macular degeneration (AMD) that has been established by a specialist in ophthalmology - Coverage of Izervay is additionally limited to GA located outside the foveal center
Duvyzat, givinostat, dru786	- Coverage is limited to ambulatory patients with genetically confirmed Duchenne muscular dystrophy (DMD) that has been established by a neurology specialist and when used in combination with a corticosteroid
Lenmeldy, atidarsagene autotemcel, dru781	- Coverage is limited to patients less than seven years old with certain subtypes of metachromatic leukodystrophy that has been established by a specialist and confirmed via ARSA enzyme activity, genetic mutation and positive urinary analysis for sulfatides
Tevimbra, tislelizumab-jsgr, dru785	- Coverage is limited to patients with a diagnosis of unresectable or metastatic esophageal squamous cell carcinoma after disease progression on or after frontline chemotherapy

Continued on page 12

Continued from page 11

Effective July 15, 2024 (cont.)	Description
Revised medication policies	
Chimeric Antigen Receptor (CAR) T-cell, dru523	- Updated coverage criteria for Abecma (idecabtagene vicleucel) and Carvykti (ciltacabtagene autoleucel) for multiple myeloma based on new evidence that led to expanded FDA indications
Gene therapies for hemophilia B, dru735	- Added newly FDA-approved Beqvez (fidanacogene elaparvovec-dzkt) to policy - Coverage is limited to patients 18 and older with severe or moderate-severe phenotype, no factor IX inhibitors and negative for AAVRh74 var antibodies when exogenous factor IX prophylaxis is ineffective
Keytruda, pembrolizumab, dru367	- Added coverage criteria for the newly FDA-approved indication for treatment of resectable non-small cell lung cancer in combination with platinum-containing chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment after surgery - Added coverage criteria for the newly FDA-approved indication for treatment of locally advanced unresectable or metastatic biliary tract cancer in combination with gemcitabine/cisplatin - Added coverage criteria for the newly FDA-approved indication for first-line treatment of locally advanced unresectable or metastatic HER2-positive gastric or GEJ adenocarcinoma when tumors express PD-L1 and used in combination with chemotherapy; coverage is limited to tumors expressing PD-L1 CPS >1 - Added coverage criteria for the newly FDA-approved indication for first-line treatment of locally advanced and unresectable or metastatic HER2-negative gastric or GEJ adenocarcinoma when used in combination with fluoropyrimidine- and platinum-containing chemotherapy; coverage is limited to tumors expressing PD-L1 CPS >1 - Added coverage criteria for the newly FDA-approved indication for locally advanced or metastatic urothelial cancer when used with Padcev (enfortumab vedotin) or as monotherapy; coverage is limited to members not eligible for platinum-containing chemotherapy - Revised coverage criteria for hepatocellular carcinoma (HCC) based on updated FDA indication - Added coverage criteria for the newly FDA-approved indication for FIGO 2014 stage III-IVA cervical cancer when used with chemoradiotherapy; coverage is limited to specific histologies

Effective August 1, 2024	Description
New medication policy	
GLP-1 Agonist-Containing Medications for Non-Diabetic Indications, dru787	- New policy for GLP-1 agonist-containing medications for non-diabetic indications - Incorporates criteria for obesity and overweight previously in dru778 when a covered benefit on the member's plan - Added coverage criteria for Wegovy (semaglutide) for reducing risk of major adverse cardiovascular events (MACE) in adults with established cardiovascular disease (CVD) and either obesity or overweight, a newly FDA-approved indication

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Effective September 1, 2024	Description
New medication policies	
Ogsiveo, nirogacestat, dru783	- Coverage is limited to patients with progressive, morbid or symptomatic desmoid tumors when sorafenib is not a treatment option
Rezdiffra, resmetirom, dru782	- Coverage is limited to patients with biopsy confirmed NASH/MASH when prescribed with a gastroenterologist or hepatologist; additional requirements include failure of lifestyle modifications, and F2 or F3 liver fibrosis
Revised medication policies	
BRAF inhibitors, dru728	- Added coverage criteria for Braftovi (encorafenib) for the treatment of locally advanced or metastatic NSCLC with a BRAF V600E mutation when used in combination with Mektovi (binimetinib) or as monotherapy if previous combination therapy with Braftovi/Mektovi was not tolerated, a newly FDA-approved indication
Ileal Bile Acid Transporter (IBAT) Inhibitors, dru699	- Added coverage criteria for Livmarli (maralixibat), for newly FDA-approved indication for the treatment of cholestatic pruritus in patients five years of age and older with progressive familial intrahepatic cholestasis (PFIC); criteria mimics that of Bylvay (odevixibat) with an additional step for Livmarli through Bylvay for PFIC1 and PFIC2 subtypes
Immune Globulin Replacement Therapy, dru020	- Added newly FDA-approved IVIG product Alyglo (immune globulin intravenous, human-stwk) to policy as not medically necessary and therefore not covered
Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors, dru621	- Added newly FDA-approved aflibercept biosimilars [Opuviz (aflibercept-yszy), Yesafili (aflibercept-jbvf)] to policy at parity with Eylea
Medications for pulmonary arterial hypertension (PAH), dru633	- Added newly FDA-approved Opsynvi (macitentan/tadalafil) to policy; criteria aligns with that of Opsumit (macitentan), Letairis (branded ambrisentan) and Tracleer (branded bosentan) - Added newly FDA-approved Winrevair (sotatercept-csrk) to policy; coverage is limited to patients with WHO Group 1 (functional class II and III PAH) as an add-on to a double or triple regimen
Medications for thrombocytopenia, dru648	- Added newly FDA-approved Alvaiz (eltrombopag choline) to policy; coverage mimics that of Promacta
Medications for transthyretin-mediated amyloidosis, dru733	- Added newly FDA-approved Wainua (eplontersen) to policy - Coverage is limited to patients with hATTR-PN confirmed by genetic testing and established by a specialist, with impairment due to neuropathy and symptoms consistent with polyneuropathy and no prior liver transplant - Coverage criteria mirrors that of Tegsedi (inotersen)
Mitogen-activate extracellular signal regulated kinase (MEK) Inhibitors, dru727	- Added coverage criteria for Mektovi (binimetinib) for the treatment of locally advanced or metastatic NSCLC with a BRAF V600E mutation when used in combination with Braftovi (encorafenib), a newly FDA-approved indication
Monoclonal antibodies for asthma and other immune conditions, dru538	- Added coverage criteria for Xolair (omalizumab) for IgE-mediated food allergy, a newly FDA-approved indication

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Effective September 1, 2024 (cont.)	Description
Archived medication policy	
lapatinib (generic, Tykerb), dru145	- lapatinib and Tykerb no longer require pre-authorization as of September 1, 2024

Effective October 1, 2024	Description
Revised medication policies	
Drugs for chronic inflammatory diseases, dru444	- Added the biosimilar Simlandi (adalimumab-ryvk) to policy as a preferred adalimumab product along with Hadlima and Humira - Added the unbranded products adalimumab-adbm (Quallent Pharmaceuticals), adalimumab-ryvk (Quallent Pharmaceuticals) and adalimumab-adaz (Cordavis) to policy as not medically necessary and therefore not covered - Added Entyvio SC (vedolizumab) as a Level 3 self-administered option for Crohn's disease (CD), a newly FDA-approved indication - Updated Entyvio SC (vedolizumab) criteria for ulcerative colitis to coverage after two Level 1 or 2 alternatives (previously required three Level 1 or 2 alternatives) - Added Rinvoq (upadacitinib) as a Level 2 self-administered option for polyarticular juvenile idiopathic arthritis (PJIA), a newly FDA-approved indication - Added Rinvoq LQ (upadacitinib), a newly FDA-approved oral solution formulation, to policy at parity with Rinvoq - Added the biosimilars Tofidence IV (tocilizumab-bavi) and Tyenne IV (tocilizumab-aazg) to policy as non-preferred and preferred tocilizumab products, respectively - Updated coverage criteria for Spevigo (spesolimab-sbzo) to include subcutaneous formulation and also newly FDA-approved indication for maintenance treatment of generalized pustular psoriasis (GPP).

Effective December 1, 2024	Description
Revised medication policy	
Anabolic bone medications, dru612	- Coverage of brand name Forteo and teriparatide 620mcg/2.48 ml will require step therapy through generic teriparatide 600mcg/2.4ml and Tymlos

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<table>
<tr><th>Effective January 1, 2025</th><th>Description</th></tr>
<tr><td colspan="2">Revised medication policies</td></tr>
<tr><td>Drugs for chronic inflammatory diseases, dru444</td><td>- Moved Actemra (tocilizumab) IV and SC to non-preferred for all applicable indications; added its biosimilar [Tyenne SC (tocilizumab-aazg)] to policy as preferred</td></tr>
<tr><td>Medicare Part B Step Therapy, drum001</td><td>- Adding the following products to policy as non-preferred:
<table>
<tr><th>Non-preferred</th><th>Preferred</th></tr>
<tr><td>Ahzantive</td><td>- Byooviz, Cimerli, Lucentis</td></tr>
<tr><td>Fyarrow</td><td>- Temsirolimus</td></tr>
<tr><td>Herceptin Hylecta</td><td>- Kanjinti, Trazimera</td></tr>
<tr><td>Hercessi</td><td>- Kanjinti, Trazimera</td></tr>
<tr><td>Onivyde</td><td>- Irinotecan</td></tr>
<tr><td>Onuviz</td><td>- Byooviz, Cimerli, Lucentis</td></tr>
<tr><td>Rituxan Hycela</td><td>- Ruxience, Truxima</td></tr>
<tr><td>Yesfili</td><td>- Byooviz, Cimerli, Lucentis</td></tr>
<tr><td>Zilretta</td><td>- Triamcinolone acetonide IR</td></tr>
</table>
- For Soliris, adding the following as cost-effective preferred options in addition to Ultomiris: Rystiggo, Vyvgart and Vyvgart Hytrulo</td></tr>
<tr><td>Mesenchymal-epithelial transition (MET) Inhibitors, dru642</td><td>- Adding monotherapy requirement</td></tr>
<tr><td>Rybrevant, amivantamab-vmjw, dru682</td><td>- Will be considered not medically necessary, and therefore not covered, when used after progression with Tagrisso</td></tr>
<tr><td>- Opdivo, nivolumab, dru390
- Tecentriq, atezolizumab, dru463
- Bavencio, avelumab, dru499
- Imfinzi, durvalumab, dru500
- Libtayo, cemiplimab-rwlc, dru565
- Jemperli, dostarlimab, dru673
- Opdualag, nivolumab-relatlimab-rmbw, dru718
- Zynyz, retifanlimab-dlwr, dru751
- Loqtorzi, toripalimab, dru774
- Bispecific T-cell engager (BiTE) Therapies for B-cell Lymphoma, dru761</td><td>- Adding reauthorization requirement at six months</td></tr>
</table>

Asuris EquaPathRx™ updates

As a reminder, the Provider-Administered Specialty Drugs benefit is in effect as plans renew throughout 2024 for fully insured group and Individual plan members. To ensure a smooth transition, we are delaying the benefit administration transition to the IntegratedRx – Medical Network. Look in future issues of this newsletter for updates to the timeline.

For now, all Asuris network providers are considered designated providers in the Prime IntegratedRx - Medical Network under the Provider-Administered Specialty Drugs benefit and are eligible to provide medications included in the Asuris EquaPathRx program (subject to otherwise applicable conditions) to members with this benefit. **This means members can continue to receive medications from you as they do today, and claims for medications included in this program will be processed based on the terms of your existing agreement.**

Notes:

- Medications included in this 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: Library>Policies & Guidelines>Medication Policies>Commercial Policies. We'll notify you in advance of any additions or changes to the medications included in the program through this newsletter.
- We have begun outreach to specific members who are receiving an Asuris EquaPathRx medication from a provider who is not yet participating on the IntegratedRx - Medical Network. If you aren't yet contracted with Prime, we'll work closely with you and our members to ensure they have uninterrupted access to their treatment on and after the implementation date.

Prime Therapeutics contracting and credentialing

If you haven't already, please reach out to your Prime contact now to complete the process of credentialing and contracting for the IntegratedRx - Medical Network. Your Prime contact will help you complete 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.

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.

Articles in this issue with behavioral health content	Pages
National Breast Cancer Awareness Month: A time for action	1
Medicare crossover claim reminders	6
Diagnosing and treating depression in primary care	17-18
Check for signs of seasonal affective disorder	19
Virtual provider spotlight: Equip for eating disorder treatment	19
Specialized virtual providers without a referral	20
DispatchHealth: Urgent medical care in your patient's home	21
The importance of medication reviews	21
Help your patients save money and improve medication adherence	22

Additionally, the following recurring articles often have policy updates that may affect your practice:

- Update your directory information
- *Administrative Manual* updates
- Pre-authorization updates
- *The Bulletin* recap
- Medication policy updates

Diagnosing and treating depression in primary care

As a PCP, you play a crucial role in your patient's mental health and substance use treatment, which are integral to a person's overall health.

Depressive disorders are the number one cause of disability and the most common types of mental health conditions. Depression can often go unnoticed by others—even by those afflicted—and having depression increases the risk for other medical illness by 40%.

During the COVID-19 pandemic, rates of depression skyrocketed across age groups, with one in three American adults reporting symptoms in 2021. Some estimates put that figure as high as 40%. Youth experienced an even greater increased prevalence of depression, with teenage girls showing the highest rates. This highlights the critical need for depression screening across age groups, as well as pursuing additional assessment and treatment for positive screens.

Best practices

Routine depression screenings in the primary care setting are considered a best practice for intervention and treatment. Patients may feel more comfortable with their PCP, with whom they have an established relationship, rather than seeking help from a behavioral health provider. Additionally, those suffering may not seek treatment because they don't recognize their symptoms or don't want to acknowledge them.

Fortunately, many primary care groups have integrated licensed behavioral health professionals who can take "warm handoffs" to begin further assessment and initial treatment without needing an outside referral.

Recognize the risk factors

Many factors may put a patient at risk of having depression. They include but are not limited to:

- Being female
- Having a history of trauma
- Having alcohol use disorder
- Death or loss of a loved one
- Low income or financial instability
- Being pregnant or recently giving birth
- Having a personal and/or family history of depression
- Having comorbid chronic medical conditions, including chronic pain

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Behavioral health corner

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Be aware of health disparities

Additionally, minoritized populations often experience inequitable access to behavior health care. Research shows that certain racial and ethnic populations, as well as the LGBTQIA+ community, are much less likely to receive behavioral health services:

- The percentage of Asian Americans and Native Hawaiian and Pacific Islanders who reported having any mental illness (AMI) in 2021 was 16% and 18%, respectively. However, only 25% of Asian Americans received mental health services compared to non-Hispanic Whites (52%).
- 21% of Black and African Americans reported having a mental illness, compared to 23.9% of non-Hispanic Whites. However, just 39% of Black and African Americans received mental health services compared to non-Hispanic Whites (52%).
- Nearly 22% of Hispanic and Latino Americans reported having a mental illness compared to 23.9% of non-Hispanic Whites. However, only 36% of Hispanic and Latino Americans received mental health services compared to non-Hispanic Whites (52%).
- American Indian and Alaska Native populations experience the highest rates of suicide of any minority group within the U.S., and rates have been increasing since 2003. These groups also experience high rates of substance use disorder (SUD) involving both illicit drugs and alcohol use.
- Two-thirds of LGBTQIA+ people (67%) reported needing a mental health service during the past two years, a considerably higher rate—39%—than non- LGBTQIA+ people. Only about half of LGBTQIA+ people with a reported need sought and received mental health services.

Common signs and symptoms

- Loss of motivation
- Weight gain or loss
- Decreased concentration
- Fatigue or lack of energy
- Neglecting responsibilities
- Unexplained aches and pains
- Loss of interest in personal appearance
- Psychological symptoms: Anger, anxiety, sadness, irritability, mood swings, lack of emotional responsiveness, feelings of worthlessness or helplessness and, in the extreme, thoughts of suicide or self-harm

Resources for PCPs

The Behavioral Health Toolkit on our provider website is designed to support PCPs. It includes an extensive list of screening tools, including the *PHQ-9*, which can be used to screen for and diagnose depression. The *PHQ-9* is both highly sensitive and specific for depression. It can be used to measure the severity of depression, as well as response to treatment.

The toolkit also includes:

- A list of in-network virtual providers with a variety of areas of expertise; telehealth visits may allow members to start treatment sooner and provide more flexible scheduling
- A presentation titled *Depression: Screening and treatment in the primary care setting*
- Information to help PCPs determine the best path forward in the early stages of a patient's evaluation and treatment
- Information about our care management services, including case management
- Resources for treating members who may have the following diagnoses and challenges:
  - Anxiety
  - Alcohol use
  - Attention-deficit/hyperactivity disorder (ADHD)
  - Bipolar disorder
  - Eating disorders
  - Gender identity
  - Opiate use
  - Pain management
  - Post-traumatic stress disorder (PTSD)
  - SUD
  - Suicide prevention

Additionally, our Health Equity Toolkit includes:

- Resources to address behavioral health disparities
- Our *Improving Care for Latinx Patients* flyer, which provides tips for depression screening
- Continuing medical education (CME) opportunities

Knowing when to refer

If a patient may be at imminent risk of suicide, **call 911 immediately**.

PCPs should consider psychiatric consultation prior to treatment in the following circumstances:

- Need for hospitalization
- Uncertainty about the diagnosis
- Comorbid psychiatric disorders

Providers in Oregon, Utah and Washington can learn more about accessing state-funded psychiatric consultations at no cost in our Behavioral Health Toolkit.

Behavioral health corner

Check for signs of seasonal affective disorder

As the days get shorter and the winter months settle in, some of your patients may start to experience symptoms of seasonal affective disorder (SAD).

SAD is a type of depression that most often occurs during the winter season and is thought to be caused by a lack of sunlight. The signs and symptoms of SAD can mirror those of depression and can include:

- Oversleeping
- Having low energy
- Restlessness and agitation
- Overeating and weight gain
- Feeling sluggish or agitated
- Having difficulty concentrating

SAD can be treated using traditional forms of care, such as psychotherapy and antidepressant medication. Patients may also benefit from light therapy and vitamin D supplements.

To help identify SAD in your patients:

- Ask about mental health issues during the patient's physical exam.
- Check for symptoms of depression by asking patients about their thoughts, feelings and behavior patterns.
- Consider using a diagnostic tool, such as the *Seasonal Pattern Assessment Questionnaire* or the *Patient Health Questionnaire 9 (PHQ-9)* quick depression assessment.

Toolkit resources

- The *PHQ-9* is available in the Depression section of the Behavioral Health Toolkit, which also includes support for treating many types of behavioral health conditions.
- Healthwise's Knowledgebase has helpful information about SAD. To share materials in English and Spanish with your patients, access the Knowledgebase site via our Quality Improvement Toolkit.
- Racial and ethnic groups, the LGBTQIA+ community, people with lower socioeconomic status, and other underrepresented and underserved groups experience disparities in behavioral health diagnosis, access to care and treatment. To learn more about behavioral health disparities, visit our Health Equity Toolkit, which includes resources to address these disparities, as well as CME opportunities.

Virtual provider spotlight: Equip for eating disorder treatment

Equip offers fully virtual eating disorder treatment for patients of all ages with:

- Anorexia
- Bulimia
- Binge eating disorder
- Avoidant/restrictive food intake disorder (ARFID)
- Other specified feeding or eating disorder (OSFED) and co-occurring diagnoses

Equip uses evidence-based modalities including family-based treatment, enhanced cognitive behavioral therapy (CBT-E); CBT for avoidant/restrictive food intake disorder CBT-AR and dialectical behavior therapy (DBT).

Equip offers a five-person multidisciplinary care team that includes a therapist, a family mentor, a peer mentor, a medical provider and a dietitian. They have one-year treatment plans.

- Months one to four are an intensive phase.
- Months five to 12 focus on holistic care and treating comorbidities.
- Additional support is available as needed for another year.

Equip has no waitlist and offers eating disorder treatment that works in the member's home:

- Patients see progress in the first eight weeks of treatment.
- 81% of patients see improvements in their eating disorder symptoms.
- 83% of patients needing to restore weight will gain weight.
- 73% of patients report improvements in depression or anxiety.

Equip is available to our commercial members and is licensed in all 50 states, including Washington, DC.

How to refer:

- Online
- Email
- Call (855) 387-4378

Behavioral health corner

Specialized virtual providers without a referral

Because timely behavioral health care is integral to patients' overall well-being, we encourage members to consider treatment from virtual, in-network behavioral health providers.

Members can easily find virtual providers who offer the appropriate specialty care, and they don't need a referral to begin treatment. These providers' diverse areas of focus include eating disorders, obsessive compulsive disorder (OCD), SUD and comprehensive therapy programs to treat a variety of age ranges, from age 5 through adulthood.

To view a complete list of in-network virtual specialized behavioral health provider groups, visit our Behavioral Health Toolkit, available on the homepage of our provider website.

To confirm a telehealth provider is in-network, members can:

- Use the Find a Doctor tool on our member website, asuris.com, to search for virtual providers or Places by Name.
- Chat online with Customer Service.
- Call the Customer Service number on the back of their member ID card.

Members can then contact the provider to schedule treatment.

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 young 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 ages 6 to 24 that includes a five-person care team - **Related**: See *Virtual provider spotlight: Equip for eating disorder treatment* on page 19.
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

DispatchHealth: Urgent medical care in your patient's home

DispatchHealth can help your moderate- to high-risk patients by bringing urgent medical care to the comfort of their homes. Whether it is after hours, on weekends or holidays, or during times of high patient volume, you can rely on DispatchHealth to help treat your patients.

They are available in the Spokane area.

DispatchHealth works as an extension of your medical team to help you:

- Extend your care after hours, on weekends or holidays, or during capacity constraints
- Improve health outcomes and patient experience
- Gain valuable insight into social determinants of health (SDoH)
- Reduce non-emergent ED usage, hospital admissions and readmissions
- Reduce overall health care costs

They can treat 95% of the top ED diagnoses in the home.

Visit our Care Options Toolkit on the homepage of our provider website to learn more.

The importance of medication reviews

As a PCP, your important roles include acting as an information resource about all the medications your patients take. Our members often take several medicines, vitamins and supplements from different sources, which can lead to duplicate therapy or potentially adverse interactions if they have multiple prescribers.

Survey results

In a survey conducted of our Medicare members in 2023, about 85% responded affirmatively to a question about whether they had talked with their provider about all the prescription medications they were taking. While this rate is good, it still means many of our members are not having the conversation or don't remember having had a conversation.

Facilitating memorable conversations

To facilitate memorable conversations about medications, many offices ask patients to bring all their medications, vitamins, supplements, herbal remedies and other products they are taking to an office visit at least once per year. During that visit, the PCP, a nurse or pharmacist can:

- Review the medications
- Identify any concerns with the medications
- Make sure the patient is taking them as prescribed
- Make sure the patient understands each product's purpose

Techniques for improving patient recall

Using techniques like the teach-back method—as well as reviewing any medication changes again at the end of an office visit and highlighting changes on an after-visit summary—are great ways to help patients remember having had a conversation.

Patient resources

Educational handouts and flyers are another great way to help patients remember conversations about their medications, and they can help PCPs and staff facilitate these conversations. We have several flyers (available in English and Spanish) that address medication management and can be shared with your patients. Look for the **Medications and Member Experience with Medications** category in the Quality Improvement Toolkit, available on the homepage of our provider website.

Help your patients save money and improve medication adherence

Asuris Medicare Advantage members who have pharmacy benefits with their medical plan can control costs and improve medication adherence by using the following options.

Home delivery

A home delivery pharmacy service offers convenient delivery to their mailbox, and standard shipping within the U.S. is free. Patients can get up to a 100-day supply of their maintenance medications on Medicare Advantage plans that include prescription medications. **Note**: Part D Plans (pharmacy benefits only) allow a 90-day supply of maintenance medications.

- Receive most medications seven to 10 days after the first order is placed.
- Refills take up to seven days to arrive.
- All orders arrive in a plainly wrapped, tamper-evident package.

Home delivery pharmacies

Express Scripts Home Delivery

- express-scripts.com
- **Phone**: 1 (833) 599-0451
- **Fax**: 1 (800) 837-0959

Costco Mail Order Pharmacy

- **Phone**: 1 (800) 607-6861
- **Fax**: 1 (800) 633-0334

AllianceRx Walgreens Pharmacy

- alliancerxwp.com/home-delivery
- **Phone**: 1 (888) 832-5462
- **Fax**: 1 (800) 332-9581

Amazon Pharmacy Home Delivery

- pharmacy.amazon.com/prescribers
- **Phone**: 1 (855) 206-3605
- Fax: 1 (512) 884-5981

Note: In 2025, Amazon Pharmacy Home Delivery will be our preferred home delivery pharmacy

Postal Prescription Services

- ppsrx.com
- **Phone**: 1 (800) 552-6694
- **Fax**: 1 (800) 723-9023

Preferred pharmacies

Patients can save money by using a preferred pharmacy. Many preferred pharmacies can also fill up to 100-day supply prescriptions. To find out which pharmacies are preferred:

- Go to asuris.com/medicare/pharmacy, scroll down to find your patient's Medicare plan name, and then select 2024 pharmacies. This will take you to the find a pharmacy page.
- In the I'm searching for section, choose preferred retail.
- Enter your patient's ZIP code or address.
- Look for a yellow letter P in your search results to find a preferred pharmacy.
- Contact the preferred pharmacy to send a new prescription.

PillPack by Amazon Pharmacy

If your patient is taking multiple medications and has difficulty staying organized or using a pillbox, PillPack by Amazon Pharmacy can help. This preferred retail pharmacy delivers to your door and makes taking your medications easy and convenient.

- Pre-sorted one-month supply of medications are packaged with a scheduled dosage time and date.
- Delivery to your patient's home is free.
- Pharmacists are available 24/7 by phone, email or mobile chat.
- PillPack will work closely with you, your patient and us to resolve any issues.

Signup is easy. Visit PillPack online or call 1 (855) 745-5725, ext. 3.

2025 commercial product and network updates

Each year, we evaluate our provider networks and product portfolio to ensure our members receive the best value for their health care dollar. Included below is an overview of the 2024 changes to our product portfolio. In addition, we will implement changes to comply with ACA requirements and state and federal mandates.

Group network and product updates

Small employer (1 to 50) group metallic products

- Adding a new RealValue provider network
- Adding a new Gold Abound 3500 plan

Fully insured groups of 51+ and administrative services only (ASO) groups

- Adding a new RealValue provider network

Individual network and product updates

Our product portfolio will include:

- Exclusive provider organization (EPO) products; EPO members only have in-network benefits, and members will be responsible for 100% of out-of-network costs except:
  - Out-of-network emergency room, ambulance and urgent care services will be covered at the in-network benefit level. Urgent care services are subject to balance billing.
  - When traveling out of our service area, urgent care, emergency room and ambulance services are covered with no balance billing if the member sees a participating MultiPlan provider.
- High-deductible health plans (HDHP) that can be paired with a health savings account (HSA)

The Individual and Family Network will support our products.

- Supports off-exchange products
- **Network and sales area**: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman counties

The open enrollment period for individuals seeking coverage beginning on January 1, 2025, is from November 1, 2024, through January 15, 2025. Individuals may qualify for special enrollment periods outside of this period if they experience certain life events.

Members whose plans are being discontinued have received notice from us about options available to them in 2025.

Benefit highlights for all our commercial products

- The mobile urgent medical care service DispatchHealth will be available to treat common to complex injuries and illnesses at the member's home in the Spokane metro area. **Related**: See *DispatchHealth: Urgent medical care in your patient's home* on page 21.
- In addition to having access to telehealth services from in-network providers, members will have access to telehealth services for urgent care and behavioral health through the national telehealth vendor Doctor on Demand. Some groups will have access to medical and behavioral health providers through MDLIVE.
- Most members will have access to either telephone or chat nurse triage lines (depending on their plan), available 24/7.
- Hinge Health, a personalized virtual exercise program, is available to help eligible members manage mobility and pain in joints, spine and muscles.
- Wellbeing rewards and incentives for qualifying activities will be expanded.
- We are updating coverage for continuous glucose monitors (CGMs).
- **Related**: Benefits (e.g., congenital anomalies, hearing aids, and neurodevelopmental therapy) will be updated to comply with ACA Section 1557; see *ACA Section 1557: Ensuring nondiscrimination in health care* on page 24 for more information.

Verify network participation

Participating providers: For a list of the networks that you participate in, refer to your Professional Network Addendum. You can also verify your network participation and find other in-network providers using our provider directory, the Find a Doctor tool, on our website.

Verify eligibility and benefits

You can verify your patients' eligibility and benefits on Availity Essentials.

More information

Information about our 2025 products will be available in the Products section of our provider website in January 2025.

ACA Section 1557: Ensuring nondiscrimination in health care

Section 1557 of the ACA is a crucial provision that prohibits discrimination in health care programs and activities to ensure all patients have access to high-quality care, regardless of their race, color, national origin, disability, age or sex.

By understanding and complying with this provision, providers (including hospitals, clinics and physician practices) and health plans can promote health equity, improve patient outcomes, and ensure that all individuals receive the care they deserve.

We have implemented and will continue to implement changes to benefits to comply with this provision. For example, on some plans we will remove age limits on benefits where they are not clinically supported (e.g., congenital anomalies, hearing aids, and neurodevelopmental therapy). Benefits will be updated upon renewal. ASO groups benefits may vary.

Resources

- U.S. Department of Health and Human Services: *Section 1557 of the Patient Protection and Affordable Care Act* outlines the requirements for providers and health plans.
- Our Health Equity Toolkit, available on the homepage of our provider website, includes trainings, CME courses and other resources to address health disparities and advance health equity.
- Verify your members' benefits using Availity Essentials.

New Quality Program guide available for APMs

We updated our *Quality Program for commercial alternative payment models* guide for 2025. The guide includes information about our quality program for commercial alternative payment models (APMs), which applies to providers with Commercial Total Care Program and Accountable Health Network (AHN) agreements.

You can view the updated Quality Program guide on our provider website: Contracting & Credentialing>APM Resources.

About Medicare corner

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

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Additionally, the following recurring articles often have policy updates that may affect your practice:

- Update your directory information
- *Administrative Manual* updates
- Pre-authorization updates
- *The Bulletin* recap
- Medication policy updates

Medicare Prescription Payment Plan starts January 1

Starting January 1, 2025, CMS is introducing a new Medicare Part D benefit, the Medicare Prescription Payment Plan. The Medicare Prescription Payment Plan gives members the option to spread out the cost of their Medicare Part D prescriptions by paying monthly payments during the calendar year. **Note**: This does not apply to medications covered under Medicare Part B.

Participation in Medicare Prescription Payment Plan is completely voluntary for members. Members can enroll in the Medicare Prescription Payment Plan at any time by contacting us. Once they enroll, members will pay $0 to the pharmacy for covered Part D medications, and Asuris will pay the pharmacy and bill the member monthly for the cost-sharing they incur.

Determining which members will benefit most

Members most likely to benefit from participating in the Medicare Prescription Payment Plan are those who have high medication costs earlier in the calendar year. Although members can start participating at any time in the year, starting earlier in the year, gives members more months to spread out their drug costs.

The Medicare Prescription Payment Plan may not be the best choice for a member who:

- Has low yearly drug costs
- Has drug costs that are the same each month
- Is considering signing up for the payment option late in the calendar year (after September)
- Is eligible for Medicare's Extra Help program
- Is eligible for a Medicare Savings Program
- Gets help paying for drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP), a coupon program or other health coverage

Help for your patients

Your patients may have questions or concerns about the cost of their prescription medications. If your patient is interested in the program, please direct them to the customer service number on their member ID card.

Learn more about the Medicare Prescription Payment Plan.

Medicare corner

2025 Medicare Advantage products

Financial pressure on Medicare Advantage plans nationwide has increased because of rising utilization, rising health care costs and changing policies. These headwinds have led to changes to our Medicare Advantage plans in 2025 so we can be financially sustainable to serve all our members. We will continue providing the best customer service, high-quality provider partnerships, an extensive network and the best quality health care for our members.

Plans available

We will offer MedAdvantage PPO plans in Spokane County. We are discontinuing MedAdvantage PPO plans in Chelan County.

Benefit changes and additions

Current Medicare Advantage members will receive the *Annual Notice of Changes*, which highlights the changes specific to their product for 2025. Some key benefit changes are listed below.

Notes:

- This is not a comprehensive list of benefit or copay changes, and some benefits are only available on specific plans.
- Please check your patient's benefits on Availity Essentials.
- Prior to referring patients, please use the Find a Doctor tool on our provider website to verify network participation.

Medical benefits

- Emergency department copay will increase to $110 or $125 (varies by plan).
- Skilled nursing facility (SNF) copay will increase to $214 per day (day limits vary by plan).
- Partial hospitalization copay will increase to $80 or $105 (varies by plan).
- Outpatient hospital and ambulatory surgical center will change to coinsurance instead of a copay.
- Opioid services will match specialist copay.

Medicare Part D changes

- We are adjusting copay and coinsurance amounts for most tiers.
- Members will have lower cost share for using preferred retail pharmacies and home delivery pharmacies.
- Amazon Home Delivery will be our preferred home delivery pharmacy.
- Our Medicare Part D formulary continues to offer several medications in all classes, as required by CMS. Some medications may have been removed from our formulary. To ensure coverage, use the real-time pharmacy benefit check tool from Arrive Health that can be embedded in your EMR. Learn more about this tool on our provider website: Programs>Medical Management>Pharmacy.
- We encourage the use of generics and biosimilars whenever possible as a safe and easy way to help save on drug costs and still maintain high-quality care.
- We are discontinuing our standalone Medicare Part D plans.

Meals post-discharge

- There will be a limit of two weeks, 28 meals for post-discharge meals provided by Mom's Meals.
- We are discontinuing meal delivery for chronic conditions.

Hearing aids

- All plans will have three tier copays: 499/$699/$999.
- Benefit continues to be administered by TruHearing.

Dental

- Dental benefits are administered by United Concordia Dental, and the network is managed by USAble. Visit our dental website for more information.

Over-the-counter (OTC) and home safety

- Benefits will be administered by PayForward.
- Over-the-counter (OTC) benefit allowance includes:
  - Home and bathroom safety equipment reimbursement
  - Certain OTC supplies and medications

Chiropractic

- Medicare-covered chiropractic visits are available on all plans.
- Supplemental chiropractic visits are not covered.

Acupuncture

- Medicare-covered acupuncture services are available on all plans.
- Supplemental acupuncture services are not covered.

Naturopathy

- Naturopath services are not covered.

Massage

- Therapeutic massage services are not covered.

Medicare retiree group plans

Medicare retiree group plans may have benefits that vary from those described here, including, but not limited to, service areas, supplemental benefits and prescription medication coverage.

MA QIP reminders for Q4

The following reminders about the 2024 Medicare Advantage Quality Incentive Program (MA QIP) will support your program participation as we approach the final months of 2024.

Final attribution update

To provide your group with roster stability in the last three months of the program year, MA QIP member attribution is locked after our last attribution file is loaded to the CGMA in early October. You may see a reduction in your roster if patients lose eligibility after the final attribution file is loaded.

Even though new patients will not be added to your CGMA roster, you may continue to see new risk adjustment and quality gaps for existing patients in the CGMA.

Risk adjustment gaps

New gaps added after October 1, 2024, will only be added to your performance denominator if the gap is closed. If you close a risk adjustment gap after October 1, 2024, the closed gap will be added to both your numerator and denominator.

Quality gaps

You may see new gaps but only for existing patients on your roster. Quality gaps that open after October 1, 2024, will be added to your denominator in accordance with the specifications for each measure.

Learn about attribution adjustment options by member type and read details about the measures in the *Quality Measures Guide* on our provider website: Programs>Medicare Quality Incentive Program.

Prioritize patients with highest number of open gaps

We are approaching the final months of our 2024 MA QIP performance year. If your patients still have gaps that require an office visit or screening to be completed this year, we encourage you to contact them to schedule now. You can review your patients and sort them by largest number of open gaps on the CGMA.

To ensure that we have the information necessary to close your gaps for the 2024 program, we will accept claims or compliant documentation until the dates listed below for each method of gap closure submission:

- December 31, 2024—Last day to perform services
- January 31, 2025—Last day to submit evidence to close gaps for MA Coordination of Care (MACOC) members
- February 28, 2025—Last day to submit supplemental data
- February 28, 2025—Last day to work in the CGMA and submit evidence to close gaps
- March 31, 2025—Last day to submit medical or pharmacy claims

CGMA user audit coming soon

Twice per year, we complete a user audit to verify that the appropriate users have access and identify inactive accounts. Note: CGMA accounts that are inactive for 120 calendar days are locked and will need to be reactivated. QIP Primary Contacts are required to respond to the audit to maintain access for themselves and others associated with their TIN. Thank you in advance for complying with this audit to ensure that protected health information remains safe.

Questions about MA QIP

Email our QIP team or visit our provider website: Programs>Medicare Quality Incentive Program.

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.

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