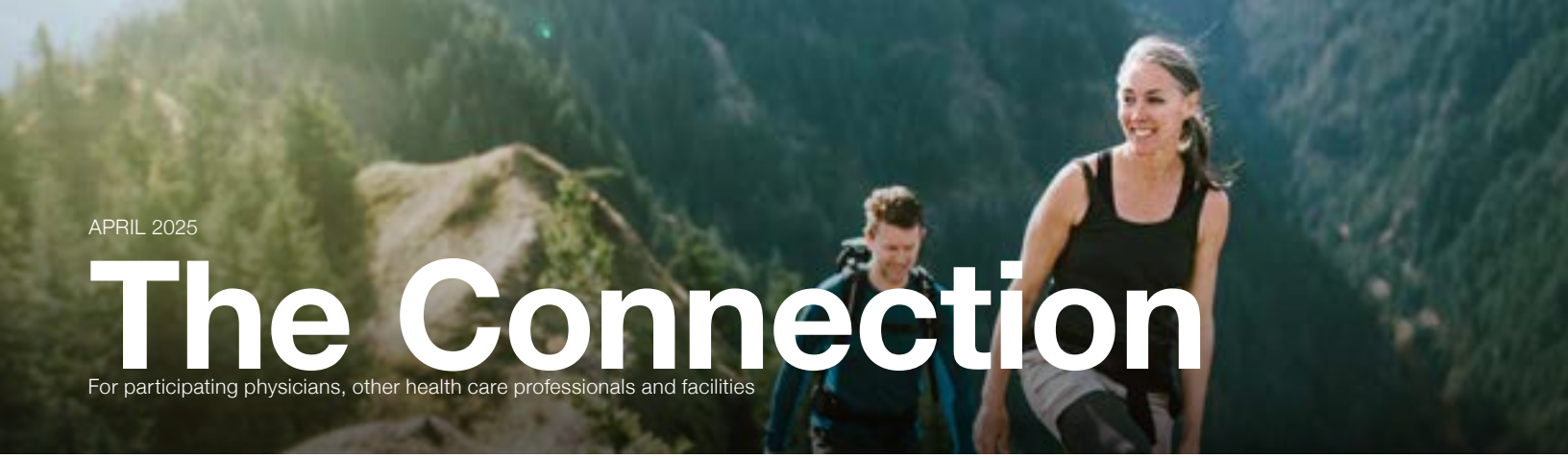

APRIL 2025

The Connection

For participating physicians, other health care professionals and facilities

In this issue

- **Automate your pre-authorization process with Availity Essentials**: Receive fast responses to authorization requests for behavioral health and substance use services, with some requests receiving automated approval.
- **Advanced imaging facilities need to register with OptiNet**: Carelon will begin reviewing radiology site of care requests submitted on or after May 1, 2025. Register with OptiNet to ensure Carelon has accurate information when determining the appropriate site of care for MRIs and CTs for our commercial members.
- **Opt-in to our quality incentive programs by June 30, 2025**: Continue to partner with us to address gaps in patient care. View our 2024 and 2025 program updates.
- **Visit the new Quality in Action section**: This new section on our provider website aims to help you improve patient engagement and health outcomes.

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.

Contents

■ Critical article ★ Star Ratings/Quality
● Radiology

ASURIS NORTHWEST HEALTH

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Get the latest news

We publish the latest news and updates in the What's New section on the homepage of our provider website.

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

The Connection

This publication includes important news, as well as notices we are contractually required to communicate to you.

In the table of contents on page 1, this symbol indicates articles that include critical updates: ■. Click on article titles to go directly to that page, and return to the table of contents by clicking the link at the bottom of each page.

We publish issues of *The Connection* on the first of 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

Published monthly, *The Bulletin* summarizes updates to medical and reimbursement policies, including policy changes we are contractually required to communicate to you.

Administrative Manual updates

The Medicare Advantage Plans and Facility Guidelines sections of our *Administrative Manual* were updated on April 1, 2025, to clarify MOON requirements.

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

PRIA updates support behavioral health and user management

We are excited to introduce two significant enhancements to our Provider Reporting Insights & Analytics (PRIA) platform that improve behavioral health services insights and streamline user management.

Behavioral Health Dashboard

Identify members who have a behavioral health diagnosis or who could benefit from outreach using the new Behavioral Health Dashboard. This solution offers providers an unprecedented 360-degree view of their patients' behavioral health needs. The dashboard consolidates critical behavioral health metrics, including diagnoses, utilization patterns, pharmacy data and demographic insights, enabling providers to quickly identify trends and intervention opportunities within their patient population.

This powerful new tool allows providers to drill down from high-level population health insights to individual patient data, supporting more targeted and timely behavioral health interventions while tracking key metrics, such as emergency room utilization, hospital admissions and prescription patterns.

By delivering actionable insights through an intuitive interface, this dashboard represents a significant step forward in our commitment to improving behavioral health outcomes and supporting providers in delivering more proactive, data-driven care.

Streamlined user management

Availity administrators can now instantly manage PRIA access for users at their organization through the new PRIA User Access tool, available on Availity's Asuris Payer Spaces. The tool populates all users at that organization, making it easy for the administrator to quickly select user(s), submit requests and grant immediate access. Administrators can also quickly withdraw access or resubmit to reinstate access for each user. Changes are immediate.

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.

In-network referral requirements

We expect our health care providers to support patients in making informed decisions about their health care. This includes directing them to in-network providers for all services, including laboratory and genetic testing.

Why directing care to in-network providers matters

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

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

Our Medicare Advantage PPO products have a higher member cost share for care received from out-of-network providers, except as required by CMS for urgent or emergent care.

Beginning August 1, 2025, if a Asuris TruAdvantage PPO member receives services from a provider outside of the Medicare Advantage PPO network, they will be responsible for the higher out-of-network benefit cost share. If you need to direct a member outside the Medicare Advantage PPO network for care, you can request an Organizational Determination by submitting the *In-Network Benefits to an Out-of-Network Provider* form on our provider website: Library>Forms.

Providing care out-of-network

Directing patients to non-participating providers can result in unexpected costs and reduced benefits. To minimize this, if you provide services to patients when you are not participating in their assigned network, it's essential to notify them in writing that services may not be covered or may lead to higher out-of-pocket costs through the use of a *Non-covered Services Member Consent Form*. View a sample form on our provider website: Library>Forms.

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 care direction, you're not only ensuring your patients receive the best possible care but also helping them spend their health care dollars wisely.

Medical record signature requirements

Proper authentication of medical records is crucial for health plans and providers to ensure that the data we report to CMS is compliant and accurate. Missing or improper signatures discovered through post-payment medical record reviews (such as those for risk adjustment) can lead to claim recoupments.

- All medical records must include the provider's valid signature, credentials and signature date.
- Providers have 180 days from the date of service to amend a record to properly authenticate it (including by recording a valid signature).
- Electronic medical record (EMR) system updates may override signature settings, requiring re-verification.

Tips to stay compliant

Using these tips to update and maintain your documentation practices can help you ensure proper authentication is happening in all your medical records:

1. Review your current signature practices.
2. Ensure all staff understand proper authentication requirements.
3. Keep CMS documentation guidelines readily available.
4. Regularly verify EMR signature settings, especially after system updates.
5. Limit EMR print settings to completed and signed records.
6. Regularly audit EMR for unsigned records and sign them (within 180 days of the date of service).

Resources

- The Medical Record Requirements section of our Administrative Manual, available on our provider website
- Visit the CMS website to access these helpful MLN fact sheets:
  - Medical Record Maintenance & Access Requirements (MLN4840534)
  - Complying with Medical Record Documentation Requirements (MLN909160)
  - Complying with Medicare Signature Requirements (MLN905364)

$0 claim submission tips

Submitting medical claims with $0 or $0.01 charges may be helpful for quality measure reporting or ensuring that we have all appropriate diagnoses documented in a calendar year for your patients. Here are some helpful tips for submitting these claims:

Reporting codes for quality

1. Submit a claim with an applicable evaluation and management (E&M), annual wellness visit (AWV) or preventive care CPT visit code on a professional claim. This code must have a billed charge more than $0. Additional CPT, CPT II and HCPCS codes (such as M1299 for flu vaccination documentation) can be included on the initial claim with a billed charge of $0 for that line.
2. To submit CPT reporting, additional CPT, CPT II and HCPCS codes on a standalone claim, the billed charge should be $0.01.

Risk adjustment diagnoses

1. Submit a claim with an applicable evaluation and management (E&M), annual wellness visit (AWV) or preventive care CPT visit code and up to 12 diagnosis codes for risk adjustment on a professional claim.
2. To submit additional diagnosis codes for risk adjustment, submit a second claim using CPT 99499 with a billed charge of $0.01. **Note**: CPT 99499 must be the **only** CPT code on this claim.
3. If additional diagnosis codes for risk adjustment remain, submit an additional claim for CPT 99499 with modifier 25 and a billed charge of $0.01. **Note**: CPT 99499 must be the **only** CPT code on this claim.

Correct coding updates

Providers are expected to follow correct coding guidelines. We are providing courtesy notice that our correct coding editors will apply denials for claims received on or after:

Post-pay edit effective April 1, 2025

- Laboratory charges for post-vasectomy semen analysis
  - Semen analysis is included in the reimbursement of the vasectomy and is not separately payable.

Pre-pay edits effective May 9, 2025

- Blood products
- Global modifiers
- Radiology transportation

These reviews are supported by industry standards and our *Correct Coding Guidelines* (Administrative #129) reimbursement policy. View our *Reimbursement Policy Manual* on our provider website: Policies & Guidelines>Reimbursement Policy.

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.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective April 1, 2025
Cardiovascular—Carelon	0913T
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	0539U
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	0538U, 0543U

Procedure/medical policy	Adding codes effective July 1, 2025
Air Ambulance Transport (Utilization Management #13)	A0431, A0436, S9961
Cardiovascular—Carelon	C7557, C7558
Electromagnetic Navigation Bronchoscopy (Surgery #179)	31626, 31627, C7509-C7511, C9751
Radiology—Carelon	75580

Medicare Advantage

Procedure/medical policy	Added codes effective March 1, 2025
Sacral Nerve Stimulation (Neuromodulation) for Pelvic Floor Dysfunction (Surgery #134)	C1778, C1883

Procedure/medical policy	Added codes effective April 1, 2025
Biochemical and Cellular Markers of Alzheimer's Disease (Laboratory #22)	0551U
Cardiovascular—Carelon	0913T
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	0539U
Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	0531U, 0533U, 0540U, 0542U, 0544U
Genetic and Molecular Diagnostics – Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83)	0537U-0539U, 0543U, 0549U, 0550U

Procedure/medical policy	Adding codes effective July 1, 2025
Air Ambulance Transport (Utilization Management #13)	A0431, A0436
Cardiovascular—Carelon	C7557, C7558
Electromagnetic Navigation Bronchoscopy (Surgery #179)	31626, 31627, C7509-C7511, C9751
Radiology—Carelon	75580

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.

Radiology site of care: Register with OptiNet today

Advanced imaging facilities need to register with OptiNet as soon as possible to ensure Carelon has accurate information when determining the appropriate site of care for MRIs and CTs for our commercial members. Carelon will review the site of care for requests submitted on or after May 1, 2025.

OptiNet is an online application accessed through the Carelon provider portal that collects service and capability information about outpatient providers. Carelon uses that information to determine available sites for services.

Facilities that should register with OptiNet

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

Providers that bill place of service (POS) 11, 49 or 81—designated as a freestanding imaging facility (physician group)—are required to register. Facilities billing POS 19 or 22 are designated as outpatient hospital departments and do not need to register with OptiNet.

If a facility doesn't register with OptiNet: Carelon won't be able to determine whether a service should be performed at that facility. An unregistered facility may:

- Fail to have services redirected to their facility
- Unnecessarily have services redirected to another facility

To register or update your facility information: Sign in to the Carelon provider portal and select **Access Your OptiNet Registration**.

If you're registered with OptiNet for another health plan: You can easily add your Asuris registration using the copy-and-paste function in OptiNet.

Have questions?

- **Attend a training**: Register today to attend a webinar about the radiology site-of-care program, using the Carelon provider portal and registering with OptiNet.
- **Contact OptiNet customer service**: Call 1 (877) 202-6543 or email.

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

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

We provided 90-day notice in the March 2025 issue of *The Bulletin* about changes to the *Bariatric Surgery* (Surgery #58) medical policy, which are effective June 1, 2025.

Easily search our *Medical Policy Manual*

From either the commercial or Medicare Advantage medical policy manual table of contents, you can search for a policy by:

- Policy name
- Medical policy ID
- Keywords
- CPT or HCPCS codes

You can also filter category names to browse policies by section or filter alphabetically by policy name or ID.

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

Reimbursement policy updates

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

- *Preventable Adverse Events* (Administrative #106)—Medicare Advantage
- *Reimbursement of Hospital Compound Solutions* (Facility #109)—Medicare Advantage

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

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

eviCore updating musculoskeletal guidelines

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

Joint surgery

- Shoulder Arthroplasty/Replacement/Resurfacing/Revision/Arthrodesis

Interventional pain

- Greater Occipital Nerve Injections and Ablation

Spine surgery

- Lumbar Microdiscectomy (Laminotomy, Laminectomy or Hemilaminectomy)
- Sacroiliac Joint Fusion and Stabilization

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

Updated Carelon guideline effective date

Carelon's Imaging of the Abdomen and Pelvis advanced imaging clinical guideline will now be updated May 18, 2025.

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

Clinical Practice Guideline updates

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 the following Clinical Practice Guidelines, effective February 1, 2025:

- Clinical Practice Guidelines for Perinatal Care
  - No changes to the guideline recommendation
- Treatment of Depression in Adults
  - Replaced the primary reference with a recent guideline from the American College of Physicians: Nonpharmacologic and Pharmacologic Treatments of Adults in the Acute Phase of Major Depressive Disorder: A Living Clinical Guideline from the American College of Physicians (2023)
  - Updated links and clarified some of the Position Statement language to align with other Clinical Practice Guidelines
  - Added two guidelines to additional resources:
    - The American Psychiatric Association practice guidelines for the treatment of patients with major depressive disorder (2015)
    - The American Psychological Association clinical practice guideline for the treatment of depression across three age cohorts (2019)

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

Medication policy updates

Editor's note, 4/17/25: Added Saphnelo, anifrolumab, dru688 to this list.

Effective July 1, 2025, we will make changes to the following medication policies:

- *Camzyos, mavacamten*, dru720
- *CGRP Monoclonal Antibodies*, dru540
- *Drugs for chronic inflammatory diseases*, dru444
- *Hemlibra, emicizumab-kxwh*, dru539
- *Medications for transthyretin-mediated amyloidosis*, dru733
- *Provider-Administered Specialty Drugs*, dru764
- *Saphnelo, anifrolumab*, dru688
- *Self-administered CGRP antagonists and 5-HT 1f agonists*, dru635
- *Site of Care Review*, dru408

Effective January 1, 2026, we will make a change to the *Drugs for chronic inflammatory diseases*, dru444 medication policy.

We now post required notification of medication policy additions and changes on our website: Policies & Guidelines>Medication Policy Updates. Visit this page to see new notifications on the first of the following months: February, April, June, August, October, December. Providers are responsible for obtaining pre-authorization as required in our medication policies.

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.

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

Automate your pre-authorization process with Availity Essentials

When patients need behavioral health or substance use care, they need it quickly. Availity Essentials is a powerful, easy-to-use tool that can help simplify your pre-authorization process and reduce manual work. It can be used to quickly see whether services require pre-authorization and to submit a request.

There is no need to call or fax a request to us: Requests submitted via Availity Essentials are processed in real-time, with some requests receiving automatic approval, reducing wait times for care. This means your patients can receive the care they need when they need it most.

By using Availity Essentials, you can:

- **Receive fast responses to authorization requests for behavioral health and substance use services, with some requests receiving automated approval**
- Reduce wait times for care, allowing you to provide timely and effective treatment to your patients
- Access all requests in the Auth/Referral Dashboard, making it easier to track and manage patient care
- Reduce manual work and increase efficiency, allowing you to focus on what matters most—providing high-quality care to your patients

We are continually making improvements to our electronic authorization tools for a better provider experience. Over the coming year you can expect to see more functionality customized for behavioral health providers.

Take the first step

Don't wait—register for Availity Essentials today and start experiencing the benefits of a streamlined authorization process.

Resources

Training is available after signing in to Availity Essentials: Help & Training>Get Trained>Catalog>Authorization Request - Training Demo. A quick reference guide is also available in the content section after you enroll in the authorization training. It includes instructions and screenshots to help you through the electronic authorization process.

You can also learn more about electronic authorization or view our step-by-step guide on our provider website: Pre-authorization>Electronic Authorizations.

Behavioral health corner

Therapy code reimbursement to increase

Effective July 1, 2025, we will increase reimbursement rates for CPT 90837 (*psychotherapy, 60 minutes with patient*) for behavioral health providers on standard *Professional Services Agreements*. This is an off-cycle reimbursement change.

The updated reimbursement rates will be posted by the effective date in Availity Essentials: Claims & Payment>Fee Schedule Listing.

Behavioral health resources to support PCPs

PCPs play a crucial role in behavioral health care, from initial discussions and diagnosis to ongoing condition management. To support this vital work, our Behavioral Health Toolkit includes information about many resources and tools available to PCPs:

- Overviews of 12 common behavioral health conditions, as well as related screening tools and evidence-based clinical resources
- Virtual care solutions
  - Members have direct access to in-network virtual providers who cover a wide range of specialty services.
  - There is no referral requirement.
  - Virtual providers can improve access to timely care.
- Our care management services, including case management
- Determining the best path forward in the early stages of a patient's evaluation and treatment, as well as ongoing condition management
  - Providers have access to state-funded, no-cost psychiatric consultations.
- Social determinants of health (SDoH)
  - PCPs are ideally positioned to identify and address patients' social needs and risk factors. By monitoring SDoH, we can identify and resolve barriers to care, promote equitable access to care and enhance health education efforts.

The Behavioral Health Toolkit is available on the homepage of our provider website.

State-funded psychiatric consultations assist PCPs

PCPs can access free psychiatric consultations through the Washington state-funded program Partnership Access Line (PAL). These services help bridge the gap in behavioral health care delivery and support better patient outcomes.

Psychiatric consultation services:

- Expand access to limited psychiatric resources
- Provide cost-free support for providers and patients at no cost
- Offer diagnostic clarification and treatment guidance
- Assist with medication management decisions
- Facilitate appropriate referrals for serious cases

They also impact health care delivery by:

- Enhancing early intervention
  - Improves quality of care
  - Leads to better health outcomes
- Integrating care
  - Promotes coordination between mental and physical health services
  - Supports whole-person care

The consultation process:

- Is simple and streamlined
- Doesn't require additional patient authorization
- Is covered under HIPAA as a provider-to-provider consultation

Important: Psychiatric consultations are designed for treatment planning and best practices discussion only. For psychiatric emergencies, call 911.

About PAL

- **Consultation line**: (866) 599-7257
- **Hours**: 8 a.m. to 5 p.m. PT, weekdays
- **Ages served**: Children and adolescents up to age 19
- **Partners**:
  - Seattle Children's Hospital
  - Washington's Health Care Authority
  - Mental Health Referral Service for Children and Teens
  - Frontier Behavioral Health, which offers a program for families experiencing suicidality
- **Note**: Consultations include direct access to child psychiatrists

Medicare Advantage incentive program updates

We appreciate providers who are partnering with us to address gaps in patient care to improve health outcomes and would like to share these important reminders.

2024 program year

Payout for the 2024 program year will be mailed by June 30, 2025.

2025 program year

2025 program data in the Care Gap Management Application (CGMA)

The 2025 program gaps and performance data are now visible in the CGMA. To be eligible for the 2025 incentive programs, your QIP Primary Contact will need to opt-in by June 30, 2025. If you're an APM provider, your enrollment is automatic.

New and updated features in the CGMA

We continue to partner with Novillus to improve the CGMA and have implemented the following enhancements for 2025:

- **Providers will opt-in** to the 2025 program through the CGMA.
- The **scorecard has been redesigned** to include measure weight and performance-only data.
- **Incentive display updates** include:
  - Changes to the program structure (**Note**: Some measures on the display are not included in the incentive programs, and are provided for information purposes)
  - Added new details about structured supplemental data submission (SDS)
- We have **enhanced reporting capabilities** by adding:
  - The full provider group name
  - The ability to easily view/access included tax identification numbers (TINs)
  - The ability to download all scorecards for a single roll-up group
- We have added a **new member indicator** on gaps

Your QIP primary contact can submit a ticket on the CGMA to add users. Email our QIP team if you have questions. You can also learn more about the 2025 programs on our provider website: Programs>Medicare Advantage Incentive Programs.

Quality in Action: Improve patient engagement and health outcomes

We're dedicated to empowering providers with resources to enhance patient engagement and drive better health outcomes.

Check out the new Quality in Action section on our provider website to:

- Discover how you can partner with us to elevate the standard of care and make a more meaningful difference in the lives of your patients.
- Explore our best practices newsfeed, as well as links to our quality programs, toolkits and publications.

Read these articles, which we've recently added to our best practices newsfeed:

- Cancer screenings and prevention
- Improving members' experience with medications
- Resources for addressing social determinants of health
- Statin use for cardiovascular disease or diabetes
- Taking control of tomorrow: National Healthcare Decisions Day
- Tobacco cessation resources for providers and patients

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.