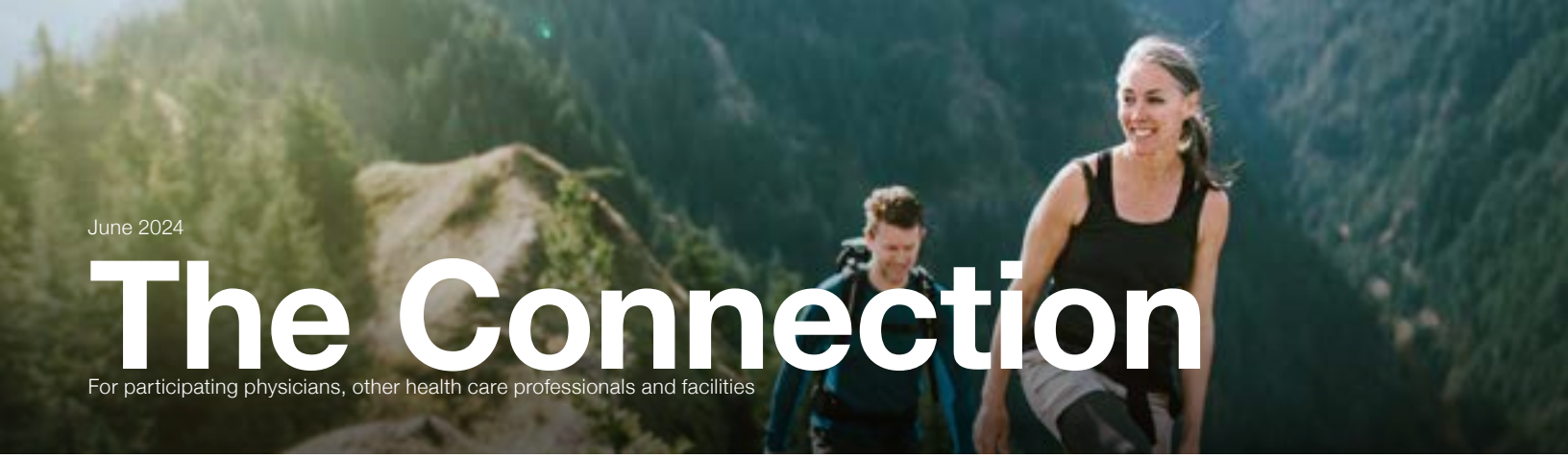


June 2024

The Connection

For participating physicians, other health care professionals and facilities

Work with us to support health equity

All people should have an equal opportunity to achieve wellness as part of a health care system that prioritizes diversity, equity and inclusion. Our commitment to whole-person support for our members means we take into consideration all the drivers of health—acknowledging that 80% of health outcomes are driven by non-clinical factors. When members have barriers to accessing care or fully engaging in their treatment plans—from transportation, to cost burdens or a lack of trust in medical care providers (as can be the case for members in underrepresented communities)—these challenges can have a major impact on their health outcomes and overall costs.

Health equity gaps impact your patients' access to treatment; length and quality of life; rates and severity of disease; and disability and death. There are several ways we can partner together to advance equitable access, experience and outcomes.

Provider directory information

Our Find a Doctor tool includes information to help our members connect with providers they feel best meet their health care needs and individual preferences. The demographics and areas of interest in our provider directory include:

- Language
- Pronouns
- Gender identity
- Race and ethnicity
- Culturally-specific care
- LGBTQ+-inclusive care
- Disability-competent care

LGBTQ+ people who see an LGBTQ+ or queer-affirming provider who validates their identity can make a big difference for their health outcomes. By indicating LGBTQ+-inclusive care, members can select providers who have competence in behavioral health and transgender medicine. It also helps our members build trusting relationships with their health care providers, resulting in more appropriate care and better health outcomes.

Continued on page 3

Alternative payment model 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 home page of our provider website for the latest news and updates.

Asuris Northwest Health

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

Contents

■ Critical article
● Dental
▲ DME
‡ Radiology
★ Star Ratings/Quality

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

Click on a title to read the article.

About *The Connection*

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

Issues are published on the first of the following months: February, April, June, August, October and December.

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

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 feedback at **provider_communications@asuris.com**.

Continued from page 1

We invite you to add health equity information and areas of interest to your directory information by submitting a *Provider Information Update Form* on our provider website: Contact Us> Update Your Information.

Together, we can advance diversity, equity and inclusion on behalf of our members and the communities we serve.

Resources for working with diverse populations

Culture, language, customs, personal beliefs and experiences all impact how patients participate in their health care. To help you support a patient with unique needs or preferences regarding their care, we created an online library that connects you to national standards and essential resources. These resources focus on ways to provide culturally sensitive health care to diverse populations, including behavioral health, health literacy, interpreter services and health equity.

New *Improving Care for Latinx Patients* flyer: Barriers to care have resulted in disparities in the quality of health care Latinx patients receive. Download our *Improving Care for Latinx Patients* flyer for best practices and resources to consider when treating your Latinx patients.

Offer language services (e.g., interpreters, forms in multiple languages) during office visits and other health care-related services (e.g., pharmacy, social work, physical therapy, dietician, nutritionists, etc.). Members can call the Customer Service number on the back of their member ID card for interpreter services. Our provider website also includes helpful resources for language access and services.

You can find these resources in our recently updated Health Equity Toolkit (formerly named the Cultural Competency Toolkit) on the homepage of our provider website. We encourage you to bookmark this page. **Note**: The toolkit will have new navigation by July 1, 2024, making it easier for you to quickly find the resources you need.

Submit SDoH Z codes to help connect patients to services and resources

Collecting and tracking social determinants of health (SDoH) information about our members is important because it helps us:

- Close health equity gaps
- Understand barriers to care
- Supports equitable access to quality health care and health education

The SDoH ICD-10-CM Z codes make it possible to measure social risk factors and social needs. They add greater specificity to capture a more holistic view of a patient's health and challenges.

Resources

- Our SDoH flyer, available on our provider website: Library>Printed Material.
- CMS, 2024 ICD-10-CM updates: **cms.gov/ medicare/coding-billing/icd-10/2024-icd-10-cm**
- CMS ICD-10-CM Official Guidelines for Coding and Reporting: **cms.gov/files/document/ fy-2024-icd-10-cm-coding-guidelines-updated-02/01/ 2024.pdf**

Social need screening and intervention

A new Healthcare Effectiveness Data and Information Set (HEDIS®) measure, Social Need Screening and Intervention (SNS-E), was introduced in 2023. It measures the number of patients screened for food, housing and transportation needs and, among those who screened positive, how many received an appropriate intervention. The National Committee for Quality Assurance (NCQA) allows the use of a variety of evidence-based, validated screening instruments. They also recommend that detailed assessment of these social needs be documented in medical records to support evidence-based interventions.

More information on this measure is included in our *Quality Measures Guide*, available in on our provider website: Library>Printed Material.

Are you?

- ☑ **Using our toolkits**: Our toolkits include helpful resources that can assist you with patient care and save your office time. Visit the homepage of our provider website to access the Behavioral Health, Care Options, Health Equity, Pain Management, Quality Improvement and Self-Service toolkits.
- ☑ **Enrolled in the free Redefining Access to Improve Patient Experience webinar**: We have partnered with Press Ganey to offer a free webinar series, providing best-in-class insights, tools and techniques to improve patient experience. Register in the Training section of our provider website for the June 7 or August 2, 2024, webinar. The sessions will be held from noon to 1 p.m. (PT).
- ☑ **Registered for Availity Essentials**: All contracted providers are required to register with Availity Essentials, submit claims electronically and receive payments via electronic funds transfer (EFT). Use Availity Essentials to access eligibility, benefits, claims-related information and submit your medical pre-authorization requests and pre-authorization determination appeals. Register today at **availity.com**.

Improve your financial and quality performance with the PRIA platform

We are excited to announce the launch of our Provider Reporting Insights & Analytics (PRIA) platform, a new business intelligence and analytics platform that unifies and simplifies access to multiple data sources. This is part of a suite of services we offer our alternative payment model (APM) partners to ensure you meet or exceed your contractual and patient care goals.

Drive high-value care, accelerate performance and control costs

PRIA is designed to help you create and execute data-driven population health management interventions that improve quality while reducing the total cost of care—ultimately improving APM financial and quality performance. **It features interactive dashboards, self-service reporting and data available at summary, claims and patient levels.**

Quickly identify care gaps and treatment opportunities that represent the greatest clinical and financial impact to your office. With PRIA, you can:

- Visualize and generate clinical insights to drive high-value care, accelerate performance and control cost
- Create action plans to focus on health management interventions
- Easily navigate layers of population health information, from the organization to patient level
- Collaborate with Asuris support teams to improve affordability and health outcomes of your patients

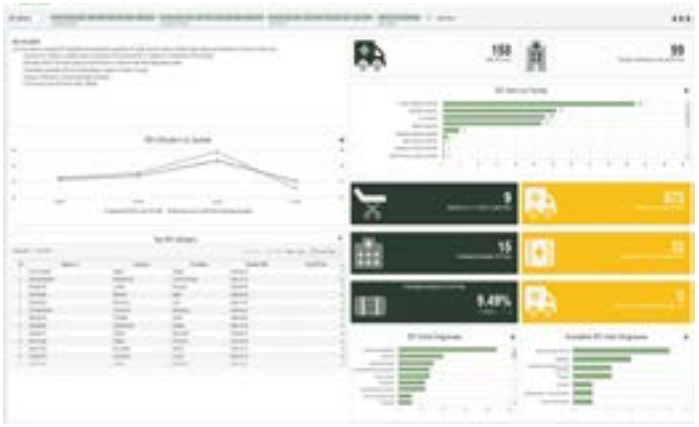
Access your data on your schedule and at your convenience

This dynamic, interactive tool was created for you. Whether you have a team of analysts, have superior actuarial skills, are a member of the care team, or simply an end user viewing reports—PRIA's ease of navigation and sophisticated data allows anyone to decide how much information they want, and how deep they want to dive. Download and share reports within minutes.

Get started today

We are actively training early adopters, and they are exploring all that PRIA can do for their organizations. Over the coming months, our Provider Relations team will offer PRIA training to additional select providers on APM arrangements with more than 1,000 attributed members.

Learn more about PRIA on our provider website: Contracting & Credentialing>APM Resources.



What providers had to say after viewing a demonstration of PRIA

*"**Cool and awesome views**. I will want time to see how my team members could use this and are currently interacting with the data they are using."*

*"Looks like it's **very intuitive and easy to use**. Usually, these types of systems are valuable because I can trust the data. … It's all about the data first and then the system's ability to translate that into insights."*

*"**Super cool tool!** I'd love to have time to dive into this tool and play with the data."*

Join us for a webinar to improve patient experience

We recognize that access to care and its impacts on patient experience are a challenge across the health care industry. We have partnered with Press Ganey Consulting to offer a free webinar series, providing best-in-class insights, tools and techniques to improve patient experience. 1.0-hour continuing education (CE) will be available.

Redefining Access to Improve Patient Experience

- The webinar will cover the following topics:
- Redefining access to improve quality and experience
- Providing access throughout the patient journey
- Setting expectations to support access to care for both PCP and specialty care
- Specific interventions that promote access beyond traditional face-to-face appointments
- Applying tactics that can be implemented starting your next day at the office

Join us for a 60-minute webinar on one of the following dates:

- June 7, 2024, noon (PT) Register
- August 2, 2024, noon (PT) Register

We are excited to offer this opportunity and hope you can join.

Administrative Manual updates

The following updates were made to the manual on June 1, 2024:

Introduction

- Clarified medical record request requirements and updated references to provider website

Alternative care

- Clarified that not all member plans require a prescription for massage therapy

Medical Record Requirements

- New section to clarify and outline requirements for medical records documentation and signature authentication in alignment with CMS rules

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

Dental providers

Visit **asurisdental.com/providers** to find dental-specific content and resources, including the new dental newsletter.

Questions?

- If you have questions related to your **dental** agreement with us, contact our dental provider relations team at **dentalproviderrelations@asurisdental.com**.
- If you have questions related to your **medical** agreement with us, call our Provider Contact Center at 1 (888) 349-6558.

Recoupment for medical record requirements

Participating providers agree to comply with all applicable laws, regulations and CMS instructions. This includes requirements relating to medical record documentation and authentication. We request medical records post-payment to support required data submissions for programs, such as risk adjustment or HEDIS.

You must ensure that your patient's medical records are properly authenticated to satisfy CMS documentation requirements, including—but not limited to—ensuring the records contain the proper provider signature, credentials and signature date. Records submitted for review that are not properly authenticated or signed may be subject to claim recoupment. A provider may amend the record to properly authenticate the record (including by recording a valid signature) within 180 days of the date of service.

Effective September 1, 2024

Starting with medical record reviews, including but not limited to Medicare risk adjustment reviews, claims audits, etc., that begin on or after September 1, 2024, if we determine that CMS authentication or documentation requirements, outlined in the Medical Record Requirements section of our Administrative Manual are not met, processed claims may be subject to recoupment.

Please ensure that you are following the CMS standards for medical record documentation and authentication. For reference, see the following Medicare Learning Network (MLN) fact sheets:

- *Medical Record Maintenance & Access Requirements* (MLN4840534)
- *Complying with Medical Record Documentation Requirements* (MLN909160)
- *Complying with Medicare Signature Requirements* (MLN905364)

Note: Some updates to your electronic medical record (EMR) system can override your signature settings and you may need to re-verify your settings during or after an update.

For more information about medical recordkeeping, please see the Medical Record Requirements section of the Administrative Manual. Our manual sections are available on our provider website: Library>Administrative Manual.

Upcoming code edits

Beginning September 1, 2024, we will implement code edits for the following billing scenarios:

- Inappropriate diagnosis code billing
- Incorrect modifiers on evaluation and management (E&M) codes
- Incorrect reporting of telehealth/telemedicine modifiers
- When a 10- or 90-global-day dislocation procedure code is billed on a professional claim with place of service (POS) 23 (emergency room) and submitted without modifier 54 (surgical care only)—this is an expansion of an existing edit

Professional VBR program reminders

Last year, standard professional providers with six predominant specialties were incorporated into our Professional Value-Based Reimbursement program (Professional VBR). This program incentivizes participating providers to deliver high-quality and cost-efficient care to their patients.

Professional VBR program metrics are specific to the following specialties:

- Dermatology
- Family medicine and general practice
- Internal medicine
- Obstetrics and gynecology
- Ophthalmology
- Psychiatry

Important reminders

- Providers participating in the Professional VBR will be able to access a performance report published on Availity Essentials by July 1, 2024.
- Providers participating in the Professional VBR will see the first performance-based reimbursement adjustment occur beginning on October 1, 2024, based on performance in calendar year 2023.
- If a provider with an eligible predominant specialty does not have credible data as defined by the program summary, reimbursement will not change, and they will not receive a VBR ScoreCard Report in Availity.

Program eligibility

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

Learn more

More information about the Professional VBR program—including a program guide and FAQ—can be found on our provider website: Contracting & Credentialing>APM Resources.

Reminder: Use of non-covered services form

As a participating provider, you have agreed to hold patients responsible only for copay, coinsurance and deductible amounts, and, when a consent form is signed, for services not covered by their benefit contract. If you bill a member prior to the processing of a claim, the bill should clearly indicate that you have submitted the claim to us. Prior to processing of the claim, **you may require member payment only for services known to be non-covered and for estimated copay, coinsurance and deductible amounts. Note**: After the claim is processed, a balance may be due to the member for any funds they paid upfront in excess of the final amount due.

A *Non-covered Services Member Consent Form* should be signed by the member before collecting for services that may not be covered. This form can be used for all lines of business. View a sample form on our provider website, under the Miscellaneous section: Library>Forms.

In addition, we encourage providers to verify their patients' benefits using Availity Essentials and to refer members to in-network providers. The Correct Code Editor (CCE), located in our Coding Tookit, can also be used to identify codes, their description, edit type and comment (e.g., 77085; Dxa bone density study; investigational denial; Always considered investigational; investigational services are denied member liability). The Coding Toolkit is available on the homepage of our provider website.

SNFs and home health agencies: Share your acuity and capacity with us

Skilled nursing facilities (SNFs) and home health agencies: Ensure optimal patient care by confirming your acuity and capacity levels with our networking team. Accurate information facilitates efficient patient referrals and enhances collaboration in delivering high quality health care services.

Send your acuity and capacity levels, along with your facility name, TIN and contact information (name, email address and phone number) to **Carla.Adon@asuris.com**.

Compliance program requirements

We want to remind you that all providers and their staff, including any board or trustee members must meet our Government Programs compliance requirements, including monthly verification that they are not on an exclusion list and annual trainings on compliance and fraud, waste and abuse (FWA).

We contract with CMS to provide health care services to members with coverage through our Medicare Advantage Plans, Medicare Part D prescription drug products and the exchanges through the Qualified Health Plans (QHP). Through these contracts, we must oversee the first-tier, downstream and related entities (FDRs) and downstream and delegated entities (DDEs) that assist us in providing services for our Medicare Advantage and QHP beneficiaries.

Exclusion lists

All Medicare- and QHP-contracted providers, medical groups, facilities and suppliers are required to check the Office of Inspector General (OIG) and General Services Administration (GSA) federal exclusion lists for all employees prior to hire and monthly thereafter. If an employee is confirmed to be excluded, they must immediately be removed from working on our government programs. We are prohibited from paying government funds to any entity or individual found on these federal lists:

- GSA exclusion list: **sam.gov/content/exclusions**
- OIG exclusion list: **oig.hhs.gov/exclusions**

Documentation of these verifications must be maintained and made available upon request by either Asuris or CMS. We ask contracted entities to verify that the entity is compliant with this requirement during initial credentialing and at recredentialing.

Required compliance training

FWA and general compliance trainings are a contractual requirement for participation in our Medicare Advantage and QHP networks. This training must be completed within 90 days of hire and annually thereafter.

Please ensure that your staff complete required training and maintain documentation for auditing purposes.

Compliance for board and/or trustee members

Your organization's board or trustee members are required to participate in all Asuris Government Programs compliance activities, including:

- Signing a conflict of interest disclosure at appointment and annually thereafter
- Completing OIG and GSA screenings prior to appointment and monthly thereafter
- Completing FWA and general compliance training within 90 days of appointment and annually thereafter

Documentation must be maintained and made available upon request by either Asuris or CMS.

Learn more

More information about our compliance program and related resources are available on our provider website:

- Products>Medical>Medicare> Medicare Compliance Training
- Government Programs Compliance Tips: Library>Printed Material.
- Administrative Manual: Library> Administrative Manual
  - Qualified Health Plans
  - Medicare Advantage Compliance Requirements

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: **nppes.cms.hhs.gov**.

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 LGBTQ+-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 determination appeals coming to Availity

Beginning June 15, 2024, Availity's Appeals application will be expanded to include medical pre-authorization determination appeals.

The application streamlines the appeals process, making it faster and easier to submit appeals directly from Availity Essentials.

Instead of manually completing and submitting a separate Provider Appeal Form, portal users can submit a medical pre-authorization determination appeal with required documentation directly from the Authorization dashboard, receive immediate confirmation of submission and review the status of their appeal—all in one place.

The Appeals dashboard will show the status of submitted appeals. Access it from Availity Essentials: Claims & Payments>Appeals.

Get trained for free

View the training options available by clicking the Help & Training link in the Availity Essentials menu.

Look for announcements about the pre-authorization appeals launch on our provider website and Availity Essentials.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective January 1, 2024
Radioembolization, Transarterial Embolization (TAE), and Transarterial Chemoembolization (TACE) (Medicine #140)	- C9797
Procedure/medical policy	**Added codes effective April 1, 2024**
Definitive Lower Limb Prostheses (Durable Medical Equipment #18)	- L5841
Procedure/medical policy	**Expanding application of codes effective September 1, 2024**
Applied behavior analysis (ABA)	- 0362T, 0373T, 97151-97158 - **Related**: See *Change to ABA authorization for members younger than 18* on page 20.

Medicare Advantage

Procedure/medical policy	Added codes effective January 1, 2024
Radioembolization, Transarterial Embolization (TAE), and Transarterial Chemoembolization (TACE) (Medicine #140)	- C9797
Procedure/medical policy	**Added codes effective April 1, 2024**
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- A2026, Q4305-Q4310
Definitive Lower Limb Prostheses (Durable Medical Equipment #18)	- L5783, L5841
Noninvasive Ventilators in the Home Setting (Durable Medical Equipment #87)	- E0468
Power Wheelchairs - Group 2 and Group 3 (Durable Medical Equipment #37)	- E2298
Powered Exoskeleton for Ambulation (Durable Medical Equipment #89)	- E0739
Upper Extremity Rehabilitation System with Brain-Computer Interface (Durable Medical Equipment #94)	- E0738
Procedure/medical policy	**Added codes effective June 1, 2024**
Biochemical and Cellular Markers of Alzheimer's Disease (Laboratory #22)	- 0346U, 0358U
Immunological Cellular Therapies and Gene Therapies (Medicine #42)	- 36511
Magnetic Resonance Spectroscopy (Radiology #27)	- 0609T-0612T, 76390
Minimally Invasive Treatments of Nasal Valve Collapse (Surgery #209)	- 30469
Periurethral Transperineal Adjustable Balloon Continence Device (Medicine #176)	- 53451-53454
Subacromial Balloon Placement (Surgery #226)	- C9781
Uterus Transplant (Transplant #19)	- 0664T-0670T

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Procedure/medical policy	Expanding application of codes effective September 1, 2024
ABA	- 0362T, 0373T, 97151-97158 - **Related**: See *Change to ABA authorization for members younger than 18* on page 20.

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.

Responding to documentation requests

If you receive a request for medical records or supporting documentation, please respond using the same format in which the request is received. If you receive a request via Availity Essentials, you must submit requested records using the Availity Attachments application.

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

Learn more on our provider website: Claims & Payment>Claims Submission> Claims Attachments.

Reminder: Cardiology program adding services

We are expanding our cardiology program to review additional outpatient cardiovascular tests, procedures and certain cardiac for commercial and Medicare Advantage members. The program requires pre-service medical necessity review and pre-authorization through Carelon Medical Benefits Management (Carelon) and will include the following additional non-emergency outpatient cardiac services delivered on or after July 1, 2024:

- Ambulatory cardiac rhythm monitoring
- Cardiac ablation
- Electrophysiology studies
- Wearable cardioverter defibrillator—*for commercial only*

We have updated the cardiology section of our pre-authorization lists to include the following additional codes, effective July 1, 2024: CPT 33285, 93650, 93653, 93654, 93656, 93228 and 93229, and HCPCS C1764, E0616 and K0606.

About the program

Carelon administers our cardiology program, which reviews outpatient cardiovascular tests, procedures and certain cardiac devices.

Providers will be able to contact Carelon to request pre-authorization for these additional services beginning June 17, 2024.

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

Learn more

- Program details are available on our provider website: Programs>Medical Management> Cardiology.
- View a complete list of codes included in the program on our Pre-authorization lists.

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 May 2024 issue of *The Bulletin* about changes to the *Knee Surgeries* (Surgery #229) medical policy, which are effective August 1, 2024.

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

- *Anesthesia Reimbursement and Services Reporting* (Anesthesia #102)
- *Global Days* (Administrative #101)
- *Virtual Care* (Administrative #132)—commercial and Medicare Advantage

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

Carelon revising cardiology clinical guidelines

Effective October 20, 2024, Carelon Medical Benefits Management (Carelon) will revise the following cardiology clinical guidelines:

- Cardiac Resynchronization Therapy
- Permanent Implantable Pacemakers

Visit Carelon's website to view the revised guidelines: **guidelines.carelonmedicalbenefitsmanagement.com/category/coming-soon.**

Reimbursement changes to modifier 25 and global periods

Modifier 25

Effective September 1, 2024: When modifier 25 is appropriately appended to an evaluation & management (E&M) service and is submitted on the same date of service as a minor procedure, by the same physician or other qualified health care provider, the E&M service will be reimbursed at 50% of the allowed amount.

We announced this change to our *Modifier 25; Significant, Separately Identifiable Service* (Modifier #103) and *Global Days* (Administrative #101) reimbursement policies in the June 2024 issue of *The Bulletin*. Both policies apply to commercial and Medicare Advantage members.

Suture removal

Effective August 1, 2024: We are adding language to our *Global Days* (Administrative #101) reimbursement policy to state that suture removal is not eligible for separate reimbursement regardless of the surgical global period.

We will begin post- and prepayment reviews of all global days claims. These reviews will include payments that were made separately from the global surgical package and are within the state's timeliness rules.

We announced this change in the May 2024 issue of *The Bulletin*.

More information

View the announcements and policies on our provider website:

- The Bulletin: What's New & Publications>Bulletins
- Our Reimbursement Policy Manual: Library> Policies & Guidelines>Reimbursement Policy

Asuris EquaPathRx™ program implementation change

As the cost of health care continues to rise—especially costs for provider-administered specialty medications—our customers continually explore ways to lower costs and look to us for solutions. Some employers have resorted to forced white-bagging options through third-party pharmacy benefit managers (PBMs) to solve for affordability.

Our Asuris EquaPathRx program is a different approach that continues to reimburse designated providers to obtain and administer specialty medications. It also allows claims submission and processing to remain unchanged. Our program:

- Keeps the provider-patient relationship intact
- Delivers predictable costs for members and employer groups
- Includes a Provider-Administered Specialty Drugs member benefit that requires medications to be supplied and administered by a provider who is participating in Prime Therapeutics' IntegratedRx - Medical® Network

New timeline for implementation

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're adjusting our implementation timeline, and are targeting a January 1, 2025, benefit administration transition to the IntegratedRx - Medical Network.

Here's what this means for you:

- **From now through the December 31, 2024**: As we work with providers to contract with the Prime IntegratedRx - Medical Network, all Asuris network providers are considered to be designated providers 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 your existing contract terms with us.**
  - 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: Policies & Guidelines>Medication Policies> Commercial Policies.
- **On the transition date**: Providers must be included in the IntegratedRx - Medical Network to be considered a designated provider under the benefit and reimbursed for administering medications included in the Asuris EquaPathRx program to members with this benefit.
  - The medication portion of the claim will be adjudicated under the terms and rates of the executed agreement you have for this program. The administration portion of the claim will be adjudicated under the terms and rates of the agreement you have with Asuris.
  - Medications included in this program must be pre-authorized according to our medication policies and require administration by a designated provider (participating IntegratedRx - Medical provider) to be covered under the member's benefits. We'll notify you in advance of any additions or changes to the medications included in the program through this newsletter (see below).
  - If you haven't contracted with Prime to participate in the IntegratedRx – Medical Network, provider-administered medications under the Asuris EquaPathRx program will not be covered for members with the Provider-Administered Specialty Drugs benefit and claims will be denied as provider responsibility.
    Note: If you haven't yet contracted with Prime by 90-120 days before the transition date, we'll work closely with you and our members to ensure they continue to have uninterrupted access to their treatment on and after the implementation date.

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Medication policy change effective October 1, 2024

In preparation for the new transition date listed above, we're making the following changes to our *Provider-Administered Specialty Drugs* (dru764) medication policy effective October 1, 2024:

Medication name	HCPCS	Associated medication policy
Adstiladrin, nadofaragene firadenovec-vncg	J9029	dru743
Elfabrio, pegunigalsidase alfa-iwxj	J2508	dru575
Izervay, avacincaptad pegol	J2782	dru517
Lamzede, velmanase alfa-tycv	J0217	dru426
Pombliti, cipaglucosidase alfa-atga	J1203	dru426
Rystiggo, rozanolixizumab-noli	J9333	dru696
Syfovre, pegcetacoplan, intravitreal	J2781	dru517
Vyjuvek, beremagene geperpavec-svdt	J3401	dru759
Vyvgart Hytrulo, efgartigimod alfa/ hyaluronidase-qvfc	J9334	dru696
Zynyz, retifanlimab-dlwr	J9345	dru751

Prime Therapeutics contracting and credentialing

If you have not 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 at **providerrelations@primetherapeutics.com**.

To start IntegratedRx - Medical Network credentialing, you can also visit Prime's credentialing website: **pharmacy.primetherapeutics.com/content/primetherapeutics/en/provider-credentialing.html**.

Start using real-time pharmacy benefit check tool

We understand that identifying which medications are available to patients on their health plan formularies can be challenging and time-consuming. To create easier access to a preferred medication database for our members, we've partnered with Arrive Health to integrate a real-time benefit check tool for prescribed medications that works within your EMR system.

Arrive Health works with many of the larger, national EMR systems (e.g., Epic and Cerner) to provide you quick access to pharmacy benefit checks. With 99% transaction accuracy and over 10 million transactions per month, Arrive Health is a trusted partner to help patients get the right medication at the right price.

Using real-time benefit check can improve the patient experience, decreasing their financial strain and improving medication adherence. It can also lead to better provider and patient conversations about treatment plans and reduce your time spent on administrative tasks.

How it works

Real-time benefit check information will display when the following criteria are met:

- Patient eligibility has been pulled (workflow varies by EMR system)
- Patient's pharmacy benefits are covered by a participating pharmacy benefits manager (PBM) (e.g., Prime Therapeutics)
- You have entered the national drug code (NDC), preferred pharmacy NPI, quantity and days supply

The tool will present the following patient-specific coverage information:

- Coverage status (covered, not covered, covered with restrictions)
- Coverage alerts (pre-authorization required, quantity limit issue, refill too soon, step therapy, etc.)
- Out-of-pocket costs for the patient
- Formulary-driven medication alternatives
- Pharmacy options

Note: This tool is only for medications filled at pharmacies, not those dispensed or administered in the provider office.

Available now

The real-time benefit check tool is available for all Medicare Advantage and commercial members now.

Learn more

Visit **arrivehealth.com** to learn more about Arrive Health for providers.

Connect through your EMR vendor

Contact your EMR vendor to find out how to connect your system to the Arrive Health solution.

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.com**.

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 us at **AsurisRxMedicationPolicy@asuris.com** 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 April 1, 2024	Description
New medication policies	
Drugs for chronic inflammatory diseases (for UMP plans), dru900	- Added Omvoh (mirikizumab-mrkz) to policy as non-preferred provider-administered option for ulcerative colitis (UC) - Changed Stelara (ustekinumab) from a non-preferred to preferred provider-administered option
Medicare Part B Step Therapy, drum-001	- Added Udenyca On-Body (pegfilgrastim-cbqv), Rolvedon (eflapegrastim-xnst), Ryzneuta (efbemalenograstim alfa-vuxw), Eylea HD (aflibercept) and Avzivi (bevacizumab-tnjn) to policy as non-preferred

Effective April 15, 2024	Description
New medication policies	
Non-Cosmetic Use of Medications and Products, dru780	- New administrative policy facilitates benefit check and approval as appropriate for medications with cosmetic and non-cosmetic indications
Medications for molluscum contagiosum, dru773	- Limits coverage of Ycanth (cantharidin) and Zelsuvmi (berdazimer) to patients with molluscum contagiosum (MC) not previously treated with Ycanth/Zelsuvmi; patients MC must be severe as defined by presence for at least six months, extremely bothersome or concomitant atopic dermatitis/bacterial infection
Loqtorzi, toripalimab-tpzi, dru774	- Limits coverage to recurrent unresectable or metastatic nasopharyngeal carcinoma with no prior use of PD-1 inhibitors and in one of the following settings: • In combination with cisplatin/gemcitabine when there has been no prior therapy in advanced setting • As monotherapy when there has been disease progression on or after platinum-containing chemotherapy

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Effective April 15, 2024	Description
Revised medication policies	
Medications for Thrombotic Thrombocytopenic Purpura (TTP), dru598	- Added coverage criteria for Adzynma (ADAMTS13, recombinant-krhn), a newly FDA-approved enzyme replacement therapy for the treatment of congenital thrombotic thrombocytopenic purpura - Limits coverage to this indication when diagnosed by a specialist and confirmed by genetic testing, ADAMTS13 activity <10% and absence of any other TTP-like disorder diagnosis - When used for prophylactic therapy, coverage requires a history of at least one acute TTP event in the last year, currently receiving plasma-based prophylactic therapy and the patient is not currently having an acute TTP event
Enzyme Replacement Therapies, dru426	- Added coverage criteria for Pombiliti (cipaglucosidase alfa) in combination with Opfolda (miglustat), two newly FDA-approved medications for late-onset Pompe disease; limits coverage of these medications to this indication when diagnosed by a specialist and confirmed by acid alpha glucosidase (GAA) enzyme deficiency and/or genetic mutation - Pombliti was also added to Site of Care Program; when administered by a provider, this medication must be given at an approved location
Medications for Primary Hyperoxaluria, dru668	- Added coverage criteria for Rivfloza (nedosiran), a newly FDA-approved medication indicated to lower urinary oxalate levels in patients with primary hyperoxaluria type 1 (PH1) and relatively preserved kidney function; coverage criteria mirrors Oxlumo requiring genetically confirmed PH1 (AGXT mutation), kidney dysfunction and failure of medical management (i.e., hydration therapy, crystallization inhibitors and pyridoxine) - Concomitant use with Oxlumo (lumasiran) is considered investigational
Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620	- Added Udenyca On-Body (pegfilgrastim-cbqv) and Ryzneuta (efbemalenograstim alfa-vuxw) to policy as non-preferred
Reblozyl, luspatercept-aamt, dru631	- The use of Reblozyl (luspatercept) in erythropoietin-stimulating agent- (ESA-)naïve myelodysplastic syndrome- (MDS-)associated anemia is considered not medically necessary and, therefore, not covered due to lack of clinically meaningful difference relative to significantly lower cost standard of care ESA therapy. - **Note**: The current policy allows for coverage in patients with transfusion-dependent MDS-associated anemia when ESAs were ineffective, not tolerated or not a treatment option
Opdivo, nivolumab, dru390	- Updated melanoma criteria to allow for coverage of early-stage (IIB/C) disease in addition to advanced disease (stage III/IV), which was already included in policy; this update is based on an FDA expanded indication in melanoma

Effective April 15, 2024	Description

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Revised medication policies, continued	
Gene therapies for beta thalassemia, dru698	- Renamed policy and added coverage criteria for Casgevy's newly FDA-approved indication for the treatment of transfusion dependent β-thalassemia (TDT) - Limits coverage to patients who are at least 12 years old with TDT diagnosed by a hematologist and confirmed via genetic mutation - Coverage also requires transfusion dependence, clinical stability, failure of or contraindication to red blood cell transfusion (RBCT) and iron chelation therapy (ICT), contraindication to hematopoietic stem cell transplant (HSCT) and no prior gene therapy or HSCT
Elahere, mirvetuximab soravtansine-gynx, dru738	- Updated epithelial ovarian, fallopian tube and primary peritoneal cancer coverage criteria to remove prior bevacizumab requirement based on a newly published confirmatory phase 3 randomized-controlled trial with mature outcomes data
Tepezza, teprotumumab-trbw, dru632	- Updated criteria to allow for coverage with clinical activity score (CAS) less than four when patient has proptosis plus significant medical complication (e.g., diplopia, eye pain or inability to perform critical activities of daily living or employment); this update is based on newly published evidence to support the use of Tepezza in low-activity disease

Effective June 1, 2024	Description
New medication policies	
Xdemvy, lotilaner 0.25% ophthalmic solution, dru772	- Limits coverage to patients with demodex blepharitis diagnosed by a specialist for whom step therapy with at least one standard of care treatment was ineffective
Augtyro, repotectinib, dru776	- The use of Augtyro for ROS1-positive advanced non-small cell lung cancer (NSCLC) is considered not medically necessary and, therefore, not covered due to its relative high cost versus similar therapeutic NCCN-recommended alternatives (entrectinib and crizotinib); use of Augtyro for other conditions is considered investigational
Ojjaara, momelotinib, dru777	- Limits coverage for myelofibrosis when the patient is anemic at baseline
Fruzaqla, fruquintinib, dru775	- Limits coverage to patients with metastatic colorectal cancer with disease progression on all the following: fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy; an anti-vascular endothelial growth factor (VEGF) therapy; and an anti-estimated glomerular filtration rate (eGFR) therapy when RAS wild type and medically appropriate
Medications for Weight Management, dru778	- Limits coverage to patients with obesity or adult patients with overweight with at least one weight-related comorbidity. Also requires concurrent use of lifestyle modification(s); reauthorization requires at least a 5% weight loss from pretreatment baseline - Benefit language supersedes this policy, which only applies for members whose benefit covers weight management medications

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Effective June 1, 2024	Description
New medication policies, continued	
High-cost medications for cholesterol, dru779	- New combination policy incorporates PCSK9 inhibitors (dru697) and Evkeeza (dru680) - Added Nexletol (bempedoic acid) and Nexlizet (bempedoic acid/ezetimibe) to policy; limits coverage of Nexletol and Nexlizet to the following indications: heterozygous familial hypercholesterolemia (HeFH), clinical atherosclerotic cardiovascular disease (ASCVD) or at risk for ASCVD event - Expanded the ASCVD risk category to include secondary prevention with diabetes, chronic kidney disease or very high LDL-C at baseline - Based on treatment guideline updates, LDL-C goal updated and coverage added for primary prevention for very high LDL-C with multiple risk factors for an ASCVD event
Revised medication policies	
High-cost medications for dry eye disease, dru472	- Added newly FDA-approved Vevye (cyclosporine 0.1% solution) to policy
Non-Preferred Drugs, dru760	- Added authorized generics for Farxiga (dapagliflozin propanediol) and Xigduo (dapagliflozin propanediol/metformin extended release) as non-preferred SGLT2 inhibitor-containing medications
PI3K Inhibitor Medications for Breast Cancer	- Added coverage criteria for Truqap (capivasertib), a newly FDA-approved medication for HR+, HER2-, locally advanced or metastatic breast cancer with one or more PIK3CA/AKT1/PTEN-alterations; limits coverage to patients with this indication and disease progression on/after an aromatase inhibitor
Isocitrate Dehydrogenase-1 (IDH1) inhibitors, dru558	- Added coverage criteria for Tibsovo (ivosidenib) for treatment of MDS; limits coverage to relapsed/refractory MDS with IDH1 mutation when at least one prior cytotoxic chemotherapy regimen has been ineffective
Bruton's tyrosine kinase (BTK) inhibitors, dru691	- Added coverage for newly FDA-approved indication for Jaypirca (pirtobrutinib) for chronic lymphocytic leukemia or small lymphocytic lymphoma (CLL/SLL) who have received at least two prior lines of therapy, including a BTK inhibitor and a BCL-2 inhibitor
Voxzogo, vosoritide, dru687	- Removed age restriction based on FDA label age expansion from ages 5 years and older to all pediatric patients; also updated quantity limit to reflect age expansion
Dupixent, dupilumab, dru493	- Removed eosinophilic esophagitis (EoE) age restriction based on FDA label age expansion from age 12 down to one year; also updated quantity limit to reflect age expansion
Medications for pulmonary arterial hypertension (PAH), dru633	- For Adempas (riociguat), Uptravi (selexipag oral) and Orenitram (treprostinil oral), updated step therapy as follows: 1) sildenafil OR tadalafil (previously just sildenafil) and 2) bosentan or generic ambrisentan (previously required both)

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Effective July 1, 2024	Description
Revised medication policies	
Drugs for chronic inflammatory diseases, dru444	- Adding Bimzelx (bimekizumab-bkzx) to policy as a non-preferred (Level 4) self-administered option for chronic plaque psoriasis - Adding Omvoh (mirikizumab-mrkz), Velsipity (etrasimod) and Entyvio SC (vedolizumab) to policy as non-preferred (Level 3) self-administered options for ulcerative colitis (UC); the provider-administered loading doses for Omvoh will follow coverage of the self-administered product - Changing Sotyktu (deucravacitinib) from a Level 3 to a Level 2 self-administered option for chronic plaque psoriasis - Adding coverage criteria for Cosentyx (secukinumab) for treatment of hidradenitis suppurativa - Updating Adbry (tralokinumab) atopic dermatitis age restriction from age 18 down to 12 years old based on FDA age expansion

Effective October 1, 2024	Description
New medication policies	
Products without individual medication policies subject to Site of Care review, dru789	- Limiting coverage of Benlysta IV (belimumab) and Trogarzo (ibalizumab-uiyk) to when Site of Care Program criteria are met - When administered by a provider, these medications must be given at an approved location
Revised medication policies	
Alpha-1 proteinase inhibitors, dru382 Amondys 45, casimersen, dru661 Enjaymo, sutimlimab-jome, dru716 Exondys 51, eteplirsen, dru480 Givlaari, givosiran, dru630	- Adding to the Site of Care Program; when administered by a provider, these medications must be given at an approved location
Drugs for chronic inflammatory diseases, dru444	- Adding Ilumya to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Gaucher Disease Treatments, dru649	- Adding Elelyso to the Site of Care Program (in addition to Cerezyme and VPRIV); when administered by a provider, this medication must be given at an approved location
Interleukin-1 Antagonists, dru677	- Adding Ilaris to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Medications for Hereditary Angioedema (HAE), dru535	- Adding Cinryze to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Medications for transthyretin-mediated amyloidosis, dru733	- Adding Amvuttra and Onpattro to the Site of Care Program; when administered by a provider, these medications must be given at an approved location

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Effective October 1, 2024	Description
Revised medication policies, continued	
Monoclonal antibodies for asthma and other immune conditions, dru538	- Adding Tezspire to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Provider-Administered Specialty Drugs, dru764	- Updating the Provider-Administered Specialty Drug list - **Related**: See *Asuris EquaPathRx program implementation change* on page 12.
Site of Care Review, dru408	- The following medications will be added to the Site of Care Program; when administered by a provider, these medications must be given at an approved location: • Alpha 1 proteinase inhibitors (Glassia, Prolastin-C, Aralast NP, Zemaira), J0256 and J0257 • Amondys 45, casimersen (J1426) • Amvuttra, vutrisiran, J0225 • Benlysta IV, belimumab, J0490 • Cinryze, plasma-derived C1-INH, J0598 • Elelyso, taliglucerase alfa, J3060 • Enjaymo, sutimlimab-jome, J1302 • Exondys 51, eteplirsen, J1428 • Givlaari, givosiran, J0223 • Ilaris, canakinumab, J0638 • Ilumya, tildrakizumab-asmn, J3245 • Onpattro, patisiran, J0222 • Tezspire, tezepelumab, J2356 • Trogarzo, ibalizumab-uiyk, J1746 • Viltepso, viltolarsen, J1427 • Vyondys, golodirsen, J1429
Viltepso, viltolarsen, dru640	- Adding to the Site of Care Program; when administered by a provider, this medication must be given at an approved location
Vyondys 53, golodirsen, dru606	- Adding to the Site of Care Program; when administered by a provider, this medication must be given at an approved location

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

ABA reimbursement update

Effective September 1, 2024, we will update reimbursement rates for ABA services provided to our commercial members (group and Individual products). Rates for all 10 ABA codes will increase.

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

Change to ABA authorization for members younger than 18

Effective September 1, 2024: ABA services for commercial and Medicare Advantage members younger than 18 will require pre-authorization. We currently require pre-authorization for ABA services for commercial and Medicare Advantage members 18 and older.

Failure to receive pre-authorization may result in an administrative denial, claim non-payment and provider write-off. Members may not be balance billed.

These pre-authorization reviews are supported by our *Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder* (Behavioral Health #18) medical policy.

Our commercial and Medicare Advantage pre-authorization lists have been updated to reflect this change.

Related: See *Pre-authorization updates* on page 9.

Behavioral health corner

State program offers psychiatric consultations to support PCPs

Through support from a Washington state program, medical practitioners can access no-cost psychiatric consultations by phone through the Partnership Access Line (PAL).

PAL psychiatric consult services support PCPs in meeting the treatment needs for their patients' mental health by:

- Improving access to the limited availability of psychiatric services
- Helping to serve patients at no cost to providers or patients
- Clarifying diagnostic information or offering other informational support
- Answering questions about medication adjustment or treatment planning
- Ensuring appropriate referrals for patients with serious behavioral health concerns

Expanding the availability of high-quality mental health treatment via timely psychiatric consultation has numerous beneficial effects, including:

- **Early interventions**: Improved quality of care and health outcomes
- **Whole health**: Promotes and improves mental health and physical health integration

Requesting a consultation is simple, and they don't require additional patient authorization because provider-to-provider consultation is covered under the Health Insurance Portability and Accountability Act (HIPAA).

Important: Psychiatric consultations are intended to discuss best practices for treatment and support. **If a patient is in crisis, call 911.**

About PAL	
Consultation line	(866) 599-7257
Hours	8 a.m. to 5 p.m. PT, weekdays
Collaborators	- Washington's Health Care Authority - Mental Health Referral Service for Children and Teens - Frontier Behavioral Health, which offers the Supporting Adolescents and Families Experiencing Suicidality (SAFES) program
Ages served	- Children and adolescents, up to age 19
Website	**seattlechildrens.org/healthcare-professionals/community-providers/pal/wa-pal**
Additional information	- Calls connect directly to a PAL child and adolescent psychiatrist. - PAL publishes an annual report for PCPs about child mental health.

Behavioral health corner

Help increase post-discharge care rates

To improve our members' outcomes and reduce or avoid readmissions, it is important that patients are seen by a behavioral health clinician within seven days of discharge.

Timely follow-up visits can occur any time between days one and seven and may be held in person, via telehealth or through billable visits by phone. (**Note**: Discharge appointments do not count as follow-up appointments.)

Care coordination and telehealth can help ensure members receive timely care.

Improve outcomes and set patients up for success

Care coordination is a vital aspect of good treatment planning and plays a critical role in improving outcomes. By working with us, the member and the member's family or support system, we can collectively ensure members have successful discharge plans and are able to function to their highest ability when they leave the hospital setting. We encourage communication among a member's providers and the health plan.

Our care management team will:

- Determine a follow-up plan during the inpatient review process
- Assist in securing follow-up appointments, including locating new providers if needed
- Offer support by contacting members after their discharge to discuss the follow-up plan
- Help our members understand the importance of follow-up appointments
- Encourage timely outpatient follow-up with a licensed behavioral health provider

Providers can connect to our case management team by calling 1 (866) 543-5765 or the Customer Service number on the back the member's card.

Your facility should:

- Begin follow-up planning at the time of inpatient admission and involve and educate the patient's family about the follow-up plan
- Discuss the follow-up plan with your patient and the importance of follow-up visits
- Schedule follow-up appointments, including one within seven days of discharge
  - Consider choosing telehealth to help meet the HEDIS standard for timely follow-up care and/or ongoing care
- Ensure accurate post-discharge contact
- Call your patient to remind them of the follow-up appointment
- Encourage your patients to sign an Authorization to Disclose Protected Health Information form, if needed, available on our provider website: Library>Forms.
  - A release of information (ROI) is required for coordinating with substance use disorder (SUD) providers or facilities.
  - Most behavioral health information can be shared among treating providers—even those in different organizations—without an ROI for the purposes of coordinating care. Additionally, requesting an ROI before coordinating care can delay appropriate care and lead to poor outcomes.

Telehealth can bridge the gap

Telehealth helps ensure our members receive follow-up care within seven days of discharge by allowing members to receive care using a computer, phone and/or tablet. We continue to add virtual care behavioral health providers to our networks to increase access to outpatient professional appointments.

To learn more about telehealth options available to our members, view the toolkits available on the homepage of our provider website:

- The Telehealth section of Behavioral Health Toolkit includes an up-to-date list of these providers. **Related**: See *Specialized virtual providers without a referral* on page 23.
- The Care Options Toolkit lists national behavioral health vendors available to some members.

Measuring success

HEDIS measure Follow-Up After Hospitalization for Mental Illness (FUH) tracks post-discharge behavioral health care to ensure members transition safely from an acute hospital setting back to their home environments. To meet the measure's standard, behavioral health clinicians should provide the following types of services within seven days of discharge:

Qualifying clinician types	Qualifying services
- Psychiatrist - Licensed clinical social worker - Licensed marriage and family therapist - Licensed professional counselor - Psychiatric nurse - Psychologist - Providers rendering services via incident-to billing criteria	- Intensive outpatient - Partial hospitalization program - Residential treatment center

See our Incident to Services commercial and Medicare Advantage reimbursement policies in our Reimbursement Policy Manual on our provider website.

Behavioral health corner

Peer support can aid recovery

Peer support offers acceptance and validation to people recovering from mental health conditions and/or SUD by allowing people with lived experience to help others develop goals and strategies through non-clinical, strengths-based support. It is:

- Evidence-based
- Empowers individuals to direct their own recovery process
- Demonstrates specific improvements in patient engagement and treatment retention

We encourage providers to refer eligible patients to our peer support program, which is open to Medicare Advantage members 18 and older.

The advantages of peer support

Peer support specialists help members address mental health and/or SUD challenges while advocating for the members as part of their care team. They share their lived experience, creating a safe environment to meet and provide mutual support.

Peer support is unique to the individual's needs, and it takes into consideration the member's level of functioning, co-morbid conditions and other life factors to address:

- Self-advocacy skills
- Employment readiness
- Peer counseling and role modeling
- Connection and referral to other community resources
- Development of a Wellness Recovery Action Plan (WRAP)
- Education (nutrition, exercise, household tasks, community safety, mental illness, etc.)

Identify candidates for peer support

There isn't a single set of guidelines to determine who can benefit from peer support, but in general, members who struggle to stay engaged in their treatment and with their health and self-care are good candidates. Additionally, members who have previously declined care management might respond more positively to working with a peer.

Members who've recently experienced increased health care needs may be particularly vulnerable. Consider a referral if a member has:

- Had two or more mental health inpatient admissions in a six-month period
- Had two or more emergency department (ED) visits in a six-month period
- Been readmitted to a mental health inpatient facility within 30 days

A referral may also be appropriate if these members:

- Lack a social support system
- Need support accessing resources related to social determinants of health (e.g., food, transportation, housing, etc.)
- Need assistance identifying or connecting with community-based supportive resources to improve treatment and recovery outcomes

Example scenarios

- A member is recently diagnosed with a behavioral health condition that will require significant intervention. The member declines case management because they have trust issues with providers. The peer support specialist can build trust with the member by providing advocacy and support.
- A member with a history of alcohol dependency begins dialysis and later stops treatment, slipping into depression. The provider refers the member for behavioral health care, but the member needs additional support. The peer support specialist can build trust with the member by providing advocacy and support.

The referral process

We encourage providers to consider referring their eligible patients to this supportive program.

You can identify Medicare Advantage members by the "MedAdv" in the top right corner of the front of their member ID card. Refer a member to our Case Management team by:

- Calling our Provider Contact Center at 1 (888) 349-6558
- Calling the Customer Service number on the back the member's ID card

Behavioral health corner

Specialized virtual providers without a referral

Because timely behavioral health care is integral to patients' overall well-being, we continue to improve access by expanding the types of specialized virtual behavioral health providers in our networks.

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**, and search 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 **ableto.com**	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 **arraybc.com**	One of the largest telepsychiatry providers in the country, employing psychiatry and behavioral health clinicians with diverse specialties
Boulder Care **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 **charliehealth.com**	Intensive outpatient treatment for teens and young adults, as well as their families
Eleanor Health **eleanorhealth.com/washington**	Addiction and SUD treatment with evidence-based outpatient care and recovery tools
Equip **equip.health**	Family-based treatment of eating disorders for individuals ages 6 to 24 that includes a five-person care team
Headway **headway.co**	Local clinicians with diverse specialties available in the next few days for telehealth and/or in-person visits
NoCD **treatmyocd.com**	Specialized care for OCD using exposure and response prevention (ERP) treatment
Talkspace **talkspace.com/partnerinsurance**	Mental health counseling available 24/7/365 via text, audio or video messaging

Connect patients to convenient in-home care with DispatchHealth

DispatchHealth, **dispatchhealth.com**, available in the Spokane metro area, provides medical attention in the comfort of the member's home.

The benefits of using DispatchHealth

DispathHealth:

- Can deliver in-home care to hard-to-reach populations (e.g., older populations or those unable to easily leave home, working parents and busy professionals)
- Can reduce unnecessary ED visits, hospital admissions and readmissions
- Can help improve health outcomes and reduce health care costs
- Shares valuable insights into SDoH
- Connects patients back to their PCP/specialist for all follow-up care and ongoing management and communicates with the patient's care team after every visit (They provide detailed notes to the patient's PCP or care team.)
- Has earned a 95% patient satisfaction score

DispatchHealth services

In-home on-call acute care (urgent care)

DispatchHealth complements and extends your practice by delivering on-demand urgent medical care to high-acuity patients in the comfort of their homes. Their credentialed medical professionals can treat a variety of conditions, including cuts, lacerations and abrasions, infections, mild to moderate abdominal pains, severe cold and flu symptoms, and sprains and strains. They can also order prescriptions for patients.

Their services are:

- **Accessible**: DispatchHealth operates from 8 a.m. to 10 p.m., 365 days a year—weekends and holidays included. (They see 48% of patients outside of standard office hours.)
- **Affordable**: DispatchHealth's services are in-network, and the costs for a visit are typically the same as an urgent care visit.
- **Fast**: The average time from appointment request to the patient's doorstep is three hours.

In-home care for patients after hospital discharge (Bridge Care)

DispatchHealth offers in-home care for patients after they've been discharged from a hospital, skilled nursing facility (SNF) or inpatient rehabilitation stay. This service, known as Bridge Care, is provided upon referral by a member's inpatient provider or Asuris care manager.

Within 24 to 72 hours of discharge, DispatchHealth visits the member's home to conduct a history and physical assessment of patient's progress since discharge, assess their condition and symptoms, assess their home and environment, reconcile medications and provide education to promote self-management. Dispatch ensures patients have everything they need to recover—including coordinating follow-up care with their PCP or specialists.

How it works

Request an appointment for your patient

- Set up an account at DispatchExpress, **dispatchhealth.com/dispatchexpress**, so you can easily request an appointment for your patient and receive visit updates.
- You can also call DispatchHealth at (425) 651-2473.
- DispatchHealth will reach out to your patient to finish scheduling the appointment.

A care team is sent to your patient's home

- A DispatchHealth care team will arrive at your patient's home with everything needed to treat your patient's illness or injury.
- The care team will include a physician associate or nurse practitioner and a medical technician, virtually supported by an emergency medicine physician, if necessary.
- All team members wear personal protective equipment and use sterilized equipment.

Follow-up communication and coordination of care

- DispatchHealth will call in any prescriptions needed, send clinical notes of the encounter back to you, and handle billing directly with Asuris.
- **They always direct patients back to you for follow-up care.**

Learn more about DispatchHealth's

- Service areas and hours: **dispatchhealth.com/locations**
- Acute care services (Urgent care): **dispatchhealth.com/partners/care-management-provider-group**
- Post-discharge care services (Bridge Care): **dispatchhealth.com/blog/category/partner-resources-tips/post-hospital-bridge-care-for-the-patient**

Help members plan ahead for care

To help your patients save time and money, we encourage you to help them plan ahead for the next time they need sudden medical care.

Resources for our members

We continue to educate our members about their care options to ensure that they are receiving the care they need in a setting that's clinically appropriate and most cost-effective.

We recently updated our member site to make it even easier for our members to find information about their care options by signing in to their **asuris.com** account. The Find Care section includes quick links to our:

- Provider and pharmacy directories
- Immediate care options, including nearby urgent care clinics and EDs
- Virtual care options, including scheduling doctor's appointments, asking a pharmacist and behavioral health support (**Related**: See *Specialized virtual providers without a referral* on page 23)
  - If you offer telehealth services, share information with your patients about how they can schedule a virtual appointment with you. To indicate whether you offer telehealth services, update your directory information on our provider website: Contact Us>Update Your Information.
  - **Note**: Certain populations may experience equity-based barriers to telehealth, such as age, income, disability, race, ethnicity, language, literacy, health literacy and digital literacy. In addition, lack of affordable broadband in some rural and urban areas can be a barrier to patients' having access to telehealth services. When recommending telehealth services to patients, be prepared to help them understand the value of and situations for using it. Having tech support and translation services/language accessibility resources can help patients who encounter difficulties with their appointments.
- In-home care (**Related**: See *Connect patients to convenient in-home care* on page 25.)

Our members can also call the Customer Service number on the back of their member ID card for help with finding care, including registering for an **asuris.com** account and navigating to the Find Care section.

Resources for providers

View the Care Options Toolkit on the homepage of our provider website. It includes:

- Information for providers about members' care options, including virtual medical and specialized behavioral health providers, our 24/7 nurse line, urgent care and more.
- *Understand your Care Options* member flyer with information about the symptoms that can be treated, cost of treatment and average wait times when seeking virtual, in-person (including urgent care centers) or emergency care.

Schedule routine checkups

To help your patients stay healthy and avoid health emergencies, it's critical that they keep regularly scheduled appointments, especially for immunizations, screenings, preventive care and chronic disease management. It's also important for your patients to continue taking all medications exactly as prescribed.

On our member website, **asuris.com**, and social media channels, we encourage members to receive the care they need to stay healthy. Our site includes tips to help members schedule and prepare for in-person routine or follow-up medical or dental care. By logging into their account, members can also see the behavioral health options available to them.

Preventive vs. diagnostic care

When scheduling appointments, please remind your patients that diagnostic care to treat a new symptom or an existing problem ordered during a preventive care visit is subject to cost share (e.g., copay, coinsurance or deductible) amounts, just as additional services ordered during a non-preventive visit would be.

Medicare annual wellness visits (AWVs)

Medicare AWVs and preventive care visits are important for reviewing and documenting your patient's current health status for chronic conditions, which should be done at least once a year. If you participate in our Medicare Advantage Quality Incentive Program (MA QIP), you can earn incentives for completing these visits when they are billed with the following codes:

- **Annual wellness visit**: HCPCS G0438, G0439
- I**nitial preventive physical examination**: HCPCS G0402
- **Annual physical exam**: CPT 99381-99387, 99391-99397

View our preventive care lists

- Commercial members (available in English and Spanish): **asuris.com/member/members/preventive-care-list**
- Medicare members: **asuris.com/medicare/resources/preventive-care**

Following up on patient test results

Our members' experiences with the health care delivery system are measured as part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. We are keeping a close eye on two measures regarding how well providers follow up with test results and do so in a timely manner.

Studies show that ineffective management of test results—both following up with test results and following up in a timely manner—can lead to waste in health care by causing additional and unnecessary tests to be ordered, or diagnoses or needed medication changes to be missed, leading to serious patient safety issues.

We encourage you to consider these tips related to test result processes to ensure that follow-up is happening promptly:

- Follow up on all test results, both normal and abnormal.
- Follow up using patients' preferred method of communication (mail, phone or email) to ensure they are notified of their results.
- Leverage your electronic medical record (EMR) to its highest potential for test tracking and follow-up, to distinguish between abnormal and normal test results, and for communication between staff, as well as communication with patients through your patient portal.
- Communicating the standard process for following up with test results (e.g., within two or three business days) can help set patients' expectations and improve the experience for patients and staff.

Consider test result follow up and following up timely as a quality improvement project for your 2024 quality program year. Here are some resources that can help:

- The Institute for Health Improvement *Plan-Do-Study-Act (PDSA) Worksheet* can help guide almost any quality improvement project: **ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx**.
- The Agency for Healthcare Research and Quality *Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement* may be helpful for improving processes and workflows within your practice: **ahrq.gov/hai/tools/ambulatory-care/lab-testing-toolkit.html**.

Women's health: Important reminders

Screenings

We cover the following preventive health services at 100% for most commercial members:

- Cervical cancer screening (Pap) (ages 21 and older)
- Screening for gonorrhea, syphilis and chlamydia
- HIV screening and counseling (ages 15 to 65 or at high-risk)
- Human papillomavirus (HPV) screening, every three years (ages 30 and older) and HPV immunizations (up to age 45)
- Screening mammogram (ages 40 and older or at high-risk)
- Sexually transmitted disease counseling during wellness exams

Members may not be aware that these services are covered at 100%. They can view the list of covered services on our member website, **asuris.com/member/members/preventive-care-list** or by calling the Customer Service number on the back of their member ID card.

Cervical cancer screening

We encourage you to schedule cervical cancer screenings with your patients who may be overdue. These screenings may find cancers earlier—when they are more easily treated. Women who have not been screened face the greatest risk of developing invasive cervical cancer.

Our most recent HEDIS results, based on 2022 care, indicate that 71% of our members who are eligible received the screening, which put our health plans at the 25th percentile nationally for this measure.

The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer with the Pap test alone every three years in women ages 21 to 29. In women ages 30 to 65, the USPSTF recommends the Pap test alone every three years or HPV testing, with or without Pap co-testing, every five years.

Chlamydia screening

Because people often do not have symptoms, many chlamydia infections go undetected and untreated, which can have severe long-term health consequences.

The HEDIS specifications for chlamydia recommend screening one time per year in women ages 16 to 24 who are sexually active. Our most recent HEDIS results, based on 2022 care, indicate that only 36.2% of our members who are eligible received the screening, which put our health plan at the 33rd percentile nationally for this measure.

The USPSTF recommends screening for chlamydia in sexually active women 24 and younger and in older women who are at increased risk for infection.

Resources

- Look for the **Chlamydia screening** category in the Quality Improvement Toolkit, available in the Toolkits section on the homepage of our provider website.
- View the list of preventive care services covered at no cost for our group and Individual members (available in English and Spanish): **asuris.com/member/members/preventive-care-list**
- List of preventive care services covered at no cost for our Medicare members: **asuris.com/medicare/resources/preventive-care**
- Healthwise's Knowledgebase, including the video *Why Get a Chlamydia Test*, available on our provider website: Programs>Member Programs & Tools
- Chlamydia—CDC Fact Sheet: **cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm**

Maternal health

The U.S. has some of the worst maternal and infant health outcomes among high-income countries, and people of color are disproportionally affected. Analysis of our claims data found that postpartum provider visit rates are low, especially for Black and Hispanic/Latinx members. We encourage providers to ensure all their patients' maternal health and postpartum visits are scheduled so that mothers receive the support they need when they need it.

Our members have access to convenient, digital tools to support their maternity journey. Our Bump2Baby program provides personalized support from nurse care managers. The app features content dedicated to supporting women of color during pregnancy, such as articles exploring the impact of racism and toxic stress, and how to find anti-racist prenatal care. Bump2Baby is included in fully insured plans and available as a buy-up option for administrative services only (ASO) groups. Learn more about Bump2Baby on our provider website: Programs>Member Programs & Tools.

Our Health Equity Toolkit includes links to free maternal health training and resources for you and your staff. The Health Equity Toolkit is available on the homepage of our provider website.

Well-child visits are important

Pediatric PCPs are a trusted resource for parents and caregivers regarding their children's health and have a vital role in ensuring children receive timely well-child care.

Well-child visits provide opportunities for infants and young children to receive recommended preventive care screenings, immunizations and vaccinations; chronic condition prevention and management; identification and treatment of major illnesses; early identification of special health care needs; and other important services. These visits can also address identified needs and provide referrals to community resources to help build and support strong families who are able to successfully care for children.

In the U.S., racial disparities exist in well-child visit completion rates. In an imputed analysis of our claims data, we found a significant gap in well-child visit completion rates for Hispanic/Latinx children. Barriers to care include language accessibility and cultural differences.

One of our 2024 goals for our group and Individual members, is to increase the number of children who receive six or more well-child visits with a PCP during the first 15 months of life as measured using HEDIS criteria. The American Academy of Pediatrics (AAP) schedule includes at least six visits at the following times:

- Birth
- Three to five days following birth
- By one month of age
- One visit each at two, four, six, nine, 12 and 15 months of age

We support the AAP recommendations for preventive pediatric health care, and we encourage you to provide well-child services at appropriate intervals and to remind parents of the need for these visits and their timing by:

- Scheduling office visits in advance, based on the recommended schedule
- Pursuing missed appointments with letters and reminder calls
- Submitting claims for well-child services using the following codes:
  - CPT 99381-99385, 99391-99395 or 99461
  - HCPCS G0438, G0439 or S0302
  - ICD-10-CM Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1 or Z76.2

Resources

- Look for the **Well-child visits** category in the Quality Improvement Toolkit, available on the homepage of our provider website for materials in English and Spanish about well-child visits.
- For best practices and resources for providing culturally sensitive care to Latinx patients, view our new *Improving Care for Latinx Patients* flyer. This flyer and other resources can be found in the Health Equity Toolkit, available on the homepage of our provider website.
- Bright Futures Health Care Professionals Tools and Resources: **brightfutures.aap.org/clinical-practice/Pages/default.aspx**
- Vaccination schedules for children and adolescents, as well as catch-up schedules, published by the CDC: **cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html**
- *Social Determinants of Health Z codes* flyer: Available on our provider website: Library>Printed Materials (under Cultural competency)

The benefits of continuous glucose monitors for diabetes

Continuous glucose monitors (CGMs) are a valuable tool for many patients with diabetes, not just those with type 1 diabetes. The table below from UpToDate, a clinical decision support solution from Wolters Kluwer, shows that lifestyle changes result in a 1-2% decrease in HbA1C, which is just as impactful—if not more—than most other interventions. Adding a CGM for patients with diabetes could teach them that lifestyle changes are needed for a predictable blood sugar reading.

Intervention	Expected decrease with HbA1C with monotherapy (%)
Initial therapy	
Lifestyle change to decrease weight and increase activity	1 to 2
Metformin	1 to 2
Additional therapy	
Insulin (usually with a single daily injection of intermediate- or long-acting insulin initially)	1.5 to 3.5
Dual GLP-1 and GIP receptor agonist (once-weekly injections)	2 to 2.5
Sulfonylurea (shorter-acting agents preferred)	1 to 2
GLP-1 receptor agonist (oral or daily to weekly injections)	0.5 to 2
Thiazolidinedione	0.5 to 1.4
Glinide	0.5 to 1.5
SGLT2 inhibitor	0.5 to 0.7
DPP-4 inhibitor	0.5 to 0.8
Alpha-glucosidase inhibitor	0.5 to 0.8
Pramlintide	0.5 to 1

Using a CGM can encourage medication adherence and may even lead to deprescribing, which can be a patient-motivating factor. CGMs can be life-changing and have been shown in studies to significantly improve A1C levels. CGMs can enable patients to fine-tune and optimize their blood glucose control. Empowering patients to make healthy changes can be a long-lasting and effective tool.

CGMs can empower and motivate patients

- Not every food has the same effect on everyone's blood sugar level, and a CGM can help patients pinpoint the foods that are best or worst for them.
- Most people will notice that their blood sugar level drops during exercise. But intense exercise, like a strenuous training session or run, can cause blood sugar to rise. CGMs can help patients understand how they respond to different types of exercise.
- When patients are ill or if they take an over-the-counter (OTC) medication for their cough/cold symptoms, they can monitor their blood glucose with a CGM.
- Long-term stress may raise blood glucose, and having a CGM can help patients be aware so they take steps to decompress.

Most providers would agree that cost is the biggest hurdle to supplying patients with diabetes with a CGM. Asuris covers Dexcom and Freestyle Libre for Medicare Advantage PPO and HMO plans (usually with 0% coinsurance), if purchased from an in-network pharmacy or durable medical equipment (DME) supplier. Manufacturer rebates may be available on a per patient basis. Asuris covers CGMs and their supplies as Tier 3 or Tier 4 on our drug list, depending on the plan for commercial members. Manufacturer rebates may be available.

The benefits of CGMs extend beyond type 1 diabetes patients and can have a significant impact on glycemic control and hypoglycemic reductions for people with type 2 diabetes as well. As health care providers, it is important to consider the value for patients with diabetes and work to incorporate them into your patients' treatment plans.

GLP-1 agonist-containing medications for diabetes

Glucagon-like-peptide-1 (GLP-1) agonists indicated for treatment of type 2 diabetes mellitus (T2DM) have been available since 2005. Due to their strong track record of safety and efficacy in managing T2DM, the American Diabetes Association 2023 Guidelines were updated to designate GLP-1s as a first-line treatment option. As a result, GLP-1 use in T2DM has increased significantly in the last few years.

GLP-1s are also proven safe and effective for chronic weight management when used as an adjunct to reduced-calorie diets and increased physical activity in adult and pediatric patients with specified high body mass index (BMI). Note: Use of these medications for weight loss in the absence of coverable medical conditions is generally a benefit exclusion.

Because of high demand, you may expect GLP-1 agonist shortages to continue. To help patients stay adherent to therapy when there is a shortage:

- Consider switching to a lower dose.
- Consider changing to a GLP-1 agonist that's given at the same interval and has a comparable dose. For example, if a patient using semaglutide 0.5 mg weekly for T2DM, consider switching to dulaglutide 1.5 mg weekly, starting when the next dose is due.

When starting GLP-1 agonists or stepping up doses, patients can expect modest, temporary GI upset (nausea, etc.). To help patients stay adherent to therapy:

- Consider starting with a low dose and titrating up slowly
- Encourage patients to eat smaller meals, eat slowly and stop eating before they feel full.
- For nausea, advise patients to ingest crackers, apples, mints or ginger-based drinks 30 minutes after GLP-1 dose and to avoid strong smells. If needed, consider short-term antiemetics and prokinetics.
- For diarrhea, advise patients to hydrate and consume chicken broth, rice, carrots and very ripe fruit without skin while avoiding sports drinks, dairy, caffeine, alcohol and soft drinks. If needed, consider probiotics, antidiarrhea agents (such as loperamide) or metformin dose reduction.
- Lastly, consider a temporary dose reduction or set a lower max dose for tolerability.

As a reminder, educate patients to promptly report severe gastrointestinal pain, which can be a red flag for rare pancreatitis, gallbladder issues or bowel obstruction.

Agent	Frequency	Equivalent dose			
Exenatide	Weekly (QW)	-	-	2 mg	-
Dulaglutide	QW	-	0.75 mg	1.5 mg	-
Semaglutide	QW	-	0.25 mg	0.5 mg	1 mg
Liraglutide	Daily (QD)	0.6 mg	1.2 mg	1.8 mg	-
Lixisenatide	QD	10 mcg	20 mcg	-	-
Oral semaglutide	QD	3 mg	7 mg	14 mg	-
Exenatide	Twice daily (BID)	5 mcg	10 mcg	-	-

Medicare corner

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.

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 Advantage SNF reimbursement schedule update

In our ongoing efforts to reward high-quality care provided to Asuris Medicare Advantage members, we review the quality ratings of participating SNFs on an annual basis each October 1. We use the Quality of Patient Care Star Ratings, which reflect the prior calendar year's data and are available in April of the current year to determine the quality rating for each SNF.

For reimbursement changes effective October 1, 2024, SNFs can view their CMS Quality of Patient Care Star Ratings at **medicare.gov/care-compare**. The criteria for determining the quality rating for SNFs is outlined in the Facility Guidelines section of the *Administrative Manual*, available on our provider website: Library>Administrative Manual.

As a reminder, reimbursement is based on a percentage of the current CMS SNF Prospective Payment System (PPS) (PDPM) reimbursement schedule, updated quarterly and available at **cms.gov/medicare/medicare-fee-for-service-payment/snfpps**.

Medicare corner

MA QIP reminders

Please review these important reminders about our Medicare Advantage Quality Incentive Program (MA QIP)

QIP 2023 payout

We expect to mail checks for any earned incentives for the 2023 program year on June 30, 2024. Providers who participate in multiple programs will receive separate payout checks for each program.

Payout disputes

If you have any questions or concerns about your 2023 program performance or payout, please email us at **QIPQuestions@asuris.com** by July 31, 2024. We will review your dispute and will contact you to determine next steps and resolution.

Final performance reports

Details regarding the incentive program structure, as well as how your payout was determined, can be reviewed in a report that will be available in our Care Gap Management Application (CGMA). When the report is available, you will see a pop-up notification after you sign in, with instructions for downloading the report.

Preventive care visits EPB important dates

The MA QIP preventive care visits (PCV) early performance bonus (EPB) offers your practice an opportunity to earn an additional $20 per closed gap if you meet both of the following qualifications:

1. Completing PCVs for 40% of your attributed members by 11:59 p.m. (PT) on June 30, 2024.
2. Completing PCVs for 70% of your attributed members by the end of the 2023 program.

Visit types that close this gap:

- Annual physical exams
- Initial preventive physical examination (IPPE or "Welcome to Medicare" visit)
- Annual wellness visit (AWV), initial or subsequent

Notes:

- The PCV gap can only be closed via claims submission.
- Preventive visits are covered without a member copay; check Availity Essentials for member eligibility.
- We cover AWVs and PCVs billed once per calendar year; there is no requirement to wait 11 months between visits.
- Members who have an in-home assessment are still eligible for an AWV/PCV; an in-home assessment conducted by a vendor does not close the PCV gap for the attributed PCP.
- We will give credit for the PCV incentive if the visit was completed in 2024, even if the member had other health plan coverage at the time of service. Please submit evidence of the previously performed PCV to **QIPQuestions@asuris.com**.

CGMA access

The CGMA is a helpful tool for reviewing and closing patient care gaps. Access to the CGMA is managed by your QIP Primary Contact. If you need access to the CGMA, have your QIP Primary Contact email us at **QIPQuestions@asuris.com** to add you as a new user. Include the following information about the new CGMA user: first and last name, title, phone number, email address, provider group name and provider group TIN(s).

Stay active to avoid lockout: CGMA accounts that are inactive for 120 calendar days are locked. It can take up to one week to reactivate and unlock your account.

MA QIP resources

You can learn more about the MA QIP on our provider website: Programs>Medicare Advantage Quality Incentive Program.

Medicare corner

Improving Health Outcomes Survey responses

Health Outcomes Survey (HOS) season is starting soon. Every year CMS administers the HOS survey. This year's survey is expected to be live from July 22, 2024, to November 1, 2024.

The HOS survey has a significant impact on plans' Medicare Star Ratings, and our providers have the best opportunity to influence positive survey results for Medicare members who receive the survey. We also use survey data to evaluate how we can support our members through innovative benefits and programs that enhance their experience with us.

Improving health outcomes

It's important for providers to focus on meaningful and measurable conversations and interactions, especially for key HOS measures that affect the member's experience with providers and staff in the health care setting, such as:

- Improving bladder control
- Reducing the risk of falling
- Monitoring physical activity
- Improving or maintaining mental health
- Improving or maintaining physical health

Please have conversations around these topics during in-office or virtual visits when possible. For example, talking about physical activity can lead to discussing and then, helping to improve, all five of these measures because we know that through physical activity, patients can work on core exercises to:

- Help prevent falls
- Reduce symptoms of urinary incontinence
- Improve both physical and mental health

For help with workflows, best practices, screening tools and educational content to share with your patients to help support the provider-patient conversation, please see our Quality Improvement Toolkit, available on the homepage of our provider website.

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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