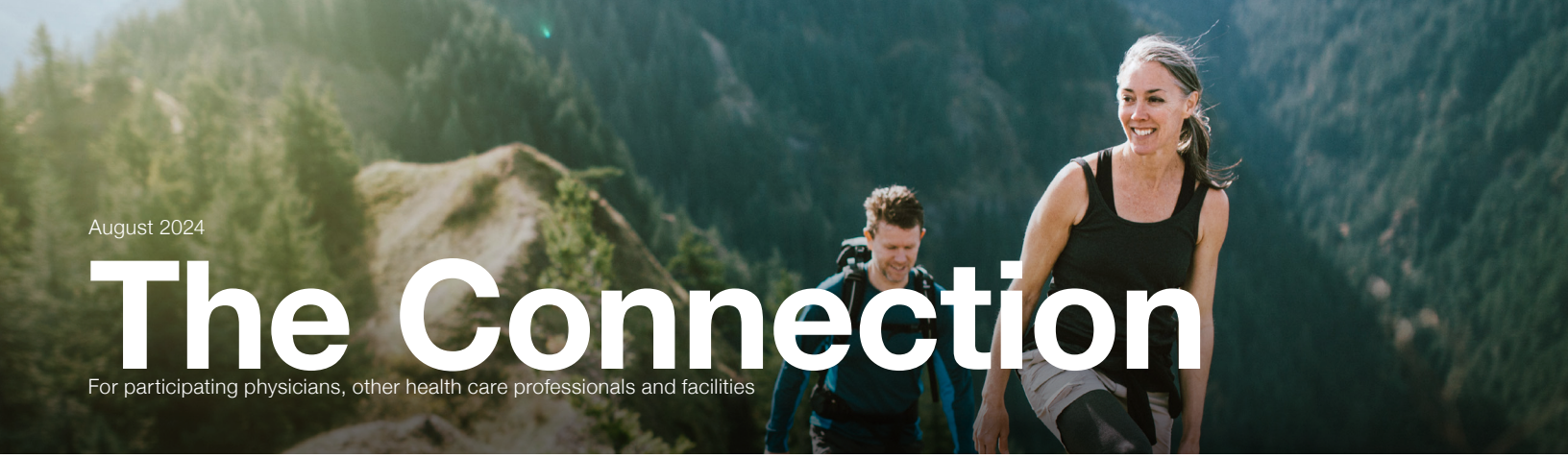

August 2024

# The Connection

For participating physicians, other health care professionals and facilities

## Help patients know where to go for care

There can be big differences between visits to a PCP, urgent care or the emergency department (ED), including cost, time spent waiting for care and whether or not follow up care is provided. We encourage you to talk to your patients about their care options before they need sudden medical care.

### Care options

**In-person care**

- Share your office hours with your patients, especially if you offer extended hours.
- If your patient does not have a PCP, encourage them to use the Find a Doctor tool on our website or call Customer Service at the phone number on the back of their member ID card for help finding an in-network provider.

**In-home care**

- With DispatchHealth, an in-network provider, members can receive urgent medical care in the comfort of their home to avoid a trip to an urgent care clinic or ED.
- They are available 7 days a week, including holidays, in the Spokane area.

**Nurse line**

- For questions about common health issues and whether they should see a provider, most members can contact Asuris Advice24.

**Continued on page 3**

### Alternative payment model (APM) providers

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

### Subscribe today

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

### Using our website

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

### Stay up to date

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

ASURIS NORTHWEST HEALTH

Asuris Northwest Health

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Spokane, WA 99202

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

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

Click on a title to read the article.



# About *The Connection*

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

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

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

### *The Bulletin*

We publish a monthly bulletin as a supplement to this bimonthly provider newsletter. *The Bulletin* provides you with updates to medical and reimbursement policies, including changes we are contractually required to communicate to you.

### Share your feedback

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

Continued from page 1

### Virtual care

- 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 provider directory information on our provider website: Contact Us>Update Your Information.
- Our members have access to in-network telehealth vendors and behavioral health providers.

### Urgent care

- Remind patients to consider urgent care clinics for illnesses and injuries beyond the scope of virtual care, such as migraine; abdominal pain; sprains, strains and cuts; and severe cold and flu symptoms. Many urgent care clinics are conveniently located and more accessible than EDs, allowing members to save time and money.

### ED care

- Educate patients about visiting the ED if they are experiencing acute or life-threatening symptoms, such as chest pain, shortness of breath, signs of a possible stroke, uncontrollable bleeding, severe burns, head injuries (especially loss of consciousness) or seizures.
- To help our members have a better understanding of their care options, our care advocates contact members who had three or more ED visits in a six-month period or who had one or more avoidable ED visits to provide information about alternative treatment options.

### Resources for providers and members

Our Care Options Toolkit, available on the homepage of our provider website, has information for providers about members' care options, including virtual medical and specialized behavioral health providers, our 24/7 nurse line, urgent care and more.

### Related:

- *DispatchHealth: In-home urgent medical care* on page 5
- *Appointment Accessibility Results* on page 7
- *Tools for PCPs* on page 17

## Are you?

✓ **Scheduling visits with your Medicare Advantage patients:** It's time to schedule annual wellness visits (AWVs) or preventive care visits (PCVs) with your Medicare Advantage patients. **Related**: See *MA QIP reminders and update* on page 24.

✓ **Helping your patients know where to go for care:** Help your patients save time and money, by reminding them about their care options before they need sudden medical care. **Related**: See *Help patients know where to go for care* on page 1 and *DispatchHealth: In-home urgent medical care* on page 5.

✓ **Educating your patients about the importance of routine immunizations:** Providers play a key role in educating patients and parents about the importance of vaccinations. Your recommendation can help protect your patients against serious diseases. **Related**: See *National Immunization Month* on page 19, *Childhood Immunizations* on page 20 and *Flu season is just around the corner* on page 21.

# Drive high-value care and control costs with PRIA

To further support our alternative payment model (APM) providers, we created Provider Reporting Insights & Analytics (PRIA), a new business intelligence and analytics platform to help improve your financial and quality performance. PRIA is part of a suite of services we offer providers on APM arrangements to ensure you meet or exceed your contractual and patient care goals.

## Access your data at your convenience

With interactive dashboards, self-service reporting and data available at summary, claims and patient levels, PRIA gives you access to your information at your convenience and at an unprecedented depth of detail:

- Easily navigate layers of population health information, from the organization to patient level
- Visualize and generate clinical insights
- Quickly identify care gaps and treatment opportunities that represent the greatest clinical and financial impact to your office
- Identify trends, download and share reports across your organization within minutes

## 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 your APM financial and quality performance.

## Created for you

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

## Support to help you succeed

We are dedicated to the success of our APM provider partners. PRIA users can expect:

- Training on the PRIA platform provided by our Provider Relations team
- Ongoing support and collaboration with our Asuris teams to help improve affordability and health outcomes of your patients
- Extensive user guides and resources on our provider website

## Provider comments about PRIA

*"We like that we can schedule reports to automatically generate each month. The scheduler feature ensures we'll routinely get the reports that are most important to us."*

*"PRIA will allow us to work collaboratively with our clinics. We can get together more often to review with other team members."*

*"I like all the information in PRIA, and that I can access it at any time."*

*"I like the look and ease of the navigation, and how I can drill-down into member and provider data. I like that I can export data in spreadsheets to share with providers or as a PowerPoint to present to leadership."*

*"PRIA is easy to navigate and intuitive. The gap list is very helpful and will be used quite often."*

## Onboarding

Several large provider groups have been trained and are currently exploring all that PRIA can do for their organizations. Our Provider Relations team is actively offering PRIA training and access 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.

# DispatchHealth: In-home urgent medical care

DispatchHealth, a provider of in-home urgent medical care for non-life-threatening medical needs, is part of our provider network for members living in select ZIP codes in Spokane.

DispatchHealth complements and extends your practice by delivering on-demand urgent medical care to high-acuity patients at home. Their credentialed medical professionals can treat 95% of the most common ED diagnoses.

What sets DispatchHealth apart:

- **Accessible**: DispatchHealth operates from 8 a.m. to 10 p.m. 365 days a year—weekends and holidays included.
- **Affordable**: DispatchHealth's services are in-network and a visit is often billed the same as a walk-in urgent care clinic.
- **Comprehensive**: DispatchHealth can treat a wide range of conditions, including UTIs, injuries, swelling, confusion, weakness, nausea, vomiting, diarrhea, rash, cellulitis, abscesses and more.
- **Seamless**: After the visit, DispatchHealth sends detailed notes to provider on record for continuity of care and directs patients back to you for follow-up if necessary. They also call in prescriptions and handle billing through the patient's insurance.

### In-home care for patients after discharge

DispatchHealth Bridge Care is a proactive, high-acuity medical intervention in a patient's home within 72 hours post-discharge from the hospital or skilled nursing facility.

Designed for moderate- to high-risk patients with a medical condition that warrants reevaluation after discharge, this service helps ensure a smooth transition from facility to home to optimize recovery; avoid readmission; and safely "bridge" patients back to their PCP or specialist.

### Get started today

- Use DispatchHealth's HIPAA-compliant online care request platform, DispatchExpress, to request a visit for your patient within minutes.
- If you are new to DispatchExpress, request an account.
- Already have an account? Log in.
  - You can also call DispatchHealth at (425) 651-2473. After submitting the visit request, DispatchHealth will contact your patient to finish scheduling their appointment.

Learn more in the Care Options Toolkit, available on the home page of our provider website.

# Changes coming to medical policies and forms

We have migrated our medical policies and online forms to a new platform. This migration brings design changes and increased security, as well as new features, to make using this content even easier.

The following content is now available on the same platform as the rest of our public websites:

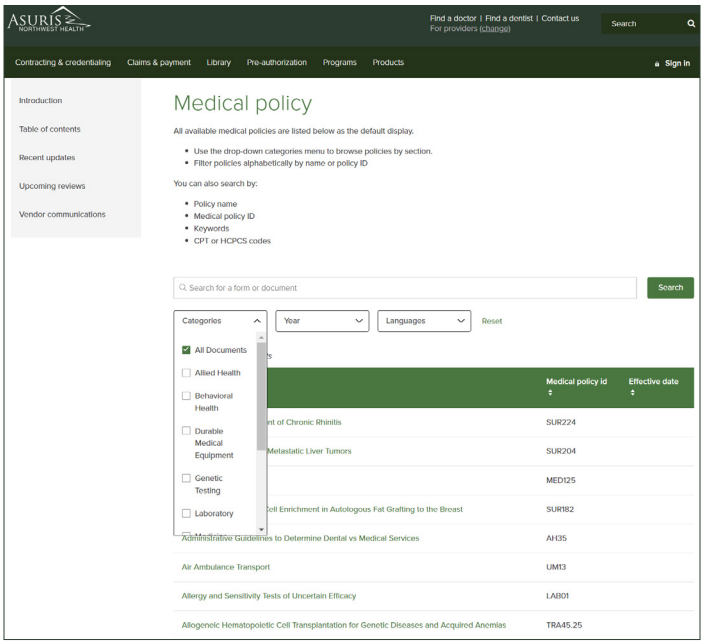
- Commercial medical policies
- Medicare Advantage medical policies
- Clinical Practice Guidelines
- Provider forms

With this migration you'll find:

- Design of this content will be consistent with the rest of our provider website
- New search functionality will allow medical policies to be searched by line of business, CPT or HCPCS code or keywords
- All medical policies will display on the same page and can be browsed by category or section—reducing the number of clicks needed to find the appropriate policy
- New forms functionality will allow conditional display of content, formatted fields and calendar date pickers

### Test drive soon

We invite you to visit the new-look for medical policies soon. Look for announcements and links to visit the new content on the homepage of our provider website. In late-August, we will update our links to automatically send you to the new content.



# 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, providing best-in-class insights, tools and techniques to improve patient experience. Attendees can earn 1.0-hour of continuing education (CE) credit.

### 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 August 2, 2024, at noon (PT)

REGISTER

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

# Reminder: Supporting our military communities with TriWest

TriWest Healthcare Alliance (TriWest) was awarded a contract to administer the U.S. Department of Defense's (DoD's) next generation TRICARE program—a uniformed services health care program for active-duty service members, their families and retirees, known as T-5—for its 26-state West Region territory. As part of our partnership with TriWest, Asuris:

- Is creating and maintaining provider networks in Washington to support both TriWest's Community Care Network (CCN) and the TRICARE T-5 programs
- Provides credentialing and contracting for both the CCN and TRICARE provider networks in our service area
- Will add our providers to the TRICARE networks beginning January 1, 2025

### Contracting for TRICARE networks

Providers on standard agreements have been emailed contracts or amendments to add them to the TRICARE provider networks.

- **If you are already a participating CCN provider**, no action is needed. You should automatically be sent an amendment to be included in the networks.
- **If you are not currently a participating CCN provider**, you will need to electronically sign the agreement via DocuSign to be added to the T-5 program.
  - **Note**: Reviewing and signing your agreements now ensures you are ready to serve these members beginning January 1, 2025. We encourage you to sign these as soon as possible.

### Learn more

To learn more about TRICARE provider networks, you can:

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

# Appointment accessibility results

This past winter, we conducted our annual Provider Access Survey related to patient appointment access for:

- PCPs
- Behavioral health providers
- Providers in high-volume and high-impact specialties

Your answers helped us measure compliance with our published standards for after-hours phone coverage and appointment wait times.

Our findings include:

- **Primary care**: We found that members' access to primary care appointments met our standards, with some delays for urgent appointments and for non-urgent appointments for persistent symptoms.
- **Behavioral health care**: Timely access to routine behavioral health care for established patients met our standards. Access for non-life-threatening crisis behavioral health and routine behavioral health care for new patients fell a little short of our standards.
- **Specialty care**: Timely access to specialty non-urgent care met our standards. Access for specialty urgent care fell a little short of our standards.

We recognize and appreciate your efforts to deliver timely care for our members despite ongoing challenges. After the survey, Provider Relations contacted a sample of providers to learn more about the challenges you are facing in meeting access standards. Your open and honest responses have helped us better understand the challenges you and our members face when it comes to timely access to care.

During our discussions with providers, common themes emerged:

- Many clinics are facing staffing shortages and are struggling to hire in a highly competitive environment, particularly when recruiting in rural locations.
- Some offices experience challenges accommodating member preferences of provider and time of service availability.
- Some offices remain inundated even after this long post-COVID-19 pandemic.
- Despite these obstacles, offices try to schedule patients as quickly as possible or help them find care elsewhere if they cannot be seen in the office as soon as needed.

**Related**: See *Help your patients know where to go for care* on page 1 and *DispatchHealth: In-home urgent medical care* on page 5.

## Access to specialty care

The survey showed us that scheduling patients for urgent specialty care appointments within 24 hours remains difficult, while patient access to non-urgent appointments within 30 calendar days improved following the scheduling difficulties of the last few years.

From our outreach, we learned that the urgent appointment requirement in rural locations is still a challenge due to lack of practitioner's availability for many specialties. However, many providers have processes in place to triage members and help them get the right care at the right time, which may or may not be within 24 hours. We ask that you remain mindful of the urgent care requirement to ensure patients can get timely care when needed.

## Access to behavioral health care

The survey data shows us that scheduling patients for behavioral health care continues to be difficult, particularly to see a new patient within 10 business days. We recognize the huge demand for behavioral health care services, and from our outreach, we learned of ways that you are working hard to meet this growing need: Offering extended hours, adding and recommending virtual visit opportunities are helping members receive behavioral health care as quickly as possible.

We appreciate your commitment to meeting our members' behavioral health needs and working to provide them access to care. We recognize the need for additional behavioral health providers and are actively recruiting providers to increase accessibility.

Please be mindful of the access requirements for behavioral health care:

- Non-life-threatening emergency (crisis) will be treated within six hours or directed to the nearest emergency room, crisis line or crisis unit.
- Urgent care appointments will be scheduled within 48 hours or directed to the nearest emergency room, crisis line or crisis unit.
- Routine office visits will be scheduled within 10 business days.

Our standards are published on our provider website: Programs>Quality>Quality Program> Accessibility & Availability Standards.

# Reminder: DME billing during an admission

During an admission, durable medical equipment (DME) is only payable if billed on the admission date or within 48 hours of discharge.

| Payable DME periods during admission | Payable | Not payable |
|---|---|---|
| On admission date | ✓ | |
| Within 48 hours of discharge | ✓ | |
| After admission date but more than 48 hours prior to discharge | | ✓ |

### Learn more

We apply the following CMS policies to billing DME during admission:

- Section 110.3 of Chapter 20 of the Medicare Claims Processing Manual describes scenarios for pre-discharge DME delivery.
- The Medicare DMEPOS Payments While Inpatient MLN Fact Sheet addresses DME billing during admission, including prior to discharge.

# Submit pre-authorization appeals in Availity

Availity's Appeals application has been expanded to include medical pre-authorization determinations. The application streamlines the appeals process, making it faster and easier to submit appeals directly from Availity Essentials.

A medical pre-authorization determination appeal can be submitted with required documentation directly from the Authorization dashboard, allowing you to receive immediate confirmation of submission and the ability to check the status of their appeal—all in one place.

Any pre-authorization on the Authorization dashboard can be appealed using the new appeals function. This can be through submitting a pre-authorization request using the Authorization application on Availity Essentials, or by submitting an inquiry and pinning the authorization to the Authorization dashboard.

The Authorization/Referral dashboard shows the status of submitted appeals. Access it from Availity Essentials: Patient Registration>Authorization & Referrals>Authorization/Referral Dashboard.

### Get trained for free

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

# Update your directory information

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

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

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

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

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

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

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

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

# Pre-authorization updates

## Commercial

| Procedure/medical policy | Added codes effective July 1, 2024 |
|---|---|
| Anterior Abdominal Wall (Including Incisional) Hernia Repair (formerly Ventral [Including Incisional] Hernia Repair) (Surgery #12.03) | Diagnosis code K42.9 |
| Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83) | 0473U |
| Invasive Prenatal Fetal Diagnostic Testing for Chromosomal Abnormalities (Genetic Testing #78) | 0469U |
| KRAS, NRAS, and BRAF Variant Analysis and MicroRNA Expression Testing for Colorectal Cancer (Genetic Testing #13) | 0471U |
| **Procedure/medical policy** | **Added codes effective August 1, 2024** |
| Transcatheter Heart Valve Procedures for Mitral or Tricuspid Valve Disorders excluding Transcatheter Edge-to-Edge Repair (TEER) (Surgery #221) | 0483T, 0484T |
| **Procedure/medical policy** | **Adding codes effective September 1, 2024** |
| Applied Behavior Analysis for the Treatment of Autism Spectrum Disorders (Behavioral Health #18) | 0362T, 0373T, 97151-97158 |
| **Procedure/medical policy** | **Adding codes effective November 1, 2024** |
| Cardiology | 36901-36909, 37241-37244, 93580, 93600, 93602, 93603, 93610, 93612, 93618-93620, 93624, 93642, 93644, 0823T, 0825T C7513-C7515, C7530 |

## Medicare Advantage

| Procedure/medical policy | Added codes effective July 1, 2024 |
|---|---|
| Biochemical and Cellular Markers of Alzheimer's Disease (Laboratory #22) | 0459U |
| Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170) | Q4311-Q4333 |
| Coronary Intravascular Lithotripsy (Surgery #233) | 92972, C1761 |
| Electrical Stimulation and Electromagnetic Therapy Devices (Durable Medical Equipment #83) | 0082T, 0083T |
| Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64) | 0455U-0457U |
| Genetic and Molecular Diagnostics – Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83) | 0020M, 0450U, 0451U, 0467U, 0470U, 0471U, 0473U |
| Genetic and Molecular Diagnostics - Testing for Inherited Cancer Risk (Genetic Testing #02) | 0474U, 0475U |

**Continued on page 11**

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| Medicare Advantage Procedure/medical policy (continued) | Added codes effective July 1, 2024 |
|---|---|
| Investigational (Experimental) Services, New and Emerging Medical Technologies and Procedures, and Other Non-Covered Services (Medicine #149) | 0888T, 0893T, 0897T, 0898T |
| Leadless Pacemakers (Surgery #217) | C1605 |
| Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders (Medicine #148) | 0889T-0892T |
| Transurethral Water Vapor Thermal Therapy and Transurethral Water Jet Ablation (Aquablation) of the Prostate (Surgery #210) | 0867T |
| **Procedure/medical policy** | **Added codes effective August 1, 2024** |
| Cosmetic and Reconstructive Procedures (Surgery #12) | 67950 |
| Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Uncontrolled Hypertension (Surgery #235) | 0338T, 0339T |
| **Procedure/medical policy** | **Adding codes effective November 1, 2024** |
| Cardiology | 36901-36909, 37241-37244, 93580, 93600, 93602, 93603, 93610, 93612, 93618-93620, 93624, 93642, 93644, 0823T, 0825T C7513-C7515, C7530 |

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.

# Cardiology program to include additional services

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

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

### About the program

Carelon administers the program, which reviews outpatient cardiovascular tests, procedures and implantable cardiac devices. **Note**: Procedures performed in an inpatient setting or on an emergent basis are not subject to this program's pre-authorization requirements.

Providers will be able to contact Carelon to request pre-authorization for these additional services in October 2024. Read the October 2024 issue of this newsletter for more details.

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

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

### Learn more

- Program details are available on our provider website: Programs>Medical Management>Cardiology.
- **Related**: See *Pre-authorization updates* for a complete list of affected codes on pages 10-11.

# *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 June 2024 issue of *The Bulletin* about changes to the following medical policies, which are effective September 1, 2024:

- *Charged Particle (Proton) Radiotherapy* (Medicine #49)
- *Screening for Vertebral Fracture or Fracture Risk with Dual X-ray Absorptiometry (DXA)* (Radiology #48)
- *Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders* (Medicine #148)

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

- *Anterior Abdominal Wall (Including Incisional) Hernia Repair* (Surgery #12.03)
- *Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products* (Medicine #170)

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

**Related**: See *Changes coming to medical policies and forms* on page 5.

### Reimbursement policy updates

We provided 90-day notice in the June 2024 issue of *The Bulletin* about changes to the following reimbursement policies:

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

**Updates to these policies have been postponed.**
**Related**: See *Modifier 25 and Global Days reimbursement policy updates* on page 13.

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

# Modifier 25 and Global Days reimbursement policy updates

We are postponing updates to the *Modifier 25; Significant, Separately Identifiable Service* (Modifier #103) and *Global Days* (Administrative #101) reimbursement policies.

We had previously announced in the June 2024 issues of *The Bulletin* and *The Connection* that we would update these policies effective September 1, 2024.

Look for more information in the October 2024 issues of our bulletin and newsletter.

View the current policies in our *Reimbursement Policy Manual*, available on our provider website: Policies & Guidelines>Reimbursement Policy.

# Updates to secondary editor modifier reviews

We implemented a secondary claims editor program in 2021 to ensure consistent application of our policies and billing standards.

We are providing courtesy notice that we will regularly enhance our secondary editor to capture quarterly and mid-year coding rule changes and to enforce current medical and reimbursement policies. If we identify an overpayment, the secondary editor will apply a change prepayment with a detailed explanation that can be reviewed on the remittance advice.

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

### Effective for claims received on or after September 6, 2024

Our secondary editor will start applying denials when:

- Modifiers RT or LT are incorrectly reported with a contradictory right or left diagnosis
- Modifiers 76 or 77 are incorrectly reported

These changes are supported by our *Correct Coding Guidelines* (Administrative #129) reimbursement policy.

### Effective for services provided on or after November 1, 2024

Claims for anesthesia services must include a role modifier (i.e., AA, AD, QK, QX, QY or QZ). Our secondary editor will start applying denials when appropriate role modifiers are not included on these claims.

This change is supported by revisions to our *Anesthesia Reimbursement & Services Reporting* (Anesthesia #102) commercial and Medicare Advantage reimbursement policies, which we announced in the August 2024 issue of *The Bulletin*.

## eviCore updating pain and joint guidelines

Effective November 1, 2024, eviCore healthcare (eviCore) will revise the following interventional pain and joint surgery clinical guidelines:

### Interventional pain

- Ablations/Denervations of Facet Joints and Peripheral Nerves
- Anesthesia Services for Interventional Pain Procedures
- Discography
- Epidural Steroid Injections
- Facet Joint Injections/Medial Branch Blocks
- Greater Occipital Nerve Blocks
- Implantable Intrathecal Drug Delivery Systems
- Sacroiliac Joint Procedures

### Joint surgery

- Knee Replacement/Arthroplasty
- Knee Surgery–Arthroscopic and Open Procedures
- Lumbar Decompression
- Lumbar Microdiscectomy

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

## Carelon revising defibrillator guidelines

Effective November 17, 2024, Carelon Medical Benefits Management (Carelon) will implement revised Implantable Cardioverter Defibrillators clinical guidelines.

View the revised guidelines on Carelon's website.

## Clinical Practice Guideline reviews

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

We renewed the following Clinical Practice Guidelines, effective July 1, 2024, with no changes to the guidelines' recommendations:

- Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: We continue to recommend the Veterans Affairs and Department of Defense (VA/DoD) guidelines.
- Management of Chronic Noncancer Pain with Opioids in Adults: We continue to recommend the Substance Abuse and Mental Health Services Administration (SAMHSA) TIPS publication.
- Preventive Services Guideline for Adults: We continue to recommend the U.S. Preventive Services Taskforce (USPSTF) screening recommendations.
- Screening and Management of Substance Use Disorders in Adults: We continue to recommend the VA/DoD guidelines.

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

# Medication policy updates

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

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

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

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

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

| Effective October 1, 2024 | Description |
|---|---|
| **New policy** | |
| Imcivree, setmelanotide, dru788 | - Will limit coverage to patients with obesity due to POMC, PCSK1 or LEPR deficiency confirmed by genetic testing or Bardet-Biedl syndrome (BBS) |

| Effective November 1, 2024 | Description |
|---|---|
| **Revised policies** | |
| Complement Inhibitors, dru385 | - Adding two recently FDA-approved drugs for paroxysmal nocturnal hemoglobinuria (PNH) to policy: Fabhalta (iptacopan) and Voydeya (danicopan)<br>- For Empaveli, removing step therapy requirement through Ultomiris in treatment-naive PNH to align with standard of care<br>- High-dose Soliris (doses above 900mg every 12 days) will be considered not medically necessary, and therefore not covered for PNH due to several available options for breakthrough PNH |
| Synagis, palivizumab, Respiratory syncytial virus (RSV) immune prophylaxis, dru029 | - In alignment with Academy of Pediatrics (AAP) Red Book and CDC recommendations, coverage of Synagis will require documentation that Beyfortus (nirsevimab-alip) is contraindicated unless prior therapy was not tolerated or Beyfortus is unavailable due to manufacturer shortage |

# Asuris EquaPathRx™ updates

As a reminder, the Provider-Administered Specialty Drugs benefit is in effect as plans renew throughout 2024 for fully insured group and Individual plan members. To ensure a smooth transition, we are targeting a January 1, 2025, benefit administration transition to the IntegratedRx - Medical network.

## Before the transition date

From now through December 31, 2024, all Asuris network providers are considered designated providers in the Prime IntegratedRx - Medical Network under the Provider-Administered Specialty Drugs benefit and are eligible to provide medications included in the Asuris EquaPathRx program (subject to otherwise applicable conditions) to members with this benefit. **This means members can continue to receive medications from you as they do today, and claims for medications included in this program will be processed based on the terms of your existing agreement.**

**Note**: 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. We'll notify you in advance of any additions or changes to the medications included in the program through this newsletter.

## On or after the transition date

Beginning January 1, 2025, 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 applicable to your participation in the IntegratedRx – Medical Network. 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.
- If you are not designated as a participating IntegratedRx - Medical Network provider, 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 September 1, 2024, we'll work closely with you and our members to ensure they have uninterrupted access to their treatment on and after the implementation date.

## Specialty pharmacy options for nonparticipating providers

If you are not a designated provider in the IntegratedRx - Medical network on or after January 1, 2025, you can continue to provide medications included in the Provider-Administered Specialty Drugs benefit to your patients when you use Accredo Specialty Pharmacy, a participating specialty pharmacy.

The pharmacy will work with you and Asuris to ensure the medication is pre-authorized before distributing it to your office for administration.

## Prime Therapeutics contracting and credentialing

**If you haven't already, please reach out to your Prime contact now to complete the process of credentialing and contracting for the IntegratedRx - Medical Network.** Your Prime contact will help you complete the process. If you don't have a Prime contact established, please email Prime Provider Relations.

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

# Behavioral health corner

## About behavioral health corner

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



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

## Reminder: Upcoming ABA changes

The following changes to applied behavioral analysis (ABA) services are effective September 1, 2024.

### Pre-authorization for members younger than 18

We will require pre-authorization for services provided to commercial and Medicare Advantage members younger than 18. ABA services for members 18 and older currently require pre-authorization for these lines of business.

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

### Reimbursement rates

We are increasing reimbursement rates for all ABA services provided to our commercial members (group and Individual products).

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

## Tools for PCPs

We recognize that PCPs serve a vital role in discussing, diagnosing and treating behavioral health conditions.

Our Behavioral Health Toolkit, available on the homepage of our provider website, includes condition-specific screening tools and trusted resources for 12 diagnoses or challenges, as well as information about:

- In-network virtual care providers
  - Virtual providers can improve access to care, don't require a referral, and are available to treat many specialty areas.
- No-cost psychiatric consultations
- Ongoing condition management
- Our care management services, including case management
- Determining the best path forward in the early stages of a patient's evaluation and treatment

**Related**: See *Screening for behavioral health conditions in primary care* on page 18.

Additionally, PCPs are often uniquely suited to discussing members' social risk factors and social needs. Tracking members' social determinants of health (SDoH) helps us understand barriers to care and support equitable access to quality health care and health education. **Related**: See *Social determinants of health resources* on page 23.

# Behavioral health corner

## Screening for behavioral health conditions in primary care

**Reminder**: We reimburse PCPs for behavioral health screening and encourage them to screen patients for behavioral health conditions.

Because some patients may not schedule routine wellness exams, we recommend that PCPs also include behavioral health screening during non-preventive encounters. View the USPSTF recommendations regarding screening for anxiety, depression and suicide risk in children, adolescents and adults.

We have expanded our network of behavioral health providers to treat members with positive screening results, and we continue to broaden the number of network providers, resources and treatment options available to our members.

Our networks include specialized virtual behavioral health providers with diverse areas of focus to treat a variety of age ranges, from age 6 through adulthood, including:

- Eating disorders
- Substance use disorders (SUD)
- Comprehensive therapy programs
- Obsessive compulsive disorder (OCD)

Find out more about these virtual providers, including contact information, in the Resources section of the Behavioral Health Toolkit, available on the homepage of our provider website. **Related**: See *Tools for PCPs* on page 17.

To find in-network behavioral health providers, members should call Customer Service at the number on their member ID card or use the Find a Doctor tool on our member website, asuris.com.

## Improving care for patients treated with antipsychotics

We continue to monitor the following Healthcare Effectiveness Data and Information Set (HEDIS®) measures evaluating the care of children, adolescents and adults who are prescribed antipsychotics. Results for each of these measures remain below national benchmarks:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics assesses annual glucose and cholesterol testing for children and adolescents on antipsychotics
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications assesses annual diabetes screening for people with schizophrenia or bipolar disorder taking antipsychotic medications
- Diabetes Monitoring for People with Diabetes and Schizophrenia assesses annual glucose and cholesterol monitoring for people with diabetes and schizophrenia

Collaborating with primary care and behavioral health providers attending our Provider Advisory Council (PAC), we work to identify actions that can improve patient care. Providers acknowledged that metabolic testing and monitoring recommended for patients taking antipsychotics can require additional coordination between primary care and psychiatry. The PAC developed these suggestions to improve the safety of care for patients treated with antipsychotics.

### Best-practice suggestions for PCPs

- Ensure you are aware of antipsychotic prescriptions by encouraging patients to bring all medications to their scheduled wellness appointments.
- When children, adolescents or adults are taking antipsychotics, ensure recommended annual HbA1c and cholesterol tests are ordered.

### Best-practice suggestions for psychiatrists

- When prescribing antipsychotics, communicate with the PCP to confirm roles in ordering tests, reviewing results, following up and managing the patient's health based on lab results.
- Establish a process for ordering labs if you are practicing telehealth exclusively.
- Coordinate care with your patients' PCPs to co-monitor and co-manage abnormalities associated with prescribed psychiatric medications.

# New *Quality Measures Guide* coming soon

**Editor's note (8/29/24)**: Updated the date for when the guide will be available to September 13, 2024

We are updating our *Quality Measures Guide* for 2024. The guide includes information about a variety of quality and member experience measures that are reported or monitored most frequently for the following programs and initiatives:

- HEDIS medical record reviews
- Medicare Advantage Quality Incentive Program (MA QIP)
- Value-based agreements (VBAs)

**Note**: The guide does not include information about all HEDIS or Star-related measures.

You can view the guide on our provider website: Library>Printed Material on September 13, 2024.

# National immunization month

National Immunization Awareness Month (NIAM) is observed each August to highlight the importance of routine vaccination for people of all ages.

Providers play a key role in educating patients and parents about the importance of vaccination. Your recommendation can help protect your patients against serious diseases, such as whooping cough, influenza, COVID-19, HPV, meningitis and shingles.

According to the National Vaccine Advisory Council disparities in immunization rates exist for many underserved and underrepresented populations, including racial or ethnic minorities, rural communities, people with disabilities, and the LGBTQIA+ community. Addressing immunization disparities is an opportunity to improve health outcomes for individuals and increase protection in the overall health of our communities. To learn more, visit the Partnering for Vaccine Equity Resource Hub.

We appreciate your continued efforts to ensure your patients receive necessary vaccinations. Ensuring patients are up to date on all vaccines and other preventive care can protect them and help them maintain good health. This is important because many people, especially children, are often behind on regular vaccinations.

## Resources

**Preventive care lists**: Most of our health plans cover preventive care services at 100%. View our lists:

- Commercial members (available in English and Spanish)
- Medicare members

**Healthwise's Knowledgebase**: This resource has helpful immunization information and tools. Our Quality Improvement Toolkit has a link to the Healthwise Knowledgebase, where you can search for materials in English and Spanish to share with your patients:

- Immunizations
- Vaccinations
- Or search for specific vaccines (e.g., coronavirus, hepatitis B)

**CDC**: Visit the CDC's NIAM website for resources to help you discuss routine vaccinations with your patients and parents during NIAM and throughout the year.

**Related**: See *Flu season is just around the corner* on page 21 and *Childhood immunizations* on page 20.

# Childhood immunizations

On-time vaccination throughout childhood helps provide immunity before children are exposed to potentially life-threatening diseases. Childhood immunization rates for our health plan currently fall below the national average.

The CDC has observed disparities in childhood immunization rates for racial and ethnic minorities, children living in rural communities, and low-income families. Addressing immunization disparities is an opportunity to improve health outcomes for individuals and increase protection in the overall health of our communities. To learn more, visit the Partnering for Vaccine Equity Resource Hub.

As a PCP, you are a trusted resource and educator to parents and caregivers about the importance of routine checkups and recommended vaccination schedule. Scheduling office visits in advance can help parents and caregivers ensure their child stays on track.

Vaccine schedules recommended by agencies and organizations, such as the CDC, the American Academy of Pediatrics and the American Academy of Family Physicians, include different vaccine types, frequencies, intervals and considerations for special situations.

Sometimes, parents and guardians are concerned about the safety of vaccines. View the CDC's resources to help you and your staff prepare for conversations around vaccine hesitancy.

- Encourage routine vaccinations
- Vaccinate with confidence
- Prepare for questions parents may ask about vaccines

Here are some tips for talking to parents who are hesitant to vaccinate their children:

- Tailor your message
- Counter any misinformation
- Ask why the parent is hesitant
- Understand the parent's concerns
- Address the parent's fears about side effects
- Prepare your staff to answer questions

### Resources

Healthwise's Knowledgebase has helpful information and tools about immunizations and vaccinations to share with your patients. Our Quality Improvement Toolkit has a link to the Healthwise Knowledgebase. Search Healthwise's Knowledgebase for materials in English and Spanish:

- *Childhood Immunization Schedule: Ages 0 to 6 Years*
- *Childhood Immunization Schedule: Ages 7 to 18 Years*
- *Why Get Your Child Immunized?* video

# Flu season is just around the corner

The CDC estimates there were at least 31 million flu illnesses, 14 million medical visits, 360,000 hospitalizations and 21,000 deaths from flu during the 2022-2023 flu season. It's difficult to know what the 2024-2025 flu season will bring, so prevention is the best protection.

The CDC recommends that everyone six months and older (with rare exceptions) be vaccinated every flu season to reduce flu illness and serious outcomes. The flu vaccine is especially important for those considered high-risk, including older adults because they are at a higher risk of getting seriously ill from influenza and serious cases of flu can lead to hospitalization or death.

Tips to consider as we approach flu season:

- Educate support staff about the importance of the flu vaccine.
- Update your standing orders and protocols for the 2024-2025 flu season.
- If you don't currently have standing orders and protocols for vaccines, consider creating them.
- Make resources about the flu vaccine available to patients to encourage informed decision-making.
- If vaccines are not included in your pre-visit planning, consider adding vaccines to your pre-visit workflow.
- With pre-visit planning, consider adding the word "flu" to the appointment note for patients who are due for their vaccine. This will help remind the care team that a patient needs their vaccine when they come in for their appointment.
- Consider hosting flu clinics or outreach campaigns to schedule patients for a vaccination appointment with a nurse or medical assistant.

### Patient resources

Educational flyers about the importance of the flu vaccine are available in English and Spanish. You can use these to reinforce the conversation with your patient or make them available for review in the waiting room before an appointment. Look for the **Influenza immunization** category in the Quality Improvement Toolkit, available in the Toolkits section on the homepage of our provider website.

# Fall prevention: How you can help

It's estimated that 25% of people ages 65 and older will experience a fall this year. Fewer than half of the people who experience a fall speak to their provider about it.

The Fall Risk Management Medicare Star Ratings measure is important for providers to understand because it is included in the Health Outcomes Survey (HOS). Our score for this measure is based on memorable and impactful conversations you have with your patients regarding falls.

The discussions you have with our members can help them prevent falls and fall-related injuries. You may want to:

- Conduct regular fall-risk screenings (screening annually or biannually) either during or outside of the AWV.
- Implement prompts within your electronic medical record (EMR) to alert providers and staff that a patient is due for a conversation regarding falls and fall prevention.
- Implement the CDC Stopping Elderly Accidents, Deaths & Injuries (STEADI) algorithm within your EMR.
- Consider implementing group visits focused on fall prevention (e.g., Matter of Balance-coached events).
- Know and refer patients to community resources focused on preventing falls (e.g., fall prevention classes, tai chi, Matter of Balance).
- Encourage regular physical activity, focusing on strengthening the core muscles.
- Regularly review and discuss medications with patients; some medications can cause issues with balance.
- Remind Medicare Advantage patients that they may have extra benefits available, such as bathroom safety device coverage (available on some plans) and the Silver & Fit fitness program.

### Patient resources

Educational flyers about the importance of fall prevention are available in English and Spanish. You can use these to reinforce the conversation with your patient or make them available for review in the waiting room before an appointment. Look for the **Fall risk coaching** category in the Quality Improvement Toolkit, available in the Toolkits section on the homepage of our provider website.

# Osteoporosis management in women who had a fracture

The Osteoporosis Management in Women Who had a Fracture (OMW) HEDIS and Star measure assesses the percentage of Medicare Advantage women ages 67 to 85 who have suffered a bone fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after their fracture. Multiple organizations recommend that postmenopausal women who experience a fragility fracture be tested or treated for osteoporosis, including the National Osteoporosis Foundation and the U.S. Department of Health and Human Services (HHS).

We consider bone mass measurements performed by in-network providers as preventive services covered at no cost to the patient as a qualified individual, every 24 months or more frequently if medically necessary.

If your patient is interested in receiving a BMD test at home, have them call us at 1 (800) 541-8981 to see if this service is available through our partners. Test results are shared with both you and your patient.

Some points to remember:

- If a BMD test was completed more than two years prior to the fracture, it is time to for the patient to get a new one.
- Consider ordering a BMD test for all women 65 and older, as recommended by the Bone Health and Osteoporosis Foundation.
- Always check that fracture codes are not used before a fracture has been confirmed through imaging. Submit a corrected claim to fix fracture codes submitted in error to ensure the patient is removed from the measure.
- If your patient has frailty and advanced illness, please submit the diagnosis codes in a medical claim to remove your patient from the measure. Our *Quality Measures Guide* includes additional details. You can view the guide on our provider website: Library>Printed Material.

If your patient has had a fracture, order a BMD test or prescribe osteoporosis treatment within six months for better bone health and long-term fracture prevention.

# Discussing urinary incontinence with members

Urinary incontinence can dramatically impact a person's quality of life. It can cause people to avoid activities (e.g., exercise), limit social outings, increase their risk of falls, affect their mental health and disrupt their sleep.

Discussing urinary incontinence can be uncomfortable; however, the more often these conversations happen with patients, the easier they become. With repetition, providers and patients can become comfortable discussing the topic.

There are many reasons to include urinary incontinence among the list of topics discussed at primary care visits.

- Many patients may see urinary incontinence as a sign of aging and just accept it as a part of life.
- Patients may hint at having issues with urinary incontinence and may want to have a conversation about it.
- Patients may be waiting for their provider to bring up the subject because they are embarrassed and do not want to bring it up on their own.
- Your patient may plan to discuss the topic when scheduling their appointment, but then forget about it as the visit takes place.

Many providers screen for urinary incontinence issues as part of the patient completing an annual health risk assessment for their annual wellness visit. You may also consider discussing issues about urinary incontinence during conversations about fall risk and physical activity because building core strength can help reduce the risk of falling, as well as address incontinence, especially if Kegel exercises are discussed. **Related**: See *Fall prevention: How you can help* on page 21.

Improving Bladder Control is a Medicare Star Ratings measure and a health issue that we closely monitor. This is also an area where we rely on our provider partners to help us improve our scores.

### Patient resources

Educational flyers about the importance of managing urinary incontinence are available in English and Spanish. You can use these to reinforce the conversation with your patient or make them available for review in the waiting room before an appointment. Look for the **Incontinence management** category in the Quality Improvement Toolkit, available in the Toolkits section on the homepage of our provider website.

## Improving health care for all

We believe that everyone should have access to affordable, quality care. That's why we're partnering with providers to address health disparities and advance health equity.

We recently updated the Health Equity Toolkit on our provider website. This toolkit includes resources to help you learn more about health disparities and to develop and improve your cultural competency and health literacy best practices as you and your staff provide care for our members.

### What's inside?

- Explore tools, trainings, continuing medical education (CME) courses and other resources to help you and your practice develop the mindset and core capabilities to advance health equity.
- Find resources to support underserved and underrepresented groups that experience health disparities.
- Learn about accreditation or distinction programs that can help your organization develop foundational health equity capabilities and earn recognition in the industry.

## Social determinants of health resources

Non-clinical factors can significantly impact the health and wellbeing of your patients. The majority of health outcomes (80%) are driven by the conditions in places where people live, work and play. Known as social determinants of health (SDoH), these powerful factors include housing stability, food security and transportation access, among others.

Connect your patients to:

- **Community resources**: Individuals can find support to address social needs, such as food insecurity, housing instability, transportation access and more by visiting 211.org or findhelp.org.
- **Asuris Customer Service**: Members can call the number on the back of their member ID card for help with SDoH resources, finding a PCP, understanding their benefits and more.

We encourage you to include SDoH Z codes in your patients' medical records. Including these codes will help us identify opportunities to provide support to our members, such as transportation or in-home care, as well as connections to food banks and other community resources.

View our *Social Determinants of Health Z Codes* flyer, which includes a list of the codes that measure social risk factors and social needs, on our provider website: Library>Printed Material.

# MA QIP reminders and update

The following important reminders about the 2024 Medicare Advantage Quality Incentive Program (MA QIP) will help you with gap closure.

## Opt-in for 2024 QIP

As a reminder, our 2024 program requires you to opt-in. To do this, you must sign in to the CGMA by October 1, 2024, and indicate that you wish to participate in the 2024 program.

## Attribution lock coming October 1

Your MA QIP member roster locks after our last attribution load in CGMA on October 1, 2024. We encourage you to prepare by reviewing your member roster on the CGMA.

- If there is a recycling bin icon next to a member's name on the member roster, you can remove the member from your roster if they are not one of your patients.
- If there is a lock icon, the member cannot be removed because of program rules that may include contractual obligations.

Learn about attribution adjustment options by member type on our provider website: Programs>Medicare Advantage QIP.

## Change to hemoglobin measure

For the Hemoglobin A1c Control for Patients with Diabetes (HBD) measure, we are now accepting submission of glucose management indicator (GMI) data as allowed in the HEDIS measurement year (MY) 2024 specifications for Glycemic Status Assessment for Patients with Diabetes (GSD).

**New denominator/eligible population**:

- For claims or encounter data the member needs to have **at least two diagnoses** of diabetes on different dates of service during the measurement year or the year prior.
- For pharmacy data the member needs to be dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year **and** have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.
- The required exclusion for members who did not have a diagnosis of diabetes is removed.

**Medical record documentation**:

- At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result.
- GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The end date in the range should be used to assign assessment date.
- If multiple glycemic status assessments were recorded for a single date, use the lowest result.
- GMI results collected by the member and documented in the member's medical record are eligible for use in reporting. There is no requirement that there be evidence the GMI was collected by a PCP or specialist.

**New numerator codes**:

Include the appropriate CPT or LOINC code along with the CPTII code that correlates to the patient's results.

- **HbA1c blood test**: CPT 83036 or 83037
- **GMI**: LOINC 97506-0
- **CPT II** (do not include modifiers):
  - HbA1c Level <7.0%: 3044F
  - HbA1c Level ≥7.0-<8.0%: 3051F
  - HbA1c Level ≥8.0-≤9.0%: 3052F
  - HbA1c Level >9.0%: 3046F

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## Preventive care visits

We encourage you to see every member every year for an AWV or PCV. PCVs and AWVs are the perfect visits at which to address your patient's MA QIP care gaps, as well as documenting the status of their chronic conditions. Conducting these visits increases gap closure rates for many measures at the same time.

**Reminders**:

- Codes that close the PCV gap:
  - CPT 99381-99387
  - CPT 99391-99397
  - HCPCS G0402
  - HCPCS G0438
  - HCPCS G0439
- The PCV gap can only be closed via claims submission.
- 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.
- Most 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.
- We will give credit for PCV visits 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.

## 2023 program year

If you participated in our 2023 MA QIP, your payout checks were mailed. If you did not receive your payout or have questions, email QIPQuestions.

## Resources for you

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


## Publications team

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