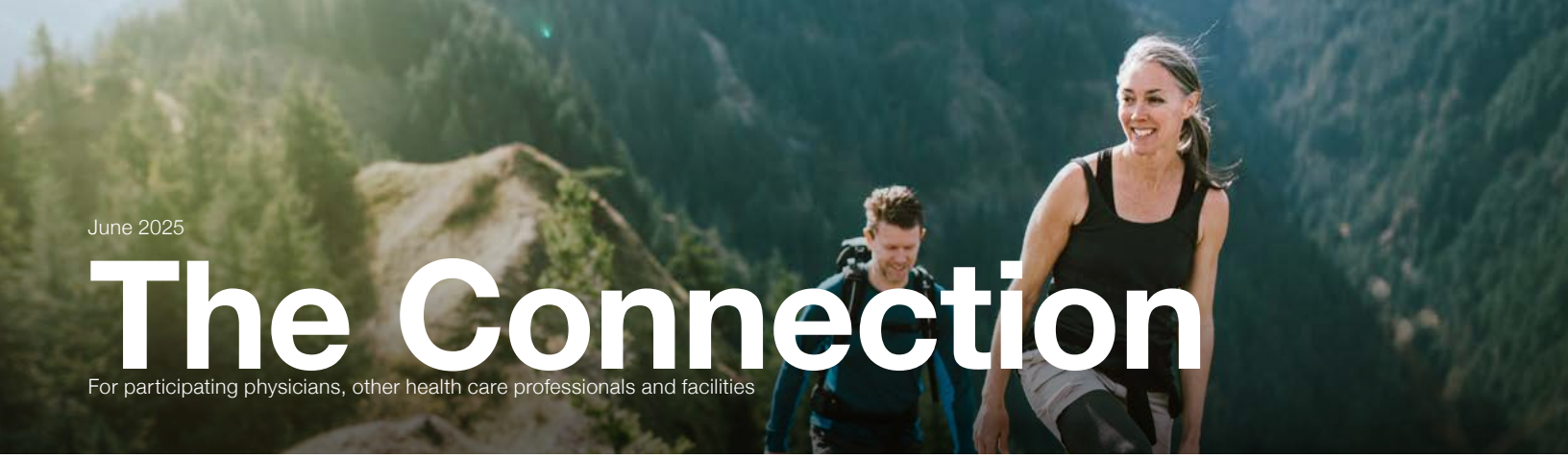

June 2025

The Connection

For participating physicians, other health care professionals and facilities

In this issue

Provider Reporting Insights & Analytics (PRIA)

We're excited to showcase a compelling real-world use case that demonstrates how PRIA is transforming health care decision-making.

New behavioral health triage line

Providers now have a direct line to our behavioral health triage team. We've also improved the member experience by dedicating additional resources to help match them with providers who align with their needs and benefits coverage.

Clinical records to be due at admission

Beginning September 1, 2025, we will require clinical documentation within 24 hours of medical inpatient admission. The simplest way to meet this requirement is to ensure records are visible via electronic medical record (EMR) at the time of admission.

Connect patients to convenient 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. Learn about our members' care options.

Using our website

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

Contents

■ Critical article ▲ DME ★ Star Ratings/Quality

ASURIS NORTHWEST HEALTH

Asuris Northwest Health

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

Get the latest news

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

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

The Connection

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

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

We publish issues of *The Connection* on the first of February, April, June, August, October and December.

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

The Bulletin

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

Administrative Manual updates

Facility Guidelines

- **Effective June 1, 2025**: Updated the list of home health codes eligible for reimbursement to align with the current reimbursement schedule
- **Effective September 1, 2025**: Updating that clinical records will be required within 24 hours of medical inpatient admission

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

Phone numbers and addresses

As a reminder, the Contact Us section of our provider website includes links to helpful resources and a list of our current phone numbers and addresses. Please be sure to check this section to ensure you have up-to-date information.

Credentialing required for locum tenens

Effective July 1, 2025, we will require that all locum tenens providers be credentialed.

Learn more about our credentialing requirements on our provider website: Contracting & Credentialing>Credentialing.

Transforming care with PRIA

Over the past year, we have been sharing updates about Provider Reporting Insights & Analytics (PRIA) platform functionality. Today, we're excited to showcase a compelling real-world use case that demonstrates how PRIA is transforming health care decision-making.

Success story

Our collaboration with a network provider with an APM arrangement demonstrates how combining clinical expertise with advanced analytics creates remarkable results. By leveraging our PRIA platform, this partnership is transforming raw data into actionable clinical strategies, fundamentally changing approaches to emergency department (ED) utilization and chronic condition management.

Identifying opportunities through data

This journey began with a comprehensive Provider Strategic Analysis (PSA) that highlighted high-impact areas of opportunity. Recognizing the importance of translating data into action, our clinical transformation advisors worked with the provider practice to connect the PSA findings with actionable insights available through PRIA.

Strategic support: A multi-faceted approach

To address the practice's specific needs, Asuris deployed a comprehensive strategy:

Performance benchmark optimization

- Our executive medical director leveraged PRIA data to demonstrate opportunities for more ambitious ED utilization targets.
- This evidence-based approach led the provider practice to recalibrate their organizational goals for improved outcomes.

Customized clinical training

- Training materials specifically designed for the practice's unique challenges using specific scenarios connected to high-impact areas identified in the PSA
- A comprehensive two-hour-long deep-dive training session on identifying clinical opportunities

This customized approach transformed how the provider practice interacts with data—shifting from consumption to active engagement with actionable insights.

Process transformation: New operational frameworks

The true value of this partnership lies in fundamental process changes now taking place:

1. **Data-driven decision-making**: Transition from clinical intuition to incorporating robust data analytics into strategic planning.
2. **Proactive care management**: Implementation of targeted patient identification protocols to identify patients with congestive heart failure (CHF) who are at high risk before they experience adverse events.
3. **Systematic ED utilization monitoring**: New systems provide visibility into emerging trends for timely interventions.
4. **Structured post-ED follow-up**: Formal post-ED follow-up workflows ensure consistent care transitions and reduce the likelihood of readmissions.
5. **Customized filters**: Custom report filters saved to the user profiles make data extraction easier, freeing staff to focus on analysis and intervention rather than data gathering.

Early success indicators

Early indicators suggest these process transformations are already yielding positive results.

- **Enhanced user capability**: After training, the practice's transformation specialists reported a dramatic improvement in PRIA proficiency. This increased confidence enables more effective use of the platform's capabilities and broader adoption across the organization.
- **Operational efficiency**: The automated CHF patient-monitoring systems have streamlined manual processes, allowing staff to redirect their efforts toward patient care rather than administrative tasks.
- **Enhanced care management**: This proactive approach to CHF patient identification enables earlier interventions and more effective resource allocation.
- **Sustainable framework**: The established data-driven decision-making processes provide a template for addressing other clinical challenges, creating a repeatable methodology for continuous improvement.

Continued on page 4

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Looking forward: The path to measurable outcomes

This collaboration demonstrates the power of combining technical expertise with clinical knowledge to drive meaningful process improvement. As we continue to enhance our data offerings and support services, we remain committed to working alongside our provider partners to identify opportunities, implement solutions and measure outcomes—ultimately improving health care delivery for the communities we serve together.

Could you use a similar workflow?

Contact your provider relations executive to have our team collaborate with you on custom workflows and solutions for your practice.

Your feedback matters

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

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

About PRIA

In today's fast-paced health care landscape, PRIA's comprehensive suite of tools and actionable insights is empowering providers on alternative payment model (APM) arrangement with 1,000+ attributed members to achieve remarkable results. From intuitive dashboards to customizable reports, PRIA delivers the critical intelligence providers need to optimize performance, improve patient outcomes, and maximize financial success.

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

- **Unparalleled convenience**: Self-service reporting when you need it
- **Easy sharing**: Quickly distribute insights across your team
- **Deep information**: Access summary, claims, and patient-level data to identify care gaps

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

Professional VBR program reports

Asuris standard professional providers with six predominant specialties (dermatology, family medicine and general practice, internal medicine, obstetrics and gynecology, ophthalmology and psychiatry) are participants in our Professional Value-Based Reimbursement program (Professional VBR). This program incentivizes providers to deliver high-quality and cost-efficient care to their patients.

Upcoming dates

Professional VBR participants will be able to access a performance report published on Availity Essentials by July 1, 2025.

The provider's performance-based reimbursement adjustment will occur beginning on October 1, 2025, based on performance in calendar year 2024.

VBR reporting

- Providers will receive a VBR ScoreCard Report in Availity Essentials if they are in one of the six eligible specialties **and** have credible data to receive a score.
- Any providers not receiving a report, either due to specialty or not having credible data, will receive Level 2 reimbursement.
- All eligible providers can view their current VBR status in Availity Essentials by July 1, 2025, regardless of whether they receive a new report.

Program eligibility

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

Learn more

View the Professional VBR program guide and provider FAQ on our provider website: Contracting & Credentialing>APM Resources.

Verify your directory information

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

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

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

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

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

Compliance program requirements

All providers and their staff, including any board or trustee members must meet our Government Programs compliance requirements. These requirements include:

- Monthly verification that they are not on an exclusion list
- 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.

We are prohibited from paying government funds to any entity or individual found on these federal lists:

- GSA exclusion list
- OIG exclusion list

Notes:

- If an employee is confirmed to be excluded, he or she must immediately be removed from working on our government programs.
- 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.

Mandatory compliance training

Compliance training is contractually required to participate 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 the required training and maintain documentation for auditing purposes for:

- FWA
- General compliance

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

The vital connection between oral and overall health

Dental health can have a direct impact on the physical and mental health of your patients, especially those with certain medical conditions. For example, untreated gum disease can make chronic conditions such as cardiovascular disease, chronic obstructive pulmonary disease (COPD), and diabetes harder to manage. Those with poor mental health are also more likely to have decayed teeth, periodontal disease and dry mouth.

By recognizing the oral-systemic link and identifying potential health issues early on, patients can be referred to a dental provider for appropriate treatment.

The role of medical providers in promoting dental health

Providers play an important role in bridging the gap between oral and systemic health care, potentially improving outcomes for patients with chronic conditions. It's important to:

- **Educate your patients** about the importance of maintaining good oral hygiene.
- **Ask your patients about their oral health** and encourage regular dental checkups.
- **Establish a referral network with local dentists** to ensure patients receive comprehensive care.

Supporting your patients' comprehensive care needs

Members with Asuris health and dental plans who have an eligible medical condition affected by oral health are automatically enrolled in our medical-dental integration program, Dental4Health®. They are provided with additional preventive and periodontal care, so it's especially important to encourage these patients to get regular dental checkups.

Visit our dental provider website to learn more about Dental4Health, including eligible conditions and how to help your patients access these enhanced benefits.

Access to clinical records to be due at time of admission notification

Beginning September 1, 2025, we will require clinical documentation within 24 hours of medical inpatient admission. This time frame coincides with our inpatient admission notification requirements.

This change affects medical inpatient admissions for all lines of business.

Ensure records are accessible or submitted

Notification requirements aren't changing. However, we will no longer provide a deadline for clinical records when acknowledging admission notification. Instead, records will be required within 24 hours of medical admission, regardless of the type of admission (i.e., elective, urgent/emergent and neonatal intensive care unit [NICU]).

- **Facilities that use PointClickCare (PCC) and grant EMR access will not experience a change in process.**
- **Change for faxed clinical records**: Providers that have not given Asuris EMR access will need to fax records within 24 hours of admission. Note: Faxes should include all clinical records; the face sheet and/or admission diagnosis alone are not sufficient.

If facilities do not submit clinical records within 24 hours of admission, the admission will be administratively denied as provider liability.

Set up EMR access today

Ensuring Asuris members are visible to the health plan via EMR at the time of admission helps avoid delays in review and administrative denials.

- We are building out new functionality around use of EMRs. Providers that allow us to integrate into their EMR will have a more automated experience with decreased review times.
- Granting access to your EMR reduces the time and resources your staff dedicates to record retrieval. Contact your provider relations executive to learn more about connecting your EMR.
- Our clinical team is experienced with multiple EMR systems and extensively trained annually on HIPAA and EMR systems.
- We retrieve only the minimum records necessary.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective April 1, 2025
Electromagnetic Navigation Bronchoscopy (Surgery #179)	- C8005
Myoelectric Prosthetic and Orthotic Components for the Upper Limb (Durable Medical Equipment #80)	- L6700
Procedure/medical policy	**Adding codes effective August 1, 2025**
Augmentative Communication Devices and Systems (Durable Medical Equipment #52) **Note**: Pre-authorization required for Individual members only.	- E2500, E2502, E2504, E2506, E2508, E2510-E2512
Power Wheelchairs: Group 2 and Group 3 (Durable Medical Equipment #37) **Note**: Pre-authorization required for Individual members only.	- K0820-K0831, K0835-K0843
Spinal Orthoses: Thoracic-Lumbar-Sacral (TLSO), Lumbar-Sacral (LSO), and Lumbar (Durable Medical Equipment #97) **Note**: Pre-authorization required for Individual members only.	- L0452, L0454, L0456, L0460, L0466, L0468, L0480, L0482, L0484, L0486, L0626, L0627, L0629-L0634, L0636-L0640
Procedure/medical policy	**Adding codes effective September 1, 2025**
Patient Lifts and Seat Lifts (Durable Medical Equipment #23) **Note**: Pre-authorization required for Individual members only.	- E0625, E0627, E0629, E0630, E0635, E0636, E0639, E0640, E1035, E1036

Medicare Advantage

Procedure/medical policy	Added codes effective April 1, 2025
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- A2030-A2035, Q4354-Q4367
Electromagnetic Navigation Bronchoscopy (Surgery #179)	- C8005
Gradient Compression Garments (Excluding Burn Garments) (Durable Medical Equipment #92)	- A6515-A6519, A6611
Mechanical Residual Limb Volume Management System for Upper Extremity Prostheses (Durable Medical Equipment #98)	- L7406
Myoelectric Prosthetic and Orthotic Components for the Upper Limb (Durable Medical Equipment #80)	- L6700
Powered and Microprocessor-Controlled Knee and Ankle-Foot Prostheses and Microprocessor-Controlled Knee-Ankle-Foot Orthoses (Durable Medical Equipment #81)	- L5827
Procedure/medical policy	**Adding codes effective September 1, 2025**
Histotripsy for Hepatic or Renal Tumor Treatment (Medicine #178)	- 0686T, 0888T
Travoprost Drug-eluting Ocular Implants for the Treatment of Glaucoma (Surgery #237)	- 0660T, 0661T, J7355

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.

Correct coding updates

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

Post-pay edit effective May 1, 2025

- Enteral therapy in the home setting
- Administration fees for enteral therapy charges will be denied when drugs did not receive pre-authorization for Individual members subject to our *Enteral and Oral Nutrition in the Home Setting* (Allied Health #5) medical policy.

Pre-pay edits effective June 1, 2025

- Add-on code billed without base code
- CMS Status I codes

Pre-pay edit effective June 27, 2025

- Capped rentals (CR) or transcutaneous electrical nerve stimulators (TENS) billed with modifiers NU (new equipment) and RR (rented monthly) for the same code and by the same provider
  - This edit is also supported by our *DME Purchase and Rental Limitations* (Administrative #131) commercial and Medicare Advantage reimbursement policies.

Pre-pay edit effective July 27, 2025

- Therapy service modifiers and frequency

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

MCG guideline updates

MCG revises its proprietary guidelines annually. We will implement the 2025 guidelines beginning in late June. Updated criteria are available in Availity Essentials.

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 April 2025 issue of *The Bulletin* about changes to the following medical policies, which are effective July 1, 2025:

- *Air Ambulance Transport* (Utilization Management #13—commercial and Medicare Advantage
- *Electromagnetic Navigation Bronchoscopy* (Surgery #179)—commercial and Medicare Advantage
- *Knee Surgeries* (Surgery #229)—commercial
- *Negative Pressure Wound Therapy in the Outpatient Setting* (Durable Medical Equipment #42)—commercial

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

- *Augmentative Communication Devices and Systems* (Durable Medical Equipment #52)—commercial
- *Power Wheelchairs: Group 2 and Group 3* (Durable Medical Equipment #37)—commercial
- *Spinal Orthoses: Thoracic-Lumbar-Sacral (TLSO), Lumbar-Sacral (LSO), and Lumbar* (Durable Medical Equipment #97)—commercial
- *Testosterone Testing* (Laboratory #81)—commercial

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 April 2025 issue of *The Bulletin* to our *Sepsis* (Facility #120) reimbursement policy—commercial and Medicare Advantage—which are effective July 1, 2025.

No changes to reimbursement policies in the May 2025 issue of *The Bulletin* required advance notice.

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

Medication policy updates

Effective May 1, 2025, we will make changes to the following medication policy:

- Trodelvy, sacituzumab govitecan-hziy, dru645

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

- Site of Care Review, dru408

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

- Blood Factors for Hemophilia A, High-Cost Extended-Half-Life (EHL) Products, dru549
- Blood Factors for Hemophilia B, Extended-Half-Life (EHL) Products, dru550
- Complement Inhibitors, dru385

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

Quality in Action articles

The Quality in Action section on our provider website is an extension to this publication.

Read the following recently published articles to improve your patients' experience and health outcomes:

- Improving Health Outcomes Survey responses
- Maximizing the impact of well-child visits
- Prioritizing women's health
- Test result follow-up processes impact patient satisfaction
- **Behavioral health**: Help increase rates of post-discharge care

Behavioral health corner

About behavioral health corner

This section highlights the articles that affect behavioral health providers. As with any specialty, other content in this newsletter will apply to your practice. We also recommend you use the search function (**Ctrl + F**) on your computer to search for keywords that concern your practice.

New behavioral health triage line

Through our new behavioral health navigation and triage line, we're transforming how we support members seeking care.

A direct line to member triage

Our new, dedicated triage line serves as a central resource for anyone seeking behavioral health support—whether they're members, family members or providers—and can typically resolve needs on a single phone call.

The triage team offers comprehensive support tailored to individual needs:

- Assesses immediate needs and identifies crisis resources when necessary
- Matches members with appropriate levels of care based on clinical needs and preferences
- Facilitates connections to in-network providers and virtual care options
- Coordinates access to support programs and community resources
- Assists health care providers with patient care coordination

Calls to Customer Service involving complex cases are seamlessly transferred to our clinical triage team through a warm handoff process. **Providers seeking assistance with care coordination may call our line directly: 1 (877) 336-8251.**

Highlighting available resources

While we've expanded our network, many of our virtual care options remain underutilized, and members still struggle to find providers who are both accepting patients and the right fit for their needs. As part of our broader strategy to simplify behavioral health care access across all entry points, our Customer Service team recently received in-depth training about available services, including virtual care options and other valuable resources.

Throughout 2025, we will continue enhancing our website and app navigation to help members independently find behavioral health care that aligns with their needs and benefits coverage.

In-network virtual providers are also listed in the Telehealth section of our Behavioral Health Toolkit, available on the homepage of our provider website.

Behavioral health corner

Get reimbursed for integrated care and e-consults

PCPs frequently treat patients with behavioral health needs, particularly those with mild to moderate conditions. However, some patients require specialized care beyond what PCPs can typically provide because of limited clinical expertise or resources.

These two approaches are effective at supporting PCPs in delivering comprehensive behavioral health services:

- Integrating behavioral health providers in primary care settings using the Collaborative Care Model (CoCM)
- Using psychiatric electronic consultations (e-consults)

For both CoCM and e-consults, PCPs should first obtain informed consent from their patients and notify the patient that they may be responsible for their cost share (e.g., copay, coinsurance or deductible).

Integrated, collaborative care

The American Psychiatric Association (APA) recognizes CoCM as the behavioral health integration model with the strongest evidence for "effective and efficient integration in terms of controlling costs, improving access, improving clinical outcomes and increasing patient satisfaction" across diverse primary care settings. **We encourage providers to participate in the CoCM approach to treat and support members with complex needs.**

The model consists of a team of three individuals delivering care: A PCP, a behavioral health care manager and a psychiatric consultant. Integrated behavioral health services may include:

- Counseling
- Medication support
- Care planning for behavioral health conditions
- Ongoing assessment of the patient's condition
- Other recommended treatment, if needed

Key elements

- Care coordination by a behavioral health care manager or psychiatric consultant working alongside the PCP
- Regular treatment and monitoring with standardized outcome measures based on targeted quality outcomes
- Regular caseload review with a psychiatrist who provides treatment recommendations

We reimburse:

- Behavioral health services provided in the primary care setting
- CoCM codes CPT 99492-99494 and HCPCS G2214

Resources

- **Reimbursement policy**: Review our *Collaborative Care Codes* (Behavioral Health #100) reimbursement policy on our provider website: Library> Policies & Guidelines>Reimbursement Policy.
- **CMS**: The Behavioral Health Integration Services booklet explains care team roles, CoCM components and code descriptions.
- **APA**: Learn about the CoCM model, including reducing care inequities and CoCM training for PCPs, behavioral health care managers and psychiatrists.

E-consults

E-consults help address challenges PCPs face when treating complex medical and behavioral health conditions by providing timely access to specialty expertise. **We recognize the value of timely access to specialty consultations and reimburse PCPs and consulting specialists.**

E-consults are asynchronous provider-to-provider consultations conducted through shared electronic medical record (EMR) systems or web platforms. PCPs request expert consultation on clinical issues, and specialists review records and provide written consultation reports.

These visits allow timely specialist advice, especially for providers who don't otherwise have access to psychiatrists in their community.

Specialty e-consults can:

- Address medication-related issues
- Provide evaluation and management (E&M) recommendations
- Clarify diagnostic considerations
- Determine whether in-person care is urgently needed

We reimburse:

- The treating PCP for CPT 99354-99359 and 99452
- The consulting specialist for CPT 99446-99449 and 99451

Resource

- **American Medical Association (AMA)**: Learn about what e-consults can do for your patients—and your practice.

Working together to create equal opportunities for wellness

We believe all people should have an equal opportunity to achieve wellness as part of a health care system that prioritizes diversity, equity and inclusion. We recognize that 80% of health outcomes are driven by non-clinical factors, which is why our commitment to whole-person support is essential to addressing health disparities.

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:

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

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.

Resources for working with diverse populations

Culture, language, customs, personal beliefs and experiences all impact how patients participate in their health care.

Our Health Equity Toolkit, available on the homepage of our provider website, provides essential resources to help you support patients with unique needs or preferences. This online library connects you to:

- National standards for culturally sensitive care
- Resources for working with diverse populations
- Continuing medical education courses
- Health literacy tools
- Social determinants of health codes
- Interpreter services information

Social need screening and intervention

The Healthcare Effectiveness Data and Information Set (HEDIS®) measure Social Need Screening and Intervention (SNS-E) 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 on our provider website: Library>Printed Material.

Together, we can advance diversity, equity and inclusion in the communities we serve.

Connect your patients to convenient care options

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.

Recent studies indicate that approximately 30% of emergency department (ED) visits could be handled in alternative care settings. Unnecessary ED visits not only increase health care costs but can also result in:

- Longer wait times for all patients
- Higher out-of-pocket expenses for your patients
- Potential exposure to other illnesses in crowded waiting rooms
- Reduced continuity of care

Resources for providers

The Care Options Toolkit on the homepage of our provider website 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.
- The *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.

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. By signing in to their asuris.com account, members can find:

- Provider and pharmacy directories
- Immediate care options, including nearby urgent care clinics and emergency rooms
- Virtual care options, including scheduling doctor's appointments, asking a pharmacist and behavioral health support
  - 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.
- In-home care urgent medical care with DispatchHealth
  - With DispatchHealth, your patients can skip the wait at the ER and get high-quality urgent medical care at home. They can treat many urgent health conditions, just like an urgent care clinic—and for a similar cost. Patients can book a same-day appointment any day of the year.
  - They are available in the Spokane area.

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.

How you can help guide appropriate care utilization

- During regular visits, educate your patients about when to use each care option and encourage them to visit our member website for more information.
- Provide after-hours guidance in your voicemail messages about appropriate care options.
- Consider sharing information about DispatchHealth information with your patient (if available in the patient's area).
- Remind patients that true emergencies (e.g., chest pain, stroke symptoms, severe bleeding) still warrant immediate 911 calls.

Medicare Advantage incentive program updates

Update your template for supplemental data

Including risk adjustment diagnoses, including place of service, in your structured supplemental data submission (SDS) files can close chronic condition gaps in the Medicare Advantage incentive programs.

Reach out to your provider relations executive if you have questions or need to work with our SDS team to update your template to include risk adjustment diagnoses and place of service for risk adjustment data.

You can learn more about the 2025 Medicare Advantage incentive programs on our provider website: Programs>Medicare Advantage Incentive Programs.

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, your QIP Primary Contact should email us 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.

2025 program enrollment deadline

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

QIP 2024 payout

We expect to mail checks for any earned incentives for the 2024 program year by June 30, 2025. 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 2024 program performance or payout, please email us by July 31, 2025. 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 CGMA. When the report is available, you will see a pop-up notification after you sign in, with instructions for downloading the report.

Resources for you

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

Publications team

Written, designed and edited by the Provider Communications team.