October 2023

The Connection

For participating physicians, dentists, other health care professionals and facilities

October is National Breast Cancer Awareness Month

National Breast Cancer Awareness Month raises awareness about the importance of early detection of breast cancer. Breast cancer is the most common cancer in women, and on average, women have a 1-in-8 chance of developing breast cancer during their lifetime. October is a great time to call attention to the actions women can take to detect breast cancer early.

As a health care provider, you are a patient's trusted resource and can encourage women to be informed and actively engage in the health care decisions that affect them, such as getting screened for breast cancer and obtaining other recommended preventive services. The U.S. Preventive Services Task Force (USPSTF) recommends that women ages 50 to 74 have a screening mammogram every two years. Women ages 40 to 49 should talk with their provider about when to begin screening and how often to get a mammogram.

Some women are at higher risk for breast cancer and should discuss with their doctor when and how often to receive mammograms. The Centers for Disease Control and Prevention (CDC) website provides helpful resources for patients regarding risk factors.

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

Resources

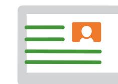
- Asuris Quality Improvement Toolkit: Programs>Quality>Quality Improvement Toolkit
- USPSTF: **uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening**
- CDC resources for patients regarding risk factors: **cdc.gov/cancer/breast/basic_info/risk_factors.htm**
- CDC resources for patient education: **cdc.gov/cancer/dcpc/resources/features/BreastCancerAwareness/Index.htm**

Easily find information

Did you know that you can search for words in this newsletter by holding down the **Ctrl** key on your keyboard and then the letter **F**? A pop-up window will appear asking if there's a word or phrase you need to find.

Subscribe today

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



Using our website

Visit **asuris.com** or **asurisdental.com/providers**. Enter a ZIP code for your location.

Stay up to date

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

Asuris Northwest Health
528 East Spokane Falls Blvd, Suite 301
Spokane, WA 99202

© 2023 Asuris Northwest Health

Contents

■ Critical article ● Dental ★ 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.

Feature

National Breast Cancer Awareness Month 1

News

About The Connection 2
Help patients know where to go for care 3
★ Fall respiratory virus season 4
● New resources and support for dental providers 5
Alternative payment model news 6
New analytics platform for APM coming soon 6

Administrative and billing

●■ Administrative Manual updates 4
Bill type 014X reminder for hospitals 6
■ Medicare Advantage home health reimbursement schedule update 7
■ Medicare Advantage termination notification requirements 7
Medicare crossover claim reminders 8
●■ 2024 brings code changes for services and supplies 7
■ Changes to mailing addresses 8
Update your directory information 21

Authorizations

■ Pre-authorization updates 9-10
■ Records requirements for admissions and inpatient concurrent review 11
■ Authorizations for Medicare Advantage post-acute care facilities, home health 12
■ 2024 cardiology program changes 13
Nuclear imaging pre-authorization reminder 14

Policies

■ The Bulletin recap 13

Pharmacy

Preferred GLP1 agonist-containing medications reminder 14
■ Update to Asuris EquaPathRx program 14
■ Medication policy updates 15-16

Behavioral health corner

Diagnosing and treating depression in primary care 18-19
SAD could affect your patients this winter 19

Products

2024 Commercial products and networks 20-21

Patient care

In-home, high-acuity care for your patients 22
★ Reviewing mediations with patients 23
Remote EMR service for HEDIS chart collection ... 23

Medicare

2024 Medicare product updates 24
★ Medicare Advantage QIP reminders 25

About *The Connection*

This publication includes important news, as well as notices we are contractually required to communicate to you, including updates to our policies (medical, dental, reimbursement, medication) and pre-authorization lists. In the table of contents, this symbol indicates articles that include critical updates: ■. To save you time, you can click on the titles to go directly to specific articles. You can also return to the table of contents from any page by clicking on the link at the bottom of each page.

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

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

The Bulletin

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

Share your feedback

Are our publications meeting your needs? Send us your feedback at **provider_communications@asuris.com**.

Help patients know where to go for care

There are big differences between visits to a PCP and visits to urgent care or the emergency department (ED), including cost, time spent waiting for care and follow up. We encourage you to remind your patients about their care options before they need sudden medical care.

Convenient 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.
- 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 directory information on our provider website: Contact Us>Update Your Information.
  - In addition to having access to telehealth services from in-network providers, members will have access to telehealth services for urgent care and behavioral health through the national telehealth vendor Doctor on Demand, **doctorondemand.com**. Some groups will have access to medical and behavioral health providers through MDLIVE, **mdlive.com.**
- Nurse line
  - For questions about common health issues and whether a patient should see a doctor, most members can contact Asuris Advice24.
- In-home care (available in the Spokane area)
  - With DispatchHealth, members can receive urgent care, hospital-level care and post-hospital 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, from 8 a.m. to 10 p.m. **Related**: See *In-home, high-acuity care for your patients* on page 22.
- 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
  - Remind patients to go to 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 one or more avoidable ED visits to provide information about alternative treatment options.

Resources for providers and members

- View the Care Options Toolkit, available on the home page of our provider website. It includes:
  - Information for providers about members' care options, including virtual medical and specialized behavioral health providers, our 24/7 nurse line, urgent care and more.
  - *Understand your Care Options* member flyer with information about the symptoms that can be treated, cost of treatment and average wait times when seeking virtual, in-person (including urgent care centers) or emergency care.
- Members can view their care options on the member website.
  - Members can sign in to their **asuris.com** account and select Find Care to see their care options. They can also contact the phone number on the back of their member ID card.

Fall respiratory virus season

With the spread of flu, COVID-19 and respiratory syncytial virus (RSV) expected this fall, providers play a key role in educating patients, parents and caregivers about the importance of vaccination. Your recommendation can help protect your patients from these viruses.

Encourage your patients to:

- **Get vaccinated**: Vaccines and immunizations are the most effective ways to prevent one of these viruses; individuals can get more than one vaccination at the same time; **Note**: Members can receive the new COVID-19 booster at a pharmacy or through their provider
  - View the CDC's website for current COVID-19 recommendations: **cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html#**
  - View the Centers for Medicare & Medicaid Services' (CMS') website for the codes and reimbursement for COVID-19 vaccines, as well as the administration: **cms.gov/medicare/payment/all-fee-service-providers/medicare-part-b-drug-average-sales-price/vaccine-pricing**
- Cover their coughs and sneezes, stay away from people who are sick, wash hands often, and improve air circulation in the home and workplace
- Stay home if they're sick (Share the CDC guidelines for isolation and precautions for people with COVID-19 at **cdc.gov/coronavirus/2019-ncov/your-health/isolation.html**)

Remind your patients how they can contact you for care or advice about their care options. **Related**: See *Help patients know where to go for care* on page 3.

Resources

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

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

Healthwise's Knowledgebase has helpful information and tools about immunizations in English and Spanish to share with your patients. Our Quality Improvement Toolkit, available on the home page of our provider website, has a link to the Healthwise Knowledgebase.

The home page of our provider website includes a COVID-19 Vaccine Toolkit with information about coverage for our members, claims submission and provider reimbursement.

Administrative Manual updates

The following updates were made to our manual on October 1, 2023:

Appeals for Providers

- Replaced outdated mailing addresses with paths to information on the provider website
- Updated references of our Fraud and Abuse department to our Special Investigations Unit

Facility Guidelines

- Updated the information about how we notify skilled nursing facilities (SNFs) and home health agencies about updates to their reimbursement schedules in issues of this publication
- Added CMS-required notice of admission (NOA) for home health agencies

Medicare Advantage Plans

- Added CMS-required NOA for home health agencies

Dental providers: As part of the launch of our new dental website, dental providers should view the 2023 *Dental Manual and Guidelines* on **asurisdental.com**: Provider>Tools and Resources>Plan Information and Documents. We will remove dental references from the following sections of the *Administrative Manual* by November 1, 2023:

- Introduction
- Appeals for Providers
- BlueCard
- Fraud and Abuse
- Policies
- Provider Facility and Resources

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

New resources and support for dental providers

Over the past few months, we have shared news about our dental partnership with USAble Life. This partnership strengthens our dental networks and provides dental providers with resources and dedicated support to help their practice.

Our new dental web experience

For members

On September 1, 2023, administrative services only (ASO) members started using our new service platform, MyDentalCoverage, accessed through their Asuris account. As members' plans renew throughout 2024, they will transition to the the new website and service platform.

For providers

Launching on October 2, 2023, our new dental provider website **asurisdental.com/providers** will be the information hub for dental providers, where they can find credentialing and contracting information, dental policies and coding guidelines, and online resources and news. **Note**: Dental-specific information historically found on **asuris.com** has been removed or updated to direct dental providers to our new dental provider website.

All dental providers should use the new dental website to:

- **Find policies and procedures**
  Dental policies previously hosted on **asuris.com** can be located in the *CDT Guide* on our dental provider website: Tools and Resources>Plan Information and Documents. The *CDT Guide* includes dental policies, procedure codes and billing information.
- **Access the *Dental Manual***
  The *Dental Manual* is a dental-specific administrative guide that accompanies a dental provider's *Participating Dental Agreement*. It includes information about dental plans and benefits, identifying members, dental claims submission and more. To access the manual, visit our dental provider website: Tools and Resources>Plan Information and Documents.
- **Register for EFT**
  If your patient's coverage is not found on MyDentalCoverage, you should continue to use Availity Essentials.

  Note: You must register to receive electronic funds transfer (EFT) payments through MyDentalCoverage. To register for EFT payments, go to Online Services section of our dental provider website. Please complete this process at your earliest convenience.

  The MyDentalCoverage service platform can also be used to:

  - View remits directly or provide approval for Electronic Remittance Advices (ERAs) to be sent to your preferred clearinghouse
  - Submit electronic claims and pre-treatment estimates via Speed eClaim®
  - Verify patients' dental benefits and eligibility
  - Review claims status
  - Contact Dental Provider Relations

  Dental providers now have a specialized provider relations support team and can find their region's provider relations executive on the Contact Us section of our dental provider website. Dental providers can also email questions to **DentalProviderRelations@asurisdental.com**.
- **Read news and announcements**
  Beginning December 2023, a new dental-specific newsletter will be available, which will include important news and announcements for dental providers. The dental newsletter will provide mandatory 60-day notice for policy changes and other updates related to dental contracting or credentialing.

  Our dental newsletter will be emailed to contracted dental providers. Newsletter articles will also be posted in the News section of our dental provider website.

Credentialing updates

We have contracted with VPoint, a Credentials Verification Organization (CVO) to verify credentials and provide ongoing monitoring services for our dental provider networks. Dental providers will receive an introductory letter from VPoint this month.

Note: When you are due for recredentialing, you will receive paperwork from VPoint.

Other dental updates will be sent from P.O. Box 45132, Jacksonville, Florida, 32232-9902, effective October 1, 2023.

Tips for claims submission

When submitting a dental claim, only include dental CDT codes where charges apply. You must also include the rendering provider's name and NPI with your claim. Additional tips for dental claims submission can be found on the American Dental Association's website, **ada.org**.

Alternative payment model news

Value-based agreements (VBAs) are now called alternative payment models (APMs).

This name change reflects Asuris' journey with health care payment innovation over the past 10 years. During this time, we've been able to connect to thought leaders in value-based care—from think tanks to fellow health plans and physician champions. We've seen terminology shift as payment innovation has evolved. We are adopting "alternative payment model" as our term for any non-fee-for-service payment model, as well as the accompanying partnerships we enter into with willing provider groups. We'll continue to use the term "value-based care" to refer to how physicians practice when APM incentives are in place.

Our provider website has been updated to reflect this name change: Contracting & Credentialing>APM Resources.

Commercial Total Care APM expansion to multiple tracks of participation in 2024

Asuris' Commercial Total Care APM has been available to providers for 10 years. We are expanding access to participation and creating a path for providers to have deeper engagement with the program.

Beginning January 1, 2024, we will introduce distinct tracks for providers to participate in the program and benefit from their performance in managing costs while providing high-quality care to our members. The new track includes provider organizations with 1000+ attributed members. It will provide an avenue to a shared savings incentive as part of reimbursement for successful performance across quality and total cost of care metrics.

Next month, a manual will be available that provides detailed information on eligibility, performance metrics and tools on our provider website: Contracting & Credentialing>APM Resources. A webinar will also be scheduled for you to learn more and ask questions. Look for a What's New announcement on our provider website about this opportunity.

2024 attribution methodology

Patient attribution is a critical part of APM agreements and defines the member population for whom a provider is accountable. Our attribution methodology for APMs will be updated effective January 1, 2024. This annual update is available now on our provider website: Contracting & Credentialing>APM Resources.

New analytics platform for APM coming soon

Asuris is committed to helping providers meet and exceed contractual goals in APM arrangements. We are excited to announce a new business analytics platform will be available in early 2024.

The new self-service performance analytics platform features interactive member-level data providers can use to generate insights needed to measure, predict and succeed in APM arrangements. Providers can create and execute data-driven population health management interventions that improve quality while reducing total cost of care. Analytics-guided care coordination ensures care gaps and treatment opportunities that represent the greatest clinical impact are addressed during in-person and virtual patient visits.

Robust reporting provides data-driven insights on population health and utilization, helping to improve quality performance and member engagement. Current reporting for similar information has significant time lag; using the new self-service business analytics platform will reduce the delay in obtaining actionable data.

Look for more information in future issues of this newsletter.

Bill type 014X reminder for hospitals

As a reminder, per CMS guidelines, bill type 014X should be used when a hospital seeks separate payment for clinical lab services in the following circumstances:

- Non-patient (referred) specimen
- A hospital collects specimen and furnishes only the outpatient labs on a given date of service
- A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished on the same day
  - **Note**: "Unrelated" means the lab test is ordered by a different provider than the provider who ordered the other lab services, for a different diagnosis.

Medicare Advantage home health reimbursement schedule update

In our ongoing efforts to reward high-quality care provided to Asuris Medicare Advantage members, we review the quality ratings of participating home health agencies on an annual basis. We use the Quality of Patient Care Star Ratings, which reflect the prior calendar year's data and are available in July of the current year to determine the quality rating for each home health agency. Effective January 1, 2024, Asuris will use the ratings reported in July 2023.

Home health agencies can view their CMS Quality of Patient Care Star Ratings at **medicare.gov/homehealthcompare/About/What-Is-HHC.html**. The criteria for determining the quality rating for home health agencies is outlined in the Facility Guidelines section of the Administrative Manual, available on our provider website: Library>Administrative Manual.

Reminders:

- Reimbursement is based on a percentage of the current CMS Home Health Prospective Payment System (PPS) fee schedule. The CMS Home Health PPS Fee Schedule is updated quarterly and is available at **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html**.
- Our annual notification of fee updates is announced in the October issue of our newsletter. You can Subscribe on the home page of our provider website to receive an email when new issues of this publication are available.

Medicare Advantage termination notification requirements

CMS has updated the enrollee notification requirements for Medicare Advantage provider terminations effective January 1, 2024, or later.

No-cause terminations

- Contracted providers are required to provide advance notice when terminating their contract without cause, according to the required notice period defined in the provider agreement.
- We will provide 45-calendar day notice (written and telephonic) to members for PCP-type providers, behavioral health and end-of-life/palliative care providers. Notifications will be to all enrollees currently assigned to that PCP and to enrollees who have been patients of that primary care, behavioral health or end-of-life/palliative care provider within the past three years, as required by CMS.
- We will provide 30-calendar day notice (written only) for all other provider types. Notifications will be sent to all enrollees who are assigned to, currently receiving care from, or have received care within the past 12 months from a provider or facility, as required by CMS.

For-cause terminations

- We will follow the scope and timelines outlined above, making our best effort to notify members as timely as possible from our receipt of the termination notice.

2024 brings code changes for many services and supplies

Please remember to review your 2024 CPT, HCPCS and CDT coding publications for codes that have been added, deleted or changed and to use only valid codes.

You can purchase the:

- CDT manual by calling the American Dental Association at 1 (800) 947-4746 or online at store.**ada.org**
- CPT and HCPCS manuals through your preferred vendor or online through the American Medical Association (AMA) at **ama-assn.org/practice-management/ama-store**

Reimbursement schedules are available on Availity Essentials.

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

Medicare crossover claim reminders

When you submit claims to Medicare for members who have Medicare as their primary coverage, please wait 30 calendar days from the Medicare remittance date before submitting the claim to Asuris. In most cases, you will not need to submit the claim to us because Medicare will send us the claim through the crossover process.

Crossed-over claims

If the indicator on the Medicare remittance advice shows that the claim was crossed-over (claim status code 19: "Medicare paid primary and the Intermediary sent the claim to another insurer"), Medicare has forwarded the claim on your behalf to us, and the claim is being processed. You do not need to file a claim for the Medicare supplemental benefits. You will be paid automatically if you accepted Medicare assignment. Otherwise, the member will be paid directly, and you will need to bill the member.

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

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

Claims that don't crossover

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

Statutorily excluded services

When you provide services or supplies that are statutorily excluded by Medicare (e.g., home infusion therapy and hearing aids), you can submit the claim directly to Asuris without waiting 30 days after the Medicare remittance date.

Claims for the service that is excluded or not covered by Medicare should be submitted with modifier GY on each line.

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

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

Changes to mailing addresses

Editor's note (10/26/23): The ZIP code has been corrected for the Portland, Oregon, mailing address.

We have made changes to our mailing addresses. We will be updating our provider website, letterhead, forms and other documents to reflect the changes by the end of this year:

- All claims and commercial appeals mail should be sent to:
  Asuris Northwest Health
  ATTN: Appeals and Grievances or ATTN: Claims
  P.O. Box 1106
  Lewiston, ID 83501
- Medicare Advantage appeals mail should be sent to:
  Medicare Advantage / Medicare Part D
  ATTN: Appeals and Grievances or ATTN: Claims
  P.O. Box 1827
  Medford, OR 97501
- The single mailing address for Portland, Oregon is now:
  Asuris Northwest Health
  200 SW Market Street, 11th Floor
  Portland, OR 97201
- We are closing unused or rarely used P.O. boxes, including the following at these locations:
  - **Portland**: 1071, 1200, 1239, 1269, 3470, 4208, 5336, 5726
  - **Seattle**: 21267, 91015
  - **Tacoma**: 2354, 2915, 2998, 3000, 3004, 3006, 3011
- Mailstops are no longer required.

Pre-authorization updates

Commercial

Procedure/medical policy	Added code effective July 1, 2023
Surgical Site of Service - Hospital Outpatient (Utilization Management #19)	- 15851
Procedure/medical policy	**Added code effective September 1, 2023**
Laboratory Tests for Organ Transplant Rejection (Laboratory #51)	- 81595
Procedure/medical policy	**Added codes effective October 1, 2023**
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	- 0409U
Digital Therapeutic Product (Medicine #175)	- A9292
Digital Therapeutic Products for Amblyopia (Medicine 175.04)	- A9292
Digital Therapeutic Products for Substance Use Disorders (Medicine #175.02)	- 98978
Genetic Testing for Primary Mitochondrial Disorders (Genetic Testing #54)	- 0417U
Procedure/medical policy	**Adding code effective November 1, 2023**
Enteral and Oral Nutrition in the Home Setting (Allied Health #05) —*policy applies only to select Individual members*	- B4148
Procedure/medical policy	**Adding codes effective January 1, 2024**
Cardiology	- 3206-33208, 33212-33214, 33221, 33227-33231 33240, 33249, 33270, 33271, 33274, C1721, C1722, C1777, C1785, C1786, C1882, C1895, C1896, C1899, C2619-C2621, G0448 - **Related**: See *2024 cardiology program changes* on page 13.

Medicare Advantage

Procedure/medical policy	Added code effective July 1, 2023
Surgical Site of Service - Hospital Outpatient (Utilization Management #19)	- 15851
Procedure/medical policy	**Added codes effective September 1, 2023**
Power wheelchairs – Group 2 and Group 3 (Durable Medical Equipment #37)	- E2300, K0830, K0831

Continued on page 10

Continued from page 10

Medicare Advantage (continued)

Procedure/medical policy	Added codes effective October 1, 2023
Biochemical and Cellular Markers of Alzheimer's Disease (Laboratory #22)	- 0412U
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- A2022-A2025, Q4285, Q4286
Cosmetic and Reconstructive Procedures (Surgery #12)	- 15832-15839
Electrical Stimulation and Electromagnetic Therapy Devices (Durable Medical Equipment #83)	- A4596, K1002
Gender Affirming Interventions for Gender Dysphoria (Medicine #153)	- 15832-15839
Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	- 0402U, 0404U-0407U, 0409U-0411U, 0413U, 0414U, 0416U, 0418U, 0419U
Surgical Treatments for Lymphedema and Lipedema (Surgery #220)	- 15832-15839
Procedure/medical policy	**Adding codes effective January 1, 2024**
Cardiology	- 33206-33208, 33212-33214, 33221, 33227-33231 33240, 33249, 33270, 33271, 33274, C1721, C1722, C1777, C1785, C1786, C1882, C1895, C1896, C1899, C2619-C2621, G0448 - **Related**: See *2024 cardiology program changes* on page 13.
Home health	- G0299, G0300, G0493-G0496 G0151-G0153, G0155-G0162, G0299, G0300, G0493-G0496 - **Related**: See *Carelon to manage authorizations for Medicare Advantage post-acute care facilities, home health* on page 12.
Post-acute care facilities (SNF, LTAC, IPR)	- Request pre-authorization from Carelon. - **Related**: See *Carelon to manage authorizations for Medicare Advantage post-acute care facilities, home health* related article on page 12.

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.

Records requirements for admissions and inpatient concurrent review

Effective January 1, 2024, we will begin enforcing the requirement that clinical documentation supporting medical and behavioral health inpatient admissions and continued stay reviews be submitted by the date required. Upon receiving notification of admission, we will fax an admission acknowledgement that includes the date we require updated clinical information. If admission notification or requested documentation is not submitted by the required date, the stay may be administratively denied.

We will update the Facility Guidelines section of our *Administrative Manual* by January 1, 2024, to reflect these changes.

This change affects our commercial and Medicare Advantage lines of business.

Current discharge notification requirements will not change.

Concurrent review

Records submission

Facilities are required to provide clinical records to support review requests. Required records may include:

- Medical records
  - Labs
  - Medications
  - Diagnosis
  - Imaging
- Progress notes
- Physician orders
- Therapy notes
- Case management and discharge planning

If facilities do not submit timely clinical records, they will not receive concurrent review approval for those days. Days that have not been authorized through pre-authorization, administrative approval or concurrent review approval will be administratively denied as provider liability.

Requests for concurrent medical necessity review must include:

- Diagnosis
- Clinical information regarding the member's current admission

Note: Providing incomplete information—e.g., only a census list, an admission notice, a diagnosis code and/or a face sheet without clinical information—will not result in authorization.

Submission options

- **Electronic medical record (EMR) access**: Requires full access—all clinical records must be available for download
- **Fax**: Includes all clinical records; the face sheet and/or admission diagnosis alone are not sufficient

Availity Essentials is not available for concurrent review submissions.

Exceptions

We recognize that extenuating circumstances may prevent a provider or facility from submitting clinical records within the allowed timeframe. We will review a stay post-service in the following circumstances:

1. The member presents incorrect insurance information or the participating provider or facility is unable to identify where to submit records.
2. Natural disaster prevents records submission.
3. The member is unable to communicate insurance information and no one present can provide that information.
4. There is compelling evidence the provider attempted to submit accurate clinical information on time.

More information

For additional information about utilization management exceptions, see the *Extenuating Circumstances* policy in the Pre-authorization section of our provider website. We will update this policy to include concurrent review exceptions by January 1, 2024.

Affected Pre-authorization lists have been updated on our provider website.

Carelon to manage authorizations for Medicare Advantage post-acute care facilities, home health

Carelon Medical Benefits Management (Carelon) will oversee authorizations for services delivered on or after January 1, 2024, to Medicare Advantage members at post-acute care facilities and through home health agencies. Pre-authorization and reauthorization (concurrent review) requests for the following types of post-acute care will need to be sent Carelon:

- Skilled nursing facilities (SNFs)
- Long-term acute care (LTAC)
- Inpatient rehabilitation (IPR), also known as inpatient rehabilitation facilities (IPR)
- Home health

Because these services are provided over a period of time and members' needs change (e.g., differing levels and lengths of care), we want to ensure members continue to receive the most appropriate services according to their medical need at time of service.

Request an authorization through Carelon

Before submitting an authorization request, register for Carelon's ProviderPortal: **providers.carelonmedicalbenefitsmanagement.com/postacute**. Carelon can help large group practices with the registration process.

To submit a request or check authorization status:

- Sign in to Carelon's ProviderPortal: **providers.carelonmedicalbenefitsmanagement.com/postacute**. Requests may receive immediate approval.
- Call 1 (844) 411-9622, 8 a.m.-5 p.m. (PT) Monday through Friday.

SNF, LTAC and IPR review timelines unchanged

Submit requests to Carelon for services delivered on or after January 1, 2024.

Home health changes

For dates of service on or after January 1, 2024:

- Requests for home health pre-authorization must be submitted to Carelon with a home health order to start care.

Carelon will require the following for home health services:

- Reauthorization for all visits in excess of the authorized number of visits or authorization period will require a new physician order
- Visit notes and an updated treatment plan upon each reauthorization
- The Outcome and Assessment Information Set (OASIS) for the initial certification period; **Note**: An OASIS must be resubmitted to Carelon for each additional reauthorization request that is for a new 60-day certification period

More information

- Look for additional information in the December 2023 issue of this newsletter for information about when providers can begin submitting these requests, as well as details about the transition period.
- We have updated the Medicare Advantage pre-authorization list on our provider website: Pre-authorization>Medicare Advantage.
- The Facility Guidelines section of our *Administrative Manual* will be updated by January 1, 2024, with information about this program.
- **Related**
  - *Medicare Advantage home health reimbursement schedule update* on page 7
  - *Pre-authorization updates* on pages 9-10
  - *2024 Medicare Advantage products* on page 24

2024 cardiology program changes

Our cardiology program's scope and participation are expanding. Effective January 1, 2024, the program will include:

- Pre-service medical necessity review for select cardiac devices
- ASO groups that choose to buy up the program

Cardiac devices

Outpatient cardiovascular tests and procedures are currently reviewed under the cardiology program. Implantable cardiac devices will be added to the program January 1, 2024. **Related**: See *Pre-authorization updates* on pages 9-10.

About the program

Carelon Medical Benefits Management (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 can contact Carelon to request pre-authorization for these additional services and/or members beginning December 18, 2023:

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

IIf 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.

Requests for supporting documentation

Beginning January 1, 2024, Carelon may request additional clinical information for cardiology pre-authorization requests for commercial and Medicare Advantage members.

If requested, providers will need to submit documentation from the patient's medical record to verify the member's condition. Carelon will request this documentation only for select procedures when certain clinical indications are present.

Learn more

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

The Bulletin recap

We publish updates to medical policies and reimbursement policies in our monthly publication, *The Bulletin*. You can read issues of *The Bulletin* or subscribe to receive an email notification when issues are published on our provider website: Library>Bulletins.

Medical policy updates

We provided 90-day notice in the August 2023 issue of *The Bulletin* about changes to the following medical policies, which are effective November 1, 2023:

- *Air Ambulance Transport* (Utilization Management #13)
- *Enteral and Oral Nutrition Therapy in the Outpatient Setting* (Allied Health #05)
- *Hysterectomy* (Surgery #218)
- *Identification of Microorganisms Using Nucleic Acid Probes* (Genetic Testing #85)

We provided 90-day notice in the September 2023 issue of *The Bulletin* about changes to the following medical policies, which are effective December 1, 2023:

- *Cochlear Implants* (Surgery #08)
- *Intensity Modulated Radiation Therapy* (IMRT) (Medicare Advantage Medicine #136)
- *Ventral (including incisional) Hernia Repair* (Surgery #12.03)

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

No reimbursement policies in the August 2023 or September 2023 issues of *The Bulletin* required 90-day notice.

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

Nuclear imaging to require pre-authorization

As a reminder, select nuclear medicine imaging services for fully insured commercial and Medicare Advantage members delivered on or after November 1, 2023, will require pre-authorization as part of our radiology program, managed by Carelon.

Providers can begin contacting Carelon on October 7, 2023, for these services using Carelon's ProviderPortal, **providerportal.com**, or by calling Carelon at (877) 291-0509, Monday through Friday, 8 a.m.-5 p.m. (PT). Program details are available on our provider website: Programs>Medical Management>Radiology.

The nuclear imaging codes are published in the Pre-authorization section of our provider website.

Preferred GLP1 agonist-containing medications reminder

In the August issue of this newsletter, we notified you of a new *Preferred GLP1 Agonist-Containing Medications* (dru 750) medication policy effective October 1, 2023. For new or refilled prescriptions beginning October 1, 2023, we will require pre-authorization and limit coverage to members with type 2 diabetes. This will ensure that the use of these medications is related to management of type 2 diabetes and consistent with our health plan benefit designs.

Update to Asuris EquaPathRx™ program

As a reminder, we are launching Asuris EquaPathRx January 1, 2024, as a provider-administered specialty medication benefit for specific drugs with a provider network solution that keeps the provider-patient relationship intact and the costs of care predictable for members.

We appreciate the feedback we have received about the administrative burden of submitting the claim for medical services to us and for the medication to Prime Therapeutics. We have identified a solution that eliminates that burden and will not require you to submit separate claims. With this solution, you will continue to submit claims directly to us as you do today, and we will adjudicate the medication portion of the claim in accordance with the terms and rates of the agreement you have with Prime Therapeutics for the IntegratedRx® - Medical network, which supersedes the terms and rates applicable to those medications under your agreement with us.

Note: You must have a contract with Prime Therapeutics to be reimbursed for administering medications included in the Asuris EquaPathRx benefit to members with the new benefit.

Please contact Prime Therapeutics to complete the process of credentialing and contracting for the IntegratedRx - Medical network. **To ensure that you're added to the network by January 1, 2024, complete the credentialing and contracting process with Prime Therapeutics before October 31, 2023**.

The list of medications (with HCPCS codes) that will be included in this program as of January 1, 2024, has been updated and is on our provider website: Programs>Medical Management>Pharmacy.

Related: See *Medication policy updates* on pages 15-16.

Medication policy updates

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

Pre-authorization: Submit medication pre-authorization requests through **covermymeds.com**.

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

New U.S. Food & Drug Administration (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 December 1, 2023	Description
Revised medication policies	
Opzelura, ruxolitinib cream, dru679	- Updating coverage criteria to state that combination use of Opzelura with therapeutic biologics, other Janus Kinase (JAK) inhibitors or potent immunosuppressants, such as azathioprine or cyclosporine, is investigational and will not be covered
Ileal Bile Acid Transporter (IBAT) Inhibitors, dru699	- Adding coverage criteria for Bylvay in Alagille syndrome (ALGS), a newly FDA-approved indication, requiring step therapy with Livmarli prior to coverage
Rearranged during transection (RET) Inhibitors, dru726	- Removing medullary thyroid cancer as a coverable indication for Gavreto because the FDA withdrew this indication
Complement Inhibitors, dru385	- Updating coverage criteria to allow for Ultomiris SC (in addition to the IV formulation) for paroxysmal nocturnal hemoglobinuria and atypical hemolytic uremic syndrome - Adding coverage criteria for Ultomiris IV for neuromyelitis optica spectrum disorder (NMOSD), a newly FDA-approved indication - Updating coverage criteria for Soliris to require step therapy with Ultomiris for NMOSD in addition to Enspryng and Uplizna
Fabry Disease Treatments, dru575	- Adding newly FDA-approved Elfabrio (pegunigalsidase alfa) to policy - Updating coverage criteria to include confirmed Fabry disease diagnosis via enzyme deficiency (<30% alpha-Gal A activity) and/or genetic mutation of GLA gene.

Continued on page 16

Continued from page 15

Effective January 1, 2024	Description
New medication policies	
Asuris EquaPathRx™, dru764	- New contract administration reference policy that identifies which provider-administered specialty injectable medications are subject to the Asuris EquaPathRx program - Under this benefit program, certain injectable medications must be preauthorized and obtained by the administering provider through the designated IntegratedRx® - Medical (specialty pharmacy for provider-administered specialty drugs) network
Non-Preferred Drugs, dru760	- New policy will combine the following existing policies: • Non-Preferred DPP4 Inhibitor Containing Medications, dru345 • Non-Preferred Inhaled Corticosteroid Containing and Muscarinic-Antagonist Containing Medications, dru380 • Non-Preferred SGLT2-Inhibitor Containing Medications, dru543 • Non-Preferred Short-Acting Beta Agonist Metered Dose Inhalers, dru584 • Non-Preferred Combination SGLT2-DPP4 Inhibitor Containing Medications, dru689 - Updating preferred ICS-containing inhaler products: • Advair Diskus (brand) will be non-preferred; covered options include the generic • Flovent HFA and Flovent Diskus will be non-preferred and require pre-authorization; covered options include fluticasone HFA and Arnuity • Generic tiotropium will be non-preferred; covered options include Spiriva HandiHaler (brand) - Adding non-preferred HCG products (Novarel and Chorionic Gonadotropin) to policy; the preferred products (Ovidrel and Pregnyl) will not require pre-authorization - Adding Veozah (fezolinetant), Gemtesa (vibegron), and Myrbetriq (mirabegron) to policy - Adding non-preferred pancreatic enzymes (Pancreaze, Pertzye and Viokace) to policy; the preferred products (Creon and Zenpep) will not require pre-authorization
Revised medication policies	
Medicare Part B Step Therapy, dru-m-001	- Updated target drug list for 2024. - For pegfilgrastim, Ziextenzo will be moved to non-preferred; the preferred products (Fulphila and Nyvepria) will not require pre-authorization. - For infliximab, Renflexis will be moved to non-preferred; the preferred products (Avsola and Inflectra) will not require pre-authorization.
Products with Therapeutically Equivalent	- Updated target drug list for 2024
Biosimilars/ Reference Products, dru620	- For pegfilgrastim, Ziextenzo will be moved to non-preferred; the preferred products (Fulphila and Nyvepria) will not require pre-authorization.
Immune Globulin Replacement Therapy, dru020	- Updating coverage criteria to consider the use of Bivigam, Gammaplex, Panzyga, Cuvitru and Hyqvia to be not medically necessary and therefore not covered - Adding coverage criteria for PANDAS/PANS - Clarifying subspecialist requirements in diagnostic criteria
Medications for multiple sclerosis, dru753	- The following medications will be considered non-preferred: Betaseron, Mavenclad and Plegridy

Behavioral health corner

About behavioral health corner

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

Articles in this issue with behavioral health content	Page
Help members know where to go for care	3
Records requirements for admissions and inpatient concurrent review	11
Diagnosing and treating depression in primary care	18-19
SAD could affect your patients this winter	19
In-home, high-acuity care for your patients	22

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

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

Behavioral health corner

Diagnosing and treating depression in primary care

Diagnosing and treating depression in primary care

Most behavioral health treatment is provided in the primary care setting, and proper mental health and substance use treatment are integral to a person's overall health.

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

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

Routine depression screenings in the primary care setting are considered a best practice for intervention and treatment. Patients may feel more comfortable with their PCP, with whom they have an established relationship, rather than seeking help from a behavioral health provider. Additionally, those suffering may not seek treatment because they don't recognize their symptoms or don't want to acknowledge them. Fortunately, many primary care groups have integrated licensed behavioral health professionals who can take "warm handoffs" to begin further assessment and initial treatment without needing an outside referral.

Recognize risk factors

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

Common signs and symptoms

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

Resources for PCPs

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

The toolkit also includes:

- A list of in-network virtual providers with a variety of areas of expertise; telehealth visits may allow members to start treatment sooner and provide more flexible scheduling
- A presentation titled *Depression: Screening and treatment in the primary care setting*
- Information to help PCPs determine the best path forward in the early stages of a patient's evaluation and treatment
- Information about our care management services, including case management

Continued on page 19

Continued from page 18

- Resources for treating members who may have the following diagnoses and challenges:
  - Anxiety
  - Alcohol use
  - Attention-deficit/hyperactivity disorder (ADHD)
  - Bipolar disorder
  - Eating disorders
  - Gender identity
  - Opiate use
  - Pain management
  - Post-traumatic stress disorder (PTSD)
  - Substance use disorder
  - Suicide prevention

Knowing when to refer

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

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

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

SAD could affect your patients this winter

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

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

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

SAD can be treated using light therapy (10,000 LUX light) and vitamin D supplements, or through traditional forms of care, such as psychotherapy and antidepressant medication. To help identify SAD in your patients:

- Ask about mental health issues during the patient's physical exam.
- Check for symptoms of depression by asking about symptoms and the patient's thoughts, feelings and behavior patterns.
- Consider using a diagnostic tool, such as the Seasonal Pattern Assessment Questionnaire or the Patient Health Questionnaire 9 (PHQ-9) quick depression assessment. The PHQ-9 is available in the Depression section of the Behavioral Health Toolkit on our provider website: Behavioral Health>Behavioral Health Toolkit.

Healthwise's Knowledgebase has helpful information about SAD. For materials in English and Spanish to share with your patients, access their site via our provider website: Programs>Quality>Quality Improvement Toolkit.

2024 commercial products and networks

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

Group network and product updates

Small employer (1 to 50) group metallic products

- Expanding wellness rewards to spouses and domestic partners
- Expanding coverage for hearing aid devices and services

Fully insured groups of 51+

- **Asuris Virtual Saver™ plans**: These plans give employees access to unlimited virtual care visits at no cost to them—before they meet their deductible.

Fully insured groups of 51+ and ASO groups

- **Classic**: No-math plan options: These plans offer a zero-dollar copay, with 0% in-network and 50% out-of-network member coinsurance after the deductible. Additional plan accumulator options have been added this year to meet market demands.

Fully insured groups of 101+ and ASO groups

- **Virtual primary care option**: Our no-math plans offer a zero-dollar copay, with 0% in-network and 50% out-of-network member coinsurance after the deductible. Additional plan accumulator options have been added this year to meet market demands.

Individual network and product updates

Our product portfolio will include:

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

The Individual and Family Network will support our off-exchange products:

- **Network service area**: Statewide
- **Sales area**: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman counties

The open enrollment period for individuals seeking coverage beginning on January 1, 2024, is from November 1, 2023, through January 15, 2024. Individuals may qualify for special enrollment periods outside of this period if they experience certain life events.

Members whose plans are being discontinued have received notice from us about options available to them in 2024.

Benefit highlights for our commercial products

- In addition to having access to telehealth services from in-network providers, members will have access to telehealth services for urgent care and behavioral health through the national telehealth vendors. **Related**: See *Help your patients know where to go* on page 3.
- Most members will have access to either telephone or chat nurse triage lines (depending on their plan), available 24/7.
- The mobile urgent care service DispatchHealth, **dispatchhealth.com**, will be available in the Spokane area. **Related**: See *In-home, high-acuity care for your patients* on page 22.
- Pharmacy updates:
  - Certain provider-administered specialty medications will only be covered under the Asuris EquaPathRx member benefit and will need to be pre-authorized and obtained by providers through the new IntegratedRx – Medical Network. **Related**: See *Update to Asuris EquaPathRx Program* on page 14.
  - **For our small group and Individual and family products**: We are introducing a new Transition Fill program, a pharmacy enhancement that provides a one-time, 30-day fill within first 90 days of eligibility.
  - **For our Individual and family products**: Pharmacy benefits will transition from a six-tier to a four-tier formulary structure.
- **For our small group and Individual and family products**: We are reducing cost-shares for diagnostic breast exams.

Continued on page 21

Continued from page 20

- **For our fully insured groups 51+ and our Individual and family products**: Employees and their spouses/domestic partners can continue to earn up to $100 through Asuris Motivate when they get certain preventive care screenings and exams. Additional activities have been added to improve member engagement with their wellness program.

Verify network participation

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

Verify eligibility and benefits

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

More information

Information about our 2024 products will be available in the Products section of our provider website in January 2024.

Update your directory information

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

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

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

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

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

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

In-home, high-acuity care for your patients

DispatchHealth extends your practice by providing comprehensive and trusted medical care for serious health concerns in the comfort of the patient's home. DispatchHealth will share clinical notes with you after every visit.

In the Spokane area, DispatchHealth can:

- Reduce health care costs by decreasing non-emergent trips to the emergency department (ED) by providing urgent medical care, hospital-alternative care and post-discharge hospital care
- Extend your reach after-hours, on weekends, on holidays or during capacity constraints
- Provide insight into social determinants of health

Get started

- Watch this short video to learn about their team and services: **dispatchhealth.com/blog/dispatchhealth-perspective-who-we are**.
- See if appointments are available in a member's ZIP code: **dispatchhealth.com/locations**.

DispatchHealth services

DispatchHealth care teams provide in-home urgent medical care, hospital alternative care and post-hospital care.

Urgent medical care

DispatchHealth care teams provide in-home high-acuity, same-day medical care to your patients for urgent illnesses and injuries, such as urinary concerns, extremity injury, swelling, confusion, weakness, nausea, vomiting, diarrhea, rash, cellulitis, abscesses and more. Urgent medical care services cost members the same as an urgent care center visit.

Hospital-alternative care

Their care team visits patients with complex medical conditions that could otherwise result in a hospital inpatient admission, including cellulitis, pneumonia, exacerbations of congestive heart failure (CHF) or COPD and more. Hospital-alternative care visits may have out-of-pocket costs.

With this program, you can:

- Improve health outcomes and patient satisfaction
- Drive significant medical cost savings, including a reduction in the 30-day readmission rates
- Reduce unnecessary ED visits, SNF stays and ancillary service utilization

View this short video about Advanced Care: **dispatchhealth.com/blog/category/partner-resources-tips/advanced-care-for-case-management**.

Post-discharge hospital care

DispatchHealth can provide a one-time visit with a patient within 72 hours of their discharge from the hospital to help prevent readmission for such conditions as cellulitis, pneumonia, exacerbations of CHF or COPD and more. Post-discharge hospital care visits are covered by the member's health plan.

Watch this short video about Bridge Care: **dispatchhealth.com/blog/category/partner-resources-tips/post-hospital-bridge-care-for-the-patient**.

How it works

1. Request an appointment for your patient

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

2. A care team is sent to your patient's home

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

3. Follow-up communication and coordination of care

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

Learn more

Visit the Care Options Toolkit on our provider website for a flyer to share with your office and answers to frequently asked questions.

Reviewing medications with patients

One of a PCP's important roles is acting as an information resource regarding all the medications their patients take. Our members often take several medicines, vitamins and supplements from different sources. They face the risk of duplicate therapy or potentially adverse interactions if they have multiple prescribers.

By reviewing all of the patient's medications during their visits, PCPs can identify potentially duplicate or dangerous combinations of medicines. We know that many of these reviews do occur. In a survey conducted of our Medicare members in 2022, about 83% responded affirmatively to a question about whether they had talked with their provider about all the prescription medications they were taking.

Although this rate is good, it still means many of our members are not having the conversation or are not remembering having had a conversation. To facilitate memorable conversations about medications, many offices ask patients to bring all their medications, vitamins, supplements, herbal remedies and other products they are taking to an office visit at least once per year.

During that visit, the PCP, a nurse or pharmacist can:

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

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

Patient resources

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

Offering remote EMR service for HEDIS chart collection

Let us take on the responsibility to retrieve medical records for the upcoming annual Healthcare Effectiveness Data and Information Set (HEDIS®) chart collection project by signing up for the remote EMR access service.

Providers can grant us access to their EMR, allowing us to pull the required documentation. Not only does this aid your office in reaching compliance, it reduces the time and cost associated with medical record retrieval.

Our EMR team is experienced with multiple EMR systems and extensively trained annually on HIPAA, EMR systems and HEDIS measure updates. We complete medical record retrieval based on minimum necessary guidelines:

- We only access medical records of members pulled into the HEDIS sample using specific demographic data.
- We only retrieve the medical records that have claims evidence related to the HEDIS measures.
- We access the least amount of information needed for use or disclosure, or we access only the specific medical records requested.
- We only save to file; we do not physically print any personal health information.

Getting started with remote EMR access

For the upcoming HEDIS chart collection beginning in February 2024, please contact Brenda Taylor or Kellee Mills.

- Brenda Taylor at (208) 798-2042 or **brenda.taylor@asuris.com**
- Kellee Mills at (208) 750-2758 or **kellee.mills@asuris.com**

2024 Medicare Advantage products

We work to ensure our members receive the best value for their health care dollar by evaluating our products and networks each year. Included below is an overview of the key changes to our Medicare Advantage (MA) products in 2024.

There are no changes to our service area or plan offerings in 2024.

Benefit changes and additions

Current MA members will receive the Annual Notice of Changes, which highlights the changes specific to their product for 2024. Some key benefit changes are listed below.

Notes:

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

Medical benefits

- Partial hospitalization copay increase
- Hospital observation copay increase
- Home health pre-authorization will be required starting on the first day of care; **Related**: See *Pre-authorization updates* on pages 9-10 and *Carelon to manage authorizations for Medicare Advantage post-acute care facilities, home health* on page 12.
- Emergency department copay will increase by $10-$30, depending on the plan
- Combined maximum out-of-pocket increase on all MA PPO plans; amount varies by plan
- Skilled nursing facility (SNF) extended day range will start at day 21, with an increased copay for mid-range of stay (varies by plan)

Dental

- All preventive and comprehensive dental benefits will be included with the medical plan. We are discontinuing optional supplemental benefit packages that included dental.
- Dental benefits will be administered by United Concordia Dental, and the network will be managed by USAble. **Related**: See *New resources and support for dental providers* on page 5.

Chiropractic

- Routine chiropractic will no longer be covered on all plans.
- Medicare-covered chiropractic and acupuncture services will continue to be covered on all plans.

Home and bathroom safety devices

- Benefit will be discontinued in 2024.

Personal Emergency Response System (PERS)

- PERS will no longer be covered on Primary PPO plans. Members who wish to continue receiving PERS services will need to pay Lively directly.

Papa Pals

- Benefit will be discontinued in 2024.

Formulary changes

- Our Medicare Part D formulary continues to offer several medications in all classes as required by CMS.
- We encourage the use of generics and biosimilars whenever possible, as a safe and easy way to help save on drug costs and still maintain high-quality care.
- Lantus will be removed from our Medicare formulary in 2024, replaced by the preferred biosimilar Semglee. Members who will be impacted by formulary changes will receive written notification listing impacts and alternatives.

Medicare retiree group plans

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

Medicare Advantage QIP fourth quarter reminders

The following reminders about the 2023 MA QIP will support your program participation as we approach the final months of 2023.

Final attribution update

To provide your group with roster stability in the last three months of the program year, MA QIP member attribution is locked after our last attribution file is loaded to the CGMA in early October. Changes will not be made to providers' member rosters after the final attribution file is loaded, except to remove members who lose eligibility.

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

Risk adjustment gaps

New gaps added after October 1, 2023, will not be added to your performance denominator.

If you close a risk adjustment gap after October 1, 2023, the closed gap will be added to both your numerator and denominator.

Quality gaps

You may see new gaps but only for existing patients on your roster. Quality gaps that open after October 1, 2023, will be added to your denominator in accordance with the specifications for each measure.

On the CGMA, visit the Medicare Frequently Asked Questions (FAQ) article *How do I Manage my Member Roster?* for information about rosters.

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

Keep up the great work

We are approaching the final months of our 2023 MA QIP performance year. If your patients still have gaps that require an office visit or screening to be completed this year, we encourage you to contact them to schedule now. You can review your patients' open gaps on the CGMA. To ensure that we have the information necessary to close your gaps for the 2023 program, we will accept claims or documentation until the dates listed below for each method of gap closure submission:

- December 31, 2023—Last day to perform services
- January 31, 2024—Last day to submit evidence to close gaps for MA Coordination of Care (MACOC) members
- February 28, 2024—Last day to submit supplemental data
- February 28, 2024—Last day to work on the CGMA
- March 31, 2024—Last day to submit medical or pharmacy claims

QIP primary contact

To better serve your practice and facilitate our MA QIP, we would like to identify the QIP primary contact for your office/group. Please be ready to identify this person for your office/group when Novillus contacts you.

The QIP primary contact is the:

- Person who can approve CGMA access for other users associated with your TIN or roll-up group
- Person who can verify or provide your QIP payout address

Questions about MA QIP

Email us at **QIPQuestions@asuris.com**, and visit our provider website: Programs> Medicare Quality Incentive Program.

Resources for you

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

Publications team

Sara Perrott: Publications editor, designer and writer

Cindy Price: Managing editor and writer

Sheryl Johnson: Writer

Carrie White: Writer

Jayne Drinan: Writer

Janice Farley: Editor