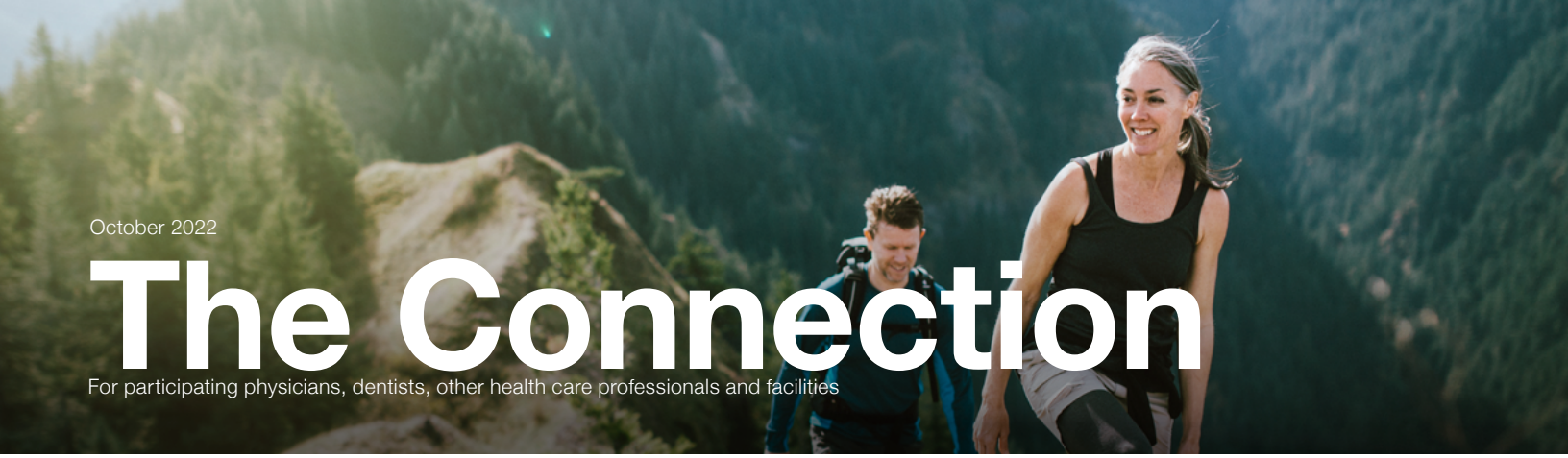

October 2022

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

- Breast Cancer Awareness Month: **nationalbreastcancer.org/breast-cancer-awareness-month**
- 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**
- Healthwise Knowledgebase: **healthwise.net/asuris**

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

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

Stay up to date

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

Asuris Northwest Health

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

Contents

■ Critical article	We encourage you to read the other articles because they may apply to your specialty.
✶ DME must read	
▲ Dental must read	
‡ Radiology must read	

Click on a title to read the article.

About *The Connection*

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

Recontracting updates

We are nearing the end of our project to replace individual provider agreements and update all *Medical Group Agreements* (MGAs) with *Professional Services Agreements* (PSAs).

If you have not already signed your new agreement via DocuSign, please sign it immediately.

VBA attribution methodology annual update

Patient attribution is a critical part of value-based agreements (VBAs) and defines the member population for whom a provider is accountable. Our attribution methodology for VBAs will be updated effective January 1, 2023. This annual update will be available on our provider website by November 1, 2022: Contracting & Credentialing> VBA Resources.

Editor's note (updated December 1, 2022): Information about our cardiology program originally appeared below in the incorrect *Administrative Manual* section.

Administrative Manual updates

The following updates were made to the manual on October 1, 2022:

Alternative Care

- Revised references to licensed massage therapists (LMTs)

Facility Guidelines

- Consolidated behavioral health information
- Added skilled nursing facility (SNF) reimbursement information for Medicare Advantage providers
- Added facility-specific utilization management information from the Medical Management section
- Removed 24-hour admission notification exceptions for holidays and weekends effective January 1, 2023
- Added information about our *Surgical Site of Service – Hospital Outpatient* (#UM19 and #M-UM19) commercial and Medicare Advantage medical policies

Medical Managment

- Added introductory content
- Simplified program information
- Added information about new cardiology utilization program
- Removed facility-specific utilization management information

Medicare Advantage plans

- Added Medicare Star Ratings information

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

SNF audits begin in 2023

For services delivered on or after January 1, 2023, we will conduct post-payment review of SNF claims for pricing and payment accuracy.

Our vendor, Performant, will contact your office if your claim is selected for review:

- To validate the services billed on the claim
- To verify the pricing method applied is correct
- To verify the payment rendered is appropriate to the member's plan of benefits

If you disagree with Performant's findings, you can appeal to Performant. Their contact information is provided on the determination letter. We will request recoupment via adjustment of a future claim payment.

Reviews will be conducted for our commercial and Medicare Advantage plans.

Medicare Advantage home health reimbursement schedule update

In our ongoing efforts to reward high-quality care provided to 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, 2023, Asuris will use the ratings reported in July 2022.

Home health agencies can view their Centers for Medicare & Medicaid Services (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 are outlined in the Facility Guidelines section of the *Administrative Manual*, available on our provider website: Library>Administrative Manual.

As a reminder, reimbursement is based on a percentage of the current CMS 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**.

Medicare Advantage dental reimbursement schedule update

We are updating our Medicare Advantage dental reimbursement schedule. Dental claims with dates of service on or after January 1, 2023, will be reimbursed based on a hierarchy of the provider's network participation with Asuris Medicare Advantage Dental Network, United Concordia Dental and/or DenteMax. View the hierarchy on our provider website: Claims & Payment>Receiving Payment>Professional Reimbursement.

View the Asuris Participating Dental Reimbursement Schedule on Availity Essentials: Claims & Payments>Fee Schedule Listing. Not all plans will have the same benefits, so it is important for you to verify member eligibility and benefits using Availity Essentials. **Note:** United Concordia Dental and DenteMax fee schedules can be accessed according to your agreement with United Concordia Dental and/or DenteMax.

Independent laboratories and billing place of service

As a reminder, there are claim submission guidelines for independent laboratories billing for tests on samples drawn at a place of service (POS) outside of their facility. The POS is defined as where the sample was drawn; the POS must be included on claims.

POS codes for samples drawn on individuals who are inpatient or outpatient at a hospital are:

- Inpatient (POS 21)
- Off-campus outpatient hospital (POS 19)
- On-campus (POS 22)

An independent laboratory taking a sample in its own laboratory would reflect POS 81 on the claim.

For more information, refer to the CMS Claims Processing Manual 26.10.6, available at **cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf**. These guidelines are also available in the Laboratory section of our *Administrative Manual* on our provider website: Library>Administrative Manual.

Advantages of using CPT Category II codes

CPT Category II (CPT II) codes are supplemental tracking codes intended to facilitate data collection about care quality. CPT II codes describe components that are typically included in an evaluation and management (E&M) service or test results that are part of the laboratory test or procedure. They provide more information about the care your patient received during a visit.

Why you should use CPT II codes

Submitting CPT II codes will:

- Share clinical data using claims
- Allow providers with value-based agreements (VBAs) to provide more complete data to us
- Improve the data used for performance measurement, such as Healthcare Effectiveness Data and Information Set (HEDIS®) reporting
- Decrease the volume of record abstraction and chart review, which reduces the administrative burden on providers
- Simplify gap closure for many of our Medicare Quality Incentive Program (QIP) measures

If you use the Care Gap Management Application (CGMA) to track your QIP performance, CPT II codes provide an automated method for closing many gaps.

Resources

Our *Quality Measures Guide* is helpful for understanding which CPT II codes can help support performance measurement data and gap closure and is available in the CGMA or on our provider website: Library>Printed Material.

These guides are available on our provider website: Products>Large Groups and Administrators>FEP>Quality Improvement Provider Toolkits.

We encourage you to use CPT II codes whenever possible to improve efficiency for quality reporting.

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 in process. 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

Hearing aid reimbursement schedule update

In May 2022, we increased reimbursement rates for hearing aids. The May 1, 2022, reimbursement change applies to all commercial lines of business and plans, regardless of benefit limits. **Excluded:** Medicare Advantage members and facilities. **Note:** This clarification supersedes previous hearing aid-related communications.

If a member chooses to upgrade to a hearing aid product above the fee schedule, the member should complete a *Non-Covered Services Member Consent Form.*

To verify a member's benefit amount, check Availity Essentials.

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/webhelp/nppeshelp**.

DRGs based on claims data

As a reminder, a provider's contract dictates the Medicare Severity Diagnosis Related Group (MS-DRG) version used to process their inpatient hospital claims. A provider's grouper version is not revised when CMS releases a new version.

ICD-10 codes are specific to each grouper version. When an ICD-10 code outside a provider's grouper version is billed, it is mapped to an ICD-10 code that is part of the grouper version in the provider's agreement. We use software based on CMS' software specifications to map these codes.

DRGs are assigned based on data submitted on a claim, including the following:

- Patient's age and gender
- Diagnosis and present on admission (POA) indicator
- ICD-10-CM codes
- Admission date
- Discharge status
- Bill type

Using those data, the grouper assigns a DRG based on the grouper version in the provider's agreement. For non-Medicare claims, the DRG grouping is based on the admission date.

For additional information about the claims data used to assign a DRG, view the *Facility DRG Validation* (Facility #111) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

New edit on chiropractic code

CPT 98943 edit: Effective January 1, 2023, we will add a ClaimsXten edit to limit CPT 98943 (chiropractic manipulation of one or more of the extra-spinal regions) to one unit per date of service. Additional units will be denied.

This change is supported by the Alternative Care section of our *Administrative Manual* and applies to all lines of business. Our manual sections are available on our provider website: Library>Administrative Manual.

Responding to documentation requests

When medical records or supporting documentation are needed for claims processing, we request them through Availity's Attachments application, fax, email or USPS. We are increasing the number of requests sent through Availity Essentials. If you receive a request for medical records, please respond using the same format in which the request is received. If you receive a request via Availity, you must submit requested records using the Attachments application.

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

The Attachments application allows fast, easy and secure transmission of supporting documentation. You can also view the status and history of submitted records in the attachments dashboard and can message us directly from the application if you have questions.

Getting set up for the Availity Attachments application is easy. Your organization's Availity administrator can assign the medical attachments role to users who need access to Attachments—New. Learn more about setup and using the application in the Getting Started Guide on Availity Essentials: Help & Training>Get Trained, then search for Attachments—New.

Notes:

- Do not submit medical records with a claim unless indicated on the *Clinical Edits by Code List* on our provider website: Claims & Payment>Coding Toolkit.
- If medical records are required to process your claim, we will send you a request.
- Sending unsolicited attachments can delay the processing of your claim. Only use the Attachments application to submit documentation when you receive a notification in your Availity Essentials work queue.

Learn more

Find on-demand and live training options or download a Getting Started Guide on Availity Essentials: Help & Training>Get Trained, then search for Attachments—New.

Editor's note (updated December 20, 2022): The cardiology program code list originally published included an incorrect code range. The corrected codes are noted in red.

Pre-authorization updates

Commercial Pre-authorization List updates

Procedure/medical policy	Added codes effective September 1, 2022
Charged-Particle (Proton) Radiotherapy (#MED49)	- 77301, 77338
Procedure/medical policy	**Added codes effective October 1, 2022**
Expanded Molecular Testing of Cancers to Select Targeted Therapies (#GT83)	- 0334U
Procedure/medical policy	**Adding codes effective November 1, 2022**
Surgical Site of Service - Hospital Outpatient (#UM19)	- 43235, 43237-43239, 43242, 43245-, 43251, 43254, 45378-45381, 45384-45386, 45390, 45398
Procedure/medical policy	**Adding codes effective December 1, 2022**
Definitive Lower Limb Prostheses (#DME18)	- L5610, L5611, L5613, L5614, L5616, L5700-L5703, L5710-L5712, L5714, L5716, L5718, L5722, L5724, L5726, L5728, L5780, L5810-L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5828, L5830, L5840, L5848, L5856-L5858, L5930, L5970, L5972, L5974, L5976, L5978-L5982, L5984-L5987
Procedure/medical policy	**Adding codes effective January 1, 2023**
AIM Specialty Health (AIM) Cardiology	- 37220, 37221, 37224-37231, 92920, 92924, 92928, 92933, 92937, 92943, 93454-93461, 93880, 93882, 93922-93926, 93930, 93931, 93978, 93979

Medicare Advantage

Procedure/medical policy	Added codes effective October 1, 2022
Genetic and Molecular Diagnostics – Single Gene or Variant (#M-GT20)	- 0338U
Genetic and Molecular Diagnostics – Next Generation Sequencing and Genetic Panel Testing (#M-GT64)	- 0334U, 0340U, 0343U, 0345U, 0352U, 0118U, 0131U, 0133U, 0134U, 0171U
Charged-Particle (Proton) Radiotherapy (#M-MED49)	- 77301, 77338
Procedure/medical policy	**Adding codes effective November 1, 2022**
Surgical Site of Service – Hospital Outpatient (#M-UM19)	- 43235, 43237-43239, 43242, 43245-43251, 43254, 45378-45381, 45384-45386, 45390, 45398

Continued on page 9

Continued from page 8

Procedure/medical policy	Adding codes effective December 1, 2022
Definitive Lower Limb Prostheses (#M-DME18)	- L5610, L5611, L5613, L5614, L5616, L5700-L5703, L5710-L5712, L5714, L5716, L5718, L5722, L5724, L5726, L5728, L5780, L5810-L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5828, L5830, L5840, L5848, L5856-L5858, L5930, L5970, L5972, L5974, L5976, L5978-L5982, L5984-L5987

Procedure/medical policy	Adding codes effective January 1, 2023
AIM Cardiology	- 37220, 37221, 37224-37231, 92920, 92924, 92928, 92933, 92937, 92943, 93454-93461, 93880, 93882, 93922-93926, 93930, 93931, 93978, 93979

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 Availity Essentials. Learn more on our provider website: Pre-authorization>Electronic Authorization.

Cardiac program to launch in 2023

We are launching a cardiology program to review outpatient cardiovascular tests and procedures. The program will require pre-service medical necessity review through AIM for cardiac services delivered on or after January 1, 2023.

AIM will administer the program, which works to improve health care quality and manage costs for the most complex and prevalent tests and treatments, helping to promote care that is appropriate, safe and affordable.

This program will apply to fully insured commercial and Medicare Advantage members.

Exclusions: Procedures performed in an inpatient setting or on an emergent basis are not subject to this program's pre-authorization requirements.

For services delivered before January 1, 2023

For services that currently require pre-authorization and will be delivered before January 1, 2023, continue to submit pre-authorization requests as you currently do.

For services delivered on or after January 1, 2023

Beginning December 19, 2022, providers will be able to contact AIM for pre-authorization of services to be performed on or after January 1, 2023, using one of the following methods:

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

If a provider does not verify that a pre-authorization request has been approved before performing an outpatient cardiac service, the claim will be reviewed post-service and may deny as provider responsibility.

Contact AIM to obtain an authorization number for the following non-emergency cardiac services:

- Diagnostic coronary angiography with or without right or left heart catheterization
- Arterial duplex
- Physiologic study arterial
- Percutaneous coronary intervention, such as coronary stents and balloon angioplasty and atherectomies; post-service review will be performed within 10 days of the service

Note: These cardiograph services currently require pre-authorization as part of our radiology program; please continue to contact AIM for pre-authorization of these services before and after January 1, 2023.

- Stress echocardiography (SE)
- Resting echocardiography (TTE)
- Transesophageal echocardiography (TEE)

Register today

Before submitting a request, providers need to register an account for AIM's ProviderPortal: **providerportal.com**.

Resources and training

AIM has resources to help your practice get started with the cardiology program with useful information and tools, such as checklists and clinical guidelines: **aimprovider.com/cardiology.**

AIM will offer webinars and Q&A sessions before the program launches for providers and office staff to learn more about the program and how to use the AIM ProviderPortal. Sessions will cover:

- How the program and pre-authorization request process work
- Which members and services will require pre-authorization
- A demonstration of the AIM ProviderPortal and how to enter requests

Once you register for training, you will be able to view training content. Reviewing the material before the training can help your facility identify questions to ask during the session. Recordings will also be available before January 1, 2023, for registered ProviderPortal users.

Look for more information on our provider website in November 2022 and in the December 2022 issue of this newsletter. **Related**: See *Pre-authorization updates* on pages 8-9.

Gastrointestinal procedures at hospitals to require pre-authorization

Reminder: Effective November 1, 2022, select gastrointestinal procedures (e.g., endoscopy, colonoscopy) performed at a hospital outpatient surgical site will require pre-authorization for the site of service.

Under our new *Surgical Site of Service – Hospital Outpatient* (#UM19 and #M-UM19) commercial and Medicare Advantage medical policies, we will require pre-authorization for the following codes when performed at a hospital outpatient place of service:

- **Colonoscopy**: CPT 45378-45381, 45384-45386, 45390 and 45398
- **Endoscopy**: CPT 43235-43239, 43242, 43245-43251 and 43254

These services will not require pre-authorization when performed at an ambulatory surgical center (ASC) or physician office.

Important date: Providers can request pre-authorization for these services beginning October 7, 2022. If faxing the pre-authorization request, providers should include an attestation form, available on our Pre-authorization lists.

We consider an individual's health status, facility and geographic availability, specialty requirements, physician privileges and other factors when determining the appropriate site of service.

Note: In addition to the site of service, the services performed may require pre-authorization; check the Pre-authorization section of our provider website.

These policies were announced in the August 1, 2022, issue of *The Bulletin*, available on our provider website: Library>Bulletins.

For more information, view the medical policies on our provider website: Library>Policies & Guidelines>Medical Policy.

NICU/PICU form streamlines admission notification

We require notification of all neonatal intensive care unit (NICU) and pediatric intensive care unit (PICU) admissions within 24 hours. Providers should use our *NICU/PICU Notification of Admission Form*, which will help streamline the authorization process for both Asuris and providers.

The form is available on the Pre-authorization section of our provider website.

Holiday and weekend notification exceptions to be removed

We have previously allowed more than 24 hours for hospital and inpatient hospice to notify us of admissions and discharges that occur on a holiday or weekend. We are removing these exceptions effective January 1, 2023. This change will align our 24-hour notification requirement across facility types.

Continue to submit notifications as you do today.

The notification period exemptions will be removed from our pre-authorization lists.

The Bulletin recap

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

Medical policy updates

We provided 90-day notice in the August 2022 issue of *The Bulletin* about the following medical policies, which are effective November 1, 2022:

- *Hypoglossal Nerve Stimulation* (#SUR215)
- *Surgical Site of Service – Hospital Outpatient* (#UM19 and #M-UM19)
  - **Related:** See *Gastrointestinal procedures at hospitals to require pre-authorization* on page 11.

We provided 90-day notice in the September 2022 issue of *The Bulletin* about the following medical policies, which are effective December 1, 2022:

- *Definitive Lower Limb Prostheses* (#DME18 and #M-DME18)
- *Pectus Excavatum and Carinatum Surgery* (#SUR12.02)

The *Medical Policy Manual* includes a list of recent updates and archived policies: Library> Policies & Guidelines>Medical Policy>Recent Updates.

All medical policies are available on our provider website: Library>Policies & Guidelines.

Reimbursement policy updates

We provided 90-day notice in the August 2022 issue of *The Bulletin* about changes to the *Drugs, Immunizations/Vaccines, Radiopharmaceuticals,* and *Skin Substitutes Reimbursed Under Medical Coverage* (Medicine #104) commercial and Medicare Advantage reimbursement policies, which are effective November 1, 2022.

Our reimbursement policies are reviewed on an annual basis.

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

To see how a claim will pay, access the Clear Claim Connection tool on Availity Essentials: Payer Spaces>Resources>Claims and Payment> Research Procedure Code Edits.

Clinical practice guidelines updates

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

We renewed the following Clinical Practice Guidelines, effective September 1, 2022:

- *Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*
  - Continue to recommend the Veterans Affairs/Department of Defense (VA/DOD) guidelines as a comprehensive evidence-based guideline, with minor changes to the title, hyperlink and year for the most recent edition
- *Management of Chronic Noncancer Pain with Opioids in Adults*
  - Continue to recommend the Health and Human Services (HHS) treatment improvement protocol (TIP) publication as a comprehensive evidence-based guideline
- *Screening and Management of Substance Use Disorders in Adults*
  - Continue to recommend the VA/DOD guidelines as a comprehensive evidence-based guideline
  - Updated the U.S. Preventive Services Task Force (USPSTF) guideline in the Other Resources section

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

Medication policy updates

Listed below is a summary of medication policy additions and changes. Links to all medication policies, medication lists and pre-authorization information for our members, including real-time deletions from our pre-authorization lists, are available on our provider website: Programs>Pharmacy. **Note**: Policies are available online on the effective date of the addition or change.

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 October 1, 2022	Description
Revised medication policy	
Drugs for chronic inflammatory diseases, dru444	- Added Skyrizi as a level 1 self-administered and provider-administered option for Crohn's disease - Olumiant for COVID-19 is considered not medically necessary when used in the outpatient setting - Olumiant for alopecia areata is considered cosmetic per contract definitions - Updated Rinvoq and Xeljanz/Xeljanz XR ulcerative colitis criteria to require Humira step therapy (vs. Humira or Stelara) - Updated Cimzia Crohn's disease self-administration criteria to require two level 1 therapies (vs. one)

Effective October 15, 2022	Description
Revised medication policy	
Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors, dru621	- Adding Cimerli (ranibizumab-eqrn) as a level 2 product

Effective December 1, 2022	Description
Revised medication policies	
Tropomyosin receptor tyrosine kinase (TRK) inhibitors, dru724	- New combination policy replacing individual policies for Rozlytrek and Vitrakvi (dru610 and dru583) - Adding step therapy requirement with Rozlytrek before Vitrakvi

Continued on page 14

Continued from page 13

Effective December 1, 2022 (continued)	Description
Revised medication policies (continued)	
BRAF Inhibitors, dru728	- New combination policy replacing individual policies for Tafinlar and Zelboraf (dru308 and dru266) - Adding coverage criteria for BRAF-mutated solid tumors with reported sensitivity to Tafinlar (dabrafenib)/Mekinist (trametinib), a new FDA-approved indication
Mitogen-activate dextracellular signal-regulated kinase (MEK) Inhibitors, dru727	- New combination policy replacing individual policies for Mekinist, Mektovi and Cotellic (dru307, dru556 and dru442) - Adding coverage criteria for BRAF-mutated solid tumors with reported sensitivity to Tafinlar (dabrafenib)/Mekinist (trametinib), a new FDA-approved indication
Effective January 1, 2023	**Description**
Revised medication policies	
Medicare Part B Step Therapy, dru-m-001	- **Complement inhibitors**: • Adding Soliris to policy as a non-preferred product • The preferred product, Ultomiris, will not require pre-authorization - **IAHA products:** • Changing preferred products to Synvisc, Synvisc One and Orthovisc • Current Euflexxa utilizers may finish their current course and ongoing coverage beyond their current course will require pre-authorization - **Infliximab:** • Moving Remicade and infliximab (Janssen) from preferred to non-preferred • The preferred products, Inflectra and Renflexis, will not require pre-authorization - **Pegfilgrastim:** • Moving Udenyca from preferred to non-preferred • The preferred products, Fulphila and Ziextenzo, will not require pre-authorization - **VEGF inhibitors:** • Adding Susvimo and Vabysmo to policy as non-preferred products • The preferred products, Byooviz and Cimerli, will not require pre-authorization
Non-Preferred Intra-Articular Hyaluronic Acid Derivatives, dru351	- Changing preferred products to Synvisc, Synvisc One and Orthovisc; these products will not require pre-authorization - Moving Euflexxa to non-preferred; current utilizers may finish the current course; ongoing coverage beyond their current course will require pre-authorization

Continued on page 15

Continued from page 14

Effective January 1, 2023 (continued)	Description
Revised medication policies (continued)	
Complement Inhibitors, dru385	- Adding additional step therapy requirements for coverage of Soliris - **The following additional products will need to be ineffective, not tolerated or contraindicated for consideration of Soliris coverage:** • Paroxysmal nocturnal hemoglobinuria (PNH): Ultomiris and Empaveli. • Atypical hemolytic uremic syndrome (aHUS): Ultomiris • Refractory myasthenia gravis (MG): Ultomiris and Vyvgart • Neuromyelitis Optica Spectrum Disorder (NMOSD): Enspryng and Uplizna - Existing utilizers will not be impacted
Non-preferred pegfilgrastim products, dru563	- Changing preferred products to Fulphila and Ziextenzo; these products will not require pre-authorization - Current utilizers of Udenyca will need to change to a preferred product or obtain pre-authorization for ongoing coverage - We will share more information about this change in the December 2022 issue of this newsletter
Follistim AQ, follitropin beta, dru731	- For members with fertility treatment coverage, Follistim AQ will require pre-authorization - The preferred product, Gonal-F, will not require pre-authorization
Acthar H.P. Gel, repository corticotropin injection, dru316	- Moving coverage from medical benefit to pharmacy benefit regardless of self- or provider-administration

Reviewing medications with members

One important role of a PCP is being 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, the PCP 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 2021, 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 the conversation. To facilitate memorable conversations about medications, many offices ask members to bring all their medications to their next visit, including vitamins, supplements, herbal remedies and other products they are taking for their health needs.

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.

Educational handouts and flyers are another great way to help patients remember conversations about their medications. Handouts and flyers can also help PCPs and staff facilitate these conversations. We have several flyers that address medication management available on our provider website: Programs> Cost & Quality>Provider Quality Resources. Some of the flyers, which are available in English or Spanish, include:

- *Your Health: Tips for Taking Medications Safely*
- *Your Health: Staying Safe When You Take Several Medications*
- *Your Health: Questions to Ask About Your Medicines* (This flyer includes space for a patient to list their medications, including the dose and frequency. If the patient completed this form in advance or in the waiting room, it could provide a starting point for a conversation about the medications.)

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.

We also recommend you review the following articles because they often have policy updates that may affect your practice.

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 it 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, overeating and weight gain, feeling sluggish or agitated, having difficulty concentrating and restlessness and agitation, among others

SAD can be treated using traditional forms of care, such as psychotherapy and antidepressant medication, and may also benefit from light therapy and vitamin D supplements. 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 PHQ-9 quick depression assessment.

Healthwise's Knowledgebase has helpful information about SAD. Access their site and materials in English and Spanish at **healthwise.net/asuris**.

Reminder: Reimbursement changes

We revised reimbursement for the following codes and licensing types for providers on our standard agreements effective October 1, 2022:

- Increasing rates for psychiatrists, psychologists and master's-level clinicians billing CPT 90837 (psychotherapy)
- Licensing differential adjustments for master's-level clinicians that may result in higher reimbursement rates for codes other than CPT 90837
- Increasing the number of payable alcohol and drug treatment services (ADTS) codes to add CPT 90832, 90837, 90839, 90840 and 90846; and increasing reimbursement rates for existing payable ADTS codes

The updated rates will be available on Availity Essentials this month.

Behavioral health corner

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%.

In the U.S., rates of depression skyrocketed across age groups during the COVID-19 pandemic, 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, 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

Some common signs and symptoms

- Loss of motivation
- Weight gain or loss
- Decreased concentration
- Fatigue or lack of energy
- Neglecting responsibilities
- Unexplained aches and pains
- Sleeping too much or too little
- Loss of interest in personal appearance
- Psychological symptoms
  - Anger, anxiety, sadness, irritability, mood swings, lack of emotional responsiveness, feelings of worthlessness or helplessness. 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 *Patient Health Questionnaire 9* (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 presentation titled *Depression: Screening and treatment in the primary care setting*.

In addition to addressing depression, our toolkit includes 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

Continued on page 19

Behavioral health corner

Continued from page 18

The toolkit also includes information about our care management services, including case management, as well as information to help PCPs determine the best path forward in the early stages of a patient's evaluation and treatment.

Knowing when to refer

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

- Imminent risk of suicide—call 911 immediately
- Need for hospitalization
- Uncertainty about the diagnosis
- Comorbid psychiatric disorders

2023 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 changes to our product portfolio. In addition, we will implement changes to comply with the Affordable Care Act (ACA) requirements and state and federal mandates.

Group network and product updates

Small employer group metallic products:

- Adding new Platinum plan with $850 deductible, simplifying the member's financial experience. Upon meeting the deductible and out-of-pocket maximum, in-network services are available at no cost.
- New embedded wellness incentives: $30 for wellness visits, $10 for both annual dental and vision exams.
- Removal of mail-order prescription discount (excluding Bronze plans)

Provider networks

No changes will be made to our provider networks in 2023.

Benefit highlight

Fully insured groups of 51+:

- **Wellness incentive increase:** Subscribers and their spouses/domestic partners can earn up to $100 in wellness incentives throughout the year. This encourages members to utilize in-network preventive services available with no out-of-pocket cost to the member.

Fully insured groups of 51+ and ASO groups:

- **Classic premium plans:** A new $0 copay, non-HSA plans have split accumulators with 0% in-network and 50% out-of-network coinsurance after the deductible. These benefits, coupled with low deductibles, will help members get affordable care.

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 products.

- Supports 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, 2022, is from November 1, 2022, through January 15, 2023. 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 2023.

Benefit highlights

- **Note:** This is not a comprehensive list of benefit or changes, and some benefits are only available on specific plans.
- The mobile urgent service DispatchHealth, **dispatchhealth.com**, will be available to treat common to complex injuries and illnesses at the member's home. It is available to members in select service areas, including Spokane.
- Bump2Baby will be available to support members with information and resources during and after pregnancy.
- Members who have specific chronic conditions will have access to expanded preventive care.
- To help manage the cost of medications for chronic conditions, members will pay less before the deductible for prescription medications on the *Optimum Value Medication List*.
- Pediatric vision will be embedded for members 18 and younger. Some of our plans include pediatric dental. Vision and dental benefits are available as an optional buy-up for off-exchange members.

Continued on page 21

Continued from page 20

- Members will have Individual Assistance Program coverage with access to four mental health counseling visits at no member cost on most plans, 24/7 crisis support and online resources.

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 the provider directory, 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 2023 products will be available in the Products section of our provider website in January 2023.

2023 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 2023.

Benefit changes and additions

Current MA members will receive the Annual Notice of Changes, which highlights the changes specific to their product for 2023. 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 specific benefits on Availity Essentials and use the Find a Doctor tool on our provider website to verify network participation prior to referring patients.

Home and bathroom safety devices

- Benefit will be available to MA Valiance, Classic and Enhanced PPO members only in 2023; MA Primary PPO and MA HMO members will not have this benefit
- Members can choose from specific items up to $100 per year
- Items include shower/bathtub grab bar and bench, commode/toilet rails, elevated toilet seats, tub stool, transfer bench or chair
- HCPCS codes E0240-E0248
- Installation and in-home assessments for safety items are not covered

Papa Pals

- Benefit will be available to all MA PPO and MA HMO members in 2023
- In-person and virtual visits will be included
- No chronic condition or benchmark assessment requirement
- Benefit is limited to 48 hours/year

Dental

- Preventive dental benefit changes:
  - Scaling and planing will be limited to one per calendar year.
  - Periodontal maintenance will be combined with cleanings; two per calendar year limit.
- MA Esteem and Valiance PPO members will have preventive and comprehensive dental benefits with a combined allowance of $1,000 included with their medical plan.
- MA Primary PPO and MA HMO members will have preventive and routine diagnostic dental benefits with a combined allowance of $1,000 included with their medical plan.
- Members on a plan with partial or no comprehensive dental may be able to purchase an optional supplemental benefit package to include comprehensive dental.

Silver & Fit fitness programs

- New Silver & Fit Well-Being Club is a personalized virtual club to meet members where they are on their health, fitness and wellbeing journey
- Expanded options for workout plans
- Expanded on-demand library of workout choices and instructors
- Continuous network expansion

Medicare Part D coverage

- Tier 4 medications will have a $100/month copay for Preferred and Standard pharmacies.
- Most vaccines will be covered with $0/month copay.
- Medicare Part D only plans will cover insulins with a $35/month copay.

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 QIP reminders

Final attribution update

To provide you with roster stability in the last three months of the program year, Medicare QIP member attribution is locked after our last attribution file is loaded to the CGMA in early October 2022.

Visit the Frequently Asked Questions topic "How do I manage my member roster?" on the CGMA for details about managing your member roster.

For details about attribution adjustment options by member type, visit our provider website: Programs>Medicare Quality Incentive Program.

Keep up the great work: December is coming

We are approaching the final months of our 2022 Medicare QIP. 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 2022 program, we will accept claims or documentation until the dates listed below for each method of gap closure submission:

- December 31, 2022—Last day to perform services
- February 28, 2023—Last day to submit supplemental data
- February 28, 2023—Last day to work on the CGMA
- March 31, 2023—Last day to submit medical or pharmacy claims

CGMA tip: Transient measures

Some measures continue to display a green submit action button in the CGMA even though they also show a closed status. These remain available on the Member Gap Summary screen to give you the opportunity to continue to submit updated information throughout the program year.

The measures included in this feature are:

- Colorectal Cancer Screening—If a member has an additional screening during the program year, we encourage you to submit your most up-to-date evidence.
- Diabetes Care–Blood Sugar Controlled—This measure relies on the last result of the year for compliance; you should submit your most up-to-date evidence.
- Blood Pressure Control—This measure relies on the last result of the year for compliance; you should submit your most up-to-date evidence.

A clearer view: The **Mark As Reviewed** functionality allows you to move these measures to the bottom of the screen if you have already worked them and prefer to see open gaps at the top.

Questions about Medicare 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 and writer

Cindy Price: Managing editor and writer

Carrie White: Designer and writer

Sheryl Johnson: Writer

Jayne Drinan: Writer

Janice Farley: Editor