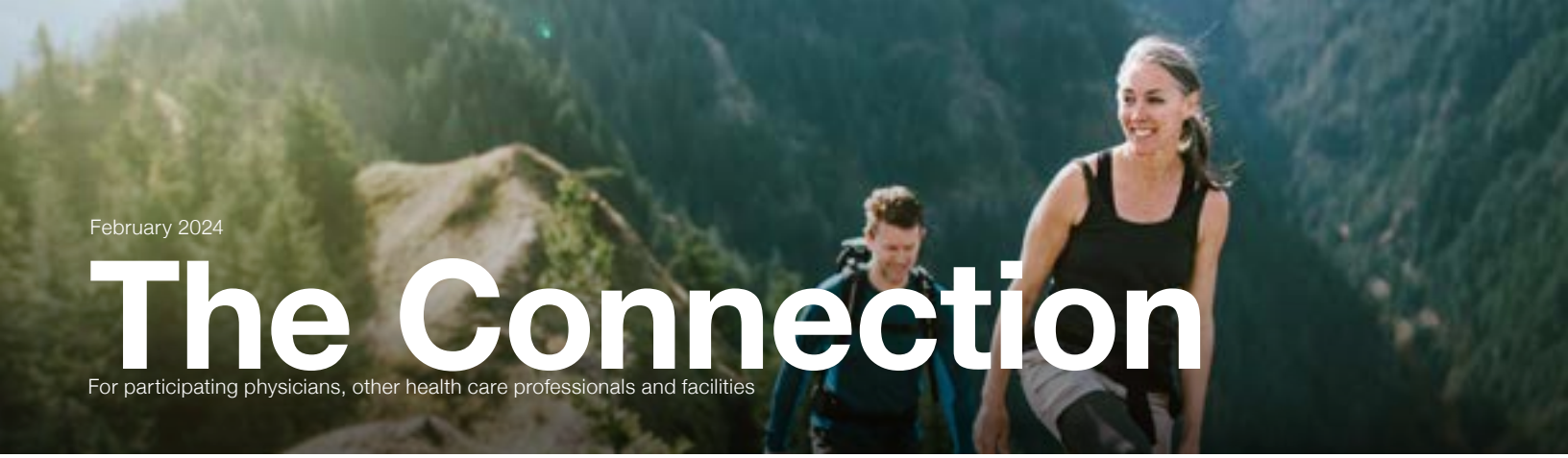

February 2024

The Connection

For participating physicians, other health care professionals and facilities

Help reduce hypertension and risk for heart disease

American Heart Month is observed each February to raise awareness about cardiovascular health. The principal risk factors for heart disease include high blood pressure, high cholesterol, smoking and obesity. According to the Centers for Disease Control and Prevention (CDC), nearly half of adults in the U.S. have high blood pressure and only about one in four people with high blood pressure have their condition under control.

Rates of high blood pressure control vary

Uncontrolled high blood pressure is common; however, certain groups of people are more likely to have high blood pressure.

- A greater percentage of men (50%) than women (44%) have high blood pressure.
- High blood pressure is more common in non-Hispanic Black adults (56%) than in non-Hispanic White adults (48%), non-Hispanic Asian adults (46%) or Hispanic adults (39%).
- Among those recommended to take blood pressure medication, blood pressure control is higher among non-Hispanic White adults (32%) than in non-Hispanic Black adults (25%), non-Hispanic Asian adults (19%) or Hispanic adults (25%).

We encourage you to educate your patients with hypertension about the importance of tracking their blood pressure, taking prescribed medications, if appropriate, and implementing lifestyle changes to reduce their risk of disease. To identify patients who are due for follow-up appointments, use registries within your electronic medical record (EMR) to review dates of past prescription refill requests and the last office visit note for follow-up instructions.

For all office visits, we recommend you submit blood pressure results on your claims using CPT level II codes to lessen our requests for medical records and to support our quality reporting for Healthcare Effectiveness Data and Information Set (HEDIS®) and Medicare Star Ratings.

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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
● 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.

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**.

Dental providers

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

Questions?

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

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Million Hearts

Million Hearts® is a national initiative to prevent one million heart attacks and strokes within five years. It focuses on implementing a small set of evidence-based priorities and targets that can improve anybody's cardiovascular health. Learn more about this initiative and find helpful resources on the Million Hearts website: **millionhearts.hhs.gov**. The Hypertension Control Change Package from Million Hearts lists process improvements that outpatient clinical settings can implement as they seek optimal hypertension control: **https://bit.ly/2Net7xY**.

Live to the Beat

Explore and direct your patients to the Live to the Beat campaign, **livetothebeat.org**, which aims to reduce the risk of cardiovascular disease (CVD) among Black adults ages 35 to 54. The campaign aims to inspire and build confidence to create behavior change by sharing healthy habits, tips and routines to help reduce the risk of heart attack and stroke.

Hypertension programs available to ASO groups

Livongo for Hypertension and Omada for Hypertension, buy-up options available to our administrative services only (ASO) groups, provide tools, insights and expert support to help make managing blood pressure simple.

Other resources

To support patient education about hypertension, blood pressure monitoring and the lifestyle changes that can help patients live healthier lives, we recommend resources found in the Conditions section of the American Heart Association website, **heart.org**.

You can also share the following Healthwise flyers, available in English and Spanish, with your patients:

- *High Blood Pressure*
- *High Blood Pressure: ACE Inhibitors and ARBs*
- *High Blood Pressure: Adding DASH to Your Life*

Download the flyers from the Quality Improvement Toolkit, available on the homepage of our provider website.

2023 newsletter and bulletin survey results

Thank you for completing our annual publications survey.

Most respondents agree that our newsletter and bulletin are easy to read and navigate. In addition, most respondents indicate that the articles in our newsletter are useful to their practice.

Key survey findings

- **Newsletter table of contents**: Respondents use the key in the table of contents to quickly and easily identify articles for their specialty type (e.g., durable medical equipment, radiology). Did you know that you can click on a title in the table of contents to be directed to the articles that impact your office?
- **Newsletter most-read articles**: The most read topics include administrative and billing updates; information about Availity Essentials; medical and reimbursement policy updates, pre-authorization changes; and programs.
- **Formatting**: Respondents indicated that it would be helpful if content was easier to read at a glance (e.g., using bullets, adding white space).

Subscribe to receive an email when new issues are available.

Additional comments

If you have additional comments about our newsletter or bulletin, please email us at **provider_communications@asuris.com**.

PRIA makes population health management easier

We are excited to announce that by the end of first quarter 2024, we are launching the Provider Reporting Insights & Analytics (PRIA) platform. It will be available to providers on alternative payment model (APM) arrangements with more than 1,000 attributed members.

PRIA is a new business intelligence and analytics platform that unifies and simplifies access to multiple data sources. It features interactive dashboards, self-service reporting and data available at summary, claims and patient levels. Information will have a reduced lag time when compared to current data reporting sources. Users can access information at their convenience without waiting for our staff to manually create reports.

The platform allows users to create and execute data-driven interventions to care gaps that improve quality while reducing the total cost of care. PRIA can help improve your financial and quality performance by offering insights into:

- Population health management
- Automated savings opportunities
- Care gap details

Interactive dashboards and self-service reports allow information to be shared across your organization—from teams of analysts and members of care teams to end users viewing reports. PRIA's ease of navigation and sophisticated data allows anyone to decide the breadth and depth of information they receive.

We are committed to helping providers on APM agreements meet and exceed contractual goals. That's why we are offering PRIA at no cost to eligible providers, along with free training and ongoing support.

Learn more about PRIA in future issues of this newsletter and on our provider website: Contracting & Credentialing>APM Resources.

Annual HEDIS medical record collection

Our HEDIS medical record reviews for measurement year 2023 will begin this month, continuing through May 2024. We have contracted with ComplexCare Solutions (formerly Inovalon) to contact providers and collect data using a HIPAA-compliant process. We appreciate your help during this process and will work with your office to collect medical records by fax, mail or onsite visit (for larger clinics).

As a reminder, it is your responsibility as a participating Asuris provider to respond to these requests in a timely manner. Unless your provider agreement specifically states otherwise, you are required to provide us or ComplexCare Solutions access to member records for these purposes free of charge. A signed release from your patient—our member—is not required for us to obtain these records. If you contract with a copy service, please remember that you are responsible for guaranteeing they deliver the charts on time, without cost, to us or ComplexCare Solutions.

You can learn more about this year's review on our provider website: Programs>Quality>Quality Program>HEDIS Reporting.

Administrative Manual updates

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

Facility Guidelines

- Updated the criteria used for behavioral health medical necessity determinations
  - **Note**: We announced in the February 1, 2024, issue of *The Bulletin* that eight behavioral health medical policies were archived as part of this change

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

Coding Toolkit updates

Our Coding Toolkit lists our clinical edits and includes information specific to Medicare's National Correct Coding Initiative (NCCI). These coding requirements are updated monthly in the Clinical Edits by Code List in the Coding Toolkit and apply to commercial claims. The Coding Toolkit is available on our provider website: Claims & Payment>Coding Toolkit.

We have enlisted the support of Lyric and their claims management solution for ClaimsXten bundling edits. Additional ClaimsXten correct coding edits will continue to be implemented on an ongoing basis. The Coding Toolkit provides a high-level description of the ClaimsXten-sourced edits. These edits are proprietary to Lyric and, therefore, we cannot provide the editing detail.

Our Correct Code Editor (CCE), also located in the Coding Toolkit, has additional CPT and HCPCS code pair edits that we have identified and are used as a supplement to Medicare's NCCI. This supplemental list of code groupings in the CCE is updated quarterly in January, April, July and October. The lists include codes, their description, edit type and comment (e.g., 77085; Dxa bone density study; investigational denial; Always considered investigational; investigational services are denied member liability). We reserve the right to take up to 30 calendar days to update our systems with CCE updates, CMS-sourced changes and Lyric-sourced changes. Claims received before our systems are updated will not be adjusted.

We perform ongoing retrospective review on claims that should be processed against our clinical edits. We follow our existing notification and recoupment process when we have overpaid based upon claims processing discrepancies and incorrect application of the clinical edits. View our notification and recoupment process on our provider website: Claims & Payment> Payment>Overpayment Recovery.

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

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**.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective January 1, 2024
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	- 0428U, 81462-81464
Digital Therapeutic Products for Post-traumatic Stress Disorder and Panic Disorder (Medicine #175.05)	- A9291
Gender Affirming Interventions for Gender Dysphoria (Medicine #153)	- 11920, 11921, 15774, 21125, 21127, 21141-21143, 21145-21147, 21188, 21193-21196, 21208, 21137, 21139, 15825, 15828, 15829
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	- 81457-81459
Implantable Peripheral Nerve Stimulation and Peripheral Subcutaneous Field Stimulation (Surgery #205)	- 64596-64598
Leadless Cardiac Pacemakers (Surgery #217)	- 0823T, 0825T
Low-Level Laser Therapy (Medicine #105)	- 97037
Occipital Nerve Stimulation (Surgery #174)	- 64596-64598
Prosthesis; Powered and Microprocessor-Controlled Knee and Ankle-Foot Prostheses and Microprocessor-Controlled Knee-Ankle-Foot Orthoses (Durable Medical Equipment #81)	- L5615
Radiofrequency Ablation (RFA) of Tumors Other than Liver (Surgery #92)	- 58580
Responsive Neurostimulation (Surgery #216)	- 61889, 61891
Sacral Nerve Neuromodulation (Stimulation) for Pelvic Floor Dysfunction (Surgery #134)	- 0786T, 0787T, 64596-64598
Sacroiliac Joint Fusion (Surgery #193)	- 27278
Spinal Cord and Dorsal Root Ganglion Stimulation (Surgery #45)	- 0784T, 0785T
Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy for Tumors Outside of Intracranial, Skull Base, or Orbital Sites (Surgery #214)	- C9795
Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy of Intracranial, Skull Base, and Orbital Sites (Surgery #213)	- C9795
Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders (Medicine #148)	- 0858T
Vagus Nerve Stimulation (Surgery #74)	- E0735

Medicare Advantage

Procedure/medical policy	Added codes effective January 1, 2024
Ablation for the Treatment of Chronic Rhinitis (Surgery #224)	- 31242, 31243, C9771
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- Q4279, Q4287-Q4304
Definitive Lower Limb Prostheses (Durable Medical Equipment #18)	- L5615

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Medicare Advantage, continued

Procedure/medical policy, continued	Added codes effective January 1, 2024
Electrical Stimulation and Electromagnetic Therapy Devices (Durable Medical Equipment #83)	- E0732, E0733
Extracorporeal Shock Wave Therapy (ESWT) (Medicine #90)	- 0512T, 0513T
Gender Affirming Interventions for Gender Dysphoria (Medicine #153)	- 11920, 11921, 11950, 15774, 21125, 21127, 21141-21143, 21145-21147, 21188, 21193-21196, 21208, 15825, 15828, 15829, 21137, 21139
Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	- 0420U, 0422U-0424U, 0428U, 0433U, 0436U, 81457-81459, 81462-81464, 87523
Leadless Pacemakers (Surgery #217)	- 0823T, 0825T
Low-Level Laser Therapy (Medicine #105)	- 97037
Multianalyte Assays with Algorithmic Analysis for the Evaluation and Monitoring of Patients with Chronic Liver Disease (Laboratory #47)	- 81517
Occipital Nerve Stimulation (ONS) (Surgery #174)	- 64596-64598
Opto-acoustic Imaging of the Breast (Radiology #60)	- 0857T
Peripheral Nerve Stimulation (PNS) and Peripheral Nerve Field Stimulation (PNFS) (Surgery #205)	- 64596-64598
Phrenic Nerve Stimulation for Central Sleep Apnea (Surgery #212)	- 33276-33281, 33287, 33288, 93150-93153
Radiofrequency Ablation (RFA) of Tumors Other Than the Liver (Surgery #92)	- 58580
Responsive Neurostimulation (Surgery #216)	- 61889, 61891
Sacral Nerve Stimulation (Neuromodulation) for Pelvic Floor Dysfunction (Surgery #134)	- 0786T, 0787T, 64596-64598
Sacroiliac Joint Fusion (Surgery #193)	- 27278
Subcutaneous Tibial Nerve Stimulation (STNS) (Surgery #154)	- 0816T-0819T
Temporary Implanted Nitinol Device (e.g., iTind) for Benign Prostatic Hyperplasia (Surgery #230)	- 52284
Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders (Medicine #148)	- 0858T
Vagus Nerve Stimulation (VNS) (Surgery #74)	- E0735
Vertebral Body Tethering and Stapling (Medicine #153)	- 0790T, 22836-22838
Procedure/medical policy	**Added codes effective March 1, 2024**
Micro-Invasive Glaucoma Surgery (MIGS)	- 0253T, 0449T, 0671T, 65820, 66710, 66711, 66982, 66987-66989, 66991

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.

Clinical records requirement begins

In December 2023, we announced a one-month postponement of administrative denials for failing to provide timely clinical records for medical or behavioral health inpatient admissions. These requirements became effective February 1, 2024.

We postponed administrative denials to ensure a successful launch. This delay was announced via:

- What's New announcements on the homepage of our provider website
- Alerts at the top of our pre-authorization lists list on our provider website
- Emails sent by provider relations executives to facilities

We already required timely admissions notification and clinical documentation for continued stay; however, in our October 2023 provider newsletter, we announced that failing to provide clinical records by provided deadlines would result in administrative denials.

Because of this one-month delay, we will not administratively deny claims for January 2024 admissions if records weren't provided by deadlines.

Supporting documentation for cardiology program

In the October 2023 issue of our provider newsletter, we announced that Carelon Medical Benefits Management (Carelon) would request additional clinical records for commercial and Medicare Advantage members as part of our cardiology program beginning January 1, 2024. The reminder in our December 2023 provider newsletter omitted Medicare Advantage members and has since been corrected.

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

Reminder: Site-of-service reviews

In the December 2023 issue of our newsletter, we announced that we would begin site-of-service reviews for additional services to be delivered on or after March 1, 2024, where a lower level of care may be appropriate. These services apply only to commercial members.

Only select procedures being performed at an outpatient hospital surgical site are reviewed for the site of service. Affected codes are posted on our *Commercial Pre-authorization List*, available on our provider website: Pre-authorization>Commercial.

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.

Save time and effort with Availity

For the fastest review, submit requests through Availity Essentials' Electronic Authorization application. Some requests will receive automated approvals. The Availity process incorporates additional questions related to site of service, so you don't need to submit the *Surgical Site of Service Additional Information Form*, which is required for faxed requests to provide attestation-based supporting documentation.

Medicare Advantage reviews ended

Due to a decision from CMS, we no longer review the site of service for Medicare Advantage members.

Reminder about requests for expedited pre-authorization reviews

Pre-authorization requests for an urgent/expedited review that do not include documentation meeting the urgent/expedited criteria will be reclassified to a standard review and standard timeframes will be applied.

To be considered for urgent/expedited review, requests must meet at least one of the following criteria:

- The member's life, health or ability to regain maximum function is in serious jeopardy.
- The member's psychological state is putting the life, health or safety of the member or others in serious jeopardy.
- The member will be subjected to severe pain that cannot be adequately managed without the service.

Reminder: Post-acute care authorizations through Carelon PAS

Carelon Post Acute Solutions (Carelon PAS) now manages home health and post-acute care (PAC) authorizations for our Medicare Advantage members.

Home health

As of January 1, 2024, Carelon PAS handles all authorizations (pre-authorization and reauthorization) for Medicare Advantage home health services. Additionally, services require pre-authorization on day one.

Authorizations are specific to a number of visits in a given period; visits beyond this quantity or past the authorized period require a new physician order and reauthorization.

PAC facilities

As of February 1, 2024, Carelon PAS handles all authorizations (pre-authorization and concurrent review) for the following Medicare Advantage PAC services:

- Skilled nursing facility (SNF)
- Long-term acute care (LTAC)
- Inpatient rehabilitation (IPR), also known as inpatient rehabilitation facilities

Contact Carelon PAS

Register for Carelon's PAS provider portal to submit requests: **providers.carelonmedicalbenefitsmanagement.com/postacute**.

Upcoming

We are working toward launching a single sign-on solution later this year to make requesting authorizations easier.

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

No medical policies in the December 2023 issue of *The Bulletin* required 90-day notice.

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

- *Coronary Intravascular Lithotripsy* (Surgery #233)—Medicare Advantage
- *Gender Affirming Interventions for Gender Dysphoria* (Medicine #153)
- *Intensity Modulated Radiotherapy (IMRT) of the Central Nervous System (CNS), Head, Neck, and Thyroid* (Medicine #164)
- *Intensity Modulated Radiotherapy (IMRT) of the Thorax, Abdomen, Pelvis, and Extremities* (Medicine #165)

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

Reimbursement policy updates

We provided 90-day notice in the December 2023 issue of *The Bulletin* about changes to the following reimbursement policies, which are effective March 1, 2024:

- *Chiropractic and Osteopathic Treatment* (Administrative #138)—commercial and Medicare Advantage
- *Intermittent Catheter Supplies* (Administrative #149)—commercial and Medicare Advantage

No reimbursement policies in the January 2024 issue of *The Bulletin* required 90-day notice.

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

Clarification to facility policies

In the October 2023 issue of *The Bulletin*, we announced updates to our *Emergency Room Visit: Level of Care* (Facility #110) and *Reimbursement of Room and Board* (Facility #103) reimbursement policies. Based on recent feedback, we have since revised policy language to clarify that the *Reimbursement of Room and Board* policy applies to emergency department (ED) charges if a member is admitted inpatient from the ED—the *Emergency Room Visit: Level of Care* policy is not applied in this scenario.

The intent and application of both policies will remain the same as in 2022.

We published the overview of the revisions to these policies in the January 2024 issue of *The Bulletin*, available on our provider website: Library> Bulletins. The complete policies are available in the *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines> Reimbursement Policy.

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 January 1, 2024	Description
New policy	
Cost-Share Exception Criteria for HIV Post Exposure Prophylaxis (PEP) Medications, dru770	- Allows for cost-share exceptions on medications used for HIV Post-Exposure Prophylaxis (PEP) pursuant to ORS OR HB2574, ORS 742.008 and ORS 743B.005
Revised policies	
Drugs for chronic inflammatory diseases, dru444	- Added coverage criteria for Olumiant (baricitinib) and Litfulo (ritlecitinib) for alopecia areata (AA) - Limits coverage to patients with severe AA (SALT score), diagnosed by a dermatologist when step therapy through oral corticosteroids or a combination of topical immunotherapy and a conventional oral immunosuppressant has been ineffective
Growth Hormone, dru015	- Added Omnitrope as a preferred product (in addition to Genotropin and Norditropin)
Monoclonal antibodies for asthma and other immune conditions, dru538	- Updated asthma coverage criteria to remove Tezspire (tezepelumab-ekko) step through other preferred asthma mab products; Tezspire (tezepelumab-ekko) is now at parity with the other asthma mabs
Non-Preferred Drugs, dru760	- Added newly FDA-approved Zituvio (sitagliptin) to policy
Opzelura, ruxolitinib cream, dru679	- Updated policy to allow for coverage of vitiligo; limits coverage to patients with a diagnosis of nonsegmental vitiligo established by or with a dermatologist, a total affected body surface area of no more than 10%, and step therapy through both topical calcineurin inhibitors and phototherapy
Products with Therapeutically Equivalent Biosimilars/ Reference Products, dru620	- Added newly FDA-approved Zymfentra (infliximab-dyyb) subcutaneous as a non-preferred infliximab product

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Effective January 15, 2024	Description
New policy	
Gene therapies for sickle cell disease, dru766	- Limits coverage to patients with severe refractory sickle cell disease, genetic confirmation of HbSS genotype, ongoing vaso-occlusive crises despite treatment with hydroxyurea, and for whom stem cell transplant is contraindicated
Revised policies	
Botulinum toxin type A injection, dru006	- Added Daxxify to policy at parity with the other Botulinum toxin type A products
Complement inhibitors, dru385	- Added newly FDA-approved Veopoz (pozelimab) to policy for CD55-deficient protein-losing enteropathy (CHAPLE disease). Limits coverage to patients with CHAPLE disease with confirmed CD55 loss of function mutation, and step therapy through Soliris (eculizumab) - Added coverage criteria for Soliris (eculizumab) for CHAPLE disease - Added newly FDA-approved Zilbrysq to policy for AChR positive generalized myasthenia gravis (MG), mirroring Soliris and Ultomiris coverage criteria
Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors, dru621	- Added Eylea HD, a new, higher-dose aflibercept product, to policy at parity with Eylea
Jemperli, dostarlimab, dru673	- Added coverage criteria for front-line advanced endometrial cancer (dMMR or MSI-H) when initiated in combination with carboplatin and paclitaxel, a newly FDA-approved indication
Libtayo, cemiplimab-rwlc, dru565	- Added coverage criteria for front-line use in locally advanced non-small cell lung cancer (NSCLC) with no EGFR, ALK or ROS1 aberrations, a newly FDA-approved indication
Medications for Multiple Myeloma, other cancers, and other hematologic disorders, dru672	- Added newly FDA-approved Elrexfio (elranatamab) to policy; limits coverage to patients with multiple myeloma and disease progression on at least four prior regimens (including anti-CD38 mAb, IMiD, proteosome inhibitor), no prior BCMA-directed therapy, and use as monotherapy - Added newly FDA-approved Talvey (talquetamab-tgvs) to policy; limits coverage to patients with multiple myeloma and disease progression on at least four prior regimens (including anti-CD38 mAb, IMiD, proteosome inhibitor) and use as monotherapy
Neonatal Fc Receptor (FcRn) Antagonists, dru696	- Added newly FDA-approved Rystiggo (rozanolixizumab) to policy for generalized myasthenia gravis (MG) that is anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive mirroring Vyvgart coverage criteria

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Effective March 1, 2024	Description
New policies	
High-cost vesicular monoamine transporter 2 (VMAT2) inhibitors, dru769	- New policy that combines dru176 (tetrabenazine, Xenazine), dru501 (Austedo/Austedo XR) and dru502 (Ingrezza) - Adding coverage of Ingrezza (valbenazine) for chorea associated with Huntington's disease (HD), a newly FDA-approved indication; criteria mirrors that of Xenazine (tetrabenazine) and Austedo (deutetrabenazine)
Sohonos, palovarotene, dru765	- Clarifying the use of Sohonos (palovarotene) will be considered investigational, and therefore not covered, due to lack of high-quality evidence of clinically meaningful health benefit
Vanflyta, quizartinib, dru767	- Limiting coverage to patients with newly diagnosed acute myeloid leukemia (AML) when an FLT3-ITD mutation is present and quizartinib is used in combination with daunorubicin and cytarabine induction and high-dose cytarabine (HiDAC) consolidation, and as continued maintenance monotherapy after HiDAC consolidation if the patient has not received a hematopoietic stem cell transplant (HSCT)
Revised policies	
CGRP Monoclonal Antibodies, dru540	- Removing specialist requirement for migraine headache prophylaxis
Gaucher Disease Treatments, dru649	- Adding Yargesa, a new generic form of miglustat, to policy
High-cost medications for dry eye disease, dru472	- Adding newly FDA-approved Miebo (perfluorohexyloctane) to policy
Immediate-release (IR) Opioid Medication Products for Pain, dru516	- Updating opioid utilization management strategy considering updated CDC opioid guideline updates
Immune Globulin Replacement Therapy, dru020	- Updated coverage criteria for Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)/Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) to require that trials of at least two clinically appropriate less-intensive treatments were not effective or not tolerated
Keytruda, pembrolizumab, dru367	- Adding coverage criteria for front-line use in endometrial cancer (dMMR or MSI-H) based on a phase 3 trial
Lynparza, olaparib, dru389	- Updating coverage criteria for ovarian cancer to limit coverage for maintenance therapy and require homologous recombination deficiency (HRD) positive status (either BRCA-mutated or genomic instability), which is in line with current FDA-labeled indication
Medications for hypoactive sexual desire disorder (HSDD), dru423	- Removing coverage criterion requiring a mental health specialist, based on provider feedback that hypoactive sexual desire disorder (HSDD) is often diagnosed and treated by OBGYNs and PCPs
Medications for multiple sclerosis, dru753	- Adding newly FDA-approved Tysabri biosimilar (Tyruko) to policy at parity with Tysabri (natalizumab)

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Revised policies, continued	
Niraparib-containing medications, dru503	- Adding newly FDA-approved Akeega (niraparib/abiraterone) to policy; will limit coverage to patients with metastatic prostate cancer, documented deleterious somatic or germline BRCA mutation, castration resistance, first-line setting use, and use in combination with prednisone/prednisolone and ongoing androgen deprivation therapy (ADT) (i.e., GnRh analog or bilateral orchiectomy) - Updating Zejula (niraparib) ovarian cancer coverage criteria to limit coverage to maintenance therapy and require deleterious germline BRCA mutation if use is in recurrent setting, which is based on updated overall survival (OS) data and in line with current FDA-labeled indication
Onivyde, irinotecan liposome injection, dru443	- Changing front-line use in metastatic pancreatic cancer setting from investigational to be considered not medically necessary based on new evidence (NAPOLI 3 open-label trial)
Opdivo, nivolumab, dru390	- Adding glioblastoma multiforme as investigational based on the results of a failed study
Rubraca, rucaparib, dru494	- Updating coverage criteria in line with current FDA-labeled indication: • Coverage criteria for ovarian cancer will limit coverage to the maintenance setting only for locally advanced or metastatic ovarian cancer • Confirmation of germline or somatic BRCA mutation will be required for recurrent ovarian cancer
Self-administered CGRP antagonists and 5-HT 1f agonists, dru635	- Removing specialist requirement for migraine headache prophylaxis
Sodium oxybate-containing medications, dru093	- Updating step therapy criteria for Lymryz (sodium oxybate) to no longer require intolerance or contraindication of generic sodium oxybate prior to coverage; this will place Lumryz (sodium oxybate) at parity with Xyrem (sodium oxybate) authorized generic

Effective April 1, 2024	Description
Revised policy	
Growth Hormone, dru015	- Removing Norditropin as a preferred product; Genotropin and Omnitrope will remain as preferred products

Effective July 1, 2024	Description
Revised policy	
Non-Preferred GLP1 Agonist-Containing Medications, dru347	- Removing Victoza (liraglutide) from preferred GLP-1 agonist policy (dru750) and moving it to non-preferred GLP-1 agonist policy (dru347)

Behavioral health corner

About behavioral health corner

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

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

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

Reimbursement changes for alcohol and drug treatment services

Based on your feedback and a recent review, we are revising reimbursement for alcohol and drug treatment services (ADTS) for providers with our standard *Participating Ancillary Provider Agreements* effective May 1, 2024.

Reimbursable ADTS CPT codes will be adjusted to align with current market rates:

- 90791
- 90832
- 90834
- 90837
- 90839
- 90840
- 90846
- 90847
- 90849
- 90853

The updated rates and codes will be available on Availity Essentials.

Update on new provider types eligible to serve Medicare members

CMS now allows mental health counselors (MHCs) and marriage and family therapists (MFTs) to serve Medicare members. Providers who have a tax ID with a Medicare Advantage agreement with us have already been added to our Asuris TruAdvantage Network.

Providers who don't have a Medicare Advantage agreement with us will receive a letter this spring with the effective date they can begin seeing Medicare Advantage members. To be added to our network earlier, call our Provider Contact Center to request a Medicare Advantage contract.

Behavioral health corner

Telehealth can support PCP and facility care

Timely access to behavioral health care is critical to patients' overall well-being. Telehealth appointments can help meet that need.

PCPs: If your patient needs a referral for behavioral health evaluation or treatment, you can recommend they check whether the following providers are in their network.

For facilities: To improve our members' outcomes and to reduce or avoid readmissions, it is critical that patients are seen by a behavioral health provider within seven days of discharge from an inpatient or residential facility. We encourage you to share the following telehealth options with your patients to help them receive needed post-discharge care. **Note**: Discharge appointments do not count as follow up appointments.

No referral needed

Members can use the Find a Doctor tool on our member website, **asuris.com**.

Not all telehealth options are available to all members. To verify a provider group is in-network, members should contact Customer Service through online chat or by calling the number on the back of their card. They can then contact a provider directly to begin treatment—no referral needed!

In-network providers

- **AbleTo**: The Therapy+ program is a structured, eight-week series of one-on-one cognitive behavioral therapy (CBT) by phone or video with a licensed therapist, with medication management and digital tools for support available between sessions
  - **ableto.com**
- **Array Behavioral Care**: One of the largest telepsychiatry providers in the country, employing psychiatry and behavioral health clinicians with diverse specialties to serve ages 5 and older
  - **arraybc.com**
- **Boulder Care**: Addiction treatment—including medication-assisted treatment (MAT) for opioid use disorders (OUD), which can begin in the ED—that offers support through peer coaching, care coordination and other recovery tools
  - **boulder.care**
- **Charlie Health:** Mental health intensive outpatient treatment for teens and young adults, as well as their families
  - **charliehealth.com**
- **Eleanor Health**: Addiction and substance use disorder treatment provider with integrated evidence-based outpatient care and recovery for opioid and other substance use disorders
  - **eleanorhealth.com/locations/washington**
- **Equip**: Family-based treatment of eating disorders for individuals ages 6 to 24 that includes a care team consisting of a therapist, physician, family mentor, peer mentor and dietician
  - **equip.health**
- **Headway**: Find local providers with appointments in the next few days with search results that include providers' specialty areas (e.g., condition-specific, grief, trauma) and whether the provider offers telehealth and/or in-person visits
  - **headway.co**
- **NoCD**: Specialized care for obsessive compulsive disorder (OCD) using exposure and response prevention (ERP) treatment
  - **treatmyocd.com**
- **Talkspace**: Mental health counseling available 24/7/365 via text, audio or video messaging
  - **talkspace.com/partnerinsurance**

Resources

- Learn more about telehealth, including national vendors not mentioned here, in the Care Options Toolkit on our provider website.
- Providers can check members' standard telehealth benefits by performing an eligibility and benefits inquiry in Availity Essentials.
- Read about the Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure, which helps ensure members transition safely from an acute hospital setting back to their home environments: Behavioral Health>Facilities>HEDIS Post-Discharge Follow-Up.

Get reimbursed for e-consults

Electronic consultations (e-consults) may help alleviate the challenges PCPs face with treating complex medical and behavioral health conditions. We recognize the value of timely access to specialty consultations and reimburse for e-consults.

What is an e-consult?

E-consults are asynchronous consultations between providers, either over a shared electronic medical record (EMR) system or via a web-based platform. During an e-consult, physicians or other qualified health care professionals discuss the care of their patient with a consulting specialist. E-consults are typically requested by a PCP seeking expert consultation on a clinical issue. A specialist (e.g., psychiatrist, dermatologist, endocrinologist, etc.) then reviews the pertinent records and provides a brief written consultation report back to the PCP.

The following e-consult codes are reimbursable:

- CPT codes for the treating PCP: 99354-99359 and 99452
- CPT codes for the consulting specialist: 99446-99449 and 99451

These visits can support and improve the delivery of health care services in primary care by providing timely specialist advice, especially for providers who don't otherwise have access to specialists—including psychiatrists—in their community.

Specialty e-consults can:

- Address medication-related issues
- Provide evaluation and management recommendations and assist with clarifying diagnostic considerations
- Determine whether a patient acutely needs a referral for in-person specialty care

PCPs should inform their patient they are asking the advice of a consultant and that the patient may be responsible for cost share (e.g., copay, coinsurance or deductible).

Resources

- Read *What E-consults Can do for Your Patients—and Your Practice*, from the American Medical Association: **ama-assn.org/practice-management/digital/what-e-consults-can-do-your-patients-and-your-practice**.
- In addition to e-consults, we reimburse for synchronous telehealth services in accordance with our *Virtual Care* (Administrative #132) commercial and Medicare Advantage reimbursement policies, available on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

Quality toolkit available to help improve member experience

Surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)/Health Outcomes Survey (HOS) are used to gauge the members' experience with their providers. CAHPS/HOS scores account for more than a quarter of a health plan's overall CMS Medicare Advantage Star Ratings. When these ratings improve, it's an indicator that Asuris members are having meaningful conversations with their providers and receiving helpful information during their provider visits to lead healthier lives.

Our Quality Improvement Toolkit includes information about member benefits, resources and best practices for having conversations with your patients. The CAHPS/HOS and other provider-driven quality measures included in this toolkit are:

- Advance care planning—**New**
- Bronchitis—**New**
- Cancer screening
- Care coordination
- Chlamydia screening
- Fall risk coaching
- Getting care quickly
- Hypertension
- Incontinence management
- Influenza immunization
- Low back pain—**New**
- Maintaining a healthy weight—**New**
- Medications, including information about reviewing a patient's medications
- Monitoring physical activity
- Overall health rating
- Pneumonia immunization
- Tobacco cessation
- Well-child visits

The Quality Improvement Toolkit is available on the homepage of our provider website.

Cultural competency and health literacy resources

State and federal legislative requirements emphasize the importance of demonstrating cultural competency when providing health care services. This means care should be inclusive of patients who may:

- Be experiencing housing insecurity
- Have physical or mental disabilities
- Have a diverse cultural or ethnic background
- Be limited in English proficiency and/or reading skills

We seek providers who speak languages in addition to English and who have an awareness of the social and cultural composition of the community. Additionally, we require that Medicare Advantage members have access to information in their primary language, and that PCP offices have provisions for non-English speaking Medicare Advantage patients.

Our Cultural Competency Toolkit includes resources to help develop and improve your cultural competency and health literacy as you and your staff provide care for our members. The toolkit includes these sections:

- LGBTQ+
- Implicit bias
- Tribal health care
- Maternal health care
- Social determinants of health
- Language access and services
- National standards and essential references
- Additional resources

The Cultural Competency Toolkit is available on the homepage of our provider website.

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

Related: See *Medicare Advantage cultural competency requirements* on page 21.

Monitoring physical activity and improving quality

The Monitoring Physical Activity Medicare Star Ratings measure continues to be an opportunity for us to improve.

As a health care provider, you understand the importance of exercise in reducing the risk of many chronic diseases and cancers, as well as managing and improving the health of patients already diagnosed with a chronic condition. You can encourage and motivate your patients to become or stay active when you assess their level of physical activity and fitness during a visit.

Tips for making the Monitoring Physical Activity measure a part of your workflow:

- Share information about regular physical activity, including endurance, muscle strengthening, and balance and flexibility exercises, which are essential for healthy aging and reducing fall risk.
- Implement exercise or physical activity as a Vital Sign into your rooming process and EMR. There are several simple screening tools that can begin with clinical support staff and then be handed off to the provider. Learn more at **cdc.gov/pcd/issues/2017/17_0030.htm**.
- Include physical activity in your patient's care plan. Help them develop an exercise plan that includes realistic goals and discuss any potential barriers they may have to becoming or staying active.
- Involve members of your team—such as a health coach, patient navigator, care manager, case manager or anyone trained in motivational interviewing—in the process to help encourage patients to stay physically active.
- Social support from family and friends has been consistently and positively related to sustaining regular physical activity. Consider ways to encourage social support.
- Talk to patients about Silver&Fit, a benefit of their Asuris Medicare Advantage or Medigap plan. Silver&Fit is designed to offer healthy activities, information and support for everyone. Whether working out at one of more than 20,000 fitness clubs and exercise centers or from the comfort of home, our Medicare members can enjoy healthier, more active lives. Visit **silverandfit.com** to learn more about the program. Additional benefits associated with the Silver&Fit program include:
  - **Home fitness program**: Choose up to two home fitness kits each year to promote staying active.
  - **Resource library**: Members can browse a library of online classes, healthy aging videos, articles and *The Silver Slate Newsletter*.
  - **Silver&Fit Connected!**: Members can track their exercise using a fitness device or app.
  - **Rewards program**: Members are rewarded for being active.

Flyers are available to help you facilitate conversations that address such topics as fitness and physical activity. The following flyers are available in our Quality Improvement Toolkit in both English and Spanish:

- *Exercise: How to Start*
- *Exercise: Stay Motivated*
- *Fitness: What's Getting in Your Way*
- *Exercise: Setting Goals to Get Active*
- *Exercise: Finding Activities That Work for You*

Access the Quality Improvement Toolkit on the homepage of our provider website.

You can also view member tools and resources on the Healthwise Knowledgebase for this and other health topics on our provider website: Programs> Member Programs & Tools.

Help members get care during flu, COVID-19 and RSV season

With the spread of flu, COVID-19 and respiratory syncytial virus (RSV) in our communities, 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—COVID-19, flu and pneumonia vaccines are safe and effective. **Note**: Most of our health plans cover preventive care services at 100%.
- 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**.

We will continue to update the COVID-19 Toolkit, available on the homepage of our provider website, to make sure you have the latest COVID-19-related information and helpful resources.

Care options

We encourage you to educate your patients about the care options they can access from their home when your office is closed or as an alternative to an ED visit for non-acute or life-threatening conditions.

Virtual care: If you offer telehealth services, as many of our medical and behavioral health providers do, remind patients how they can schedule an appointment that will take place without them having to leave their home. Most of our members also have access to medical and behavioral health telehealth vendors that offer convenient appointment times.

- **Related**: See *Telehealth can support PCP and facility care* on page 16 for information about in-network virtual behavioral health providers.

At-home care: Asuris members in the Spokane area have access to at-home care through DispatchHealth. View the DispatchHealth service area: **www.dispatchhealth.com/locations**.

Urgent care clinics: Many urgent care clinics are conveniently located and are more accessible than EDs.

Our Care Options Toolkit, available on the homepage of our provider website, includes the following flyers:

- *Help Your Patients Plan Ahead for Care*: Includes best practices and links to helpful resources to educate your patients
- *Know Your Behavioral Health Options*: Includes information about behavioral health providers and vendors available to our members
- *Know Where to go for Care*: Includes information about our nurse line, virtual visits, at-home urgent care (if available), urgent care clinics and ED care
- HealthWise's *Using the Emergency Room Wisely*: Includes information about when to go to the ED for care

Help your patients know their options before they need care

Encourage your patients to sign in to **asuris.com** and use the Find a Doctor tool to locate care options near them so they know where to go when they need care.

In addition to informing our members about care options through content on our public and authenticated member websites, we have included content in blogs, social media and email campaigns. Our care managers also contact members who have had several ED visits to educate them about their care options.

We're here to help

Members can call the Customer Service number on the back of their member ID card for help understanding their care options.

Resources available for treatment of low back pain

Patients often look to their providers to refer them for expensive imaging studies, such as MRIs and CT scans, to support the diagnosis of low back pain; however, these technologies often are not needed.

Health plans, including Asuris, are measured on the appropriate use of technology in the diagnosis of low back pain by the National Committee for Quality Assurance (NCQA) based on the HEDIS measure *Use of Imaging Studies for Low Back Pain*.

The measure looks at the percentage of members with a primary diagnosis of low back pain who **did not** have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. Asuris scored in the 75th percentile for this measure when compared to similar plans nationally.

Care support flyers

Flyers are available in our Quality Improvement Toolkit in both English and Spanish to help you facilitate conversations that address topics related to back pain. They address different aspects of back pain, including:

- How to protect the back
- Exercises for low back pain
- How to relieve low back pain
- How to keep low back pain from coming back
- Information about whether the patient should have an MRI to help diagnose back pain
- Information about options to treat back pain, including surgery, spinal manipulation or use of pain medicine

Access the Quality Improvement Toolkit on the homepage of our provider website.

We depend on our providers to use the best evidence-based guidelines available when making decisions about how to diagnose and treat back pain, with the most important aspect of care being the provider's clinical experience and judgement. We hope these tools help you provide the most efficent, high-quality care possible.

Medicare Advantage cultural competency requirements

Medicare Advantage organizations are asked to ensure that services are provided in a culturally competent manner and allow members to choose those providers who may best serve their needs. In a recent technical rule, CMS broadened its application of the policy and amended the list of populations to include people:

- With limited English proficiency or reading skills
- Of ethnic, cultural, racial or religious minorities
- With disabilities
- Who identify as lesbian, gay, bisexual or other diverse sexual orientations
- Who identify as transgender, nonbinary and other diverse gender identities
- Who were born intersex
- Who live in rural areas and other areas with high levels of deprivation
- Who are otherwise adversely affected by persistent poverty or inequality

As first-tier, downstream or related entities (FDRs), providers also need to comply with these requirements. You can do this by:

- Keeping the information in our provider directories up-to-date by:
  - Confirming that practice information, including cultural competencies available within your practice, are correct in our provider directory
  - Indicating non-English languages you may speak, including whether you use American Sign Language (ASL)
  - Following the steps to validate and update the information in our provider directory, available on our provider website: Contact Us>Update Your Information
- Assisting patients in your offices by:
  - Keeping your location accessible for people with physical disabilities
  - Having skilled medical interpreters to help those members who need assistance

Occasionally, CMS calls providers to review the accuracy of our data in our provider directories. During those calls they may ask if you offer "Asuris" or the formal marketing name of the plan in their system. Please keep your staff up to date on the various names the member plan could be listed under.

Related: See *Update your directory information* on page 5 and *Cultural competency and health literacy resources* on page 18.

Medicare Advantage QIP reminders

2023 Medicare Advantage Quality Incentive Program (MA QIP)

December 31, 2023, was the last day to provide services or screenings to close gaps for the 2023 program. You may continue to submit gap closure information for the 2023 MA QIP according to the following deadlines:

- **February 29, 2024**—Last day to submit supplemental data
- **February 29, 2024**—Last day to work in the Care Gap Management Application (CGMA)
- **March 31, 2024**—Last day to submit medical or pharmacy claims

The CGMA will display 2023 data through June 2024 to allow you to monitor your progress.

2024 MA QIP

Use CGMA reporting to get a head start on improving medication adherence

As we wrap up our work in 2023, we are focusing on improving medication adherence for members who ended 2023 nonadherent. Here are our recommendations:

- **Identify nonadherent patients**: Utilize the proportion of days covered (PDC) metric from your final 2023 CGMA Pharmacy Engagement Program (PEP) report
  - Access your PEP report by:
    1. Selecting the menu icon (three horizontal lines in the upper right-hand corner of CGMA)
    2. Select **Reports** then **PEP Report** to download the PDF
  - Start by reviewing patient charts for any discontinuation of medication or intolerances/allergies (keep statin exclusion criteria in mind)
  - Address gaps by helping patients refill before "Must Fill By" dates
- **Communication strategies**:
  - Inquire about adherence during patient interactions
- **Addressing barriers**:
  - Simplify regimens for forgetfulness
  - Promptly address side effects through dose adjustments or alternative prescriptions
  - Enhance patient understanding through clear explanations and the use of teach-back techniques
- **Financial considerations**:
  - Explore cost-effective options, including generic medications and lower-cost alternatives
  - Encourage the use of preferred pharmacies
  - Consider prescribing up to a 90- or 100-day supply
- **Additional support**:
  - Identify and address social determinants of health (SDoH) barriers.
  - Direct members to Customer Service for resources like **211.org**, **needymeds.org**, **findhelp.org** and **fullcart.org**.

Your dedication to discussing medication adherence with your patients is crucial. Together, we can empower our members to achieve better health outcomes. Thank you for your commitment to improving patient care and for adding value to our member's lives.

Jumpstart your 2024 MA QIP performance: Start scheduling members for their preventive care visits (PCV) or annual wellness visits (AWV) today.

We recommend that you **see every member every year** for their PCV/AWV and use this visit as an opportunity to assess your patient's chronic conditions and address all of their preventive care needs. Please email **QIPQuestions@asuris.com** if you have workflow suggestions for how to use a nurse-led model to schedule and complete Medicare AWVs for all your patients.

PCV/AWV tips

- AWVs are reimbursable on the same day as acute care visits (excluding visits at rural health centers and federally qualified health centers). Ensure that your documentation represents that **both** visits took place.
- AWV and PCV will be reimbursed **separately** when billed on the same date of service. Ensure that your documentation represents that **both** visits took place.
- We will reimburse for AWVs and PCVs billed once per calendar year. There is no requirement to wait 11 months between visits.

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Flu vaccines

Encouraging patients to get their annual flu vaccination is a year-round project.

- **Our Annual Flu Vaccine Measure does not include a timing component:**
  - Report that your patient had a flu shot in 2024, at any time during the year, and earn credit for 2024 gap closure in the MA QIP.
  - It is acceptable to bill HCPCS G8482 by itself on a $0.00 claim after receiving verbal confirmation that a member received their flu vaccine from another provider and documenting this in the medical record.
- **No matter when you see your patients throughout the year:**
  - Talk to your patient about the importance of having a flu shot this year.
  - Remind your patient that you want to know if they got their shot from another provider.
  - Ask your patient to call the office and report when and where they receive their immunizations.
  - If you give vaccinations in your office, schedule your member to come back in the fall to receive their vaccination.

MOON required for Medicare members

All hospitals and critical access hospitals (CAHs) are required to provide written notification and an oral explanation to Medicare beneficiaries receiving outpatient observation services for more than 24 hours using the *Medicare Outpatient Observation Notice (MOON)*, form CMS-10611.

You can find the notice and accompanying instructions at: **cms.gov/Medicare/Medicare-General-Information/BNI/MOON**. A link to this form is also available on our provider website: Library>Forms.

The MOON is designed to inform Medicare beneficiaries when they are an outpatient receiving observation services and are not an inpatient of the hospital or CAH. The notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility (SNF) services. Hospitals and CAHs must deliver the notice to the health plan within 36 hours of the start of observation services or sooner if the individual is transferred, discharged or admitted.

Resources for you

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

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