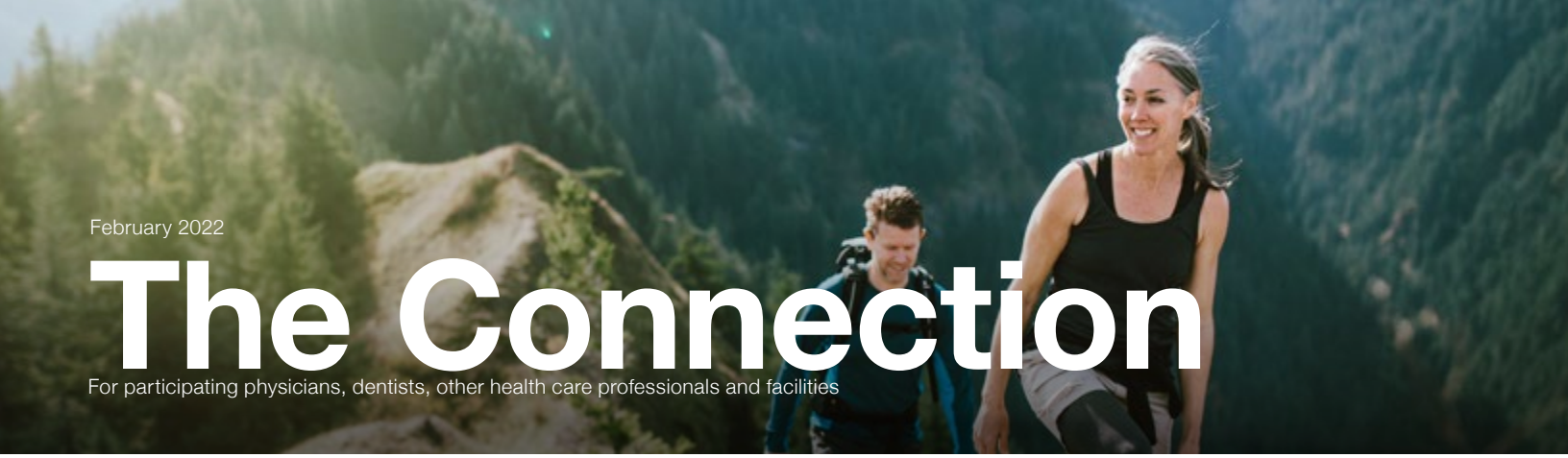

February 2022

The Connection

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

Help reduce hypertension and risk for heart disease

February is American Heart Month and is observed to help 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%) have high blood pressure than women (44%).
- 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 on the importance of tracking their blood pressure, taking prescribed medications, if appropriate, and implementing lifestyle changes to reduce their risk of the disease. To identify patients who are due for follow-up appointments, use registries within your electronic medical record 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

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.
✶ Behavioral health must read	
▲ Dental must read	
‡ Physical Medicine 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 policies, reimbursement policies and Clinical Position Statements, including changes we are contractually required to communicate to you.

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Share your feedback

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

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Million Hearts

Million Hearts® 2022 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. The initiative brings together communities, health systems, nonprofit organizations, federal agencies and private sector partners from across the country to fight heart disease and stroke. We invite you to join in this initiative. Learn more at **millionhearts.hhs.gov**.

Livongo for Hypertension available to ASO groups

This buy-up option, available to our administrative services only (ASO) groups, provides tools, insights and expert support to help make managing blood pressure simple. Learn more in the Medical Management section of our *Administrative Manual*: Library>Administrative Manual.

Recommendations

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 at **heart.org**. You can request health education flyers addressing *High Blood Pressure*, *High Blood Pressure ACE Inhibitors and ARBs*, and *High Blood Pressure: Adding DASH to Your Life* by emailing our Quality Team at **Quality@asuris.com**.

Annual HEDIS medical record collection

Our HEDIS medical record reviews for measurement year 2021 will begin this month, continuing through May 2022. We have contracted with 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 our vendor 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.

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

2021 newsletter and bulletin survey results

Thank you for completing our annual newsletter and bulletin survey.

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

Key survey findings

- ***The Bulletin* vs. *The Connection***: Respondents indicated that they are unclear on the difference between our publications.
  - ***The Bulletin***: This monthly publication includes updates to our medical and reimbursement policies. It is posted on our provider website: Library>Bulletins.
  - ***The Connection***: The newsletter is published in February, April, June, August, October and December. It includes updates to our pre-authorization requirements; dental and medication policies; and other important changes that impact providers. It is posted on our provider website: Library>Newsletters.
- **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., behavioral health and dental).
- **Newsletter most read articles**: The topics identified as the most read include administrative and billing updates; information about Availity Essentials; *The Bulletin* recap; pre-authorization changes; and programs that impact providers.

New for 2022 based on your feedback

- **Direct links to newsletters and bulletins in emails**: Email notifications we send when new issues of our publications are available will link directly to issues of *The Bulletin* and *The Connection*.
- **Behavioral health corner**: *The Connection* now includes a Behavioral Health corner that will feature behavioral health-specific articles and identify the other content that impacts behavioral health providers. **Related**: See *Behavioral health corner* on page 10.
- **Other improvements**: In *The Connection*, we will make it easier to quickly identify important updates and we'll reduce the number of articles.

Additional comments

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

Administrative Manual updates

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

Facility Guidelines

- Updated minimum level of service requirements for mental health and chemical dependency partial hospitalization levels of care

Laboratory Services

- Revised the documentation requirements section

Medical Management

- Updated kidney health program information

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

Self-Service Tool

Our Self-Service Tool gives you the information you need, on demand, online 24/7. Review helpful answers to our most frequently asked questions and quickly navigate our website resources—all without the need to call or email for help. Easily access the tool in the Quick Links section of our provider website.

Health care provider requirements regarding surprise medical billing

Effective January 1, 2022, the No Surprises Act established new federal protections against most surprise out-of-network (OON) medical bills.

Section 104 of the No Surprises Act, states that out-of-network health care providers (including facilities, physicians and other health care professionals) may not balance bill patients for covered emergency services or certain covered non-emergency services provided at in-network facilities unless certain conditions are met. Health care provider requirements regarding surprise medical billing:

- Prohibit OON facilities providing emergency services and out-of-network providers at in-network facilities from balance billing patients
- Permit OON providers to continue to balance bill if they give the patient written notice that includes all of the following information:
  - Their network status
  - A list of in-network providers at the facility
  - Information about pre-authorization or care management limitations
  - An estimate of charges 72 hours prior to receiving the OON care
  - **Note**: The patient must also provide consent to receive the OON care for a provider to balance bill.
- Do not apply to providers furnishing ancillary services in the exception and prohibit them from balance billing patients with or without consent regardless of their specialty; ancillary services include emergency medicine, anesthesiology, pathology, radiology, laboratory, neonatology, hospitalists, assistant surgeons and intensivists
- Prohibit using the notice and consent option in instances where the OON provider is the only provider at the in-network facility who can perform the service (i.e., the patient cannot choose someone in-network)
- State law does not allow Washington providers to obtain notice and consent

Learn more about the No Surprises Act on the Centers for Medicare & Medicaid Services (CMS) website: **cms.gov/nosurprises**.

Reminder: Include place of service on professional claims

Professional claims billed with a facility place of service code require the facility's National Provider Identifier (NPI) to process the claim accurately. Including the NPI allows us to process the claim timely and ensure that our members are receiving the appropriate benefit, including balance billing protection when applicable.

Effective January 1, 2022: Professional claims from out-of-network providers that identify a place of service (inpatient/outpatient hospital, ambulatory surgical center, emergency room, inpatient psychiatric facility, psychiatric facility partial hospital and comprehensive inpatient rehabilitation facility) but do not reflect the facility NPI number will be denied back to the provider. The denial code (GVH) will indicate: "Place of service requires service facility information."

Note: The service location should not be the same as the billing provider NPI.

When appropriate, the service facility NPI should be included in loop 2310, segment NM109 on an ANSI 837P claim.

A facility NPI can be provided by the facility or by searching the National Plan & Provider Enumeration System (NPPES), **npiregistry.cms.hhs.gov**.

All providers are responsible for submitting accurate and complete claims for all medical, dental and surgical services, supplies and items rendered to members using industry standard coding guidelines. Please refer to the *Correct Coding Guidelines* (Administrative #129) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

Pricing disputes versus appeals

We created a new pricing dispute workflow, intake form and response team to address the number of pricing disputes being incorrectly submitted as appeals. By reducing the number of intake points for pricing disputes, we can ensure the most efficient handling.

We respond to pricing disputes submitted using our new *Pricing Dispute Form* within 30 days. When pricing disputes are incorrectly submitted as an appeal, they can take up to 50 days for a response and will require the provider to resubmit the issue using the pricing dispute process.

To receive the most efficient response, submit your pricing dispute using the correct process and validate your dispute against available resources.

Pricing disputes occur when contracted providers disagree with our decision about how a claim or claim line was processed. Some examples include disagreeing with the:

- Allowed amount on a claim line
- Percent of billed charges paid
- Diagnosis-related group (DRG) on a facility claim

Appeals may concern:

- Adverse determinations
- Provider contract termination
- External audit and investigation
- Medical or reimbursement policy reconsideration

Learn more about pricing disputes and appeals on our provider website: Claims & Payment>Payment> Appeals. If you need additional help determining which process to follow, contact our Provider Contact Center.

Directory attestation to be required every 90 days

Accurate provider directories are essential for members to use when making informed health care decisions. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills. The Consolidated Appropriations Act (CAA), 2021, effective January 1, 2022, 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.

Effective March 1, 2022, our *Provider Directory Attestation Requirements for Providers* policy will require:

- 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
- All participating providers to comply with Asuris 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)
- Providers to review, update and return roster validation requests from Asuris

Failing to verify directory information is grounds for removal from our provider directory and/or termination of the provider's agreement with Asuris.

We are researching ways to make the process of validating directory information as easy as possible, including launching a tool on Availity Essentials. If you or your organization do not already have an Availity Essentials account, please register at the tax ID level today at **availity.com**.

View our *Provider Directory Attestation Requirements for Providers* policy and instructions for verifying your directory information on our provider website: Contact Us>Update Your Information. **Related**: See *Keep your information current* on this page.

Keep your information current

Our members rely on the information in our online provider search tool, Find a Doctor, to determine whether physicians, dentists, other health care professionals and facilities are included in their health plan's provider network.

We require you to verify your practice information and the networks you participate in at least once every 30 days through February 28, 2022. Beginning March 1, 2022, you will need to validate your practice information no less frequently than every 90 days.

Validate your practice information

Take time now to validate your practice information by following the steps outlined on our provider website: Contact Us>Update Your Information.

Each month, please verify that we have correctly listed your specialty, degree, primary care designation (if appropriate) and whether you are accepting new patients. This helps members find you when they need specialty care or a particular service. If your clinic is a retail health clinic, let us know so we can update your information.

Submit changes or corrections

Notify us immediately if you have changes to your practice information. Submit the *Provider Information Update Form* for changes as listed on our provider website: Contact Us>Update Your Information. Thank you for helping our members connect with you.

New provider agreements coming

We are replacing individual provider agreements and updating all Medical Group Agreements (MGAs) with Professional Services Agreements (PSAs).

Make sure you don't miss important contracting notifications. It is critical that we have the correct email address for the person delegated to receive contractual notifications and sign provider agreements on behalf of contracted physicians, dentists or other health care professionals at your practice. Please submit an Electronic Contracting Registration form to provide this information today, respond promptly to requests to validate signatory information and sign new agreements promptly.

The form and more information about this recontracting project are available on our provider website: Contracting & Credentialing>Contracting.

Availity tips for authorizations

Use the Authorization tool in Availity Essentials at **availity.com**, to quickly see if a pre-authorization is required for a medical service and to submit your medical pre-authorization request. Some procedures may receive instant approval.

Pre-authorizations for dental procedures

We accept pre-authorization requests for medical procedures but not for dental procedures. If a dental authorization is started, the user will receive an error message. Dental predeterminations can be submitted electronically for a courtesy review but cannot be viewed on Availity Essentials. Learn more about dental predeterminations on our provider website: Claims & Payment>Claims Submission>Dental Billing.

Pre-authorizations through third-party vendors

Pre-authorizations for sleep medicine, physical medicine or complex radiology services can be started in the Availity Authorization tool. If the authorization needs to be completed with a third-party vendor, such as AIM Specialty Health (AIM) or eviCore healthcare (eviCore), the user will be routed to the appropriate site to complete the request. If errors are received after being routed to the third-party site, the user must contact the vendor directly.

Coordination of benefits (COB) error during a medical pre-authorization request

Occasionally, if a member has a dental plan as primary in our claims system, the medical pre-authorization request cannot be completed and the user will receive an error message during the member eligibility check. When this occurs, the user will need to submit the request manually via our provider website: Pre-authorization.

Authorization attachment limitations

Acceptable file types for attachments are TIF, JPG, PDF, and DOCX. Acceptable file size must be less than 60 MB, and the total combined size of all attachments for a single request cannot exceed 150 MB.

Get free training

View the training options available by clicking the Watch a demo link in the Authorizations tool.

Learn more about electronic pre-authorizations on our provider website: Pre-authorization> Electronic Authorization.

Look for more Availity tips in our April 2022 newsletter.

EFT required

Effective May 1, 2022, we will require all participating providers to receive claims payment via electronic funds transfer (EFT). Failure to receive claims payment via EFT is grounds for termination of the provider's agreement with us. Use the Transaction Enrollment tool in Availity Essentials to enroll today at **availity.com**: My Providers>Enrollments Center> Transaction Enrollment. The Transaction Enrollment dashboard will display the status and progress of your enrollments.

Notes:

- Only your organization's administrator, administrator assistant and users with the Transaction Enrollment role may enroll for EFT and change or update EFT setup.
- For security purposes, you will receive a phone call from our EFT enrollment team to validate the information you provide.
- If your EFT enrollment was completed prior to April 2021, your dashboard will not reflect that you are currently setup for EFT—only organizations that enrolled for EFT after April 2021 will show on the dashboard.

Learn more about EFT and view a step-by-step guide to enrolling or changing your EFT setup on our provider website: Claims & Payment>Payment.

Pre-authorization requirements to end for chiropractic, acupuncture and massage services

Pre-authorization will no longer be required for most chiropractic, acupuncture and massage services delivered April 1, 2022, or later. Currently, providers submit pre-authorization requests for these services to eviCore.

Pre-authorization will still be required for:

- Services occurring through March 31, 2022
- Services provided to members of administrative services only (ASO) groups that have purchased our Physical Medicine program with the chiropractic/ acupuncture/massage (CAM) component

Use Availity Essentials at **availity.com**, to check whether services require pre-authorization.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective January 1, 2022
Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer (Genetic Testing #42)	81523
Bariatric Surgery (Surgery #58)	43845
Chromosomal Microarray Analysis (CMA) or Copy Number Analysis for the Genetic Evaluation of Patients with Developmental Delay, Intellectual Disability, Autism Spectrum Disorder, or Congenital Anomalies (Genetic Testing #58)	81349
Digital Health Products (Medicine #175)	0702T, 0703T
Digital Health Products for Attention Deficit Hyperactivity Disorder (Medicine #175.01)	0702T, 0703T
Digital Health Products for Substance Use Disorders (Medicine #175.02)	0702T, 0703T
Evaluating the Utility of Genetic Panels (Genetic Testing #64)	81349
Gait Analysis (Medicine #107)	0693T
Gender Affirming Interventions for Gender Dysphoria (Medicine #153)	54400, 54401, 54405, C2622
Genetic and Molecular Diagnostic Testing (Genetic Testing #20)	81349
Genetic Testing for the Evaluation of Products of Conception and Pregnancy Loss (Genetic Testing #79)	81349
Genetic Testing; Reproductive Carrier Screening for Genetic Diseases (Genetic Testing #81)	81161
Hypoglossal Nerve Stimulation (Surgery #215)	64582, 64583
Invasive Prenatal Fetal Diagnostic Testing for Chromosomal Abnormalities (Genetic Testing #78)	81349
Laser Interstitial Thermal Therapy (Medicine #177)	61736, 61737
Preimplantation Genetic Testing of Embryos (Genetic Testing #18)	81349
Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy of Intracranial, Skull Base, and Orbital Sites (Surgery #213)	77301, 77338
Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy for Tumors Outside of Intracranial, Skull Base, or Orbital Sites (Surgery #214)	77301, 77338
Transcutaneous Bone-Conduction and Bone-Anchored Hearing Aids (Surgery #121)	69716, 69719, 69726, 69727

Procedure/medical policy	Adding codes effective March 13, 2022
Radiology: AIM Specialty Health	0042T, 0648T, 0649T

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Procedure/medical policy	Adding codes effective April 1, 2022
Negative Pressure Wound Therapy in the Outpatient Setting (Durable Medical Equipment #42)	CPT 97605-97608; HCPCS E2402

Medicare

Procedure/medical policy	Added codes effective January 1, 2022
Autologous Blood-Derived Growth Factors as a Treatment for Wound Healing and Other Miscellaneous Conditions (Medicare Advantage—Medicine #77)	HCPCS G0465
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicare Advantage—Medicine #170)	HCPCS A2001-A2010, Q4199
Gait Analysis (Medicare Advantage—Medicine #107)	CPT 0693T
Gender Affirming Interventions for Gender Dysphoria (Medicare Advantage—Medicine #153)	CPT 54400, 54401, 54405, C2622
Genetic and Molecular Diagnostics – Next Generation Sequencing and Genetic Panel Testing (Medicare Advantage—Genetic Testing #64)	CPT 81349, 81523
Genetic and Molecular Diagnostics – Single Gene or Variant Testing (Medicare Advantage—Genetic Testing #20)	CPT 81349
Hypoglossal Nerve Stimulation (Medicare Advantage—Surgery #215)	CPT 64582, 64583
Laser Interstitial Thermal Therapy (Medicare Advantage—Medicine #177)	CPT 61736, 61737

Procedure/medical policy	Adding codes effective March 13, 2022
Radiology: AIM Specialty Health	CPT 0042T, 0648T, 0649T

Procedure/medical policy	Adding codes effective April 1, 2022
Negative Pressure Wound Therapy in the Outpatient Setting (Durable Medical Equipment #42)	CPT 97605-97608; HCPCS E2402

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 at **availity.com**. Learn more on our provider website: Pre-authorization>Electronic Authorization.

Behavioral health corner

Inpatient behavioral health to require new forms

Effective May 1, 2022, we will require providers to submit a behavioral health intake form for the following:

- Initial intake
- Concurrent review
- Stepdown request to a lower level of care
- Discharge confirmation

Standardizing our behavioral health utilization management process will greatly reduce the turnaround time needed for reviews and approvals.

The new forms will be available on our provider website in April 2022. You will be able to submit them to our behavioral health team by email or fax. Additionally, initial intake forms can be attached to new initial pre-authorization requests in Availity.

Look for additional information, including where to find the forms on our provider website, in the April 2022 issue of this newsletter.

ABA reimbursement update

Effective May 1, 2022, we will update reimbursement rates for applied behavior analysis (ABA) services provided to our commercial members (group and Individual products).

The updated reimbursement rates will be posted by May 1, 2022, in Availity Essentials, **availity.com**: Claims & Payment>Fee Schedule Listing> Fee Schedules. Select the plan name and then enter the organization, tax ID and NPI. Click Next. Select the Actions button on the right to enter specific codes or a code range.

About behavioral health corner

Behavioral health corner is a new section in which we highlight 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 particular practice.

This newsletter contains the following articles that pertain to behavioral health care.

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

The Bulletin recap

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

Medical policy updates

We provided 90-day notice in the December 2021 issue of *The Bulletin* about changes to the *Extracorporeal Membrane Oxygenation (ECMO) for the Treatment of Cardiac and Respiratory Failure in Adults* (Medicine #152) medical policy, which are effective March 1, 2022.

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

- *Bariatric Surgery* (Surgery #58)
- *Negative Pressure Wound Therapy in the Outpatient Setting* (Durable Medical Equipment #42)
- *Negative Pressure Wound Therapy Pumps* (Medicare Advantage—Durable Medical Equipment #42)

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 December 2021 issue of *The Bulletin* about changes to the *Associated Claims* (Administrative #119) reimbursement policy, which are effective March 1, 2022.

We provided 90-day notice in the January 2022 issue of *The Bulletin* about the following reimbursement policies, which are effective April 1, 2022:

- *Cellular and Gene Therapy Products* (Medicine #112)
- *Modifier 90; Reference (Outside) Laboratory* (Modifiers #118)

  - We updated our January 2022 bulletin on January 4 to add the following statement: Laboratory codes submitted with modifier 90 when billed by a physician or other qualified health care provider will result in a recommended denial because of a ClaimsXten edit.

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 at **availity.com**: Payer Spaces>Resources>Claims and Payment> Research Procedure Code Edits.

Telehealth reminders

Our *Virtual Care* (Administrative #132) reimbursement policy was updated on January 1, 2022.

Updates to the policy include, but are not limited to:

- Claims for eligible telehealth services must be billed with place of service (POS) 02 or POS 10, as appropriate, and modifier GT. The updated policy includes the procedure codes that will be considered telehealth when billed with the appropriate POS modifier. View the CMS guidelines for the appropriate use of the POS codes at **cms.gov/files/document/mm12427-newmodifications-place-service-pos-codes-telehealth.pdf**.
- Claims for audio-only telehealth services should use modifier FQ. **Notes**:
  - For the encounter to meet the Medicare telehealth face-to-face requirement, telehealth visits with your Medicare Advantage patients must be conducted using real-time via audio and video, and the use of audio and video must be documented in the patient's chart note.
  - The policy includes the definition of an established provider-patient relationship and the requirement of the established relationship for audio-only services. Member consent must be obtained and documented in the medical record prior to a virtual service performed using audio-only technology.
- Providers must be licensed in both the state where the member is located, as well as the state where the provider is physically located.

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

Notification about the update to this policy was also included in the February 2022 issue of *The Bulletin*.

Vitamin D testing reminder

We cover vitamin D testing for members with a clinically documented underlying disease or condition which is specifically associated with vitamin D deficiency or decreased bone density or in the evaluation or treatment of conditions associated with defects in vitamin D metabolism.

The U.S. Preventive Services Task Force (USPSTF) and the Institute of Medicine have found a lack of evidence to support routine testing for vitamin D levels in healthy patients. Therefore, we do not cover routine testing for vitamin D levels in otherwise healthy patients because it is not considered medically necessary. Billing for services that are not medically necessary will be denied as a provider write-off. Verify member benefits using the Patient Cost Estimator Tool on Availity Essentials at **availity.com**.

For more information, view the following resources on our provider website:

- Coding Toolkit: Claims & Payment>Coding Toolkit>Other Edits>Other Specific Edits
- Vitamin D medical policies: Library>Policies & Guidelines>Medical Policy
  - Commercial (Laboratory #52)
  - Medicare (Medicare-Laboratory #52)

Medication policy updates

Effective June 1, 2022, we are revising the following medication policies

- *Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors* (dru621)
  - Coverage of Susvimo will require a trial of bevacizumab and Lucentis
- *Interleukin-1 Antagonists* (dru677)
  - For existing utilizers new to the Plan, clarifying Continuation of Therapy (COT) criteria; adding step therapy requirement with anakinra (Kineret) when medically reasonable
  - For new starts, adding step therapy with anakinra (Kineret) for periodic fever syndromes [CAPS (NOMID, MWS, FCAS), FMF, TRAPS, HIDS/MKD] and DIRA, as the lowest-cost IL-1 antagonist

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.

Strive Health is our new kidney health partner

Strive Health is our new kidney health management partner for fully insured commercial and Medicare Advantage members. Strive began contacting providers with eligible members in January 2022.

In this time of unprecedented health system constraints, this program supports providers and their patient care plans. It also helps members with chronic kidney disease (CKD) stages 3 to 5 or end-stage renal disease (ESRD) by providing a continuum of care management and direct clinical care as their disease progresses.

Partnering for wraparound care

Kidney care sometimes focuses on dialysis alone after a patient's health has deteriorated, but Strive's goal is to engage members early and throughout their entire kidney care journey, supporting modality choice aligned with each member's needs. Early identification and high-touch engagement:

- Improves health outcomes
- Simplifies the member's experience
- Lowers health care costs

Strive partners with the patient's primary care provider (PCP) and/or nephrologist to provide wraparound care and to ensure effective care coordination. They assist patients with adherence to providers' care plans, acting as an extension of that provider's services. Strive does not replace the PCP and/or nephrologist; instead, it deploys a multi-disciplinary team to provide high-touch support to patients between provider visits. Strive will contact you about your eligible patients to discuss how they can best support your care plan, but most of their outreach is member-focused.

Eligible members can receive assistance with finding cost-effective and convenient dialysis and kidney transplant options. Support is customized to fit the patient's needs and preferences.

Members may choose to opt out of Strive's program.

Related: See *Administrative Manual updates* on page 4.

Provider quality resources

Each year, our members are surveyed on various aspects of their health care experience through the *Consumer Assessment of Health Care Providers and Systems (CAHPS®)* survey, the *Health Outcomes Survey (HOS)* or a hybrid *CAHPS-HOS* survey for members attributed to specific provider groups.

Some of the topics measured by these surveys relate to whether a member's health care provider talks to them about fall risk reduction strategies, incontinence management or increasing their amount of physical activity. **Related**: See *Fall prevention: How you can help* on page 14.

We've gathered resources and best practice tips to help you understand how the care your patients receive impacts these scores and to provide you with information about how access to care and care coordination can improve patient outcomes. View these tools on our provider website: Programs> Cost & Quality>Provider Quality Resources.

Fall prevention: How you can help

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

The Fall Risk Management Medicare Star Ratings measure is included in our 2022 Medicare Quality Incentive Program. Our score for this measure is based on memorable and impactful conversations you have with your patients regarding falls.

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

- Conduct regular fall risk screenings (screening annually or biannually) either during or outside of the annual wellness visit (AWV).
- Implement prompts within your electronic medical record (EMR) to alert providers and staff that a patient is due for a conversation regarding falls and fall prevention.
- Implement the CDC Stopping Elderly Accidents, Deaths & Injuries (STEADI) algorithm within your EMR.
- Consider implementing group visits focused on fall prevention (e.g., Matter of Balance-coached events).
- Know and refer patients to community resources focused on preventing falls (fall prevention classes, tai chi, Matter of Balance).
- Encourage regular physical activity, focusing on strengthening the core muscles.
- Regularly review and discuss medications with patients; some medications can cause issues with balance.

We can help facilitate these conversations with educational member flyers that address such topics as fall prevention. The flyers, available in both English and Spanish, include:

- *Aging Well: Making Your Home Fall Proof*
- *Your Health: How to Prevent Falls*
- *Senior Health: Preventing Falls*
- *Senior Health: When Medications Affect Your Balance*

The flyers are designed to reinforce learning objectives after a coaching encounter and can also be made available for patients to review in the waiting room before an appointment.

If you'd like a copy of these flyers, please send an email to **Quality@asuris.com**.

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 who are receiving observation services as outpatients for more than 24 hours, via 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 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.

Benefits to support Medicare Advantage members

Our Medicare Advantage plans include supplemental benefits. These benefits can add to the care you provide to maintain and improve the health of your patients.

Personal emergency response system (PERS)

Members can receive a Lively Mobile Plus PERS device to help them stay safe and maintain independence at home and on the go for a $0 copay. This PERS benefit and support is provided by Best Buy Health.

Bathroom safety devices

Members can purchase items to facilitate home safety. Items include a shower/bathtub grab bar and bench, commode/toilet rails, elevated toilet seats, a transfer bench or chair or a tub stool. The benefit is limited to specific items up to $100 per year, using HCPCS E0240-E0248. Installation and in-home assessments for safety items are not covered.

Mom's Meals

We offer two meal delivery benefits through Mom's Meals. Each benefit offers:

- High-quality, refrigerated meals delivered to the member at home that last for 14 days in the fridge–ready for the member to heat, eat and enjoy in two minutes or less
- Health-specific menus designed to support the nutritional needs of your patient, including the following types of diets: diabetic, gluten-free, heart-friendly, renal-friendly, vegetarian, pureed, low sodium, cancer support or general wellness

The post-discharge meal delivery benefit following an inpatient hospital, skilled nursing facility or inpatient rehabilitation stay is $0 copay per meal, two meals per day up to 28 days, for a total of 56 meals per discharge. The member can receive meals with each discharge during the plan year; there is no limit to the number of times the benefit can be accessed.

The chronic conditions meal delivery benefit for members with an eligible chronic condition (see below) who are enrolled in care management is $0 copay per meal for two meals per day up to 56 days for a total of 112 meals per episode. There is no limit to the number of times the benefit can be accessed.

Papa Pals

We offer a virtual companionship benefit through Papa Pals to help solve issues that affect social determinants of health, such as loneliness, social isolation and food insecurity.

- Papa Pals connects the member with a curated network of young adults for welfare check-ins, benefit plan guidance, technical assistance or assistance with grocery and prescription pickup/delivery.
- We cover up to four one-hour visits per month for $0 copay.
- The member will be assessed for these needs and must also have at least one of the chronic conditions listed below to participate.

Eligible conditions for chronic condition meals and virtual companionship

The eligible chronic conditions for the meal and companionship benefits described above are listed on our provider website: Products>Medicare.

If you have a Medicare Advantage patient who needs any of these benefits, please ask them to contact Customer Service at the number on their member ID card or submit a care management referral for Mom's Meals or Papa Pals through our provider website: Programs>Medical Management>Care Management.

$0 copay on medications for Medicare Advantage members

Certain medications on our formulary have a $0 copay for Medicare Advantage members. This applies to Tier 1 medications when filled either through home delivery or a preferred retail pharmacy. **Note**: The $0 copay does not apply during the pharmacy coverage gap when normal cost shares apply.

Switching your patient to a Tier 1 medication can reduce financial barriers and improve medication adherence. For your convenience, here are the Tier 1 medications for the Medication Adherence Star Rating measures:

Star measure	Tier 1 medications
Medication adherence for diabetes medications	- Metformin, metformin ER - Glimepiride, glipizide, glipizide ER/XL - Glipizide/metformin - Pioglitazone - Nateglinide, repaglinide
Medication adherence for hypertension (RAS antagonists)	- Benazepril, enalapril, fosinopril, lisinopril, quinapril, ramipril, trandolapril - Irbesartan, losartan,, olmesartan, valsartan - Enalapril/HCTZ, lisinopril/ HCTZ - Irbesartan/HCTZ, losartan/HCT, olmesartan/HCTZ, valsartan/HCTZ - Amlodipine/benazepril, amlodipine/valsartan
Medication adherence for cholesterol (statins)	- Atorvastatin - Lovastatin - Pravastatin - Rosuvastatin - Simvastatin

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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